York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 24th April 2024
Time: 10:00am – 12:45pm
Venue: Blue Room, Scarborough Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Martin Barkley	Verbal	-	10:00
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 March 2024** To be agreed as an accurate record.	Martin Barkley	Report	5	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log. • TPR Cancer Changes	Martin Barkley	Report	16 18	
6.	**Chair's Report** To receive the report.	Martin Barkley	Report	20	10:05
7.	**Chief Executive's Report** To receive the report.	Simon Morritt	Report	23	10:10
8.	**Quality Committee Report** To receive the April meeting summary report.	Steve Holmberg	Report	63	10:30

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Resources Committee Report** To receive the April meeting summary report.	Lynne Mellor	Report	65	10:35
10.	**Trust Priorities Report (TPR)** April 2023-24 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Claire Hansen Dawn Parkes Polly McMeekin James Hawkins Andrew Bertram	Report	 71 101 120 134 140	10:40
	Break 11.30				
11.	**CQC Compliance Update Report** To consider the report.	Dawn Parkes	Report	150	11:40
12. 12.1 12.2	**Maternity and Neonatal Reports** To consider the reports: • Maternity and Neonatal Quality & Safety Update • CQC Section 31 Update	Dawn Parkes	Report	 156 169	12:00
13.	**Emergency Preparedness Resilience and Response (EPRR) Action Plan Update** To consider the report.	Claire Hansen	Report	177	12.15
Governance					
14.	**MRI 3 YH Business Case**	Andy Bertram	Report	193	12:20
15.	**2024/25 Board Work Plan** To approve the work plan.	Mike Taylor	Report	222	12.30

Item	Subject	Lead	Report/ Verbal	Page No	Time
16.	**Q4 Board Assurance Framework (BAF)** To approve the Q4 BAF.	Mike Taylor	Report	227	12.35
17.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	12:40
18.	**Time and Date of next meeting** The next meeting held in public will be on 22 May 2024 at 9:30am at York Hospital.				
19.	**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.				
20.	**Close**				12:45

Minutes
Board of Directors Meeting (Public)
27 March 2024

Minutes of the Public Board of Directors meeting held on Wednesday 27 March 2024 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9.30am and concluded at 12.30pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (& Maternity Safety Champion)
- Mr Jim Dillon
- Mrs Jenny McAleese
- Mrs Lynne Mellor
- Prof. Matt Morgan

Executive Directors
- Mr Simon Morritt, Chief Executive
- Mr Andrew Bertram, Deputy Chief Executive/Finance Director
- Ms Claire Hansen, Chief Operating Officer
- Mrs Dawn Parkes, Interim Chief Nurse & Maternity Safety Champion
- Miss Polly McMeekin, Director of Workforce and Organisational Development
- Dr Karen Stone, Medical Director
- Mr Steven Bannister, Managing Director of York Teaching Hospitals Facilities Management LLP (YTHFM)

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
- Ms Sascha Wells-Munro, Director of Midwifery (for Item 158 23/24 Maternity Reports)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Julie Southwell, Staff Governor
- Ms Linda Wild, Public Governor (East Coast)
- Mr Michael Clarke, trustee of St Monica's

Mr Barkley welcomed everyone to the meeting.

144 23/24 Apologies for absence
Apologies for absence received from:
- Dr Stephen Holmberg, Non-Executive Director
- Mr James Hawkins, Chief Digital and Information Officer

145 23/24 Declaration of Interests

There were no declarations of interest to note.

146 23/24 Minutes of the meeting held on 28 February 2024

Mr Barkley recorded his thanks to Miss Gaynor for the quality of the minutes.

Subject to a minor correction, the Board approved the minutes of the meeting held on 28 February 2024 as an accurate record of the meeting.

147 23/24 Matters arising/Action Log

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

BoD Pub 21 – this action around Freedom of Information response times was deferred to the next meeting, as the Chief Digital Information Officer was not present to provide an update.

BoD Pub 25 – the CQC revised standards/inspection regime would be presented at the Board seminar on 17 April.

BoD Pub 32 – the quarterly report on the progress of the Emergency Preparedness, Resilience and Response (EPRR) was deferred to the April meeting.

148 23/24 Chair's Report

Mr Barkley reported that Ms Julie Charge would be joining the Trust Board on 1 June 2024 and Ms Helen Grantham would join the Board as an Associate Member, hopefully on 1 May 2024.

Mr Barkley had recently visited two departments at Scarborough Hospital and had been very impressed with the services. He had also visited Nelson Court and Whitecross Court.

149 23/24 Chief Executive's Report

Mr Morritt highlighted the key areas from his report:

- the outcomes from the 2023 NHS staff survey actions were clearly disappointing for the Trust and actions were in progress to address the issues raised by the responses;
- the planning guidance update had still not been received; the final submission for 2024/25 was likely to be due in May; Mr Morritt underlined the scale of the challenge facing the Trust, particularly in terms of staff engagement and resources;
- the Trust had been awarded a £3m grant by the National Institute for Health and Care Research (NIHR) for research led by Professor James Turvill; this was very good news and would serve also to enhance the reputation of the Trust in the region;
- positive recognition of staff embodied in the Star awards.

It was agreed that Mr Morritt would write to Professor Turvill on behalf of the Board to congratulate him. It was suggested that the Board should be updated on a regular basis on research work within the Trust.

Action: Mr Morritt

150 23/24 Quality Committee Report

Dr Boyd briefed the Board on key discussion points from the meeting of the Quality Committee on 19 March. She reported first that there had been a detailed discussion on

the use of the Unplanned Care Standard Operating Procedure (SOP) which, it was agreed, was not a long term solution.

Referring to the report, Mr Barkley queried the reference to the lack of areas for elective orthopaedic/breast surgery. Ms Hansen explained that there were currently insufficient beds for these specific procedures, which would be addressed through an ongoing right-sizing process. A draft outline of these plans had been shared with the relevant teams, with actions likely to be implemented in May. Ms Hansen confirmed that the elective orthopaedic/breast surgery beds were located together but the presence of medical outliers was an added complication.

Ms Hansen observed that right-sizing was the longer term solution to the Unplanned Care SOP, alongside a new model of acute care.

Clarification was provided for some of the terminology in the report. There were no further questions or comments.

151 23/24 Resources Committee

Mrs Mellor briefed the Board on the key discussion points from the meeting of the Resources Committee on 19 March. In summary:

- the results of the staff survey had been discussed;
- it had been a challenging month for Emergency Departments (EDs) with the highest daily average of ambulance arrivals; this had impacted on staff and work was in progress in the department and with Yorkshire Ambulance Service (YAS) to address the challenges by implementing new ways of working;
- actions were in place designed to ensure that the 2023/24 financial plan was met, and funding had been received from the Integrated Care Board (ICB) to support this; the 2024/25 Group Operational Financial Plan was even more challenging;
- a significant level of capital work had been managed by YTHFM;
- the Committee had received the Green Plan;
- there had been lengthy discussions around workforce, and it had been agreed that the outcomes of the establishment review were key to informing future planning.

Mr Barkey queried why there had been a discussion on cancer communications when this seemed more relevant to the Quality Committee. Mrs Mellor explained that this was in the context of the cancer statistics provided to the Committee and she provided further background. Dr Stone advised that an appointment had been made to the Cancer Lead Clinician role and this individual would have capacity to focus on strategic improvements.

152 23/24 Audit Committee Report

Mrs McAleese reported that no concerns had been raised by the auditors at the Audit Committee meeting. She highlighted that the Board seminar scheduled for 19 June 2024 had been earmarked for the approval of the 2023/24 Annual Report and Accounts.

Mrs McAleese advised that the Head of Internal Audit had raised no concerns in relation to the audits completed to date which was an excellent outcome. Mr Morritt noted that Executive Directors had ensured that audit actions had been delivered.

Mrs McAleese observed that the current Board Assurance Framework needed to be reviewed to reflect the latest strategic objectives. The Audit Committee asked that the Board identify a timescale for the completion of the new Trust Strategy. It was agreed that the new strategy would be presented in September, and that the Board Assurance Framework, amongst other governance documents, could then be updated.

153 23/24 Trust Priorities Report (TPR)

Operational Activity and Performance

Mr Barkley commented on the reduction of 12 hour trolley waits in ED compared to the previous month and congratulated staff on this improvement.

Mr Barkley listed a number of key metrics which he considered were missing from the TPR and undertook to communicate these to Mr Hawkins. Mr Dillon commented that it would be helpful to have a glossary of acronyms added to the report.

There was further discussion on the key metrics published in the TPR and it was noted that previously the choice was informed by NHS England targets, as the Trust would be held accountable to these key metrics, but it was agreed that crucial, relevant Trust statistics should be included as proposed by Mr Barkley.

A question was raised about the recording of patients arriving at EDs, for whom this was not a suitable treatment option. Ms Hansen outlined the challenges of collating this information, which would likely require more staffing capacity than it saved. The priority was to improve on the management of patient flow within the system.

Referring to page 76, Dr Boyd noted an inaccuracy in the narrative relating to the Virtual Hospital Project: the area referred to as South Hambleton and Richmondshire should be described as Ryedale.

Mr Barkley asked for further clarification about the metrics used in the Cancer Scorecard. Ms Hansen advised that these were the nationally reported metrics and that there were nuances between each of them. She would provide written clarification.

Action: Ms Hansen

Ms Hansen noted that the key metrics for cancer patient care were related to delays in diagnosis and to first treatment. The key challenge from NHS England was to reduce the number of patients waiting more than 63 days for first treatment and to improve the Faster Diagnosis Standard. Mr Morritt commented that substantial improvements in cancer waits had been made in the last six months. Ms Hansen explained that that main delays to diagnosis were in scanning, endoscopy and histopathology.

Referring to the Outpatients and Elective Care Scorecard, Mr Barkley suggested the inclusion of metrics showing the total number of day patients and inpatient electives, as these would provide valuable information about trends.

In response to a question relating to the Children and Young Persons Scorecard, Ms Hansen advised that the number of children waiting over 65 weeks was unlikely to be reduced to zero but only six were currently recorded. This metric would be changed to waiting over 52 weeks in future TPRs.

Referring to the KPIs for Operational Activity and Performance in the community, Mr Barkley asked who made referrals to community teams. Ms Liley responded that referrals originated from a number of sources and provided further details. Self-referrals to community teams were not possible.

Quality and Safety

Referring to the Quality and Safety scorecard, Professor Morgan raised the issue of the potential underreporting of incidents since changes had been made to the Datix form. Dr Stone explained that the form was being amended to facilitate reporting. She added that

the matter had been discussed at Quality Committee and at the Patient Safety and Clinical Effectiveness Sub-Committee. Mrs Parkes advised that her team was analysing trends in incident reporting and that, in fact, the level was comparable in some areas to the same period last year. She agreed, however, that reporting levels needed to increase overall. The Board requested an update on the position at the next meeting.

Action: Mrs Parkes

Mr Barkley questioned why the maternity unit in Scarborough had closed twice. Mrs Parkes responded that this was due to a lack of staff, although the duration of each closure had only been for a few hours, usually covering shift handovers. No women had been affected by the closure of the unit although four women had been affected by the suspension of the homebirth service. Further explanation of the mitigating actions taken was provided; a significant improvement in reducing the number of closure periods was noted.

Workforce

In response to a question, Miss McMeekin explained that, as there were no nationally set targets for workforce, the control limits in the Statistical Process Control (SPC) Charts were set based on the previous trajectory. Her team was reviewing how the metrics were calculated and represented, in order to provide more meaningful information.

It was noted that the midwifery vacancy rate was a minus value. This had not been explained in the narrative as it was not unusual for an area to be staffed over establishment. Mr Bertram reported that a meeting had been held with the ICB to discuss the need for extra funding to support continued improvements in the Maternity Unit. Mrs Parkes added that she had also met with Mrs Wells-Munro, Director of Midwifery, and representatives from the ICB on this matter; the Trust had been asked to identify specific projects for funding. Mrs Parkes noted that the over establishment within the Maternity Unit related to specialist roles and these were funded by the ICB.

Referring to the metric for total nursing temporary staffing requests, Miss McMeekin advised that the figure had been converted into hours. The accuracy of this, and the metric relating to medical and dental temporary staffing requests, was queried. Miss McMeekin would investigate further to ensure accuracy in the next TPR.

Action: Miss McMeekin

In terms of the workforce report, Mr Barkley observed that the key metrics for the organisation related to whether staff would recommend the Trust as a place to work and to receive treatment. Miss McMeekin explained that these key metrics formed part of the advocacy questions in the National Quarterly Pulse Survey. The response rate was still low, and advocacy rated lowest of the response areas.

Mrs Mellor highlighted the building of relationships with local universities which, it was hoped, would support future recruitment of nursing staff. Miss McMeekin confirmed that the conversion rate of students to appointments was tracked and was positive. This would reduce the reliance on international recruitment, which would focus on medical and Allied Health Professionals.

Digital and Information Services

There were no comments or questions on this section of the TPR.

Finance

Mr Bertram highlighted the marked improvement in the financial position as at Month 11. The Trust was now only £3.8m adrift of plan. He reported that discussions around high

cost drugs and devices had been successfully concluded with the ICB. NHS England had released £30m of funding to the ICB, which now had a balanced plan. £15m of this had been released to the Trust.

Mr Bertram emphasised the pressure on the Trust to deliver a year end balanced position, noting that the actions designed to achieve this had already been put in place. He reported that the cash position for the year end would be healthy, and that to achieve a balanced position overall would be very positive.

In terms of the capital programme, Mr Bertram advised that there was £25m budgeted to be spent in March and the actual expenditure would be close to this figure. Discussions were taking place with Integrated Health Projects (IHP) in relation to the Scarborough building and a significant payment had been made in relation to the Scarborough Community Diagnostic Centre (CDC). Mr Bertram recorded his thanks to the YTHFM team for their delivery of multiple capital projects, and to the Procurement and Finance teams who had been making every effort to maximise opportunities to spend the capital budget before year end, which the Board fully endorsed.

154 23/24 Staff Survey Report

Miss McMeekin presented the report and summarised key areas for the Board to note:

- the overall response rate had deteriorated from 41% to 39%;
- the survey had included staff from YTHFM; previously they had completed the survey separately;
- of the nine themes in the survey, seven related to the people promise;
- responses to all elements of the survey were below the benchmarks;
- there had been a deterioration in six of the nine themes, with a marginal improvement in one;
- the free text comments had been summarised in a table, only 8% of which were positive in nature.

Miss McMeekin highlighted that overall, the survey results represented a significant deterioration against the Trust's peers, particularly in "we each have a voice that counts" and advocacy questions. Miss McMeekin reported that there were a number of initiatives and actions underway, of which she provided details, but these were clearly not yet having an impact. She observed that some of the free text comments highlighted the need to ensure that staff understood that their terms and conditions of employment were set by the NHS, not the Trust individually. The Equality, Diversity and Inclusion agenda was also an area of focus.

Miss McMeekin flagged the importance of consistent and sustained implementation of the initiatives. The Trust's plans had been endorsed by NHS England, and it was clear that change would take a number of years. An action plan informed by the survey would be developed and brought to the Resources Committee.

Action: Miss McMeekin

Miss McMeekin advised that different themes had been raised across different areas and it would therefore be important to share learning.

Board members spent some time discussing the disappointing outcomes of the staff survey and the following points were made:

- it was concerning that the outcomes had deteriorated from last year and there were no signs at all of improvement;
- the focus in the free text comments was on how teams were managed, on the quality of equipment and the working environment – they had been made by staff

delivering the Trust's core business which was worrying as staff morale could impact patient care;
- poor working environments could have a significant impact on staff morale;
- there was particular criticism expressed of line management in the comments, and it was clear that this was a priority for a major review of how to better support line managers;
- improving staff engagement, whilst being a crucial priority, was a huge challenge, particularly in the light of the financial pressures.

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Mr Morritt suggested that the immediate focus should be on improving line management which would require investment. Miss McMeekin advised that formal training for those in line management roles had been dispensed with a number of years ago, but a wider issue was that line managers needed to feel more empowered about how they managed their teams.

Ms Hansen highlighted the work which had been completed already as part of the leadership programme and underlined the need to support line managers in communicating effectively to their teams the rationale behind high level decisions. It was agreed that the failure was not necessarily with line managers but with senior leaders not always providing quality supervision and support.

It was noted that Change Makers were analysing the comments from the survey which would feed into information which they were gathering.

Mr Morritt advised that he had established a senior leadership meeting to consider the new Trust strategy; the outcomes of the staff survey could be included as a further focus for the meetings.

155 23/24 Q3 Mortality Review – Learning from Deaths Report

Dr Stone presented the report, which had also been presented at the last meeting of the Quality Committee, and she advised that there were no particular areas of concern to highlight. She noted that investigations were continuing into the diagnostic coding for the Hospital Summary Mortality Indicator (HMSR) as, whilst it did not raise any concerns, there was some uncertainty around the accuracy of the data.

156 23/24 CQC Compliance Update Report

Mrs Parkes presented the report, which set out progress of the delivery of actions within the Trust's CQC Improvement Plan, overseen through fortnightly Journey to Excellence meetings. Mrs Parkes noted that the report had also been presented at the Patient Safefy and Clinical Effectiveness Sub-Committee and the Quality Committee. Progress against the actions was positive, the majority of outstanding actions had now been signed off and the Trust was on track to deliver the action plan. Mrs Parkes underlined that a high level of assurance was required before actions were declared closed, including evidence that the position could be sustained. The relationship with the Trust's new CQC inspector was developing well, and the openness and transparency shown by the Trust to the CQC was being well received.

In response to a question, Mrs Parkes advised that the pie chart representation of progress against the CQC actions was the format required by the CQC. She explained that "pending closure" meant that closure of the action had not yet been formally agreed through the Journey to Excellence meetings.

Mrs Mellor noted that the report contained no detail of the original target date for an action where it was now "off track" and, if there was a risk arising from this slippage, this was not recorded. Mrs Parkes responded that any risks arising were recorded in the Corporate Risk Register (CRR) and assured the Board that the progress of all actions was carefully tracked. She agreed to add information about initial target dates to the report and confirmed that there were no new risks associated with actions not on track.

Action: Mrs Parkes

Mr Barkley referred to the details of the three actions most recently closed and asked about the process for reviewing national patient safety alerts in ED which Dr Stone clarified. She explained how the Trust would be able to demonstrate continued compliance with this requirement.

Referring to the work of the Digital Information Service (DIS) in developing a learning hub training module outlined in Section 5 of the report, Mr Barkley queried the timescale for this project, as there had been no progress since the last report. Mrs Parkes responded that the DIS team were currently experiencing capacity issues.

157 23/24 Governance Update

This item was taken next.

Health and Safety Policy

Mr Bannister explained that YTHFM was required to hold a separate Health and Safety Policy which needed to be approved by the Board. He advised that the policy had been reviewed by the management group of YTHFM and the relevant Committees of the Trust Board. The policy fulfilled the statutory responsibilities of YTHFM as limited company. Mr Bannister confirmed that the Health and Safety Officer was employed by the Trust, with these services bought in by YTHFM.

The Board approved the YTHFM Health and Safety Policy.

Revision of the Reservation of Powers and Scheme of Delegations and Standing Financial Instructions

It was noted that this document had been reviewed by the Audit Committee.

The Board approved the Revision of the Reservation of Powers and Scheme of Delegations and Standing Financial Instructions for YTHFM.

The meeting returned to the agenda as Mrs Wells-Munro, Director of Midwifery, joined the meeting.

