York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 29th November 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 29th November 2023

TIME	MEETING	ATTENDEES
9:00 – 12:00	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
12:30 – 2:00	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**	Martin Barkley	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Martin Barkley	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.	Martin Barkley	Verbal	-	
4.	**Minutes of the meeting held on 27 September 2023** To be agreed as an accurate record.	Martin Barkley	Report	7	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Martin Barkley	Report	18	
6. 6.1 6.2	**Chief Executive's Report** To receive the: • Chief Executive's Update • The November 2023-24 Trust Priorities Report	Simon Morritt	 Report Report	 19 59	9:10
Trust Priority: Our People					

Item	Subject	Lead	Report/ Verbal	Page No	Time
7.	**Trust Priorities Report: Our People** To receive an update on the Our People priority of the Trust Priorities Report (TPR) (Item 6.2).	Polly McMeekin	Item 6.2	-	9:30
8.	**Research and Development Update** To receive the report.	James Turvill	Report	110	9.40
9. 9.1	**People and Culture Assurance Committee** To receive the: • November meeting exception report	Jim Dillon	 Report	 115	9:55
Trust Priority: Quality and Safety					
10.	**Trust Priorities Report: Quality & Safety** To receive an update on the Quality and Safety priority of the Trust Priorities Report (TPR) (Item 6.2).	Karen Stone & Dawn Parkes	Item 6.2	-	10:00
11.	**CQC Compliance Update Report** To receive an update on the CQC actions.	Dawn Parkes	Report	116	10:05
12. 12.1 12.2	**Maternity Reports** To receive the report including: • Maternity and Neonatal Quality & Safety Update • CQC Section 31 Update	Dawn Parkes	 Report Report	 125 129	10:15
13.	**Guardian of Safe Working Hours Q2 report** To receive the report.	Karen Stone	Report	139	10:30

Item	Subject	Lead	Report/ Verbal	Page No	Time
	10.40 - Break				
14.	**Q1 Mortality and Learning from Deaths Report** To receive the report.	Karen Stone	Report	148	10:50
15. 15.1	**Quality and Safety Assurance Committee** To receive the: • November meeting exception report	Steve Holmberg	 Report	 166	11:05
Trust Priority: Elective Recovery & Acute Flow					
16.	**Trust Priorities Report: Elective Recovery and Acute Flow** To receive an update on the Elective Recovery and Acute Flow priorities of the Trust Priorities Report (TPR) (Item 6.2).	Claire Hansen	Item 6.2	-	11:15
17.	**Emergency Preparedness Resilience and Response (EPRR) Core Standards – Amendment to Compliance Grading** To approve the amended assessment.	Claire Hansen	Report	169	11:25
18. 18.1	**Digital, Performance and Finance Assurance Committee** To receive the: • November meeting exception report	Denise McConnell	 Report	 188	11:35
Governance					

Item	Subject	Lead	Report/ Verbal	Page No	Time
19.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 6.2).	Andrew Bertram	Item 6.2	-	11:40
20.	**Premises Assurance Model (PAM)** To approve the submission.	Steven Bannister	Report	192	11:50
21.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	11:55
22.	**Time and Date of next meeting** The next meeting held in public will be on 31 January 2024 at 9:00am.				
23.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
24.	**Close**				12.00

Minutes
Board of Directors Meeting (Public)
27 September 2023

Minutes of the Public Board of Directors meeting held on Wednesday 27 September 2023 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9:00am and concluded at 12:25pm.

Members present:

Non-executive Directors
- Mr Mark Chamberlain (Interim Chair)
- Mrs Denise McConnell
- Dr Lorraine Boyd
- Dr Stephen Holmberg (virtual)
- Mrs Jenny McAleese (virtual)
- Mr Jim Dillon (virtual)

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

Executive Directors
- Mr Simon Morritt, Chief Executive
- Mr Andrew Bertram, Deputy Chief Executive/Finance Director
- Mrs Dawn Parkes, Interim Chief Nurse
- Miss Polly McMeekin, Director of Workforce and Organisational Development
- Mr James Hawkins, Chief Digital and Information Officer
- Dr Karen Stone, Medical Director
- Ms Claire Hansen, Chief Operating Officer

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

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

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

60 23/24 Apologies for absence
Apologies for absence received from:

- Mrs Lynne Mellor

61 23/24 Declaration of Interests
There were no declarations of interest to note.

62 23/24 Minutes of the meeting held on 26 July 2023

The Board approved the minutes of the meeting held on 26 July 2023 as an accurate record of the meeting.

63 23/24 Matters arising from the minutes

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

BoD Pub03 – Mr Morritt advised that Ellen Armistead, Interim Quality Support Director, leaves the Trust at end of October and would ask Ellen to report to the Board in November.

Bod Pub 05 – Mr Chamberlain suggested that Mr Taylor, Mr Morritt and Mrs Brown, along with himself, pick up the action offline and report back to a future Board with a view and reflect on the right approach. Looking at February for a follow-up session with the Board which would include paper light as a topic of discussion.

BoD Pub 06 – Mr Taylor updated that he continued to chase the action. Mr Hawkins advised that the work continued to evolve around the Trust Priorities Report with a variety of metrics being built in or required to be built in. It was agreed that this would be picked up with the new Chair and see what the specific need will be. It was acknowledged that remained important to have a conversation around the Board on the expectations around this reporting.

BoD Pub 12 & BoD Pub 13 – points were picked up later in the agenda. Item can be closed.

BoD Pub 17 – Tara Filby, Deputy Chief Nurse has met with the member of the public and there was some really helpful advice shared. The lead for the quality and patient lead for EDI was working together to implement and build on the advice. The action was now completed in terms of the Board and the policy was being revised.

64 23/24 Chief Executive's Update

Mr Morritt presented his report to the Board and highlighted some key areas:

- Industrial action – 2 further dates approaching in October. The longer it goes on the more challenging it is to resolve with no clear signs of resolution being seen. Noted this will have to continue to be managed through the winter period which would have impact for the Trust in terms of both flow within the hospital and also on the collective recovery.
- Lucy Letby Case – Reminded the Board of a discussion at the August Time out around this, evident that how people raise concerns and how easy that is was really important to the Board. The Interim Chief Nurse had commissioned a piece of work as reported, which would be shared with the Board.
- Our Voice, Our future – Launched a Culture and Leadership Framework. Looking for change makers and individuals who can have voice that we ordinarily struggle to reach. These individuals will be involved in engaging with or staff in terms of understanding what it is like to work in the Trust.
- Care Group structure – new structure formally commenced from 2 October and have now recruited to all posts. Mr Morritt described the new positions. October will kick off

with the leadership development programme for leadership teams within the care groups and the Corporate Directors which will be about setting our expectations of behaviours and expectations of the behaviours of the care groups and the relationships with the staff they are responsible for.

- Vaccination programme - beginning our staff vaccination campaign for flu and COVID-19 on 2 October
- Public Sector Decarbonisation Scheme – Unsuccessful in previous bids for the Scarborough site. There will be new invitations for bids in October and Mr Morritt asked the Board for advance permission for the sustainability team to submit those bids. Anything that required further permissions in terms of any contribution from the capital programme would be brought back to the Board.
- Celebration of Achievement – awards on 9th November. Nominations were closed but encouraged attendance of the Board.
- Chair appointment – Martin Barkley starts 1 November. The Board thanked Mark Chamberlain for his support to the Board and the organisation in his short time as Interim Chair.

The Board approved the advanced permission for bids on the Public Sector Decarbonisation Scheme.

Trust Priority Report
Nothing further added outside of the relevant sections in the agenda.

65 23/24 Risk Management update – Board Assurance Framework

The Board received and noted the current Board Assurance Framework.

66 23/24 Trust Priorities Report: Our People

Miss McMeekin updated the Board on the people priorities. Miss McMeekin highlighted the medical vacancy rate graph (page 27) and described the line increasing rapidly from May time. This was a result of data being pulled from a ledger and not the payroll system. There remained 124 GP Trainees within the establishment that hadn't been removed from the ledger, but were TUPED out the organisation in May and that was creating that elevated vacancy rate. The board were assured that this would be corrected by next month reporting.

Miss McMeekin highlighted mandatory training with mandatory training month being in August along with Junior Doctor changeover which can impact on compliance. It was reported that the Trust maintained and improved marginally on overall training compliance and were now reporting 85% compliance which was on target. Target to be increased to 87% in future months.

Medical staff training remained an area of concern. Miss McMeekin advised a recent draft from internal audit had been received which was requested to be annotated about robustness or chasing up and following up around starter training. Recommendations from that were around line management robustness needing to be strengthened within the care groups. It was hoped the care group development sessions would start to strengthen that. Ms Hansen described that the Trust was introducing performance meetings with the Care Groups where this would be a key measure so the leadership teams within the care groups would be monitored and accountable for the deliver of that through those meetings.

Miss McMeekin also touched on the appraisal rate and reported that the Trust was currently in the appraisal window which had been extended to end of November, and the Learning Hub data was reporting 48.6% compliance.

67 23/24 Workforce Race and Disability Equality Standard (WRES) and (WDES) Acton Plans 2023-2024

Virginia Golding prepared and presented the report. Virginia described that the WRES and WDES action plans were to address the disparities in the data that was submitted in the annual reports in May 2023. The action plans required approval prior to the deadline and publication date of 31 October 2023. Virginia advised that both plans addressed the areas that required improvement.

The Board noted that the analysis of the WDES data implied that there was steady progress with disability equality. However, the WRES data implied that there was a need for improved progress around race equality.

The Board were asked to discuss and approve the WRES and WDES action plans and note that funding was required for training to continue to be implemented to increase staff knowledge, awareness and competency.

The Board discussed the progress of certain actions and the need for accountability. Mr Morritt suggested a clearer focus on priorities and a link between the action plan and the Our Voice Our Future. Mr Bertram suggested addressing finance barriers and prioritising what was currently available. Mr Chamberlain emphasised the importance of treating everyone with kindness and value, being supportive and realistic, and leading from the top down. Mr Chamberlain summarised to reflect on the plan and prioritising asked the Board to approve subject to the fact that it will be reviewed in that light.

The Board approved and supported the plan subject to it being reviewed.

68 23/24 Gender Pay Gap Report

Virginia Golding prepared and presented the report. Virginia reminded the Board that in March 2023 the Board 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 was 31 March 2024. Virginia advised that another action plan had not been devised as the relevant teams and Staff Network were currently addressing the issues that were identified in the March 2023 report.

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

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

Mr Chamberlain questioned the discrepancy in clinical excellence awards, Dr Stone stated that it was normal due to historical and current reasons, such as ensuring more female applicants and encouraging their self-belief in applying. Encouraging applications was noted as key.

Dr Holmberg raised that the Board had not yet seen data on job planning, particularly between male and female genders. Dr Holmberg questioned if there's a predominance of gender in higher PA job plans, and then how that might feed into other opportunities. Recognising this disparity was not beneficial for the organisation as a whole. Dr Stone described that there was uncertainty about the availability of data to provide a satisfactory answer. It was suggested that the current round of job planning will result in everyone's job plan being signed off and ready for 1st April. After this point there will be the opportunity to interrogate the data and be more confidence that this data would then be accurate.

69 23/24 Nurse Staffing Report

The Board received and noted the nurse staffing report. Mrs Parkes described that the report highlighted variations in fill rates across various care groups and a need to include registered nursing associates to provide a full registered picture as this was not currently applied. The fill rates over night time were high for the non-registered workforce due to bank shifts to cover patients that required observation known as enhanced care. The vacancy gap was slowly closing, and the team was recruiting registered nurses. Many new graduate nurses joined over September and October, which will have a significant impact next month as they finish their inductions and are added to the rotas. The attrition rate was starting to lower, thanks to the team's recurrent recruitment and retention actions and mentorship at a global level. The team should be proud of their progress. International recruitment was going well, with a goal of recruiting 124 international nurses by the end of the year. Collaborative work with colleagues in Kerala and the bridging program had helped achieve an ethical and sustained program of international recruitment.

Mrs Parkes also highlighted that within the establishment there was a band 6 one day a week from the student tariff and their role was to support new registrants. The staffing levels will reflect this as a really great way of maintaining a low attrition rate and ensuring people have a brilliant start to their careers with the Trust.

Mrs Parkes went on to highlight that there was a vacancy gap in the HCA's and the Trust was receiving support from NHS England on that. She noted that the work that the teams were doing, notably the Healthcare Academy which happens in October, which was to be based in Bridlington to ensure a great start and will then consequently impact on the quality of care that patients receive. This was to involve a 4-6 week induction which included really practical skills. Also engaging with local colleges and commence HCA apprenticeships in December.

Mrs Parkes concluded her update on celebrating the high percentage fill rate from the Trust's own bank staff, which filled around half of the requests. This was reassuring for the Board as the impact on the quality of care and experience of patients is improved as there is more assurance around the quality of those groups of staff.

Mrs McAleese touched on flexible working for the healthcare workers rather than them feeling the need to move to bank shifts to gain flexibility. Mrs Parkes advised that discussions had commenced with senior teams around flexibility working offers across all of the workforce and highlighted that this was something included in the National Chief Nursing Officer Strategy. There was a definite culture shift to make with frontline managers about what this means. There were 2 wards currently piloting self-rostering so that will enable teams to take control however, they are currently only on a 4-week roster and the aim is for twelve weeks.

Ms Liley added assurance to the Board that the international recruitment was a collaborative approach to include AHP's.

70 23/24 Freedom to Speak Up Annual Report

Stephanie Greenwood prepared the report and attend to present.

Mr Morritt opened the discussion with a reflection on an earlier discussion on speaking up. Looking at the themes, it speaks to that point that the vast majority of speakers were around behaviours, relationships, bullying and not around patient safety issues. Connecting this to the review work of the Interim Chief Nurse around the Lucy Letby Case with some thought about moving forwards in encouraging staff to be more forward and proactive in thinking about patient safety.

Using the Lucy Letby Case as a platform for discussion, Stephanie asked the Board to reflect on what their response would be if a member of staff approached them raising concerns about potentially unsafe clinical practice. There may be no factual evidence but they had raise the concern because they were unsure where else to turn.

Stephanie described the Letby Case illustrating the consequences when organisations don't listen to its staff and listening is what protects patients. She went on to describe how important it is to listen to staff as silence ultimately kills patients and a common theme from external reports such as the CQC report, staff surveys and speak up feedback, articulates that staff in the Trust currently do not feel safe to raise concerns. Stephanie described seeing similarities in the way in which the Letby concern was handled in terms of the shutdown signals that staff can often get and the fact that they were told that they needed factual information or evidence. The Board were reminded that it is their response that would lay the foundations for any speak up individual going forwards and would affect whether they feel heard, valued or feel the Trust is interested to investigate further and consequently affect whether they would speak up again in the future.

Overall, the discussion highlighted the importance of understanding and addressing concerns raised, agreeing that it was important to listen to and understand the approach of those who raise them.

The discussion touched on the recommendation of prioritising Health Education England's Speak Up, Listen Up, Follow Up eLearning being made mandatory. Considering the impact of this on workforce capacity, Miss McMeekin suggested that some members of the Board try the training and consider whether this aligns with existing workstreams.

Dr Boyd discussed the recommendations of the People and Culture Assurance Committee, including the third one about triangulation. They felt it needed to be further strengthened to ensure that actions are completed and playing in with the overall outcome. The Committee had agreed to increase visits to its committee to review staggering attendance to ensure an overview on a much more frequent basis. The Committee had also asked about the risk register status of this work, which Mr Taylor was to investigate further. The committee agreed to address these concerns.

The Board:

- **Suggested further work on the Health Education England Speak Up, Listen Up, Follow Up eLearning being made mandatory. Report back to the Board on a decision outcome.**
- **Agreed the survey would be in conjunction with the Letby review through the Interim Chief Nurse.**

- **Agreed a formal monthly meeting to triangulate data, discuss themes, evaluate and share learning.**
- **Agreed to receive 2 Freedom To Speak Up update reports a year.**

71 23/24 People & Culture Assurance Committee

The Board received and noted the July People and Culture Assurance Committee minutes and Mr Dillon provided an update of the items discussed at the September meeting. There were no specific points of escalation from the meetings and no comments raised by the Board.

72 23/24 Trust Priorities Report: Quality & Safety

The Board received and noted the quality and safety update included in the priorities report and acknowledged there was nothing further to add to the information already reported.

73 23/24 CQC Compliance Update Report

The Board received and noted the progress with delivery of actions within the Trust CQC Improvement Plan which was overseen through the fortnightly Journey to Excellence meeting. Mrs Parkes advised that the monthly section 31 maternity submission was last made on 23 August 2023.

74 23/24 Maternity Reports

Sascha Wells-Munro, Director of Midwifery attended the meeting and presented the report. The Board were provided with a summary of all measures in place to ensure safet 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. A summary of key workforce measures was also provided for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 5.

Sascha reminded the Board that on 25 November 2022 the CQC had 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. The CQC were updated monthly with progress against the S31.

Sascha shared an overview of her first few weeks in post, she described a planned engagement event (3 November) with the maternity team to define their overarching maternity improvement plan. This event was to involve Board members should they wish to attend but ultimately frontline staff such as obstetricians, anaesthetists, midwives, and support workers. The aim was to reduce duplication and move things forward more meaningfully and respectably.

Scanning capacity issues had been addressed, with 73% of achievement in the 72-hour requirement. However, saving babies lives care bundle three has moved, now requiring scans within 24 hours. It was important to understand if all scans requested were appropriate and required.

The Board acknowledged that overall the maternity team was ready for change and wanted to make improvements. They were are working with the Interim Chief Nurse to address staffing challenges and engage to perform a full birth rate review.

Mrs Parkes expressed gratitude for Sascha's overarching plan, which will help teams understand the purpose and goals of the organisation. Dr Stone expressed the Board's need for assurance of maternity services, and Mr Chamberlain noted the importance of this. Dr Boyd expressed concern about staff fatigue and weariness, and suggested preparing for potential recommendations around capacity and demand. Sascha had completed a tabletop of ward capacity and a recommendation would be shared with the Board in due course. Ms Liley added the need to understand the challenging workforce of sonographers.

The Board briefly discussed various communications of the services and Mr Chamberlain suggested linking with Mrs Brown to explore communication strategies and engagement with the wider community. Mr Bertram also suggested articulating a single action plan, focusing on investment with the ICB and clear communication about immediate and future issues.

Dr Boyd highlighted the lack of cross-site recruitment in maternity services, and Sascha agreed that travel should be included in their shifts, taking into account their health and wellbeing. Continuity of Carer was mentioned and the impact cross site working would have on the achievement of this however, cross site working remained a focus for future working.

Mr Chamberlain emphasised the need to continue to update the Board on progress.

75 23/24 Responsible Officers and revalidation Update

The Board received and noted the report and acknowledged that, 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 was being placed by Dr Stone as the Responsible Officer. Dr Stone highlighted that in 22/23 the Trust had achieved 87% compliance for medical appraisal. She advised that the Trust had appointed an Appraisal Lead to drive that agenda and ensuring the right training is sought.

76 23/24 Safeguarding Annual Report

The Board received and noted the escalations as described in the recommendation of the report.

Mrs Parkes referred to section 2.1 of the report (Deprivation of Liberty Applications) and highlighted nearly 100% of patients were being referred appropriately.

Mrs Parkes focussed on areas of training compliance and the need for staff to understand the importance of assessing patients' mental capacity and recording their information. The Board were hopeful that the Learning Hub technical issues experienced earlier in the year will have contributed to the current low-level position. Mrs Parkes shared her interest in the workforce planning and the need to fill roles around safeguarding where there were currently gaps. She planned to consult with the ICB safeguarding team to review the current team and provide valuable insights and recommendations to address these areas. Mrs Parkes reminded the Board that there would be interest in the Trust demonstrating its national safeguarding accountability and assurance framework, which was identified in the CQC inspection. The Board welcomed and an external review.

Mr McAleese highlighted to the Board that low levels of compliance with MCA (Mental Capacity Act) had consistently been a concern and requested a regular reporting to the Board. **The Board welcomed a 6 monthly reporting of compliance.**

77 23/24 Quality and Safety Assurance Committee

The Board received and noted the July minutes and the September meeting exception report.

Dr Holmberg noted that there had recently been a change in the way in which the Committee receives its information and there was now a much clearer line of site that change is happening. Although all the workstreams that derive from the CQC report were daunting, the Committee were assured they were making good progress. Dr Boyd highlighted the escalation in relation to the Committees concerns with gaps in medical neonatal staffing.

Mr Morritt proposed that a full plan of workstreams that cover all of the core actions as a Trust be shared with a future Board meeting.

78 23/24 Trust Priorities Report: Elective Recovery and Acute Flow

The Board noted the report and associated actions.

Mrs Hanson described the impact of the industrial action and thanked all of the staff who had been able to support those colleagues who wanted to be on the picket line. Mrs Hanson went on to give a brief summary of the current operational performance including:

- 473 outpatient appointment
- 127 procedures cancelled
- 69.4 against 71.9 target for ED - Emergency Care Standard (Trust level)
- Patients up 2% to 38.1% - corresponding with admission rates
- Good piece of work around same day emergency care which will help to address some of the conversion rates
- Other levels of care around preventing attendance initially or sending home with assurance of follow-up pathway.
- Working closely with ambulance service and there is some embedding of the pathways in the ED department.
- Only half of new ED build open in York and the other coming in the near future
- Appointed in the Medicine Care Group one director across York and Scarborough (Dr Gary Kitching). Attending and ED listening session to understand what the staff need. A number of actions that were taken aware both for Senior Leaders to do and also them to take away.
- Focus patient reviews each week – there was a focus in the City of York area where this was being addressed. That said, patients remained on the wards who were still awaiting care packages
- Working through with partners on ward coordination.
- Closure report shared with NHS England which was positive. Will be further capacity and demand work and included some shared good practice and improvements.
- Cancer – did see some high referrals in June which was common but was significantly high with around 300 more than expected and consequently had an impact on diagnostics targets. MRI, endoscopy and histopathology pressures too.
- Report on diagnostics planned to be shared with the Board in December.
- Cancer Alliance had continued to support MRI scanner until end of March 2025.

- New function on Core Patient Database went live on 4th September and can now live diagnose a cancer or not.
- Total elective list growing 4,500 more than planned and nearly equivalent to number had to cancel due to industrial action. 4 patients of 104 weeks as a result of a serious incident being investigated and also patient's choices through holidays etc.
- 78 weeks slightly off track but recoverable to achieve 0 by end of November, however, this was not considering any future industrial action and would also include additional capacity.
- 61.6 achieved against 70.7 target for Cancer - Faster Diagnosis Standard
- 7-day therapy provision – working with PLACE colleagues on this.

79 23/24 Winter Plan

The Board received and noted the report and the actions that were to be taken in the Trust to respond to the operational pressures envisaged over the winter period.

Mrs Hanson highlighted that the previous years plan had been reviewed, noting national winter funds were unavailable this year. NHS England's guidance focused on four areas (UEC Recovery Plan, Operational and Surge Planning, Effective System Working and Supporting Our Workforce), identifying key risks for the Trust to address.

80 23/24 Emergency Preparedness Resilience and Response (EPRR) Core Standards

Richard Chadwick attending the meeting and presented the report.

Richard announced 51 key objectives for the year, stating that previously acquired knowledge and skills had faded. A branch review of the business continuity review was to be conducted, with a new Business Continuity Manager recruited in June. The review was to conclude in January, and LIVEX will be launched in June/July next year. The Trust was prepared to respond to incidents but needed to improve practical and tackle responses over the next 12 months.

The Board approved the report and assurance rating of 'Partial' with the NHS England EPRR Core Standards.

81 23/24 Digital, Performance and Finance Assurance Committee

The Board received and noted the Committees July Minutes with September exception report.

82 23/24 Group Audit Committee Escalation

The Board received and noted the Group Audit Committee escalation report. MRs McConnell enquired about reviewing the annual report while MRs McAleese explained that external audit was held accountable through the Risk Committee.

83 23/24 Finance Update

The Board received and noted the finance update. Mr Bertram described a significant deterioration in the Income and Expenditure (I&E) position, with a deficit growing to £11.8m. Cash flow problems were predicted for November, and Mr Bertram had made an emergency cash application and was in discussions with NHS England on this. 4 specific issues were causing concern financially: Strike, which was causing income and net cost

issues, and the core improvement program, which was proving difficult to deliver efficiencies.

Pay award funding was another issue causing concern but was expected to be resolved, however, the shortfall from the agenda for change pay award was yet to be addressed. Drugs and devices were also a continuous approximately £10m concern, and a deep dive was being conducted to identify specific drugs that were financially challenging. **Mr Bertram agreed to report this back to the Board in due course**. External solutions were being explored, and the financial plan was shared through the Digital, Performance, and Finance Assurance Committee.

Mr Bertram described that recovery actions were underway, but significant incomes were missing. The plan was for Executive Committee to out a call out to Care Groups on their financial recovery plans and asked that interactions with Care Groups from Board members also included updates on plans. Mr Bertram was working with Mrs Brown and Mr Morritt on communicating and socialising the recovery plan ask.

84 23/24 Any Other Business

No other business.

85 23/24 Time and Date of next meeting

The next meeting if the Board of Directors held in public will be on 29 November 2023.

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 05	**155**	21 March 2023	71 23/24	People & Culture Assurance Committee Escalation Report	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 Directors27.09.23 update - Mr Taylor, Mr Morritt and Mrs Brown, along with himself, pick up the action offline and report back to a future Board with a view and reflect on the right approach. Looking at February for a follow-up session with the Board which would include paper light as a topic of discussion.	Feb-24	Green
BoD Pub 06	-	29 March 2023	165 22/23	Chief Executive's Update	Associate Director or Corporate Governance to arrange a further TPR session for the Board.	Associate Director of Corporate Governance & CDIO	MT - Update 06.06.23 chasing up with James Hawkins and Nikki Slater 27.09.23 update - Mr Hawkins advised that the work continued to evolve around the Trust Priorities Report with a variety of metrics being built in or required to be built in. It was agreed that this would be picked up with the new Chair and see what the specific need will be. It was acknowledged that remained important to have a conversation around the Board on the expectations around this reporting. 22.11.23 - A 'Making Data Count' Board session is currently beign scheduled with NHS England.	Feb-24	Green
BoD Pub 09	-	24 May 2023	27 23/24	TPR: Our People - People & Culture Assurance Committee Report	Priority discussion for Board on agile and flexible working 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	Action 09 - Priority Discussion on agile and flexible working and Action 10 workforce planning and resource management for e-rostering - merged	Nov-23	Green
BoD Pub 18	-	26 July 2023	54 23/24	Quality and Safety Assurance Committee	The Board requested that a report or presentation of the diagnostic review is submitted to a future Board meeting following the deep dive exercise already planned.	Chief Operating Officer	Board to receive a diagnostic review outcome report.	Dec-23	Green

Report to:	Board of Directors
Date of Meeting:	29 November 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: Our Voice Our Future, Fairness Champions, Refreshing our Strategy, Collaboration of Acute Providers update, Celebration of Achievement and Star Award nominees.

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	29 November 2023	

Chief Executive's Report

1. Our Voice, Our Future

As I briefed in my last Chief Executive's report we have now launched our Culture and 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.

I am pleased to report we received a positive response to our campaign to recruit 'Change Makers'. Due to the quality of applications and the level of interest, we have recruited 52 Change Makers, which is more than originally intended. These individuals are from roles across the Trust, from a range of professions, sites, and, importantly, levels of seniority.

Stage two of the Our Voice Our Future programme, the 'Discovery' phase, launches on 6 December, when we will meet with our new Change Makers to introduce them to the role and the tools available to support them.

Change Makers will gather feedback over a six-month period and put forward suggestions for improvements we can make to help us develop a compassionate culture and a place where people want to come to work.

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

2. Fairness Champions

October was Speak Up Month and we took the opportunity to raise awareness of the importance of speaking up and raising concerns, and to have a drive to recruit more Fairness Champions.

Fairness Champions are members of staff that have been recruited by the Trust in a voluntary capacity to support the work of the Freedom to Speak Up Guardian, uphold the Trust's values and promote equality, diversity and human rights.

As a result we have shortlisted 24 new champions from a range of roles and sites, which is great news and will provide greater scope for staff to have important conversations about issues and concerns.

3. Refreshing our strategy

At the end of October we held a Strategy Development Session at the Community Stadium. Attended by the full Board, a number of partner organisations, and the senior leadership teams of the newly-created care groups, we worked collaboratively to start the process of reviewing and refreshing our current strategy 'Building Better Care Together'. It was an opportunity to revisit what our vision, mission, and strategic goals should be for the next period, as well as to agree the strategic themes and programmes of work to inform a review of our strategy with our staff and wider stakeholders.

It was a constructive and productive session, and the feedback has been positive, most notably around the wide range of contributions and ideas and the opportunity to work

together as a wider leadership team. I will provide updates on the progress of this work as it develops.

4. Collaboration of Acute Providers Update

To provide focussed leadership at a system level, the three Chief Executives of the three acute provider organisations in the Humber and North Yorkshire Integrated Care Partnership have each taken the lead SRO role for one of the Collaboration's key priority areas. Jonathan Lofthouse, Joint Chief Executive for Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust is the SRO for elective care, Jonathan Coulter, Chief Executive of Harrogate and District NHS Foundation Trust, is the SRO for diagnostics and I will be the lead for cancer.

As a consequence of taking on this role I will also Chair the Humber and North Yorkshire Cancer Alliance, and chaired my first Cancer Alliance System Board on 22 November.

5. Celebration of Achievement Awards

At the start of November we held our annual Celebration of Achievement awards at Scarborough Spa.

Always the highlight of the year, the fully sponsored event recognises the exceptional achievements of individuals and teams working for our Trust.

Hundreds of nominations were received from colleagues and patients, recognising the fantastic work that has been happening across the organisation over the past year.

This year I chose to give two Chief Executive's awards. My first went to Liz Alinaitwe, who has been instrumental in leading and developing the cultural awareness programme, initially on the Scarborough site where she works as a deputy sister, then supporting the York teams to develop their own special events. Liz had a wide range of help and support from staff to make these events successful, but there is no doubt that the enthusiasm, creativity, and vision lies with Liz.

My second award went to the Nucleus Project Team. This small team has been instrumental in ensuring we embed the use of digital technology to promote patient safety and the flow of information as patients move through their hospital journey.

In Autumn 2022, Nucleus digital documentation was successfully deployed in all 39 adult in-patient areas across all sites within six weeks, successfully delivering a quality product, on time and within budget. The difference Nucleus has made to our staff is tangible, and nurses now spend more time delivering patient care than recording it.

It is 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, to the judging panels, who had a difficult job on their hands, and congratulations to all our winners and finalists.

6. Star Award nominations

Our monthly Star Awards are an opportunity for patients or colleagues to recognise individuals or teams who have made a difference by demonstrating the Trust's values of kindness, openness and excellence through their actions.

Going forward, I will be including the nominees as an appendix to my board report to share these wonderful examples of how our staff are living our values every day. Five finalists are selected each month, and I visit all of them in the areas where they work to present them with their award.

It is fantastic to see the nominations coming in every month in such high numbers, and I know that staff are always appreciative when someone takes the time to nominate them.

November's nominees are in Appendix 1.

Date: 29 November 2023

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

November 2023

Paige Glenwright, Healthcare Assistant **York** **Nominated by Joyce Burrows, patient**

Paige is an absolute breath of fresh air. She is cheerful, has a word with everybody and lights up the whole ward. She is also quick to notice if you are feeling down and will stop and chat to make you feel better. She is a great benefit to this ward.

Fiona Campbell, Staff Nurse **York** **Nominated by Joyce Burrows, patient**

Fiona is a good old-fashioned nurse and as such has a good touch with her patients. She knows when you are in pain or feeling down and does her utmost to ensure you have pain medication as soon as possible. She is so sympathetic and caring when you are feeling down because everything that has been done has gone wrong and you need a second operation.

Tim Smith, Security Officer **York** **Nominated by Nicholas Griffiths, colleague**

Tim was assisting drivers during a situation where traffic lights had caused Woodlands Drive to back up and the hospital was becoming gridlocked. A car arrived and became stuck in the traffic.

The passenger was in active labour. After reporting to control to warn the delivery suite, Tim got the car to a safe place and helped the female into a wheelchair and took the couple to delivery. Showing quick thinking and care Tim got the female to delivery safely.

Maple Ward **Scarborough** **Nominated by Lorraine Noble, colleague**

The hospital has been under such demand for placing patients in beds that have had extended time in ED, one of our escalation areas in the hospital is the Maple Ward SAU. Consistently Maple staff have, on a night, created capacity for the hospital by placing patients into the escalation area, which creates much more work for them. Their hard work shows compassion, kindness, and empathy to others. I hope they realise how much this is appreciated not only be me, but I am sure by all the patients in ED who benefit because Maple Ward help us out like this, creating bed space for the night after a long wait in ED and providing free cubicle spaces in ED. This enables multiple patients to then be seen in a much more timely and comfortable manner.

Amanda Bridge, Healthcare Assistant **Scarborough** **Nominated by colleague**

Amanda was transferred to our ward a couple of years ago and we are so glad she did as she is a vital member of the team. She brings sunshine and positivity to each shift and really does go above and beyond with her patients. She has recently introduced a falls pack for our patients to improve patient safety and we are very pleased to call her our own. No task is too big, and she always brings a smile with her. Thank you for being you Lady Bridge.

Tricia Pelling, Generic Therapy Assistant | **York** | **Nominated by Ebony Carlton, colleague**

Tricia went above her duty when attending a therapy session with a pupil at a school. Tricia arrived at the class of a child she was going to see. The child was very dysregulated. They were visibly distressed and struggling to process what was going on around them. Tricia took the child out of the classroom and attempted to proceed with the planned therapy intervention. The child was too dysregulated to follow the instructions of the task. Tricia could have stopped the session there and reported back to me that the child was not engaging. However, she didn't do this. Tricia spent time with the child and helped calm them by using her advanced knowledge of working with children. She was able to bring the child back down to a place where they could perform some of the therapy program and then return to their class calmer. This is just one example of Tricia going above and beyond her role for her service users, and why she deserves the recognition of a star award.

Susan Wilson, HR Advisor | **Scarborough** | **Nominated by Charlotte Kershaw, colleague**

I am an employee of the Trust on long term sickness. Susan has gone above and beyond frequently in supporting me during a time of need. She treats me with kindness and compassion, making me feel like I am still a valued member of staff despite my absence, and I am included in the decisions made about me. She has checked in on me via email on regular occasions when a meeting isn't scheduled as she has deep empathy for how my condition is affecting both my mental and physical health. If I have a situation and need information Susan is my first port of call, she will promptly reply and reassure me by keeping me constantly updated while she finds the answer I need. She always treats me with respect and dignity, she supports me and for her care, empathy, compassion and dedication I will be eternally grateful.

Kanak Patel, Consultant | **York** | **Nominated by Georgina Cherry, colleague**

Each time I have had to contact Dr Kanak with a query about a patient with learning disabilities, he has responded promptly and asked relevant questions about what needs to happen going ahead. One case was around mental capacity and a best interest discussion, and I could not see who the surgeon was specifically, but could see Dr Kanak on her CPD. He was indeed not the right person, but he did some in investigating and contacted management and his colleagues, as he was concerned about the situation and knew it needed addressing imminently. Dr Kanak was also on annual leave at the time, but wanted to help get this sorted, which was very much appreciated.

I have worked with him again recently and felt I could approach him to ask for guidance on a situation with a patient of mine. She was on her way for a Maxillofacial outpatient appointment but had an accident and was admitted to York Hospital. I asked if he thought it might be possible that she is seen on the ward whilst she is an inpatient, so that it did not delay her being seen. He agreed that it would be best to do this if possible and to also reduce the number of times she comes into hospital, which is a reasonable adjustment for her. Again, it was not specifically for him (even though CPD guided me to him) but he responded to my email promptly and included the specialty nurses and is writing a letter to his consultant colleague who may be able to assist with this.

Dr Kanak is a very supportive colleague who clearly shows respect for our LD service and goes above and beyond to help and support us. He is more than willing to take time to help source the right people for the job and keep good communication. Having colleagues who work this way with us makes our job so much easier and means the outcome for our patients is much more positive. Thank you.

Jacob Harlow, Staff Nurse **York** **Nominated by Robert Trinder, relative**

My mother-in-law was unfortunately admitted to York Hospital and put onto the end-of-life pathway whilst in A&E. Jacob was her nurse during the last moments of her life in his department. If I could describe him in three words, I would say: compassionate, endearing, and exceptional. In all my 62 years on this earth, never have I seen a nurse with such care for their patients. When the difficult moment arose, and my mother-in-law required medication to make her comfortable, Jacob was there to talk us and her through it, even when she may not have heard him. He reassured us every step of the way and held her hand tight during those last moments, even when we didn't have the strength to do it ourselves. He is a star for not only his department, but the NHS itself. He showed compassion during the end of her life, allowing her to pass with dignity and comfort. I wish him all the best in his career.

Aneeka Shah, Mammographer **York** **Nominated by Maeve Saunders, colleague**

Aneeka recently went the extra mile for a patient who had been in the department for a long procedure, and then the taxi company left them waiting for hours. Off her own back, Aneeka went to the canteen and bought them food, which the patient was very grateful for. She has a heart of gold.

Multidisciplinary Team (Mark Smith and Mark Whitehead, Shift Engineers, Michelle Butler, Healthcare Assistant, Midhun Gangadharan, Staff Nurse, Lizzie Bishop, Deputy Sister, Will Lea, Speciality Doctor, and the York Security Team)	**York**	**Nominated by Amy Gains, colleague**

I would like to thank all the individuals mentioned above for their multi-disciplinary approach to a very challenging situation out of hours on Ward 32. Everyone involved in the patient's care contributed in a timely and professional manner to ensure the patient and staff safety.

Special thanks to Michelle who offered to support the patient all afternoon and evening for continuity and to protect her colleagues who were nervous about caring for the patient. She did this with real compassion and respect for the patient, always concerned about the patient's dignity. She was a real asset.

Both nurses on the ward took leadership and escalated to me as the on-call manager the risks posed to the ward and the patient and ensured a calm environment. They came up with proactive and creative ideas about how we could help to maintain safety in a very difficult situation.

The security team were very vigilant and gave reassurance to the ward staff. When they could deescalate, they were proactive in offering regular visits to the ward through the evening to anticipate a change in the patient's behaviour

and offer extra support timely.

Although the speciality doctor was busy on another ward with a poorly patient elsewhere, he attended as soon as he could and spoke with the team calmly and spent time to come up with a comprehensive plan for the evening that everyone was happy with.

Lastly, the shift engineers Mark and Mark were very responsive to our call for support and made the side room that the patient was in safe as quickly as possible. They listened to the ward staff and came up with quick solutions to ensure safety for all.

I was so grateful for everyone's contribution on that evening. As the first on-call manager we often find ourselves in difficult and unpredictable situations but on this occasion, I felt the team really came together and went the extra mile and offered a solution focussed plan, which was enacted timely. I was so grateful but also so proud of the way they responded and came together, especially for individuals who do not normally work together on a daily basis. Well done team. Thank you so much.

Kim Hartnett, Bereavement Specialist Midwife	**Scarborough**	**Nominated by Anna Goode, colleague**

Kim is a wonderful midwife. Not only is Kim one of our community midwives, but she is also our Bereavement Specialist Midwife based at our Scarborough site. Kim goes above and beyond to ensure the service users she cares for receive the best care possible and is always there to respond to their questions and needs.

During the recent Baby Loss Awareness Week, Kim organised some lovely events for both staff and members of the public to attend to remember babies taken too soon. Her dedication to this role is outstanding and she makes a difference to everyone who has the pleasure of being cared for by her. She is kind and caring and always striving to provide the best services possible for our service users.

Christine Ross, Staff Nurse	**York**	**Nominated by patient (c/o Lindsay Truscott, colleague)**

After getting in touch with us to provide feedback on their experience the patient was keen for Chris to be nominated for a Star award.
The patient said: in recovery Chris was the nicest person out of everyone (and everyone had been wonderful). She was attentive, got help when I couldn't stop shaking and ensured I was as pain free as could be. Chris was described as a shining example of a compassionate nurse, and I felt so looked after and safe with her.

Jason Angus, Healthcare Assistant | **York** | **Nominated by Natalie, relative**

A few months ago, my 4-year-old daughter was brought in. Jason did some magic tricks with her and made her believe she could do magic. He gave her chocolates and a teddy. She still talks about how she can do magic and wants to go back to see the magic man. You certainly made a worrying time much better, thank you.

Lizzie Verity, Midwife | **York** | **Nominated by Hannah Greenfield, patient**

Lizzie cared for me after the birth of my son back in 2019 and really put me at ease. Nothing was too much and she made me feel listened to. She even took him for a few hours on the night so I could try get some sleep.

August just gone I went into labour with my daughter and Lizzie helped deliver her. As soon as I saw her walk into my delivery room, I was instantly relaxed because I remembered how amazing she was when I had my son. Again, she was amazing, helped me so much and really made me feel like I was doing a good job. She spoke to me like I was an individual and not just a 'random girl in labour'. Even though she will help so many people give birth, I was really made to feel like I wasn't just one of the many. She made me feel like at that time I was all that mattered.

I just want to say the biggest thank you, labour is hard and scary, but I felt safe the whole time. Out of all the midwives she is the one I will remember. They all do an amazing job, but Lizzie really went above and beyond both times and I just want to say the biggest thank you.

Altaf Waraich, Consultant | **York** | **Nominated by Zoe Dunning, colleague**

Mr Waraich is a very friendly and approachable consultant and responds quickly to any queries. He is very upbeat and keeps staff morale up within the department, particularly within the admin team, he never passes the desk without speaking to you. He is very accommodating with regards to clinical activity and will see patients as additions in his clinic at short notice. We regularly receive comments from patients saying how friendly, approachable, and professional he is.

Catherine Shepherd, Staff Nurse | **Scarborough** | **Nominated by Jason Wilsher, colleague**

From the moment I stepped in the door to have my COVID and flu jabs, Catherine made me feel at ease with a smile and good humour while explaining the form process. It was the same when she took me for the jabs, she made me feel at ease, and the jabs were painless and over in a flash.

I've always found the teams carrying out the jabs to be helpful and friendly, but Catherine made the experience very comfortable and obviously prided herself in making it a positive experience. Our interaction was only for a short period of time but enough for Catherine to demonstrate the Trust's values, which is so important as part of the vaccination experience. Well done, Catherine.

Maxillofacial Dental Nurses **York** **Nominated by Ciaran Ferris, colleague**

The dental nurse team continue to go over and above when supporting the maxillofacial clinics. These clinics are often fully booked and the nature of them can also mean that procedures are required immediately from clinics that are running alongside them. The nurses are always adjusting their activity to help with capacity and undertaking additional clinical work at little notice. This can mean working between multiple clinicians at any one time or missing out on their admin/non-clinical sessions. They never complain and are always cheerful and incredibly helpful. I don't think we could successfully run our clinics without them.

Marion Lyons, Domestic Assistant **York** **Nominated by Lorraine Handley, colleague**

Marion is the Domestic Assistant on Ward 14 and has been for all the time I have worked here. As well as having Ward 14 to do, she also covers the whole of the Surgical Assessment Unit. She does all this without complaint and with a smile. We always notice the difference on the wards when she is away and during these times she is sorely missed. Nothing is too much trouble for her, and she will help wherever she can. She is thoroughly deserving of a star award.

Ianthe Abbey, Consultant **York** **Nominated by Georgina Thompson, patient**

Dr Ianthe has looked after me for the past few years. I will now be looked after in adult services. Dr Ianthe is the best doctor ever. She always talks to me and listens to me and not just my mum. I'm really going to miss her. Thank you, Dr Ianthe.

Rachel Cooke, Clinical Educator | **York** | **Nominated by Hannah West and Nikki Whitehead, colleagues**

The endless support Rachel gives to the staff on the surgical floor is admirable. Nothing is ever too much, and each staff member feels comfortable approaching Rachel for advice or asking for help. She is happy to get her hands dirty and will help with anything, from washing patients and bed moves to clinically supporting new nurses and managers. Rachel is committed to ensuring each patient is receiving gold standard care by teaching nurses correct techniques and practice.

She also supports the wards by organising ward specific study days as well as rolling monthly clinical skills and RN/HCSW days. Rachel also gives her own team endless support and pushes her junior team to be the best that they can be, to their full potential. She knows when to give responsibility and support.

Rachel goes above and beyond in her role and deserves recognition for her hard work and extensive knowledge.

Kelly Dobbin, Staff Nurse, Katie Chudley, Staff Nurse, and Caroline Sutton, Staff Nurse

York

Nominated by Pam Toas, colleague

Kelly Dobbin, Katie Chudley and Caroline Sutton have worked tirelessly together to achieve UNICEF stage 1 accreditation for Baby Friendly Initiative (BFI) for both our neonatal and special care units on both York and Scarborough site.

This work involved developing an effective training curriculum for all staff and annual updates ensuring accurate records are maintained. Several documents have been developed which set a firm foundation to deliver the 3 neonatal standards: enable babies to receive breast milk, value parents as partners in care, promote close and loving relationships between babies and their families. As well as demonstrating the Trust values the report states "the units have demonstrated a clear commitment to the ethos of the standards".

This has been a huge piece of work and great achievement, and they are now working towards achieving level 2 accreditation.

Scarborough Bed Management Team, Angela Molero, Bed and Duty Manager, Lucy Powers, Bed and Duty Manager, Jemma Cropley, Staff Nurse, Nik Coventry, Chief Nirsing Information Officer, Vicci Anderson, Ward Sister, and Digital and Information Service Team	**Scarborough and York**	**Nominated by Tara Filby, colleague**

I wanted to put a star award nomination in for those involved supporting the wards during the CPD downtime on the night of 8 September.

There was fantastic teamwork by bed managers and ED shift leads. They stayed calm, created systems to track patients, kept everyone else calm, and kept patients safe.

Nik & Vicci worked the night shift, floor walking and supporting the transfer of patient records from digital to paper. This provided a huge amount of confidence to the teams on the ground.

DIS provided effective management of the whole process before, during and after.

Lindsay Robinson, Healthcare Assistant **York** **Nominated by Khaled Shahein, colleague (1); Sulaimaan Mahmood, colleague (2)**

(1) Lindsay welcomed me and other medical students with open arms to the wards. She helped us complete all our clinical skills. She is extremely skilful at her job and always works with a big smile on her face. She lightens up everyone's mood on the wards, both patients and staff. She was always there to help us whenever we needed her. She has been the best member of staff I have worked with since I started medical school and I am in my fifth year.

(2) Lindsay has amazing personal qualities. She was extremely helpful to me and my colleagues regarding clinical skills, and she improved everyone's mood on the wards, both patients and staff. I believe Lindsay wholeheartedly deserves this award.

Declan Moon **York** **Nominated by Gemma Granger, colleague**

Declan has been painting and decorating the paediatric wards in York for several months. He is very accommodating and nothing is too much trouble. At times, due to the need to use cubicles or other areas he may be working in, he must change his plans at short notice. The wards are looking fantastic; we have had a big change and a burst of colour and as a result the wards are looking very welcoming and friendly. He always has a smile on his face and upholds the trust values. We will miss his presence when he finishes decorating the area.

Pharmacy Clinical Trials Team **York** **Nominated by Tanya Hartley, colleague**

The Clinical Trials team are a fantastic team to be part of. They are professional and committed to their jobs and always strive to provide the best customer service they possibly can. The members of the team, especially management, always encourage personal development, and will motivate colleagues to further their career path and always find appropriate training and that will further develop their skills and knowledge.

The whole team are positive, fun to work with (whilst still maintaining their professionalism) and make coming to work a pleasure every day. I am lucky to have found colleagues that are understanding and encouraging, and who make the job interesting, using extensive knowledge to teach new members of staff all about the world of clinical trials.

Sue Jordan, Post Room Worker | **Scarborough** | **Nominated by Lisette Backhouse, colleague**

The post room team at Scarborough Hospital are fabulous. They handle, frank, sort, and deliver mail all around the hospital and to external addresses. They get mail and parcels of any kind ready for collection from Transport Services, to go to all of Scarborough, Ryedale, Bridlington and Whitby GPs as well as Bridlington, Malton and York Hospital, several times per day. There are also probably many other jobs they do, unbeknown to me. They are the unsung heroes of Scarborough Hospital.

I wanted to say a big thank you specially to Sue Jordan, who has worked in the Trust, and mostly in this role, for over 30 years. Sue is committed, approachable and kind, she goes out of her way daily, to ensure smooth running of all the mail in and out of the post room. She is extremely knowledgeable and helpful, as are all the post room staff. They ensure the smooth organisation of the hospital paperwork, usually out of sight, quietly and unknown by many.

Sue will be retiring in January 2024, and I would like her exceptional commitment and service to the NHS to be recognised.

Roberto Fanti, Occupational Health Advisor | **York** | **Nominated by Alex Cowman, colleague**

Roberto has been one of the main vaccinators behind the COVID and flu vaccination campaign this year. Since the beginning of October, he has been on site at York Hospital from 7:45am to open the hub and vaccinate hundreds of staff. He has filled in when other staff have been unable to attend their shifts, sometimes very last minute, and is always there with a smile on his face, happy to help. A huge thank you to Roberto.

Debbie Done, Occupational Health Advisor	**York**	**Nominated by Alex Cowman, colleague**

Debbie has been one of the vaccinators behind the covid and flu vaccination campaign this year. Since the beginning of October, she has been on site at both York and Bridlington hospitals vaccinating hundreds of staff. Debbie has filled in when other staff have been unable to attend their shifts, sometimes very last minute, and has done this alongside juggling her usual responsibilities in Occupational Health. A big thank you to Debbie.

Lauren Mancrief, Senior Outpatient Services Administrator	**Scarborough**	**Nominated by colleague**

Lauren is the youngest member of our team, and she is also a senior administrator. As part of her role, she gives guidance and assistance to all the team, as well as carrying out her own roles within the department. She has always gone above and beyond to do anything she can to help me.