158 23/24 Maternity and Neonatal Reports

Maternity and Neonatal Quality and Safety Update

Mrs Wells-Munro presented the report and highlighted the following:

- a reduction in postpartum haemorrhage (PPH) rates from the previous month; Mrs Wells-Munro cautioned that this was unlikely to be due solely to the quality improvement work taking place, but she was hopeful of a sustained trajectory of reduction;
- all milestone actions were articulated in the maternity and neonatal improvement plan and would be shared at the Engagement level event scheduled for 23 April;
- progress in each of the workstreams was detailed in the report. Mrs Wells-Munro noted that service user feedback had been useful;
- in terms of the CQC maternity survey, the Trust had declined in five key areas and the questions had been added to the weekly and monthly Tendable audits;

- the team was working to develop an in-house patient experience survey to inform further action.

Mr Barkley queried the survey response to the question about postnatal care, which was particularly low. Mrs Wells-Munro explained that this was a question about partners being able to stay in hospital once the baby was born. The Trust could not currently offer this option due to the restrictions of the physical space, but it was being considered.

Returning to her update, Mrs Wells-Munro drew attention to the following points:

- the senior leadership team had met to discuss workforce issues and how best to model Trust values and behaviour;
- feedback received from student midwives was very positive; more opportunities for them to experience a wider variety of placements was an area for improvement;
- an NHS England funded Culture score survey was being undertaken and every effort was being made to encourage staff engagement; the number of respondents was positive thus far;
- the Local Maternity and Neonatal System (LMNS) had undertaken a quarterly review of services' position against six elements of the savings babies lives care bundle; the Trust was moving towards compliance but was hindered by a lack of scanning capacity;
- the Badgernet electronic patient record system was of concern; the Trust was working with Information Technology at the Trust and across the LMNS to address ongoing issues with lack of connectivity; the service contract was due to finish at the end of May and Mrs Wells-Munro planned to meet with Mr Hawkins to discuss the service going forward;
- the National Maternity and Neo Natal Service survey was due to be submitted on 8 April, the focus of which was capital funding;
- representatives from the LMNS had undertaken a joint assurance visit with the ICB on 29 February - verbal feedback had been very positive; Mrs Wells-Munro advised that a full written report had been received but would be reviewed first through the appropriate governance processes before being presented to the Board at its next meeting.

Mr Morritt noted the positive engagement of maternity staff with the Culture score survey and suggested that the work which had brought this about might be replicated in other areas to increase engagement in the staff survey. Mrs Parkes agreed that the learning could be shared. Miss McMeekin added that it would feed into work being undertaken by Change Makers.

Mr Barkley proposed that he meet with Mr Morritt and Mrs Wells-Munro as an opportunity to learn from her wealth of experience in leading improvement in maternity services in other trusts.

Mrs Mellor asked Mrs Wells-Munro, in terms of risk, which concerned her most. Mrs Wells-Munro responded that the service would need significant investment to enable it to continue on a positive trajectory to meet national standards. If no further investment was forthcoming, there would be difficult choices ahead about which services might be discontinued. She added that other trusts were in a similar position as the requirement to meet national standards was not supported with funding. Discussions with the ICB on this issue were ongoing.

CQC Section 31 Update

Mrs Wells-Munro advised that the Trust was not yet meeting the elements of the Section 31 notice around ante-natal risk assessments, which was in part due to connectivity

issues. She was pleased to report however that a supply of ipads was being delivered which would help midwives to complete relevant documentation in the community. Mrs Wells-Munro was thanked for her comprehensive report and the improvement work she was leading.

The Board approved the Section 31 Update.

159 23/24 Equality, Diversity and Inclusion Annual Report 2024
160 23/24 Public Sector Equality Duty Objectives 2024-2028

Miss McMeekin presented the reports: the purpose of the Equality, Diversity and Inclusion Annual Report was to summarise the Trust's performance against the Public Sector Equality Duty objectives. These objectives for the next four years were set out in the second report. Ms McMeekin observed that there was a certain amount of duplication in the reports.

There was some discussion on the period covered by the Equality, Diversity and Inclusion Annual Report which was unclear. It was agreed that Ms McMeekin would write to the Board to clarify the period to which the report related.

Action: Miss McMeekin

Professor Morgan noted that the equality objectives set out on page 10 of the Public Sector Equality Duty Objectives 2024-2028 report were, in some cases, not well-defined or measurable. This had been raised when the report was presented to the Resources Committee but the imminent deadline for submission meant that making major amendments to the report would be challenging. It was noted that work would be undertaken to ensure that processes were put in place to produce measurable outcomes but currently there was, in many cases, no baseline data to use for target setting.

Mr Barkey highlighted the response time to complaints which was still an area for improvement.

It was agreed that the reports would be submitted for publication to meet the deadline, but comments would be shared outside of the meeting, such that updated and corrected versions could then be re-submitted to NHS England and put on the Trust's website.

Action: Miss McMeekin

It was also agreed that these reports should be considered next year by the Resources Committee in or before February 2025.

Action: Mr Taylor

The Board approved the Equality, Diversity and Inclusion Annual Report 2024 and the Public Sector Equality Duty Objectives 2024-2028.

160 23/24 Green Plan

Mr Bannister presented the plan. He advised that it had been presented to the Resources Committee; comments about the plan had been made but these had not yet been incorporated. Mrs Mellor had offered further guidance which would also be incorporated.

Mr Bannister reported that good progress was being made in implementing the plan and he provided some further details, highlighting that funding of £2m had been received to install LED lighting. He explained that the priority areas were around culture change in the workforce and better utilisation of space. YTHFM had begun work with Newcastle Hospitals NHS Foundation Trust to learn from its best practice in this area. Mr Bannister summarised the Trust was making good progress in terms of environmental sustainability.

The Board approved the Green Plan, subject to the amendments proposed.

157 23/24 Governance Update

Continued from above.

Modern Slavery Statement
Trust Constitution Amendments

The Board approved both of these documents.

161 23/24 Questions from the public

There were no questions from members of the public.

162 23/24 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 24 April 2024 at 9.30am.

Action Ref.	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 20	29 November 2023	89 23/24	Matters arising	Diagnostic Capacity and Demand update to be presented to Board	Chief Operating Officer	28.02.24 update - although a presentation had been received at Board previously, it was limited on information and no recovery plan detailed. It was agreed at the time the presentation was delivered, that a detailed diagnostic recovery plan would be shared in due course but this had not yet been presented. Agreed to bring back a recovery plan to Resources Committee in March/April and subsequently Board in April. Due date amended to reflect this.	Apr-24	Amber
BoD Pub 21	29 November 2023	90 23/24	Chief Executive's Update - TPR	Freedom of Information Response Times	Chief Digital Information Officer	To review the process and collectively improve response times. 31.01.24 Update - Mr Hawkins updated that some central changes had been made to the central aspects of the process but suggested the action remained open as work continued to review the activity and its process. The Board agreed to amend the due date to March 24. 27.03.24 Update - Mr Hawkins did not attend the meeting due to annual leave. The due date was therefore amended to April 2024.	Apr-24	Amber
BoD Pub 23	29 November 2023	92 23/24	Research and Development Update	Share relevant connections with established clinical activities to support portfolio research delivery	Medical Director	31.01.24 - Miss McMeekin requested the due date be extended from February. As this was in tandem with the strategy programme and the research strategy, it was more realistic for July 24. The Executive Lead was to be amended to the Medical Director following recent changes in portfolios.	Jul-24	Amber
BoD Pub 25	29 November 2023	95 23/24	CQC Compliance Update Report	CQC new inspection regime - Presentation to be delivered to the board to understand the impact on the Trust	Chief Nurse	31.01.24 - reference to the CQC regime included in the agenda. A briefing report had also been circulated to the Board as the Northern region began in the week. It was proposed to come back to the Board in a development session. 28.02.24 update - Mr Barkley to agree a date with Mrs Parkes outside the meeting for a planned session as part of a future Board seminar. 27.03.24 update - the report would be presented at the Board seminar in April.	Apr-24	Red
BoD Pub 30	29 November 2023	99 23/24	Quality and Safety Assurance Committee	Waiting List Harms Task and finish Group proposal for a process of identifying and monitoring patients on waiting lists to be presented to Ms Hansen and to the Quality Committee.	Chief Operating Officer	31.01.24 Update - Ms Hansen reported that the waiting time harms task and finish group was set up in October 23 to review the process for reviewing specifically, harm a s a result of waiting lists (elective or acute). This was extended further to review how to proactively manage elective waiting lists for other areas such as paediatrics as an example as the impact this has on children for waiting extended periods of time. An outcome of this is a report to the Executive Committee 7th February 2024 for discussion and engagement with care groups and deputies before it is socialised further. 28.02.24 update- Mrs Hinton described a proposal report had been presented to the Executive Committee on 7 February and was discussed with an outcome of further work required before this could be ratified and reported to the Quality Committee. This would sit with the elective programme work going forwards as a specific workstream but required a consistent approach were possible and it was this that was taking the time. It was anticipated that it would be reported to the Quality Committee in April 24, appreciating that this may not be a complete picture but at minimum an update on progress. The deadline was amended to reflect this.	Apr-24	Amber
BoD Pub 31	29 November 2023	100 23/24	Trust Priorities Report: Elective Recovery and Acute Flow Elective Update	The theatre staffing, retention and sickness rates in theatre were an issue that were being addressed. The Board requested the Digital, Performance and Finance Assurance Committee receives a detailed briefing around the issues in relation to theatre staffing and mitigations to address.	Chief Operating Officer	Delegated to Digital, Performance and Finance Assurance Committee 28.02.24 update - No report received to date, due date amended to April.	Apr-24	Amber
BoD Pub 32	29 November 2023	101 23/24	Emergency Preparedness Resilience and Response (EPRR) Core Standards – Amendment to Compliance Grading	Quarterly update on progress of EPRR action plan to Board	Chief Operating Officer/Associate Director of Corporate Governance	27.03.24 update - the quarterly report on the progress of the Emergency Preparedness, Resilience and Response (EPRR) was deferred to the April meeting.	Apr-24	Amber
BoD Pub 39	28 February 2024	138 23/24	Trust Response Letby Review Summary Report	Online briefing for the Board with Chair of the independent investigation.	Chair		Apr-24	Green
BoD Pub 40	27 March 2024	149 23/24	Chief Executive's Report	Write to Professor Turvill on behalf of the Board to congratulate him. Consider how the Board should be updated on a regular basis on research work within the Trust.	Chief Executive		Apr-24	Green
BoD Pub 41	27 March 2024	153 23/24	TPR - Operational Activity and Performance	Provide further written clarification about the metrics used in the Cancer Scorecard.	Chief Operating Officer		Apr-24	Green

BoD Pub 42	27 March 2024	153 23/24	TPR - Quality and Safety	Provide update to the Board on Datix reporting levels	Interim Chief Nurse		Apr-24	Green
BoD Pub 43	27 March 2024	153 23/24	TPR - Workforce	Ensure accuracy of data in TPR relating to total nursing, medical and dental temporary staffing requests.	Director of Workforce and OD		Apr-24	Green
BoD Pub 44	27 March 2024	154 23/24	Staff Survey Report	Develop action plan from Staff Survey to be brought to the Resources Committee	Director of Workforce and OD		May-24	Green
BoD Pub 45	27 March 2024	156 23/24	CQC Compliance Update Report	Add information about initial target dates for actions to the report	Interim Chief Nurse		Apr-24	Green
BoD Pub 46	27 March 2024	159 23/24 160 23/24	Equality, Diversity and Inclusion Annual Report 2024 Public Sector Equality Duty Objectives 2024-2028	Write to the Board to clarify the time period covered by the Equality, Diversity and Inclusion Annual Report	Director of Workforce and OD		Apr-24	Green
BoD Pub 47	27 March 2024	159 23/24 160 23/24	Equality, Diversity and Inclusion Annual Report 2024 Public Sector Equality Duty Objectives 2024-2028	Ensure that the reports are submitted for publication to meet the deadline, and then incorporate comments such that updated and corrected versions are then re-submitted to NHS England and uploaded to the Trust's website.	Director of Workforce and OD		Apr-24	Green
BoD Pub 48	27 March 2024	159 23/24 160 23/24	Equality, Diversity and Inclusion Annual Report 2024 Public Sector Equality Duty Objectives 2024-2028	Ensure that these reports are considered by the Resources Committee by February 2025 at the latest.	Associate Director of Corporate Governance		Apr-24	Green

Report to:	Board of Directors Public
Date of Meeting:	24 April 2024
Subject:	Trust Priorities Report: Changes to Cancer Scorecard.
Director Sponsor:	Claire Hansen, Chief Operating Officer
Author:	Andrew Hurren, Operational Planning and Performance Manager

Status of the Report (please click on the appropriate box)
Approve ☐ Discuss ☐ Assurance ☒ Information ☒ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☐ Our People ☐ Quality 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 highlights

This paper details the changes that will be made to the Trust's Priorities Report (TPR) following changes made to bring the TPR in line with changes to the cancer waiting times standards agreed by NHS England and the Department of Health and Social Care on the 1st of October 2023.

Recommendation:

That Board of Directors note the changes that are being made to the Cancer Scorecard within the TPR.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)
No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

Meeting	Date	Outcome/Recommendation

1. Introduction and Background

From the 1st of October 2023 NHS England and the Department of Health and Social Care agreed changes to the cancer waiting times standards. The changes included the removal of the two-week wait standard in favour of a focus on the Faster Diagnosis Standard, and the rationalisation of standards into three core measures for the NHS:

- The 28-day Faster Diagnosis Standard.
- One headline 62-day referral to treatment standard.
- One headline 31-day decision to treat to treatment standard.

This paper details the changes that will be made to the Trust's Priorities Report (TPR) in time for the April report in time to be presented to the Trust's Committee and Board during May 2024.

2. Changes to TPR Cancer Scorecard

The following changes will be made to the Cancer Scorecard within the TPR:

Metric	Change
Cancer - Faster Diagnosis	No change
Cancer - 62 Day waits for first treatment	Update to include all referral types (urgent suspected cancer referral, breast symptomatic referral, urgent screening referral or a consultant upgrade).
Cancer - Number of patients waiting 63 or more days after referral	No change
Cancer Treatment Volumes	No change
Number of people referred onto a non-specific symptoms pathway	No change
Percentage of patients waiting 63 or more days after referral	No change
Cancer 2 week wait (all cancers)	To be removed
Cancer 31 day wait from diagnosis to treatment	No change

3. 2024/25 priorities and operational planning guidance: Cancer ambitions

The following objectives relating to Cancer were included in the 2024/25 priorities and operational planning guidance released by NHSE on the 28th of March 2024:

- Improve performance against the headline 62-day standard to 70% by March 2025.
- Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.

Recommendation

That Board of Directors note the changes to the Cancer Scorecard within the TPR.

Date: 15th of April 2024.

Report to:	Board of Directors
Date of Meeting:	24 April 2024
Subject:	Chair's Report
Director Sponsor:	Martin Barkley, Chair
Author:	Martin Barkley, Chair

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 Chair on recent visits and meetings.

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	24 April 2024	

Chair's Report to the Board - April 2024

1. Later in the afternoon after our March Board meeting and visits (I visited two wards with Lucy Brown), Simon Morritt and I had our monthly briefing meeting with the Trust's Council of Governors. The purpose of these briefings is to share information with the Governors about what the Trust had discussed/decided and take any questions about what we have said or indeed anything else. This was the third such briefing meeting. I estimate that they are attended by 40 to 50 per cent of Governors. The briefings and opportunity to "touch base" between the quarterly Council of Governor meetings seems to be appreciated, making them very worthwhile.
2. I have had discussions with the Chairs of the Board's Committees to consider the priorities of the issues that should be the subject of particular focus. I very much valued those discussions – thank you.
3. I attended for the first time the Council of Governors' Membership Committee. It was agreed to update and modernise our leaflet that describes the work of the Council and reasons why members of the public might want to be a Member of the Trust. Consideration will also be given how to publicise on our premises the opportunity to be a Member. In addition, a further discussion will be held on how to best survey our existing Members and the questions that should be in the survey.
4. I met one of the prospective Parliamentary candidates standing in the Scarborough constituency. I have now met the prospective candidates, both at their request, of both of the biggest political parties.
5. I visited St Monicas in Easingwold for the first time and will be visiting again in June when I meet with the Chair and two colleagues of the Friends of St Monicas. I received an excellent briefing of how the 12 bed hospital works including clinical pathways etc. followed by a conversation with the daughter of a patient at the hospital who informed me how fortunate they were to have a hospital like St Monicas in their locality.
6. I spent 14 hours over two days visiting 18 wards, depts. and teams largely based in the north wing of Scarborough General Hospital (SGH). In every instance it was my first visit to these areas and first conversations with the wide variety of colleagues I met and listened carefully to the briefings they gave me. It gave me a valuable further insight and understanding of the Trust, as well as the opportunity to thank colleagues in person for all that they do. In my future visits to SGH I will visit and listen to colleagues in South wing and Woodlands House.
7. I received a very helpful and informative briefing on how our estates and soft FM benchmark both regionally and nationally. But during the conversation I was informed that long term sick leave in one of the soft FM services is at quite a concerning level. The overall sick leave levels also seem to be higher than peers.
8. I have had very constructive discussions with James Hawkins and Business Intelligence colleagues about the statistical information that is needed to inform the discussions that we will have on Friday 3rd May, at the Council of Governors workshop" Local Services for Local People". All members of the Board are invited to attend. The Council agreed to hold such a workshop at its meeting held in November 2023 in the context of the Trust developing its new 5 year strategy.

9. I have continued to have my regular 121 meetings with Simon Morritt, Mike Taylor and Rukmal Abeysekera (Lead Governor). I have also had introductory 121 meetings with Rebecca Bradley, staff Governor community (Matron, District nursing community teams), Dr. Donald Richardson Chief Clinical Information Officer, Mr James Stanley Clinical Director Designate Surgical Directorate, Julie Charge who will be our new NED on 1st June, and Dr. Marcus Nicholls, Radiology.
10. I have attended preparatory meetings for the forthcoming important Segmentation meeting with NHS England which will take place the day before our April Board meeting; and the meeting of the HNY Collaborative of Acute Providers (CAP) Committee in Common which I will be chairing for the first time the day after our Board meeting.

Martin Barkley

Report to:	Board of Directors
Date of Meeting:	24 April 2024
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: Planning guidance released, industrial action, integrated urgent care service launches, New Scarborough Coastal Health and Care Research Collaborative, and Star Award nominations.

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	24 April 2024	

Chief Executive's Report

1. Planning guidance released

The priorities and planning guidance document for 2024-25 was published at the end of March. Before I summarise some of the key areas of note I want to give a brief update on our position at the end of last year (2023-24). Further detail is available in the Trust Priorities Report.

In terms of our finances, I am pleased to be able to report that we achieved the NHS England-required balanced position. This was a product of our recovery actions and open and transparent system working.

We made steady improvements with our performance against the key operational standards, exceeding our trajectories on both RTT and the 62 day cancer standard, and whilst we still have further to go we have made huge progress on the faster diagnostic standard to cancer.

The emergency care standard remains the most challenging of these standards, however in the closing months of the year we have seen improvement, and plans are well developed to drive this further.