I am a lot older, and she has taught me so much about outpatient services and given me the confidence to stay working for the NHS as sometimes I have been a bit overwhelmed by the number of things I needed to learn. Lauren brightens up our day, she deserves a star award.

George Milner, Junior Doctor	**Scarborough**	**Nominated by Lauren Margetts, patient**

At the beginning of October, I was presented at Scarborough due a foot injury caused by getting pieces of glass in my foot. Dr Milner explained the whole process to me and supported me all the way through. I was distressed and in a lot of pain, but Dr Milner was great and reassured me.

I just wanted to thank George for all his kindness and support. He was a brilliant doctor who deserves recognition. He is a real asset to Scarborough Hospital, and I wish him all the best in his career.

Labour Ward Midwives	**York**	**Nominated by Phyligona Mmbele and Loxley Mmbele, patients**

I want to nominate this team, especially Abbi Smith and Kate Fahy, who attended to me when I delivered my daughter. The team was compassionate, caring and very supportive. They explained everything I needed to know before, during and after delivery. After the delivery I had a postpartum haemorrhage and the team acted fast to control the bleeding, reassuring me that I will be okay, even when I was almost giving up.

The staff also made sure baby was attended to even when my husband stepped out for some time. Abbi went out of her way and kept attending to me even when her shift was done, just to make sure I was okay before she left. Keep up the good work team; you are all stars.

Emma Welburn, Administrator, and Outpatients Department Team

Selby

Nominated by Jill Wilford, colleague

Selby town and rural Selby Primary Care Networks (PCN) are working together with the local Urgent Treatment Centre (UTC) to support the transition of the service from Harrogate District NHS FT to York and Scarborough Teaching Hospitals NHS FT. They have provided this system of partnership support in the way of clinical sessions from local GPS and practice nurses.

For this partnership to be effective and have an impact, clinical space was needed. The lack of identifiable space was and still is a challenge, but Emma Welburn, Sister Jo Cawthray and her Outpatients Department (OPD) team, came up with a plan around existing outpatient clinics. These existing clinics would provide consultation rooms, allowing clinicians from local GP surgeries to work alongside the UTC to care for local patients requiring same day urgent care, consequently reducing the stream of patients to York Emergency Department. Emma, working together with Sister Jo Cawthray and her OPD team, has planned how to provide some routine space for this collaborative work, ensuring it has a noticeable effect. Emma, Sister Jo and the OPD team did this with a clear understanding that they wanted to provide a better patient experience for the local population by dedicating time in their busy work schedules to support this.

The space created has mainly been in the busy outpatient clinic where Jo and her team have gone out of their way to welcome PCN colleagues. They have demonstrated the Trust's values of kindness, openness and excellence through their support of making this integrated way of working together as a community a success. The PCNs are very grateful and appreciative of this support.

York Endoscopy Decontamination Unit and Scarborough Endoscopy Decontamination Unit	**York and Scarborough**	**Nominated by Tracy Spicer, colleague**

The Endoscopy Decontamination unit at York Hospital recently had to close for 15 days to undergo refurbishment. This meant all the endoscopes being transferred to the Scarborough Endoscopy Decontamination unit, along with all the staff from York. Over these 15 days when the York team were working out of the Scarborough unit, there was very little disruption to the Endoscopy Departments in both York, Scarborough, and Bridlington. This was down to excellent teamwork and to the organising of equipment by the York supervisors, Alek and Lukasz. A big thank you to all the York Endoscopy Decontamination team for going above and beyond to ensure the service was maintained. Also, a huge thank you to the Scarborough decontamination team for their help and support.

Tracy Rix, Domestic Assistant	**Selby**	**Nominated by Claire Ramsay, colleague**

Tracy arrived for her early shift and approached me to ask if a lactose intolerant patient had been admitted to the ward overnight. Tracy had received a message the night before her shift from a colleague informing her that a lactose intolerant patient was due to be admitted to the ward. Tracy informed me she had been to the supermarket in her own time to buy alternative milk and food products as she knew the ward would not have these alternative products until they were ordered.

Tracy's actions went above and beyond her role, demonstrating the Trust Values and Behaviours of kindness and professionalism. Tracy truly put the patient at the heart of her role by ensuring they were able to have a food and fluid choice for breakfast and until alternative options were ordered.

Andy Dundas, Staff Nurse **York** **Nominated by Phil Hannington, patient**

Following a motorcycle collision, Andy was my first real regular point-of-contact. In the initial stages of my care, he was very communicative, attentive and demonstrated a genuine caring attitude towards me that made me feel that I mattered and that I wasn't just a number in what was clearly a very busy night in ED. A big thanks to Andy who helped reassure my wife, my friend and I that I was in safe hands. He clearly had a very good understanding of his job. Andy is a top man and real credit to the NHS.

Tracey Robinson, Healthcare Assistant **York** **Nominated by Jennie Nesom, colleague**

Tracy is consistently kind, patient and caring with patients and colleagues. Recently she happened to pass an elderly lady who had fallen on the way to her GP. Tracey, even though she was off duty, helped her get to the GP for her appointment. During the appointment the GP decided they wanted her to be checked out at the ED. Though this lady was a stranger, Tracey took her to the ED and stayed with her for 6 hours. She also communicated with the lady's son who would have to travel some distance to reach them.

I think this is above and beyond what many people would do, and I think she is a wonderful example of someone who embodies the Trust's values. She is very deserving of this nomination, and I hope that she receives the recognition that this act of kindness deserves. The entire team on Ward 27 reiterate the sentiments above.

Philip Lim, Consultant | **York** | **Nominated by Srinivas Chintapatla, colleague**

Mr Lim came in while he was on annual leave so that an operation that a patient had been waiting a year for did not get cancelled. The lady was scheduled to have a combined operation for a large and complex abdominal wall hernia. She had been on the waiting list for a long time and was brought in for surgery. Due to a scheduling error, the plastic surgeon who was working that day was not available to perform the surgery. While the patient had been on the waiting list, the hernia had grown even larger. Without an available plastic surgeon, the surgery could not proceed and would have to be cancelled. I reluctantly rang Mr Lim and he generously agreed to come in to help with the surgery. This meant the lady could proceed to her surgery.

By putting the patient first and going beyond call of duty, Mr Lim demonstrated the Trust's value of kindness. Both the patient and I were very grateful for his support during the surgery, and the grace with which he gave up his own time during annual leave and came to help.

Paediatric Dietetic Team **York** **Nominated by Jenna Tucker, colleague**

The Paediatric Dietetic Team has been working in challenging circumstances for the last 12 months. They were at 60% staffing capacity with difficulties with recruitment, particularly on the east coast.

In the first instance, the team have worked tirelessly to support the service by picking up extra hours to ensure that waiting times stayed under 12 weeks, and by prioritising challenging patient groups. The team did this without any extra encouragement and purely because they are passionate that our service users get the right care at the right time.

Beyond this, the team have been able to think innovatively around recruitment, and as such looked to support two new Band 5 positions on the York site who started in post in September. This requires the whole team to work more flexibly and across site, but again this has been supported whole heartedly. Finally, the team has successfully supported a previous member of the team to work bank hours from overseas to enhance their clinic capacity.

This team has displayed all the Trust's values in the work they have done over the last 12 months. I am proud and grateful to support a team that can think outside of the box and try hard every day to meet the demands of the service and support our children and young people so well. A huge thank you to all the team.

Gale Pether, Domestic Supervisor | **Bridlington** | **Nominated by Chris McFarlane, colleague**

During October, Gale Pether, a domestic supervisor at Bridlington Hospital, received a call from the intensive care unit at Scarborough Hospital explaining that one of their staff members was in intensive care and very seriously ill. The ward had been trying to contact his next of kin but with no success. The member of staff was in and out of consciousness but managed to say to them, that Bridget Bean and Gale Pether, who he works with, could contact his next of kin.

Both Gale and Bridget tried to contact the staff member's next of kin but also had no luck. Gale and Bridget then made the decision to go around to the staff member's next of kin's home when they both finished work for the day. When they got to the house of the next of kin, they were unfortunately not in, so the search to find them continued. Both Gale and Bridget eventually managed to track down the next of kin and pass on the message, explaining what had happened to the member of staff.

The next of kin was incredibly grateful for their actions and thanked them both for going above and beyond their normal duty of care. Thankfully, the member of staff pulled through and is now on the mend. Last week the staff member came back into work to personally thank Bridget and Gale for all their help in passing on the message.

Bridget Bean, Domestic Supervisor | **Bridlington** | **Nominated by Chris McFarlane, colleague**

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Medical Illustrations Team | **York** | **Nominated by Stef Greenwood, colleague**

This team always go above and beyond to help their colleagues, regardless of whether they work closely with them or not. They are always friendly, warm, and will do their upmost to help. Their "can-do" attitude is a breath of fresh air. They work tirelessly in the background, so I therefore want them to know that they are hugely valued and appreciated.

Georgie Garry, Speech and Language Therapist	**Malton**	**Nominated by Catherine Leatherbarrow, colleague**

Georgie is always promoting our speech courses to schools, nurseries, parents, and other medical professionals - she's such a great advocate for our team. She's also brilliant at liaising and talking to people about our speech courses.

Georgie recently supported a vulnerable child, who was at risk of abuse, by prioritising a phone call with a concerned party. This led to getting the child into a clinical appointment so they were able to communicate with a trusted professional if needed. She's happy, enthusiastic, willing, and a valued member of the team.

Laura Ivinson, Staff Nurse	**York**	**Nominated by Juliet Robinson, colleague**

Laura came to help us on Ward 35 on an extremely busy day when we were short staffed with some very unwell patients. She took over tasks that we hadn't been able to do with a smile on her face and with the most professional attitude. When one member of staff had to leave unexpectedly, she helped with all the jobs that had been left behind.

She came to work with us until 6pm when her shift ended, but as soon as it was apparent that the shift was getting even busier, she didn't hesitate to offer to stay until 8pm, even though it was a Friday and her family were waiting for her at home.

Jill McEnaney, Pharmacist	**York**	**Nominated by Donna Scaife, colleague**

Jill is an invaluable member of the paediatric team. She provides essential support with the medications we are required to give, and always goes the extra mile to help ensure we have got the necessary information so we are able to administer medications safely with as little stress as possible. She sources medication that is not a stock item and stays and goes through the administration with us if we are unfamiliar with the preparation. Jill is always on hand for queries and often makes herself available for help outside of her working hours. Jill always has a smile on her face and is friendly, kind, and approachable. She ensures we have what we need, even when if it is a stressful situation that is constantly evolving with the required medications changing rapidly.

Louise Winter, Healthcare Assistant	**Selby**	**Nominated by Lisa Noble, colleague**

I would like to nominate Louise for a star award as she is the definition teamwork. This nomination is not for one act, but is for being consistent in the way she works and demonstrating the Trust's values every day. Louise is always organised and uses her initiative on the ward, which in return has a positive impact on patient experience and the wellbeing of her colleagues. She is always actively trying to find ways to help her colleagues and support them. She understands and respects the roles of everyone within the team on the ward, which is very important in such a close working MDT. Even on days when the ward is busier than usual, or when our staffing levels are not as they should be, Louise has a calm and fun presence, and it is a pleasure to work with her. She builds up good relationships with patients and their families, as well as her colleagues, and generally creates a really nice atmosphere on the ward. Louise is a really valued member of our team.

Stephen Palmer,	**York**	**Nominated by**

Renal Technicians Team Leader

Sonia Crawford, colleague

Stephen joined Renal Services a few years ago during a very stressful period. Renal Services have been under immense pressure following the covid pandemic and increased demand in general. Stephen is a team player who will support teams and individual staff in working out the best solution to a problem and then assist them with reaching this goal. He has achieved so much during his short time with us, from getting projects moving, to having our gardens sorted out at Easingwold. If Stephen can help, he will.

If you need someone who lives our Trust's values, he is absolutely it. He will take time out of his busy schedule to provide training to nurses and always goes above and beyond to enhance the patient experience. Stephen is like a safety net, such as if there is an emergency and our busy estates colleagues are delayed, we can rely on Stephen for help and advice.

I speak for the whole Renal Team with this nomination and have a few quotes below from some colleagues:

Dr David Border said, "Promptly organising covid dialysis points, problem solving water plant issues, and working on non-contracted days to ensure the dialysis service can run, to name only three of his qualities."

Eleanor King, Deputy Operational Manager, said, "Stephen and his team are constantly positive and solution focused. They support the ops team with all necessary information for business cases etc. and they are unfailingly vigilant, identifying threats to the service. We are all so thankful and grateful for Stephen's dedication and support."

The HHD nurses gave a list of everything he does and deserves praise for:

1. Organising a re-install and de-install within five weeks for a house move saving patients rent and stress.

2. Being part of MDT each month to give advice on blood tests, water tests, safety and checking information needed.

3. Being on hand for queries, even out of hours.

4. Organising educational visits and a project with the HHD nurses to link industry to young people.

5. Organising and looking at new areas for HHD to support teaching and opportunities for growing the service.

6. Updating the safety of HHD services in line with other units and protocols such as water quality and chlorine testing for our patients.

7. Regularly coming on home visits and supporting his team to work with the HHD nurses which has really impacted our learning and growing as a service.

8. The amount of time spent on the tender processes, trying to get new equipment such as BCM and USS for home will be of so much benefit to our home patients so we can do it at home rather than in-centre, preventing admissions and not taking up valuable spaces.

9. Educating staff and HHD patients.

10. Being the person who seems to be able to make things happen in renal.

Debbie Pullen, Domestic Supervisor **Scarborough** **Nominated by colleague**

Debbie is always caring and understanding. She understands the stresses we domestics are under and goes out of her way to make sure we are ok.

Debbie Goldfield, Speciality Doctor **York** **Nominated by Alison Greenhalgh, relative**

In the early hours of Monday 6 November, my 93-year-old Mum was admitted to ED unconscious following a collapse at home. I accompanied her and my sister joined us later in the cubicle. From the second Debs arrived in the cubicle she demonstrated professionalism, skill, and compassion. She introduced herself warmly as Debs and let us know that she was the senior doctor in the ED and would be looking after Mum. My Mum was struggling to breathe and was unresponsive. Debs assessed her and always kept us informed. She recognised that Mum was so poorly that she was unlikely to recover and quickly ascertained that we were all three on the same page. Instead of performing futile investigations, the end-of-life pathway was commenced, and it was ensured Mum was comfortable and we were supported. She made us feel that we were in charge, and she was there to facilitate my Mums care, prioritising her best interests. She organised her transfer into a cubicle with low lighting on a quieter corridor. The nursing staff put on a lamp and gifted my Mum a crocheted blanket which was a very personal touch and much appreciated. Mum died very peacefully with us both at her side about three hours later.

Debbie's experience and skill had enabled this very peaceful and calm end to her life. A 'good death'. To achieve this in a very busy ED was amazing. Debs came to certify Mum after her death. She made us feel like she all the time in the world for us. She was so kind, warm, and genuinely lovely, and inspired us with great confidence. She talked, hugged, and informed us skilfully about the next steps, never rushing and giving us time. I remember her saying when she came into the cubicle after Mum had died "your Mum is beautiful". She then led us out of the ED a quiet way and took us to the front door ensuring that we were okay. She encouraged us to take time to grieve as this was the most significant life event.

Debs has very finely tuned communication skills and in a snapshot of time built a professional relationship with us that means we will never forget her. We will be forever grateful for this amazing specialist who got things just right for Mum. I hope she knows what a difference she makes.

Ophthalmology Secretaries | **York** | **Nominated by Martin Fletcher, colleague**

The Ophthalmology secretarial team has consistently ensured patients are put first and demonstrated a holistic approach towards all the patients that they meet. The team has had some difficult times due to vacancies and increases in workloads, as well as the ever-increasing demands of the service. The team deals with patients politely and professionally. They are often named in thanks from patients. The team takes a 'nothing is too much' approach to most queries, often taking ownership of issues or concerns from patients which may not be directly linked to their workload or department. The team is an absolute asset to the department, the Trust, and the NHS.

Emma Broadley, Waiting List Coordinator | **York** | **Nominated by Jacquie Lazenby, relative**

I wanted to make the Trust aware of Emma and what a real star she has been in relation to her help and support securing a faster treatment time for my 87-year-old father. My father was on the York waiting list for maxillofacial surgery and due to the time he had waited (19 weeks), I took it upon myself to contact the waiting list team in September 2023 for an idea of when he might expect the treatment.

Emma very sensitively informed me that the wait could be long, potentially into spring 2024. I expressed my concern at the impact this would have on my father when I relayed the message and if there was anything that could be done to expedite things. Emma said there might be an opportunity to move my father onto another list, but she would have to contact the specialists involved in my father's treatment. Emma did this, and even followed up my father's case immediately after returning from her leave to make sure things were progressing. Thankfully, after seeking advice, Emma contacted me with the good news that she could offer an appointment at Selby Hospital on 9 November. I immediately let me father know, and he was really relieved that things could move forward.

My father had the procedure today and I cannot emphasise what a relief it has been for all the family. We are all exceptionally grateful to Emma who was not only helpful and reliable in always returning calls, but also kind and empathetic. I have rung Emma personally to thank her but feel she deserves further recognition. For me and my father Emma has made the best difference.

Reyden Hombid, Deputy Charge Nurse	**York**	**Nominated by Rachel Bissell, colleague**

Reyden is always an extremely helpful individual who constantly ensures patient safety and continuous patient flow. I always have positive conversations with Reyden, and he consistently tries to help patients as and where he is able. He puts his patients first and is extremely accommodating when it comes to patient flow. He is an absolute joy to work with and his continuous support towards patient flow cannot go unnoticed. He is always willing to try and change the way in which he works to ensure patients are placed in the right place and the right time. He is a credit to his team, and I feel he is 100% deserving of a star award.

Helen Hope, Staff Nurse Grade E	**York**	**Nominated by Nina Findlay, patient**

I first met Helen in March 2023 when I unfortunately suffered a miscarriage. Helen's kind personality, reassurance, help and knowledge made the unbearable process a little easier. I was in and out on multiple occasions and was extremely upset. Helen did everything in her power to ensure I was in and out as efficiently as possible and that I had the privacy needed to process the well-presented information and choices. Then in September 2023 and I find myself back in EPAU with my second pregnancy. Helen immediately remembered me, and a friendly face was just what I needed. I fully feel that Helen has done everything in her power to help me in this pregnancy and has found answers for me when others did not know. Nothing is too much, and she will help any problem or question, and if she does not know how to help, she goes above and beyond to find an answer.

Helen also cared for my sister-in-law last year who told me I would be fine when I first attended EPAU because there is a lovely lady called Helen working there. Without having the help and reassurance from Helen throughout both of my pregnancies I would not have coped with the upset and anxiety as well as I have. York Hospital is in both mine and my sister-in-law's opinions and experiences so lucky to have her. Thank you for everything, I will never forget you.

Sophie Atkinson and Mia Beeson, Midwives	**York**	**Nominated by Laura Ingram, patient**

I had a rough run up to labour and the minute these two wonderful midwives had me in their care I felt better immediately. I felt listened to and respected in every way, and they put me and my husband at ease throughout the whole process. Their whole standard of care from start to finish was amazing and I felt they really did go above and beyond. Every step of my care and what was happening was explained to me with kindness. Nothing was too much bother for them. I really would love for these two to be recognised and rewarded in some way. Mia told me it was her first day at York Hospital and my baby was the first she had delivered in York, which I thought was even more incredible.

Occupational Therapy Team	**Selby**	**Nominated by Eileen Watson, colleague**

The occupational therapy (OT) team at Selby IPU work in a collaborative and caring manner every day. However, they have gone the extra mile during OT week raising the profile of OTs working in rehabilitation, educating the wider MDT, and providing opportunities for the patients to engage in worthwhile and stimulating activities. These included a quiz, a spa and knitting activities. The feedback from the unit and the patients involved has been great. They have successfully implemented a breakfast club on the unit and have great future plans of expansion and engagement working alongside the physios to improve rehab at Selby. Thanks to you all for your dedication to improve patient care.

NHS
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NHS Foundation Trust

TRUST PRIORITIES REPORT

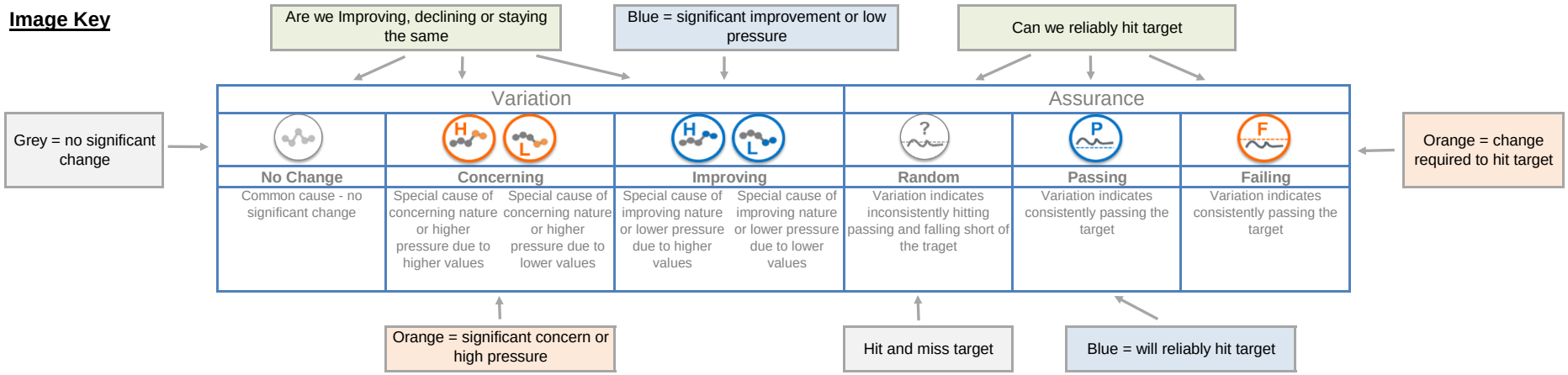
November 2023

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

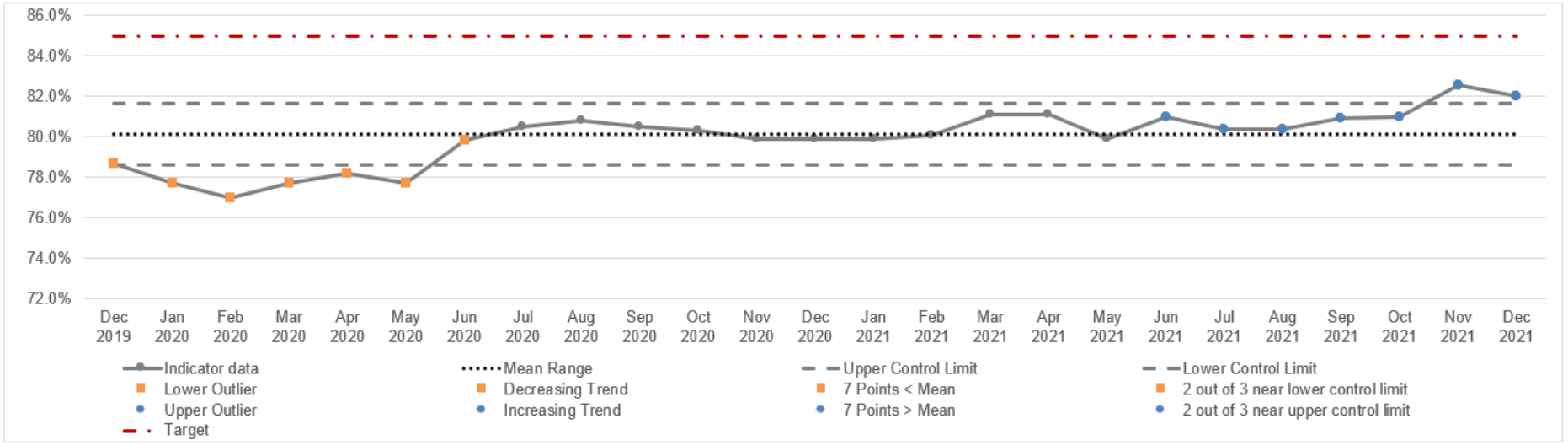
York and Scarborough Teaching Hospitals NHS Foundation Trust

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



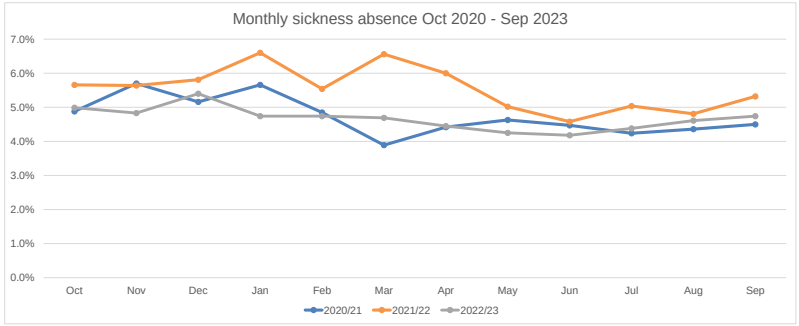
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

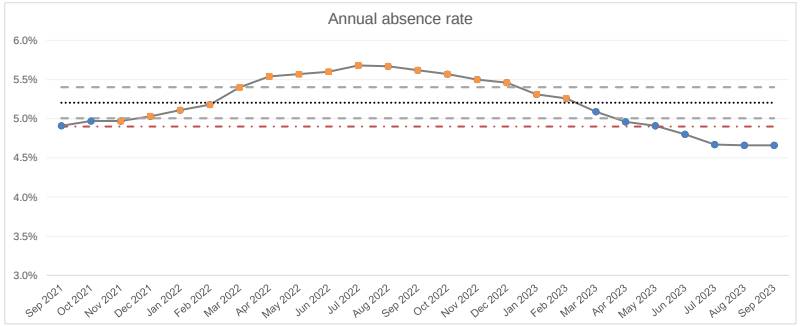
OUR PEOPLE - Sickness Absence and Staff Survey

York and Scarborough Teaching Hospitals NHS Foundation Trust

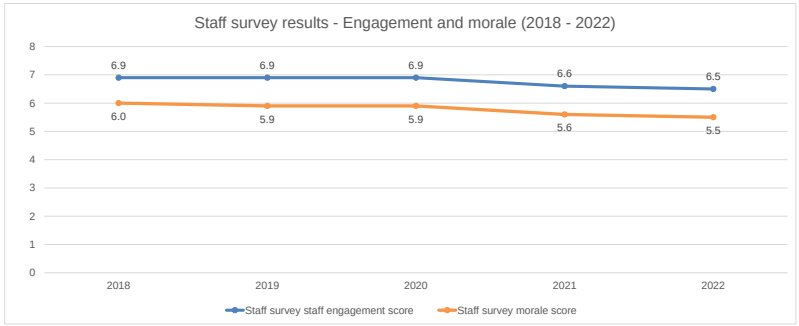
REPORTING MONTH : OCTOBER 2023



Sep 2023
4.74%
Target
No Target
Variance
Assurance



Sep 2023
4.66%
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 Sep 2023 (4.74%) is lower than that seen last year (5.32%).
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 staff survey remains open until the 24th November and there is further communication going out within the organisation, along with regular email reminders, to try and encourage an increase in response rates. As of 9th November 31.8% had completed the survey.

The Change Makers will be launched in the organisation for a 6 month period from 6th December. 52 Change Makers have been appointed to help us discovery what it is like to work for the Group and to put forward recommendations for improvements.

In 2022, the covid vaccination campaign launched earlier than the 2023 campaign. Only covid booster vaccinations were given for the first three weeks of the campaign (beginning 12th September), with flu vaccinations also being given from the beginning of week four (3rd October).

This years frontline uptake (up to 31st October 2023) saw a total of 2104 flu vaccines administered and 1904 covid vaccines administered in comparison to last years (up to 4/11/22) 1767 flu and 2588 covid vaccines administered. Last year we started the campaign on 12th September 2022 compared to this year which started on 2nd October 2023.

22.56% of all frontline staff have received their flu vaccination and 20.41% received their covid vaccination. At this stage in 2022 we were at 20.25% for flu vaccinations and 29.65% for covid vaccinations.

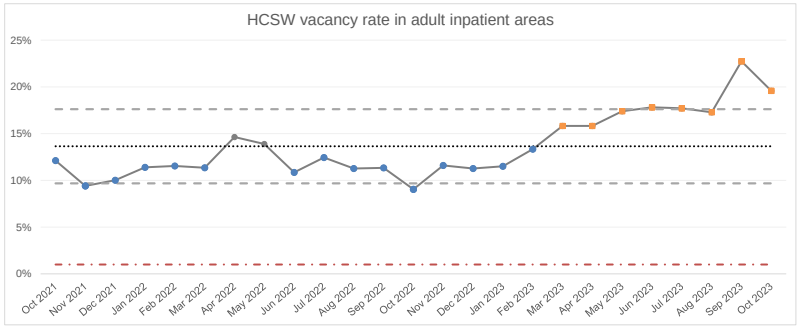
This year's overall uptake (up to 31st October 2023) saw a total of 2850 flu vaccines administered and 2631 covid vaccines administered in comparison to last years (up to 4/11/22) 2431 flu and 3524 covid vaccines administered.

24.83% of all frontline staff have received their flu vaccination and 22.92% received their covid vaccination. At this stage in 2022 we were at 22.67% for flu vaccinations and 32.87% for covid vaccinations

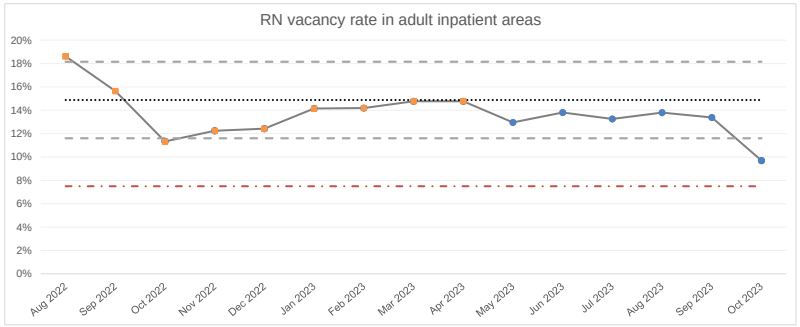
OUR PEOPLE - Vacancy Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

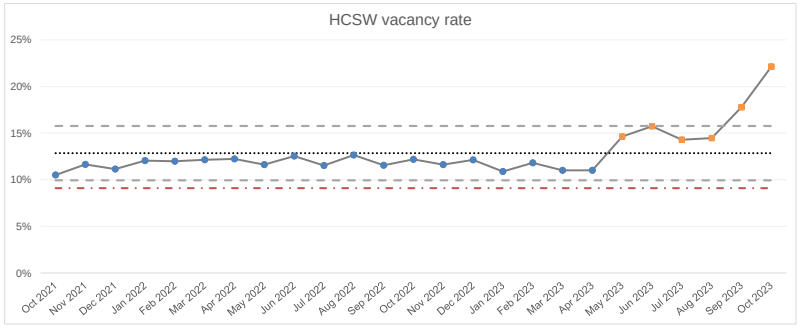
REPORTING MONTH : OCTOBER 2023



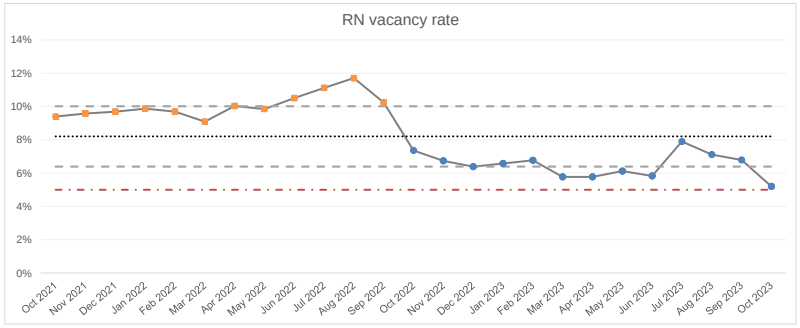
Oct 2023	19.58%
Target	1%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates consistently falling short of the target



Oct 2023	9.70%
Target	7.5%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Variation indicates consistently falling short of the target



Oct 2023	22.13%
Target	9.10%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates consistently falling short of the target



Oct 2023	5.20%
Target	5%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Variation indicates consistently falling short of the target

Data Analysis: (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 mean from Mar 2023 with points from May 2023 above or around the upper control limit. 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. The target is consistently not being met.
HCSW vacancy rate: The indicator is showing special cause concern above or around the upper control limit from May 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 Sep 2022 were above the upper control limit. The target is consistently not being met.

Operational Update

The increase in establishments for HCSWs in September's budgets means the vacancy rate remains high. The first HCSW Academy commenced on 30 October. The Academy will support our newly recruited HCSWs with a full induction to their role and the organisation, providing valuable support which the Trust hopes will help to reduce the turnover within the role. A recruitment event was held on the 2 October at the Community Stadium, resulting in the appointment of 20 HCSWs, 5 PSO's and 5 Nurses. NHSE continue to provide support the to Trust in relation to our HCSW vacancy position.

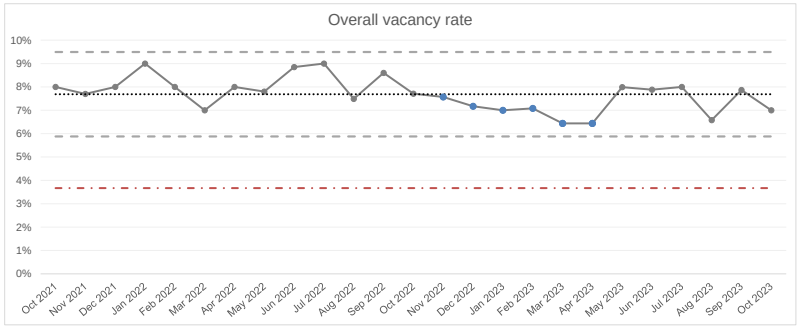
The Trust has sent a small team of staff to Kerala, India, to participate in the latest Recruitment Fair, organised by the ICB. The Trust will be supporting the recruitment of staff for the Trust and region, along with continuing efforts to build relationships with schools of nursing in the area to support our future pipeline of international recruits. The Trust is due to welcome 23 nurses for our November cohort and continues to make preparations for cohorts in January and February.

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 4.17%.

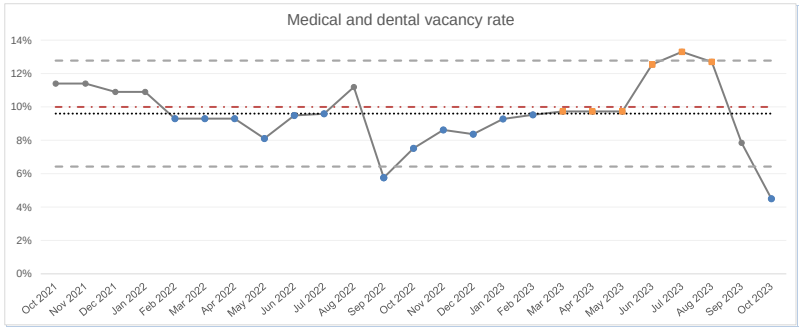
OUR PEOPLE - Vacancy Rate and Turnover Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

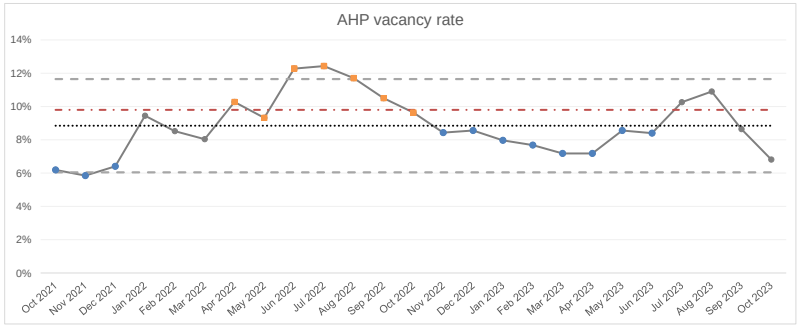
REPORTING MONTH : OCTOBER 2023



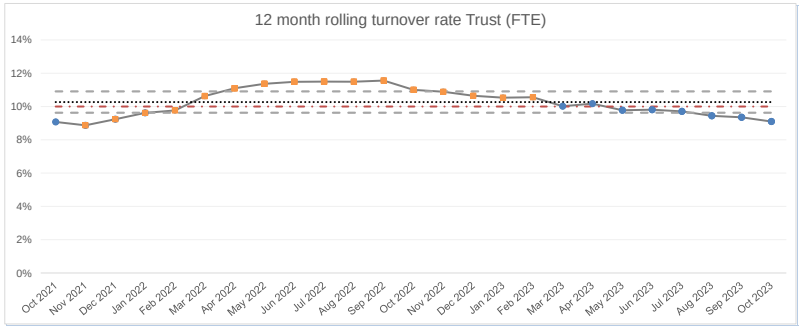
Oct 2023	Target	Variance	Assurance
7.00%	3.67%	Common cause - no significant change	Variation indicates consistently falling short of the target



Oct 2023	Target		
4.5%	10.00%	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target



Oct 2023	Target	Variance	Assurance
6.8%	9.80%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Oct 2023	Target	Variance	Assurance
9.10%	10%	Special cause of improving nature or lower pressure due to lower values	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 around 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-Aug 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 below the mean and special cause improvement. The target is currently just below the mean.

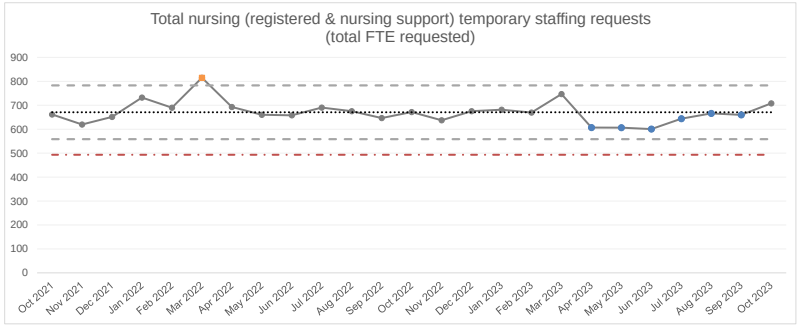
Operational Update

Starting in next month's TPR we will look to include the vacancy rate for midwives. Currently the vacancy rate for midwives is at 2.02%.

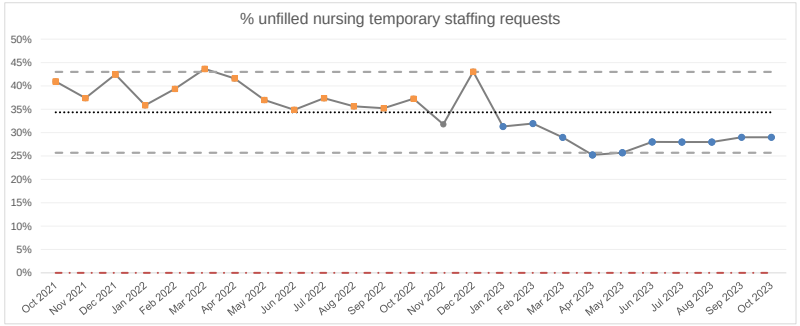
OUR PEOPLE - Temporary Staffing

York and Scarborough Teaching Hospitals NHS Foundation Trust

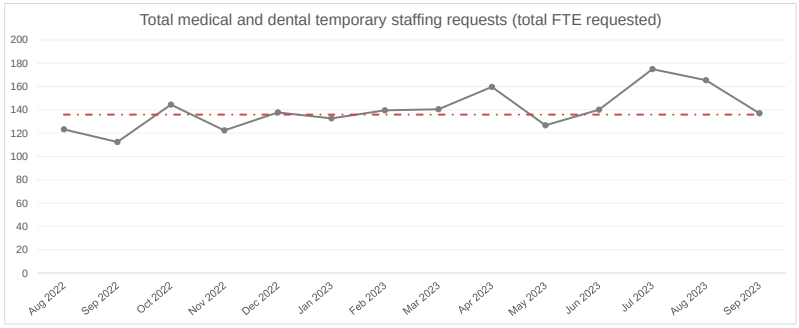
REPORTING MONTH : OCTOBER 2023



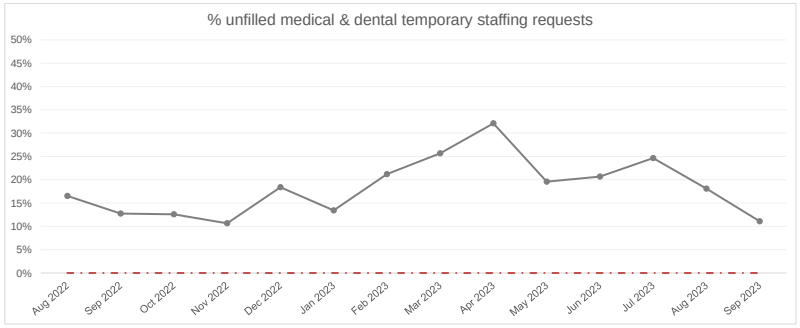
Oct 2023
708.00
Target
493.33
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Oct 2023
29.00%
Target
0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



Sep 2023
137.05
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



Sep 2023
11.10%
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 slightly above target.
% unfilled medical & dental temporary staffing requests: This indicator is not currently shown as an SPC chart due to insufficient data points. For the available data points, it is consistently failing the target of 0%.

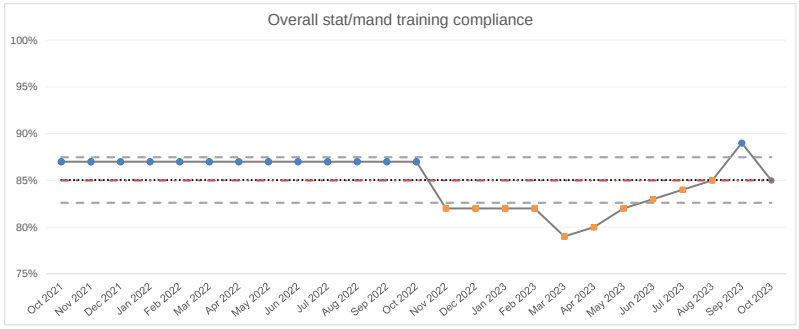
Operational Update

The Trust has successfully ended all off framework agency, a significant milestone for the organisation. Non-clinical agency use has been reduced significantly, with the majority of bookings converted to bank or ended, leaving a small number of essential roles in place that continue to be monitored. A recent paper to Executive Committee has approved the creation of a Temporary Staffing Review Group to monitor agency use in the Trust, alongside this increased governance steps have been agreed to ensure greater control around the escalation of bank and agency rates. Executive Committee have also approved a winter incentive package for substantive and bank staff that will come into effect from December to support with staffing pressures and reduce reliance on agency over the winter period.

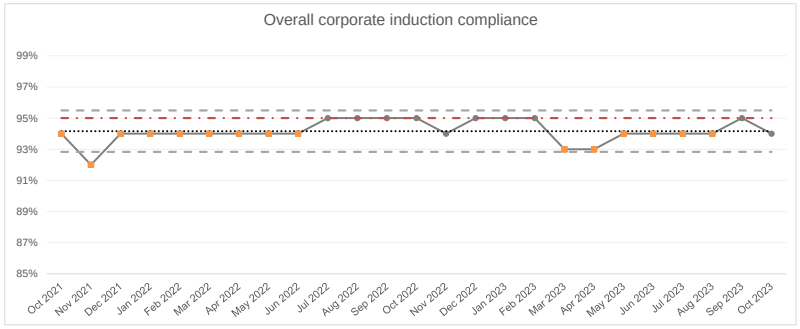
OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

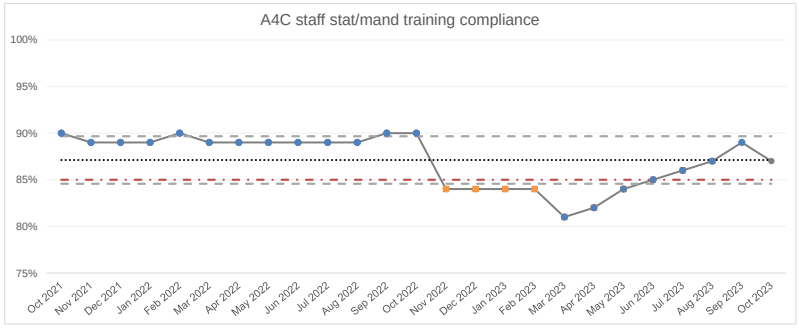
REPORTING MONTH : OCTOBER 2023



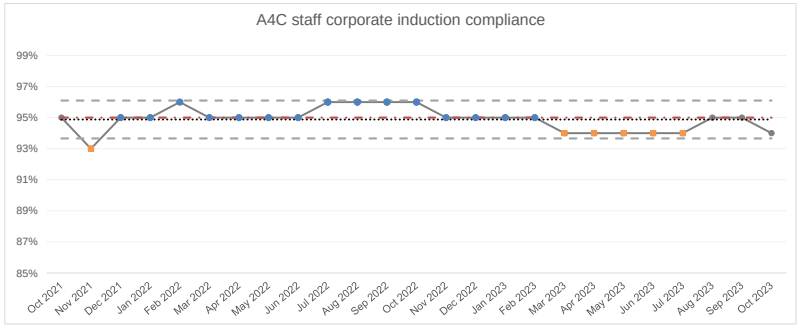
Oct 2023	85%
Target	85%
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



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



Oct 2023	87%
Target	85%
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



Oct 2023	94%
Target	95%
Variance	Common cause - no significant change
Assurance	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. From Nov 2022 to date the data points are below the mean, but we now see an upward trend above the upper control limit. Aug, Sep and Oct 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 and showing common cause variation. The target is just below the upper control limit, with Sep 2023 meeting target.and Oct 2023 just below.
A4C staff stat/mand training compliance: This indicator was showing special cause improvement up to Oct 2022 with all data points above the mean. However, from Nov 2022 to Feb 2023 the data points were below the mean, thus showing special cause concern. It is now on an upward trajectory and has met target since Jun 2023.
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 latest months Aug-Sep 2023 have met target, however Oct is just below target.

Operational Update

The overall mandatory training compliance rate has reduced slightly from last month, to 85% (-1%). This is -2% against the updated Trust compliance target of 87% (increased from 85% from October).
At subject level, 1-year refresher courses (overall completion rate 76%) and facilitated training (often delivered wholly or partly in classrooms - overall completion rate 72%) continue to see comparatively low completion rates. Of note since last month are increases in compliance for Equality, Diversity and Human Rights (+1% to 83%), Adult Life Support (+2% to 75%) and Mental Capacity Act Level 2 training (+1% to 82%). Compliance for Resus courses, particularly Advanced Life Support (Adult 70% and Paediatrics 48%) and Safeguarding Children Level 3 specialist training (62%) is challenged, while Deprivation of Liberty Safeguards training is also below 80% at Levels 1 (79%) and 2 (72%). Low compliance rates for Life Support and Safeguarding training in the Medicine Care Group, along with DoLS training overall, were among some of the findings the CQC asked the Trust to remedy.

Overall, the Trust is achieving 87% compliance in 10 out of 26 subjects and levels on the mandatory training curriculum.

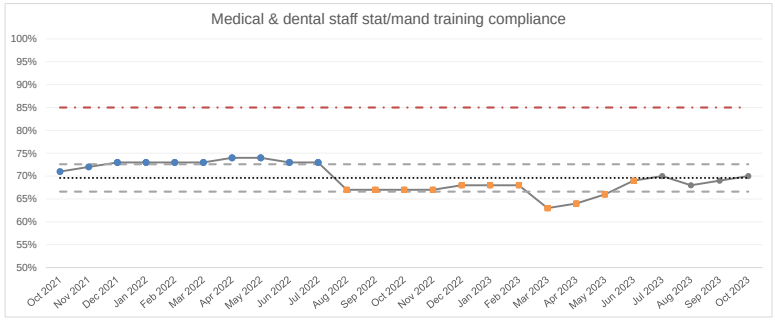
Corporate Induction compliance has reduced to 94% (-1%) which is 1% below target. This follows the re-introduction of a face-to-face programme in October, meaning some staff now have to wait longer to complete induction. Of 34 attendees who provided feedback on the first two events, 33 found the sessions helpful, with people most enjoying how interactive they have been. More broadly, those providing feedback have given the Trust an average rating of 4.29/5 for their overall induction experience to date.

Due to the restructuring of the care groups you will now notice on the core compliance tab that the competencies have been grouped using the new care group structure.

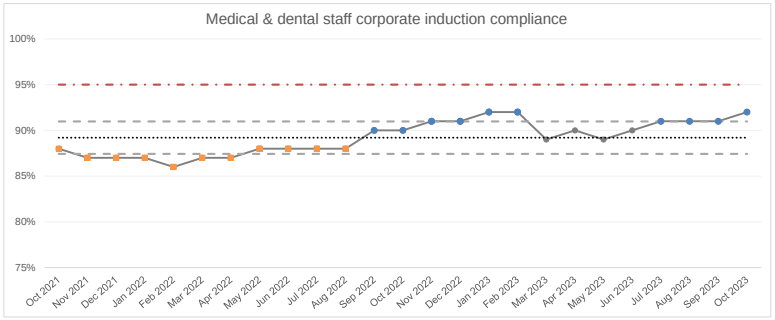
OUR PEOPLE - Training / Induction (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : OCTOBER 2023



Oct 2023	Target	Variance	Assurance
70%	85%	Common cause - no significant change	Variation indicates consistently falling short of the target



Oct 2023	Target	Variance	Assurance
92%	95%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently falling short of the target

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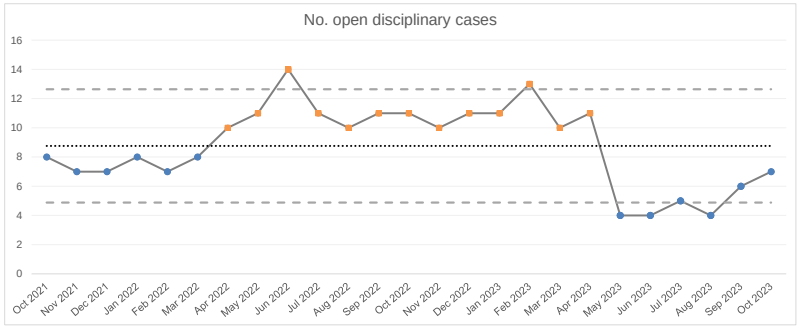
Data Analysis: (Please note Feb 2023 data is unavailable due to the Serious Incident on Learning Hub, the data points on the charts for Feb 2023 are the same as Jan 2023).