Looking forward to 2024-25 year, there are few surprises and the focus remains on pandemic recovery, with the restoration of core services and increased productivity. Key performance expectations outlined in the priorities include:

- Maintaining the collective focus on the quality and safety of services – with specific reference to maternity and neonatal services.
- An improvement to ambulance response and A&E waiting times, with a minimum of 78% of patients seen within four hours in March 2025. An incentive scheme will be introduced for trusts achieving the greatest level of improvement and/or delivering 80% against the four hour target by the end of 2024-25. Further details are yet to be released.
- A reduction in waits of over 65 weeks for elective care.
- Improvement in core cancer and diagnostic standards, (62-day standard at 70% by March 2025, 28-day Faster Diagnosis Standard at 77% by March 2025)
- Improving staff experience, retention and attendance.
- ICBs, trusts and primary care providers to collectively plan and deliver a balanced net system financial position.
- Improving access to community and primary care services, including dentistry.
- Improving access to mental health services for patients across all age groups.

As shared in previous reports we have been working both with our internal teams and our system partners ahead of the publication of the final guidance to develop this year's plans, incorporating activity, workforce and finance. Final submissions are provisionally expected to be in May.

You can access a summary of the full guidance on NHS England's website.

2. Industrial action

Since my last report the BMA has announced the outcome of its ballot on the latest pay offer for consultants, with 83% voting in favour of accepting the deal. In contrast there are no material signs of progress with negotiation on junior doctors' pay, with members being re-balloted to extend the strike mandate, and also for action short of a strike, up to mid-September 2024. Junior doctors voted in favour of both strike and action short of strike, although further dates for action have not been announced.

3. Integrated Urgent Care Service launches

As Board colleagues will recall from previous discussions, the ICB has commissioned our trust to be the prime provider for a new Integrated Urgent Care specification of services for the GP registered populations of York and a large proportion of GP registered patients in North Yorkshire, which I can confirm took effect from the start of this month.

The aim is to ensure that all parts of the system work together, with a lead organisation taking responsibility for coordinating Urgent Care across the York, Selby, Malton and Scarborough areas.

Following a competitive tender process, Nimbuscare has been selected to deliver the primary care out of hours services element of this for York, Selby, Malton and Scarborough. Nimbuscare will also deliver primary care out of hours services for Whitby, through a contract with Humber Teaching NHS Foundation Trust.

During this initial transition period we will continue to actively monitor all aspects of the service and will conduct a review after three months to ensure the service model is appropriate and that we are providing a safe, efficient and high-quality service.

4. New Scarborough Coastal Health and Care Research Collaborative

I will end my report with news about a positive development in research to benefit our coastal communities.

Researchers from our trust will collaborate with academics from York St John University together with the coast's social enterprise sector including charities and health organisations to benefit people living on the Yorkshire coast.

The new partnership, called Scarborough Coastal Health and Care Research Collaborative (SHARC) has been established to understand and reduce health inequalities affecting Scarborough's population.

York St John University's new Institute for Health and Care Improvement and the SeeCHANGE project will support the development of research and it is hoped the partnership will tackle a range of multiple long and short-term health and care priorities and improve outcomes for patients.

It will establish new networks of researchers, patients, healthcare professionals and other stakeholders to support the research that is important to the population of Scarborough and its surrounding rural areas.

Rural and coastal health inequalities are increasingly well known with a life expectancy gap increasing as you move east across North Yorkshire. SHARC offers the opportunity to better understand the causes for this and test interventions that may make a difference. As the partnership develops, we hope it will also offer local patients new opportunities to be involved in national and international research and clinical trials into new and emerging therapies.

This is a hugely positive step forward in our efforts to understand address health inequalities and to increase our research offer in the trust.

5. 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.

April’s nominees are in Appendix 1.

Date: 24 April 2024

York and Scarborough Teaching Hospitals NHS Foundation Trust

Item 7a

STAR AWARD

April 2024

Daisy Lamb, Student Nurse | **York** | **Nominated by colleague (1), and colleague (2)**

(1) Daisy participated in the care of a man who had a ruptured aortic aneurysm and was palliated in VIU.

Daisy went above and beyond the expectations of a student nurse and comforted the patient and his family members during this difficult time. She showed a level of care, compassion, respect, and maturity far excelling what would be expected of someone with her age and level of training. She will make an exceptional nurse. She should be recognised for her excellent contribution; it was valued by the clinical team, and I am sure very much so by the family.

(2) During a very difficult case on a ruptured aneurysm, Daisy exceeded in her role as a student nurse she demonstrated care and compassion towards the patient. Holding his hand, reassuring him, and telling him what was going on while we all attended to his medical needs. Unfortunately, the patient passed away, but Daisy and a few others sat with the patient and his family while the patient took his last breaths.

She went above and beyond, displaying the Trust values, demonstrating the most caring mannerisms to the patient's family, and supporting them through the most difficult period. Daisy will make the most amazing nurse and it has been a pleasure working with her while she has been on placement in VIU.

Charlie Oldfield, Student Operating Department Practitioner	**York**	**Nominated by colleague (1), and colleague (2)**

(1) Charlie is always cool and calm in emergency situations. He goes above and beyond what is expected of a student ODP. Yesterdays he was involved in a case of a man with a ruptured abdominal aortic aneurysm. He acted quickly and helpfully to ready equipment for the emergency surgery. He was proactive and quick under pressure. The patient sadly worsened despite treatment and was palliated and passed away.

Charlie was caring and professional with the family and helped organise a family room for the family. He then stayed past his shift time to complete the last offices. He will make an excellent ODP.

(2) During a difficult case in theatres which involved the eventual death of a patient, Charlie was part of the team that looked after and attended to the patient and their family. Despite officially ending his shift at 6.30pm, he stayed behind until after 8pm to ensure that last offices were undertaken. He showed exemplary kindness and caring along with a student nurse. Both had spoken to the patient through their theatre journey and had ensured the patient was comforted and his relatives looked after.

Emme Lee, AHP Team Manager	**York**	**Nominated by colleague**

We had a patient on our ward who had dislocated her hip. When working with the patient, it became apparent her husband's funeral was very soon and the patient did not think she would be able to go. We organised for orthotics to come as an urgently and were then able to assess the patient with it in situ. Emma offered to teach the family how to assist with the hip brace to bridge the gap when the patient goes home.

When the patient was discharged, Emma went to the patient's house to deliver equipment. She then went back before her shift to support the patient in putting her hip brace and to get ready for the funeral. Emma went above and beyond for the patient to ensure she was able to go to her husband's funeral and return home afterwards to be with her family.

Ed Smith, Consultant and Care Group Director | **Scarborough** | **Nominated by colleague**

The Patient Experience Team would like to nominate Dr Ed Smith for his continued support, engagement and involvement with the Scarborough & Ryedale Patient and Carer Experience (PACE) Forum. Ed attends the forum meetings, chats with members, and welcomes the opportunity to speak at the forum. His updates about the new UEC build and model of care at Scarborough have been a real draw for the patients, carers, and the public in the East Coast and Ryedale, often cited as one of the reasons people want to come along.

We are grateful to Ed for kindly giving up his time to come and engage with patients, carers, and the public in this way. His style of delivery and discussion is clear, is honest, uses plain English, and explains medical jargon. Ed does not shy away from tricky or difficult questions from forum members. This is welcomed by both us and the Humber Team who manage the forum, but also the forum members who often comment on how good Ed is at telling them about the developments in both the building and the model of care at Scarborough.

In joining the forum meetings and updating about what is going on, Ed helps to shine a light on the positives for the NHS and for our Trust, which is well received. We hope Ed's example will encourage more staff to join the forum and come along to meetings to talk with our patients, carers, and members of the public.

Donna Ginders, Sister | **Scarborough** | **Nominated by colleague**

I want to nominate Donna for her dedication and professionalism in how she undertakes her role on the Women's Unit. Donna has been the EPAU Sister for some time and is extremely experienced and supportive to the team. Recently, due to team absences, Donna has stepped in to ensure the clinics were covered and that the team had their roster. In addition, she has supported our new Deputy Clinic Sister who is new in role. Well done, Donna, and thank you from me for all your support in ensuring a smooth-running Women's Unit.

Endoscopy Team | **Scarborough** | **Nominated by patient**

I attended Scarborough Endoscopy Unit for a procedure. From the receptionist and admin to the nurses and the endoscopist, all staff were friendly, reassuring, cheerful, caring, and professional. They all made what could have been an uncomfortable and embarrassing procedure entirely bearable and put me completely at ease. Everything was explained as we went along, and I felt really looked after during the whole procedure. This team deserves recognition.

Joanne Bellwood, Deputy Sister **York** **Nominated by colleague**

A patient with very complex needs was coming to endoscopy for an outpatient planned appointment. The patient and the mother had previously had a bad experience and were concerned about this happening again, which caused a lot of anxiety for them. I liaised with Joanne to put in all the reasonable adjustments the mum asked for, which included a specific hoist and sling for the patient and a hospital bed, rather than a trolley, to aid with movement and space.

Joanne's communication with me was prompt and constant, making sure the correct equipment was being sourced. I know Joanne spoke to numerous people (including equipment team and management) to put the adjustments in place and make sure the plan would be as smooth as possible. This admission would not have gone well (or gone ahead at all) without Joanne's support and understanding of how important the reasonable adjustments were for the patient's wellbeing and experience. Thank you!

Rob Tyas, Advanced Clinical Specialist **York** **Nominated by patient**

I am nominating Rob Tyas because he is very dedicated, showed a lot of professionalism, and has a very good understanding of people with disabilities. He is an amazing physiotherapist, and I cannot thank him enough. He believed in me, and he deserves a star award nomination for everything he has done for me. He is a true NHS star.

Josh Allenby, Security Officer | **York** | **Nominated by colleague**

Josh deserves to be recognised and nominated for a star award for thinking quickly and remaining calm when a colleague suffered a seizure during work hours. Josh displayed fantastic leadership skills, remained calm, and collected, calling the crash team immediately and staying with the colleague. With Josh acting fast and calm like he did, he saved his colleague from any further injury. I am very proud of Josh for showing great initiative and leadership skills and remaining calm and collected during a stressful and dangerous situation.

Lisa Melody, Orthotic Administrator | **Archways** | **Nominated by colleague**

Lisa is always so helpful. She is accommodating and goes the extra mile for patients. We have a group of patients in paediatrics who have serial casting and can often require orthotic intervention at specific times and sometimes at short notice. Lisa always manages to find a solution that means the appointments can be coordinated so the patient can travel less and receives seamless intervention. We had a patient having a course of serial casting who required an AFO. Lisa arranged an appointment on the same day he was due in for casting. The orthotist came over to the casting clinic to measure the child. Lisa then organised a fitting date two weeks later so that as soon as the child comes out of cast, he will have an orthotic appointment to go into to maintain the improvements he has gained.

This is certainly not the first time Lisa has done something like this alongside serial casting clinics. She is also available to give advice when I call about orthotic intervention and products and helps facilitate liaison between therapies and orthotics, enhancing the patient experience and intervention. She has chased up orders for me when there have been time pressures. Due to children growing they are often unable to wait very long for Orthotic appliances. She demonstrates the Trust values daily. Lisa is a credit to the orthotics department, and I want her to know she is appreciated by the children's therapy team.

Jawahr Badsha, Cleaning and Catering Operative	**Scarborough**	**Nominated by a colleague**

A newcomer on to the team, always friendly and chatty to staff and patients. Always willing to lend a hand and go the extra mile for his colleagues on the wards. Works late shifts without complaint and works to a high standard. A genuine pleasure to know.

Nicole Kerslake, Senior Sister	**York**	**Nominated by colleague**

I have been away on maternity leave and before I went off there were plans to improve the department. I have recently returned and all the improvements that were previously planned have almost all been implemented. I am so impressed with the positive changes that have been made and it has been down to Nicky to make this happen. She is worked so hard.

Lucy Kendall, Healthcare Assistant	**York**	**Nominated by colleague**

I want to nominate this lovely colleague. She is always happy and helpful. She was asked to design a special notice board for patients struggling with Charles Bonnet syndrome. She did it immediately and so beautifully. She deserves to be recognised for her hard work.

Sophie Nicholls, Senior Surgical Physiotherapist	**York**	**Nominated by colleague**

Sophie has shown exceptional character in her work ethic, team spirit, and overall willingness to support patients and colleagues. Sophie has worked tirelessly through her pregnancy to ensure both her work, and that of the team, remains to the highest of standards and patient centred. She was unfortunate to break her toe but returned to work the very next day with an orthotic boot and her characteristic smile. It is such a joy to work with somebody with such passion for her role and the willingness to keep flying the AHP flag. Thank you, Sophie, it is a pleasure working with you.

Judy Frost, Waiting List Co-ordinator	**York**	**Nominated by colleague**

Judy Frost is the waiting list co-ordinator who manages the waiting list for intravesical treatments for benign and malignant treatments. Judy is always polite, helpful, responsive, and professional. We have recently had a complicated time with using a new drug and an unlicensed drug to treat bladder cancer patients and because of this we have had to adapt to new ways of working. Judy has been excellent at streamlining this process. This has also led to capacity issues where it has been important to get our cancer patients in for treatment, and Judy produced a potential solution to allowing us to treat two more patients a week. Judy is always happy to go above and beyond her role to ensure our patients receive the best care in a timely manner.

Emergency Department Team	**Scarborough**	**Nominated by patient**

I was brought in by ambulance following a cyclist hitting me, causing me to hit my head on a stone wall. I want to thank all the nurses who cared for me, including the triage sister, the nurse with four cats, the x-ray nurse who said I had given her the finger when she was x-raying me, and the CT scan nurse after I bleed all over the pillow, the first assessment doctor, the person who gave me a warmed blanket, and so many more. My family and I cannot thank you enough. Your humour helped us cope, your dedication is exemplary, and your professionalism puts many in public life to shame. In the nicest possible way, I hope I do not see you professionally again, but if I can buy you lunch sometime, it would be my honour.

Sarah York, Advanced Nurse Practitioner	**York**	**Nominated by colleague**

I had a complex general anaesthetic dental admission to plan and one of the reasonable adjustments was to have another clinical intervention under the same general anaesthetic to save this lady have multiple admissions. I contacted Sarah a few months ago with a heads up and she was more than happy to help when we had a date in place. As soon as I knew the date, I let Sarah know and she was prompt with her communication again and very supportive. Nothing was too much to ask and it was all organised and arranged from their specialty. Working with colleagues like Sarah makes my admission planning so much easier and is a relief when staff are willing to help and understand the importance of such reasonable adjustments. Thank you!

Jillian Robertson, Community Midwife **York** **Nominated by colleague**

Jill and I share a caseload in the community. Jill regularly goes above and beyond for our women, often thinking outside the box when it comes to caring for women with more complex needs.

Recently we have had a lady on our caseload with learning difficulties. Jill recognised that providing the birth information verbally or in text would not be suitable for this woman. Therefore, to prepare her for birth, Jill went to the couple's home for the birth planning meeting with easy-to-understand information sourced and printed out for the woman including picture diagrams to help the woman and her partner understand the information provided allowing them to make informed decisions for themselves regarding her care in labour. Jill also assisted the couple to source baby equipment via local charities and delivered it to their home.

Jill has supported this couple, attending the majority of their social care meetings, even on her days off, providing consistency for this couple during these meetings. Jill has acted as an advocate for the woman making referrals to parenting classes and adult social care to help her the support she needs.

Rachel Middleton, Waiting List Coordinator **York** **Nominated by colleague**

Rachel made me aware of an appointment for a patient with learning disabilities and was checking if anything else needed putting in place. I advised on some important adjustments and Rachel had already put what I suggested in place and had also already liaised with management on the admitting ward, the consultant, and the anaesthetist. Rachel had put a lot of effort into the admission planning and had thought through everything that someone with a learning disability might need. At point of contact with me, it was just to check if anything else needed adding, but it did not as she had been so vigilant. Thank you!

Sara Shearing, Senior Healthcare Assistant | **York** | **Nominated by colleague**

Sara performed an ECG on a lady who had been triaged after self-presenting to emergency department. She was very concerned about the ECG and raised this to the EPIC and NIC. She was adamant that this lady required an urgent cubicle as the ECG appeared unusual to her. The ECG demonstrated complete heart block and Sara helped this patient to have timely intervention and assessment when there was a long wait to be seen.

Heather Hastings, Staff Nurse | **Scarborough** | **Nominated by relative**

After a night in ED, my son was taken to Rainbow ward, where we were met by Heather in the treatment room. From the minute she started treating him, her care and understanding was unmatched. Our son has Down syndrome and he finds hospitals very unsettling and distressing. Heather advocated on his behalf to the doctors on the ward to make sure he received ambulatory care allowing him to go home whilst receiving treatment. This alleviated our distress and allowed our son to settle whilst tests were being done on him.

Nothing was too much for her. She made him a drink, provided both me and his dad with refreshments after a long night. She showed compassion, empathy and put the needs of her patient first. She listened to our concerns and consistently involved him in his own care.

Heather is an outstanding nurse who encompasses all the Trust's values. She made a huge difference to my son and our family, and she should be celebrated. The ward was very busy that night, yet she made sure our son was a priority for her. I hope she knows just how special she is. If it were not for her, I do not know what would have happened with our son. The way she respected his additional needs is something that we will not forget. From the bottom of our hearts, thank you so much.

Lucy Machon, Midwife **York** **Nominated by colleague**

On a very busy day in maternity, Lucy was working in maternity triage, an area which saw more than a 30% increase in usual activity. Whilst she did receive support on shift from other colleagues, they were less familiar with the area. Lucy demonstrated her supportive leadership skills whilst delivering safe care. This shift was very challenging for all concerned but made much easier by Lucy's calm and approachable manner.

Eilis Birks, Midwife **York** **Nominated by colleague**

Eilis was in charge on G2 on a shift which saw very high activity. During the shift, Eilis was concerned about the deterioration of a patient and escalated her concerns in a calm, cohesive manner and safely managed the patient's transfer to labour ward where she required emergency treatment in theatre. She then stayed several hours past her finish time to support the team.

Eve Bennett, Community Midwife **Community** **Nominated by colleague**

A patient’s mother rang the community base to offer the following feedback: I accompanied my daughter to the antenatal clinic where she was seen by Eve. Eve was so lovely, professional, and human, and is a credit to the NHS. The whole appointment had been so positive and had such positive impact on my daughter just before her induction was due. We both spent all evening talking about how lovely Eve had been.

Sophie Keely, Labour Ward Coordinator | **York** | **Nominated by colleague**

Maternity services had a busy day and Sophie was in charge as labour ward coordinator, where she demonstrated her considerable leadership skills and led and supported the whole team throughout the shift. Sophie ensured all staff had their break and remained calm, approachable, and accessible.

ENT Team | **York** | **Nominated by patient**

Having been treated for cancer in my neck for about 18 months, I have been helped in recovery by the team at York Hospital. I needed a small operation by day surgery as recommended and arranged by Mr Coatesworth and Mr Shayah. My treatment by them has been outstanding with no questions left unanswered and they have maintained professional and personal care for me throughout. This has been enhanced by the day surgery team where I was seen by Mr Sandeman and a registrar who performed the surgery in my mouth and throat. Again, the personal treatment I received was exceptional, helping alleviate any stress and making sure all my questions and concerns were dealt with in a clear and sensitive manner, so I was fully prepared for the op and its aftereffects.

Also worth a special mention from this day surgery trip was the special care given by nursing staff that day. First was my admissions contact nurse Matt, my surgery recovery nurse Kate and Kevin who assisted Kate, and finally, Jo, the lead nurse in the recovery ward. In each case these individuals seemed to me to go above what might be considered normal and their understanding approach was personal and very helpful to my wellbeing.