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. The indicator is consistently failing target.

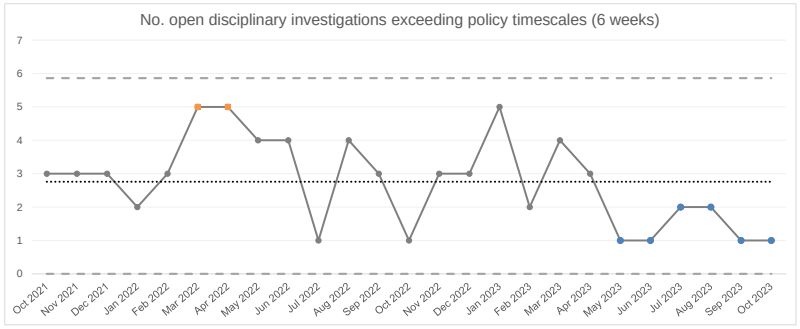
OUR PEOPLE - Employee Relations Activity

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

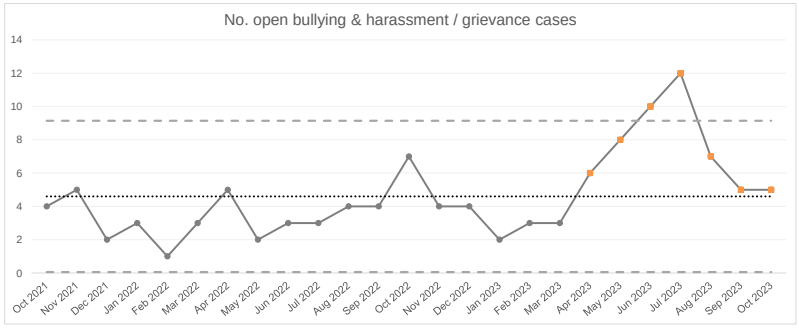
REPORTING MONTH : OCTOBER 2023



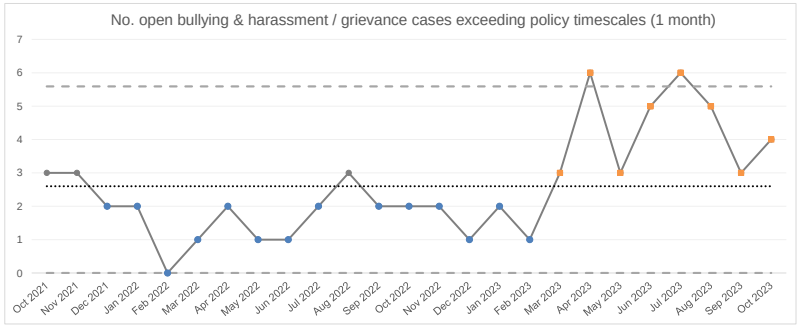
Oct 2023	Target	Variance	Assurance
7	No Target	Special cause of improving nature or lower pressure due to lower values	There is no target, therefore target assurance is not relevant



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



Oct 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



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

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 was seen from May to Aug 2023, below or around the lower control limit, but has risen back towards the mean in Sep and Oct 2023.
No. open disciplinary investigations exceeding policy timescales (6 weeks): The indicator is currently showing special cause variation below the mean from May 2023.
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, Sep and Oct 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.

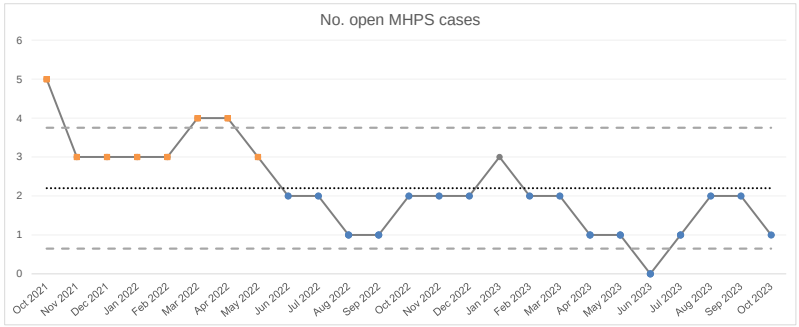
Operational Update

The operational HR team continue to deal with a high number of informal cases, reducing the amount that progress into formal processes. This is positive for the individual and the organisation, embedding the principles of a Just Culture.

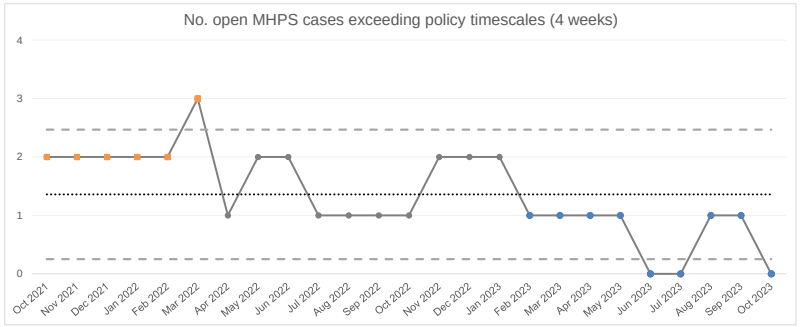
OUR PEOPLE - Employee Relations Activity and Appraisals

York and Scarborough Teaching Hospitals NHS Foundation Trust

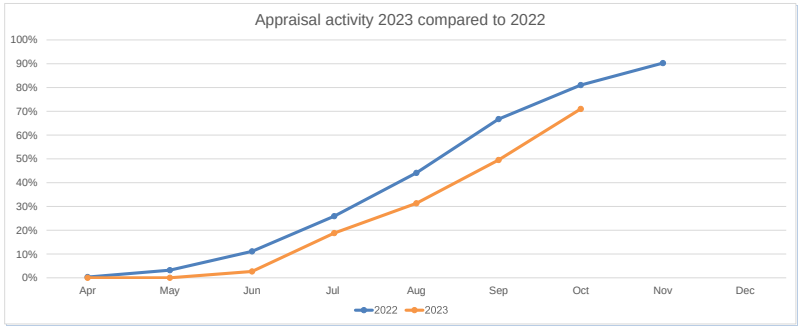
REPORTING MONTH : OCTOBER 2023



Oct 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



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



Oct 2023	71.00%
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 October this was 68.23% in 2023 compared to 81.00% in 2022, however the start of the appraisal window was delayed in 2023).

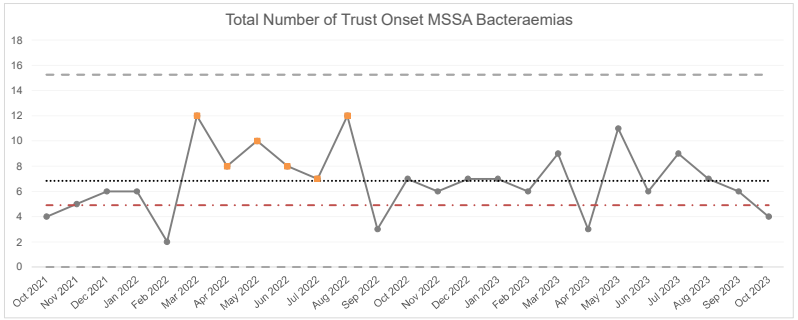
Operational Update

The appraisal window is due to come to close at the end of November. We are currently behind the completion rate for last year with a number of factors, including the disruption caused by industrial action, playing into this. Significant efforts will go into closing the gap over the coming weeks.

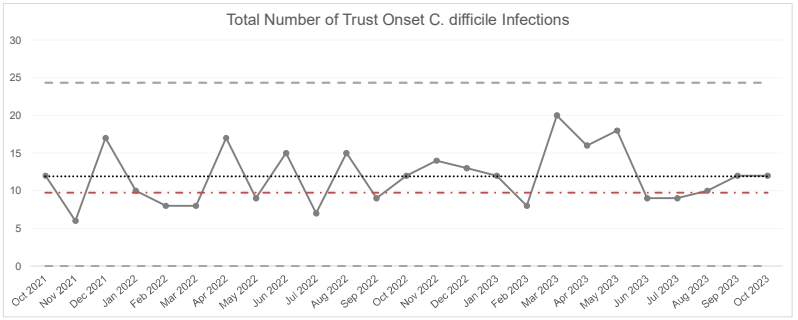
QUALITY AND SAFETY - Priority Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

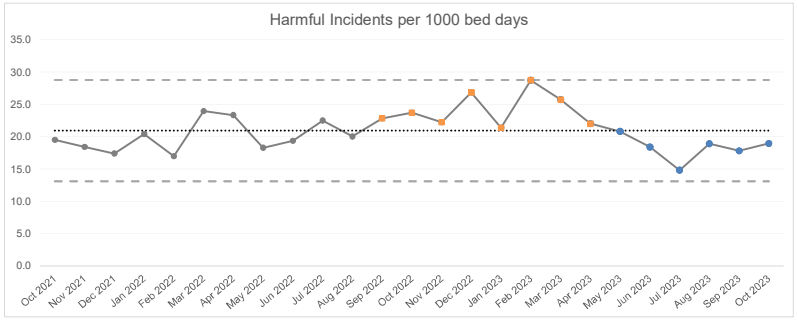
REPORTING MONTH : OCTOBER 2023



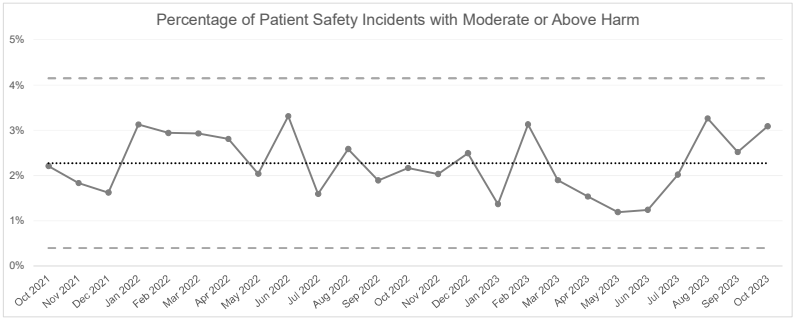
Oct 2023	Cumulative 12-month Target	Variance	Assurance
4	59	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



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



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



Oct 2023	Target	Variance	Assurance
3.1%	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant

Data Analysis:

Total Number of Trust Onset MSSA Bacteraemias: The number of infections of patients with MSSA is currently showing common cause variation.
Total Number of Trust Onset C. difficile infections: The number of infections of patients with C.difficile is currently showing common cause variation.
Harmful Incidents per 1000 bed days: The number of harmful incidents per 1000 bed days was showing special cause improvement due to the data points below the mean from May 2023.
Percentage of Patient Safety Incidents with Moderate or Above Harm: The percentage of patient safety incidents with moderate or above harm is currently showing common cause variation.

Operational Updates:

Total Number of Trust Onset MSSA Bacteraemias
MSSA bacteraemia remains over trajectory by 11 cases to the end of October. The Staphylococcus aureus bacteraemia reduction working group continues to drive initiatives to improve cannula management. The roll out of cannula trollies combined with VIP score refresher training will commence on the York site week beginning 13th November.

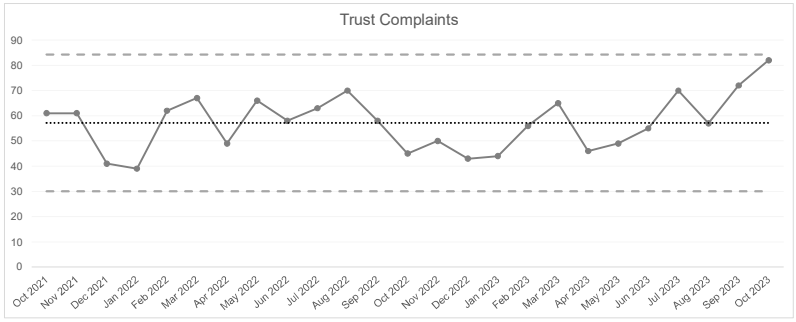
Total Number of Trust Onset C. difficile infections
The C.difficile performance remains poor overall with the trust being over trajectory by 19 cases to the end of October. An increased incidence of C.difficile has been noted for Cherry and Chestnut wards where there have been 12 cases (7 on Cherry and 5 on Chestnut) since 1st August 2023. Three of the cases are repeat samples after the 28 day mandatory surveillance cut off, so 9 patients account for 12 cases attributed to YSHFT. A C.difficile summit is being held on the Scarborough site at Monday 13th November at 3pm with all key stakeholders to provide a supportive review of the situation, agree an improvement plan and weekly monitoring of the agreed actions.

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 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. We have continued to see an increase in the number of Datix reported daily.

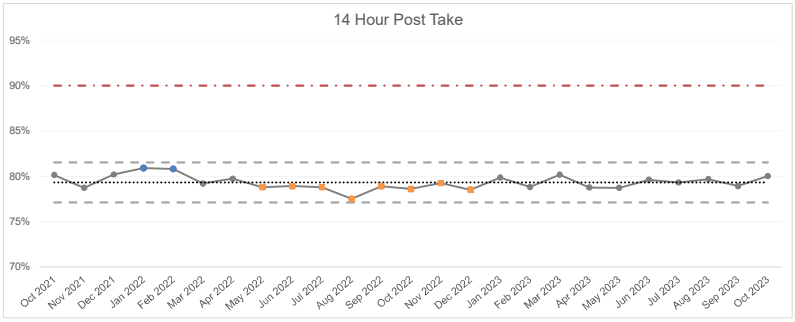
QUALITY AND SAFETY - Priority Metrics (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

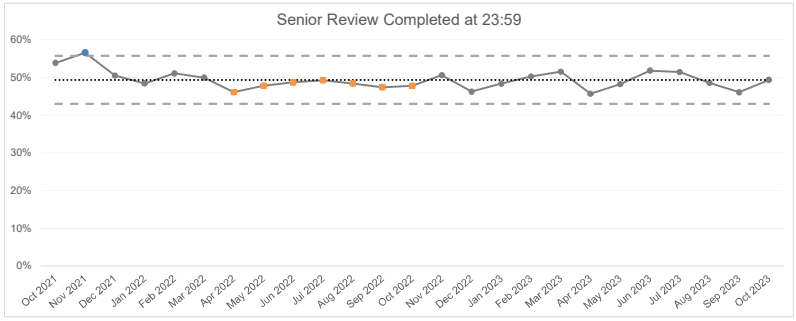
REPORTING MONTH : OCTOBER 2023



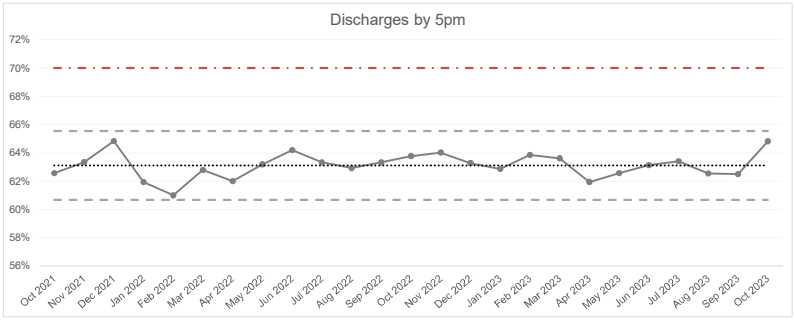
Oct 2023	Target	Variance	Assurance
82	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Oct 2023	Target	Variance	Assurance
80.0%	90%	Common cause - no significant change	Variation indicates consistently falling short of the target



Oct 2023	Target	Variance	Assurance
49.3%	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Oct 2023	Target	Variance	Assurance
64.8%	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 Apr 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.

Operational Updates:

Trust Complaints
Sustained increase in number of people complaining is putting pressure on small complaints and concerns team. Care groups also have an unprecedented 137 open complaints.

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)

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F	◌	Total
Improvement			3		3
H					
L			3		3
Common Cause		2	3		5
◌		2	3		5
Concern		3			3
H		2			2
L		1			1
Neither					
↗					
↘					
Empty					
◌					
Total		5	6		11

MetricName	Date	Variation	Assurance	Target	Latest Value
ED - Proportion of Ambulance handovers waiting > 60 mins	2023-10	◌	F	10.0	26.1
ED - Proportion of all attendances having an initial assessment within 15 ...	2023-10	◌	F	66.0	40.5
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2023-10	◌	F	7.5	19.7
ED - Median Time to Initial Assessment (Minutes)	2023-10	◌	?	18.0	19.0
ED - Emergency Care Standard (Trust level)	2023-10	◌	?	73.6	68.3
Cancer - Faster Diagnosis Standard	2023-09	L	?	70.7	48.3
Cancer - Number of patients waiting 63 or more days after referral from C...	2023-10	H	?	152.0	405.0
RTT - Total Waiting List	2023-10	H	?	48146.0	51670.0
RTT - Waits over 104 weeks for incomplete pathways	2023-10	L	F	0.0	0.0
RTT - Waits over 78 weeks for incomplete pathways	2023-10	L	F	0.0	86.0
RTT - Waits over 65 weeks for Incomplete Pathways	2023-10	L	F	610.0	949.0

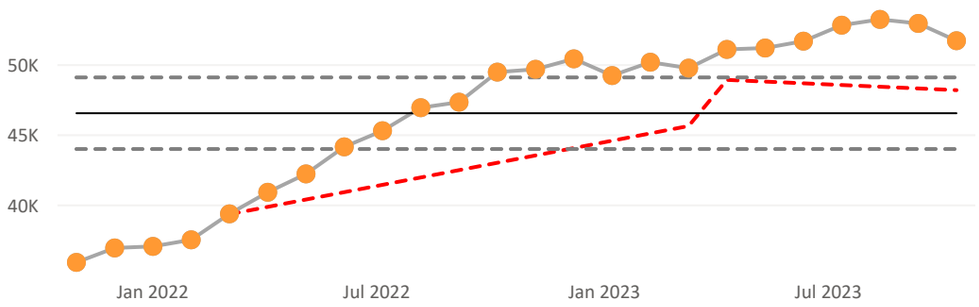
TPR: Elective Recovery Priority Metrics

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: ?



LATEST MONTH 2023-10

Value 51.7K

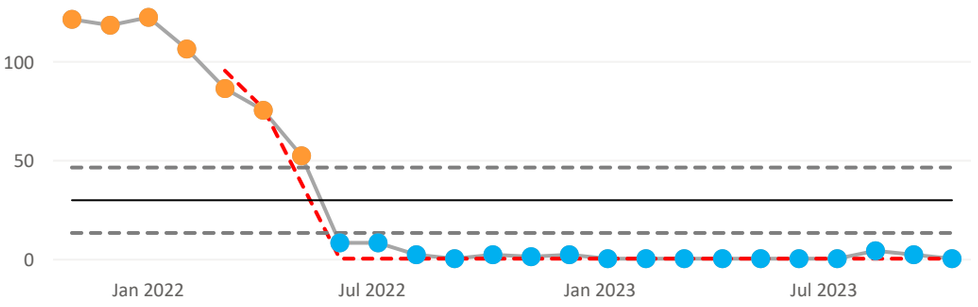
Target 48.1K

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

The latest months value has **decreased** from the previous reporting month, with a difference of **1232.0**.

MetricName: RTT - Waits over 104 weeks for incomplete pathways

Variation: L | Assurance: F



LATEST MONTH 2023-10

Value 0.0

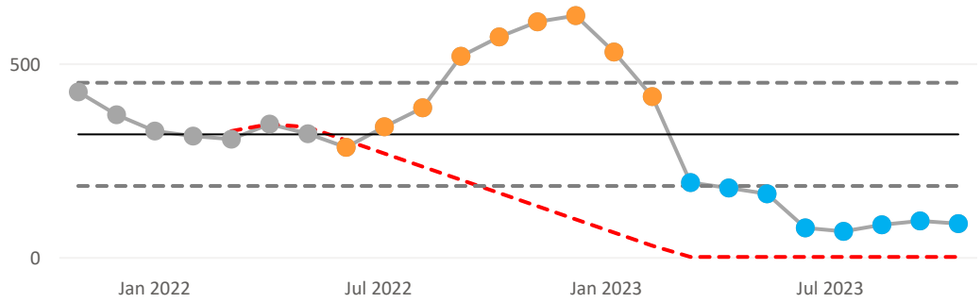
Target 0.0

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

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

MetricName: RTT - Waits over 78 weeks for incomplete pathways

Variation: L | Assurance: F



LATEST MONTH 2023-10

Value 86.0

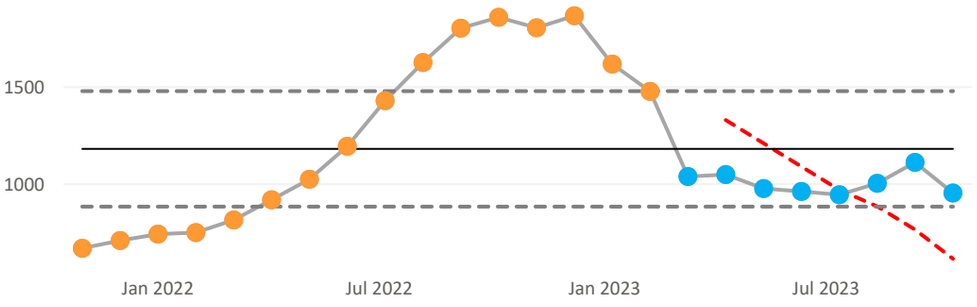
Target 0.0

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

The latest months value has **decreased** from the previous reporting month, with a difference of **7.0**.

MetricName: RTT - Waits over 65 weeks for Incomplete Pathways

Variation: L | Assurance: F



LATEST MONTH 2023-10

Value 949.0

Target 610.0

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

The latest months value has **decreased** from the previous reporting month, with a difference of **158.0**.

Narrative for Elective Recovery Priority Metrics

Challenges & Risks	Actions & Mitigations
Challenges: The Trust is in Tier 1 Elective Recovery and Cancer support (National intervention). Insufficient established workforce in MRI to meet demands on service. National mandate to reduce outpatient follow up activity by 25% compared to 2019/20 outturn and convert to new patient capacity to support elective recovery.	Actions: 1. The Intensive Support Team (IST) work with the Trust has now concluded. The IST has supported the Trust on a range of issues including governance, speciality recovery planning, skills and development of the teams and data to support operational teams. The IST continue to support the Trust moving forward on ad-hoc workstreams. 2. The Tier 1 regime has moved to fortnightly meetings which will alternate between a system meeting one fortnight and then individual meetings on the alternative fortnight with HUTH and York and Scarborough. The intention is that this will enable the cycle to undertake detailed oversight of both the actions required at Trust and system level. The Trust had 86 RTT 78-week waiters remaining at the end of October. 3. Waiting List Harms Task and Finish Group established. Requirement for CPD changes identified. 4. Electronic platform for patients to access guidance on keeping ‘fit for surgery’; ‘My Planned Care’ platform live with patient specific information ongoing. 5. Agreed SLAs with cancer alliance for funding to target improvements associated with faster diagnosis, earlier diagnosis and treatment and pathways.
Risks: Ongoing management of high levels of acute activity and delayed discharge impacting ordinary elective work. Theatre staffing vacancy, retention, and high sickness rates. Industrial action by BMA Junior Doctors and Senior Clinicians.	Mitigations: Tier 1 meetings with National Team on elective recovery. Trust continues to utilise the nationally provided Digital Mutual Aid System (DMAS) to offer long waiting patients who are willing to travel an alternative provider. DMAS live for diagnostic patients, the Trust continues to explore the opportunities this presents as well as insourcing options. Conversations continue with partner providers within the ICB around provision of mutual aid. On the 31st of October NHS England launched the Patient Initiated Digital Mutual Aid System (PIDMAS) to offer RTT patients the ability to opt-in to move provider when they had been waiting over 40 weeks for care. There were two cohorts of RTT patients who were given the option to move provider, those who were: 1. On an admitted pathway who didn’t have a booked TCI in the following eight weeks. 2. Non-admitted pathway patients who had not had their first outpatient appointment and did not have a booked appointment in the following eight weeks.

Challenges & Risks	Actions & Mitigations
	Prisoners, under eighteen-year-olds and those who have already been referred to our Trust by a secondary care provider were excluded. The Trust utilised text messaging and letters to contact circa 3,300 patients in these two cohorts on the 31st of October. The text message and letter provided patients with a link to the NHSE PIDMAS system and a national telephone number that patients can utilise if they require assistance in registering themselves onto PIDMAS. A link to further guidance on the Trust's website was also included. As of the 9th of November, 109 of our patients had registered on PIDMAS, we are now working through the validation stage and with HNY ICB colleagues to identify alternative providers. Cohort two (patients waiting over 32 weeks) was previously scheduled for the 1st of December however NHS England have delayed this timetable and will "communicate a decision on future cohorts and inclusions in February 2024". Weekly Elective Recovery Meetings in place for long wait RTT patients. Use of IS capacity to support delivery of diagnostic activity (currently MRI and CT). Additional Endoscopy insourcing sessions started on the 30th of October 2023, 18 additional lists per week allowing Trust clinicians to concentrate on FT patients. Nurse endoscopists job plans are being reviewed; additional weekend lists are in place for November. NLAG mutual aid, discussions ongoing around NLAG clinicians travelling to York to provide endoscopy lists. 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. Diagnostic Services are utilising the IST diagnostic services sustainability assessment tool to aid with identifying themes which either support or hold-back successful diagnostic delivery, which consequently may impact upon diagnostic performance. The tool has been completed for Radiology, Endoscopy, Neurophysiology, Urodynamics and a submission has been provided representing diagnostics at the East Coast (Echocardiography, Electrophysiology and Sleep Studies). Tools are expected for Audiology, Echocardiography (York), Electrophysiology (York) and Sleep Studies (York) by early December 2023.

TPR: Health Inequalities (RTT)

RTT PTL by Ethnic Group
At end of October 2023

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	22	34,017	98.20%	94.34%
Black, Black British, Caribbean or African	22	67	0.19%	0.94%
Mixed or multiple ethnic groups	21	144	0.42%	1.26%
Asian or Asian British	23	280	0.81%	2.97%
Other ethnic group	24	131	0.38%	0.49%
Unknown	21	13,235	-	-
Not Stated	21	3,403	-	-
Grand Total	**22**	**51,277**	**-**	**-**

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 October 2023

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	22	5,965	11.96%	8.88%
2	21	7,036	14.10%	13.59%
3	22	10,622	21.29%	20.94%
4	22	10,786	21.62%	20.68%
5	22	15,486	31.04%	35.90%
Unknown	16	1,382	-	-
Grand Total	**22**	**51,277**	**-**	**-**

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.

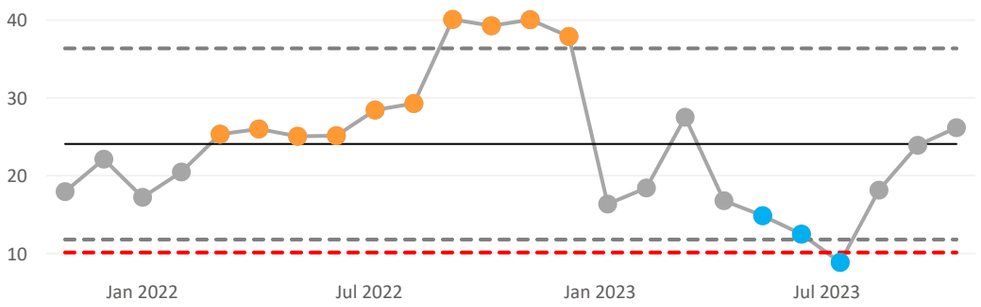
The next steps for this work will be to understand any differentials between the population base and the waiting list. Further analysis will be undertaken in coming months, and this piece of work will also be expanded to include Urgent Care, Cancer, Learning Disabilities and Military Veterans.

TPR: Acute Flow Priority Metrics

MetricName

ED - Proportion of Ambulance handovers waiting > 60 mins

Variation Assurance



LATEST MONTH
2023-10
Value
26.1
Target
10.0

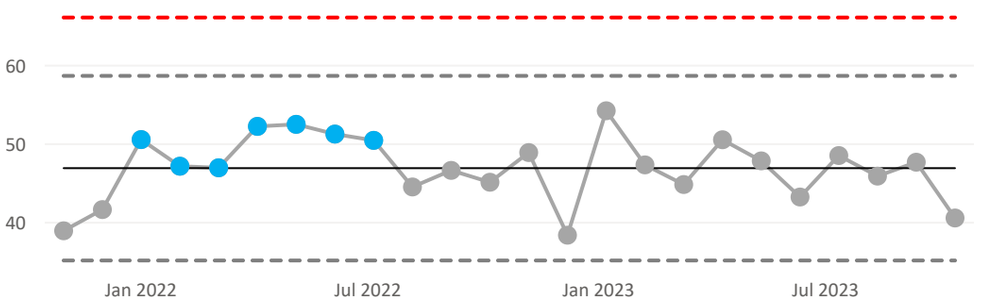
The indicator is **higher than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **increased** from the previous reporting month, with a difference of **2.3**.

MetricName

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

Variation Assurance



LATEST MONTH
2023-10
Value
40.5
Target
66.0

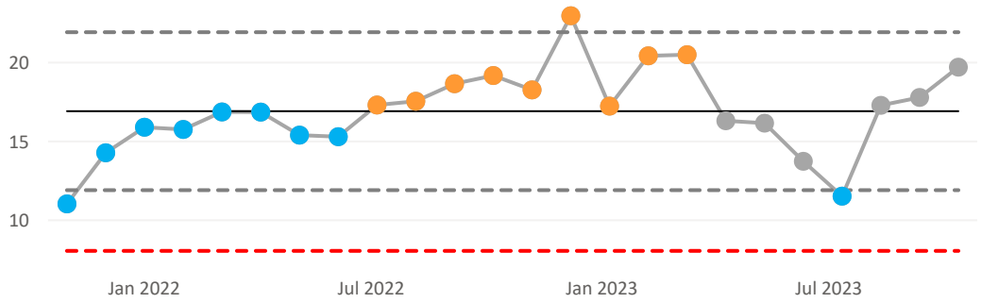
The indicator is **lower than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **decreased** from the previous reporting month, with a difference of **7.1**.

MetricName

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

Variation Assurance



LATEST MONTH
2023-10
Value
19.7
Target
7.5

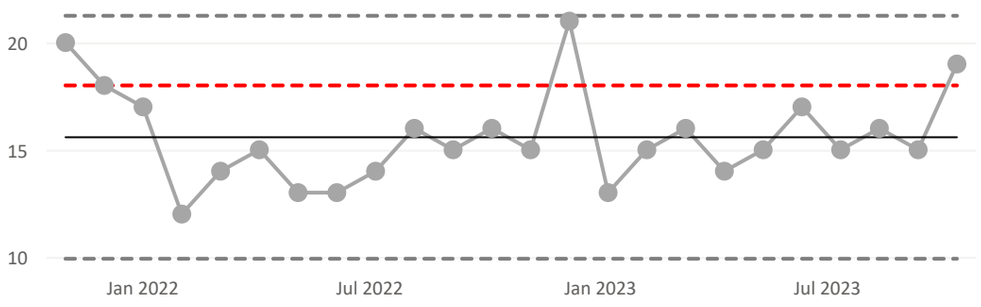
The indicator is **higher than** the target for the latest month and **is** within the upper and lower control limits.

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

MetricName

ED - Median Time to Initial Assessment (Minutes)

Variation Assurance



LATEST MONTH
2023-10
Value
19.0
Target
18.0

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 **4.0**.

Narrative for Acute Flow Priority Metrics

Challenges & Risks	Actions & Mitigations
Challenges: High number of patients without a 'Right to Reside' (232 on 10th of November 2023) in acute inpatient beds affecting flow and ability to admit patients from ED in a timely manner. The Trust is expected to have less than 10% of beds occupied by NCTR patients, the current position is 28%. Increased levels of COVID+ patients; 80-100 in our inpatient bed base throughout October. Staffing constraints (sickness, vacancies, use of agency and bank staff). Reduced workforce levels in the EDs (Christmas Day staffing levels) during industrial action periods.	Actions: 1. UEC Programme 1.1 Virtual Hospital Project Virtual Hospital patient figures are on trajectory to meet the ICB requirements i.e.15 patients in October. With regards to the plans to go further with this project there is an issue regarding the pace of mobilising new pathways and converting mapped-out ideas into reality. This is in part due to operational pressures and the time investment required to progress plans, and in part due to a lack of resources to fund and support new ways of working. Specialty level working groups continue to meet and report to the Virtual Hospital Delivery Group. The group is identifying and addressing key barriers and will present to the committee a deep dive in December. In October a bid for £350k to introduce a technology / remote-monitoring element which will increase potential for early discharges and admission avoidance across several specialties was submitted to NHSE. The project is expected to deliver 28 virtual beds by 31st March 2024; however the project delivery group are working to achieve beyond this and within a sooner timescale. With patients being admitted directly to virtual wards within the virtual hospital this will reduce ED attendances as well as inpatient bed days and therefore contributing to improvement in the emergency care standard and ambulance handover times by reducing the number of attendances at ED. 1.2 Integrated Urgent Care Project Integrated Urgent Care work remains on track with the tender closing in November for the Primary Care Out of Hours Service and design work underway in preparation for the transfer of the full Scarborough, York and Malton UTCs to the organisation as prime provider from 1st April 2024. Selby UTC successfully transferred in October to the organisation from Harrogate and District Foundation Trust with positive feedback from the Selby team and work is ongoing regarding improving the session and integration with primary care. The overarching aim of the IUC is to deliver a clinically safe, streamlined, and integrated urgent care service to ensure that service users are seen in the right place, at the right time by the most appropriate health professional. This is expected to reduce pressure on the Emergency Departments through improved streaming and access to Urgent Care Services, both Urgent Treatment Centres and out of hours services.

Challenges & Risks	Actions & Mitigations
	The performance measure for the project is the Proportion of type 3 attendances in York and Scarborough ED from all ECS activity. The baseline was at 31% with a planned improvement to 40% upon full implementation of the IUC service. The project is on track for commencement from 1st April 2024. 1.3 Internal Professional Standards Project The month of October focused on a QI approach to support ward and specialty teams to develop into their ward routines and provide the required escalation support to ensure the standards are delivered daily. The Internal Professional Standards have been discussed with a wide range of frontline staff, through ward engagement exercises. There is a risk of poor medical engagement preventing the required behaviour changes, however, Clinical Director support has been gained and clinical governance meetings have been identified as a route to gain more support. Good practice against these standards should result in earlier discharges from our hospitals; proportion of discharges before 5pm have been very stable for over a year at ~63% but in October they were up to 65%. Achievement of these will contribute to delivery of the required improvement trajectory of ECS to 76% by March 2024. 1.4 SDEC project The focus on SDEC direct continues, however a key issue reducing ability to improve SDEC performance is the workforce limitations for medicine SDEC in York, key actions are being progressed with the senior team to mitigate and address this and the proportion of patients being streamed from ED to SDEC within 60 minutes has improved and is at 22%, the highest in over a year. Direct access to York SAU for YAS is established but the proportion of unsuccessful referrals has led the to the withdrawal of support for a rollout in Scarborough. The programme team is working with YAS and SAU to carry out PDSA / improvement actions. Capability to take higher acuity patients from ED into SAU is hampered by a lack of facilities such as oxygen and suction on SAU. Until this is resolved, SAU's ability to increase risk tolerance and carry out more SDEC activity is limited. A working group has been established and the programme team will support progression at pace. The plans to develop the trusted assessor model for medicine in York in relation to the new build pathways continue and will be tested in an improvement week at the start of December. The project is expected to deliver reduced ED attendances as patients will be attending SDEC directly which will contribute to delivery of the required improvement trajectory of ECS to 76% by March 2024.

Challenges & Risks	Actions & Mitigations
	1.5 Integrated Intermediate Care The original aim of the Integrated Intermediate Care Project (IIC) was to scope the development of a long term 24/7 domiciliary care service for York. This scoping led to a decision not to develop a new service but work with local partners to develop Intermediate Care with a focus on Integration. The York crisis Frailty Hub is on track to open from November as a key part of stage one actions. The hub has a Duty Social Worker, a CRT/UCR therapy triage worker, a Social Prescriber with protected voluntary care capacity for the Frailty hub to support and a GPwSI in Frailty. The team work together in a live MDT approach to keep vulnerable frail residents safe at home whenever possible, we want to prevent clinicians from having to call 999 if they feel they have no other options available due to concerns about patients not being safe at home. In addition, the team have options to step up into the Virtual Frailty Ward, nursing home short-term step-up beds and the new Frailty Unit in ED (when it opens). There is a risk of the full IIC service specification not reaching potential due to a single reablement specification being developed by CYC. A priority meeting has been scheduled in November for all partners to revisit aims and joint-working principles. Plans are also in place for a Multi-Agency Discharge Event (MaDE) to take place in early November with all partners to facilitate prompt discharge of patients and identify key themes to be addressed to improve timely discharge for patients. This will also inform actions in the rapid improvement plan in relation to bank holiday resilience as the Christmas period approaches. The project is expected to deliver a reduction in the number of patients who do not meet the criteria to reside down to 155 and therefore contribute to delivery of the required improvement trajectory of ECS to 76% by March 2024. 2. Rapid UEC Improvement Plan In addition to the UEC Programme a focused rapid improvement UEC plan has been developed in partnership with front line teams and built up from listening exercises with these teams. The plan covers key themes of capacity, processes, pathways and people and concentrates on immediate actions which will impact on the Emergency Care Standard and Ambulance Handover times which will support achievement of the requirements to Category 2 response times. Within this plan there is specific focus on the ambulance handover process and how this can be streamlined with operational and tactical meetings now routinely in place between the Trust and YAS to enable this work.

TPR:

Narrative for Acute Flow Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

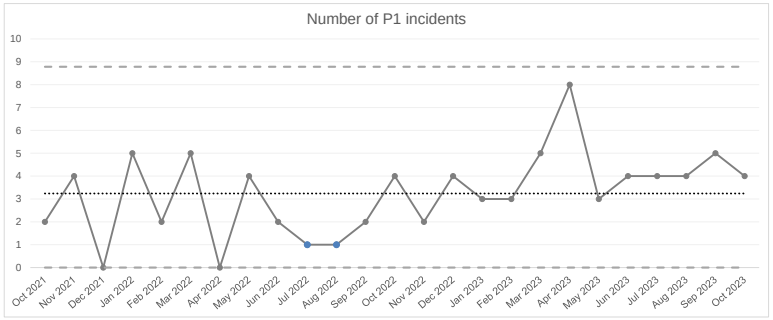
BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Risks: Inability to achieve Ambulance Handover targets due to patient flow within the hospital although implementation of CIPHER has seen improvements. A Rapid Improvement Plan has been developed which includes key actions on focussed management support in our Emergency Departments, review of operational site management, improved discharge processes and a specific focus on the ambulance handover process and how this can be streamlined with operational and tactical meetings now routinely in place between the Trust and YAS. 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.

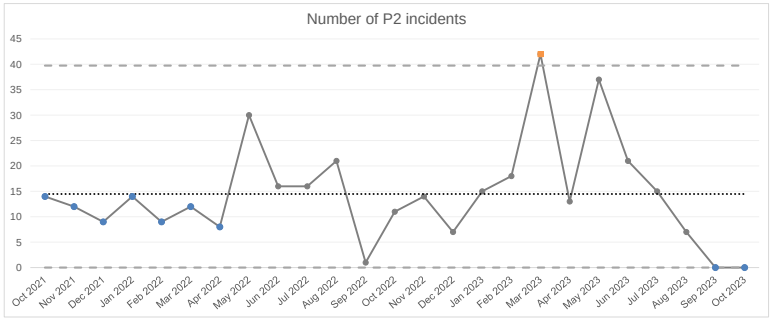
DIGITAL - Digital Indicators

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

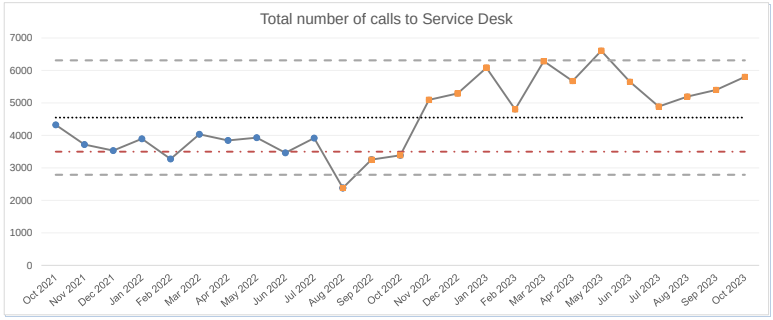
REPORTING MONTH : OCTOBER 2023



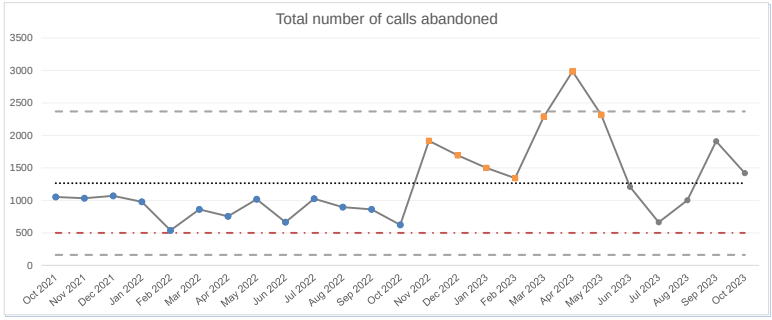
Oct 2023	Target	Variance	Assurance
4	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



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



Oct 2023	Target	Variance	Assurance
5801	3500	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Oct 2023	Target	Variance	Assurance
1420	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. P2 calls have been decreasing for the last five months.

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. The data point for May 2023 was 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 in Apr 2023 it increased above the upper control limit. Data points have fluctated around the mean for the last five months. 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:

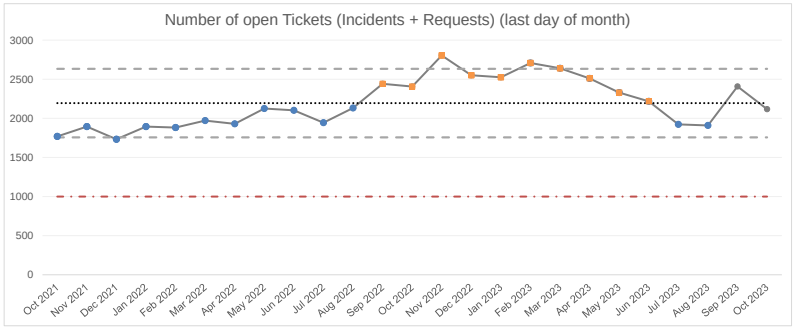
P1 incidents:

2/10 CPD performance - not accepting new connections
4/10 Finesse call queue system
11/10 G2 dictations on CPD worklist
27/10 CPD certificate errors

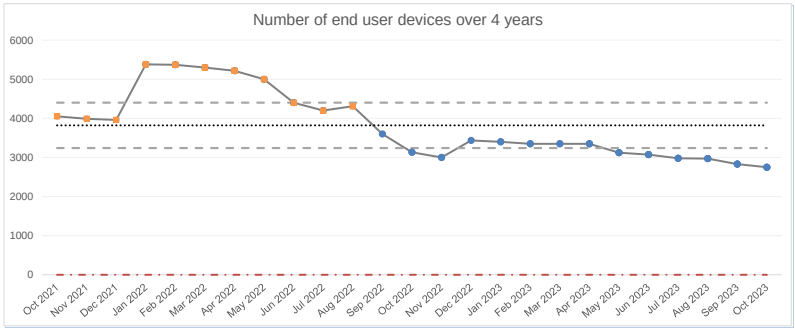
P2 incidents: [not categorised on 4Me] reporting KPIs under review

Total number of calls / number of abandoned calls:

- aside from P1 incidents driving demand, there is no specific factor causing the increase from Sep to Oct.
- Staff Comms to promote use of IT Self Service are being prepared to guide non-urgent demand away from phones.



Oct 2023
2117
Target
1000
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Oct 2023
2750
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 or close to the upper control limit. Special cause improvement was seen in Jul and Aug 2023 and the Oct 2023 data point is below the mean. 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 2750 devices now over 4 years old.

Operational Update:

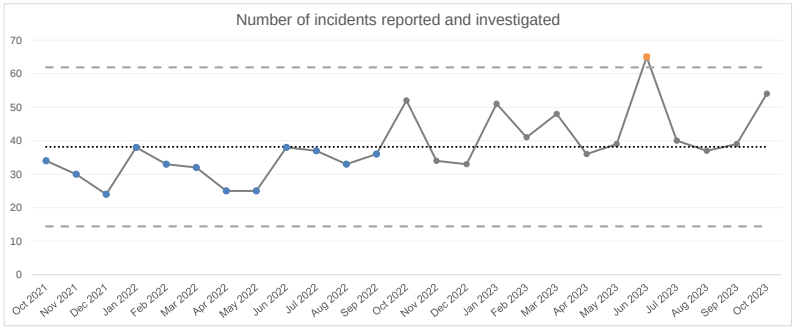
Number of open Tickets (Incidents + Requests) (last day of month)
- 30% open tickets are "Clock Stopped" awaiting user response/confirmation resolved.
- support teams are now becoming more familiar with using 4Me to improve resolutions. Work underway to expand use of Knowledge Article content and resolve more tickets using standardised solutions/guidance articles.

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.

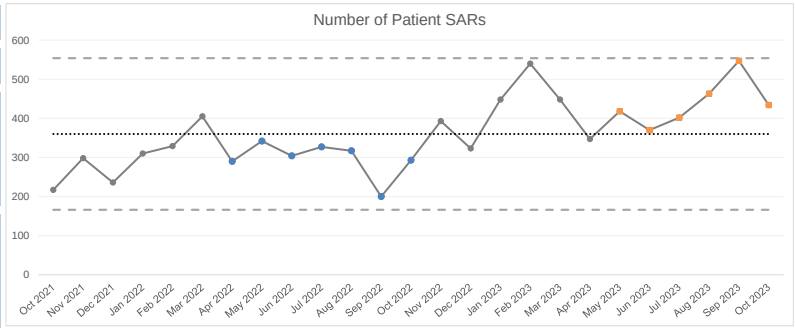
DIGITAL - Information Governance Indicators

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

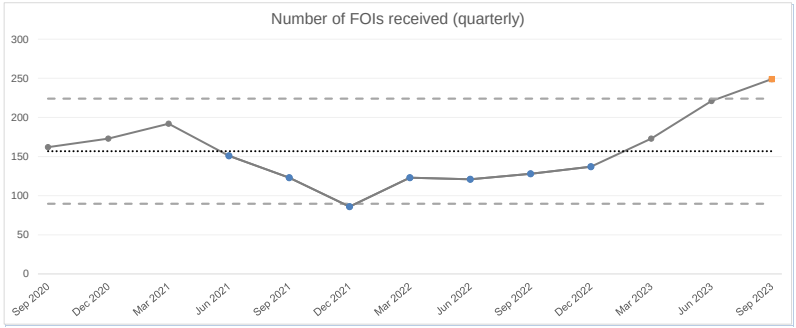
REPORTING MONTH : OCTOBER 2023



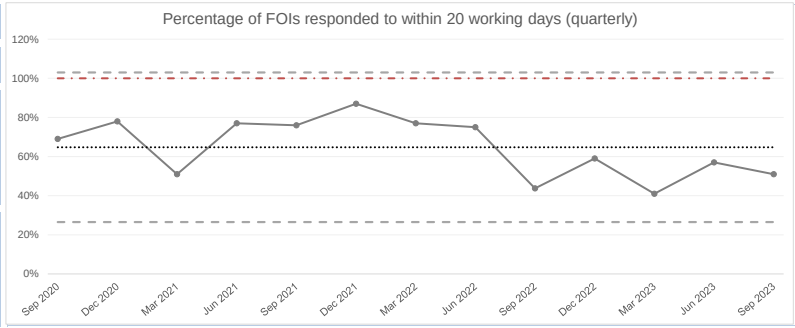
Oct 2023
54
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Oct 2023
434
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



Sep 2023
249
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



Sep 2023
51.0%
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, the data points have been above the mean since May 2023
Number of FOIs received (quarterly): This indicator is showing special cause variation in Sep 2023, with the data point being above the upper control limit.
Percentage of FOIs responded to within 20 days (quarterly): This indicator is showing common cause variation, however the latest five data points have been below the mean.

Operational Update:

Number of incidents reported and investigated:
There was an increase in incidents in June 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:	29 November 2023
Subject:	Financial Position – October 2023 (Month 7)
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 £31.0m against a planned deficit of £13.3m for the period to October 2023 (month 7). The Trust is £17.7m adversely adrift of plan.

Recommendation:

The Board of Directors is asked to discuss and note the October 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	21 November 2023	The report was discussed, and the financial position of the Trust was noted.

Financial Position – October 2023 (Month 7)

1. Summary Dashboard

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend
I&E Variance to Plan	£15.7m adverse	£17.7m adverse	↓ Deteriorating
Forecast Outturn I&E Variance to Plan	£0.0m	£0.0m	Static
Core CIP Delivery Variance to Plan	£0.4m Adverse	£0.9m Adverse	↓ Deteriorating
Core CIP Planning (£21.4m Target) Value Identified	£19.0m identified	£19.1m 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)	£3.1m Above	£3.7m Above	↓ Deteriorating
Month End Cash Position	£8.5m	£11.4m	↑ Improving
Capital Programme Variance to Plan	£2.7m behind plan	£0.6m behind plan	↑ Improving

2. Income and Expenditure Position

Summary Position

The I&E table confirms an actual adjusted deficit of £31.0m against a planned deficit of £13.3m for October. The Trust is £17.7m adversely adrift of plan.

TRUST PRIORITIES REPORT : October-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Income and Expenditure Account

	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	FOT £000's
NHS England	81,538	47,564	50,734	3,170	85,668
Integrated Care Boards	556,134	325,169	328,013	2,843	556,425
Local authorities	4,821	2,812	2,795	-18	4,851
Non-NHS: private patients	344	200	509	309	939
Other Operating Income from Patient Care	1,466	855	1,042	187	1,746
Operating Income from Patient Care Activities	**644,303**	**376,601**	**383,093**	**6,492**	**649,629**
Research and development	1,614	941	1,621	680	2,874
Education and training	20,738	12,287	12,915	628	20,925
Other income	37,135	21,708	26,983	5,275	43,120
Other Operating Income	**59,486**	**34,937**	**41,520**	**6,583**	**66,919**
Employee Expenses	-488,267	-284,622	-294,548	-9,926	-488,322
Drugs Costs	-59,997	-35,134	-43,274	-8,141	-68,776
Supplies and Services - Clinical	-67,712	-39,922	-47,991	-8,069	-73,113
Depreciation	-20,281	-11,831	-11,831	0	-20,281
Amortisation	-1,641	-957	-957	0	-1,641
CIP	12,698	858	0	-858	12,698
Other Costs	-83,056	-47,176	-51,842	-4,667	-82,939
Total Operating Expenditure	**-708,256**	**-418,782**	**-450,444**	**-31,661**	**-722,374**
OPERATING SURPLUS/(DEFICIT)	**-4,467**	**-7,245**	**-25,832**	**-18,587**	**-5,826**
Finance income	830	484	1,157	673	2,250
Finance expense	-956	-272	-561	-288	-956
PDC dividends payable/refundable	-10,800	-6,300	-5,740	560	-10,800
NET FINANCE COSTS	**-15,393**	**-13,333**	**-30,975**	**-17,642**	**-15,332**
Other gains/(losses) including disposal of assets	0	0	-61	-61	-61
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**	**-13,333**	**-31,036**	**-17,703**	**-15,393**
Remove Donated Asset Income	-800	-469	-467	2	-800
Remove Donated Asset Depreciation	740	432	431	0	740
Remove Donated Asset Amortisation	28	16	16	0	28
Remove Peppercorn Depreciation	11	6	7	0	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**	**-13,347**	**-31,048**	**-17,701**	**-15,414**

Corporate Overview of Key Drivers

Variance	Favourable/ (adverse) £000	Commentary
Strike Impact – lost income	-2.256	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	-1,010	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 strikes, is £2.50m. 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 £1.49m, thereby leaving a net pressure of £1.01m.
ERF ahead of plan	607	Elective activity has significantly increased in October representing a £1.5m favourable swing in month and is now back ahead of plan. The assessed increased ERF payable to the Trust at M7 is £2.09m of which £1.49m is linked to the 2% reduction in the ERF target and offset against the strike costs incurred above.
CIP Shortfall	-858	Included in the reported position. See section 4 below.
Stretch Target Shortfall	-3,309	Included within the reported position. Current full year shortfall is £7.4m.
Short funding of 2023/24 Agenda for Change and Medical pay awards	-1,142	Equates to £2.0m annual shortfall (£1.2m A4C; £0.8m Medical) for full establishment. Although the pressure for staff in post for the period is £0.27m, 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	-2,837	Relates to covering vacancies. Total agency overspending is £3.7m, with minimal levels relating to the cost of covering strike action included above. £0.9m of the pressure is linked to the pay award shortfalls referred to above.
Covid test costs more than allocation	-306	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	-5,639	These were previously contracted with commissioners on a pass-through cost basis but are now fixed 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. Of this sum, £4.4m is an increase over the M6 22/23 outturn spend levels.

Treatment area	£	Drug or Device	Comment
Drugs			
Wet AMD	-381,790	Aflibercept, Ranibizumab, Faricimab	
Crohn's Disease or Ulcerative Colitis (IBD)	-980,726	Ustekinumab, Vedolizumab, Infliximab, Certolizumab Pegol	
Rheumatoid Arthritis	-342,221	Baricitinib, Abatacept, Tofacitinib	Following further analysis, the key driver for these increases in cost have been established as volume driven, with minimal price impact,
Plaque Psoriasis, Psoriatic Arthritis, and Ankylosing Spondylitis	-725,739	Risankizumab, SECUKINUMAB	
Auto Immune, Rhumatoid Arthritis	-217,767	Etanercept, adulimumab	
Other	-1,066,863		
	-3,715,107		
Devices			
Sleep Apnoea	-178,596	CPAP machines	
Diabetic Pumps	-563,140	Insulin Pumps and Consumables, Continuious Glucose Monitoring Systems, Insulin I-Ports	
Other	72,878		
	-668,859		
Unbundled Radiology	-846,911		
Pathology Direct Access	-408,000		
	-5,638,877		

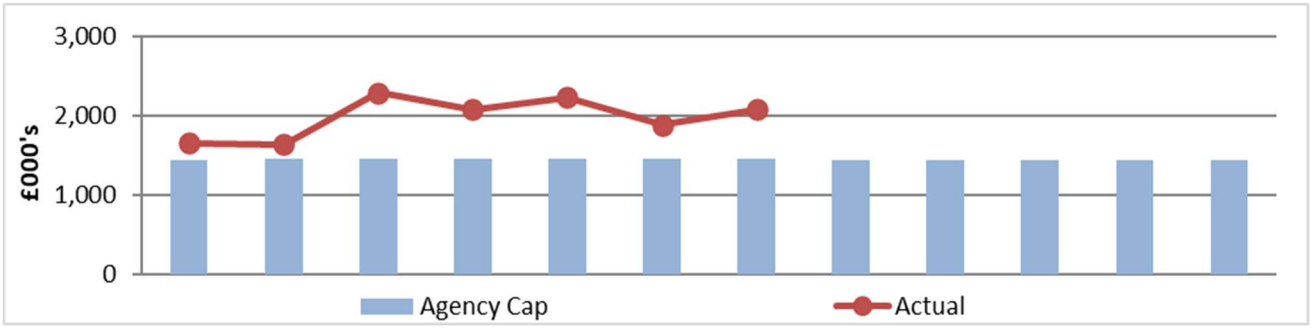
Key Subjective Variances

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	3,170	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	2,843	Predominantly linked to ERF being ahead of plan boosted by NHSEs 2% reduction in the ERF baseline to compensate for the April strikes.	No mitigation or action required
Other income	5,275	Primarily relates to the sale and leaseback of mattresses and endoscopes, which is offset by increased costs under clinical supplies and services; and income for hosting the Collaboration of Acute Providers.	No mitigation or action required
Employee Expenses	-9,926	Agency, bank and WLI spending is ahead of plan to cover vacancies and in part to cover during strike action. There is a funding shortfall on both the 23/24 A4C and Medical 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 and response to the CQC 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	-8,141	Relates to high-cost drugs and devices (£3.1m), 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; and increased homecare drug costs.	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	-8,069	Relates to sale and leaseback of mattresses and 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. Increased spending on blood products, reagents, disposables.	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	-858	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	-4,667	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 October expenditure on agency staffing was £3.7m 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 agreed but as yet undrawn CQC and nursing investments.

The table illustrates that a key driver for the pay position is spend against Medical and Dental staff, although establishment is under plan. The key drivers for the residual adverse variance include the cost of strike cover, and agency cover for vacant posts across the Care Groups.

	Establishment			Year to Date Expenditure		
	Budget WTE	Actual WTE	Variance WTE	Budget £000	Actual £000	Variance £000
Registered Nurses	2,434.65	2,300.79	133.86	75,301	76,016	-715
Scientific, Therapeutic and Technical	1,237.29	1,178.14	59.15	37,557	36,693	864
Support To Clinical Staff	1,871.11	1,626.83	244.28	35,045	35,538	-493
Medical and Dental	1,026.40	979.70	46.70	75,614	84,569	-8,955
Non-Medical - Non-Clinical	3,047.44	2,838.24	209.20	59,947	60,683	-737
Reserves				156	0	156
Other				1,002	1,049	-46
TOTAL	**9,616.89**	**8,923.70**	**693.19**	**284,622**	**294,548**	**-9,926**

3. 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 £2.1m surplus for the period to M7.

This position includes the 2% reduction on the Trust's elective target confirmed by NHSE as acknowledgement of the impact the strikes have had on elective activity and represents a £1.5m improvement on the prospective surplus reported last month. ICB activity continues to be ahead of the revised 102% target value, whereas NHSE Specialist Commissioned activity continues to remain behind plan.

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) v7 baseline inc strike	ERF Month 7 Phase (Av 58.385%)	Activity to Month 7 Actual	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	101.63%	£122,845,481	£71,723,334	£74,087,484	£2,364,150	105.0%
West Yorkshire	101.00%	£1,292,492	£754,622	£624,157	-£130,465	83.5%
Cumbria and North East	113.00%	£162,882	£95,099	£102,406	£7,307	121.7%
South Yorkshire	119.00%	£144,649	£84,453	£77,334	-£7,119	109.0%
Other ICBs - LVA / NCA	-	£581,389	£339,444	£318,761	-£20,683	-
All ICBs	***102.00%***	***£125,026,893***	***£72,996,952***	***£75,210,142***	***£2,213,191***	**105.09%**
NHSE Specialist Commissioning	113.00%	£4,489,000	£2,620,903	£2,523,387	-£97,515	108.8%
Other NHSE	101.00%	£269,196	£157,170	£134,313	-£22,857	86.3%
All Commissioners Total	**102.00%**	**£129,785,089**	**£75,775,024**	**£77,867,842**	**£2,092,818**	**104.8%**

4. Cost Improvement programme

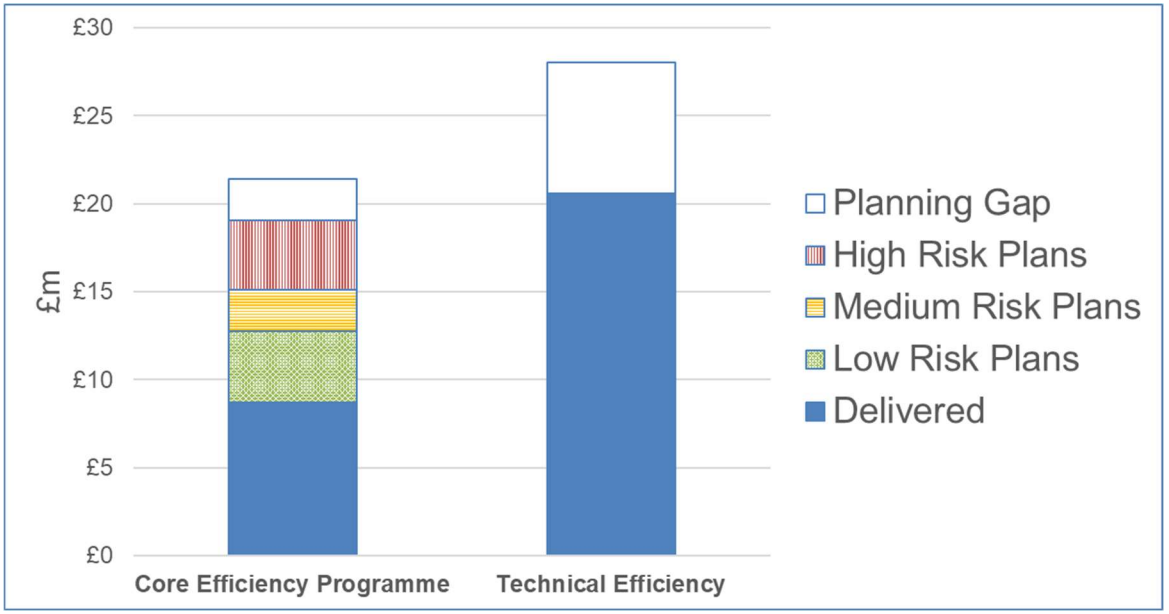
Summary Position

	Full Year CIP Target	October Position			Planning Position		Planning Risk		
		Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Core Efficiency Programme	£21,389	£6,853	£5,994	£858	£19,055	£2,334	£12,763	£2,361	£3,931
Technical Efficiency	£28,059	£15,076	£11,767	£3,309	£20,613	£7,446	£20,613	£0	£0
Total Efficiency Programme	**£49,448**	**£21,929**	**£17,761**	**£4,167**	**£39,668**	**£9,780**	**£33,376**	**£2,361**	**£3,931**

The core efficiency programme requirement for 2023/24 is £21.4m. This is the core value to be removed from operational budgets as we progress through the financial year and deliver cash releasing savings.

Through the financial plan presentations NHSE required technical efficiencies, covid spend reductions, estimated productivity gains, and the stretch target to be expressed as CIPs. These total a further £28.1m and are shown separately within this report as technical efficiencies.

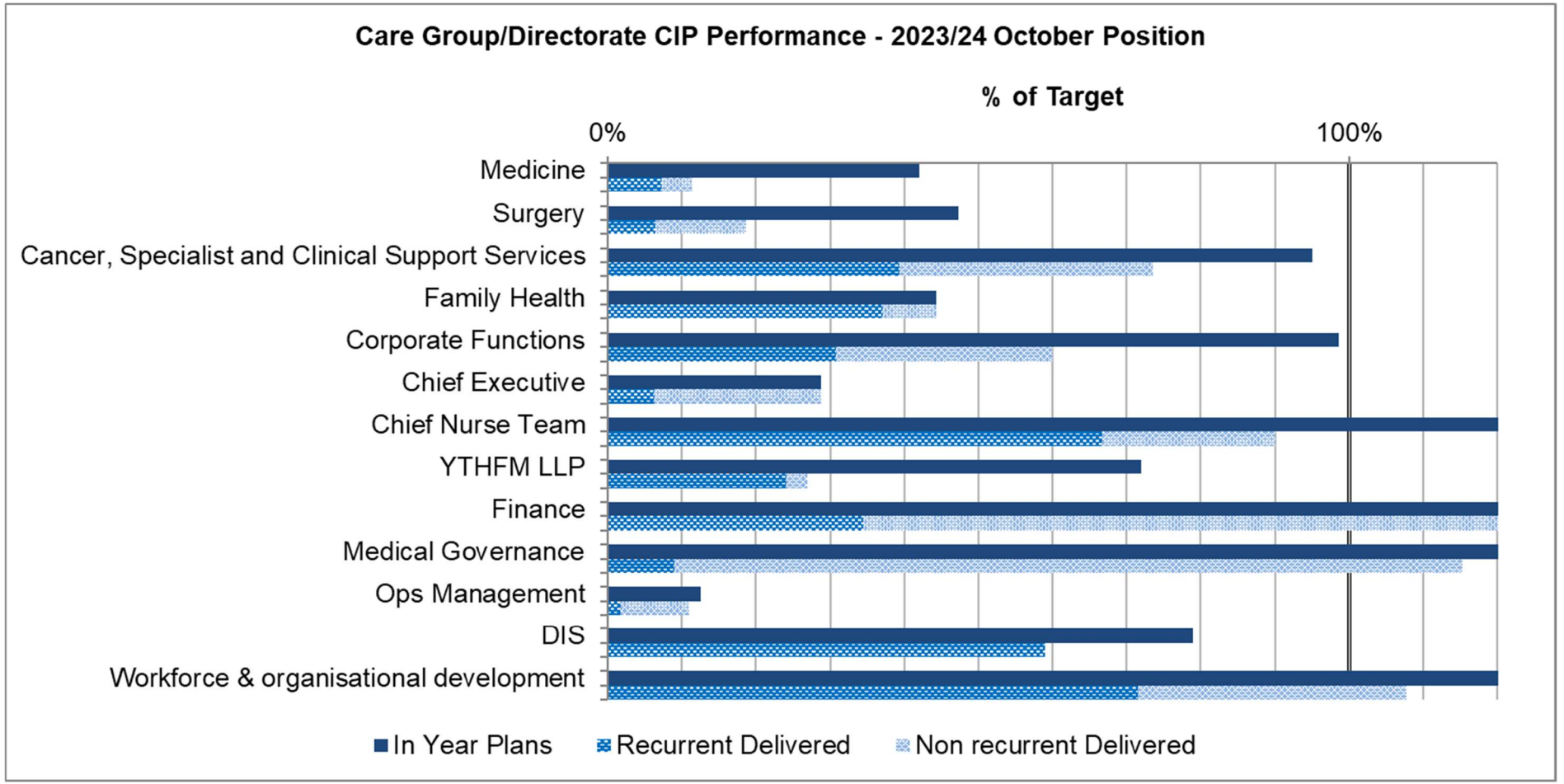
This gives a combined total efficiency target of £49.5m



In-Year Performance by Care Group, Directorate and YTHFM LLP.

2023/24 Cost Improvement Programme - October											
2023/24 Cost Improvement Programme - Technical CIP - October											
				October Position				**Planning Position**		**Planning Risk**	
		Full Year CIP Target		**Target**	**Delivery**	**Variance**		**Total Plans**	**Planning Gap**	**Low**	**Medium**	**High**
Technical CIP		**£28,059**		**£15,076**	**£11,767**	**£3,309**		**£20,613**	**£7,446**	**£20,613**	**£0**	**£0**
2023/24 Cost Improvement Programme - Core CIP - October											
				October 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
Medicine		£7,164		£2,295	£580	£1,715		£3,013	£4,150	£2,225	£749	£40
Surgery		£5,475		£1,754	£744	£1,010		£2,590	£2,884	£2,270	£320	£0
Cancer, Specialist and Clinical Support Services		£3,995		£1,280	£2,080	-£800		£3,795	£200	£3,708	£0	£87
Family Health		£2,073		£664	£533	£131		£920	£1,153	£920	£0	£0
Corpotate Functions												
Chief Exec		£130		£42	£34	£8		£37	£93	£37	£0	£0
Chief Nurse Team		£270		£86	£168	-£81		£358	-£88	£358	£0	£0
Finance		£92		£30	£502	-£473		£653	-£560	£653	£0	£0
Medical Governance		£83		£27	£82	-£56		£141	-£58	£141	£0	£0
Ops Management		£303		£97	£31	£66		£38	£265	£38	£0	£0
Corporate CIP		£0		£0	£813	-£813		£6,093	-£6,093	£1,618	£894	£3,581
DIS		£260		£83	£89	-£6		£205	£55	£205	£0	£0
Workforce & OD		£145		£46	£109	-£63		£205	-£60	£205	£0	£0
Sub total		**£19,988**		**£6,404**	**£5,765**	**£639**		**£18,047**	**£1,941**	**£12,377**	**£1,963**	**£3,707**
YTHFM LLP		£1,400		£449	£229	£219		£1,008	£392	£386	£399	£224
				.								
Core Programme - Group Total		**£21,389**		**£6,853**	**£5,994**	**£858**		**£19,055**	**£2,334**	**£12,763**	**£2,361**	**£3,931**
CIP PROGRAMME TOTAL		**£49,448**		**£21,929**	**£17,761**	**£4,167**		**£39,668**	**£9,780**	**£33,376**	**£2,361**	**£3,931**

The graph below summarises the Core programme in year planning position vs target, and the split of actual recurrent and non-recurrent delivery by Care Group, Directorate and YTHFM LLP.



Key points to note are:

- £670k of savings were actioned during October, 80% of which was non recurrent schemes.
- Four care groups/directorates are currently fully planned; Finance, Medical Governance, DIS, and Workforce & Organisational Development.

- Finance, Medical Governance and Workforce & Organisational Development have delivered their CIP targets in full, albeit with a significant proportion non-recurrently.

Long Term Planning

The current 4-year planning position for the Core CIP Programme shows a gap of £23.5m against the target of £54.9m.

Work is ongoing with Care Groups, Directorates, and YTHFM LLP to reduce this figure by identifying both in year savings schemes and medium to long term schemes.

2023/24 Cost Improvement Programme - Core CIP 4 Year Planning Position				
Care Group	**4 Year Target**		**4 Year Plans**	**Gap in Plans**
	£000		£000	£000
Medicine	£16,968		£3,416	£13,552
Surgery	£12,508		£7,029	£5,479
Cancer, Specialist and Clinical Support Services	£12,425		£4,987	£7,438
Family Health	£5,145		£1,712	£3,433
Corpotate Functions				
Chief Exec	£237		£37	£199
Chief Nurse Team	£610		£418	£193
Finance	£617		£672	-£54
Medical Governance	£106		£141	-£35
Ops Management	£521		£38	£483
Corporate CIP	£0		£10,368	-£10,368
DIS	£798		£205	£593
Workforce & OD	£696		£331	£366
Sub total	**£50,632**		**£29,354**	**£21,278**
YTHFM LLP	£4,235		£1,969	£2,266
Core Programme - Group Total	**£54,868**		**£31,324**	**£23,544**

Key Risks

- **Planning Risk 2023/2024** - as part of the overall planning guidance there is an expectation that we plan and identify how we will deliver recurrent savings by the end of Q3 to compensate for any non-recurrent delivery in the year. The planning gap of £2.3m and the value of the High and Medium Risk plans (£6.3m combined) highlight the significant challenge faced by the Trust to meet this.

  We also need to factor into this the requirements of meeting the targets for Elective Recovery which will be the CG's focus and which in the main will provide productivity gains but not necessarily cash releasing efficiencies.

  It should be noted that the recent Care Group re-structure may present a further risk to the delivery of the programme if momentum is temporarily lost.

- **Planning for future years** - the current 4-year planning gap represents a big risk to future years' CIP delivery. Work continues to identify plans which will help to close this gap and ensure work begins now to ensure delivery in those future years.

- **Cash releasing efficiencies** - a real challenge exists to realise cash releasing savings. The work ongoing through the deep dives will have an element of cash releasing, however, we are finding that most opportunities are non-cash releasing (improving productivity being the main theme). Opportunities remain around Procurement however these are not as great as previous years due to the economy at present. Collaboration across the Integrated Care System (ICS) may produce some real system opportunities. This will be discussed with the Procurement Lead.

  The majority of workstreams within the Elective Recovery Programme relate to the recovery of elective activity and as such will not realise cash releasing savings.

- **Recurrent delivery** - at Month 7, recurrent delivery is £2.9m (£5.4m FYE) which is 43% of the Core Programme YTD target (25% FYE). Care Groups, Directorates and YTHFM LLP have reviewed non-recurrent delivery from 22/23 and converted these to recurrent, where feasible, in 2023/24. These savings are included in the above figures.

5. 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.

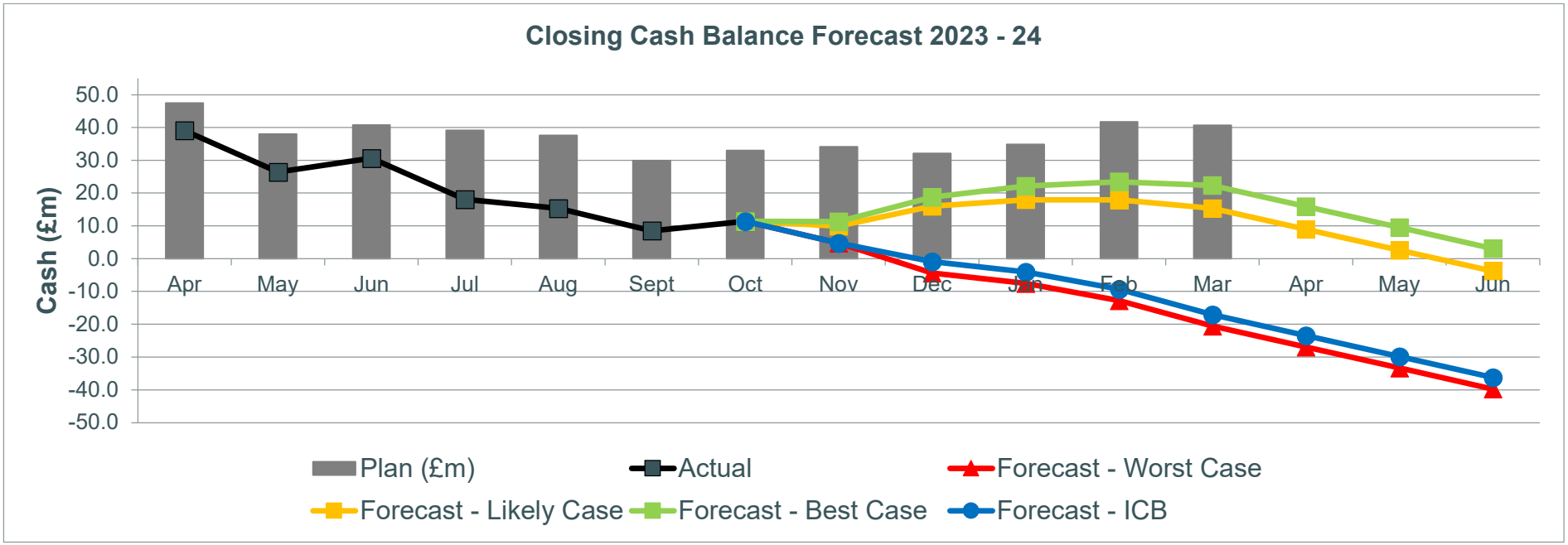
October's cash balance showed a £21.5m adverse variance to plan, which is mainly due to the creditors and accrued expenditure being below plan (£4.8m) and the I&E position behind plan (£17.7m). These negative impacts are offset by the positive impact of the debtors and accrued income position being below plan (£1.7m). The table below shows our current planned month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	47,455	37,960	40,729	39,099	37,524	29,841	32,947	34,072	32,068	34,842	41,691	40,625
Actual	39,054	26,392	30,644	18,082	15,382	8,523	11,426					

An application to NHSE for cash support was made during September to access £15m of cash support during Q3. £5m of support has been approved to draw in November. We are awaiting approval of the December application. Discussions are ongoing with the ICB to identify any opportunities where the ICB can support the Trust from a cash perspective.

The cash scenario graph below shows the cash position based on the actual cash balance at the end of October with income and expenditure in line with current run rates so in effect the worst-case scenario. This has been adjusted to model the latest scenarios of best and likely cases emerging from the recovery plan actions. The cash support anticipated for December is included within the best and likely cases but is not within the worst case due to pending approval. An additional forecast has been included to model the ICB actions outlined above.

Each scenario has been extended in to the first quarter of 2024/25 to provide illustrations of the potential cash trajectories. In the absence of clarity around funding allocations, high level assumptions have been made using the current cash run rates of income and expenditure.



The Board are aware that we have managed supplier payments closely through October to prioritise cash availability for the payment of monthly salaries. This has impacted on the Better Payments Practice Code (BPPC) in section 7 below. We will continue to manage supplier payments closely through November.

6. Current Capital Position

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

Capital Plan 2023-24 £000s	Capital FOT 2023-24 £000s	Mth 7 Planned Spend £000s	Mth 7 Actual Spend £000s	Variance £000s
45,852	61,863	19,438	18,795	-643

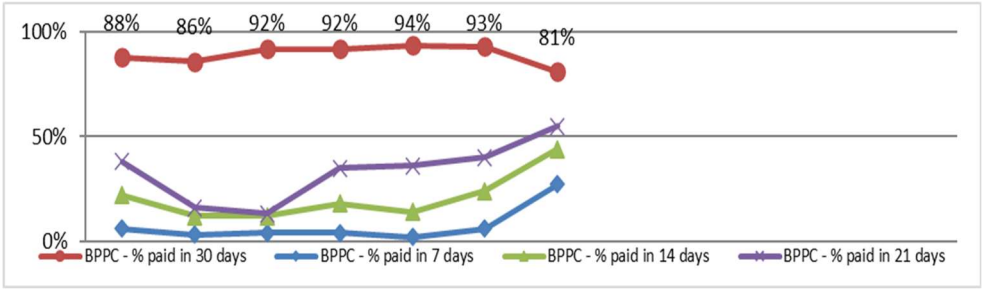
The capital programme at month 7 is £643k behind plan. This is a significant improvement on previous months. Of this, £324k relates to IFRS 16 leases. Several equipment leases went live in October which positively influenced the expenditure position.

If we remove the impact of IFRS 16 figures the capital programme is £319k (2%) behind plan. This is due to the Scarborough UEC scheme (£1m) running behind the planned expenditure profile offset by other schemes running ahead of plan.

Most of the capital programme allocation has now been approved, this leaves £0.9m discretionary expenditure to be allocated, which is currently under review by Care Group teams.

7. Better Payment Practice Code (BPPC)

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



The table illustrates that in October the Trust managed to pay 81% of its suppliers within 30 days.

8. 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 and as required by NHSE for M7; 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

	Summary of Recovery Programme		
	Worst Case Scenario	**Most Likely Scenario**	**Best Case Scenario**
	£	**£**	**£**
Current Forecast			
Forecast outturn at M6 before any recovery actions	-43,449,000	-43,449,000	-43,449,000
2023/24 Plan	-15,414,000	-15,414,000	-15,414,000
Distance from plan	**-28,035,000**	**-28,035,000**	**-28,035,000**
Recovery Actions			
(a) Potential additional income	5,775,138	8,275,138	11,120,138
(b) Internal recovery to stop/reduce spending	3,975,904	8,189,132	10,608,549
(c) Resolution of pressures on the Block contract from previously pass-through costs	0	5,743,834	6,306,313
Revised Forecast	**-33,697,958**	**-21,240,896**	**-15,414,000**
Revised Distance from Plan	**-18,283,958**	**-5,826,896**	**-0**

Following the finalisation of the month 7 financial position, NHSE briefed out to the wider NHS that a series of additional allocations would be made in time for month 8 reporting. These would primarily address the strike pressures being experienced by the Provider

sector. We are currently working through the detail of this funding in the context of how this will impact the forecast information. The Board will be updated under a separate report as at the tie of finalising this report the detail was not known.

9. Recommendation

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

Research & Development Performance Report : Oct-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 1396 accruals so far, we are struggling to open news studies due to lack of clinical engagement.

•We have had confirmation that the CRN the high-level objectives have changed. Trusts will now only be monitored on Recruitment to Time and Target for open studies and that we must make sure 80% of our studies (not 60% as it was originally) are on target as of the 31st March. Currently we are 100% for commercial studies and 65% for non-commercial studies. We are looking at the data to ensure we got up to as near as we can to 80% by March.

•We have submitted two grants this month

- £149,646 submitted to 2nd Stage to National Institute for Health Research A mixed methods study using co-production to develop an intervention to help nurses improve the assessment and care of the sexual health needs of men with Inflammatory Bowel Disease (MenSH-IBD). Led by Sara Ma
- £10,922 submitted to Royal College of Emergency Medicine Feasibility study to demonstrate patient acceptability and system performance of DAISY in the Emergency Department. Led by Dr Ol'Tunde Ashaolu

•I'm thrilled to say we won an award £149,700 submitted to Integrated Care System Research Network Development Programme – Phase 2 Funding Focus on engaging our coastal communities in research via our VCSE partners Led by Lydia Harris and Lisa Ballantine. The majority of the income will go the VSCE sector but we do have some funds within this ward to pay for our staff contribution to this work.

•We continue to work with the community and volunteer sector at Scarborough and we are working hard 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 are working with academics from Leeds Beckett University for this submission.

•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 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: Nov-2023

TRUST PRIORITIES REPORT : October 2023

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023-24	170	225	377	251	198	184	195						1600
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 September 2023

Care Groups	Accruals Running Total 23/24
Medicine (York) Total	422
Medicine (Scarborough) Total	282
Surgery Total	173
Cancer, Specialist & Clinical Support Total	442
Family Health Total	0
Cross Trust Studies Total	281
ACCRUAL TOTALS	1600

Accruals Still Required	1900
Trials Open to Recruitment	75

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	49%	46%	*Weighted 11*
Observational	34%	16%	*Weighted 3.5*
Large Interventional	5%	3%	*Variable weighting by study*
Large Observational	7%	34%	*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	0%	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 : OCTOBER 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 10/11/2023
* 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%)	Oct-23	65%	70%	68	39/119	*Oct 23
	UEC	ED - Median Time to Initial Assessment (Minutes)	Oct-23	19	18	25	90/120	*Sep 23
	RTT	RTT - Total Waiting List	Oct-23	51670	48146	35	111/171	*Sep 23
	RTT	RTT - Waits over 104 weeks for incomplete pathways	Oct-23	0	0	15	146/171	*Sep 23
	RTT	RTT - Waits over 78 weeks for incomplete pathways	Oct-23	86	0	16	143/171	*Sep 23
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Oct-23	4	59 (12-month)	9	123/135	*Aug-23
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Oct-23	12	116 (12-month)	9	123/135	*Aug-23
	Patient Experience	Trust Complaints	Oct-23	82	No Target	23	162/210	*Q4 21/22

TPR: Icon Summary Matrix - Elective Recovery (i)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F	◌	Total
Improvement		**1**	**3**		**4**
H			1		**1**
L		1	2		**3**
Common Cause		**7**	**5**		**12**
		7	5		**12**
Concern	**1**	**2**	**4**		**7**
H	1	1	4		**6**
L		1			**1**
Neither					
↗					
↘					
Empty					
◌					
Total	**1**	**10**	**12**		**23**

MetricName	Date	Variation	Assurance	Target	Latest Value
% of patients waiting 63 or more days after referral from cancer PTL	2023-10	L	?	12.0	12.0
Cancer - 62 Day 85th centile waits	2023-09	H	F	62.0	114.0
Cancer - 62 Day waits for first treatment (from urgent GP referral)	2023-09		F	85.0	49.8
Cancer - Faster Diagnosis Standard	2023-09	L	?	70.7	48.3
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2023-10	H	?	152.0	405.0
Cancer 2 week wait (all cancers)	2023-09		F	93.0	67.9
Cancer 2 week wait (breast symptoms)	2023-09		?	93.0	70.8
Cancer 31 day wait for second or subsequent treatment - drug treatments	2023-09		?	94.0	98.0
Cancer 31 day wait for second or subsequent treatment - surgery	2023-09		?	94.0	87.5
Cancer 31 day wait from diagnosis to first treatment	2023-09		?	96.0	96.4
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	2023-09		?	90.0	86.1
Cancer treatment volumes (Total number of patients receiving first definitive treatment for cancer)	2023-09		?	149.0	151.5
Diagnostics - Proportion of patients waiting <6 weeks from referral	2023-10	H	F	95.0	63.6
Diagnostics: 99th centile all (not split by modality)	2023-10	H	F	6.0	62.0
Diagnostics: 99th centile, split by: Cardiology û echocardiography	2023-10		F	6.0	27.0
Diagnostics: 99th centile, split by: Colonoscopy	2023-10	H	F	6.0	71.0
Diagnostics: 99th centile, split by: Computed tomography	2023-10	L	F	6.0	18.0
Diagnostics: 99th centile, split by: Flexi sigmoidoscopy	2023-10	H	F	6.0	71.0
Diagnostics: 99th centile, split by: Gastroscopy	2023-10		F	6.0	44.0
Diagnostics: 99th centile, split by: Magnetic resonance imaging	2023-10		F	6.0	36.0
Diagnostics: 99th centile, split by: Non-obstetric ultrasound	2023-10	L	F	6.0	22.0
Number of people referred onto a non-specific symptoms pathway	2023-09	H	P	79.0	63.0
Total Endoscopy Surveillance Backlog (Red)	2023-10		?	713.5	628.0

TPR: Icon Summary Matrix - Elective Recovery (ii)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F		Total
Improvement	**1**	**2**	**2**		**5**
H	1	1	1		**3**
L		1	1		**2**
Common Cause	**1**	**11**	**2**		**14**
?	1	11	2		**14**
Concern		**2**	**2**		**4**
H		1	1		**2**
L		1	1		**2**
Neither					
↗					
↘					
Empty					
○					
Total	**2**	**15**	**6**		**23**

MetricName	Date	Variation	Assurance	Target	Latest Value
% of SLA	2023-10	?	?	90.0	80.1
AHP Outpatients: DNA rates	2023-10	?	?	8.5	7.4
AHP Outpatients: 1st Attendances	2023-10	H	?	2422.7	2991.0
AHP Outpatients: 1st to FU Ratio	2023-10	?	?	2.2	2.0
AHP Outpatients: Follow Up Attendances	2023-10	H	?	5350.1	5863.0
AHP PIFU %	2023-10	H	P	4.2	11.6
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-...	2023-09	?	?	0.0	21.0
Day Cases (based on Activity v Plan)	2023-10	?	?	6326.0	7022.0
Electives (based on Activity v Plan)	2023-10	?	F	732.0	516.0
No urgent operation should be cancelled for a second time*	2023-10	?	P	0.0	0.0
Outpatients - DNA rates	2023-10	L	F	5.0	5.1
Outpatients - Proportion of appointments delivered virtually (S017a)	2023-10	L	F	25.0	19.8
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2023-10	H	F	4.2	3.3
Outpatients: 1st Attendances	2023-10	?	?	15057.0	14294.0
Outpatients: All Referral Types	2023-10	?	?	20770.8	19862.0
Outpatients: Consultant to Consultant Referrals	2023-10	?	?	2030.7	1737.0
Outpatients: Follow Up Attendances	2023-10	?	?	40666.0	36558.0
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2023-10	H	F	0.0	27439.0
Outpatients: GP Referrals	2023-10	?	?	10067.8	9802.0
Outpatients: Other Referrals	2023-10	?	?	8672.3	8323.0
Specialist Advice (including A&G) activity levels (S016a)- Placeholder	2023-10	L	?	4182.0	2874.0
Theatres: Touch Time Utilisation	2023-10	?	F	85.0	82.1
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2023-10	L	?	99.0	52.5

TPR: Icon Summary Matrix - Elective Recovery (iii)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F		Total
Improvement			**3**		**3**
H					
L			3		**3**
Common Cause		**2**			**2**
		2			**2**
Concern	**1**	**4**	**3**		**8**
H	1	2	2		**5**
L		2	1		**3**
Neither					
↗					
↘					
Empty					
Total	**1**	**6**	**6**		**13**

MetricName	Date	Variation	Assurance	Target	Latest Value
Number of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways at end of month*	2023-10	H	P	944.1	1099.0
Percentage of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways under 4 weeks at end of m...	2023-10	L	?	54.7	54.2
Proportion of BAME pathways on RTT PTL (S056a)	2023-10		?	1.8	1.8
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2023-10		?	12.0	12.0
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2023-10	L	?	68.5	67.7
RTT - 92nd centile RTT weeks wait	2023-10	H	F	18.0	50.0
RTT - Mean Week Waiting Time - Incomplete Pathways	2023-10	H	F	9.0	21.4
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2023-10	L	F	92.0	50.7
RTT - Total Waiting List	2023-10	H	?	48146.0	51670.0
RTT - Waits over 104 weeks for incomplete pathways	2023-10	L	F	0.0	0.0
RTT - Waits over 52 weeks for Incomplete Pathways	2023-10	H	?	3529.0	3606.0
RTT - Waits over 65 weeks for Incomplete Pathways	2023-10	L	F	610.0	949.0
RTT - Waits over 78 weeks for incomplete pathways	2023-10	L	F	0.0	86.0

TPR: Icon Summary Matrix - Acute Flow

York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F		Total
Improvement		**2**			**2**
H		1			**1**
L		1			**1**
Common Cause	**1**	**4**	**9**		**14**
	1	4	9		**14**
Concern	**1**	**1**	**1**		**3**
H	1	1			**2**
L			1		**1**
Neither					
↗					
↘					
Empty					
Total	**2**	**7**	**10**		**19**

MetricName	Date	Variation	Assurance	Target	Latest Value
% ED attendances streamed to SDEC Within 60 mins	2023-10	H	?	18.0	22.3
% of SDEC admissions transferred to downstream acute wards	2023-10	L	?	20.0	20.4
Daily discharges as % of patients who no longer meet the criteria to reside in hospital (S005a) (Trust total)	2023-10		?	33.4	30.6
ED - 12 hour trolley waits	2023-10		F	0.0	883.0
ED - Emergency Care Attendances	2023-10	H	?	18907.0	20588.0
ED - Emergency Care Standard (Trust level)	2023-10		?	73.6	68.3
ED - Emergency Care Standard (Type 1 level)	2023-10	L	F	73.6	41.7
ED - Median Time to Initial Assessment (Minutes)	2023-10		?	18.0	19.0
ED - Proportion of all attendances having an initial assessment within 15 mins	2023-10		F	66.0	40.5
ED - Proportion of all attendances seen by a Doctor within 60 mins	2023-10		F	55.0	23.1
ED - Proportion of Ambulance handovers waiting > 30 mins	2023-10		F	5.0	51.0
ED - Proportion of Ambulance handovers waiting > 60 mins	2023-10		F	10.0	26.1
ED - Proportion of Ambulance handovers within 15 mins	2023-10		F	65.0	22.4
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2023-10		F	150.0	2063.0
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2023-10		F	7.5	19.7
Inpatients - Proportion of patients discharged before 5pm	2023-10		F	70.0	64.8
Lost bed days for patients with no criteria to reside (monthly count) (>=7 LOS for Acute sites only)	2023-10		?	1883.7	2341.0
Non Elective Admissions (excl Paediatrics & Maternity) - based on date of admission	2023-10	H	P	5473.0	5218.0
Non Elective Admissions (Paediatrics) - based on date of admission	2023-10		P	988.0	827.0

TPR: Icon Summary Matrix - Community and Children and Young persons

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F	○	Total
Improvement			1		1
H					
L			1		1
Common Cause	1	9	1		11
?	1	9	1		11
Concern	2	2	1		5
H	1	1			2
L	1	1	1		3
Neither					
↗					
↘					
Empty					
○					
Total	3	11	3		17

MetricName	Date	Variation	Assurance	Target	Latest Value
% Community Therapy Team Patients Seen within 6 weeks of Referral	2023-10	L	?	66.6	66.9
% of End of Life Patients Dying in Preferred Place of Death	2023-10	?	?	79.6	76.9
2-hour Urgent Community Response (UCR) care Referrals	2023-10	?	?	75.3	73.0
2-hour Urgent Community Response (UCR) Compliancy %	2023-10	?	P	70.0	90.1
Children & Young Persons: Cancer 2 week wait (all cancers)	2023-09	?	?	93.1	100.0
Children & Young Persons: Diagnostics - Proportion of patients waiting <6 weeks from referral	2023-10	?	F	95.0	45.4
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2023-10	L	P	73.6	76.4
Children & Young Persons: ED - Patients waiting over 12 hours in department	2023-10	?	?	0.0	9.0
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2023-10	L	F	92.0	58.4
Children & Young Persons: RTT - Total Waiting List	2023-10	H	P	4533.8	4281.0
Children & Young Persons: RTT Waits over 65 weeks for incomplete pathways	2023-10	L	F	0.0	48.0
Community Inpatient Units Average Length of Stay (Days)	2023-10	?	?	24.3	20.0
Number of Adults (18+ years) on community waiting lists per system	2023-10	?	?	873.0	836.0
Number of District Nursing Contacts	2023-10	?	?	21235.6	20880.0
Number of Selby CRT Contacts	2023-10	H	?	2241.2	2756.0
Number of York CRT Contacts	2023-10	?	?	4792.0	5341.0
Referrals to District Nursing Team	2023-10	?	?	2127.2	2254.0

Report to:	Board of Directors
Date of Meeting:	29 November 2023
Subject:	Research & Development Update
Director Sponsor:	Polly McMeekin, Director of Workforce and OD
Author:	Lydia Harris, Head of Research and Development

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 paper is produced to update the Board of Directors on R&D activities, every quarter and provide assurance progress is made to deliver the R&D strategy.

Recommendation:
The report is read and discussed.

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
N/A	N/A	N/A

R&D Update May 2023 to November 2023

1. Introduction and Background

The R&D Department is a department that facilitates and delivers research across all our Care Groups, on most of our sites, with teams based in York, Scarborough, Labs and Pharmacy. We usually have about 100 clinical trials (commercial and non-commercial) running at any one time and are tasked by our main funder, Clinical Research Network, to support around 3000 patients into clinical trials every year, which we do.

We are not just about research though as we can support the Trust in income generation, raising the profile (internal and external) of the Trust thus improving recruitment and retention prospects by the work we do. Research is also key to workforce development and staff career progression/retention and recruitment.

2. Considerations

This report is an update on the team's progress since May 2023 and provides assurance on progress against the R&D strategy. Included is a section that identifies opportunities still progressing.

3. Current Position/Issues

3.1 Research update since May 2023 Research Metrics

We have recruited around 1400 patients into clinical trials so far this year with 65% of our trials being on track in terms of recruitment. This is important as the way we are measured by the Clinical Research Network has also changed this year with a much bigger focus on recruitment to time and target (so achieving the total number of patients you said you would in a trial on time). However, the accruals will still be important, and our figure is lower than where it is usually is at this time of year, to be on target we would need to be nearer 2200 now. This is for a variety of reasons, we have struggled to open studies due to lack of engagement with clinic staff, and we do have a high level of long term sickness in our research team this year which is having a significant impact

We have also seen early sight of the new proposed metrics from 2024 there appears to be a real focus on UK wide trial targets (not Trust specific targets) and how quickly a trial can get open to recruitment.

3.2 Grants, Collaborations and Strategic matters

- 7 grants have been submitted since the last report.
    - £149k to **National Institute for Health Research -** How does an Acute Care Model provide patient benefit and address compound pressure on the health and social care system in a rural coastal town in the North of England?: a qualitative study Led by Dr Bella Scantlebury, Dr Ed Smith, Dr Gerry Robins and Lisa Ballantine Been passed to 2nd and final Round
    - £3.24million to through to final stage to **National Institute for Health Research -** What is the diagnostic accuracy of colon capsule endoscopy

compared to standard colonoscopy? Led by Professor James Turvill Successful

- £149,700 submitted to **Integrated Care System Research Network Development Programme – Phase 2** - Funding Focus on engaging our coastal communities in research via our VCSE partners Led by Lydia Harris and Lisa Ballantine Successful
- £149,646 **National Institute for Health Research** - A mixed methods study using co-production to develop an intervention to help nurses improve the assessment and care of the sexual health needs of men with Inflammatory Bowel Disease (MenSH-IBD). Led by Sara Ma Been passed to 2nd and final Round
- £10,922 submitted to **Royal College of Emergency Medicine** - Feasibility study to demonstrate patient acceptability and system performance of DAISY in the Emergency Department. Led by Dr Ol'Tunde Ashaolu Unsuccessful
- £144,341 to **National Institute for Health Research Programme Development Grants Developing Innovative, Inclusive and Diverse Public Partnerships Call -** Turning the Tide - Creating an inclusive and sustainable community research partnership for Scarborough that will work to develop more system-focussed solutions for supporting regular physical activity. Led by Lisa Ballantine and Professor James McKenna (Leeds Beckett University) TBC just submitted
- £1,061,290.49 to **National Institute for Health Research Health and Social Care Delivery Research (HSDR) Programme -** Identifying innovative models of emergency care in rural and coastal areas in England: a mixed methods study Led by Led by Dr Bella Scantlebury, Dr Ed Smith, Dr Phil Dickinson and Lisa Ballantine TBC just submitted

As you can see, we can won our biggest research grant to date via Professor James Turvills NIHR bid, winning just over £3.0Million. In addition to this, and very importantly to the Trust, this will attract significant Research Capacity Funding to our hospital, for every year the study runs (three years) that can be spent on increasing research capacity in our Trust.

For example, see section 3.4 showing parts of the R&D strategy that we have yet to meet, many could be worked on if we had support to do so with the RCF income we are about to bring in.

On the 5th October we held an away day in Scarborough to talk to our stakeholders about what we should do with the (currently called) Multiple Long Term Conditions Research Hub based at Scarborough hospital. We had a lively discussion with about 40 attendees on how we should shape our research hub, discussing its new name, vision, objectives and aims. We are currently looking at the feedback from the day and deciding next steps.

However, our biggest issue with this is we cannot identify a clinical lead to support the research hub at Scarborough, due to all interested staff based at Scarborough being at capacity.

We have been successful is securing CPMG and Trust Charity funding to help convert a small space at Scarborough hospital to see our research patients. This is so important to us if we are to take on commercial studies as currently, we really struggle to see them as we have no dedicated space.

We are trying to build a stronger framework of research support and metrics in Care Groups and if possible, create research KPIs that are monitored and reported on quarterly. Further information to follow.

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

3.3 Update against the R&D Strategy

Overall we are still making very good progress against our R&D strategy, in reality there are a few aspirations we have been unable to achieve.

- Create a York Institute for Bioanalytics
- Recruit Clinical Academic in Data Science
- Increase commercial research funding by 20%
- Ensure we are placed within top 30 in national NIHR recruitment league table

3.4 Challenges

The research programme is progressing in the delivery of its strategy. This is a journey, potentially made more challenging by the current post-pandemic health and social care environment. Further engagement from the Care Groups is required to deliver our objectives. The specifics are listed below:

- Secure support and finance for research training (MsCs, ACFs. PhD stipends, MsC Bench fees etc)
- Increase by 25% number of staff per Care Group trained in Good Clinical Practice (across all professional groups)
- Ensure research is part of Trust statutory and mandatory training available for all staff and students
- Increase by 10% number of staff per Care Group trained as PI's (across all professional groups)
- Ensure all JDs/interviews/appraisals systems embed research into their processes
- Recognise research time in ALL research active staff rotas
- Develop our capacity and capability by recruiting and retaining the best research active staff and students.
- Implement consultant research SPA matrix to be part of Trusts consultant job planning.
- To recognise research time in research active AHP and Nursing & Midwifery job plans
- Secure support and funding for locally funded ACFs
- Secure funds to support local innovation and research awards
- Appointment of 1 x clinical academic per Care Group
- Create Performance Operating Framework (POF) for research activity
- Ensure research performance is routinely discussed at Care Group meetings

These are key if we wish to have a research active workforce and even more important now we are about to get some significant Research Capacity Funding.

3.5 Research Quality Assurance update

There are no issues of note to raise with the committee regarding quality assurance.

Research Quality Assurance May 2023- August 2023:

- 3 research related incident reports were submitted and investigated during the above period. None of the reported incidents resulted in a serious breach (no impact on patient safety or quality of research data). Upon further investigation 2/3 incidents related to participant eligibility. 1/3 incidents related to a participant consenting to the same study twice.
- There was one reported serious adverse reaction for the RADAR study.
- There were no serious Breaches to GCP or study Protocol.
- There has been one monitoring visit for a Trust Sponsored study, a system audit for the archiving facility, a routine audit for a hosted study and one for cause audit for a hosted study. No serious findings identified. Reports are in progress.