These doctors and nurses helped the day of surgery pass without significant difficulty, and I left hospital feeling well treated and fully informed about what had happened and what I had to do to aid recovery. In all these contacts with these staff, my treatment has been exemplary and well above what I expected. They are a credit to the hospital and enhance your good reputation for patient care. Well done.

North Yorkshire Diabetic Eye Screening Programme (NYDESP) team and York Hospital imaging team

Community

Nominated by colleague

When NYDESP team were told that a patient on transport to their diabetic eye screening clinic at Regus Centre (NYDESP office) was being taken to York Hospital site by mistake, the NYDESP team contacted the transport team and tracked the patient to the eye clinic.

They liaised with the York Hospital imaging team, York Hospital secretarial and NYDESP admin team to create an immediate clinic slot on CPD. They then arranged for the York Imaging team to provide an "ad hoc" screening encounter for the patient so that she had not wasted her journey. Without the NYDESP team and the imaging team working together - and without their passion for making every mile of patient travel count - the patient would have simply been returned home without any medical intervention, then to have the same process repeated and rebooked later.

That would have been the easiest thing to do. Instead, the two teams united to do the right thing and turned this into a successful eye screening encounter. I believe that no other hospital in the UK can achieve this level of harmonised healthcare.

Key members of the NYDESP team were Phoebe Plant, Georgia Craven and Jo Booth. Key members of the York Hospital team were Gillian Little, Sara Goldsmith, Caroline Duncan, and Dave Mason.

Speech and Language Team	**Scarborough**	**Nominated by colleague**

The Speech and Language team at Scarborough hospital are dedicated hard working always professional and genuinely have hearts of gold. They are always helpful and willing to help, always striving to do more and help that extra bit more. They need some recognition for their hard work.

Ruth Newbould, Specialist Speech and Language Therapist	**York**	**Nominated by colleague**

Ruth specialises in providing speech and language therapy support for children with complex needs across the York area. As a result, many of the children she works with require statutory paperwork submissions from our service as part of their Education Health Care Plan.

Ruth recently received an influx of these requests, resulting in a significant increase in her workload just before she was due to go on annual leave. Ruth communicated effectively with the relevant members of the team to ensure the relevant deadlines were met.

Ruth is a very highly regarded member of our team who always places the child at the centre of her work. We are very lucky to have her.

Helen Rowland, Medical Secretary	**York**	**Nominated by colleague**

We recently had a member of our team off for a long period with illness. Helen did not let this absence affect the flow of the department. She picked up twice her workload, worked extra hours and still had a smile on her face. She is such an important member of the team, and the department would be lost without her.

Leigh Tamaca, Staff Nurse **York** **Nominated by patient**

Late February I have found out that I am pregnant and cannot express how happy I was when we found out. Unfortunately, not long after I have started to experience sharp pain and after two weeks of constant testing it was proven to be an ectopic pregnancy.

After discussing my treatment options with the consultant surgery was the best choice for my condition. The entire surgical team was amazing and cared for me to the highest standards, but I must mention Leigh the staff nurse that looked after me when I came out from my surgery.

I have known Leigh for three years now, but only knew her as a colleague, as we worked together on another department. I knew she was a calm and collected nurse with great knowledge and happy to share her knowledge with her colleagues. But this time I found myself in one of the worst situations a woman can find herself, with a pregnancy loss and, well, one of my tubes removed as well.

Leigh cared for me in every way a nurse should care for her patients, she ensured that physically I am comfortable and as pain free as possible. But I feel truly blessed to have received care from someone as dedicated and compassionated as her. I could not have had a better nurse to look after me in the most vulnerable moment of my life. Leigh not only cared for me physically but also provided a comforting presence that had a significant impact on my wellbeing.

Leigh, your impact upon me will always be remembered with gratitude and I cannot find the words to describe how much it meant for me to have you as my nurse. Thank you.

Bernadette Darby, Deputy Sister **York** **Nominated by colleague**

Bernie is the deputy sister in Ophthalmology Outpatients, York. Bernie is helping the team so much by supporting and guiding colleagues under her care. Particularly recently Bernie has been instrumental in leading the improvement of how the team manages acute walk-in patients. Bernie shares her knowledge and experience of managing acute eye conditions with the team and has communicated the importance of urgent assessment of acute eye patients presenting in an emergency in need of help. Bernie has been extremely supportive by providing feedback so patient care and experience is improved.

Thank you, Bernie, for looking after us and communicating well as we all aim for excellence, thank you for being kind and caring as a team leader and sharing your knowledge. Thank you for helping with the education of the need for urgent and prompt assessment of acute patients with pain, or trauma.

Zoë Bulmer and Michelle Lee, paediatric outpatient administrators **York** **Nominated by colleague**

Zoë and Michelle are consistently keeping the department going - other members of staff go to them as a first point of call with any queries that need sorting or dealing with. They both have a wealth of knowledge to help solve these problems and deal with sometimes difficult situations. Zoë has really taken the lead on manging and organising the Bowel & Bladder service - she has shown me what it takes to be an effective and efficient worker. Michelle and Zoë really help to move this service forwards and offer guidance to the rest of the team. They are always willing to help anybody and everybody with the highest level of service. I want to thank both colleagues for helping me with my time working for the NHS - I will miss them and their kindness and most of all Michelle's jokes.

Eve Thrower, Staff Nurse **York** **Nominated by a colleague**

Recently one of York Hospital's emergency department (ED) sisters, Eve, was involved in caring for a trauma patient at the side of the road.

Eve was travelling home after a long shift in ED when she saw a motorcyclist involved in a road traffic accident. Stopping and approaching the scene, it became clear how serious the situation was, as the patient was in a semi-upside-down position with a compromised airway.

No one else on scene was confident enough to approach the patient, so Eve took charge. She knelt with the patient for over 25 minutes holding the patient's head, keeping their airway secure until the ambulance crew arrived. While waiting, she was also able to direct members of the public to help as appropriate while she kept a close eye on the patient's condition. I am sure that the support Eve provided to this patient's airway in this situation saved their life as their breathing was very much hindered by their injuries.

Eve is humble, and brave and acts out of selfless care for her patients. She is an absolute asset to the York Hospital team, and I feel sure her ED colleagues would agree. She is not only a very skilled and competent nurse, but also a well loved and respected member of the ED family.

Robert Garner, Healthcare Support Worker **Scarborough** **Nominated by colleague**

Robert began a new role within the Trust and undertook the first Healthcare Support Worker (HCSW) academy in October last year. He kindly volunteered some of his own time, to speak to the new HCSWs in our March academy, to share his experiences as a new HCSW on Lilac Ward. The academy HCSW's were able to get a good insight into the HCSW role. Rob was engaging and demonstrated all the Trust values. He was a great ambassador for both the HCSW role and the academy. The feedback from the group was that they would like Robert to look after then on admission to hospital, a great testament to his caring and compassionate nature.

Rachel Maloney, Admin Assistant | **York** | **Nominated by colleague**

A child attended for cast removal. He was extremely upset and refusing to allow the cast to be taken off, becoming hysterical. As he was so distraught Rachel very kindly stepped up to physically help him to remain still, while he sat on his Mum's lap, to allow the cast to be removed. Rachel was so calm and reassuring, he soon settled down. The child's mother and I were so grateful for her help in a challenging situation that was well out of her normal job role. The child was relaxed and happy when he left the session and when he returned the following week was confident with his treatment.

Rachel is a wonderful member of our team. She consistently demonstrates the trusts values and is always helpful to both families and staff. Thank you, Rachel.

Cate Barry, Pain Nurse Specialist | **York** | **Nominated by colleague**

Cate is one of us who enjoys the new cycle shed near Park House. When it opened there were many things that needed improving. Spurred on by a colleague who had their bike stolen Cate has tirelessly campaigned for these improvements, including gaining charity funds when we were told there was no money.

We now have a secure facility with high secure sides, a door which close behind us, a dropped curb and great lighting and CCTV.

Amy Batchelor, Midwife **York** **Nominated by patient**

Following an incredibly fast and intense labour, I was feeling very anxious and overwhelmed as I was transferred into Amy's care. Right from the moment I met her Amy did a fantastic job of explaining what was happening to me, coaching me through the final parts of my labour and safely delivering my little girl less than ten minutes later. Amy then made me feel safe and comfortable throughout my after care, listening to my concerns and worries from my first birth and ensuring I understood what was happening and had the opportunity to make informed choices.

I felt listened to and cared for which made a huge difference to my experience and allowed me to feel in control again after an overwhelming labour. Amy is an absolute credit to the department - thank you so much for taking such good care of me and baby Wren.

Emma Gibbs, Staff Nurse **York** **Nominated by relative**

Emma was outstanding my 10-month-old daughter was admitted to ward 17. Emma was so efficient during her two-night shifts where she was supporting my daughter, and us. She was so on the ball with all observations, medications and support for me and Dad when we were exceptionally anxious. Emma was thorough, took the time to explain things when I had questions and her bed side manner with Isobel was so lovely. She always discussed findings, plans and anything else with us that was so reassuring. Finally, if we needed something and Emma said she would sort it - she did.

Thank you so much Emma, you should be so proud of the work you do.

Sharon Addey, Deputy Sister/Charge Nurse **Nominated by colleague**

Sharon went out of her way to support me in the resuscitation of a neonate, and in giving emotional support following the event. Sharon made the effort to come and ensure she debriefed with me after the event, and then offered and provided neonatal resuscitation to me. Her kindness made me feel so supported during a difficult situation, and her teaching enabled me to feel more confident in future situations like this. Thank you, Sharon.

Beech Ward **Scarborough** **Nominated by colleague**

I was recently redeployed for three weeks to work on Beech Ward to ease staffing pressures. The whole team welcomed me and made my time with them so enjoyable. Every single member of staff I came across were very helpful and nothing was too much trouble. Their approach to patient care was outstanding and exemplify the Trust values of kindness, openness, and compassion. I am beyond proud of how exceptional they are, and it was an absolute honour to work with them through staffing pressures and increased patient demand. The whole team is an absolute credit to this Trust.

Annmarie Cashin, Outpatient Services Administrator **Scarborough** **Nominated by colleague**

Annmarie always strives to help patients to her very best, she will always go above and beyond to help patients. She is always approachable and friendly to patients and staff alike. She always puts patients first and has a very caring approach.

Dawn Smith, Patient Service Operative	**York**	**Nominated by colleague**

Dawn is a credit to our surgical team since she started as a PSO on ward 14. She is always supportive and goes above and beyond for not only the patients but also her colleagues. Dawn ensures the patients have everything they require and has such a caring character. For example, she will often by a card and cake for patients on their birthdays and make the day as special as she could for them. We are very lucky to have Dawn as part of our team and she is a great example of someone upholding the Trust's values.

Yvonne Heaps, Outpatient Services Administrator	**Scarborough**	**Nominated by relative**

My daughter and I attended ED as her arthritis in her knee had flared up causing swelling. We were triaged and seen by a nurse, but she was not able to help us. We decided to try speaking to someone at the outpatient's reception. We were seen by Yvonne who went above and beyond to assist us having heard our story. She was able to contact rheumatology straight away and get us a phone appointment within the hour. It was not Yvonne's job to assist us, and I wanted to make you aware how helpful and kind she was.

Lynda Robson, Healthcare Play Specialist Team Leader	**York**	**Nominated by relative**

While my daughter was in hospital for suspected appendicitis, Lynda was fantastic with her and made her feel at ease when she was worried. Lynda supported her during her first ever blood test and came in to check on her the next day. Lynda gave her toys that she did not ask for, treats to make her smile, and even sent messages from home (via other members of staff). She brightened up a horrible time for my daughter and we will never forget her. Thank you, Lynda, for everything you did for my daughter.

Ashley Cowton, Specialist Doctor **York** **Nominated by relative**

My daughter was admitted to the day unit to have some teeth removed. She was extremely nervous about going to sleep and did not like needles. Ashley was so understanding and patient with my daughter. He got down to her level and took time to talk her through what they were going to do in a reassuring way. I really appreciate the efforts he took to look after my daughter and his kindness. Thank you, Ashley.

Julie Edmond, Sister **York** **Nominated by colleague**

Daily Julie demonstrates all our core Trust values, gaining admiration and love from all the staff on ward 33. Nothing is too much for Julie, she has an open-door policy, is always ready to assist in patient care, listens to queries and ideas, and takes an empathic approach to individual staff members concerns, both personal and professional. Julie sets clear and realistic expectations, never asking anyone to undertake anything she would not do herself. Julie is always there, never impatient, always has a smile and encouraging word, is a team player, and is the one to lead our wonderful team. So, from all of Ward 33, we feel Julie Edmond deserves a Star award nomination.

Kate Simpson, Deputy Sister | **Scarborough** | **Nominated by colleague**

I am nominating Kate for multiple reasons. She consistently exhibits kindness and compassion towards patients, their families, and colleagues, fostering an environment of respect and empathy. She demonstrates a strong sense of leadership, effectively coordinating the team, and participating in ward rounds. She is always happy help and is helpful to juniors and colleagues. Kate is often the reason a shift on the ward is pleasant as she has a lovely attitude and prioritises urgent tasks. Her positive demeanour and exceptional nursing skills make her an invaluable asset to the orthopaedic team.

I truly feel that my time on the team has been significantly impacted by Kate, and I feel grateful to have her as a colleague. She is the type of Sister I would want if I was a patient. During the bank holiday weekend, Kate was the only nurse scheduled on the ward. We are meant to have three nurses, and she managed the job by herself. She appropriately escalated this for patient safety and maintained a positive attitude. Her workload had increased, but she was able to safely care for patients. I was impressed by her level of professionalism and ability to complete tasks in a timely manner. Throughout all this, she remained pleasant to work with.

Labour Ward | **Scarborough** | **Nominated by patient**

My wanted and loved little boy was born sleeping in the Snowdrop Suite due to him being diagnosed with left sided hypoplastic heart syndrome. The care I received whilst being a patient there was phenomenal, and over the weeks that followed they allowed me to spend time with my little boy, arranging for him to be brought up to the Snowdrop Suite every day until he moved to the funeral directors. They were so compassionate, and all the lovely midwives allowed me to make memories that I could bring home and keep forever. Whenever I pressed my buzzer, they were in instantly, nothing was too much trouble. I will never ever be able to repay them, but I hope by nominating them for this award they can see they make a huge impact on the people they care for, and I will be so grateful forever.

Emma Carter, Sister | **York** | **Nominated by patient**

During my time on Ward 11, Emma provided amazing care and support following my amputation. On the day of my discharge, she went out of her way to ensure I left the hospital in time for my daughter to pick me up. Following my discharge, over the bank holiday I had no dressings for my wound and Emma again went out of her way by conducting a home visit to help dress my wound until I could get to my GP.

Joseph Nash, Speciality Registrar | **York** | **Nominated by patient**

Joseph showed genuine compassion and advocated for me in a time I felt vulnerable. He pushed for me to get the care I needed in a time I felt overwhelmed. I cannot thank him enough for making me feel like I was not a burden and that I deserved to feel OK again. Thank you.

May Bragado, Critical Care Outreach Sister | **Scarborough** | **Nominated by colleague**

May must have one of the hardest jobs in the hospital, but she always does it with such kindness and calmness. One particularly shift, she was asked to visit a gentleman who had become very unwell, and, as always, she looked after the man with empathy and compassion. She spent a lot of time with this man and started many different treatments. He needed specialist equipment, which is usually done on another ward, but no beds were available so May got the equipment and stayed with the patient throughout to ensure he received the best care.

This was a lengthy process with constant observation meaning May did not get her lunch break, putting the needs of the patient first all the time. Not only did she do this, but she was so helpful to me and a student nurse by explaining everything to us so we could support her and learn. May stayed with this patient and followed through when he was taken to another ward, on which he had made a huge improvement which was lovely to see.

Anas Ahmed, Speciality Doctor **York** **Nominated by colleague**

Anas has been a fantastic colleague to work alongside. He is extremely kind, helpful, and professional. He joined the ophthalmology team to provide cover for another doctor's leave. He has been brilliant throughout his time at the eye clinic, and we are so pleased that he has been retained.

On multiple occasions Anas has gone above and beyond when patients who, due to capacity, have been booked to virtual glaucoma clinics. When the patients have been found to have more complex care, Anas has instead reviewed the patient face-to-face and sorted out the treatment and care for the patient there and then. Anas also regularly offers to help in the urgent clinic when the numbers or complexity of patients have been challenging. In addition, there are occasions when patients who are struggling to access support for their glaucoma treatment have walked into the department. Anas has always been more than happy to help, even when he is not on call.

Scarlet Scarah, Midwife **York** **Nominated by patient**

I wanted to recognise my midwife, Scarlet, who delivered my baby. Scarlet was, from start to finish, the most calming person I could have wished for to help me birth my son. She was so attentive, and you can see she genuinely adores her job. It all happened so fast at first but then stalled when my baby turned back-to-back. By that point I had lost all focus on breathing, but Scarlet made me feel so calm. She was the only person I could focus on and listen to so she made sure I could see her during every contraction and never left my side. She is truly made for that job. Thank you so much, Scarlet.

Lorraine Dodd, Midwife	**York**	**Nominated by patient**

Where do I start? Lorraine completely changed our whole birth experience for the better and has been a pillar of support before and after the birth of our son. She has gone above and beyond every step of the way and we cannot thank her enough for her support, guidance, and care. She is a true gem and an asset to the Trust and to the midwifery profession. My partner and I will be forever grateful to her.

Terence Seed, Security Officer, and Tim Smith, Security Officer	**Scarborough**	**Nominated by colleague**

Whilst on patrol, Terence Seed noticed an elderly female sat alone and in distress in the back seat of a car parked in the visitor car park. After Terence checked on the female and reported the situation, Tim Smith attended to assist. The two security officers checked on the lady, who was extremely confused, ensured her safety, and provided care and reassurance to her. The woman had with her a small dog, so Tim found a number on the dog's collar and was able to contact her daughter. The two officers remained with the woman until she was reunited with her daughter. The two demonstrated the Trust values, in particular kindness and excellence.

Raegan Humphrey-Smith, Maternity Support Worker	**Scarborough**	**Nominated by colleague**

We recently had some new starters join the Trust. They all shared how supportive Raegan has been when they have had the pleasure of shadowing her in their supernumerary time. They said she is knowledgeable and approachable and that they have learnt so much from her. Raegan is proactive in her development and her passion shines through during even the hardest of shifts. She is kind, open, and willing to learn and give both staff and patients alike a good experience. We are very lucky in maternity to have her.

Sophie Barber, Midwife	**Scarborough**	**Nominated by colleague**

We have recently had some new starters join our team. They told me how wonderful Sophie has been with them. They said she was kind, open and approachable. She was also happy to show them around the unit and made them feel very welcome. Sophie is a glowing role model who works so hard and never compromises on compassion as well as her brilliant clinical skills.

Ruby Ellerby, Maternity Support Worker	**Scarborough**	**Nominated by colleague**

Ruby is always kind, welcoming, assertive, and one of the hardest workers I have met. She has welcomed some new starters with open arms and helping them find their feet. On maternity we do not know what we would do without her.

Kent Ward Team	**Bridlington**	**Nominated by patient**

Mr Mannam and the staff on Kent ward made my recent operation incredibly fantastic. They have been so good, helpful, professional, and attentive. What I was dreading, was turned into a great experience. We should all appreciate the NHS and how beneficial it is for all our wellbeing. Thank you very much.