  A cause audit was conducted for the Concept study after the research nurse had identified multiple additional instances of unmasked members of the team performing masked visits. The Sponsor was advised that this had been identified and that QA would be conducting the audit. Multiple minor findings were identified by the audit however there were no serious findings. This has been communicated to the Sponsor and the research team is completing the actions.

  The first 'GCP and Research Processes' training that was delivered by QA was discussed. The session took place face to face at York Hospital and was well attended. Feedback so far was positive. Managers to ask staff who did not attend the session to attend future sessions. The next training will be delivered at Scarborough Hospital.

  Representatives from the key support departments for research (Pharmacy, Labs and Radiology) were present at the meeting and provided update on their services and quality assurance processes (equipment maintenance and temperature monitoring; log of deviations from SOPs, protocols or relevant standards; progress with archiving of research documents; relevant licences and certificates; reconciliation of the list of current research studies between their internal records and the main research database: EDGE).

  Portfolio of the home grown/ Trust sponsored research projects was discussed in the context of quality assurance, and the R&D Unit's responsibilities as a clinical research sponsor. Quarterly Review Forms were submitted for all active Trust sponsored studies and any outstanding actions highlighted, including risk assessment and quality control needs.
  None of the current Trust sponsored studies involve investigational medicinal products (IMP) or medical devices. The focus is on observational data collection, and sample collection projects with large recruitment targets: Autoflow (Dr Davies), YoGi (Dr Turvill), PinPoint (Dr Turvill), Fit5 (Dr Turvill). Since the previous meeting the MABY study (Nicola Spark) has now opened to recruitment.

4. Summary

We feel we could do a lot in the Trust to develop the research agenda further, alongside developing a research active and aware workforce

People and Culture – Chair's Assurance Report

Date of Meeting:	15 November 2023			**Quorate (yes/no):**	Yes	
Chair:	Jim Dillon (Chair)					
Members present:	Lorraine Boyd (NED), Matt Morgan (NED), Polly McMeekin, (DW&OD), Lucy Brown (Dir Comms), Dawn Parkes (Int. CN). Mike Taylor (ADCG)			**Key Members not present:**	Karen Stone (MD) – apologies given	
Trust priorities assured to Committee	**1. Our People**	**X**	**2. Quality and Safety**		**3. Elective Recovery**	
	4. Acute Flow					
BAF Risks assured to Committee	**PR1 - Quality Standards**		**PR2 - Safety Standards**		**PR3 - Performance Targets**	
	PR4 - Workforce	**X**	**PR5 - Inadequate Funding**		**PR6 - IT Service Standards**	
	PR7 - Integrated Care System		**Comments:**			

Key Agenda Items	RAG	Key Assurance Points	Action
None			

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

Report to:	Board of Directors
Date of Meeting:	29 November 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 20 October 2023.

There are 16 open enquiries with the CQC.

Recommendations:
The Quality Oversight Group is asked to:

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

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Quality Oversight Group	8 November 2023	Presented and accepted
Quality Committee	21 November 2023	*Not yet presented*

1. CQC Inspection Update

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

The Trust CQC Improvement Dashboard is held in **Appendix A**. Narrative updates and evidence to support the progress made with actions has continued to be logged in the improvement plan.

There is one action (with two sub-actions) which was not completed by the original target date of 31 October 2023. The detail is below:

Ref	Action	Outcome metric	Target Date to Complete	BRAG rating
▼ BRAG rating **Off track**				
72	**The trust must ensure that in Maternity, the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance**	• Up to date policies and guidelines. • Evidence of monthly IPC walk rounds, with outcomes, consecutively for three months • 85% of substantive staff in Maternity to have completed face-to-face Infection Prevention and Control training.	31/10/23	**Off track**
72.2	Regular monthly Infection Prevention and Control walk rounds will be undertaken in Maternity with the link Infection Prevention and Control Nurse.	Evidence of weekly IPC walk rounds, with outcomes, consecutively for three months	31/10/23	**Off track**
72.3	A programme of Face to face Infection Prevention and Control training will be developed and delivered to Maternity staff.	All substantive staff in Maternity to have completed face-to-face IPC training.	31/10/23	**Off track**

A schedule of infection prevention and control walkarounds is in development, led by the matrons, and the clinical skills midwives are focussed on improving compliance with the aseptic non touch technique (ANTT) training in November 2023.

There are also two actions which delivery by the original target date is at risk. **See Appendix B**.

If an action is considered 'complete', 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.

Two actions have been approved for closure at the Journey to Excellence meeting in October 2023 and two actions are showing as complete. These can be seen in **Appendix C**. The action closure forms are being drafted for completed actions.

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 20 October 2023.

3. 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.

At the time of writing this report, the content of the Mental Health Risk Assessment has been approved and the electronic assessment is currently in system testing.

4. CQC Cases / 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 three CQC cases in October 2023. Of these cases:

- One related to care within the new Emergency Department at York. The Chief Nurse initiated an on-site CQC Engagement Meeting focusing on the Emergency Department for 11 January 2024.
- One was regarding a complaint relating to an inpatient admission on ward 34. To note, four enquiries have been received from the CQC for ward 34 since January 2023.
- One requested further assurance on the fundamentals of care given to patients on ward 28.

At the time of writing (25 October 2023) the Trust had 16 open cases / enquiries. The majority of these remain open for the submission of finalised Serious Incident Reports.

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

5. CQC Updates

The State of Care Report 2022/23
The CQC annual assessment of the state of health care and adult social care in England has been published.

The State of Care Report looks at the trends, shares examples of good and outstanding care and highlights where care needs to improve. Click here to view the report.

New Regulatory Approach
From 21 November 2023, the CQC will start using our new single assessment framework in our South region.

Between 21 November 2023 and 4 December 2023 the CQC will undertake a small number of planned assessments with 14 early adopter providers. The new assessment approach will then be expanded to all providers based on a risk-informed schedule.

6. Recommendations

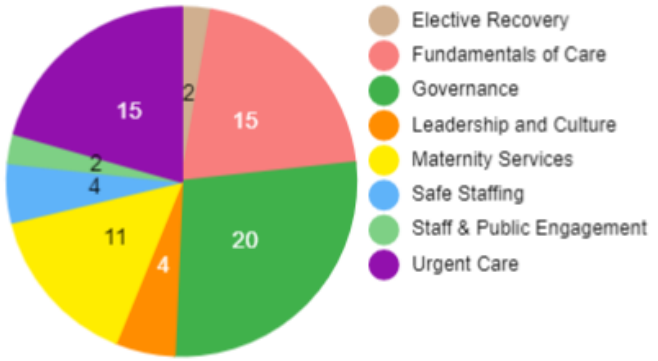
The Board of Directors is asked to:

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

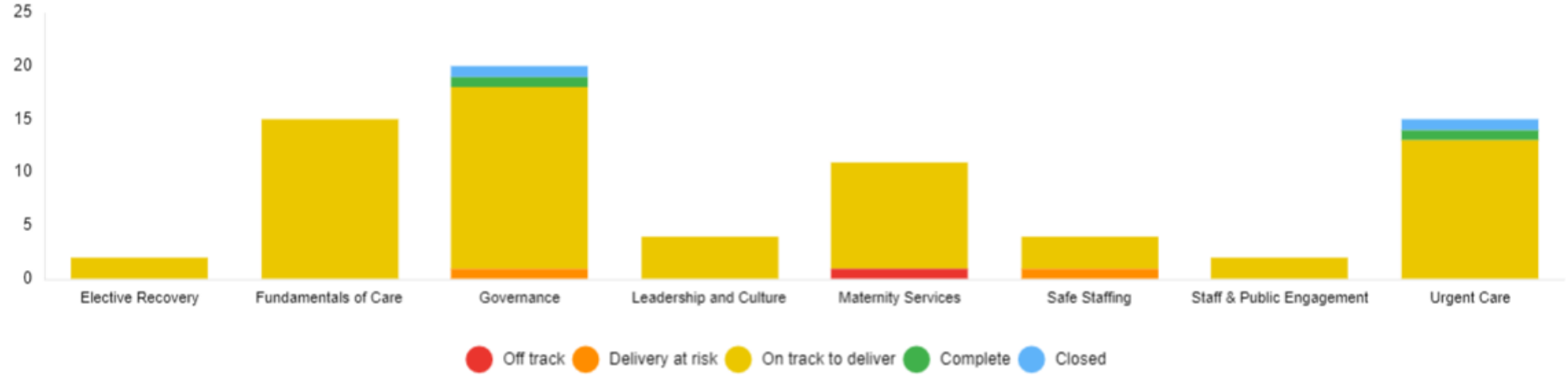
Appendix A
Trust CQC Improvement Plan Dashboard

Progress Rating by Service

Number of Actions per Workstream



Progress Rating by Workstream



Appendix B
Delivery at Risk

Ref	Action	Outcome metric	Target Date to Complete	BRAG rating
▼ BRAG rating **Delivery at risk**				
23	**The trust must ensure that in Maternity and Medical Care, all staff are aware of and consistently follow the trust policy to safely store medicines including controlled drugs and controlled substances hazardous to health (COSHH). The trust must also ensure adequate action is taken following audits which identify medication storage issues.**	• Maternity services and medical care will achieve 85% (or above) compliance in the Tendable ward audits for questions relating to the storage of medicines for three months consecutively. • Comprehensive COSHH portfolio of substances in each area. • Audit of COSHH compliance to be completed by the Trust Health and Safety Team.	29/12/23	**Delivery at risk**
23.1	Ensure that all staff in Maternity and Medical Care have a clear understanding (and relevant training) on the appropriate storage of medicines.		29/12/23	**Delivery at risk**
25	**The trust must ensure that all staff groups in Medical Care, Maternity and Urgent and Emergency Services complete designated mandatory training sessions. Including: - Safeguarding, PREVENT, Adult Life Support and Advanced Life Support (MC York and Scarborough) - Theatre recovery training, practical obstetric multi-professional training and saving babies lives version 2 (Mat York and Scarborough) - ED Medical Staff, esp. Safeguarding, learning disabilities and dementia (Scarborough)**	• Three months sustained compliance at 85% for: - Safeguarding, PREVENT, Adult Life Support and Advanced Life Support (Medical Care York and Scarborough) - Theatre recovery training, practical obstetric multi-professional training and saving babies lives version 3 and core competencies framework v2(Maternity York and Scarborough) • - ED Medical Staff, Safeguarding, learning disabilities and dementia (Scarborough)	31/01/24	**Delivery at risk**
25.1	Devise and implement a training plan (including a trajectory) to achieve and sustain compliance for mandatory training.		31/01/24	**Delivery at risk**

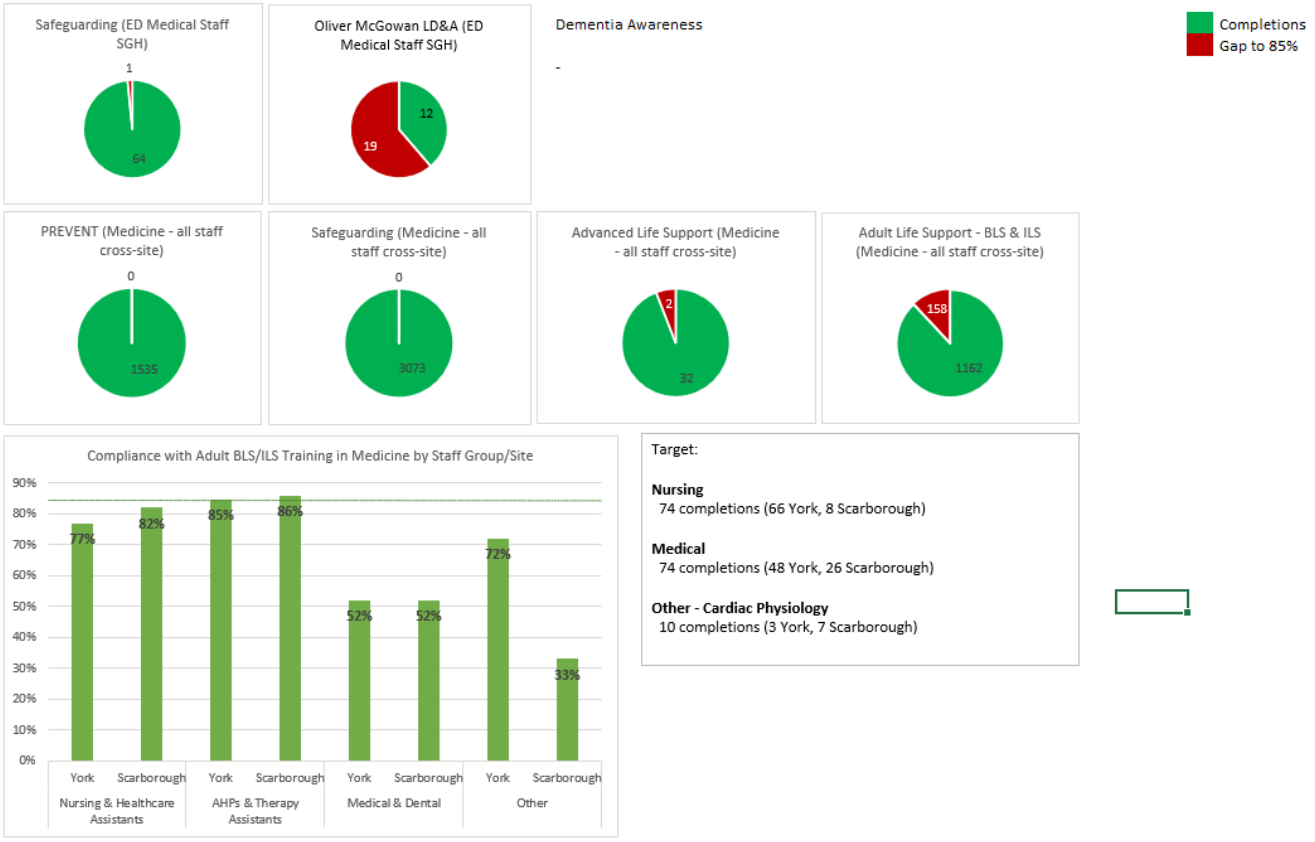
Action 23
Discussions are taking place between Director of Midwifery, the Medicines Management Lead Nurse and Chief Pharmacist to plan for cross site standardisation and back to basics medicines management training for all staff. This will require 3 months scoping before mobilisation and we are likely to need to include this as a separate e-learning module and/or deliver as part of PROMPT training for all staff.

Appendix B
Delivery at Risk

Action 25

Mandatory Training compliance has increased month-on-month since March 2023 - now 1% above organisation target (86% v 85%).
A group has been established to deep-dive areas highlighted by CQC. Across subjects highlighted for ED Scarborough (medical staff) and Medicine (all staff), Oliver McGowan training (ED - 19 completions short of 85%) and Adult Life Support (Medicine - 158 completions short of 85%) are off-track. The group is co-ordinating a push on these.
Dementia training not currently a requirement - being reviewed.
Maternity baseline being reviewed.

Dashboard

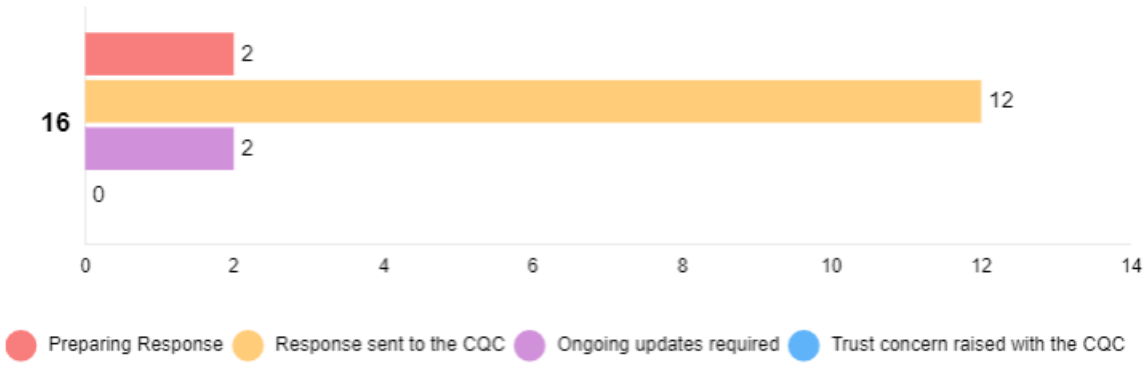


Appendix C
Closed and Completed CQC Actions

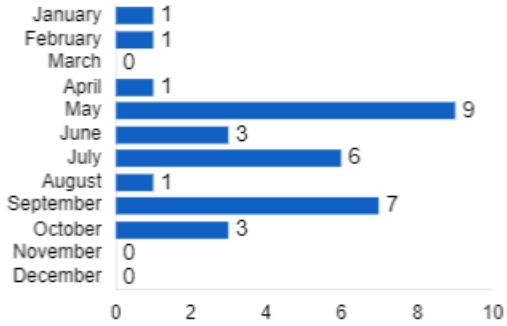
Ref	Action	Outcome metric	Target Date to Complete	BRAG rating	Latest Comment
16	The trust should ensure that it follows the recommended period for repeating and recording Disclosure and Barring Service checks for directors.	• Compliant DBS checks for all Directors. • Evidence of a robust process for undertaking DBS checks if they fall due.	31/10/23	Complete	Emma Shippey - Extension Request Form approved at J2E 02.10.23. Amended from 31.08.23 to 31.10.23
41	The trust must ensure all patients in ED at York are wearing wristbands at all times for improved safeguarding, security and easier identification when prescribing and administering medications.	• Monthly wristband audits show 100% compliance monthly since the visit. Three months compliance will be evidenced for the action.	31/08/23	Complete	Emma Shippey - Action Closure form is being drafted. Awaiting audit evidence.
44	The service should review pharmacy CD inspection policy to ensure it is clear how often inspection should take place.	• Clarity on the frequency of Controlled Drug inspections to be included in the Controlled Drug Inspection Policy.	29/09/23	Closed	Sharon Jones - Action closure approved at the Journey to Excellence meeting 16/10/23
49	The trust must ensure the Care Group 2 risk register identifies all the current risks including none compliance to referral to treatment targets, consultant, and nursing staffing shortfalls.	• Copy of the risk register including the risks identified in the CQC improvement action.	31/08/23	Closed	Sharon Jones - Action closure approved at the Journey to Excellence meeting 16/10/23

Appendix D
CQC Cases / Enquiries

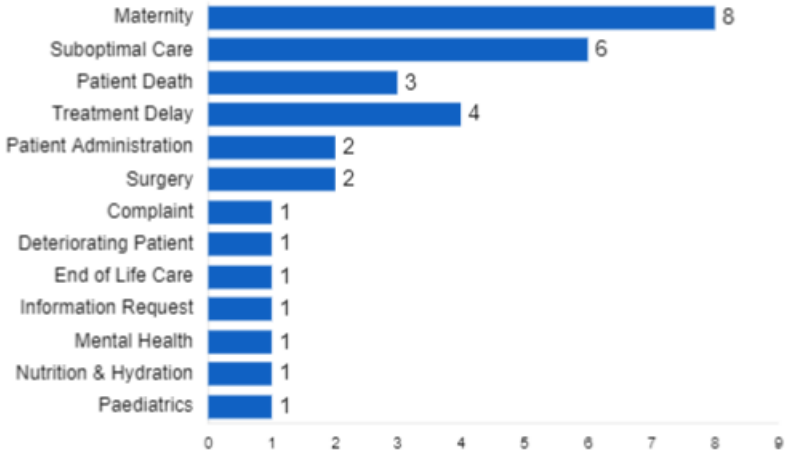
Number of Open CQC Enquiries / Cases



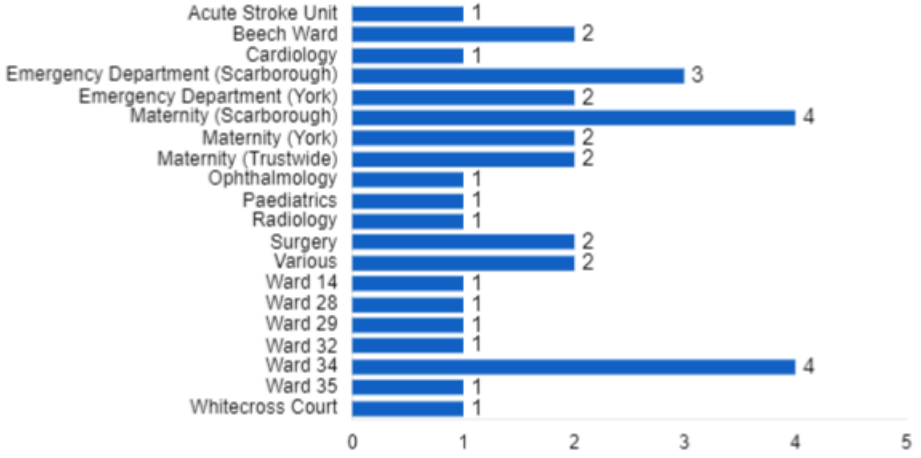
Number of Enquiries Received by Month



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Report to:	Board of Directors
Date of Meeting:	29th November 2023
Subject:	Maternity Neonatal Safety Report
Director Sponsor:	Sascha Wells-Munro, Director of Midwifery
Author:	Caroline Alexander, Associate Chief Operating Officer, Family Health Care Group

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

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

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

Summary of Report and Key Points to highlight:

This report provides an update on the maternity and neonatal service delivery in line with locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020) and the three year national Maternity Delivery Plan 2023.

The purpose of the report is to inform the LMNS Board and Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'Ward to Board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team.

The information within the report reflects actions and improvements in line with Ockenden and the national Maternity Incentive Scheme Year Five, incorporating Saving Babies Lives Care Bundle Version 3; as well as progress made in response to any identified concerns at provider level and the monthly reporting in relation to the CQC Section 31 notice areas of concern reported in November and December 2022.

There is oversight and assurance of the progress and immediate response to emerging concerns through the monthly Trust Maternity Assurance Group (MAG) and formal reporting to the Trust Quality & Safety Assurance Committee.

The report will also provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the clinical quality group and to the Quality Improvement Group (QIG) to support reporting to the Integrated Care Board for the Humber, Coast and Vale.

As advised at September Trust Board the Trust maternity and neonatal quality and safety reporting will be refreshed during October and November with a new formal reporting format in place for reporting in place for December 2023 following the Maternity and Neonatal Improvement Engagement and Planning event on the 24th November 2023.
The summary outlined below captures the headlines and escalations from the presentations to Maternity Assurance Group and Quality & Safety Assurance Committee in November.
Annex 1 provides the current delivery position for the service against the core national safety metrics.

This report is received alongside the October monthly update to CQC on the service progress against the Section 31 concerns and key improvement workstreams in place in the maternity improvement programme.

Recommendation:

The Board is asked to receive the updates from the maternity and neonatal service for October and consider the progress with safety actions and any emerging safety concerns with proposed mitigations.

Report History

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

Meeting	Date	Outcome/Recommendation
Quality & Safety Assurance Committee	22/11/23	To note the progress with the safety actions and improvement work in maternity and neonatal services. To formally receive the CQC Section 31 monthly report.

Report to Trust Board from Quality & Safety Assurance Committee

The maternity and neonatal services are working to deliver a range of safety and quality improvements which are supported through a dedicated improvement programme.
The progress with the individual workstreams and specific safety actions are monitored monthly with the impact on core maternity and neonatal quality and safety metrics reported to both Maternity Assurance Group and Quality and Safety Assurance Committee.

Annex 1 provides the current delivery position for the service against the core national safety metrics. There are no escalations to Quality and Safety Assurance Committee in relation to these metrics.

The Maternity Improvement Programme

The maternity improvement programme has been in place since January 2023 to support the delivery of the immediate actions, urgent must do actions and improvement projects which address the:

- Concerns identified by the CQC in their Section 31 notice (Nov 2022)
- Must dos actions identified by the CQC in their final report (June 2023)
- Recommendations from the national Maternity Safety Support Programme (MSSP) diagnostics report (July 2023)
- Compliance requirements of Ockenden, MIS Year 5 and SBLV3
- Themes and issues identified through incident reporting and identification of harm
- Concerns and feedback from maternity staff captured in the CQC final report, staff surveys, informal and formal escalations and the NHSE health and well-being report (June 2023)
- Concerns and feedback from birthing individuals (complaints/ investigations) and via forums and MNVP partners
- Delivery of the three year single Maternity Delivery Plan (2023 – 2026)

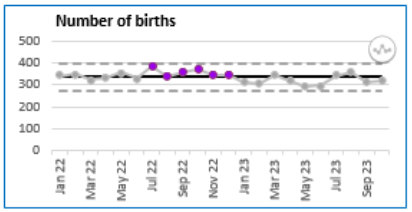
The key areas to note progress in relation to critical service development and improvement work include:

- Completion of the desk top midwifery workforce review as a pre-cursor to the Birthrate Plus review which will report in full in March 2024 and the confirmation of a shortfall in core and integrated and specialist midwifery staff across both sites which will require investment. In the meantime this shortfall is being mitigated by the deployment of agency staff
- Mobilisation of the obstetric medical workforce review in order to prepare the workforce plan for medical staff as indicated in the bi-annual workforce planning report received in September
- On-going development of the business case to support the expansion of the ante-natal scanning capacity to ensure the delivery of all scanning required in line with Saving Babies Lives Care Bundle Version 3
- On-going progress with the theatre demand and capacity review to support development of a business case to expand theatre capacity to meet the increasing need and demand for planned C-sections
- On-going progress with the refresh of the Induction of Labour standard operating procedure
- Completion of the refresh of the maternity escalation policy and opel framework
- Development of maternity and neonatal communication strategy in collaboration with MNVP
- £62,400 secured recurrently to support Neonatal Medical staffing compliance. Internal business case in development to support implementation (Safety action 4)
- Training Guideline for core maternity training requirements to meet all Core Competency Assessment for Saving Babies Lives V3 across the multi-disciplinary teams

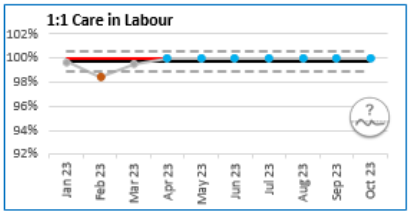
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery October 202

Maternity overview | **Trustwide**

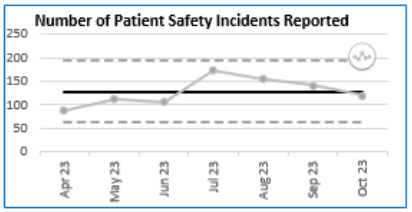
Latest month 01/10/23
Number of births 321
No significant change



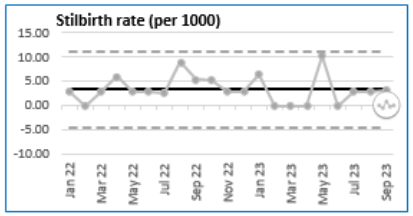
Latest month 01/10/23
1:1 Care in Labour 100%
Significant Improvement



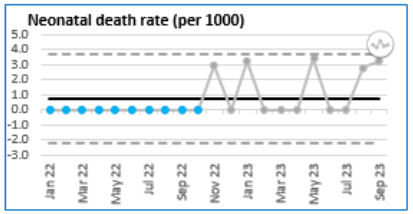
Latest month 01/10/23
Number of Patient Safety Incidents 120
No significant change



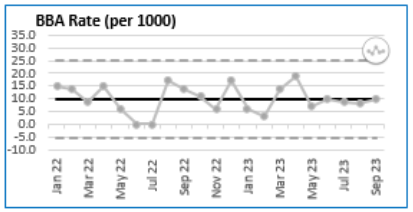
Latest month 01/09/23
Still birth rate/1000 3.2
No significant change



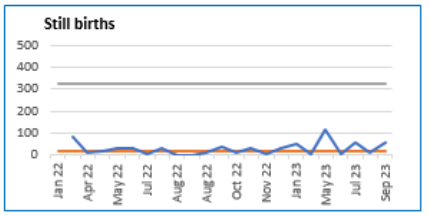
Latest month 01/09/23
Neonatal Death rate/1000 3.2
No significant change



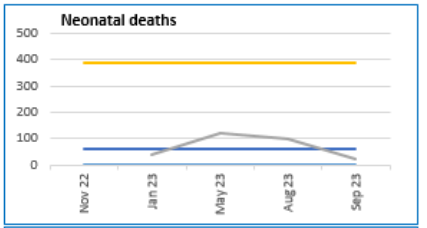
Latest month 01/09/23
BBA rate/1000 10.0
No significant change



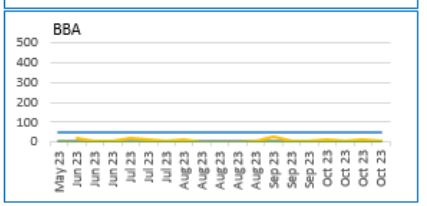
Date of last stillbirth 26/09/23
Average days between stillbirths 18.8
No significant change



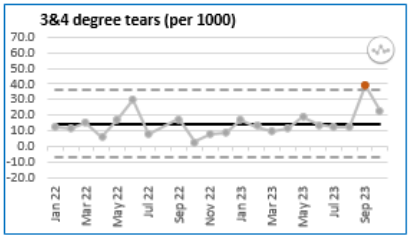
Date of last neonatal death 07/09/23
Average days between deaths 62.1
No significant change



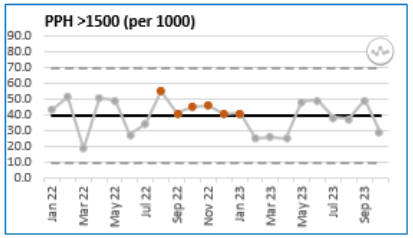
Date of last BBA 31/10/23
Average days between BBA 6.6
No significant change



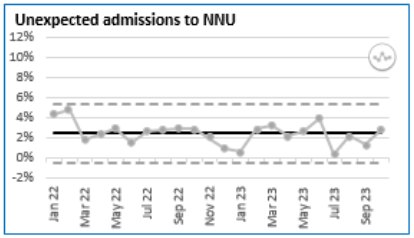
Latest month 01/10/23
3&4 degree tears (per 1000) 23.0
No significant change



Latest month 01/10/23
PPH >1500 (per 1000) 28.0
No significant change



Latest month 01/10/23
Unexpected admissions to NNU 0.0
No significant change



Report to:	Board of Directors
Date of Meeting:	29 November 2023
Subject:	CQC Section 31 Update
Director Sponsor:	Dawn Parkes - Interim Chief Nurse
Author:	Sascha Wells-Munro, Director of Midwifery

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

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

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

Summary of Report and Key Points to highlight:

On the 25 November 2022, the CQC, under Section 31 (S31) of the Health and Social Care Act 2008 imposed 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 notice.

Recommendation:

- To approve the November 2023 monthly submission to the CQC which provides assurance on progress and impact on outcomes October 2023.

CQC Section 31 Progress Update

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

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

A. Assessing and Responding to Patient Risk

A.1 Effective Systems and Processes to Respond to Patient risk

During the CQC inspection in November 2022, it was highlighted that a patient with an arterial line was being cared for on the labour ward which was outside Trust policy and the competency of the midwives working that day.

Since November 2022 the service has provided a monthly PROMPT – CiPP Course (Care of the critically ill pregnant or postpartum woman), this includes invasive monitoring and covers the subjects of arterial lines and arterial blood gases. All Labour ward Coordinators have attended this course and currently over 50 midwives. A competency skills pack has been developed and the current guideline updated to reflect the updated skills of the midwives, this will be approved in the November Clinical Governance Meeting.

Any woman who requires care on the labour ward and an arterial line is sited is discussed and agreed by the multidisciplinary team and a clear care plan agreed. This is overseen by the Consultant Anaesthetist and the Director of Midwifery.

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 October 2023.

The procurement for telemetry equipment (seven units) is in progress and a revised quote for the equipment was resubmitted to MERG committee in September and approved. The timeline for delivery is still to be confirmed.

York Hospital Area	No of CTG Machines (SOP Requirement)	7 November 2023
Labour Ward	10	12
Triage	3	3
G2	6	5
Antenatal Day Unit	2	3
In repair	2	0

Scarborough Hospital Area	No of CTG Machines (SOP Requirement)	7 November 2023
Labour Ward	11	10
Hawthorn Ward	4	4
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 Fetal Monitoring Training

There has been an expected drop in training compliance during September and October 2023 due to the rotation of medical staff. There are recovery plans in place and a trajectory to improve compliance.

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

Staff Group	York	Scarborough
Midwives	95%	90%
Consultants	93%	86%
Obstetric medical staff	78%	80%

CTG training compliance projections for November 2023

Staff Group	York	Scarborough
Midwives	94%	92%
Consultants	100%	86%
Obstetric medical staff	90%	100%

A training plan for 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.

A.2.3 Fresh Eyes Audit

In the November 2022 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.

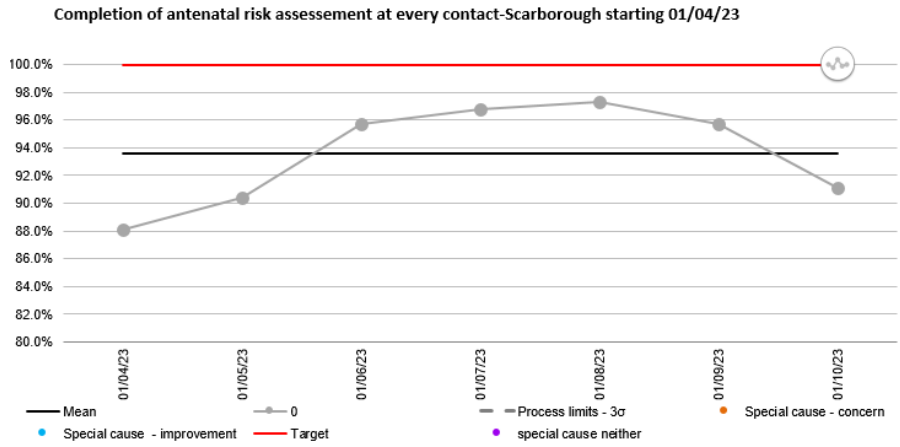
The hourly completion of 'Fresh Eyes' is a requirement of the Saving Babies Lives Care Bundle v3, Element 4: Effective fetal monitoring in labour. A detailed audit plan is under development with the LMNS and reported on quarterly for their oversight and assurance.

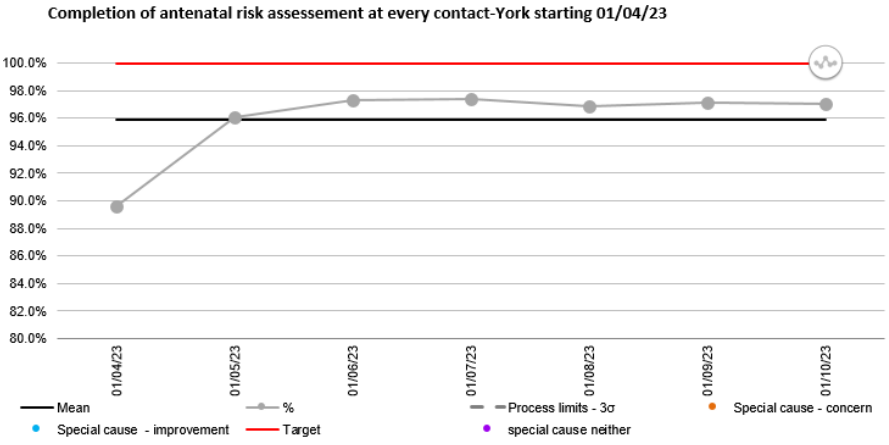
A snap shot audit of 10% of patients requiring CTG has been completed for October 2023

Required number of Fresh Eyes completed:	**88%**
Of these:	
Within 1 hour 15 minutes	**67%**
Within 1 hour 16 minutes – 2 hours	**28%**
Over 2 hours	**5%**

A.3 Risk Assessments

The CQC found evidence in patient records which showed incomplete assessments of risk and plans of care to mitigate such risks. All antenatal risk assessments are recorded on BadgerNet.





As the completion of the antenatal risk assessment is a mandatory field on BadgerNet, the Digital Midwives are working with CleverMed to understand why the software is reporting less than 100% compliance.

A.3.1 High Risk Category Audit

Assurance was provided on the appropriate classification of c-sections through the audit undertaken by the Maternity Improvement Advisor in August 2023. There has been one incident reviewed in October where the classification of the c-section has been questioned and an SI investigation is underway.

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.

Following a BadgerNet system wide update, live triage data is now available. An assessment of data quality is currently underway to obtain assurance on the performance information provided.

An internal audit review has been commissioned to gain assurance on the triage process. The draft report is anticipated by the end of November 2023.

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

Due to constraints with the Scarborough Hospital estate and staffing levels, triage is currently situated in the labour ward. In terms of progress:

- A capital investment request has been submitted to the Trust Capital Planning and Equipment Group with an outcome confirmed in December 2023.
- Recruitment to support the relocation of the triage unit is expected to be complete by January 2024.

B. Governance and Oversight of Maternity Services

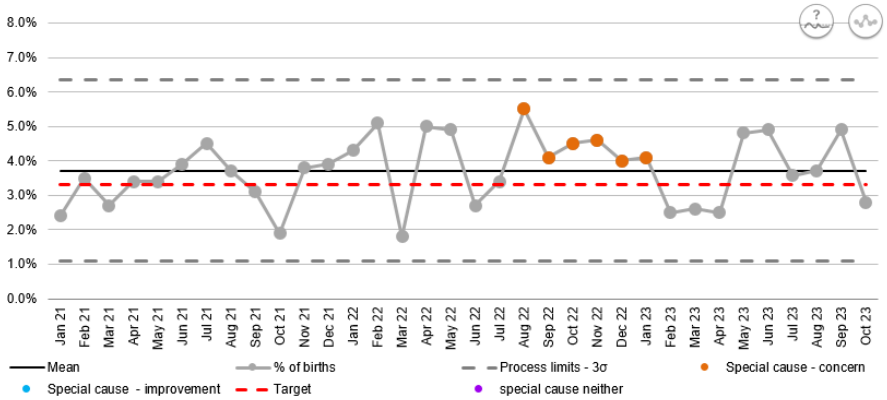
B.1 Post-Partum Haemorrhage

PPH over 1.5 litres

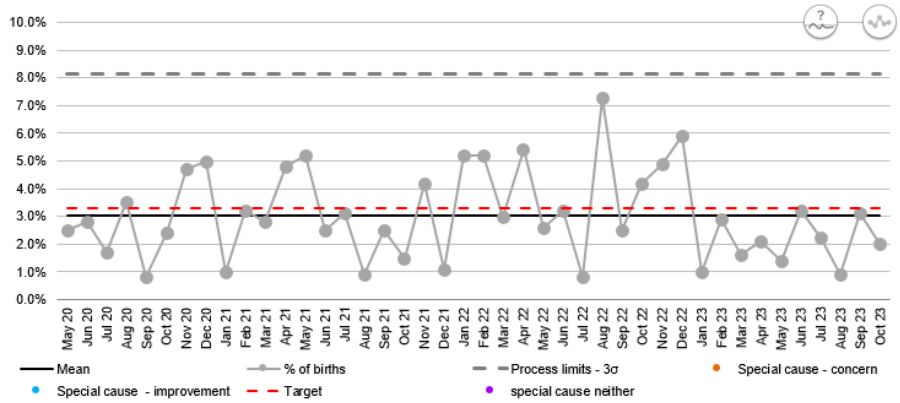
The Trust wide PPH over 1500ml decreased in October 2023. PPH is included as one of the key priority areas in the Trust Patient Safety Incident Review Plan due to be launched in December 2023.

Blood Loss	Number in October 2023
1.5l – 1.9l	6 (range 1.5l – 1.7l)
2l – 2.4l	2 (range 2l – 2.2l)
> 2.5l	1 (range 2.7l)

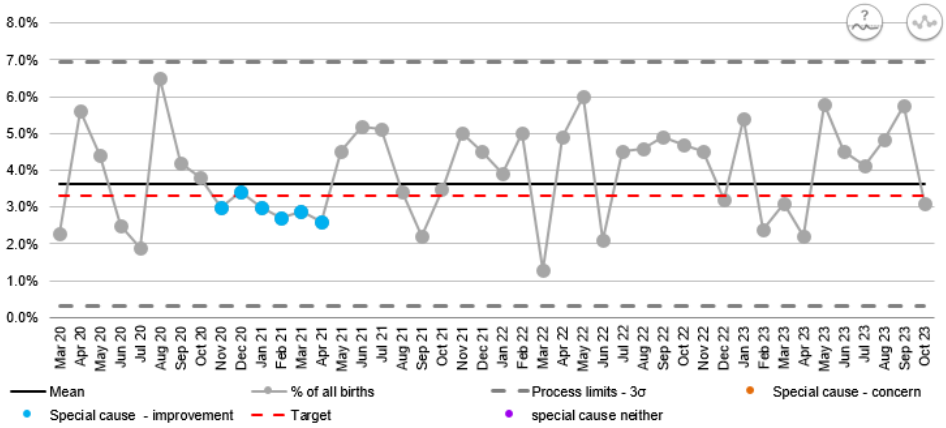
PPH > 1500ml-Trustwide starting 01/01/21



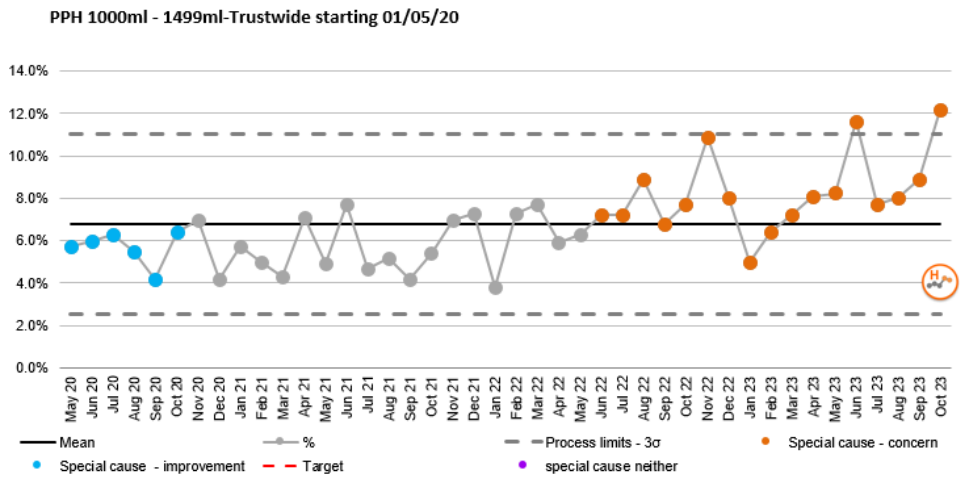
PPH > 1500ml-Scarborough starting 01/05/20



PPH > 1500ml-York Maternity starting 01/03/20



PPH between 1000ml – 1499ml



The rate of PPH between 1000ml and 1499ml continues to show special cause variation concern. Support with a PPH improvement workstream is being provided from the Trust Quality Improvement team.

B.2 Incident Reporting

The following moderate harm incidents were reported in September 2023, with the outcomes completed (not included in the October 2023 update):

Datix Number	Incident Category	Outcome/Learning/Actions	Outcome
3330	PPH 2300ml	Case reviewed at the sprint, identified areas for improvement in the management of the PPH	To be reviewed using the PPH review tool and feed into the improvement group
3341	PPH 6.5l and admission to ICU	Case review at the sprint, good MDT working in a complex emergency/acute case	Declared SI 2023/20119
3949 & 4486	Theatre Capacity	AAR undertaken, theatre pathway and capacity at Scarborough needs review	4486 declared SI 2023/20129 3949 will feed into the actions
4584	Intrauterine death at 24 weeks	Reported via MBRRACE for review with PMRT	To be reviewed using the perinatal mortality review tool (PMRT)
4704	Hypothermia in a newborn	Hot debrief required with the staff involved	To be reviewed at case review
4718	Scalp laceration following emergency caesarean section	Immediate action taken to care for the laceration, being	Appropriate care taken at the time,

		reviewed by Maternity Matron	complications of the procedure
4840	3b tear following episiotomy	When there is ongoing bleeding ensure transfer to theatre is not delayed	To be included in the perineal tear cluster review

There were eight moderate harm incidents reported in October 2023.

Datix Number	Incident Category	Outcome/Learning/Actions	Outcome
4742	PPH 2000ml	For review using the PPH review tool and feed into the improvement group	PSIR completed awaiting review
4840	3b Perineal Tear	Obstetric Anal Sphincter Injury care bundle used, and episiotomy performed	To be included in the perineal tear cluster review
4869	PPH 2700ml	Massive Obstetric Haemorrhage protocol well used	For review using the PPH review tool and feed into the improvement group
5076	PPH 2200ml	Awaiting Obstetric review	For review using the PPH review tool and feed into the improvement group
5239	PPH 1500ml	Awareness of ongoing blood loss during delivery	For review using the PPH review tool and feed into the improvement group
5514	Medication Error	Electronic system change led to the error, no harm caused	Local investigation identified no harm to the patient
5517	PPH 2500ml and hysterectomy	Awaiting Obstetric review	PSIR to be completed
5858	Misidentification of baby	Individual learning about checking identification identified	PSIR to be completed to identify any wider learning

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 in place 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 has been delayed due to the work required following flooding from adverse weather in October 2023. The start date for installation will be agreed based around the plans for room utilisation while installation goes ahead. The timelines for completion are four weeks from start date.

B.4.2 Scrub and Recovery Roles

Our recruitment advert for experienced band 5 for the maternity theatre was first published in May. Since then, the advert has been live and as at the end of October 2023,

- X1 Band 5 full time in Scarborough (already in post).
- X1 Band 5 full time in York (already in post).

Alongside this, via internal transfer we have recruited:

- X1 Band 5 18 hours/week in Scarborough (already in post).
- X1 Band 5 full time in York (already in post).
- X1 Band 5 11 hours/week in York (starting 1st January 2024).

In August 2023, we advertised for band 6, two in York and two in Scarborough, and we have recruited:

- X1 Band 6 full time in Scarborough (starting 11th December 2023).
- X1 Band 6 30 hours/week in Scarborough (starting 4th December 2023)
- X1 Band 6 full time in York (already in post).
- X1 Band 6 33 hours/week in York (already in post).

On 8th November 2023 we appointed another full time Band 5 who will be based at either York or Scarborough.

There are two agency nurses working at York five days a week. Unfortunately, we have not been able to attract agency theatre nurses for Scarborough yet, however, recruitment is ongoing.

Since June 2023, York and Scarborough have followed a support programme for current theatre staff to promote overtime in maternity. Overtime is offered 24/7 to theatre staff as well as midwives. There is an online system including a spreadsheet accessible to everyone and a mailbox for staff to email their requests This system has proven very successful as everyone has access from any available computer.

The pay rate offered for overtime is x 1.5 hourly rate up to 37.5 hours/week and x2 from 37.5 hours/week and above.

For the future:

- We will maintain the advert targeting experienced staff via the advert. This will be reviewed in six months' time and consider if we can support less experienced theatre staff.
- Maternity is included as part of the rotation theatre programme. This means that theatre staff on rotation in main theatres will have the opportunity to work in maternity after having had 4-6 months experience in each of these specialities: General Surgery, Vascular, Urology and Gynae.
- We will consider supporting international nurses when main theatres have the capacity to provide adequate training.
- We will continue to offer shifts 24/7 as overtime.

In order to provide adequate support and training to meet the service needs, a workshop day in planned for 5 December 2023 with Clinical Educators from York and Scarborough, Family Health and Surgery Care Group.

The aim of this workshop is to identify the skills required to provide the theatre service in maternity, design a competency pack for theatre staff and midwives and plan how to provide the support and training required. The role of the HCA in theatre will also be discussed.

Report to:	Board of Directors
Date of Meeting:	29 November 2023
Subject:	Guardian of Safe Working Hours 2023-2024 Q2 report
Director Sponsor:	Dr Karen Stone
Author:	Dr Ruwani Rupesinghe

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

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

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

Summary of Report and Key Points to highlight:

- The pursuit of robust and easy access to emergency rest facilities is ongoing with support from Estates and Facilities and Procurement teams.
- Exception reports from York Urology have reduced which is positive following previous issues.
- A new pathway laying out time scales in which leave applications should be reviewed and how to escalate delays has been approved.
- Junior Doctors' Forum Vice-Chairs and Representative selection is underway.

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

No ☒ Yes ☐

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

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

Board report: Guardian of Safe Working Hours 2023-2024 Q2 report

1. Introduction and background

This is the 2023/2024 Q2 report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training. The quarterly report is for 01 July 2023 to 30 September 2023 and summarises key findings from the Junior Doctor Forum (JDF), Exception Reporting and Agency/Bank shift data.

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

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

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

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

2. Current position/issues

2.1 *Guardian funds*

In Quarter 2, two Guardian fines have been levied:

- In August 2023, 1 fine was levied against Care Group 1 for a doctor on a General Medicine placement. The doctor worked a 13.25 hour shift, meaning a breach of 0.25 hours in total. This also meant that the trainee did not achieve the minimum 11 hours rest between this shift ending and the following shift beginning.
  The total Guardian fine for this breach of safe working hours was £21.77. This was split as per the TCS as follows: £8.16 to the trainee and £13.61 to the Guardian.

- In September 2023, 1 fine was levied against Care Group 5 for a doctor on a Paediatrics placement at Scarborough Hospital. The doctor worked a 13.5 hour shift, meaning a breach of 0.5 hours in total.

The total Guardian fine for this breach of safe working hours was £37.66. This was split as per the TCS as follows: £14.12 to the trainee and £23.54 to the Guardian. However, in this instance the doctor portion of the fine was less than the amount that would have been paid for a usual overtime claim and was uplifted to £14.52 to compensate.