Ear, Nose and Throat Team	**York**	**Nominated by colleague**

I would like to nominate the whole team in the ENT department for their support over the last year of my employment. All the staff have been so welcoming and friendly throughout my journey in a new career. I would like to especially praise Jackie, a fellow HCA, on her willingness to share the knowledge she has learnt while working for the Trust. I would also like to mention the sisters, Kirsty, Clair, Leigh, and Lucy. They have been so supportive, with not only my development, but also with personal areas. Thank you, ENT team.

Richard Hodgson, Radiology Services Administrator **York** **Nominated by colleague**

Richard looked after one of our patients on a busy day when we were unavailable. The patient was really upset and stressed as they were going to undergo surgery later in the day. Richard stayed by their side and chatted to and comforted the patient until we became available. After the patient's appointment with nuclear medicine, Richard then went above and beyond to take them back to the day unit so they would not have to wait for an ISW, chatting and comforting her to take her mind off any stress. Richard demonstrates all the values of the Trust; he went above and beyond in his care and job role, and he really helped us on a stressful day. We are very grateful and believe he is very deserving of a star award nomination. Thank you, Richard!

Sue Barrowcliffe, Administrative Co-ordinator **York** **Nominated by colleague**

I was recently asked to raise an order for an iPad. Sue really helped and supported me with the order. Despite it being the end of the financial year, Sue was able to get it authorised and the order placed. When I needed a delivery date, Sue got straight onto it and gave me updates so I could feed it back to management. As soon as the item was delivered, Sue told me and arranged for me to come over and collect it. She has been fantastic, and myself, my managers and the member of my team that required the iPad are so grateful for everything Sue has done.

Jocelyn Wood, Deputy Sister | **York** | **Nominated by colleague**

When Joss joined the Trust as a Deputy Sister, she was tasked with taking on the line management of ward staff immediately. This involved taking over sickness processes for staff. Being new to the Trust, Joss was keen to ensure she understood our policies, so proactively sought training and support when needed from HR to assist her with her line management duties. Joss worked very hard to ensure the information relating to staff absence was all in order and spent several weeks organising and holding meetings to ensure staff were offered relevant support and the processes were adhered to. Joss is a dedicated nurse and line manager, her passion for excellence is obvious, and she is a credit to the ward, care group, and Trust.

Dawn Richardson, Deputy Sister | **Bridlington** | **Nominated by patient**

Dawn was simply wonderful, and I cannot highlight or praise this angel enough. Having been given dreadful news, it was Dawn who held my hand, cuddled me and was by my side throughout that tragic morning. She also contacted my daughter who again could not praise the lovely lady enough. She has gone above and beyond by giving me her name and number to call any time. During another visit after the bad news, Dawn was again outstanding. The cuddles and care she showed has engraved a loving memory in my heart. Dawn is a credit to the whole hospital and should be rewarded and recognised for her compassion, not as a nurse, but as one of your angels.

Jay Varner, Senior EUC Engineer | **York** | **Nominated by colleague**

I would like to nominate Jay for a well-deserved Star Award for his outstanding provision of support and diligence for the Renal team. Jay completes any request with excellent customer service and exceptional customer care skills and provides first class support for our service and the Trust. One could say that Jay is 'only doing his job', but what makes a considerable difference is the way he undertakes his role and the commitment and attitude to helping members of the team resolve complex IT issues in a way that makes them feel supported and valued.

A recent example was when the operating system was upgraded to Windows 11. Unfortunately, the renal programme had not been part of the update leaving the team unable to print prescriptions. Jay recognised the urgency of the situation and prioritised his workload to ensure the renal service was up and running in a few hours. Jay also checked in later in the day to see if everything was functioning as it should.

Asela Dassanayake, Speciality Registrar | **Scarborough** | **Nominated by patient**

Dr Asela performed my c-section, which was a semi-emergency due to multiple episodes of reduced movements. I wanted to say thank as Dr Asela was fantastic and really put me at ease. He listened to me when I made requests and he spoke to me after the operation about the complications and then came to see me on the postnatal ward. He is a lovely man and a caring and conscientious doctor whose colleagues also think highly of him. Whenever I had mentioned the positive experience to other staff the response was always an instant genuine smile and positive comment. Thank you, Dr Asela, for making a nerve-wracking experience less so, and for making me feel listened to. You are a credit to your profession.

Nuwanthi Wanigasinghe, Trust Grade Doctor, Suzi Ord, Staff Nurse, Helen Shepherd, Healthcare Assistant, and Megan Tuplin, Student Nurse	**Scarborough**	**Nominated by colleague**

I would like to nominate Nuwanthi, Suzi, Helen and Megan for the kindness, care, and compassion they showed to a domestic abuse victim. This team of four worked tirelessly to ensure the patient's journey was as quick and gentle as possible. They had to ask difficult questions but did so with kindness and dignity. The patient was clearly very scared, and the team ensured they were reassured and that everything was explained to them. The team demonstrated the Trust values, they were kind, they were open when explaining everything, and they ensured the patient received care which was excellent.

Lita Anderson, Administrator	**York**	**Nominated by colleague**

Lita has shown outstanding patient care. She went above and beyond what is expected of her when an elderly patient came to the Orthopaedic Outpatient department confused as to where she needed to be. Lita showed care and compassion towards this patient who was worried about missing an appointment. It was made over the phone at short notice, so the patient was not sure where they needed to be. Lita made a sensible decision to keep them with her and phone around the hospital to find where the appointment was. This led to taking the patient to where they needed to be.

Lita could not have been any more help. I am sure this made the patient's day and made sure they got the care they needed at a vulnerable time. Well done, Lita, for being part of our team and showing the Trust values every day.

Clinical Coding Team | **York** | **Nominated by colleague**

I would like to recognise the outstanding work that I have had the pleasure of seeing from the Trust's Clinical Coding Team. Like all services within the organisation, the team has felt the impact of the ever-increasing number of admissions. Upon discharge, every inpatient spell is clinically coded by a team of expert professionals supported by a fantastic clerical team. There were over 13,000 more spells for coding in 2023/24 than the preceding financial year.

Despite these pressures, as well as recruitment and retention challenges, the team has managed to continue to deliver a highly accurate, timely service. This achievement means we can continue to support the Trust in meeting national data submission requirements and provides valuable and rich health data which is available to services in the Trust for various purposes. As more and more has been asked of the team, our coders have continued to work hard to meet the extremely demanding requirements placed upon them.

In addition to guiding their colleagues through some very challenging deadlines, the leadership and training element of the team has also delivered some significant transformational improvement projects which have contributed to ongoing efficiency. My sincere thanks go out to everyone in clinical coding for their ongoing commitment and professionalism - you make a genuinely positive impact, and it is a delight to work in such a great department.

Melanie Hill, Administrator **York** **Nominated by colleague**

I have worked with Mel for the last five years. She is the most compassionate and helpful colleague with whom I have ever worked. She goes above and beyond daily and looks after all members of our team. Mel also has a very caring and empathetic way with our patients who are often scared and anxious on arrival. She immediately puts them at ease, and they leave with smiles on their faces, commenting to us on how lovely she is.

Melanie shows the Trust values in everything she does and takes on extra work to help support our team. She has even recently become a change maker and mental health first aider. I would like her to be recognised for all her hard work and keeping our team together for the last five years in very difficult and challenging times. I do not know what we would do without her.

Frailty Virtual Team **York** **Nominated by colleague**

This team helped us give care and support to an individual we support, and shared their knowledge with our team so we can give the best care. They were very responsive, compassionate, and caring. Thank you.

Diabetes Team **York** **Nominated by patient**

My husband and I attended today, after spending time in ED yesterday. We were anxious when attending, but the moment we walked into the waiting room we were greeted with compassion and reassurance by Lisa Laverick on reception, and the nursing team who we saw including Emma McDonnell and Joanne Gill. I would like to say a huge thank you because it is daunting when faced with a diagnosis, and we were treated with compassion and non-judgmentally and were left knowing that we could contact for anything, and they would welcome the contact.

As a team they worked well together and are ambassadors for York Hospital and the NHS. I cannot remember the names of two other people we spoke to, including an apprentice from the University of Huddersfield who helped by keeping us in conversation. Thank you so much.

Committee Report

Report from:	Quality Committee
Date of meeting:	16th April 2024
Chair:	Steve Holmberg

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
Medicine – Risks associated with UEC. See detailed text below
ASSURE
Maternity – DDoM post to be advertised. Assurance that actions from SI investigations were being incorporated into improvement plan **Clinical Governance –** Assurance that new Committee sub-committee structure was functioning well with appropriate escalations

ADVISE
Medicine – Committee received detailed presentation from Care Group. • Urgent & Emergency Care – Risks associated with long ED waits, boarding SOP, sub-optimal structure of medical rotas for acute take and difficulties in consistently admitting patients to most suitable ward are all impacting quality of care and leading to increased LoS with associated stranded costs and increased bed occupancy. High numbers of complaints, staff survey results and poor FFT in ED are consistent with this position (complaint response metrics are in themselves good). The backlog in coding has shown some short-term improvement although further assurance is required that this is sustainable and that the issue has not been passed on to other areas within the clinical services • Renal – ICS/Regional shortage of dialysis beds is putting service at risk • Respiratory – Shortfall in consultant capacity. Prospect of substantive appointment to address this in part • Stroke – Review of SSNAP position. Refurbishment of stroke ward should improve rating but concern that some elements may not be completed for some months. Consultant vacancies remain but potentially a substantive appointment can be made shortly. SaLT shortfall remains a problem with impact on patient care and rating • Leadership – Committee discussed that the scope of the agenda in CG. Noted the commitment and focus of the leadership team and were assured by cooperative and open working with executives. The CG is carrying a high level of risk and the Committee discussed the work that was needed to unlock some of these problems. Rightsizing, clinical strategy, including a model for acute care, and service demand and capacity modelling were all identified as key issues as well as the imperative of staff adopting new ways of working with a focus on multi-disciplinary teams. Committee was concerned about the timelines for improvement but understood current mitigations and the need to ensure that staff were aligned with these changes. Committee agreed that it should receive a bespoke reporting template to continue to receive assurance. Committee also reflected the scope, scale and desired pace for improvement and felt that a robust change management

programme was required drawing on combined expertise from a number of existing resources in the Trust that could support change management most effectively

Maternity – PPH rate shows recent month on month reduction but remains above national average. Improvement potentially due to change in practice and better recognition and recording of blood loss
Business cases still in progress that are key to service improvement

- Scanning capacity
- Theatre capacity for elective LSCS

SI investigations response time shows significant improvement. Concern that low number of reported low/zero harm incidents continues
CQC Section 31 April report reviewed and approved

CQC – Committee continues to receive assurance that CQC is responding positively to Trust plans and progress. Committee received Journey to Excellence report but noted that this is currently monitoring progress against actions and is not designed to provide assurance on quality improvements or sustainability of actions. Committee agreed that it should receive information on developing Quality Framework from CN that would also incorporate and supersede the nurse staffing paper

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Maternity (IT) – Committee advised that level of Badgernet purchased had significant limitations e.g. no interface with CPD and concerns that cessation of support from SystemOne would result in data difficulties particularly for staff in the community
Malton UTC – Reputational risk associated with difficulties with TUPE of existing staff
CPD – Risk associated with NOTIFY in that alerts could go to 'closed' accounts and potentially be lost
NJR Alert – Knee prosthesis used on East Coast subject to alert and patient recall. Scale of problem difficult to quantify at this stage

Committee Report

Report from:	Resources Committee
Date of meeting:	16 April 2024
Chair:	Lynne Mellor

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
• **Operations**: The Trust did not meet its Emergency Care Standard trajectory for the end of March, with a performance of 67.4% against an ambition of 76%. Significant rise in ED attendances (Type1) and continuing high daily averages of ambulances across Acute sites. • Patients without a 'criteria to reside' (NCTR) remains concerning; NCTR is still circa 20% of York and Scarborough hospitals' bed base. • For Faster Diagnosis Standard the Trust ranked 130 out of 142 providers (albeit some specialities are seeing significant improvements e.g. Urology – 46.5% over 12 months). • **Finance:** The Trust's draft Group Operational Financial Plan for 24-25 remains challenging – particularly the cost improvement programme. Agency spend £8M ahead of cap – large proportion medical staffing – plans underway to reduce. • **Workforce**: Committee noted high-cost long term locum bookings – discussed plans in place for locums.
ASSURE
• **Nursing and Midwifery:** The Committee noted the Healthcare Support Worker (HCSW) turnover continues to improve – the academy paying dividends. • **Finance**: The Committee congratulated all involved in contributing to the delivery of the Trust's 2023/24 plan resulting in an I&E adjusted surplus of £97k against a balanced I&E plan. The Committee recognised the effort needed to achieve the end of year result across all areas of the Trust. The Committee also recognised and thanked those in the system who worked collaboratively to support each other and help the Trust achieve its financial position. • **Operations:** The Committee welcomed the draft plan for the Unscheduled Care Improvement programme (UCIP). This 2-year change plan proposes to introduce new models of working including front door ED changes with a Multi-Disciplinary Team assessing patients at the front door, thus reducing the number of admissions to the Emergency Department team (e.g. Type 1). The draft UCIP plan with 8 key areas will be submitted to Board for approval. • The Trust's RTT position has seen improvements e.g. end of March: zero RTT 104 and 178 week waits and a 13% reduction in Total Wating list (TWL) numbers – lowest since July 2022. RTT waits over 65 weeks for incomplete pathways was ahead of trajectory of 350 by 112 patients, ending the year with 238 waits. The committee asked for assurance that plans are in place to meet RTT targets this coming year, including the national guidance planned target of zero waits over 65 weeks by September – the current trajectory provides some assurance, although still more work to do. The committee discussed the Children and Young Person (CYP) RTT trajectory and monitoring plans for improvements with the establishment of the CYP Board.

- The Committee welcomed the news that the Trust went live on Urgent Treatment Centres and that the Trust has resolved the risk for co-horting with CIPHER being replaced by internal Trust co-horting given additional funding from Place
- **Workforce:** The Trust noted the continued reduction in nurse agency staffing.

ADVISE

- **Nursing and Midwifery:** The Committee noted there is more work to do on behavioural change, staffing models including rostering, ensuring e.g. 'fill rate numbers' reflect reality on the wards.
- **Operations:** The Committee noted the Trust bid of Capital £6M and revenue ~£4M for budget to support the increase in assessment areas and links to the rightsizing work (e.g. reviewing number of patient beds per specialty and location).
- National Performance Planning guidance 2024/5 now released, Trust on track to submit its plans by 2 May 2024.
- The Committee noted the Multi Agency Discharge event and sought assurance that benefits will be prioritised and progress will be reported from the themes identified in the relevant improvement programmes.
- The Committee for assurance wants to see a tighter 'grip' of Governance on the management and reporting of improvement plans. For example: the Committee welcomed the Diagnostics deep dive and would welcome improvements to reporting e.g. clear risk mitigation, clearer dates for deliverables (actual v forecast), outcomes, and benefits realisation plans i.e. what are the prioritised workstreams which will impact on improving diagnostic results for patients. For instance, the Committee noted in Cellular pathology – potential for significant patient benefits when LIMS goes live including faster diagnosis with AI – the plans need quantifying/qualifying as per above.
- **Finance:** The Committee sought assurance that a summary of key items which will impact on run rate and benefits profile over the next year will be available for the next meeting.
- **Workforce:** The Committee discussed the need to review the current measures for workforce around temporary staffing versus establishment.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Risk discussed with each report. No additions to current registers

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 10

TRUST PRIORITIES REPORT

April 2024

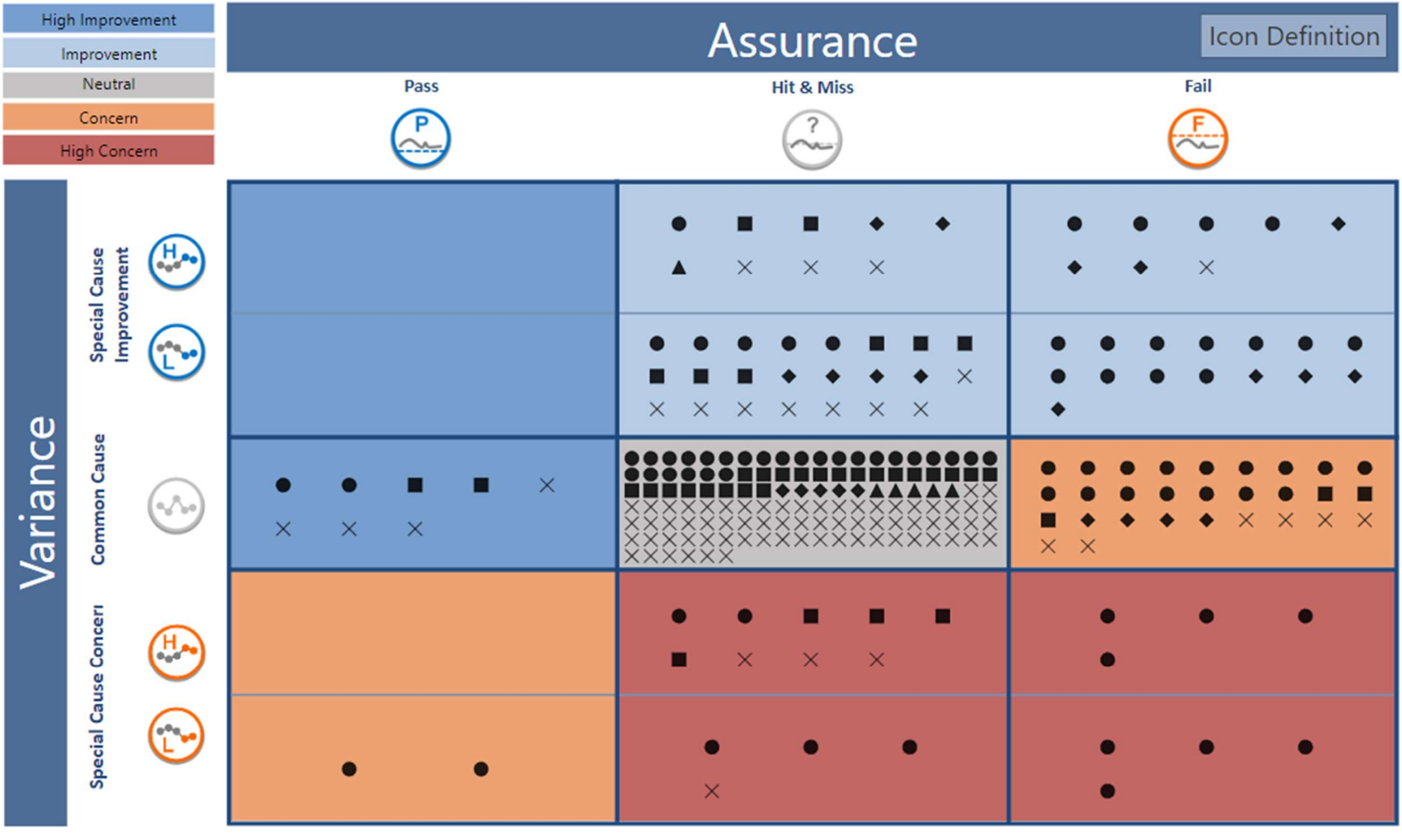
Table of Contents

Summary Matrix

The table below provides an overview for all metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

High Improvement
Improvement
Neutral
Concern
High Concern



●Activity and Performance ■Quality and Safety ◆Workforce ▲Digital ✕Maternity

Executive Summary - Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
ED - Proportion of Ambulance handovers waiting > 60 mins	2024-03		F	10%	23.5%
ED - Proportion of all attendances having an initial assessment within 15 mins	2024-03		F	66%	46.6%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024-03		F	7.5%	15.9%
ED - Emergency Care Standard (Trust level)	2024-03	L	F	76%	67.4%
ED - Median Time to Initial Assessment (Minutes)	2024-03		?	18	13
Cancer - Faster Diagnosis Standard	2024-02		?	66%	71.4%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2024-03		?	143	143
RTT - Total Waiting List	2024-03	L	?	47530	46044
RTT - Waits over 104 weeks for incomplete pathways	2024-03		?	0	0
RTT - Waits over 78 weeks for incomplete pathways	2024-03	L	F	0	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024-03	L	F	350	238

The March 2024 Emergency Care Standard (ECS) position was 67.4%, against the trajectory of 76%. Median wait time to initial assessment in ED improved from fifteen minutes in February 2024 to thirteen minutes in March 2024.

The Cancer performance figures for February 2024 saw an improvement in the 28-day Faster Diagnosis standard to 59.3% (compared to 57.8% in January 2024). This was behind of the trajectory submitted to NHSE for the end of February 2024 (66%). Please note; in line with national reporting deadlines cancer reporting runs one month behind.

The Trust achieved the trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 143 against the trajectory of 143 for the end of March 2024.

There were zero RTT 104-week and zero RTT 78-week waiters at the end of March 2024.

At the end of March 2024, the Trust had 238 RTT patients waiting over sixty-five weeks, 112 ahead of the end of month trajectory of 350. This is a decrease of 160 on the end of February 2024 position (398).

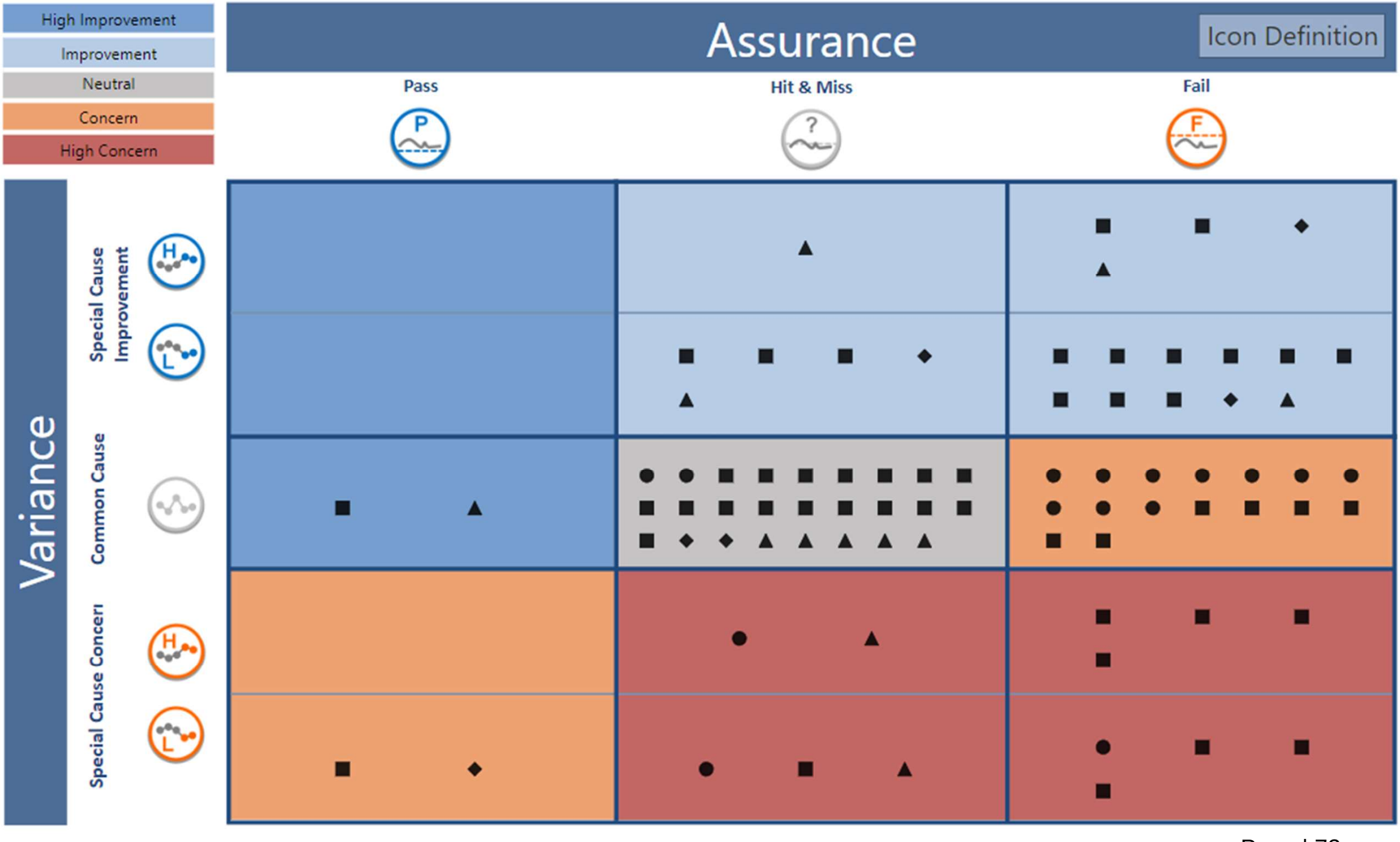
OPERATIONAL ACTIVITY AND PERFORMANCE

April 2024

Summary Matrix - Operational Activity and Performance

The table below provides an overview for all operational activity and performance metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust



Acute Flow (1) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
ED - Proportion of all attendances having an initial assessment within 15 mins	2024-03		F	66%	46.6%
ED - Proportion of all attendances seen by a Doctor within 60 mins	2024-03		F	55%	23.8%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024-03		F	7.5%	15.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2024-03		F	150	2156
ED - 12 hour trolley waits	2024-03		F	0	722
ED - Emergency Care Attendances	2024-03		?	19662.9	20423
ED - Emergency Care Standard (Trust level)	2024-03	L	F	76%	67.4%
ED - Emergency Care Standard (Type 1 level)	2024-03	L	?	43.9%	41.4%
ED - Median Time to Initial Assessment (Minutes)	2024-03		?	18	13

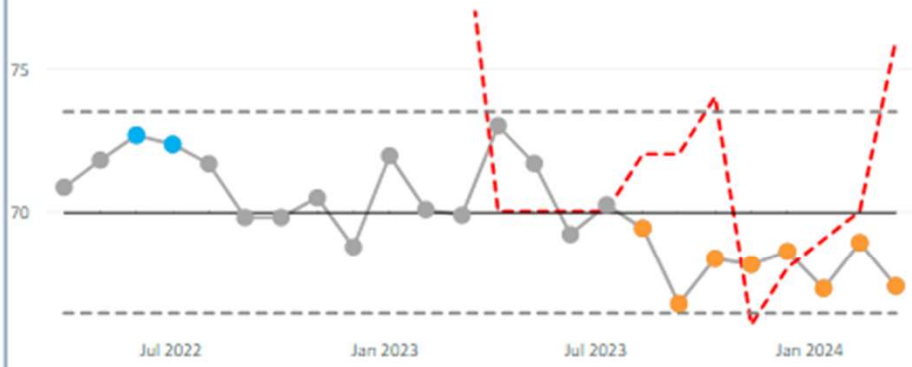
KPIs - Operational Activity and Performance

Acute Flow (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

ED - Emergency Care Standard (Trust level)



Latest Month

2024-03

Value

67.4%

Target

76%

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

The latest months value has **deteriorated** from the previous month, with a difference of **1.5**.

Variation Assurance

ED - Emergency Care Standard (Type 1 level)

Latest Month

2024-03

Value

41.4%

Baseline

43.9%

The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **2.9**.

The Trust did not achieve the Emergency Care Standard trajectory with performance of 67.4% against the end of March 2024 ambition to achieve above 76%.

Urgent and Emergency Care was impacted by several factors. The number of lost bed days because of patients without a 'criteria to reside' (NCTR), 1,016 in March 2024 (1,147 in February 2024). As of the 3rd of April, there were 172 NCTR patients which equates to approximately 20% of the Trust's bed base at Scarborough and York Hospitals.

March 2024 saw the highest daily average of ambulance arrivals at Scarborough ED in the last thirteen months. Scarborough saw a daily average of 63 ambulance arrivals compared to the previous twelve-month (March 2023 to February 2024) daily average of 57 ambulances per day. York with its fourth highest daily average in the last thirteen months saw a daily average of 79 ambulance arrivals over the month compared to the previous twelve-month average of 75.

March 2024 saw a significant rise in type one attendances at the Scarborough and York EDs compared to previous years. 10,880 compared to 9,574 in March 2023 (+14%), 9,397 in March 2022 and 9,888 in March 2021.

In the latest nationally published data (February 2024) the Trust ranked 69th out of 122 providers (with a Type 1 ED) for ECS (All types), the Trust was ranked 72nd in January 2024. In the North-East and Yorkshire region the Trust ranked eleventh out of twenty-two providers (thirteenth in January 2024).

UEC Strategy: 2024-2026 and beyond.

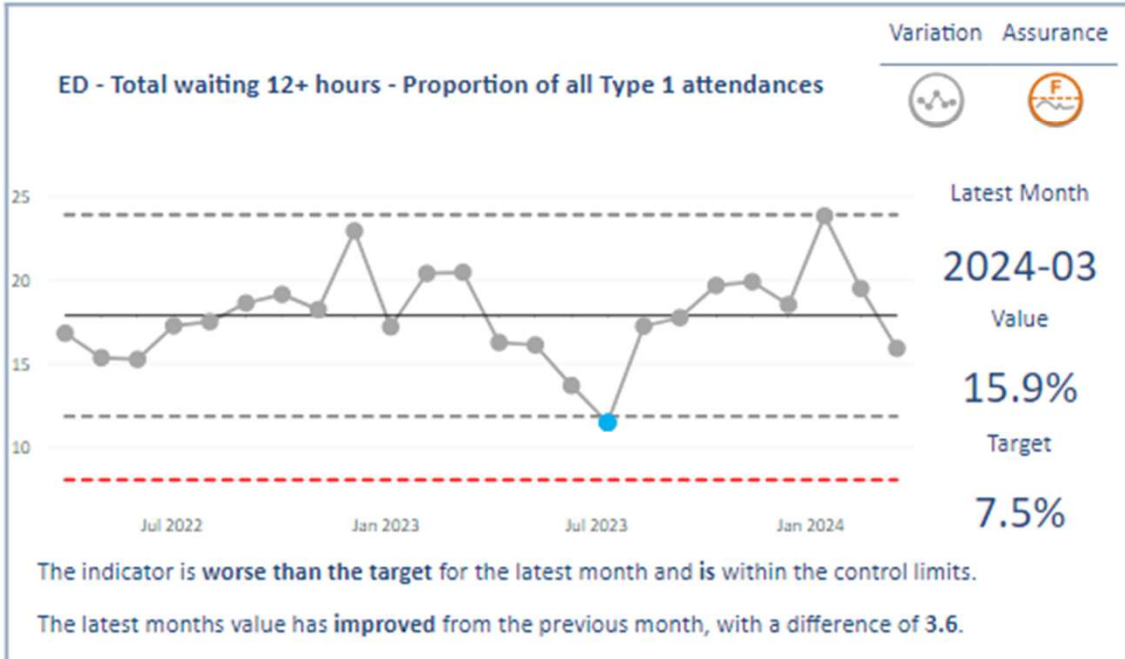
Our new UEC strategy is drafted and ready for sign-off in April 2024. There are eight programmes at the heart of this strategy:

- Optimal Care Service (front loading and optimal care service including UTC).
- Integrated Assessment Unit.
- Frailty Care (Acute Frailty as well as Community Frailty Crisis Hub).
- Discharge and Discharge to Assess.
- Community urgent and emergency care
- Site management
- 7-day standards
- Roles and responsibilities

These projects will require strong partnership working across the system, and will be monitored, managed, and supported through the new **Unscheduled Care Improvement Programme (UCIP).**

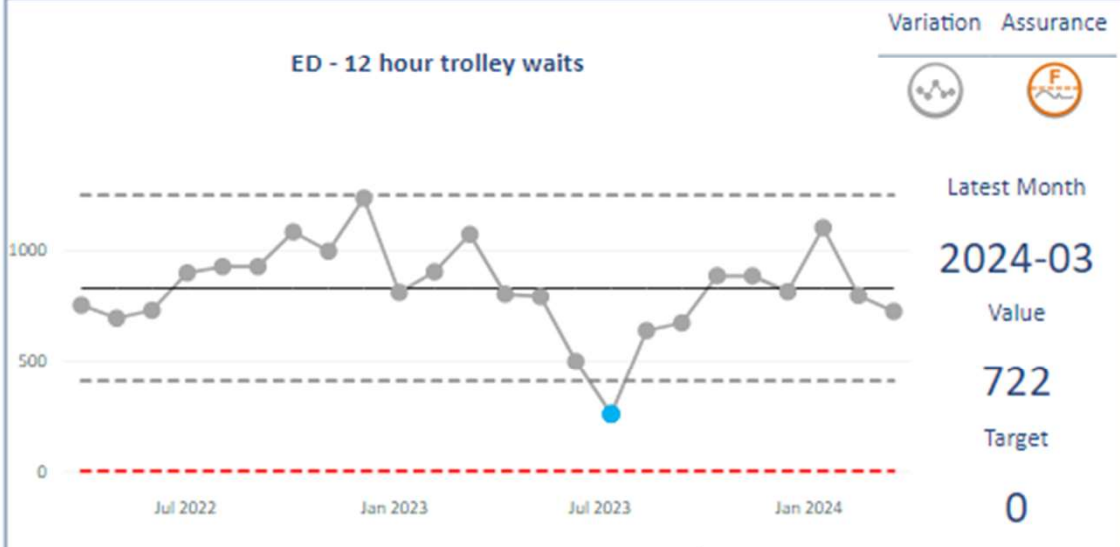
KPIs - Operational Activity and Performance

Acute Flow (2)



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

The latest months value has **improved** from the previous month, with a difference of **3.6**.



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

The latest months value has **improved** from the previous month, with a difference of **72.0**.

Continued from previous slide.

Unscheduled Care Improvement Programme

In the short term two areas have been prioritised; Optimal Care Service (OCS) and Discharge with other programmes coming online later in the year.

We anticipate the front-loading programme (a process of ensuring minor injuries and minor illnesses are streamed rapidly to a ring-fenced service named OCS) once completed will improve the patient journey and ECS performance towards achieving the national ambition of 78% by March 2025.

Some of the work already underway includes:

- A pilot of a GP in the YAS control room 8am - 6pm Mon-Fri recently took place. Outcomes show a significant impact on YAS caseload, with the GP completing cases off the YAS stack that were more appropriate to primary care and undertaking clinical triage to support redirection to other pathways such as Frailty Crisis Hub. This GP created capacity for YAS to attend CAT 1 and CAT 2. Nimbus and YAS are in conversations about the future of this service.
- Urgent Treatment Centres – Trust as prime provider successfully went live on 2nd of April.
- Improving ambulance handover – Reduce Category 3 and Category 5 conveyance with YAS and maximise use of fit to sit working with YAS senior leader on sites. Programme is reviewing the Trust's Unplanned SOP utilisation as part of this work.
- New Discharge Improvement Group – first meeting 12/04/2024. Will involve system and community partners in embedding principles of national discharge policy.

MaDE+ (Multi Agency Discharge Event) took place week commencing 25/03, to recognise causes for delays in safe discharges and unblock some on-the-day issues while identifying themes that require long-term consideration. Themes identified are outlined on the "Acute Flow(3)" page.

Additional ED Programme of work

- Scarborough ED build due to go live October 2024.

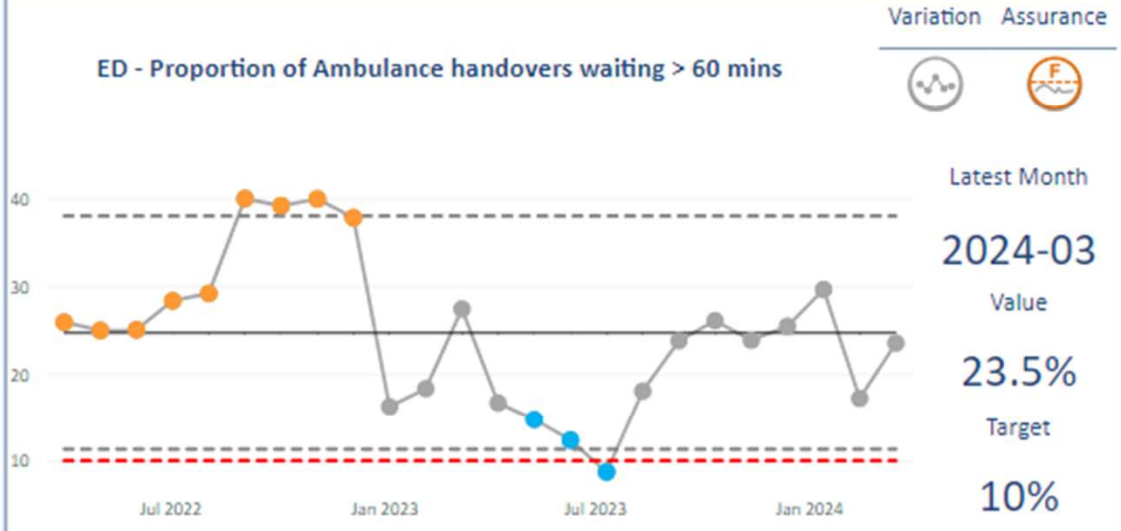
Acute Flow (2) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
ED - Proportion of Ambulance handovers within 15 mins	2024-03		F	65%	22.7%
ED - Proportion of Ambulance handovers waiting > 30 mins	2024-03		F	5%	48.5%
ED - Proportion of Ambulance handovers waiting > 60 mins	2024-03		F	10%	23.5%
Inpatients - Proportion of patients discharged before 5pm	2024-03		F	70%	64%
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2024-03		F	96	139
Lost bed days for patients with no criteria to reside	2024-03	H	?	849.8	1016

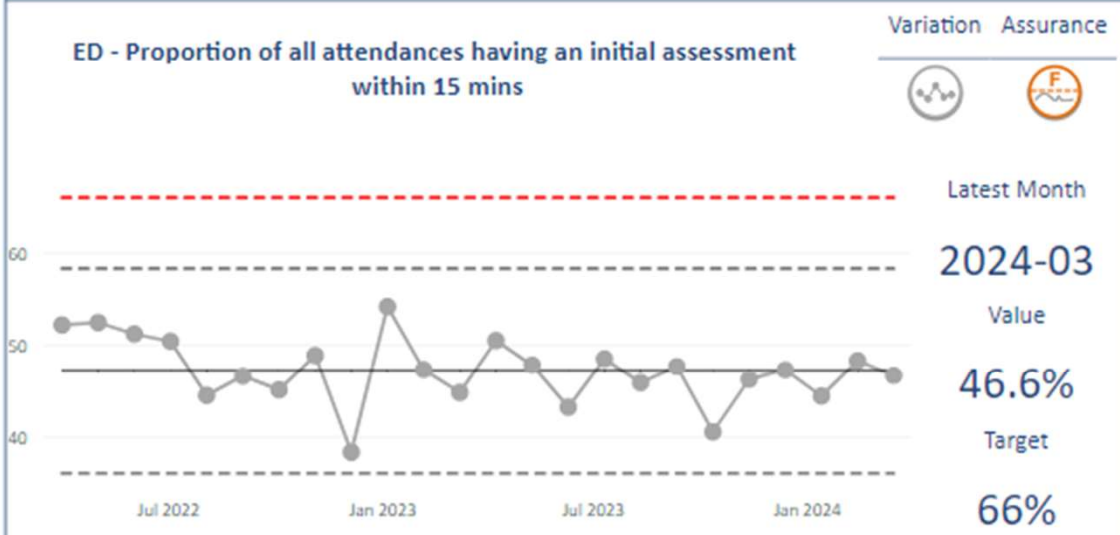
KPIs - Operational Activity and Performance

Acute Flow (3)



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

The latest months value has **deteriorated** from the previous month, with a difference of **6.3**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **1.6**.