The end of quarter balance from fines levied is £1,333.69. However, £600.00 has been ringfenced. Details presented below:

Guardian funds: Q2 activity

Detail	+/-	Balance
Opening balance on 1 June 2023		**£1,443.02**
(+) Guardian fines	+£37.15	£1,480.17
(-) JDF meeting catering	*-£97.23*	*£1,382.94*
(-) JDF wellbeing gifts (plants) for Junior Doctor Inductions	*-£49.25*	*£1,333.69*
Closing balance on 30 September 2023		**£1,333.69**

Ringfenced funds	+/-	Available Balance
Games console for York Doctors' Mess	*-£500.00*	*£833.69*
Parasol for York Junior Doctors' Mess	*-£100.00*	*£733.69*
Available funds at 30 September 2023		**£733.69**

2.2 *Exception reporting trends*

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

89 reports were received in this quarter compared to 67 in Q1. A spike is seen every Q2 which coincides with the largest junior doctor changeover of the year in August.
There is a noticeable change in where they originated with reports spanning almost all Care Groups. A complete breakdown is provided in Appendix 1, Table 1. Key points are:

- 25 reports (28%) from Trauma and Orthopaedics, Scarborough: 1 in July, 19 August and 5 in September. Approximately half cited doctors being told to start work at 07:30 instead of 08:00 as per their work schedule and were submitted in quick succession shortly after changeover. Early intervention following receipt of these reports has seen a resolution of the matter.
  Late finishes were investigated by the relevant supervisors who identified inexperience and settling in time as significant contributors. This is borne out by the low reporting rate in the months either side of changeover.

- 14 reports (16%) from Gastroenterology, Scarborough: 13 related to hours and rest and 1 educational. All bar 2 were submitted in August. Half reported excessive workload as a driver. Acutely unwell patients accounted for a further third. All the reports are being managed by a single supervisor due to the low number of Gastroenterologists. The Guardian is aware that they are working closely with the Medical Education Team to enhance support for the doctors as much as possible.

- 9 reports (10%) from Paediatrics, Scarborough. Multi-factorial causes such as ‘unusually busy ward’, ‘late influx of patients’, acute emergencies, and delayed/prolonged handover. The latter item is the only one that can be influenced. The department are exploring ways of ensuring handover is carried out in a timely fashion enabling doctors to leave on time.

- A significant positive finding is the dramatic reduction in reports from Urology, York, which has previously been an area of concern: 2 related to difficulty balancing workload and supporting FY1 shadowing. This has been shared with the education team for future consideration. Additionally, a deviation in process regarding completion of discharge letters for day cases was noted. Remedial action was taken to reduce workload.

Tables 2 and 3 in Appendix 1 give a breakdown of exception report by the grade of doctor and type of exception. The majority continue to be submitted by Foundation Year 1 doctors. The most common type remains overtime, primarily late finishes.

The number of exception reports reviewed within 7 days has declined from 51% in Q2 to 43% (Appendix 1, Table 4). This is probably a consequence of the rapid rise in reports, with many requiring further information and action, coupled with consultant and junior doctor strikes. It remains an area for improvement.

2.3 *Summary of rota gaps and locum usage*

Internal locums (bank) are managed via the Patchwork application and external locum (agency) shifts are through Medacs. At the time of writing Medacs data was not available. Data on internal locums is in Appendix 2.

2.4 *Junior Doctors’ Forum (JDF)*

2.4.1 Vice-Chair and Representatives

As per the JDF constitution the process of annual re-appointment commenced in August. New starters were given the opportunity, and encouraged, to submit expressions of interest at induction. We should have a separate Vice-Chair in Scarborough and York after an interlude in 2022/23.

2.4.2 Twenty-four-hour resident shift

No exception reports were submitted for this matter but two events of this nature occurred in quick succession and were raised at JDF. On both occasions there wasn’t a registrar grade doctor for the night shift. The doctor on late shift ended up working through the night. The events unveiled the need for a pathway to manage such situations. Colleagues in the Medical Employment team will be leading on this work. A statement has been issued to all junior doctors reminding them that working beyond safe hour limits may seem like the right thing to do but fatigue will impact decision making placing them, and patients, at risk.

2.4.3 Management of leave requests and queries from doctors

The leave escalation pathway has been approved after being reviewed by JDF. A copy is accessible via the JDF handbooks on Staffroom and through the Healthcare Toolbox app.

3. Overtime in Obstetrics and Gynaecology, Scarborough

No exception reports have been received regarding this item despite advising affected doctors to do so. Doctors working in the department raised the fact that handover occurs daily at 5pm which is when their shift is scheduled to finish. As such, they consistently work an extra 30minutes on average each day. Having discussed the matter with consultant colleagues it was agreed that the best course of action is a change in work schedule to reflect the 17:30 finish. Colleagues in the Medical Employment team have been asked to review the impact on working hours and pay, implementing the necessary changes, as a matter of priority.

4. Emergency rest facilities

Work is ongoing to establish an easy and robust process for doctors to access emergency rest facilities out-of-hours and post night shift. The Estates and Facilities team is on hand to support doctors Monday-Friday. However, it is not possible to guarantee a room is available before midday for doctors completing a night shift. Doctors are being informed of the limitations at every induction, and to request transport home if a room is not available.

5. Summary

Quarter 2 has seen a spike in exception reporting. This is consistent with previous years as it coincides with August changeover.

Recruitment of JDF Vice-Chairs and Representatives has been incorporated into induction with early signs being positive.

Access to emergency rest facilities is an ongoing challenge but progress is being made in the pursuit of Trust managed provisions. Alternatives to ensure staff and public safety are in place by arranging transport home.

Date: 17 October 2023

Appendix 1: Exception reporting data for 2023-2024 (Q2)

Table 1: Exception reports by department			
Care Group/ department	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions open**
CG1			
Cardiology	6	6	0
Diabetes and endocrinology	3	3	0
Elderly/rehab medicine	7	5	2
Emergency medicine	1	1	0
Renal medicine	1	1	0
Respiratory	1	1	0
CG2			
Acute Medicine	2	2	0
Diabetes and endocrinology	4	1	3
Emergency medicine	1	1	0
Gastroenterology	14	8	6
CG3			
General surgery	2	2	0
General surgery: vascular	5	5	0
Urology	4	4	0
CG4			
CG5			
Obstetrics & gynaecology	1	0	1
Paediatrics	9	2	7
CG6			
Trauma & orthopaedics	25	23	2
Orthogeriatric	3	3	0
Total	**89**	**74**	**15**

Table 2: Exception reports by grade				
Grade	No. exceptions in **previous quarter**	Proportion of reports **previous quarter**	No. exceptions raised **this quarter**	Proportion of reports **this quarter**
F1	42	63%	71	80%
F2	9	13%	5	6%
CT1-2 / IM1-2/ ST1-2	14	21%	12	13%
IMT3/ ST3+	2	3%	1	1%
Total	67	100%	**89**	**100%**

Table 3: Exception reports by type				
Type	No. exceptions in **previous quarter**	Proportion of reports **previous quarter**	No. exceptions raised **this quarter**	Proportion of reports **this quarter**
Late finish	48	72%	62	69.66%
Late finish & early start	0	0%	13	14.61%
Early start only	0	0	1	1.12%
Missed breaks	6	9%	2	2.25%
Late finish and missed breaks	3	4%	8	8.99%
Difference in working pattern	0	0%	0	0%
Missed breaks & Difference in working pattern	0	0%	0	0%
Inadequate supervision	2	3%	1	1.12%
Inadequate clinical exposure	0	0%	0	0%
Inadequate supervision & unable to achieve breaks	0	0%	1	1.12%
Inadequate supervision & unable to attend scheduled teaching/training	0	0%	1	1.12%
Unable to attend scheduled teaching/training	2	3%	0	0%
Unable to attend scheduled teaching/training & late finish	2	3%	0	0%
Unable to attend clinic/theatre/session & late finish	1	1%	0	0%
Teaching cancelled	1	1%	0	0%
Difficulty completing workplace-based assessments (WPBAs) & Inadequate clinical exposure/experience	1	1%	0	0%
Difficulty completing workplace-based assessments (WPBAs) & Inadequate clinical exposure/experience & Inadequate supervision & Lack of feedback	1	1%	0	0%
Total	**67**	**100%**	**89**	**100%**

Table 4: Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
FY1	23	8	26	14
FY2	2	0	3	0
CT1-2/ST1-2	1	7	3	1
IMT3/ST3+	1	0	0	0
Total	**27**	**15**	**32**	**15**

43.24% addressed within 7 days (51% in previous quarter)

Appendix 2: Locum booking (bank) data

Table 5: Locum bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine SGH	204	164	2,172	1,689
Acute Medicine YH	967	537	9,884	5,456
Cardiology YH	17	6	81	31
Cellular Pathology (SHYPS Network)	2	2	11	11
Community In Patient Units	11	11	84	87
Community Rehabilitation - Selby	7	5	56	40
Elderly Frailty Unit RAFA ED YH	1	0	10	0
Elderly Medicine YH	117	80	1,164	842
Emergency Department SGH	635	548	6,323	5,512
Emergency Department YH	977	719	9,302	6,965
Endocrine YH	49	48	392	384
ENT YH	52	51	715	707
General Medicine SGH	770	525	7,572	5,092
General Medicine YH	149	81	1,303	678
General Surgery SGH	88	68	1,049	820
General Surgery YH Consultants	3	3	42	42
General Surgery YH Juniors	208	138	2,314	1,532
Haematology YH	0	0	0	0
Home First Unit (HFU) SGH	312	296	3,176	3,062
Maxillo Facial YH	149	141	1,258	1,201
Obstetrics & Gynaecology SGH	151	137	1,658	1,516
Obstetrics & Gynaecology YH	233	140	2,378	1,424
Oncology YH	30	22	222	166
Ophthalmology YH	17	17	159	159
Paediatrics SGH	277	257	3,196	2,991
Paediatrics YH	272	231	2,815	2,384
Radiology YH	21	21	64	64
Renal YH	1	0	8	0
Respiratory YH	84	78	807	749
Stat and Mand Training	13	13	41	41
Stroke/Rehab Senior YH/SGH	20	20	104	104
Theatres, Anaesthetics and Critical Care SGH Consultants	98	98	1,399	1,404
Theatres, Anaesthetics and Critical Care SGH Juniors	61	60	594	591
Theatres, Anaesthetics and Critical Care YH Consultants	2	2	13	13
Theatres, Anaesthetics and Critical Care YH Juniors	24	21	290	252
Trauma & Orthopaedics SGH	106	44	1,032	387
Trauma & Orthopaedics YH	283	237	2,758	2,289
Urology YH	6	5	62	53
York Virtual Frailty Ward	1	1	8	8
Totals	**6,418**	**4,827**	**64,515**	**48,744**

Table 6: Locum bookings (bank) by shift grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Anaesthetic ICU different base cover	40	40	622	622
Anaesthetic Juniors & SAS	84	80	871	830
Anaesthetics General different base 24 hr on-call gap	15	15	284	285
Anaesthetics General different base Mon-Fri on-call gap	13	13	171	173
Anaesthetics General same base 24 hr on-call gap	1	1	24	24
Anaesthetics General same base Mon-Fri on-call gap	1	1	14	14
Anaesthetics ICU same base Mon-Fri on-call gap	1	1	3	3
Anaesthetics ST3+/Specialty Doctor/SAS	4	4	33	33
Consultant	411	384	3,405	3,221
Consultant WE/Bank Holiday/Discharge	124	119	1,330	1,294
CT/GPStR/ST1-2	2,900	2,233	29,185	22,765
FY1	240	98	2,420	1,000
FY2	788	313	7,801	2,958
On-call consultant	42	42	537	534
On-call ST1+/SD	22	19	231	194
ST3+	1,274	1,083	13,078	11,092
ST4+	400	324	4,080	3,296
T&O ST3+/Specialty Doctor/SAS	58	57	427	407
Totals	**6,418**	**4,827**	**64,515**	**48,744**

Table 7: Locum bookings (bank) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Agency Locum Cancelled	4	3	32	21
Annual Leave	92	85	916	849
Bank Holiday	8	8	95	95
Bed Pressure	31	27	339	296
Compassionate Leave	3	3	19	19
COVID-19 (Staff sickness/isolation cover)	7	7	122	122
Extra Clinic	37	35	258	233
Extra Weekend Support	8	8	84	86
Induction	23	22	222	219
Industrial Action	654	360	7,187	4,062
Maternity Leave	30	22	203	145
On-call cover	253	217	2,576	2,194
Paternity Leave	13	7	161	89
Service Requirement	1,365	1,031	12,900	9,849
Sick Leave	340	224	3,354	2,190
Sickness - Long Term	21	18	265	230
Sickness - Short Term	12	10	107	79
Special Leave	20	16	209	174
Stat & Mand training	14	14	44	44
Vacancy	3,483	2,710	35,427	27,750
Total	**6,418**	**4,827**	**64,515**	**48,744**

Report to:	Board of Directors
Date of Meeting:	29 November 2023
Subject:	Quarter 1 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Ed Smith – Deputy Medical Director Alice Hunter – Patient Safety Specialist

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

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

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

Summary of Report and Key Points to highlight:

This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
  - HSMR (Hospital Summary Mortality Indicator)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:
  - Nationally mandated data
  - Locally mandated data
  - Quality account data
- Learning from deaths – themes and actions
  - Themes from SJCRs considered by the LfD Group in Q4
  - Improvements underway
- Service developments

Metric	Result
Crude mortality	Crude mortality is **2.90%** for this current fiscal year (3.08% last year)
SHMI – HES HED[1] (Data to Dec 2022)	SHMI year to December 2022is **96.56**
SHMI - NHS Digital[2] (Data to Oct 2022)	SHMI for year to October 2022 is **96.46**
HSMR[3] alerts	

[1] SHMI HES HED - Summary Hospital Mortality Indicator using Hospital Episode Statistics and published by Healthcare Evaluation Data for UK Health Data Benchmarking
[2] SHMI NHS Digital - Summary Hospital Mortality Indicator
3 HSMR – Hospital Standardised Mortality Ratio published by Dr Foster

- Themes from Learning from Deaths (LfD) remain consistent compared with previous reports.
- The number of death reviews completed by the Medical Examiners at the Scarborough and York sites during Q1 have decreased. This is thought to be due to ME sickness.
- The number of open SJCRs is steady and Scarborough site in Q1 has received a similar percentage of referrals from the Medical Examiner as to York in comparison to previous quarters where they received a higher percentage.
- There continues to be a limited number of trained SJCR investigators and there is continued exploration of how to provide this training in house. Recent planned training was cancelled by HSIB.
- This report has included for the first time Incidents Reported by Referral Type for the last 2 Quarters.

Recommendation:

Board of Directors receive the report and note the escalations.

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
LfD Group	17/08/2023- cancelled	For OQG 13th Sept 2023
Quality Oversight Group	13/09/2023	Approved

1. Y&SH NHS FT mortality rates

The references in section 6 provide details about the methodologies for measuring mortality and their context.

1.1 Crude Mortality - unadjusted

The crude mortality stands at 3.4% of all non-elective admissions. Crude mortality was 3.08% during the previous fiscal year

Benchmarking of crude mortality against other Trusts is not recommended due to significant operational variations between Trusts. Instead Trusts should monitor local trends comparing data from the same month or quarter each year. This takes account of seasonal variation seen locally and nationally.

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust, including those receiving palliative care, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the Trust. It covers patients who died either while in hospital or within 30 days of discharge.

A standard approach is taken to 'adjust' the figures so that the England average is always reported as '100'. Values below 100 represent a better outcome, ie lower mortality, and vice versa.

Further information regarding the methodology can be found in the references towards the end of the report.

Two risk-adjusted mortality rates are presented:

- HED HES-SHMI: This is provided by Healthcare Evaluation Data for UK Health Data Benchmarking (HED). It uses Trust hospital episode statistics (HES) to generate the outcomes. Data is available 3 months in arrears.
- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.

Table 1 gives the latest SHMI data supplied by **HED-HES.** It shows the monthly SHMI figures from information and provides an overall SHMI of 0.95

Table 1– Latest SHMI data (HED-HES) Data up to December 2022

Table 2 – NHS Digital SHMI data (up to Nov 2022)

Site level breakdown (experimental statistics)

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
RCB55	York Hospital	54,205	1,565	1,730	0.9047	As expected SHMI
RCBCA	Scarborough General Hospital	26,125	1,055	1,020	1.0298	As expected SHMI
RCB07	The New Selby War Memorial Hospital	300	45	25	1.7735	Higher than expected SHMI
RCB05	St Monicas Hospital	165	40	15	2.3098	Higher than expected SHMI
RCB14	Peppermill Court		0			
RCBCP	Clifton Park Treatment Centre	55	0			

The latest **NHS-Digital Summary Hospital Mortality Index (SHMI)** to November 2022 shows the SHMI was 96.46

This is categorised ‘as expected’.

Figure 1 SHMI in comparison with other Trusts

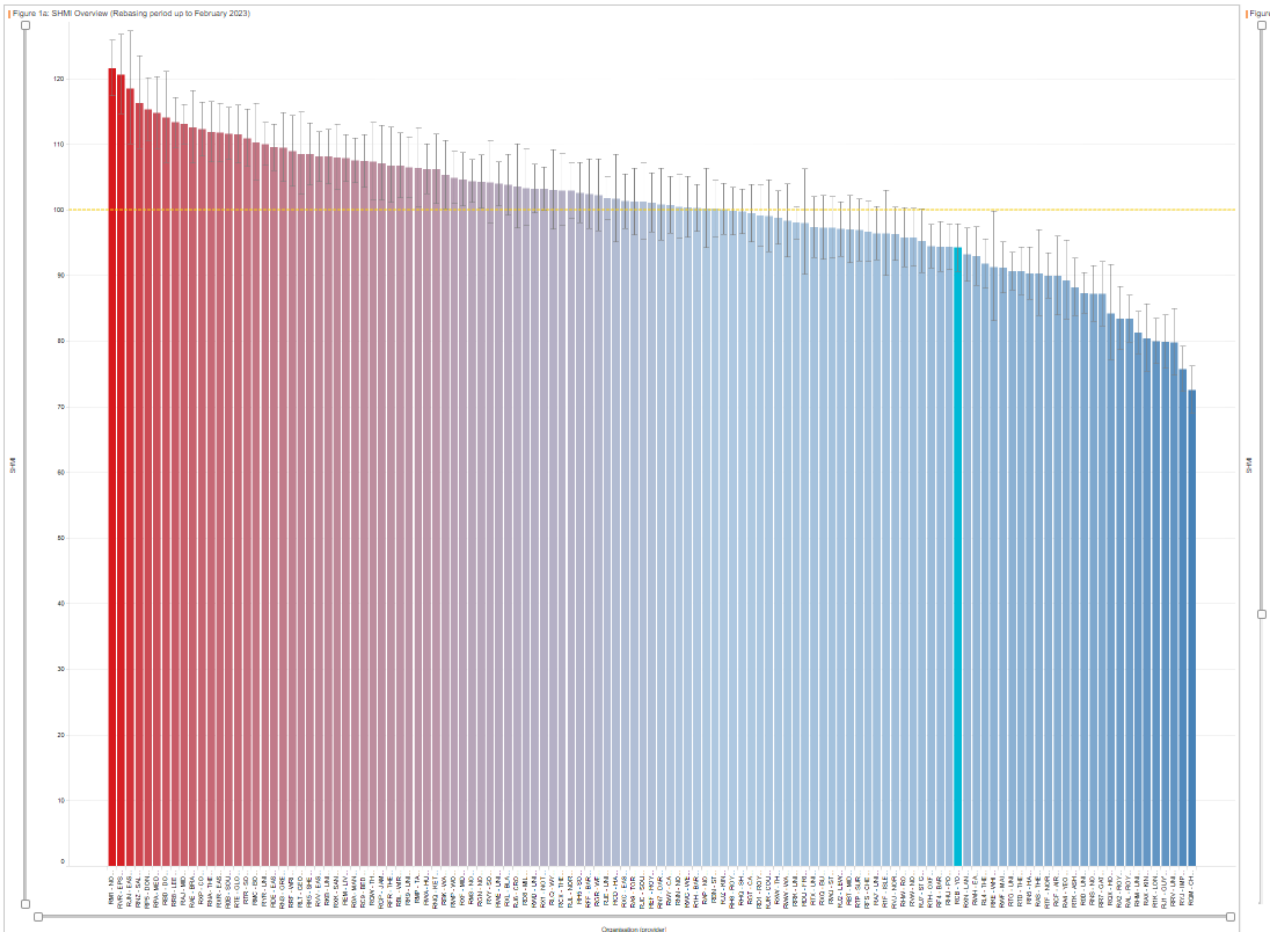
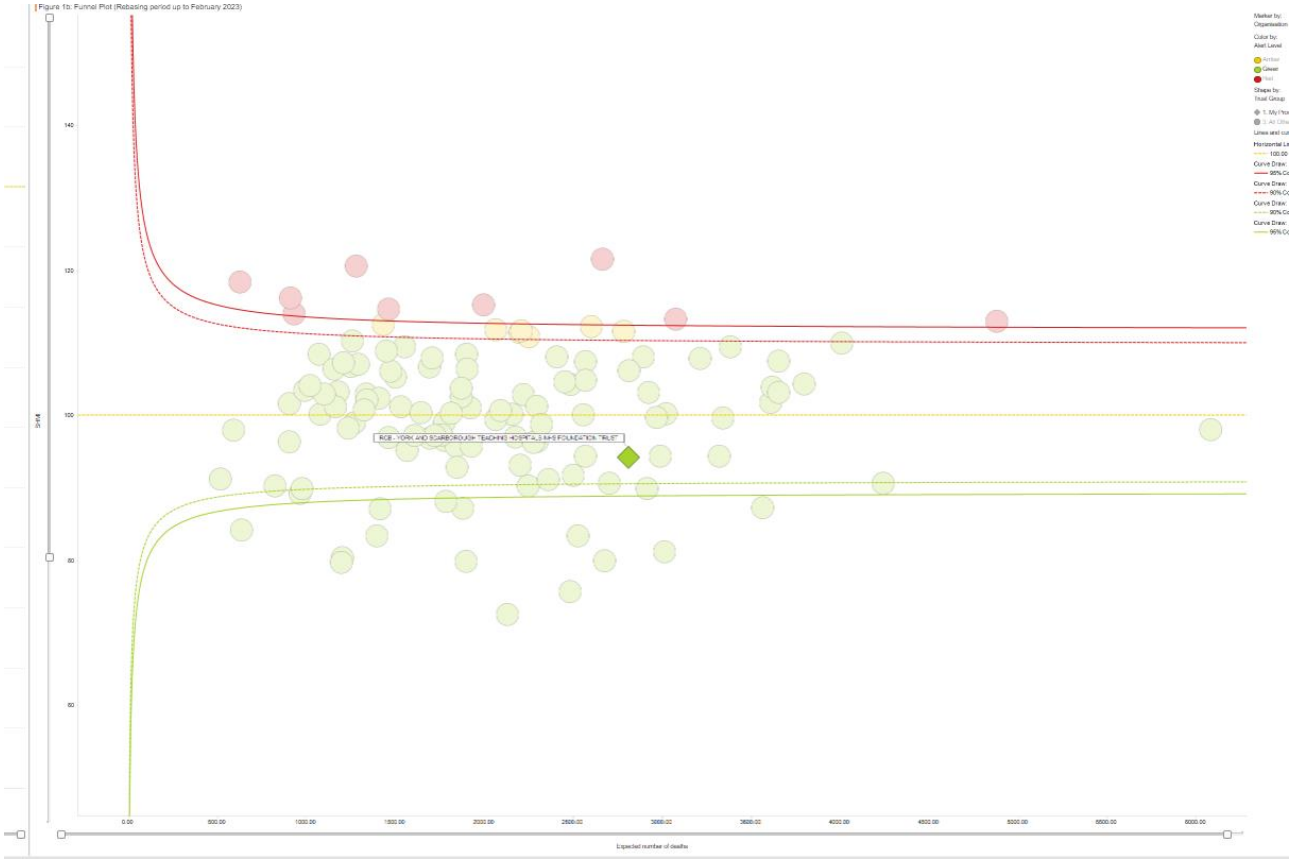


Figure 2 SHMI Funnel Plot



1.3 Hospital Standardised Mortality Ratio (HSMR)

The HSMR measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics e.g., demographics. It is not adjusted for palliative (end of life) care and does not include as many diagnostic groups as the SHMI.

The hospital HSMR is monitored in the background but not reported. However, any flags / alerts identified by HSMR that otherwise are not already identified by other mortality statistics would be reported as they arise.

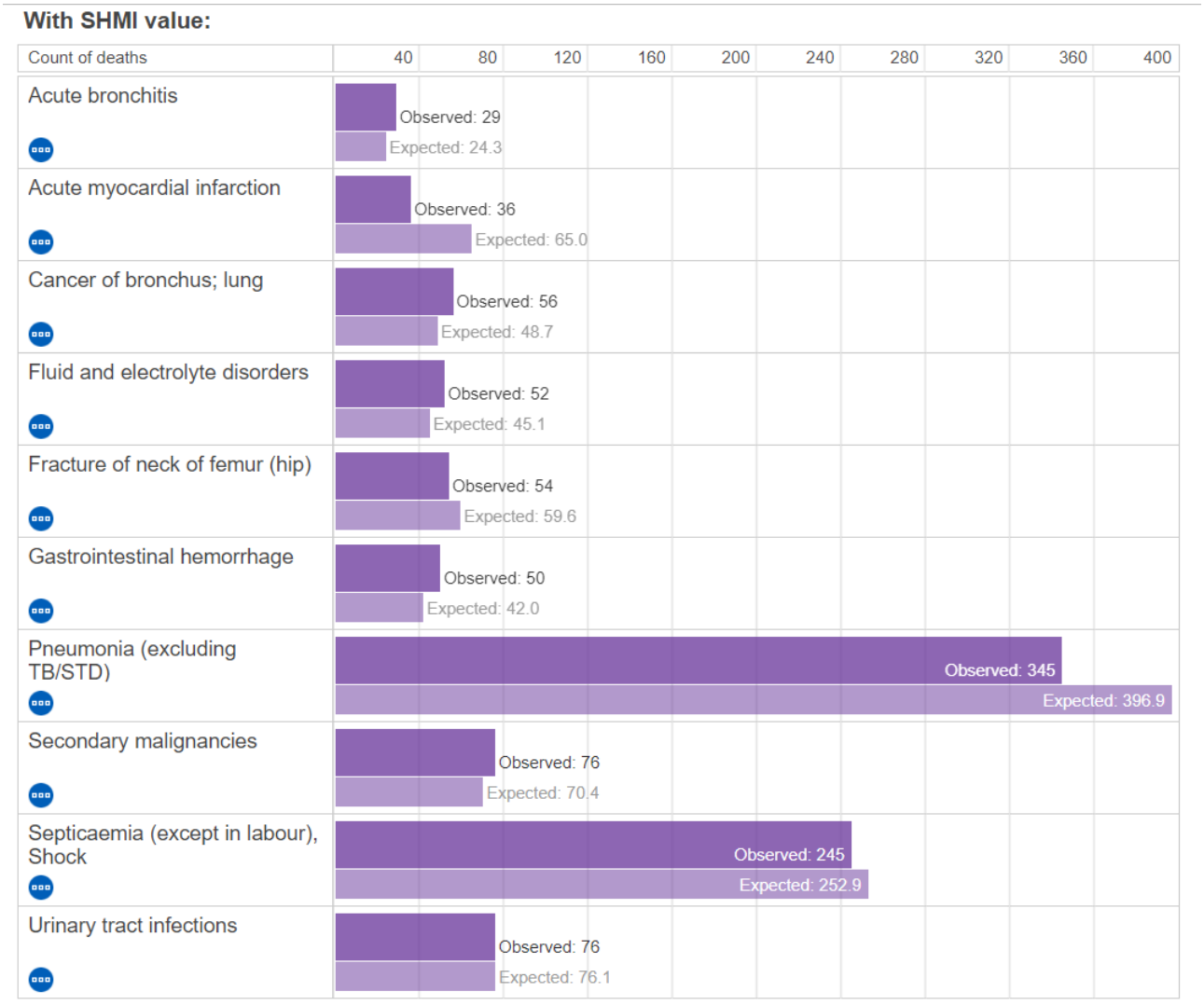
2. Diagnostic groups most contributing to our mortality rates

There are 142 diagnostic codes that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

For a subset of diagnosis groups, a SHMI value and SHMI banding is also provided. The bandings are ‘higher than expected’, ‘as expected’, or ‘lower than expected’.

These diagnosis groups are shown below in Figure 8. We look at both these and the diagnostic codes contributing to the SHMI to identify conditions potentially alerting for increased mortality.

Figure 8 - NHS-Digital SHMI Diagnostic Observed vs Expected Chart



Action Taken in Response to Excess Mortality

Diagnostic codes alerting in the SHMI and HSMR data through NHS Digital monitoring are triangulated with LfD themes and reviewed by the medical director's office to assess trends.

3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

This section provides data and outcomes in line with the requirements of the:

- National Guidance on Learning from Deaths (National Quality Board, 2017)
- Trust's Learning from Deaths Policy
- Department of Health and Social Care NHS (Quality Accounts) Amendment Regulations 2017

Whilst the report focuses on quarter 1 data, some information is provided for quarter 4 for comparison.

3.1 Nationally mandated data and information

The data provided in the table below is mandated by the national LfD framework. A narrative on learning and actions is provided in section 4.

SJCRs are Structured Judgement Case-note Reviews; SIs are Serious Incidents.

Table 2 – National data summary

	Jan	Feb	March	April	May	June
	Quarter 4 (22/23)			Quarter 1 (23/24)		
Total in-patient deaths (inc ED, exc community)	246	177	209	192	177	199
No. SJCRs commissioned for case record review[1]	7	6	5	1	9	8
No. SIs commissioned of deceased patients	6	5	4	4	3	6
No. deaths likely due to problems in care	See tables below					

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 2021/22, 22/23 and 23/24).

National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Tables 3 and 4 show the outcomes of the SJCRs **completed and reviewed** during Q4 and Q1:

- Table 3 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission.
- Table 4 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q1 18 SJCRs were reviewed (14 in Q4):

- The overall care score was given in 18/18 of cases.
    - The Reviewer found care good in 8/18 (44%) of cases and excellent in 1/18 (5.5%) of cases.
    - The Reviewer found care to be adequate in 5/18 (28%) of cases.
    - Reviewers found there to be 2/18 (11%) cases with poor care and 1/18 (5.5%) with very poor care.
- The Learning from Death Group agreed harm leading to death in 1/18 (5.5%) cases, moderate harm in 2/18 (11%) cases, minor in 1/18 (21%) of cases and no harm in 14/18 (78%) of cases.
- The incident leading to an agreed level of harm as death was in relation to an Elective Death WEB165902.

Table 3 – SJCR outcomes assigned by the Reviewer (overall score)

Overall score	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	TOTAL
Very poor care	0	0	0	0	0	1	**1**
Poor care	0	0	0	2	0	0	**2**
Adequate care	1	2	2	3	1	2	**11**
Good care	3	4	2	4	3	1	**17**
Excellent care	1	0	0	1	0	0	**2**
TOTAL	**5**	**6**	**4**	**10**	**4**	**4**	**33**

Data extracted from Datix on 24 July 2023

Table 4 – SJCR outcomes following review by LfD Group (degree of harm)

Degree of harm	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	TOTAL
Death	0	0	1	1	0	0	**2**
Severe	0	0	0	0	0	0	**0**
Moderate	0	0	0	1	0	1	**2**
Minor	2	1	0	0	1	0	**4**
No harm	3	5	3	8	3	3	**25**
TOTAL	**5**	**6**	**4**	**10**	**4**	**4**	**33**

3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance as we move towards the Medical Examiners review of 100% of deaths; and the timely completion of structured judgement case-note reviews.

Table 5 – locally mandated data

	Jan	Feb	Mar	April	May	June
	Quarter 4 (22/23)			Quarter 1 (23/24)		
No. of cases reviewed by ME (Scarborough)	87	57	75	60	75	84
No. of cases reviewed by ME (York)	129	102	113	108	84	95
% deaths reviewed by ME (Scarborough)	97.8%	96.6%	94.9%	88.2%	98.7%	97.7%
% deaths reviewed by ME (York)	97.7%	100.0%	100.0%	93.1%	87.5%	93.1%
% reviews resulting in further enquiry (Scarborough)	32.6%	16.9%	43.0%	10.3%	14.5%	11.6%
% reviews resulting in further enquiry (York)	18.9%	9.8%	8.0%	7.8%	15.6%	19.6%
No. SJCRs requested[1]	7	6	5	1	9	8
No SIs commissioned	6	5	4	4	3	6

1 The SJCRs are those requested in month (adjusted to account for reassignments and including deaths from 2021/22, 22/23 and 23/24).

Points to note:

The % of deaths receiving ME review during Q1 has reduced in both Scarborough and York Hospitals compared to Q4. Scarborough had reduced to 88.2% in April, where as York had reduced in all three months April (93.1%), May (87.5%) and June (93.1%). The medical examiners were asked to comment and feedback was their ability to review does depend on the availability of a Medical Examiner. There is often occasion, especially during the warmer periods, when the ME's are on annual leave and there is a struggle to fill the gaps (especially if there is sickness absence as well). There will be occasion where we have had to release an MCCD without scrutiny. Once the scrutiny becomes statutory from April next year, the percentage scrutinised will significantly increase.

The percentage of referrals from the ME for further enquiry is similar on both sites in Quarter 1 Scarborough site (10.3%-14.5%) and York site (7.8%-19.6%) in Q1. In Q4 there was a much larger comparison in further enquiries between the two sites. The national figure for further review is approximately 10% and we are now more in line with this.

Table 6 - Incidents Reported by Referral Type for Last 2 Quarters

	Quarter 4 (22/23)		Quarter 1 (23/24)	
	Family Concerns	ME Concerns	Family Concerns	ME Concerns
Scarborough	36.8%	63.2%	64.3%	35.7%
York	62.5%	37.5%	67.4%	32.6%

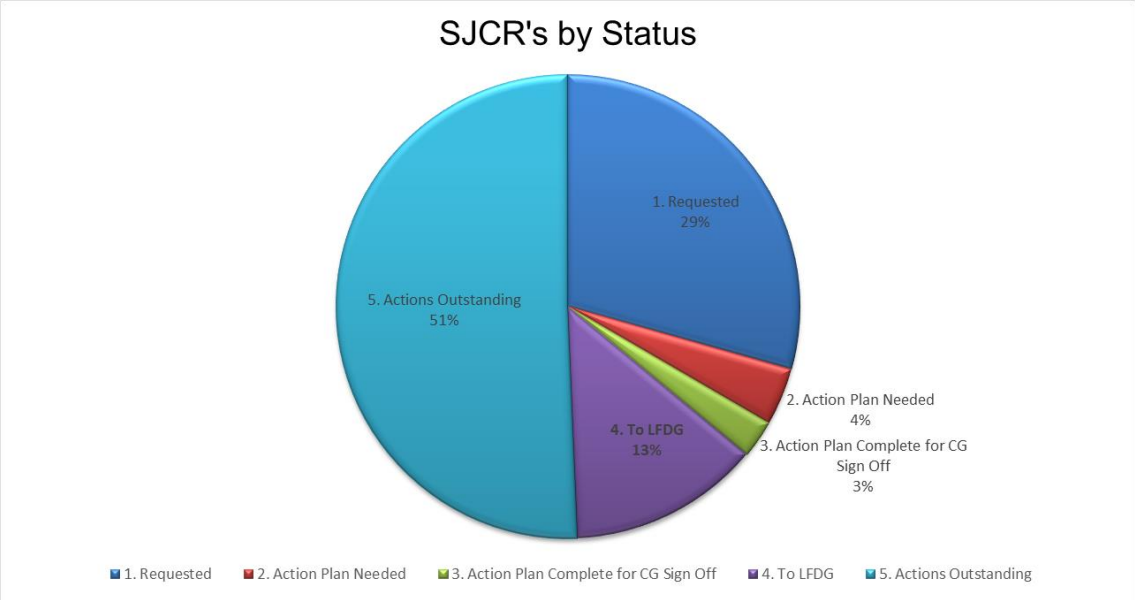
This is new data collated from the Medical Examiner team.
The main themes noted in the last quarter were:

- Next of Kin reporting lack of privacy and inappropriate bed moves at End of Life.
- Next of Kin reporting patient readmissions for the same or similar conditions
- Patients under several different consultants on consecutive days which resulted in difficulties find a Doctor to discuss a cause of death with and may also cause potential difficulties with the quality of care due to lack of continuity.

Data at point of reporting (20/07/2023)

Overall no. of SJCRs open: 75 (previously 72)

Figure 11 – Status of open SJCRs



There has been a slight increase in the number of open SJCRs compared with the previous quarter. However, there has been a reduction in the number of reviews overdue with 11 more than 60 days overdue, compared with 14 in the previous quarter.

	Current	Previous report
Number under review	22	21
Awaiting action planning	5	3
Actions outstanding	38	33
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	11	14

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 7 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2022/23.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2021/22 but were investigated during 2022/23 and hence not reported in the 2021/22 Quality Account.

Item	Requirement	Q3 data	Q4 data	Q1 data	Q2 data
27.1	Total number of in-hospital deaths	724	632	568	
27.2	No. of deaths resulting in a case record review or SI investigation (requested reviews of patients who died in 22/23 and 23/24)	ME: 634 SJCRS:36 SI:14	ME:563 SJCRS:18 SI:15	ME:506 SJCRS:14 SI:13	
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 23/24)	1	2	0	
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 3 SI:1	SJCR:1 SI:0	SJCR:18 SI:1	
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	2	0	1	
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	14	14	Previously stated: 5 Updated total: 6	

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group

[2] Reviews completed in 2023/24 after the 2022/23 Quality Account was published

Items 27.4-6 relate to learning from case record reviews and investigations; a description of actions taken and proposed; and an assessment of the impact of the actions. These items are covered in the next section.

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

These require review following national processes; their findings are escalated to the Quality & Patient Safety Group (QPaS) as per scheduled report.

Local serious incident investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs. A specific report is escalated to QPaS summarising the learning.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.
- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

Table 8 below shows the source of SJCR requests between October 2022 and March 2023, primarily generated by concerns from the Medical Examiner.

Table 8 – Source of request for SJCR

SJCR Request Source	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	TOTAL
1. Initial Mortality Review	0	0	0	0	0	0	**0**
2. Medical Examiner Review	1	2	2	3	2	0	**10**
3. Q & S Meeting	0	0	1	0	0	0	**1**
4. Learning Disabilities	2	1	1	2	2	1	**9**
5. Elective Admission	0	0	0	2	0	0	**2**
6. NoK Concern/Complaint	1	2	0	2	0	0	**5**
7. Care Group	1	1	1	1	0	3	**7**
TOTAL	**5**	**6**	**5**	**10**	**4**	**4**	**34**

4.1 Themes from SJCRs considered by the LfD Group in Q1:

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work.

Assessment against five themes, collated over many months as part of the SJCR, are shown as per Datix dashboard in Table 8. This information is based upon the judgement of the Reviewer.

Table 9 – Thematic review of all SJCRs reviewed

Theme	Yes	No	Total	Compliance	Previous report
Senior review appropriate	156	29	185	**84%**	**85%**
Ceiling of Care documented	156	27	183	**85%**	**85%**
Deterioration recognised and managed	146	37	183	**79%**	**81%**
Good communication between the MDT	151	30	181	**83%**	**81%**
Good communication with patient / family	150	26	176	**85%**	**85%**
Was there a Healthcare associated infection?	149	36	185	**80%**	**81%**

Clearly in the vast majority of cases appropriate care was given and communication was reasonable, there has been a slight improvement in 1 of the themes.

A new addition to Datix is the capturing of themes (1&2), aligned with those used for serious incidents. The themes identified are shown in Table 10 (primary theme) and Table 11 (secondary theme if relevant).

Table 10 – Primary themes identified

	Jan	Feb	Mar	April	May	June	Total
No Themes Identified	2	2	0	2	0	0	**6**
Comms / Documentation	1	2	2	0	1	1	**7**
Delayed Diagnosis / Treatment	0	1	0	0	0	0	**1**
Escalation	0	0	1	0	0	0	**1**
Pathways/Process	0	0	0	0	0	0	**0**
Capacity / Demand	0	0	0	0	0	0	**0**
Clinical Assessment	0	0	0	0	1	0	**1**
Nutrition and Hydration	1	0	0	0	0	0	**1**
Medication Errors	0	0	0	0	0	0	**0**
Learning disabilities	0	0	0	1	1	0	**2**
Patient factors	0	0	0	0	1	0	**1**
Guidance/Policies	0	0	0	1	0	0	**1**
Other	0	0	1	1	0	0	**2**
Total	**4**	**5**	**4**	**5**	**4**	**1**	**21**

Table 11 – Secondary themes identified

	Jan	Feb	Mar	April	June	May	Total
Environment	0	0	0	1	0	0	**1**
Capacity / Demand	0	0	0	0	0	0	**0**
No Themes Identified	3	2	2	3	0	0	**10**
Comms / Documentation	1	1	0	0	1	0	**3**
Staffing/Workload	0	1	0	0	0	0	**1**
Clinical Assessment	0	0	0	1	0	0	**1**
Learning disabilities	0	0	0	0	1	0	**1**
Other	0	2	1	0	0	1	**4**
Total	4	6	3	5	2	1	**21**

More specific detail about the themes can be seen in the boxes below.

End of Life care

- Inappropriate decision to reverse end of life care.
- Clear evidence patient approaching the end of life and no decision made- delay in decision making resulted in patients wishes not being able to be followed.
- Paper notes missing and the quality of record keeping was highlighted several times within Q1 and escalated in the monthly report to OQG.

Observation / Assessment / Escalation

- Delay in review and initiation of sepsis pathway specifically antibiotic
- No evidence of formal assessment of capacity.
- MCA not clear completed- requiring further review by MCA team before LfD able to sign off SJCR.

Operational matters

- Decision making effected by several ward moves.
- Multiple ward moves.
- Patient experience effected by outliers and multiple ward moves

Documentation/ Notes

- Notes not in order effecting efficiency in completing SJCR reviews.
- Missing notes within the medical records for example not able to find MCA form in patients records.

4.2 Improvements underway:

Most of the themes identified from death reviews are aligned with existing improvement initiatives.

4.2.1 Datix Cloud IQ

A mortality module has been built on the new Datix cloud IQ incident reporting system where all SJRs will be highlighted and held, this went live on 1st August 2023. Both the Bereavement Team and Medical Examiner teams were heavily involved in the development of this module.

Care groups and the patient safety team now have the ability on Datix to refer incidents to the relevant Improvement Groups.

5. Service developments

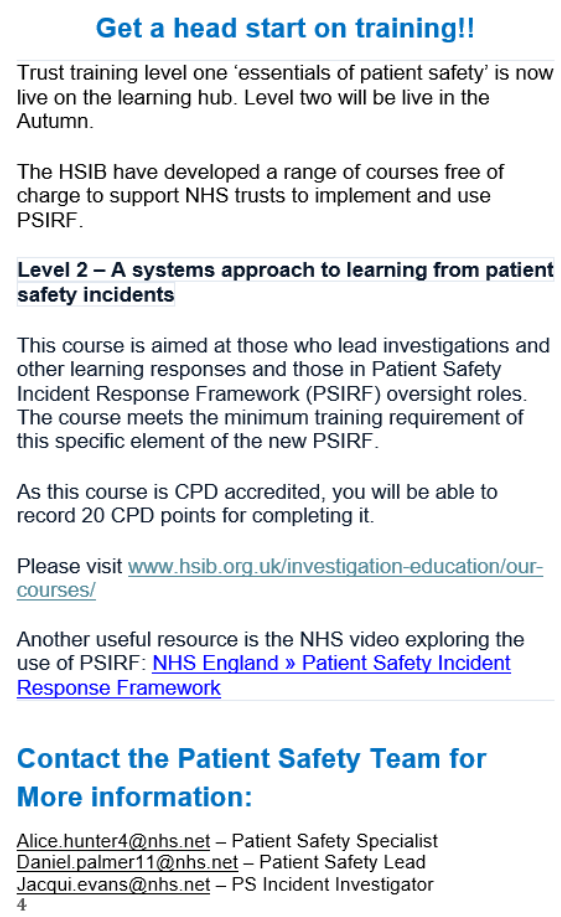
1.1 Developments undertaken.

5.1.1 End of Life

An End of Life working group has been implemented in addition to the Learning from Deaths meeting. Both meetings will feed necessary information into one another when required.

5.1.2 PSIRF

A booklet has been developed informing staff of PSIRF There is a project plan developed and a project group established.



Get a head start on training!!

Trust training level one 'essentials of patient safety' is now live on the learning hub. Level two will be live in the Autumn.

The HSIB have developed a range of courses free of charge to support NHS trusts to implement and use PSIRF.

Level 2 – A systems approach to learning from patient safety incidents

This course is aimed at those who lead investigations and other learning responses and those in Patient Safety Incident Response Framework (PSIRF) oversight roles. The course meets the minimum training requirement of this specific element of the new PSIRF.

As this course is CPD accredited, you will be able to record 20 CPD points for completing it.

Please visit www.hsib.org.uk/investigation-education/our-courses/

Another useful resource is the NHS video exploring the use of PSIRF: NHS England » Patient Safety Incident Response Framework

Contact the Patient Safety Team for More information:

Alice.hunter4@nhs.net – Patient Safety Specialist
Daniel.palmer11@nhs.net – Patient Safety Lead
Jacqui.evans@nhs.net – PS Incident Investigator

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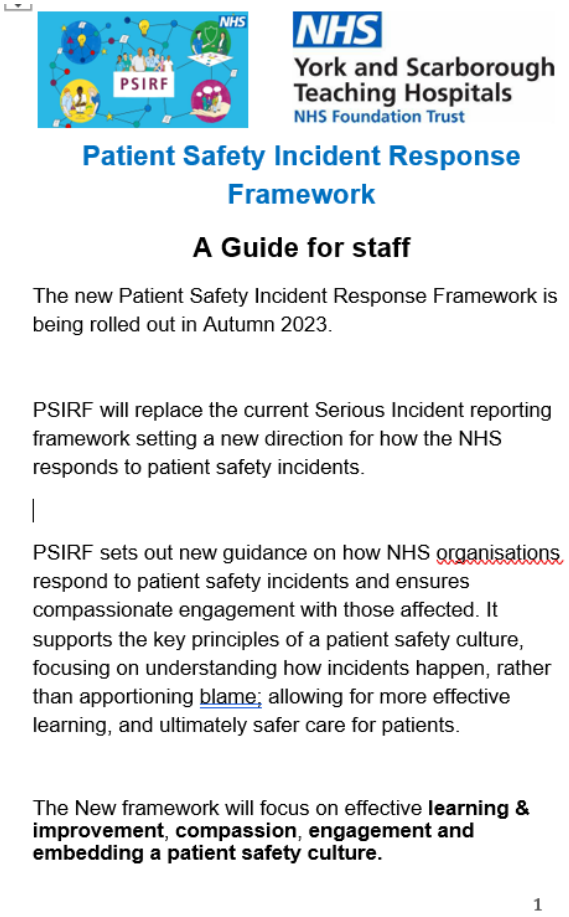


PSIRF

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Framework

A Guide for staff

The new Patient Safety Incident Response Framework is being rolled out in Autumn 2023.

PSIRF will replace the current Serious Incident reporting framework setting a new direction for how the NHS responds to patient safety incidents.

PSIRF sets out new guidance on how NHS organisations respond to patient safety incidents and ensures compassionate engagement with those affected. It supports the key principles of a patient safety culture, focusing on understanding how incidents happen, rather than apportioning blame; allowing for more effective learning, and ultimately safer care for patients.

The New framework will focus on effective **learning & improvement**, **compassion**, **engagement and embedding a patient safety culture.**

1

What does it mean for me?

- Greater focus on understanding the impact of system and human factors in patient safety incidents
- Understanding the '**what**' not the '**who**' in investigations to support a just and learning culture.
- Not all serious events will lean to a Patient Safety Incident Investigation – other tools such as after-action reviews, can be used.
- Greater support and involvement for those involved in patient safety incidents.
- In some cases, where it is already clear why the incident happened, it will be more appropriate to concentrate on making improvements rather than spending more time on investigations.
- Essentially, there will be fewer formal investigations of incidents, but you will be more likely to be involved in other approaches to learn from incidents and improve patient safety.
- A new training package will be procured by the trust in the near future.

?? Frequently asked questions ??

Why has the Trust decided to change this process?
This is a national change driven by NHS England with a move toward a systems-based approach to reviewing incidents.

What does PSII stand for?
Patient Safety Incident Investigation

Is my SI investigations training valid in this new process?
No, unfortunately not. The new framework uses different methodologies to the serious incident framework which means a new training package will need to be implemented.

The band 7's currently complete falls and pressure AAR's can they still do this?
Yes, in the new framework Band 7 's and 6's will be able to complete AAR's however they will have to be commissioned signed off formally by a Band 8a and above member of staff trained in PSIRF.

How long is the training?
This is a one-off training program; once completed staff will not have to repeat the training. Most training is delivered over 3 – 4 days with a range of flexible ways of completing including an online program.