The Trust, against a target to have a monthly average ambulance handover time of less than 44:33 (MM:SS) achieved an average of 45:44 minutes for March 2024.

Time lost to ambulance handover delays and handovers >60 minutes remains above target with 23.5% of ambulances having a handover time of over 60 minutes against the <10% target.

Ambulance handover improvement work is included in UCIP.

Additional actions in relation to ambulance handover include:

- Focus on YAS handover project with daily operational meetings with YAS – close operational management with the Ambulance Regional Command (ARC) to identify immediate actions required to address flow.
- Increased operational resource in the Emergency Departments to have oversight of performance and implement focused escalations.
- Dedicated YAS 'cohorting' space from November 2023. Agreed process with YAS of 1:4 cohort of 8 patients, releasing 6 crews.
- Review of shift leadership by ECIST to identify areas for improvement including management of ambulance handovers. To implement and embed SOP for NIC and EPIC as per ECIST recommendations:
    - YAS direct access to SAU, avoiding ED.
    - Establish care co-ordination service as part of integrated urgent care model in partnership with YAS to reduce category 2 ambulance dispatch.
    - Primary Care to ensure face to face clinical assessment prior to Category 4 ambulance request to reduce conveyance from baseline of 4% (average of 6 a day).
    - YAS clinical assessment of 111 calls to reduce conveyance.
    - NHS 111 increase proportion of calls marked for ED reviewed by clinician
    - Implementation of Missed Opportunity Audit recommendations.
    - Additional senior leadership resource for winter with focus on patient flow.
    - Trust 'cohorting' through additional funding from Place.
    - Maximise use of fit to sit.

CIPHER co-horting has now ended and is being replaced by internal Trust co-horting.

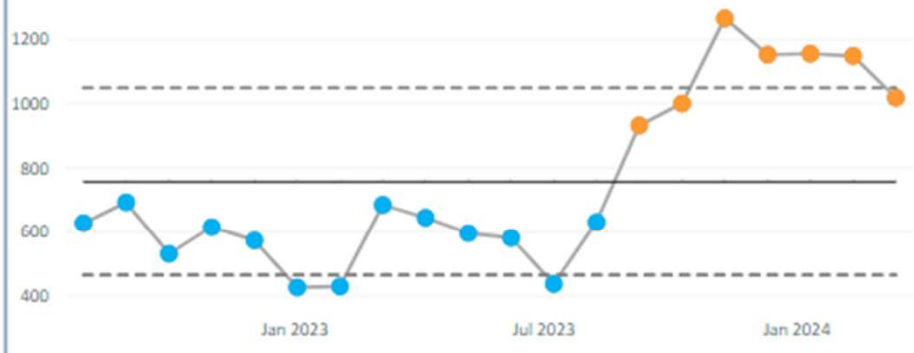
KPIs - Operational Activity and Performance

Acute Flow (4)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

Lost bed days for patients with no criteria to reside



Latest Month

2024-03

Value

1016

Baseline

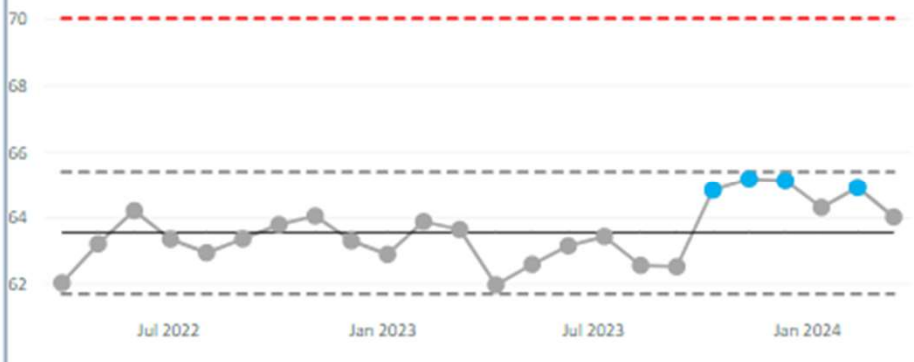
849.8

The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **130.0**.

Variation Assurance

Inpatients - Proportion of patients discharged before 5pm



Latest Month

2024-03

Value

64%

Target

70%

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

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

Multi-Agency Discharge Event

A Multi-Agency Discharge Event (MaDE+) was conducted from the 25th of March to the 1st of April inclusive. Several of the themes identified during the MaDE+ were:

- Board round timeliness, attendance and effectiveness to improve.
- Holistic approach to managing patients, discussing all patients on the ward irrespective of which consultant, would be beneficial.
- 'Discharge bloods' need clearer purpose to reduce delays.
- Criteria-led discharge processes are needed on all wards .
- Delays repatriating patients to other Trusts need to be addressed and escalated.
- People are becoming medically unfit after the trusted assessment form (TAF) has been submitted due to delays in discharge processes.

These will be addressed through a combination of UCIP work and quality improvement projects.

Virtual Hospital

We now have capacity for 40 patients on our virtual wards:

- Frailty (10 with a view to increase in April)
- Heart Failure (reporting capacity for 10 but trialling 15 and testing sustainability of this before increasing)
- Vascular (10 and no need to increase)
- Cystic Fibrosis (10 and in early days of virtual hospital but finding benefits already)

The Trust has procured Inhealthcare as a digital solution to enhance virtual hospital capability, with monies achieved through a successful bid via NHS England.

Humber NHS Trust virtual frailty ward, which serves our East Coast community will also benefit from this technology contract.

Once the technology is established in our existing virtual wards, it will be rolled out to other specialties which could streamline some existing check-in processes through remote monitoring.

As previously briefed, additional virtual ward capacity cannot be delivered without further resource.

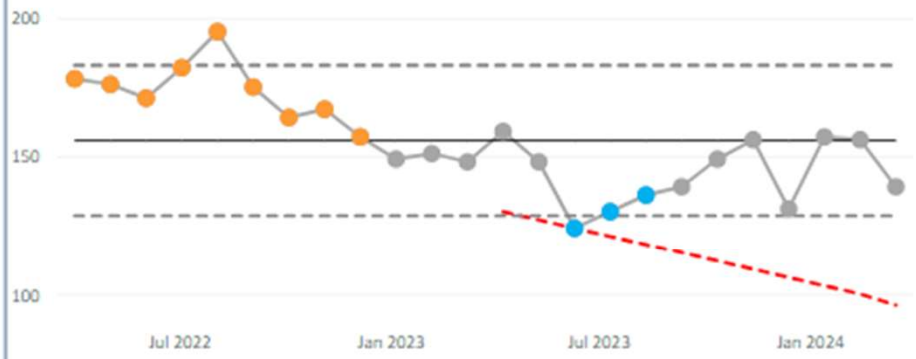
KPIs - Operational Activity and Performance

Acute Flow (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

Inpatients - Super Stranded Patients, 21+ LoS (Adult)



Latest Month

2024-03

Value

139

Target

96

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

The latest months value has **improved** from the previous month, with a difference of **17.0**.

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Cancer Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Cancer - Faster Diagnosis Standard	2024-02			66%	71.4%
Cancer - 62 Day waits for first treatment (from urgent GP referral)	2024-02			85%	49.3%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2024-03			143	143
Cancer treatment volumes (Total number of patients receiving first definitive treatment for cancer)	2024-02			155.5	150
Number of people referred onto a non-specific symptoms pathway	2024-02			79	49
% of patients waiting 63 or more days after referral from cancer PTL	2024-03			12%	6.7%
Cancer 2 week wait (all cancers)	2024-02			93%	65.4%
Cancer 31 day wait from diagnosis to first treatment	2024-02			96%	96%

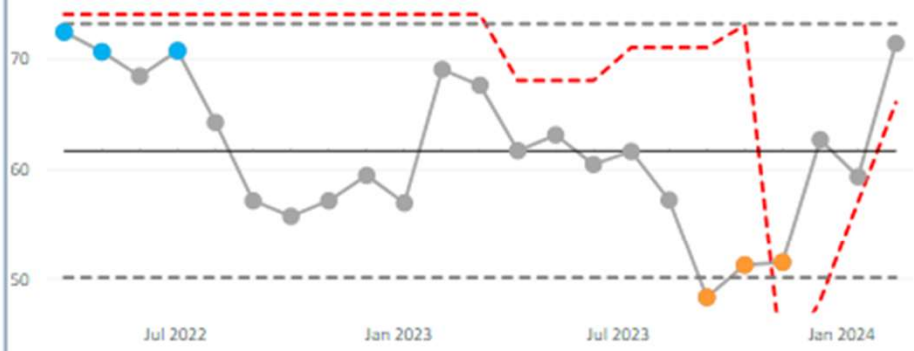
KPIs - Operational Activity and Performance

Cancer (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

Cancer - Faster Diagnosis Standard



Latest Month

2024-02

Value

71.4%

Target

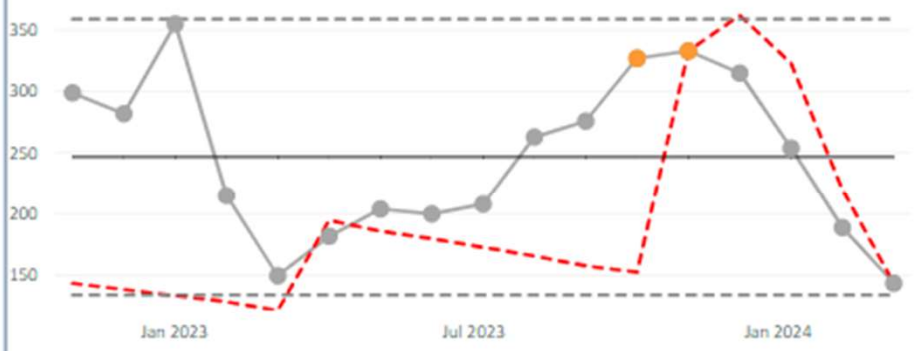
66%

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

The latest months value has **improved** from the previous month, with a difference of **12.1**.

Variation Assurance

Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL



Latest Month

2024-03

Value

143

Target

143

The indicator is **equal to the target** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **45.0**.

Cancer Position

The FDS cancer position for the trust was at 68.7% across cancer sites for March 2024, an improvement compared to the March position in 2023 (67.0%). External NHSE and Cancer Alliance Funding enabled resources to be targeted at specific pathways with the intention of creating additional diagnostic capacity and reducing turnaround times. Internal process have also been reviewed and changed on several pathways, including Skin and Head and Neck. Urology demonstrated a significant improvement in FDS at 46.5%, the highest percentage achieved at the Trust in over 12 months.

The national ambition for 2024/25 is to achieve 77% for FDS by March 2025.

In the latest nationally published data (January 2024) the Trust ranked 130th out of 142 providers for FDS (130th in December 2023) and 89th out of 144 providers for 62-day wait for first treatment (all referral routes) (89th in December 2023).

The Trust achieved the trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 143 against the trajectory of 143 for the end of March 2024.

Cancer Programme

The aim of the Cancer Programme is to deliver 77% against the Faster Diagnosis Standard and maintain an internal performance standard of having a maximum of 143 patients waiting over sixty-two days on the cancer PTL by the end of March 2025. A summary of the current actions can be seen below:

- 24/25 cancer alliance funding planning is ongoing, and Y&S have developed a range of plans to support earlier diagnosis, faster diagnosis and operational performance. Expectation that £7.3 SDF will be received into Cancer Alliance and the Trust has put forward schemes totalling more than £2 million to the Alliance for funding consideration.
- 24/25 internal trust planning has produced a final draft for submission against operational planning guidance, system expectations and national programme deliverables. Work is taking place at pace to use the IST Pathway Analyser to identify where pathway changes could be implemented in specific pathways.

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KPIs - Operational Activity and Performance

Cancer (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Cancer treatment volumes (Total number of patients receiving first definitive treatment for cancer)

Variation Assurance

Latest Month

2024-02

Value

150

Baseline

155.5

The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **7.5**.

Cancer - 62 Day waits for first treatment (from urgent GP referral)

Variation Assurance

Latest Month

2024-02

Value

49.3%

Target

85%

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

The latest months value has **improved** from the previous month, with a difference of **3.3**.

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- FIT dashboard is now completed and the next stage in the FIT workstream is to analyse the FIT - /no Fit test patients who have colonoscopy, with expected national guidance to state this cohort should make up a maximum of 20%. Currently the Trust position is within this range.
- Work is underway with the internal BI team to develop an Inter-Provider Transfer performance dashboard on Signal to allow visibility of this performance metric.
- Scoping work is underway for Multi Cancer Blood Test Programme pilots, both of which will contribute to earlier diagnosis of cancer in specific patient cohorts, with system engagement from across the alliance. Implementation is expected in Autumn 2024, subject to the national evaluation findings (expected Summer 2024).
- Work has formally commenced to develop the Trust delivery model for Targeted Lung Health Checks (TLHC), due to commence in April 2025. This is the pre-curser to a national screening programme which will provide an important opportunity to diagnose lung cancer, and other serious disease, at an earlier stage. An internal project board has been set up, with engagement from system partners in the Alliance, primary care and public health underway.
- Scoping work is also underway for a pilot to target interventions based on health inequalities in suspected cancer patients.
- Work continues to implement Personalised Stratified Follow-Up (PSFU) in 8 agreed cancer sites. PSFU aims to streamline the administering of follow-up or surveillance pathways by placing patients on pre-agreed follow-up pathways that suit their needs, similarly to PIFU. Digital Remote Monitoring to aimed be introduced in Colorectal in Q1 of the new financial year, with other sites following as the year progresses. The 8 PSFU sites are: Breast, Colorectal, Prostate, Endometrial, Haematology, Thyroid, Skin & Lung.

Outpatients and Elective Care Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Outpatients - Proportion of appointments delivered virtually (S017a)	2024-03		F	25%	20.5%
Outpatients - DNA rates	2024-03		?	5%	4.8%
Outpatients: 1st Attendances	2024-03		F	17065	12378
Outpatients: All Referral Types	2024-03		?	20805.7	18470
Outpatients: Consultant to Consultant Referrals	2024-03		?	1989.8	1651
Outpatients: Follow Up Attendances	2024-03		?	41829	34132
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2024-03	H	F	0	25848
Outpatients: GP Referrals	2024-03		?	10014.8	9216
Outpatients: Other Referrals	2024-03		?	8801.1	7603
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2024-03	H	F	5%	3.7%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2024-03		?	99%	26.9%
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days*	2023-12		?	0	6
Day Cases (based on Activity v Plan)	2024-03	L	?	6873	7360
Electives (based on Activity v Plan)	2024-03	H	F	707	659

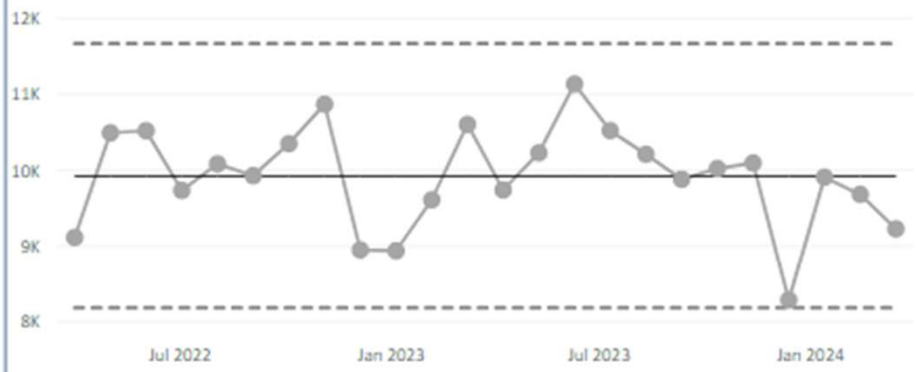
KPIs - Operational Activity and Performance

Outpatients (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

Outpatients: GP Referrals



Latest Month

2024-03

Value

9216

Baseline

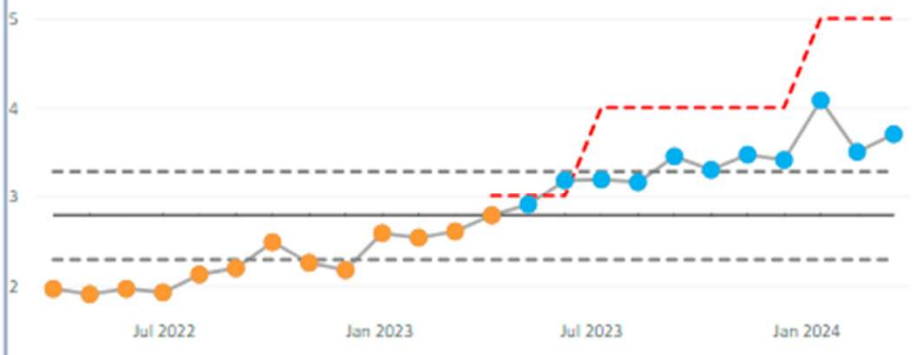
10014.8

The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **455.0**.

Variation Assurance

Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)



Latest Month

2024-03

Value

3.7%

Target

5%

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

The latest months value has **improved** from the previous month, with a difference of **0.2**.

Activity and Performance Planning 2024/25

National Planning Guidance for 2024/25 was released on the 28th of March. The headlines include:

- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties).
- Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%.
- Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25. Improve performance against the headline 62-day Cancer standard to 70% by March 2025.
- Improve performance against the 28-day Faster Diagnosis Cancer Standard to 77% by March 2025 towards the 80% ambition by March 2026.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

Care Groups are in the process of reviewing their plans against the guidance. The Trust is engaged with Place and ICB planning leads on a weekly basis ahead of the deadline for the final plan to be submitted on the 2nd of May 2024.

Outpatient Transformation programme

The primary focus for the Trust is the 'Further, Faster' programme. The Trust has joined a GIRFT National Outpatient Transformation Programme – Going Further, Going Faster, across 18 specialties. Our Trust joined in cohort 2, along with 26 other providers. On boarding sessions continue, with anticipation that any positive developments will feed into specialty recovery plans. The Programme will link into system outpatient transformation and inform the established clinical networks going forward. The aim of the programme is to support Trusts to significantly reduce or achieve zero RTT52 week waiters by the end March 2025.

- PIFU, ambition to deliver over 5% by end of March 2025 (March 2024 was 3.7%).
- Roll out of Rapid Expert Input (REI). REI is a process for clinically reviewing a referral prior to booking into a secondary care service. First working group set for 12th of March 2024. Plan is to roll out to medical specialties, internal work with Clinicians ongoing to decide upon process, timings and pathways.