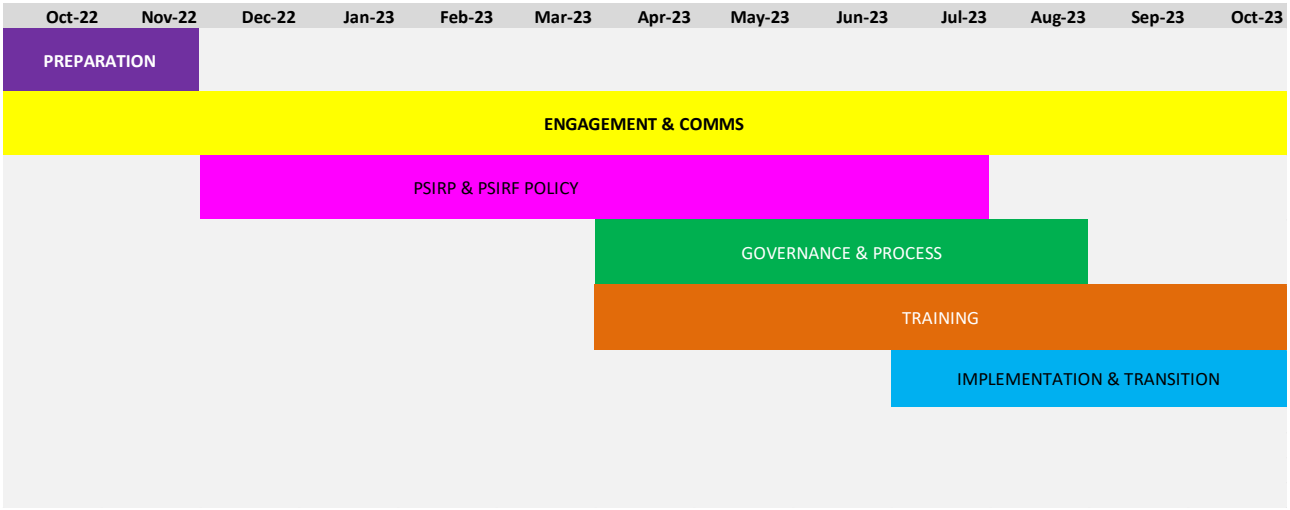
Who will be an investigator?
The investigators will be chosen by the Care Groups. It is recommended that these members of staff are working at Band 8a and above.

What review options are now available to us?
After Actions Reviews, MDT reviews, SWARM huddles,

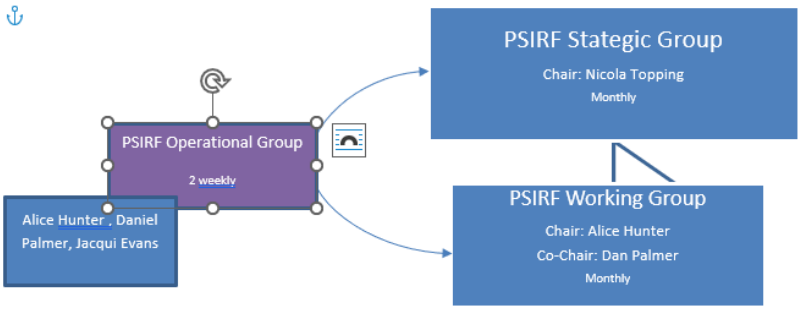
When would we do a Patient Safety Incident Investigation?
Investigations are required for 'never events' and where an incident has resulted in a death. A flowchart will be available to guide staff on investigations and alternative responses.

Will this add to the long list of actions resulting from incidents?
No, actions will be themed, more focus placed upon the improvements needs to close actions rather than repeating the same action over and over in different reports.

There is a PSIRF project plan comprising actions required for the implementation by autumn 2023. The plan is divided into tabs summary of which will be detailed below along with their progress and any concerns.



PSIRF Group Structure



6. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -
   a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.
   b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
   c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.
   d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have

exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

Quality Committee – Chair's Assurance Report

Date of Meeting:	21st November 2023			**Quorate (yes/no):**	Yes	
Chair:						
Members present:	Stephen Holmberg (Chair), Lorraine Boyd (NED), Jenny McAleese (NED), Dr Nicola Topping (Deputy MD), Dawn Parkes (CN), Mike Taylor			**Key Members not present:**	Dr Karen Stone (MD)	
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
10 Maternity Services (Ockenden)		To inform the Board of on-going work to address concerns by CQC and to achieve compliance with Ockenden and other maternity standards. There remain gaps in assurance regarding the safety and quality of services but the committee was assured that the new approach in the leadership team is building evidence of sustainability in the improvement trajectory	Information and escalation
11 CQC Compliance Report		To inform the Board of on-going work to address regulatory action imposed by CQC and to address additional	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

		recommendations for improvement in the Trust. Committee received a progress report with evidence of improvement and further assurance from the evolving relationship with the CQC	
15 IPC		The committee has renewed concerns about hospital acquired infections. C. diff levels have stabilised but remain high. MSSA infection rates are a cause for concern and the Committee was encouraged to hear of work to improve cannula management and asked that MSSA infections should be subject to a PIR process	Information and escalation
10 Maternity Services		Concerns were presented regarding staff and patient toilets and other facilities in different areas of maternity. Slow progress to address these is causing significant problems within the service	Escalation
6 & 8 Surgery CG & MD Report		The Committee retains concerns about unidentified patient harms associated with delays in diagnosis and treatment or care in sub-optimal settings (e.g. long stays in ED). The Committee was encouraged to hear that work is planned to develop a programme of clinical reviews for patients on long waiting lists for elective care but the detail of this needs to be better understood. The burden on diagnostic services was understood and while a further focus on this was welcomed, the Committee is looking for assurance that all such initiatives are targeted to reduce patient harm as much as possible	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

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:	29 November 2023
Subject:	Emergency Planning Resilience and Response (EPRR) – Core Standards Revised Assurance Rating
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 the Trust EPRR Core Standards submission, endorsed on 20 September 2023, has been subjected to a new NHS England assurance rating process and as a result the Trust assurance rating has been revised down from partial compliance to non-compliance.
- Note that this new process has resulted in a down grading across all providers in the Humber & North Yorkshire ICB.
- Note that introducing this model in the region this year was about establishing a baseline compliance level – a hard reset of the region's readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.
- Note the key priorities and revised action plan for EPRR that will be implemented over the next 12 - 24 months.

Recommendation:

The Board of Directors is requested to:

- To approve the revised assurance rating of "Non-Compliant" with the NHS England EPRR Core Standards.

- Endorse the revised EPRR Action Plan.

Report Exempt from Public Disclosure

No ☒ Yes ☐

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS – REVISED ASSURANCE RATING

1. Introduction

The Executive Committee endorsed the EPRR Annual Self-Assessment paper on 20 September 2023 and the Board of Directors endorsed the same paper on 27 September 2023. The overall assurance rating grade in that paper was PARTIAL and the paper provided a narrative on a significant change to the NHS England assurance process for 2023/2024 whereby evidence to support the self-assessment had to be provided to NHS England.

The NHS England assurance process has been completed and the Trust evidence reviewed. This has resulted in a requirement to downgrade the assurance rating from PARTIAL compliance to NON-COMPLIANT.

The Board of Directors is requested to note this revised 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 24 months.

2. Background

2.1 Rationale for Change In Assurance Process. Over recent years the EPRR world has seen significant disruption and change – from the UK's exit from the EU to the COVID-19 pandemic, the Manchester Arena attack, and the recent series of industrial action. The demands of Accountable Emergency Officers, EPRR professionals and Boards ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public enquiries (Manchester Arena, Grenfell and the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirwell Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried and tested plans is one which requires a dedicated assurance framework which can assure NHS England collective system resilience.

2.2 2023/2024 EPRR Assurance Model. A pilot of the amended assurance process was conducted in the Midlands Region last year. The process resulted in 66% of organisations having their self-assessment assurance ratings downgraded; 7% dropped 3 compliance levels (FULL to NON-COMPLIANCE), 39% dropped 2 compliance levels (FULL to PARTIAL or SUBSTANTIAL to NON-COMPLIANCE) and 54% dropped 1 compliance level (FULL to SUBSTANTIAL, SUBSTANTIAL to PARTIAL or PARTIAL to NON-COMPLIANCE).

Implementation of the same model within North East and Yorkshire region was agreed with the intention to undertake an open, honest and transparent review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving collective resilience for patients and communities.

Introducing this model in the region was about establishing a baseline compliance level – a hard reset of the region's readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

3. 2023/2024 EPRR Assurance Ratings

3.1 2023/2024 EPRR Assurance Rating – Self Assessment Submission.

The Trust submitted an initial self-assessment as follows:

Core Position Standard Position After Self-Assessment			
Number of Core Standards Applicable	Fully Compliant	Partially Compliant	Non-Compliant
62	51	10	1

3.2 2023/2024 EPRR Assurance Rating – Initial Check and Challenge.

NHS England conducted a check and challenge process in October 2023 on all ICB organisations. Panels of NHS England and ICB EPRR professionals reviewed uploaded evidence to support the organisation's self-assessment and the results across the ICB were as follows:

Organisation	Total Applicable Standards	Organisational 2023 Self Assessment				Panel 2023 October Assessment				Level of challenge	
		Number non-compliant	Number partially compliant	Number fully compliant	Overall self assessment rating	Number non-compliant	Number partially compliant	Number fully compliant	Overall panel assessment rating	Total standards accepted	Total standards challenged
City Healthcare Partnership	58	0	2	48	83%	6	42	10	17.24%	20	38
Humber FT	58	1	9	45	78%	8	44	6	10.34%	19	39
HNY Integrated Care Board	47	0	10	37	79%	1	35	11	23.40%	21	26
Hull Teaching Hospitals	62	0	8	54	87%	13	41	8	12.90%	17	45
NAVIGO	58	0	17	33	57%	21	35	2	3.45%	27	31
Northern Lincolnshire and Goole	62	0	8	54	87%	7	41	14	22.58%	22	40
York and Scarborough	62	1	10	51	82%	13	36	13	20.97%	25	37
Care Plus Group	58	1	11	37	64%	Pending feedback					
Harrogate and District	62	3	21	36	58%	Pending feedback					

3.3 2023/2024 EPRR Assurance Rating – Final Recommendation.

The Trust were provided with feedback on the initial self-assessment and had 7 days to provide supplementary evidence to further respond to NHS E challenges. The initial check and challenge gradings in paragraph 3.2 were amended after the further evidence review into the final core position as follows:

Core Position Standard Position Recommendation After Check & Challenge			
Number of Core Standards Applicable	Fully Compliant	Partially Compliant	Non-Compliant
62	14	47	1

4. EPRR Core Standards Action Plan

The results of the 2023/2024 EPRR Core Standards assurance process have been particularly disappointing for the Trust EPRR team and significant subsequent work has been conducted to identify the reasons for the variance between the Trust submission and then the subsequent NHS England position. There are varying reasons such as:

- The Trust EPRR team acknowledge that the operational pressure on staff and the response support that the EPRR team have been engaged in has prevented training and testing of plans. The Trust initial submission recognised this in the Training and Exercising Domain however the lack of training and exercising is relevant to every other domain resulting in what was deemed a fully compliant standard in those domains being downgraded to partially compliant.
- The interpretation of the core standards has varied from provider to provider and this year is the first where this variance has been removed and one set standard mandated for all.
- The downgrading of some core standards is as a result of a very minor omission in a plan or policy i.e. "The role of the COO be explicably aligned as the AEO and be described in the job description" attracted a downgrading from fully compliant to partially compliant.
- In some instances, the benchmark to be achieved in the standard referred to guidance and policy that the Trust EPRR team were unaware of.

A revised Statement of Compliance can be found at Appendix 1 and a revised EPRR Action Plan for 2023/2024 can be found at Appendix 2. It should be noted that formal updates against the action plan will be submitted to NHS E quarterly and that monthly progress discussions will take place with the ICB.

5. Summary

The Regional Head of EPRR for the North East & Yorkshire and North West Regions has provided an overview of the EPRR Core Standards assurance process for provider boards and is provided separately to this report. In his summary of the way forward he provides the following narrative:

> "It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery".

Work is now underway with the ICB and partner providers to rectify the concerns raised by NHS England. There will be quick wins that will contribute to an improvement for the 2024/2025 assurance process however, it is likely that a grading of non-compliance may endure beyond next year's report as the larger projects are completed.

Appendices:

1. EPRR Core Standards Assurance – Revised Statement of Compliance.
2. EPRR Core Standards Assurance – Revised Action Plan 2023-2024.

Date: 15 November 2023

Appendix 1 – EPRR Core Standards Assurance – Statement of Compliance

North East & Yorkshire 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 v1.0

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 Non-compliant 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 Accountable Emergency Officer (AEO) pending submission to the Board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

15/11/23

Date signed

29/11/23	29/11/2023	01/06/2024
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix 2 – EPRR Core Standards Assurance – Revised Action Plan 2023/24

Ref	Domain	Standard name	Standard Detail	Y&SFT Grading	NHS E Final Grading	NHS E Concerns Raised	NHS E Recommended Action	NHS E General Observation or Secondary Challenge	Trust Action	Actionee	Target Date	Remarks / Updates
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.	G	A	Whilst the JD & PS that was submitted as evidence denotes the COO role for business continuity and emergency preparedness **there is no reference of the COO role being the Accountable Emergency Officer role.** It is detailed within the EPRR policy but the **version submitted is out of date**. No evidence has been provided to confirm **who the AEO is for the organisation.**	The role of the COO be explicitly aligned as the AEO and **be described in the job description** and outlines their accountability, authority and responsibilities with regards to EPRR		1 - Amend COO JS to include a clear statement that COO appointment is AEO and outlines their accountability, authority and responsibilities. 2 - Cross check that EPRR Policy includes accountability, authority and responsibilities as per the JS and then publish EPRR Policy update.	AB RC	Q3 - 23 Q3 - 23	
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.	G	A	The EPRR policy that has been submitted as evidence has a review date of September 2023. **The Policy is out of date.**	Trust to provide relevant evidence as part of supplementary evidence submission					
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	G	G			Whilst a report to public Board is evident, the 2022 report does not detail all areas as set out in the supporting information section of the EPRR core standards. In order to ensure compliance for 2023, **the Trust should ensure that training & exercising, a summary of any incidents experienced, lessons identified and learning from incidents and exercises should also be incided in future Board reports. A good practice example is to set out your Board report along the lines of each of the 10 domains of the core standards.**	3 - The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation.	RC	Q2 - 24	
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.	G	A	National requirement for organisations to outline the work programme being driven by guidance, lessons identified, identified risks and the outcome of any assurance reports. The work programme provided was developed in July 2023 and doesn't provide evidence of whether **EPRR work programmes in the Trust run calendar year to calendar year, or financial year to financial year**. The EPRR work programme should be driven by updates to national guidance, identified risks (national, regional & organisational), lessons identified from incidents and exercises and outcomes of any assurance processes. Whilst there is clear evidence on the work programme of a schedule of work identified by the Trust in relation to EPRR the areas outlined on the core standard summary are not integrated e.g. **no evidence of the full set of actions identified in the 2022/23 core standard review being included in the work programme for 2023, no evidence of any lessond identified from incidents and exercises, no evidence to indicate plans or policies to be reviewed in line with new or amended guidance etc**. Additionally, whilst the Terms of Reference for the EPSG have been provided, no evidence has been included which provides **assurance that the work programme is regularly reported on and shared**.	Evidence of governance and reporting arrangements, alongside ownership and completion dates being included in the organisations work plan to be evidenced - **we would have anticipated a monthly or quarterly review schedule being in place since its implementation in July 2023.** Evidence of a work programme which outlines the core areas as set out in the standard detail, supporting information and examples of evidence.	Work programme to take the form of a workstream and action tracker, and which would enable a wider range of the Trusts schedule.	4 - The EPRR Work Schedule is to be reviewed to include the following: a) A register to capture monthly checks by EPRR team and quarterly by the EPSG. b) A table to capture lessons identified, changes to risk assessments and government guidance. Table is to include thumbnails of the appropriate reference document. c) Include this action plan in the schedule. d) Amend title of schedule to indicate financial year. 5 - Amend the EPSG ToRs and Standing Agenda to ensure that the EPRR Work Schedule is reviewed at each meeting and the EPRR Schedule of Work Record of Checks is annotated accordingly. 6 - Amend the WG ToRs and Standing Agendas to ensure that the EPRR Work Schedule is reviewed at each meeting and a record of the check is included in the action notes.	AB AB AB AB RC RC / AB	Q3 - 23 Q3 - 23 Q3 - 23 Q3 - 23 Q3 - 23 Q3 - 23	
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.	G	A	National requirement for the Board/Governing body to be satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties. **No evidence has been provided that the resources available to the Trust have been assessed by the organisation** as sufficient - capacity versus demand.	Evidence that the Board/Governing body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties to be provided - e.g. **statement in Board minutes confirming that resourcing is adequate in response to EPRR portfolio**		7 - Review of EPRR resource to be conducted in 2024 and recommendation included in 24/25 EPRR Core Standards report to Executive Committee and Board of Directors	RC	Q3 - 24	
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.	G	A	National requirement for the organisation to have a clearly defined process for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements, and that this process is explicitly described in the EPRR policy statement. Whilst the need to identify lessons is mentioned within the policy and is included in the Terms of reference for a number of EPRR groups, **there is no explicit section which describes the process by which identifying lessons from incidents and exercises takes place in order to ensure that they are captured centrally and embedded across the organisation, there is no evidence of these lessons being reported to Board, and whilst the ToR indicate learning in a number of groups, there is no standing agenda item which covers lessons identified, learning or continuous improvement for EPRR**. (noted that there is a section bespoke for BCMS continuous improvement)	Evidence of standard detail, supporting information and examples of evidence elements as outlined in the national spreadsheet in order to demonstrate compliance		8 - Include in EPRR Policy review the process for identifying lessons from incidents and exercises. 9 - Include in 24/25 Executive Committee and Board of Directors reports a section on lessons from incidents and exercises. 10 - Amend standing agendas for EPSG and WGs to review lessons identified, learning and continuous improvement.	AB RC RC / AB	Q2 - 24 Q3 - 24 Q3 - 23	

Ref	Domain	Standard name	Standard Detail	Y&SFT Grading	NHS E Final Grading	NHS E Concerns Raised	NHS E Recommended Action	NHS E General Observation or Secondary Challenge	Trust Action	Actionee	Target Date	Remarks / Updates
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.	G	A	National requirement is that the organisation has in place a process to regularly assess risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers. Whilst the EPRR policy makes reference to a need to undertake risk assessment, and the EPSG includes this requirement as both a requirement under their Terms of Reference and standing agenda items, there is no evidence of risks being assessed or governed in regards to EPRR prior to July 2023, or **minutes which demonstrate this has taken place**. There is no evidence that the EPRR risks have been regularly considered and recorded or that these are represented on the Trust corporate risk register. **No evidence has been provided which outlines the governance arrangements for EPRR risks in regard to the consideration or recording of risks, the schedule in which risks are reviewed, how EPRR risks are assessed, actioned and included in the work programme or linked to the Trusts risk register and the thresholds for escalation of risk within the Trusts risk framework**.	Evidence that the Trust has a process in place to assess risks, the Trust EPRR risk register inclusive of governance processes and the associated arrangements for reviewing and mitigating risks within the Trust to be provided		11 - Review EPRR Policy to expand risk assessment governance and responsibilities. 12 - Review EPRR Risk Register and introduce a Risk Assessment form for each serial on the register and include as a thumbnail. Include a check sheet as the first sheet to record checks conducted at the EPSG. 13 - Check that EPRR Risk escalation process is included in the Trust Risk Framework specifically.	RC RC / AB AB	Q3 -23 Q3 - 24 Q4 - 23	12 - Accept that all risk assessment forms will take 2024 to complete therefore EPRR Core Standards likely to ramin AMBER with evidence of progress.
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	G	A	Please see comments for core standard 7	Please see evidence requested for core standard 7					

Ref	Domain	Standard name	Standard Detail	Y&SFT Grading	NHS E Final Grading	NHS E Concerns Raised	NHS E Recommended Action	NHS E General Observation or Secondary Challenge	Trust Action	Actionee	Target Date	Remarks / Updates
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	A	National requirement is for plans and arrangements to have been developed with relevant stakeholders and have undergone a clear consultation process. **Records of consultations and any changes made to documents as a result of those consultations should also be maintained**. Evidence provided does demonstrate clear evidence of collaborative working with partners, however the **governance element has not been provided and is not included in the EPRR Policy**.	Evidence of the governance arrangements to ensure partner organisations are collaborated with to be provided as outlined in the standard detail, supporting information and examples of evidence		14 - Add to version control front sheet on every policy and plan the details of any consultation with partners. 15 - Add section on collaborative planning to the EPRR Policy.	RC RC	Q3 - 23 Q3 - 23	
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.	A	A				16 - In response to several general recommendations, review layout of Trust IRP and in Annexes only include information required for the reader to initiate response. Move all other information such as roles, responsibilities, governance, training and exercising to a stand alone policy document.	RC	Q3 - 24	16 - RC to contact ST to discuss the rationale of the seperation of information and to confirm the provenance of the guidance.
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.	G	G			Recommendation - The Trust Adverse Weather Plan is of a significant size (80 pages). We would advise a plan of that size sits as a stand-alone plan, or the response elements alone sit as an annexe to the IRP, with a summary adverse weather Framework which details the governance and planning the Trust undertakes (e.g. seperating out preparedness from response to enable people picking up the plan to use to easily find the response element they need). **No evidence of testing or exercising of the plan has been provided**, and whilst we recognise that the plan will have been enacted and shows amendments as a result of the heatwave, **there is no governance which indentifies what lessons were identified or what changes were made as a result of this reflection taking place**.	17 - Testing and exercising to be captured in central register. Where amendments to the plan have been done as a result of lessons identified then include thumbnail of document on the version control sheet.	AB	Q4 - 23	
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.	G	A	National requirement for organisations to have arrangements in place to respond to an infectious disease outbreak, whose scope includes the management of HCID. Whilst a draft HCID SOP in development has been provided, no evidence has been provided of an **infectious diseases or outbreak plan which includes FFP3 resilience principles, an IPC policy being in place, swabbing, prophylactic pathways, contact tracking or PPE. No evidence of testing, exercising or training associated with a plan.**	Evidence to be provided of arrangements to respond to infectious diseases which covers the elements outlined in the standard detail, supporting information and compliance requirements sections provided to the Trust,	Supplementary evidence and commentary provided by the organisation indicates that there is an outbreak plan (owned by IPC) which has been included - we cannot find evidence of this being uploaded, and a respiratory virus guideline (which has been included) - the respiratory guidelines document is robust and provides details on core elements of managing both an infectious respiratory patient and any subsequent tracking, however **in the absence of the wider outbreak plan this does not extend to a wider infectious diseases outbreak as required by the standard.** As noted in the original feedback to the Trust the standard has a requirement for arrangements to include HCID of which the Trust plan remains in draft - as such we would advise the Trust to submit a rating of partial compliance until their **HCID sop is ratified and tested**, and their outbreak documents can be confirmed as being in line with the requirements of this standard.	18 - Determine the requirement for an infectious disease and outbreak policy separate to the Pandemic Flu Plan. 19 - Ratify and publish the HCID SOP and test.	RC RC	Q3 - 23 Q4 - 23	18 - RC to speak with ST to clarify the requirements of Infectious Disease, Outbreak, HCID and Pandemic Flu

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	G	A	National requirement for the organisation to have arrangements in place to respond to "new and emerging pandemics" which reflect recent lessons identified. The Pandemic plan provided as evidence was due for review in August 2023, and whilst it has robust governance in place there is **no evidence of review post publication of the national IPC manual in 2022**. The requirement is that lessons should be identified from the most recent pandemic response and translated into the Trust plan - the document provided was last reviewed in 2020 and is a pandemic influenza plan which does not cover the scope of other pandemics as indicated in the standard. **There is no mention of the considerations and impacts identified through COVID on EDI or health inequalities and how the Trust will consider these in its planning and response. No evidence of testing, exercising or training associated with a plan.**	Evidence to be provided of arrangements to respond to new and emerging pandemics which covers the elements outlined in the standard detail, supporting information and compliance requirements sections provided to the Trust, or standard to be marked as partially compliant until the arrangements are updated to meet the assurance standards	Supplementary evidence provided by the organisation includes their respiratory viruses plan and again indicates an infectious disease plan having been uploaded which we cannot see. The initial feedback to the Trust indicated that their **pandemic plan is in need of review in line with national guidance, the national IPC manual and the relevant lessons identified from COVID-19.** Whilst supplementary evidence does provided evidence of both outbreak and IPC arrangements within the Trust, this still does not provide evidence of "in date and in line with national guidance and legislation, and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic - as such we would advise the Trust to submit a rating of partial compliance **until their pandemic plan can be amended in line with the requirements of the standard and published guidance**	20 - Review the Pandemic Plan in line with national guidance, the national IPC manual and relevant lessons identified from COVID-19.	RC	Q3 - 24	
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	G	A	Standard applies to both mass vaccination and countermeasures as well as requests for countermeasures in response to a Hazmat/CBRN event and whilst evidence has been provided pertaining to countermeasures access (e.g. Nerve agent antidote) and COVID/influenza vaccination of Trust staff, **no evidence has been provided of training and testing of these arrangements, clear guidance for staff on how to activate these and the requirement for mass countermeasures arrangements include arrangements for administration, reception and distribution of mass prophylaxis in addition to mass vaccination. No evidence of testing, exercising or training associated with a plan.**	Trust to provide relevant evidence as part of supplementary evidence submission	Supplementary evidence and commentary provide sufficient information in regard to accessing Hazmat/CBRN countermeasures but not in regard to mass countermeasures. The Trust commentary indicates that arrangements for both countermeasures and vaccination of staff would be through normal arrangements and indicates that the Trust would not be likely to support a wider mass countermeasures or mass vaccination effort in the community. As a provider of both acute and community services **the Trust is required to have "arrangements in place to support an incident requiring countermeasures or a mass countermeasures deployment which includes arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination"**. No evidence of this has been provided, and the commentary confirms that this is not in place - as such we would advise the Trust to submit a rating of partial compliance until they can demonstrate their compliance against this standard.	21 - Capture specific Countermeasures Training in the central training log. 22 - Write a new policy to consider mass vaccination and issue of prophylaxis.	AB RC	Q3 - 23 Q4 - 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.	A	A				23 - Publish the Mass Casualty Plan	RC	Q4 - 23	
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.	A	A				24 - Publish the Evacuation & Shelter Plan	RC	Q3 - 23	
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.	G	A	National requirement for organisations 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 organisations premises and key assets in an incident. A copy of the Lockdown plan has been provided and this is robust in nature. **The core standard requires arrangements to have been tested and to outline staff testing and whilst this is summarised in the document, no evidence of lockdown training or testing** of the plan can be found in the EPRR work programme, or has been provided as evidence.	Evidence of the organisations testing and exercising for the plan, and evidence of staff training records.		25 - Implement lockdown training and exercises to include: a) Both EDs exercising. b) Table Top exercise for BC Leads and Security.	AB	Q2 - 24	
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.	G	A	National requirement is for organisations to have arrangements in place to respond and manage "protected individuals" including VIPs, high profile patients and visitors to the site. Whilst evidence provided outlines the arrangements for a visiting VIP (e.g. an MP), **there is no evidence of a plan as such**, and no evidence of the estates, governance and security management arrangements which fall within this domain for protected individuals, such as high profile patients, or wider VIPs, inlcuding evidence regarding decontamination of persons under police protection or treatment of high profile prisoners.	Evidence to be provided of arrangements to response and manage protected individuals which covers the elements outlined in the standard detail, supporting information and compliance requirements sections provided to the Trust, or standard to be marked as partially compliant until the arrangements are updated to meet the assurance standards	Supplementary evidence and provided by the Trust include their arrangements for the management of prisoner visits, which extends to include some of the overarching security management arrangements. **There is no supplementary evidence which provides clear arrangements in place for protected individuals (VIPs, high profile patients, those under police protection as examples) who require admission**. This plan or SOP should include all the contingent elements of managing the overarching "command" of the situation, security, estates/site profiles as well as the relevant media considerations. Again, no evidence has been provided which includes this in patient element and as such we would advise the Trust to submit a rating of partial compliance until they can demonstrate their compliance against this standard.	26 - Write Trust Protected Individuals Policy	RC	Q4 - 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.	G	A	National requirement is for Trusts to hold a excess fatalities plan which details the organisations role in responding to both excess deaths and mass fatalities. **Whilst the Trust has provided a copy of the LRF plan this does not extend to excess deaths and no evidence has been provided which outlines Trust specific expectations in managing psychosocial support for bereaved families associated with mass casualty incidentst and the health role in dealing with mass fatalities**	Evidence to be provided which covers excess deaths and mass fatalities planning within the Trust	Supplementary evidence provided by the Trust includes an MOU and a BCP for mortuary services and signposting back to the Trust major incident plan for the sections on relatives' management and the NYLRF MIRT. Whilst the MIRT will endeavour to provide support to the organisation, the Trust needs to be cognisant of the fact that this is not a Trust owned resource, and that there may be a need to deploy MIRT (who are volunteers) to survivor and family reception centres, as such the Trusts arrangements for the management of bereaved families cannot be solely contingency on this resource. **The Trust understanding and arrangements in responding for excess deaths and mass fatality plans should contain the wider requirements of the organisation in complying with this standard - e.g. delays in the death management system, triggers for activated storage and the Trusts role in supporting the system response (e.g. psychosocial support for those affected in an incident not necessarily just staff and over what may be a prolonged period)** Again no further evidence has been provided which includes this and as such we would advise the Trust to submit a rating of partial compliance until they can update their plans accordingly	27 - Write Trust Excess Fatalities Policy	RC	Q4 - 24	

Ref	Domain	Standard name	Standard Detail	Y&SFT Grading	NHS E Final Grading	NHS E Concerns Raised	NHS E Recommended Action	NHS E General Observation or Secondary Challenge	Trust Action	Actionee	Target Date	Remarks / Updates
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.	G	A	National requirement for organisations to have a dedicated and resilient mechanism to enable 24/7 receipt and action of incident notifications and escalations, this should be through to Executive level. **There is an "explicit requirement for on call processes to be described in the on call policy statement" and whilst the role of on call, and evidence provided indicates on call arrangements are in place, this is not found in the EPRR policy and no governance arrangements to confirm the 24/7 dedicated mechanisms have been provided. Folder also does not contain any evidence of a communications test.**	Trust to provide relevant evidence as part of supplementary evidence submission		28 - Amend EPRR Policy to include On Call arrangements, roles and responsibilities and governance of the arrangements. 28A - Ensure CONFIRMER Tests are captured as a Lessons Template.	RC AB	Q4 - 23 Q3 - 23	
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	G	A	National requirement for organisations to have trained and up to date staff 24/7 to manage escalations, make decisions ad identify key actions. Whilst evidence has been provided of good uptake of PHC, limited evidence has been provided of a wider schedule and compliance with training and which can be evidenced through the development of a draft training schedule. The requirement is very specific around the elements to be met in order to meet compliance. **This includes - the process being explicitly described in the EPRR policy, that individuals need to be trained in accordance with NHS England EPRR competencies as set out in the Minimum Occupational Standard 2022 and evidence of staff training which can be clearly evidenced through records.**	**Evidence to be included of the following - the process being explicitly described in the EPRR policy, that individuals need to be trained in accordance with NHS England EPRR competencies as set out in the Minimum Occupational Standard 2022 and evidence of staff training which can be clearly evidenced through records.**		29 - Amend EPRR Policy to include reference to MOS 2022 and link into action 28.	RC	Q4 - 23	

Ref	Domain	Standard name	Standard Detail	Y&SFT Grading	NHS E Final Grading	NHS E Concerns Raised	NHS E Recommended Action	NHS E General Observation or Secondary Challenge	Trust Action	Actionee	Target Date	Remarks / Updates
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.	A	A				30 - Develop and publish Trust Training Needs Analysis	RC / AB	Q2 - 24	30 - TNA to include analysis of indvidual training requiements in detail, an overview of collective training both voluntary and mandatory and to capture routine testing requirements. Minimum requirement for Q2-24 is collective training overview and routine testing. The individual training analysis may still be partial for next year's assessment.
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)	A	A				31 - Capture all training into central log / register	AB	Q3 - 23	
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	R	R				32 - Develop Trust MS Teams Channel to manage responder training for On Call Staff.	RC / AB	Q4 - 24	32 - Barrier to completion exists as ICB and NHS E need to provide the centralised training programme to allow the Trust to plan to fill the gaps.
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.	G	A	National requirements that mechanisms are in place **to ensure that ALL staff are aware of their role in an incident and where to find plans relevant to their areas of work**. The expectation is that this is part of mandatory training. We cannot see evidence provided which outlines general awareness of where plans are available outside of to on call staff, or the number of staff that have been trained as part of mandatory/general awareness training - for example % of staff trained against total number within the organisation, and associated reports of Trustwide compliance to Board	Evidence to be provided of mandatory training or general staff awareness training Trustwide in order to meet the element about "role awareness"		33 - Develop EPRR Awarenes statutory and mandatory training for all staff and hosted on Learning Hub	RC / AB	Q4 - 24	
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 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.	G	G			Recommendation - ICC arrangements should provide evidence of business continuity in regards to loss of utilities which must include telecommunications and resilience to external hazards. **Testing regime for equipment should be outlined in the ICC documentation - there is no schedule or record of this provided in the governance documents or evidence which we would recommend included as part of the standard compliance section.**	34 - Amend Command and Control Policy to include narrative for routine document checks of ICCs. 35 - Add Documention Check (6 monthly) into TNA - Testing and Auditing Regime ensuring check sheet is clear that hard copy plans are up to date (connect to Ser 27). Checks to include ICC, EDs, ITUs, Theatres, Wards and IPUs.	RC AB	Q3 - 23 Q3 - 23	
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.	G	A	National requirements that version controlled current documents are available to relevant staff at all times, staff should be aware where they are stored and should be easily accessible. Whilst the Trust evidence provides assurance of electronic copies, and the ICC guidance indicates access to hard copies for the ICC staff, **no evidence has been provided regarding the availability of hard copies within key locations, for wider staff groups - including on call managers at home, and there is no evidence provided which details the governance arrangements by which this is overseen and implemented on a rolling basis as part of the Trusts governance arrangements.**	Evidence to be provided of the Trusts hard copy plans in place (e.g. extension of the photo included in the ICC training document), and to outline their governance for maintaining this requirement	Supplementary evidence and commentary provided by the Trust indicates that hard copies are not kept with managers and that these are held on SharePoint and staffroom - we would ask the Trust to ensure it has considered the resilience of this in the event of BC issues (power outage, internet failure, software failure etc). However, the challenge was largely in regards to access to version controlled response documents which included hard copies - supplementary evidence provided indicates the Trust has an intent to maintain these in their ICC (ICC documentation 19/7/23) but whilst supplementary evidence indicates that this is to be checked, **no evidence of checks have been provided and the checklist indicates that as of July 2023 the EPRR plans "need printing out" - as such no evidence has been provided which gives assurance that these plans are in date** and as such we would advise the Trust to submit a rating of partial compliance until they can demonstrate their compliance against this standard.	36 - Add all 1st and 2nd On Call Managers to the EPRR MS Teams Channel in order to have access on mobile phone application to all plans and policies.	RC	Q3 - 23	
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).	G	G							

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	G	A	National requirement for organusations to ensure decisions are recorded during business continuity, critical and major incidents, this requirement includes the Trust having access 24 hour access to a trained loggist to support the decision makers. The **assessment guidance issued to Trusts in June 2023** outlines the evidence requirements for those with Organisations with formal on call arrangements to provide copies of their rota and evidence of inclusion of Loggist on call in their communication test (last 6 months), where an organisation doesn't have a formal on call arrangements for Loggists, evidence should be provided of communications tests both in and out of hours over the last 6 months in order to be compliant with this standard (this has been the standard agreed with organisations for the last few years) – this must detail how long it took to obtain Loggist support and whether there was sufficient Loggist capacity to meet the needs of the communications test scenario - we cannot find evidence of to demonstrate the availability of loggists to respond - although the Trust has provided an overview of loggist training records. Additionally we would request additional evidence to comply with standard detail 1 of the national template, as revidence of key response staff being aware and reminded of the logging requirement is not clearly evident.	Evidence of loggist availability 24/7 via either a rota or informal arrangement, as outlined in the assessment guidance issued to Trust in June 2023, alongside supplementary evidence of key response staff awareness of their own responsibilities in regards to logging.	Trust has accepted challenge and indicates they will submit a final assurance rating of partial or non-compliance. Decision as to a submission of partial or non-compliance relates to the ability of the Trust to complete within the next 12 months and is for Trust determination. In regards to commentary there is no formal requirement to have a loggist rota, but there is a requirement to have 24/7 access to a trained loggist, the Trust indicates that it "will tolerate this decision through the maintenance of a loggist rota" - again we would refer the Trust back to the guidance which was issued to the Trust in June 2023 which indicated that t**his model was acceptable in order to meet compliance as long as they were able to demonstrate the availability of Loggists sufficient to their needs in both in and out of hours communications tests**	37 - Amend the Trust Call In Policy to include, in addition to the 6 monthly CONFIRMER Test, a bespoke loggist campaign test and a manual ring round test by the loggist manager. Record of test to be a Lessons Identified Template submission.	RC / AB	Q3 - 23	
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.	G	G			**Recommendation - Testing and exercising of the SitRep process is a requirement for the standard, and we would advise this is included in the evidence provided.**	38 - Include exercising of SITREP process in LIVEX 24 exercise objectives.	RC	Q2 - 24	
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.	G	A	National requirement is for key clinical staff (especially ED) to have access to the clinical guidelines for major incidents and mass casualty events handbook. **No evidence has been provided as to the requirment for hard copies to be available to staff** in addition to electronic versions.	Evidence to be provided as set out in the standard detail, supporting information and evidence examples					Note: Action to comply is in Action 35.
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)	G	A	National requirement is for key clinical staff to have access to the CBRN incident clinical management and health protection guidance. **No evidence has been provided as to the requirement for hard copies to be available to staff** in addition to electronic ones	Evidence to be provided as set out in the standard detail, supporting information and evidence examples					Note: Action to comply is in Action 35.

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33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	G	A	National requirement is for the organisation to align communications planning and activity with the organisations EPRR planning activity. This standard includes a requirement for an out of hours communication system (24/7) to allow trained comms support for senior leaders during an incident which should include on call arrangements. The organisation summarises communications requirements in its IRP but there is no formal steer around warning and informing. No evidence has been provided which provides confirmation that the Trust has access to 24/7 communications advice (e.g. through an on call rota, neither is there evidence of having a process in place to log incoming requests, track responses to these requests and ensure that information related to the incidents is stored effectively.	Evidence to be provided of the Trust on call communications rota and that those colleagues have been included in the Trust TNA or undertaken training in line with the requirement to be current, qualified and competent from an EPRR perspective.	Supplementary commentary provided by the Trust confirms that they do not have an on-call rota in place due to staffing considerations and as such the role for managing the communications strand in an incident would sit with the 1st & 2nd on call. The standard requires the organisation to have an out of hours communication system in place (24/7 365) which allows access to trained comms support for senior leaders during an incident - this should include on-call arrangements. **In the absence of an on-call rota there should be evidence that the relevant guidance is available to on call staff stepping into this role and that they have undergone the necessary training as outlined in the Trusts TNA.** There is no evidence of this being in place for 1st and 2nd on calls in order to demonstrate compliance with this standard and as such we would advise the Trust to submit a rating of partial compliance until they can demonstrate their compliance against this standard.	39 - Confirm that comms training is included in the TNA, is referenced in the On Call Policy and is included in the Responder Training package. Connect to actions: 30, 28 and 32.	AB	Q2 - 24	
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	A	A				40 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comma action cards. c) review social media guidance and deliver media training to Executive members.	Comms Team	Q2 - 24	
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.	G	G							
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	A							

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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.	G	A	National requirement is for the AEO, or a director level representative with delegated authority to attend the LHRP. **This includes a requirement for AEO or Director level representatives to attend 75% of LHRPs, with the AEO needing to attend at least 1** as a recommendation from the Manchester Arena Inquiry. Evidence provided by the Trust and ICB indicate that 1 meeting has been attended by a Director level representation and the remainder have been attended by the resilience team	Recommendation that standard remains at Amber until attendance that complies with requirements is reviewed for next review cycle	Supplementary commentary provided by the Trust confirms the current AEO has attended 1 meeting since being in post, but in reviewing the evidence across the last 12 months (Trusts are required to have an AEO at all times - see standard 1) we have evidence of 1 meeting being attended by the AEO/Director level representative and the remainder being attended by the EPRR team. The standard requires "AEO or Director Level representation at 75% of LHRP meetings" which the Trust has not been able to evidence. The contradiction the Trust referred to is in regard to the level of delegation take place between the AEO and a director level representative where the recommendations from the Manchester Arena Inquiry state that the AEO needing to attend a minimum of 1 rather than delegating all meetings to another Director level attendee. The evidence provided continues to show that there has only been AEO/Director level representation at one meeting in the last 12 months and as such the Trust is unable to demonstrate compliance with this standard and we would advise the Trust to submit a rating of partial compliance against this standard.	41. EPRR Team to ensure availability of AEO or another Director to attend LHRP.	RC / AB	Q3 - 23	
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.	G	G	Recommendation - Whilst we are assuming that the Trust has entered a compliant rating with this standard due to the historic agreement that the Trust is represented at LRF meetings by the ICB (formerly NHS England), it is worth noting that the ICB has not provided sufficient evidence that meets the 75% compliance against this standard, and as such the Trusts compliance with standard 38 could be questioned. **We would advise a discussion with ICB colleagues around compliance against this standard moving forwards, and the Trust should consider whether they are maintaining a statement of compliant for this standard.**		Comment - please note the statutory responsibility to engage with LRFs sits with all Category 1 responders. We are not disputing the Trusts rating of green, however we are advising them that further work needs to be undertaken with system partners around engagement as currently the representation by ICB partners does not give sufficient assurance for the engagement with the LRF and the Trust is still responsible for that agreement and its statutory responsibility to respond,	42. AB to clarify exact requirements for LRF attendance and dissemination (if requirred) of information after which determination of any actions can be made.	AB	Q3 - 23	42 - Barrier to completion eis that responsibility for clarification fresides with ICB.
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.	G	A	National requirement is for organisations to have agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. No mutual aid process or document has been provided	Evidence to be provided of a mutual aid arrangements which outline the process for requesting, coordinating and maintaining mutual aid.	Supplementary commentary and evidence provided by the Trust includes a number of ambulance divert documents, escalation arrangements for ambulance handovers and escalation contact details. The initial feedback submitted to the Trust requested evidence which demonstrated that the organisation had an agreed mutual aid arrangement in place, and which outlined the process for requesting, coordination and maintaining mutual aid resources. Whilst evidence of ambulance divert arrangements is an example of mutual aid in practice, this standard requires the governance arrangements for these to be clearly detailed in respect of EPRR - **an example would be - a documented section in the IRP which details who can authorise, how requests are made, how they overseen and managed, decision making to maintain or stand-down etc.** As no supplementary evidence which provides this governance element has been provided, we would advise the Trust to submit a rating of partial compliance against this standard.	43 - Review Trust IRP to include a table under mutual aid that defines by Incident Level (1-4) how, who, when and for long mutual is requested.	RC	Q2 - 24	

43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	G	A	National requirement is for the organisation to have an agreed protocol for sharing information pertinent to the response. Evidence provided does detail a process by which decisions on information sharing should be considered, however there is no evidence of a documented or signed information sharing protocol being in place in the Trust	Evidence to be provided of the Trust internal information sharing process/arrangements and associated governance inclusive of ICBs and health partners	Supplementary commentary and evidence provided by the Trust includes an example ISA for lower limb clinics and a list of the ISA's the Trust currently has in place across the Trust, **what we still cannot see is evidence that the Trust has an information sharing protocol in place for sharing information with partners and stakeholders during incidents - an example of this would be an information sharing agreement in place between the Trust and their local system in regards to patient tracking in the event of a major incident in order to support reunification with families, or an overarching ISA which agrees the sharing of information between all partners during a range of different incidents - but for clarity the requirement is specifically associated with information sharing during incidents as outlined on the standard detail** . As such we would advise a rating of partial or non-compliance (depending on whether the Trust views this as achievable within the next 12 months) on their final submission	44 - AB to liaise with RB and LC-P to determine the following: a) Can the ISA be a generic agreement that articulates which command nodes in the Trust (BRONZE Incident Command, SILVER Comand and GOLD Command) can share information with external partners. b) Is the external partner just the ICB or do we have to lst all potential agencies. If not then possibility of a list or multiple ISAs required for ICB, EPRR, healthcare partners, LAs, coastguard, utilities companies etc.	AB	Q2 - 23	

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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.	G	G			Recommendation - as an NHS organisation under standard contract and in line with the minimum set of standard outlined within the NHS EPRR core standards we would advise the organisation to review their current BCM arrangements in line with the requirements as set out in domain 8 for Business Continuity and the NHS England Business Continuity Toolkit 2023	45 - Review of BC Framework and EPRR Policy to confirm compliance.	AB	Q2 - 24	
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.	G	G			**Recommendation - whilst the core headings of a BCMS are contained within the BCMS section of the Trust BCP Annexe, these elements are very light touch in comparision with the level of detail we would anticipate a Trust of this size having in summarising its BC activities and associated governance. We feel this is likely due to the BCMS (planning) sitting in an annexe to the Trust Major Incident Plan (response) and we would advise that these elements are included in either a standalone BC Policy or BCMS framework which goes into the level of detail outlined in the NHS England Business Continuity Toolkit 2023.**				Note: Recommendation incorporated into Action 45.
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).	G	A	National requirement for the organisation to annually assess and document the impact of disruption to its services through Business Impact Analyses (BIAs). Whilst evidence of single impact assessment templates have been provided there is no evidence included in the folder which outlines the following - **he organisation has identified prioritised activities by undertaking a strategic Business Impact** Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it.	Evidence to be provided as set out in the standard detail, supporting information and evidence examples	Recommendation - as an NHS organisation under standard contract and in line with the minimum set of standard outlined within the NHS EPRR core standards **we would advise the organisation to review their current BCM arrangements in line with the requirements as set out in domain 8 for Business Continuity and the NHS England Business Continuity Toolkit 2023**	46 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. 46 - Develop a Trust BIA in accordance with the NHS BC Toolkit. 47 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs.	AB AB AB	Q2 - 24 Q2 - 24 Q2 - 25	

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	A	A				48 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. 49 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust.	AB AB	Q2 - 23 Q4 - 25	
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.	G	A							Note: The TNA, Trust Training Policy and capture of testing and exercsing in a Lessons Identified Template will resole this issue.
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.	G	G							
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.	G	A	National requirement is that the organisations BCMS is monitored, measured and evaluated against established Key Performance Indicators (KPIs) - with reports on these, and the outcome of any exercises and the status of any corrective actions to be reported to the Board annually. **No evidence has been provided of KPIs being used to monitor or evaluate the Trust BCMS, and there is no evidence of oversight of governance of theses reports being overseen by EPRR groups or reported to Board.**	Evidence of the BCMS being monitored, measured and evaluated against established KPIs with reports to Board.		50 - Develop a process of KPIs for inclusion in Executive Committee and Board of Directors reports. 51 - Include in TNA - Testing and Audit section an annual report through Executive Committee and Board of Directors to describe BC activity, compliance and KPIs.	AB AB	Q2 - 24 Q2 - 24	
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.	G	A	The organisation is required to have **a process in place for internal audit, with outcomes reported to the Board.**The assurance compliance requirement for organisations sets out a requirement for **internal audits to be undertaken annually** and **external audits to be undertaken 3 yearly**. No evidence that any formal audit has been undertaken and not outlined in Board report.	Evidence to be provided of internal and external audit processes	Recommendation - **we would recommend that this process is included within the Trusts Business Policy in more detail**	52 - Confirm and develop the process for conducting BC audits. Include any audits to be completed in the TNA - Testing & Audit section.	AB	Q2 - 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.	A	A				53 - Review BCMS continuous improvement process and include in EPRR Policy. Process must include completion of Lessons Identified Template plus the follow tracking of action completion.	AB	Q2 - 24	53 - Link to Action 8.
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.	G	A	National requirement for organisations to have in place a system to assess the business continuity of commissioned providers and suppliers. Whilst evidence has been provided that this is planned as part of the Trust BCMS **no evidence has been provided that this has taken place within the last assurance cycle**. Additionally whilst the BCMS outlines a summary of the intent, the wider requirements outlined on slide 64 of the assessment criteria issued to Trusts in detailing the formal governance of the process to be used an how suppliers will be identified has not been provided.	**Evidence to be provided to support compliance with standard detail, supporting information and compliance requirements**		54 - Confirm existance or develop a policy for the assurance of commissioned providers / suppliers.	AB	Q2 - 24	

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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	G	G			Recommendation - The Trust Hazmat/CBRN Plan is of a significant size (126 pages). We would advise a plan of that size sits as a stand-alone plan which would then enable key areas to sit as Annexes. Recent inquiries have highlighted the sheer scale and size of plans being a significant contributory factor with staff being unfamiliar with the asks of them whilst responding to an incident. We would also advise that in future submissions, evidence of testing and exercising of the plan is included.				Note: Recommendation resolved in Action 16.
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	G	A	National requirement for organisations to have Hazmat/CBRN risk assessments in place. **No evidence provided of Hazmat/CBRN specific risk assessments or arrangements in place for management of identified risks - e.g. actions or risks identified in the annual CBRN audit, although the need to undertake risk assessments are outlined in the Trust Hazmat/CBRN plan**	Evidence to be provided of Hazmat/CBRN risks inclusive of the process by which these are managed through internal governance					Note: Concern resolved in Action 12.

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	G	G							
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 arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	G	A	National requirement is for organisations to have up to date CBRN plans and response arrangements aligned to the risk assessments of the Trust. Whilst the Trust has an extensive CBRN plan, **clarity is requested as to the expectations on staff welfare and wellbeing (maintaining lists of staff deployed for record, differential between the role of a DASO and an ECO etc)**, and also the use of the term "Copper command" - this is not a recognised command layer and clarity should be given as to how this aligns with national guidance on command hierachies (is this not the same as the role of an area specific lead nurse/clinician function? **Additionally no evidence of risk assessments have been provided by which the plan has been aligned**	Evidence to be provided of Hazmat/CBRN risks inclusive of the process by which these are managed through internal governance and how local risks are used to inform stakeholder engagement and training & exercising programmes	Recommendation - The Trust Hazmat/CBRN Plan is of a significant size (126 pages). We would advise a plan of that size sits as a stand-alone plan which would then enable key areas to sit as Annexes. Recent inquiries have highlighted the sheer scale and size of plans being a significant contributory factor with staff being unfamiliar with the asks of them whilst responding to an incident. We would also advise that in future submissions, evidence of testing and exercising of the plan is included.	55 - Review CBRN Policy	RC	Q2 - 24	
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.	G	A	National requirement is that organisations have adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenters 24/7 and to a minimum of 4 patients per hour. Requirement extends to include the need to consider this capability when filling rotas and making sure staff are suitably trained. The evidence provided is and action cards for the unit but guidance issued as part of the assessment criteria required organisations to provide evidence of the 24/7 requirement to demonstrate compliance with the standard a capability assessment and dip sampling of ED staffing was provided - see slide 71 guidance notes. Additionally, the Trust has sighted their CBRN self-assessment response as evidence behind their compliance rating, however this indicates that only 1 member of staff has been trained in the last 12 months.	**Evidence to be provided including capability assessment – evidence of the number of staff expected to be required to maintain the 4 patients per hour requirement in the standard and facilities to enable this to happen (Tent versus fixed structure and tested throughput) and evidence from dip sampling of ability to provide service 24/7 – 1 assessment in core hours, 1 at a weekend and 1 overnight required as a minimum (an example of this evidence would be a copy of the ED rota for the designated shift with the number of staff required to establish decontamination facilities as well as ECO role and marking which staff are in date with the relevant training competencies to deploy)**		56 - Review CBRN policy post development of TNA to determine if capability can be sustained for 24/7 and develop a methodology to evidence for core standards.	RC	Q4 - 24	
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	G	A	National requirement is for organisations to hold appropriate equipment to ensure safe decontamination of patients and protection of staff and there is an accurate inventory of the equipment required for decontamination. For acute Trusts this is **outlined in the NHS England equipment checklist. No evidence has been provided to demonstrate that equipment is in place (in line with the acute provider equipment checklist) or that has any formal governance behind it to ensure that an inventory log is maintained on a regular basis to ensure that it remains fit for purpose and that risk assessments have been undertaken to support any decisions behind the equipment available. Trust CBRN plan does not go into detail outside of the need for checks to take place.**	Evidence that the Trust holds the appropriate equipment to ensure safe decontamination of patients and protection of staff to be provided including all areas outlined in the standard detail and supporting information section (e.g. **Equipment lists and inventory including date of last check, frequency of checks and governance of escalation in the event a fault is found. PRPS count including asset registry etc)**		57 - Review CBRN Policy to include equipment husbandry to include registers, audits and fault finding flow charts. 58 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57.	RC RC	Q2 - 24 Q2 - 24	
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 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	G	G	National requirement for organisations to have a Preventative Programme of Maintenance (PPM) in place for their CBRN equipment, which must include - a named individual with responsibility for completing checks. routine checks of equipment, maintenance and repair (including servicing), and replacement of out of date/end of life equipment. This needs to have a documented process which describes how this takes place and the associated escalation and governance arrangements. No evidence provided to support the wider programme of PPM or governance associated within this standard	Evidence to be provided to support compliance with standard detail, supporting information and compliance requirements	The Trust has provided supplementary evidence in relation to core standard 61 and having reviewed this we would accept the Trusts self-assessment of compliant for this standard. We would advise moving forward considering **a more robust equipment checklist which details which site, which individual etc as a more defensible record should the Trust need to provide it for evidentiary purposes**				Note: Recommendation resolved in Action 57.
62	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	G	G							

NHS England

NHS England EPRR Core Standards Overview for Boards

Applicable to – NHS organisations in the North East & Yorkshire and North West regions

Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle

Version – 1.0 FINAL November 2023

Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

Publication reference: NEY&NWEPRRAssurance2023

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

The 2023/24 EPRR Assurance model

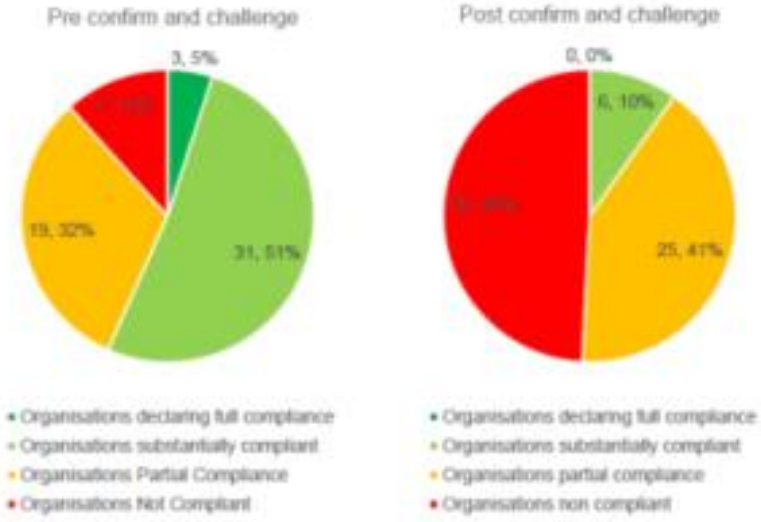
In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

This model required commissioners and providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

NHS England Midlands

Levels pre and post confirm and challenge



The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

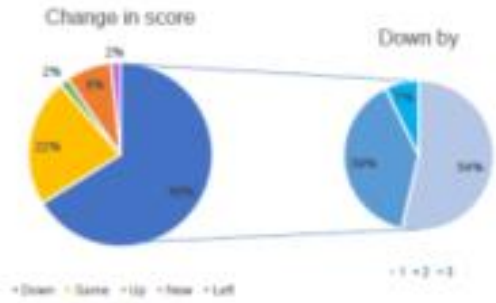
The maximum of accepted challenges to an organisational assessment was 30 standards.

OFFICIAL – SENSITIVE

Change from 2021/22

Breaking down the change into positive or reduced positions:

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
  - 7% dropped three compliance levels (full to non compliance)
  - 39% dropped two compliance levels (full to partial or Sub to non)
  - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year's assurance cycle.

Chair Brief: Digital, Performance & Finance (DPF) Board Assurance Committee	Chair: Denise McConnell	Date: 21 November 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 Dr Foong Wong to the Committee as an observer who had been paired with Andy Bertram under the Trust's reciprocal mentoring scheme.			
Digital			
i)	- The Committee discussed the KPIs . - Calls to the service desk had increased, while an analysis for the increase had not yet been produced, the increase was believed to be as a result of the CPD outages.	BOARD	INFORMATION
ii)	- The Committee were informed a portion of the EPR funding for 2023/24 was potentially going to be deferred to the next financial year. - With the investment being deferred some of the EPR preparation projects, such as "paper-lite" would be delayed or cut down. - There had been two recent CPD outages, that had influenced the decision to delay the Oracle upgrade planned for 24 November. - There had been increased cyber phishing activity in the month. To test resilience simulated emails had been sent to staff and 10% of staff had clicked on the email. - The department were in receipt of two awards at the Celebration of Achievement event for their work on the Nucleus project.	BOARD	INFORMATION
	-		
Operational Performance			
i)	- The Committee were informed October had been another very challenging month and focus was being placed on winter. - The October Emergency Care Standard position was 68.3%, an improvement on September 66.7% - The Committee were given a presentation on UEC care flow showing the detailed work planned to support delivery over winter.	BOARD	INFORMATION

	- In October there were 2,341 lost bed days due to criteria to reside which was 28% compared to a target of 10%/ - Time lost to ambulance handover delays and handovers over 60 minutes remains above target with 26.1 % (24% September) 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 20% (18% September)against a target of 8%.		
ii)	For Elective Backlogs: The Committee noted 78 week waits position improved from 93 to 86. The Committee was pleased to hear the overall total RTT waiting list position has seen another month of decrease to 51.5k (September 52.9k) - Cancer position – the Committee noted the Trust remains off trajectory for the 62-day Cancer backlog (375 patients versus 152 planned trajectory). The Trust is currently 137 out of 140 providers. - As in the previous month, the Committee discussed how the Trust is becoming under increasing pressure, resulting in October having the highest number of ED attendances in two years.	BOARD	INFORMATION
Finance			
i)	- The Committee briefly discussed the Finance paper reporting the Trust's adjusted deficit of £31.1M against a planned deficit of £13.3M for the period to October. The Trust is £17.7.M adrift of plan. - It was agreed by the Committee that the focus of the discussion should not be on the October DPF papers but on the letter 8 November from NHS England. The letter had been discussed by the Board 20 November. The proposed actions the Trust was planning to take in response to the letter are as follows: • Complete the workforce analysis to assess VFM ✓ 112 Post Implementation Reviews (PIRs) were requested relating to 130 WTE posts (some related to team investments). 73 have been completed with 64 rated GREEN and 9 rated AMBER. 39 have no PIR and are rated RED. The Exec Committee has been asked to confirm the 39 RED rated PIRs do not represent VFM and consideration should be given to the removal of the posts. For the AMBER rated PIRs the Exec Committee has been asked for a view. ✓ This work will be completed by the end of November.	BOARD	INFORMATION

	• Continue to press delivery of the Trust's Financial Recovery Plan (FRP). At month 7 the most likely scenario suggests £8.2m of expenditure reduction schemes can be achieved. This has been modelled into the revised forecast. Close monitoring of delivery is necessary. • The development of an Expenditure Cessation Programme is now necessary. This work is being undertaken at ICB level. Care Groups and Corporate Teams have been requested to prepare a list of any and all expenditure that could be stopped should this be required. The lists will identify anything that can physically be stopped (i.e. where no contractual commitment exists). These will be Quality Impact Assessed (QIA) and will be reviewed by the Exec Committee. The first round of information requested has just been submitted and is being reviewed. • Full delivery of the Trust's efficiency programme is a must do under the current financial regime. • No developmental business cases that increase cost can be approved in the short term. Funding must be identified or agreed with the ICB before progression. • Elective recovery should be pushed for any and all opportunities to increase income and the potential for a contribution to the financial position of the Trust. At present ERF will continue to flow. • We will work closely with the ICB and our system partners on the potential further use of slippage on investment programmes, further release of allocations and any further opportunity to improve the financial position of the ICB and system partners. - The Committee thanked Andy and the finance team for the work they were undertaking to respond to the current finance challenges.		
Governance			
BAF/Corporate	- The Committee discussed the risk paper and noted the changes to the risks during and following the discussion. In particular there was a discussion on CRR ID 6 - Failure to deliver the annual plan, and noted the application for emergency cash from NHSE had been approved. - - The Committee also discussed CRR 23 -" The potential inability to provide Health services to the main Scarborough Hospital block due to the deterioration of the South wing roof" – and was re-assured from the update from the LLP this risk had not reduced to amber.	BOARD	INFORMATION
YTHFM			

	- The Committee were presented with the Premises Assurance Model which is an annual statutory report NHSE covering a broad range of non-clinical support disciplines and subjects within the NHS. The report was prepared using self-assessment and a recommendation was made for a request to be made to internal audit to audit the process of the preparation of PAM.					
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**	☐
	PR1 - Quality Standards	☐	**PR2 - Safety Standards**	☐	**PR3 - Performance Targets**	☐
	PR4 - Workforce	☐	**PR5 - Inadequate Funding**	☐	**PR6 - IT Service Standards**	☐
	PR7 - Integrated Care System	☐	**Comments: PR7 is interrelated across our agenda, and will be noted as discussions arise.**			

	Key Agenda Items	RAG	Key Assurance Points	Action
PR2	YTHFM agenda item 8		The report was prepared following the require process of self-assessment.	Committee requested internal audit to audit the PAM process.

NHS
York Teaching Hospital
Facilities Management

Report to:	Board of Directors
Date of Meeting:	29th November 2023
Subject:	Premises Assurance Model
Director Sponsor:	Steven Bannister, Managing Director
Author:	John Dickinson, Assistant Head of Estates

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

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

Trust Priorities	YTHFM Board Assurance Framework
☐ Our People	☐ People
☒ Quality and Safety	☒ Quality & Safety
☐ Elective Recovery	☐ Financial
☐ Acute Flow	☐ Growth
	☐ Sustainability
	☐ Partnerships

Summary of Report and Key Points to highlight:

NHS Premises Assurance Model (NHS PAM) is an annual statutory report to NHSE covering a broad range of non-clinical support disciplines and subjects within the NHS.

This report provides a high-level summary overview of the NHS PAM process undertaken throughout the financial year and details the results of the self-assessment exercise in readiness for reporting in September.

The Question sets have changed significantly since last year's reporting in some areas and there is also the inclusion of BMS & Switchboard, Helicopter pad and FM Maturity as new items. There has also been additional questions asked regarding Document Management, Medical Gas, Catering services, Cleanliness & Infection Control.

Improvements recorded over the past year in the following areas:

- SH 16 Business Continuity Planning
- SS1 Catering Services
- SS2 Decontamination
- SS 1 Catering Services

- E3 Capital Procurement, Capital Planning , Refurbishment & Land Management
- E4 Financial Controls
- P5 Grounds & Gardens
- P6 Catering Standards
- F2 Well Managed Approach to Improved Efficiency in Running the Estate

Recommendation:

In line with guidance the NHS PAM is presented to Board of Directors for approval. The Board of Directors is asked to note the internal NHS PAM assessment outcomes and note and approve the contents of the report.

Report History

Meeting	Date	Outcome/Recommendation
Management Group	Via email – 25th August 2023	Assurance / recommend proceeding to BoD for approval.
DPFAC	21st November 2023	Approved / recommend proceeding to BoD for approval.

Premises Assurance Model

1. Introduction and Background

The YTHFM Estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the Trust provides a safe, high quality, efficient and effective estate. The NHS Premises Assurance Model (PAM) is a national Estates and Facilities benchmarking tool designed to be used by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners. Completion of NHS PAM was made mandatory for all NHS Trusts from April 2020.

The objectives of NHS PAM are to support the NHS constitution pledge to:

"Provide services from a clean and safe environment that is fit for purpose based on national best practice" and the current regulatory requirements to ensure that "service users are protected against risks associated with unsafe and unsuitable premises".

NHS PAM is a self-assessment management tool, designed to provide a nationally consistent approach to evaluate NHS premises performance against a set of common indicators. NHS PAM has eight domains:

- Safety (Hard),
- Safety (Soft),
- Patient Experience,
- Efficiency,
- Effectiveness,
- Governance.
- Helipad
- FM Maturity

Each domain has a set of Self-Assessment Questions (SAQs), with a subset of questions known as prompt questions covering specific areas eg. fire safety, car parking and cleanliness. There is a total of 392 prompt questions applicable to the Trust. The response to the prompt questions is scored/rated with due regard to the evidence gathered in relation to the following requirements:

- **Relevant guidance and legislation**: Policies, procedures, working practices etc. should comply with any relevant guidance and legislation,
- **Evidence should demonstrate**: The approach (policies, procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited, and reviewed.

This provides a structured framework to facilitate evidence based self-assessment and measure compliance with each of the requirements. Most of the evidence supporting the self-assessment is held within the Trust's existing policies, operational processes, and systems.

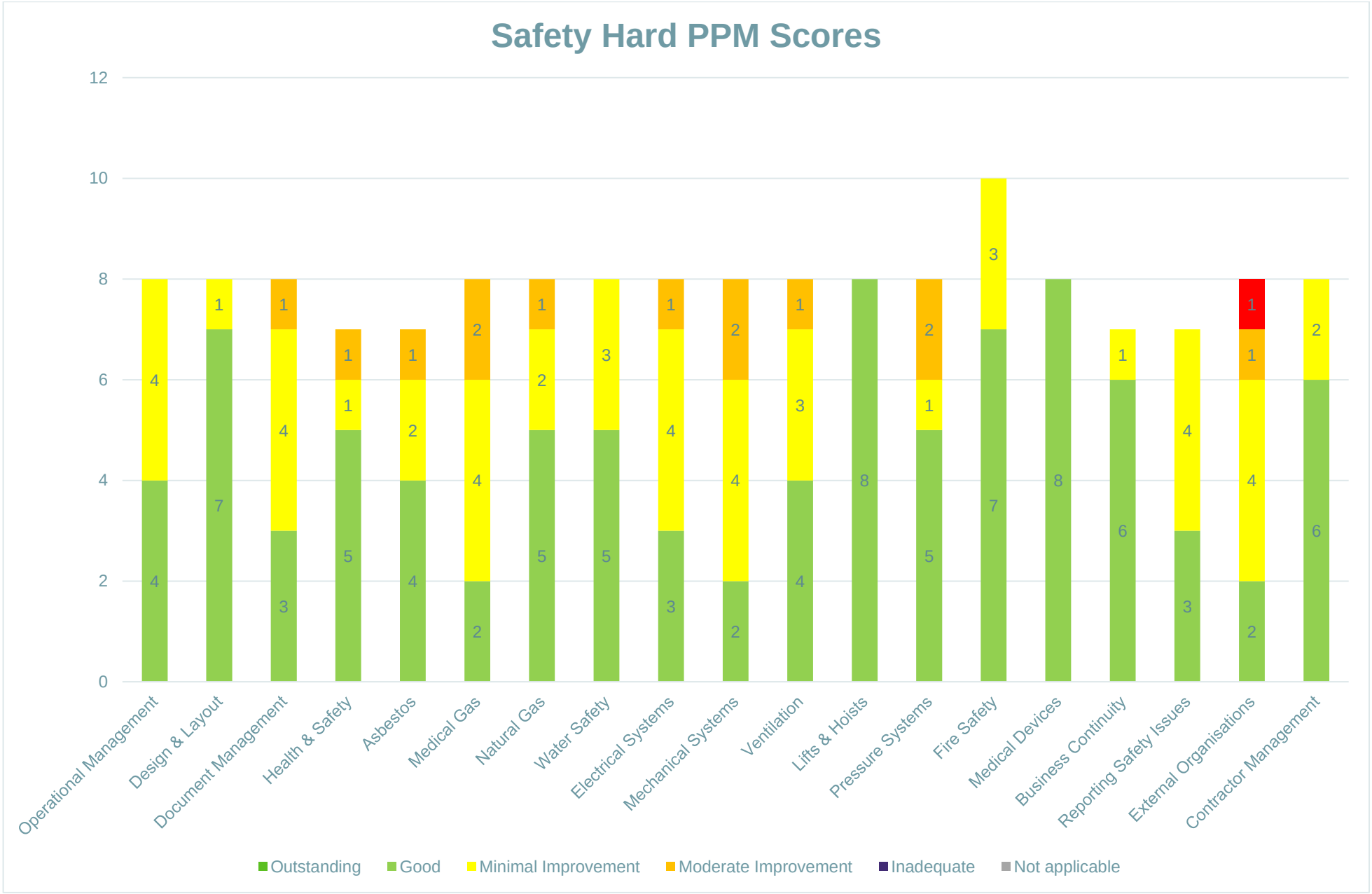
NHS PAM data is also incorporated into national metrics such as the Model Hospital, a data driven tool that provides hospital provider-level benchmarking to identify areas for improvement. Although it should be noted making comparisons between differing providers

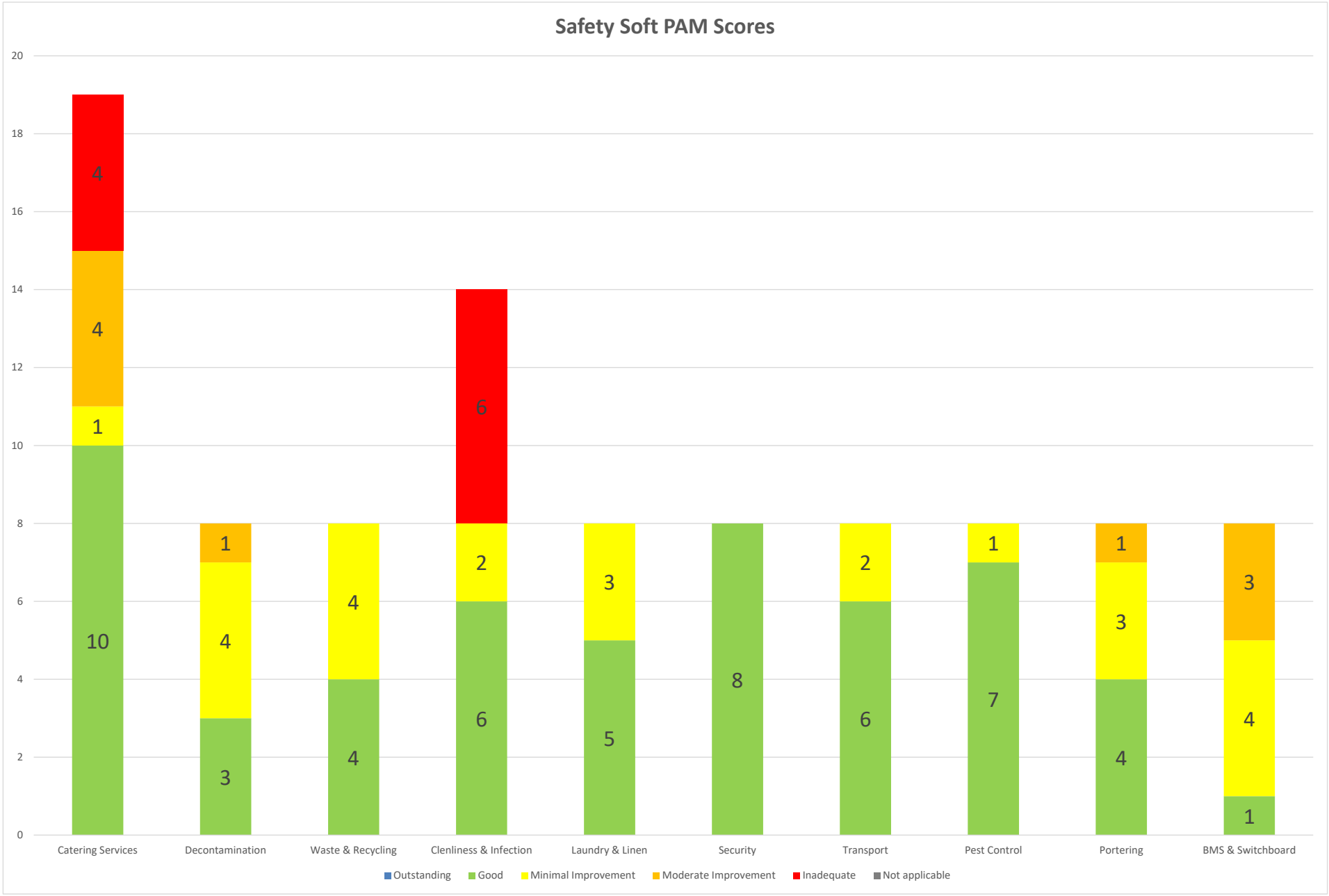
may need be treated with a degree of caution due to the unique, and often widely varying interpretations of the questions posed, nature of the buildings and sites used by providers, which can make direct comparisons misleading.

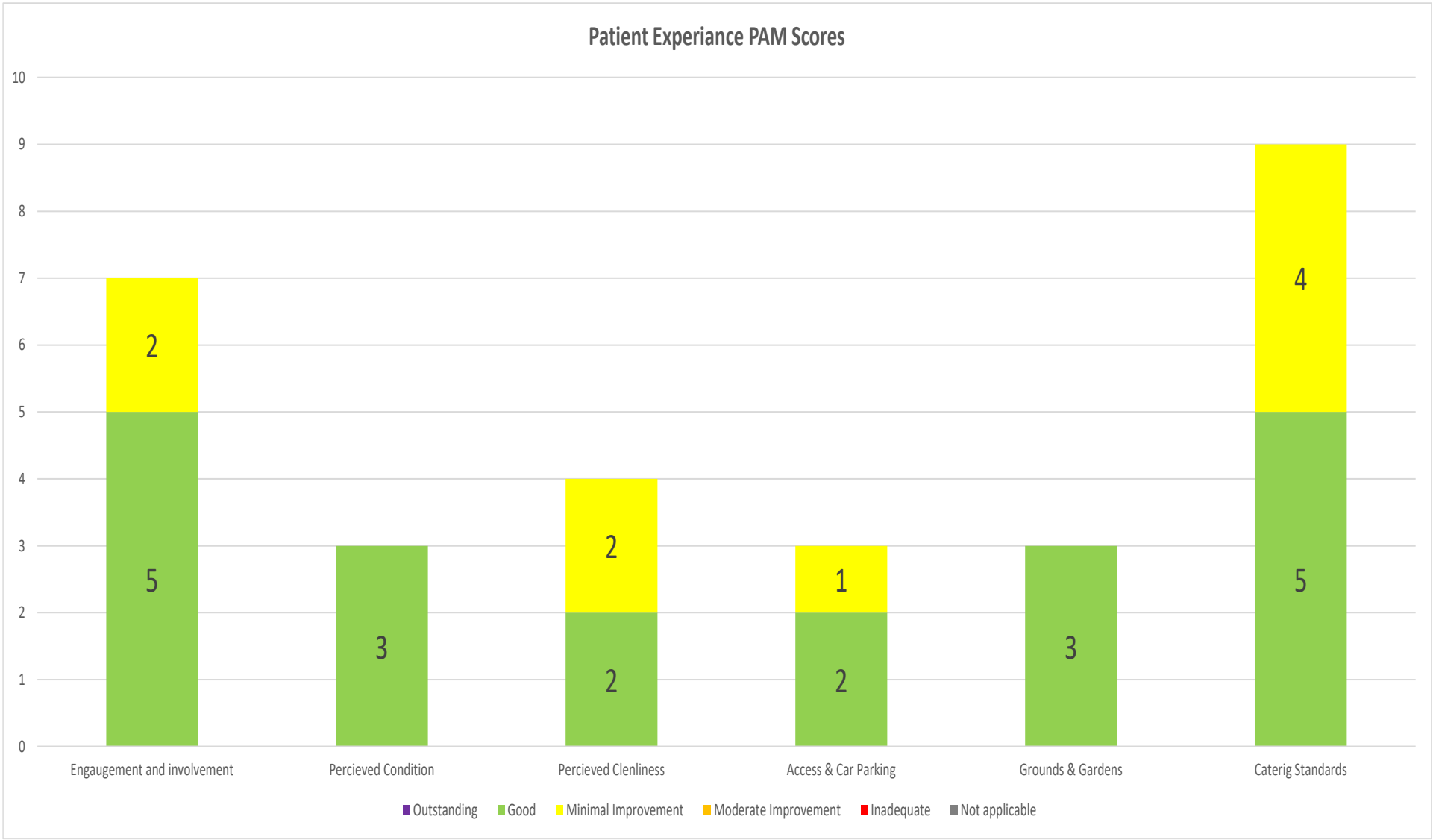
2. Assessment Methodology

PAM Working Groups were established with members of the Estates Directorate and the Facilities Directorate alongside key stakeholders including Estates & Facilities Managers, Directors, Capital Planning, Clinical Leads, FM Compliance and General Managers across YTHFM and Trust. The Working Groups participated in a series of discussions explaining the process the YTHFM is required to undertake to complete the PAM assessments. The groups then identified and collated evidence to support the PAM self-assessment process.

3. Senior Managers from Estates, Facilities, and Patient Experience teams conducted a review of the evidence collated by the Working Groups. Each applicable SAQ element was assigned a rating using a 5-point scale (Inadequate, Requires Moderate Improvement, Requires Minimal Improvement, Good, and Outstanding) Summary of Assessment Outcome 2022/2023


Safety Hard PPM Scores
12
10
8
6
4
2
0
Operational Management
Design & Layout
Document Management
Health & Safety
Asbestos
Medical Gas
Natural Gas
Water Safety
Electrical Systems
Mechanical Systems
Ventilation
Lifts & Hoists
Pressure Systems
Fire Safety
Medical Devices
Business Continuity
Reporting Safety Issues
External Organisations
Contractor Management
Outstanding
Good
Minimal Improvement
Moderate Improvement
Inadequate
Not applicable


Safety Soft PAM Scores
20
18
16
14
12
10
8
6
4
2
0
Catering Services
Decontamination
Waste & Recycling
Clenliness & Infection
Laundry & Linen
Security
Transport
Pest Control
Portering
BMS & Switchboard
Outstanding
Good
Minimal Improvement
Moderate Improvement
Inadequate
Not applicable


Patient Experiance PAM Scores
10
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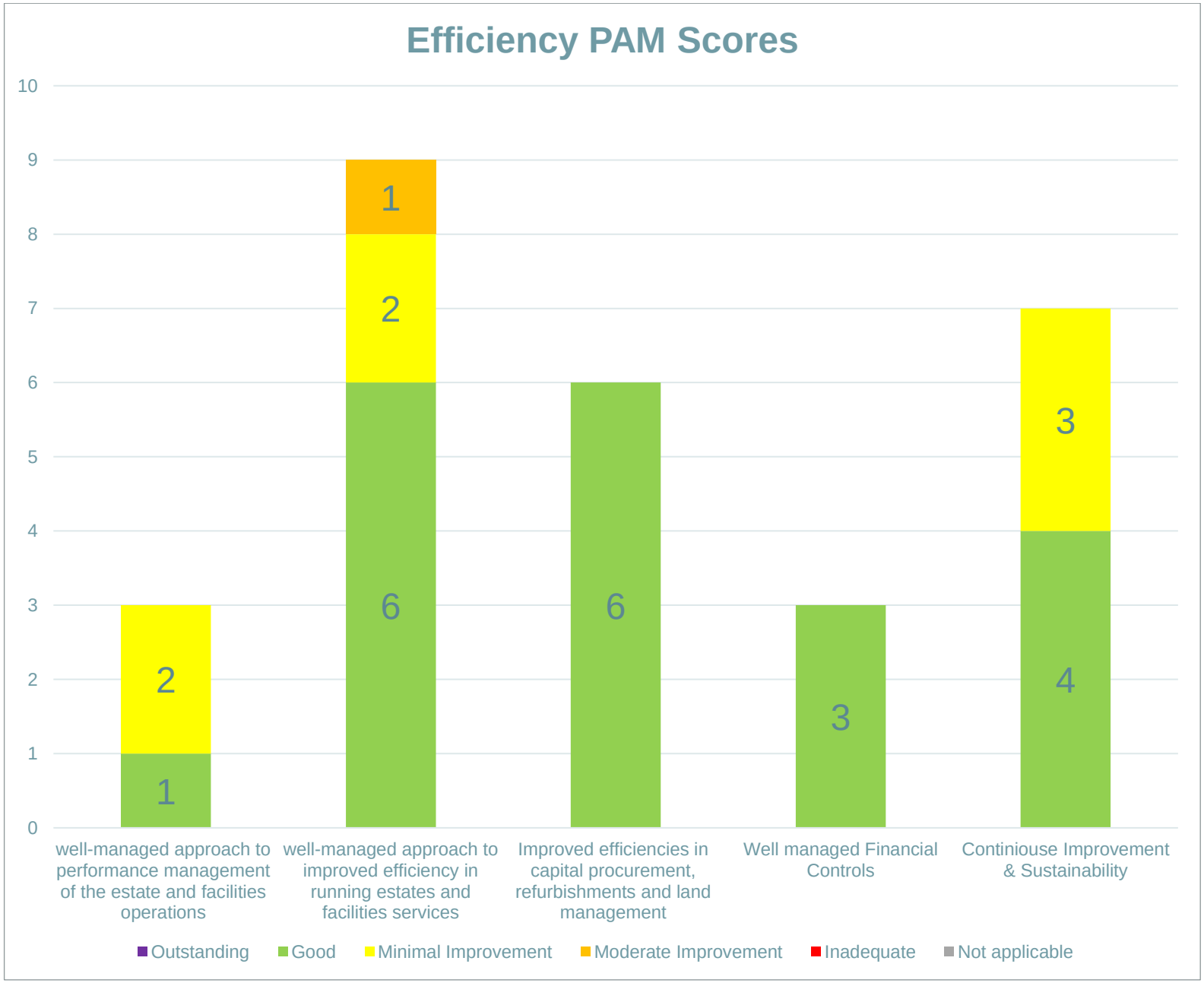
1
2
3
4
5
Engaugement and involvement
Percieved Condition
Percieved Clenliness
Access & Car Parking
Grounds & Gardens
Caterig Standards
Outstanding
Good
Minimal Improvement
Moderate Improvement
Inadequate
Not applicable


Efficiency PAM Scores
10
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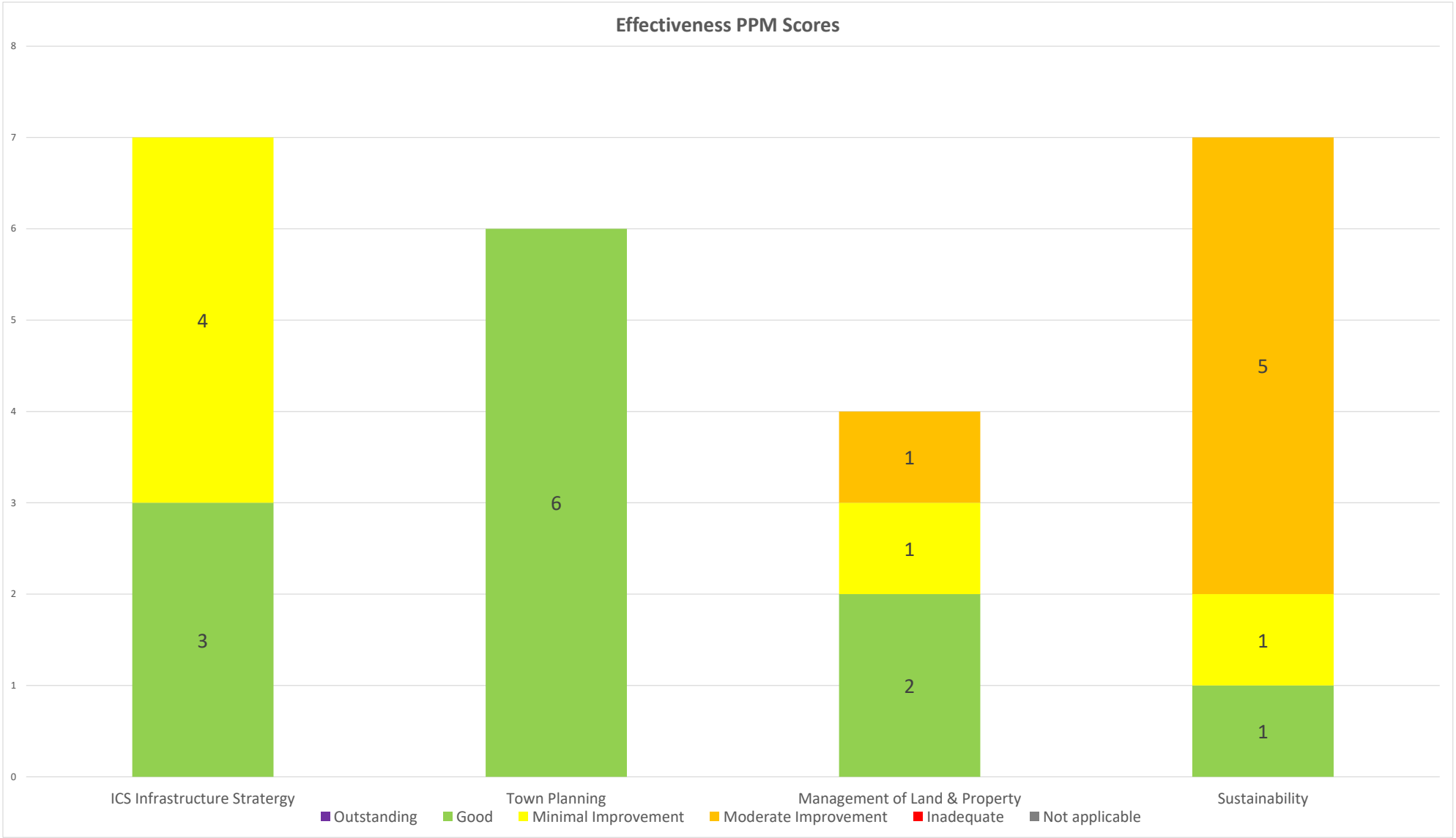
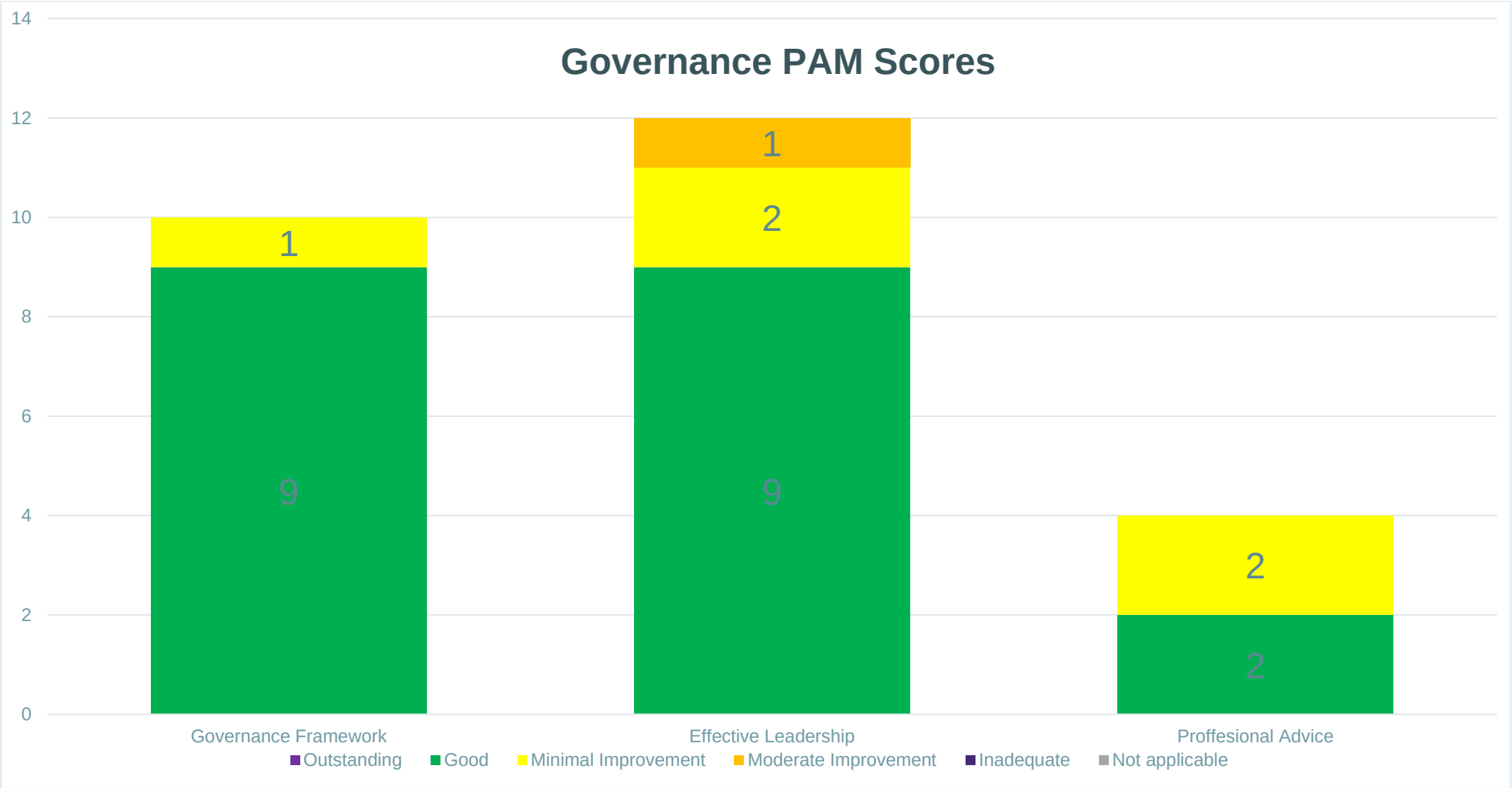
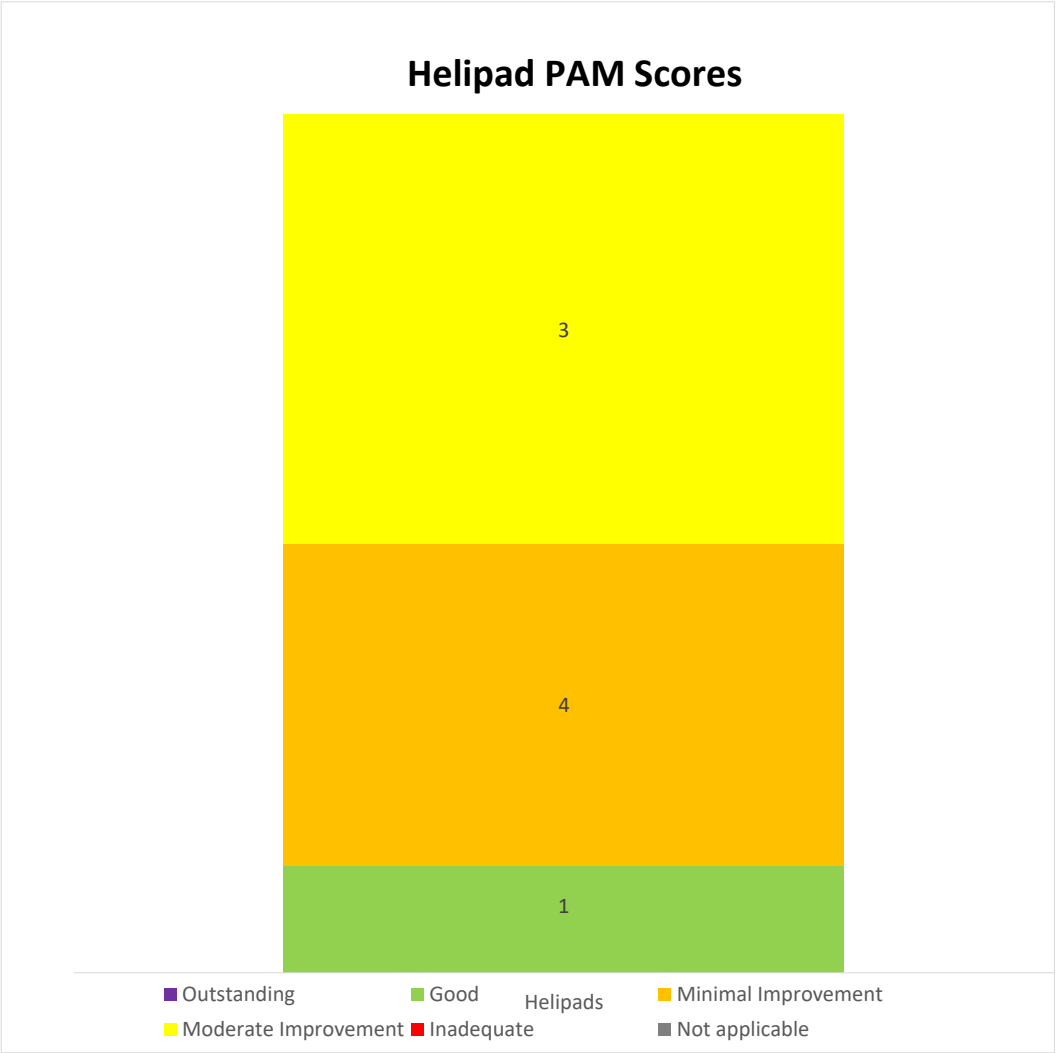
4
3
well-managed approach to performance management of the estate and facilities operations
well-managed approach to improved efficiency in running estates and facilities services
Improved efficiencies in capital procurement, refurbishments and land management
Well managed Financial Controls
Continiouse Improvement & Sustainability
Outstanding
Good
Minimal Improvement
Moderate Improvement
Inadequate
Not applicable


Effectiveness PPM Scores
8
7
6
5
4
3
2
1
0
4
3
6
1
1
2
5
1
1
ICS Infrastructure Stratergy
Town Planning
Management of Land & Property
Sustainability
Outstanding
Good
Minimal Improvement
Moderate Improvement
Inadequate
Not applicable


Governance PAM Scores
14
12
10
8
6
4
2
0
1
9
1
2
9
2
2
Governance Framework
Effective Leadership
Proffesional Advice
Outstanding
Good
Minimal Improvement
Moderate Improvement
Inadequate
Not applicable


Helipad PAM Scores
3
4
1
Outstanding
Good
Minimal Improvement
Helipads
Moderate Improvement
Inadequate
Not applicable

The 2022/2023 overall assessment results are:

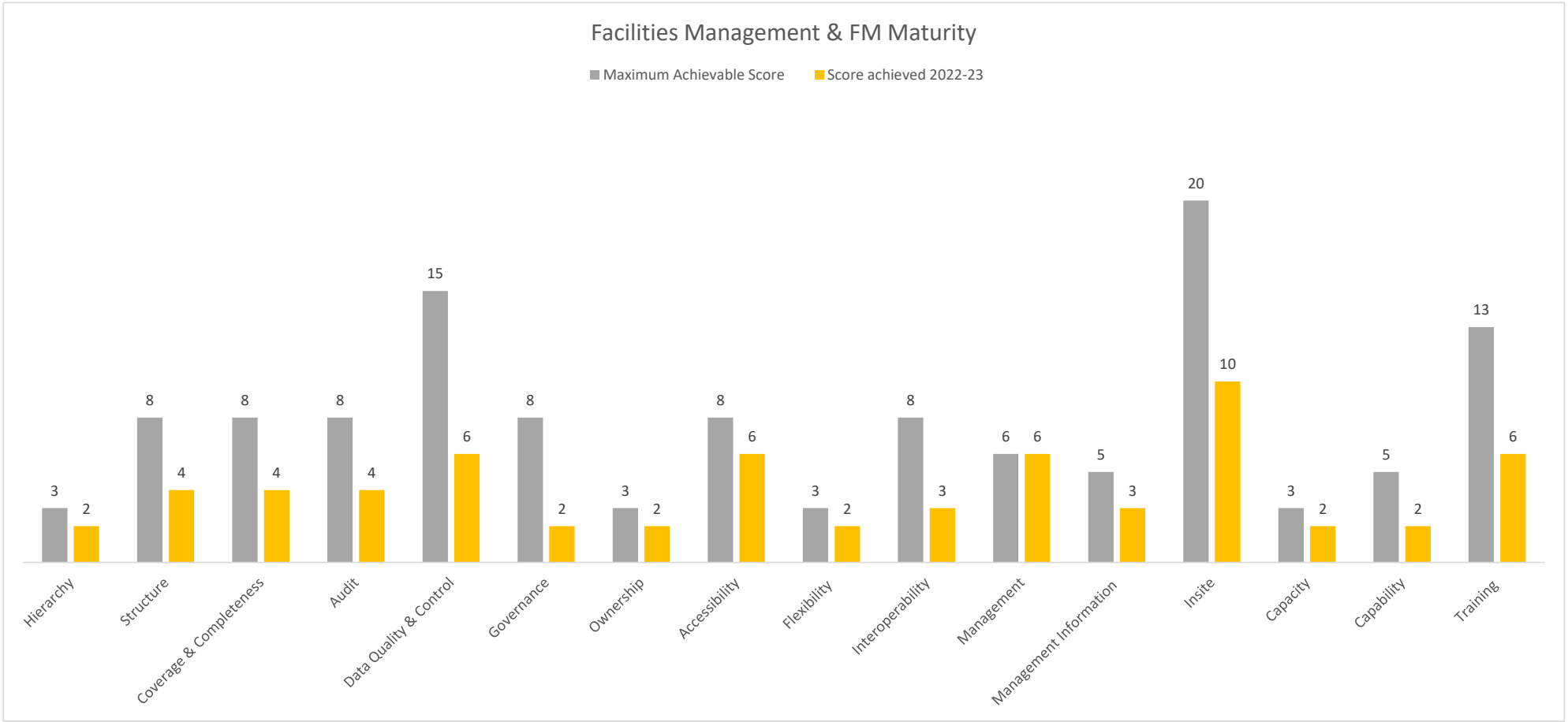
0% have been rated as Outstanding.
62.43% have been rated as Good.
28.45% as Requiring Minimal Improvement.
6.35% as Requiring Moderate Improvement.
3.03% No area has been assessed as Inadequate.

4. Areas for Improvement

i. External Organisations – Policy requires developing to include our external properties managed by other providers and our properties that have tenants in place.
ii. Food standards and the levels of service provide through risk assessments.
iii. Cleaning Standard auditing and star ratings applied.
iv. BMS policy to include additional links to other alarm systems.
v. Helipads to meet CAP1264 standards.

5. FM Maturity

This is a new standard to achieve, Facilities Management (FM) Maturity. We have limited assurance that we are achieving this standard but will improve as part of the asset sanitisation and capture program that is in place as part of Micad (CAFM) implementation project that is currently in progress.


Facilities Management & FM Maturity
Maximum Achievable Score
Score achieved 2022-23
3
2
8
4
8
4
8
4
15
6
8
2
3
2
8
6
3
2
8
3
6
6
5
3
20
10
3
2
5
2
13
6
Hierarchy
Structure
Coverage & Completeness
Audit
Data Quality & Control
Governance
Ownership
Accessibility
Flexibility
Interoperability
Management
Management Information
Insite
Capacity
Capability
Training

6. Summary

The NHS PAM assessment process offers a mechanism to evaluate the current position of Estates and Facilities performance against a set of common indicators, and to provide assurance that the estate is safe, efficient, effective and of high quality.

Areas of improvement

1. Catering Standards, provision of out of hours.
2. Cleaning Standards requires more work on star ratings.
3. Policy requires improvement on the management of external organisations where we have services based or we owe a duty to tenants.
4. BMS policy requires reviewing.
5. Helicopter Pad not compliant with CAP 1264.
6. FM Maturity requires improvement work on CAFM system.

This report concludes that an NHS PAM Standards Assurance Group be established, led by the Estates Directorate, which will report to the YTHFM Operational Management Group. This will ensure a standardised approach to the NHS PAM assessment is in place with appropriate peer review; that actions identified through the PAM process are monitored, and that any identified risks are escalated where appropriate, and further escalated to the Health & Safety/Non-Clinical Risk Group as necessary.

7. Recommendations

In line with guidance the NHS PAM is presented to Board of Directors for approval. The Board of Directors is asked to note the internal NHS PAM assessment outcomes and note and approve the contents of the report.