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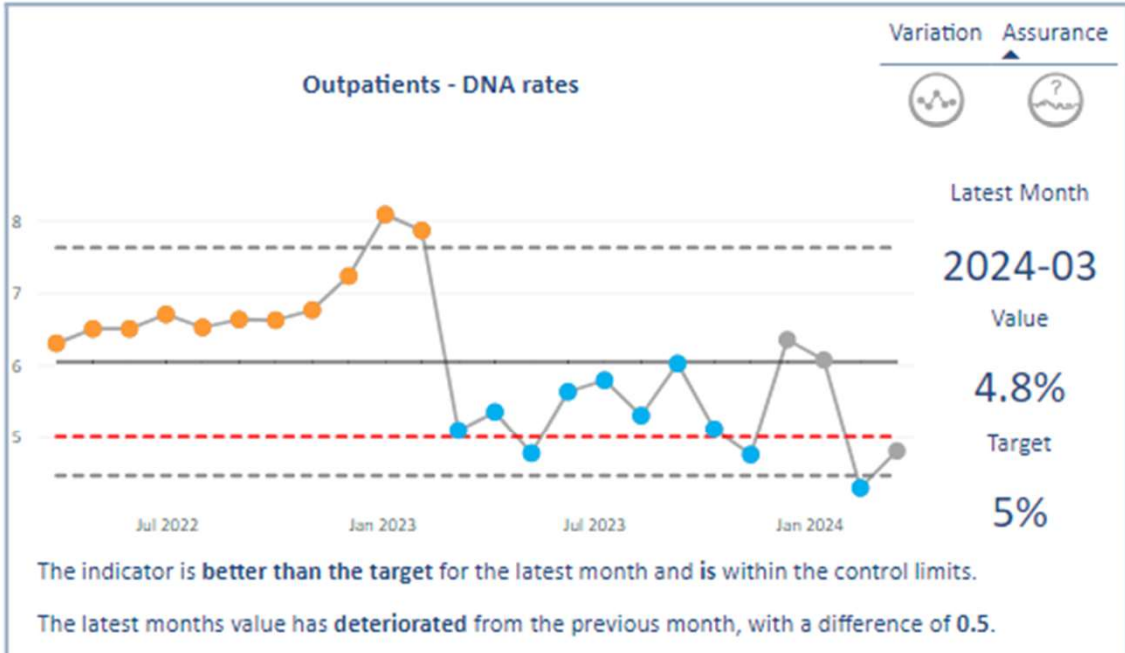

The indicator is **better than the target** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **0.5**.

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- Percentage of outpatient capacity setup as FU appointments. 2-way text reminders to inpatients and all outpatient specialties is now live.
- Clinical validation of Trust waiting list. Pilot in gynaecology of primary care clinician validating secondary care waiting lists to identify patients who could be managed in primary care commenced in February 2024 for three months.
- Use of international OPCS codes in outpatients and elective inpatients rather than local codes. Outpatients went live on the 3rd of April. This will positively impact the new 24/25 ambition to increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46%.

Theatre Improvement Programme

The latest available programme update shows performance against the 85% theatre utilisation target was 83.8% for March 2024 (excluding Maternity sessions), which is an improvement from 82.8% in February 2024. The following specialties were below 80%:

- Plastic Surgery achieved 73.6% (decrease from 77.1% in February).
- Maxillofacial Surgery achieved 77.7% (increase from 75.5% in February).
- Urology achieved 76.5% (increase from 75.4% in February).
- Gynaecology achieved 75.9% (decrease from 80.1% in February).

Those specialties achieving less than 80% will change their theatre production meetings to be chaired by a more senior member of the operational team as well as the Clinical Lead or Clinical Director.

The Trust continues to engage with provider colleagues across the ICB to understand the discrepancy between Model Hospital data and the Trust's view of theatre utilisation performance. Hull University Teaching Hospitals NHS Trust had similar issues last year. A meeting with the ICB to look at the data quality issues was held on the 20th of March. A follow up meeting is scheduled for 15th of April to understand how these issues can be resolved.

Referral To Treatment (RTT) Scorecard

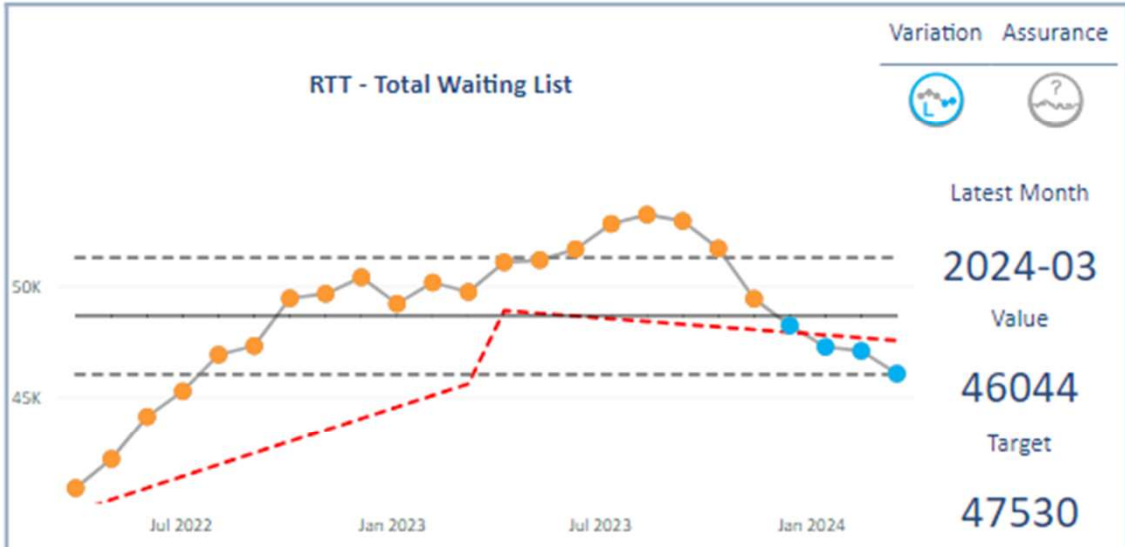
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
RTT - Total Waiting List	2024-03			47530	46044
RTT - Waits over 104 weeks for incomplete pathways	2024-03			0	0
RTT - Waits over 78 weeks for incomplete pathways	2024-03			0	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024-03			350	238
RTT - Waits over 52 weeks for Incomplete Pathways	2024-03			3190	1947
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024-03			92%	51.1%
RTT - Mean Week Waiting Time - Incomplete Pathways	2024-03			9	20.3
Proportion of BAME pathways on RTT PTL (S056a)	2024-03			1.8%	1.7%
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2024-03			12%	12%
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2024-03			67.7%	66.1%

KPIs - Operational Activity and Performance

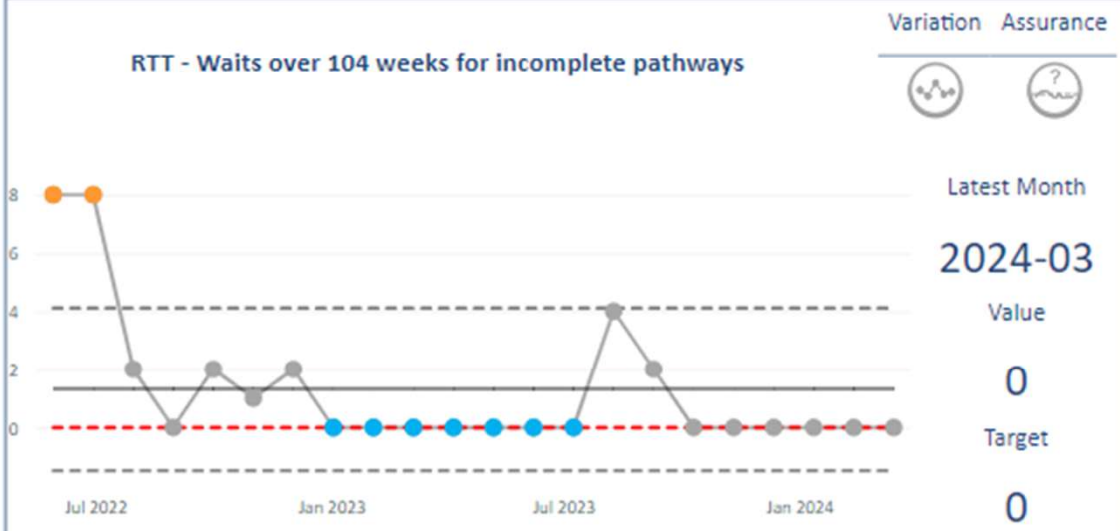
Referral To Treatment (RTT) (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust



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

The latest months value has **improved** from the previous month, with a difference of **1024.0**.



The indicator is **equal to the target** for the latest month and **is** within the control limits.

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

RTT position

There were zero RTT104 and zero RTT78 week waits at the end of March 2024.

In the latest nationally published data (January 2024) the Trust had the 94th highest number of RTT78 week patients out of 168 providers. At the end of December 2023, the Trust had the 85th highest. In the North-East and Yorkshire region the Trust ranked 12th highest out of twenty-two providers at the end of January 2024 (at the end of December 2023 the Trust had the 9th highest).

At the end of March 2024, the Trust had 238 patients waiting over sixty-five weeks. As part of the national priority to focus on cancer care the Trust signalled as part of the H22023/24 trajectories submission that it could result in 350 RTT patients waiting over 65 weeks at the end of March 2024, the Trust was 112 below that end of month trajectory. This is a decrease of 160 on the end of February 2024 position (398).

In the latest nationally published data , at the end of January 2024 there were over 88,000 RTT65 week waits across NHSE Trusts. The Trust ranked 60th highest with 0.6% of the total national RTT65 week waiters (October 2023 the Trust ranked 40th highest with 1% of the national total).

Progress continues to be made on the Trust's RTT total waiting list (TWL). At the end of August our TWL was 53,190, at the end of March the position was 46,044. This is a reduction of 7,146 or 13% over the last seven months and is the Trust's lowest TWL since July 2022. This is ahead of the end of March 2024 trajectory (47,530) submitted as part of 2023/24 annual planning.

RTT 52-week waits have continued to reduce with 1,947 at the end of March 2024, the fewest RTT52 week waiters since February 2022 and 1,243 ahead of the trajectory of 3,190 that was submitted for March 2024 as part of 2023/24 annual planning.

Variation Assurance

RTT - Waits over 78 weeks for incomplete pathways

Latest Month

2024-03

Value

0

Target

0

The indicator is **equal to the target** for the latest month and **is not** within the control limits.

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

Variation Assurance

RTT - Waits over 65 weeks for Incomplete Pathways

Latest Month

2024-03

Value

238

Target

350

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

The latest months value has **improved** from the previous month, with a difference of **160.0**.

See previous page.

Diagnostics Scorecard

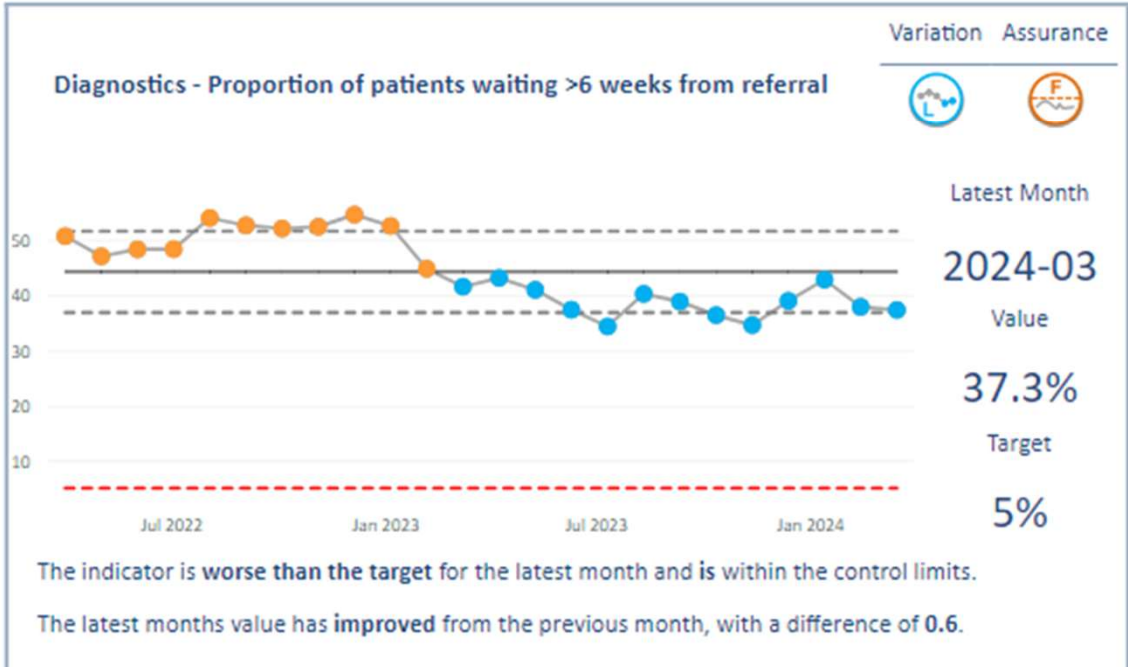
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Diagnostics - Proportion of patients waiting >6 weeks from referral	2024-03	L	F	5%	37.3%
Diagnostics - Proportion of patients waiting >6 weeks from referral - MRI	2024-03	L	F	5%	36.2%
Diagnostics - Proportion of patients waiting >6 weeks from referral - CT	2024-03		F	5%	38.8%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Non-obs Ultrasound	2024-03		F	5%	33.4%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Barium enema	2024-03		?	5%	21.3%
Diagnostics - Proportion of patients waiting >6 weeks from referral - DEXA Scan	2024-03	L	F	5%	45.4%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Audiology	2024-03		F	5%	30.6%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Echocardiography	2024-03	H	F	5%	81.9%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Neurophysiology peripheral	2024-03		?	5%	5.3%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Sleep studies	2024-03	L	F	5%	12.7%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Urodynamics	2024-03	H	F	5%	76.8%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Colonoscopy	2024-03	L	F	5%	30.6%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Flexi Sigmoidoscopy	2024-03	L	F	5%	44.7%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Cystoscopy	2024-03		F	5%	42.2%
Diagnostics - Proportion of patients waiting >6 weeks from referral - Gastroscopy	2024-03	H	F	5%	24.9%

KPIs - Operational Activity and Performance

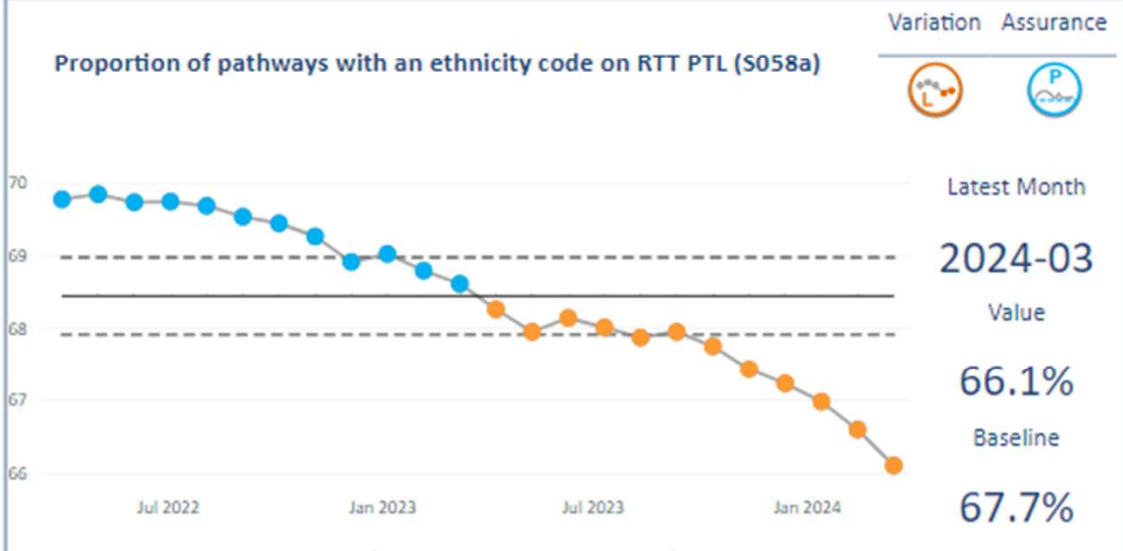
Referral To Treatment (RTT) (3) and Diagnostics

York and Scarborough Teaching Hospitals NHS Foundation Trust



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

The latest months value has **improved** from the previous month, with a difference of **0.6**.



The indicator is **below the baseline** for the latest month and **is not** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **0.5**.

Diagnostic Position

Diagnostic performance data for February 2024 showed an improvement to 37.3% from 38.1% at the end of February 2024 for patients waiting more than six weeks. There were improvements seen in Colonoscopy and Sleep Studies, 31% (February 2024: 51%) and 13% (February 2024: 44%) respectively at the end of March 2024.

The CSCS Care Group work stream incorporating review of pathways, validation of waiting lists, changes in administration processes, only supporting fast track work as insourcing for reporting and conversion of more capacity to fast track rather than routine long waiters continues.

The Trust, incorporating the impact of the CDC Programme, is forecasting improvement to 12% of patients waiting more than six weeks by March 2025 as part of the 2024/25 planning submission.

CDC Programme

Askham Bar Spoke

- All preliminary work is complete, and the pad is now live and receiving CT patients as of the 3rd of April.
- NOUS, Phlebotomy, Spirometry, Fractional Expelled Nitric Oxide, Echocardiograms and Point of Care Testing went live w/c the 8th of April.
- DEXA will be installed and operational by the 22nd of April and Lung Function by the end of April.

Selby Spoke.

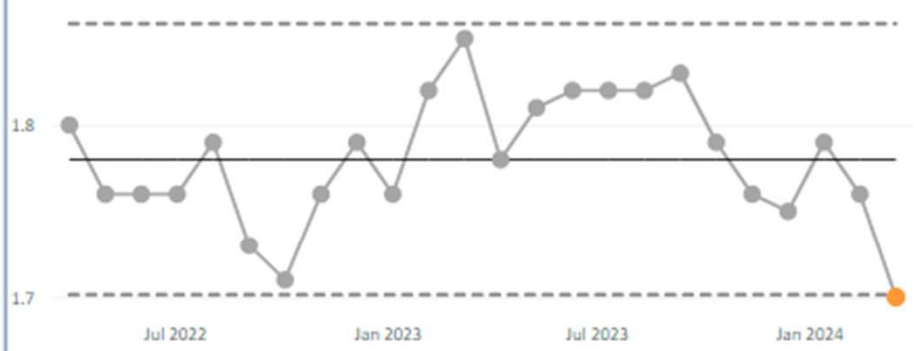
- CT/MRI, USS and phlebotomy continue to be delivered.
- Work has commenced to create additional space for enhanced phlebotomy delivery as well as new POCT modalities.
- The internal works to create additional cardio-respiratory space has now been costed and will likely require financial authority to proceed.
- The additional NOUS space requires only minor works and is awaiting an internal reorganisation prior to commencement.

Scarborough Hub.

- Scarborough CDC continues to progress with the contractor working concurrently with the Trust.
- The land has been purchased, now awaiting planning permission. The contractor has continued with off-site construction and preparation work to ensure that the go-live date remains achievable.

Variation Assurance

Proportion of BAME pathways on RTT PTL (S056a)



Latest Month

2024-03

Value

1.7%

Baseline

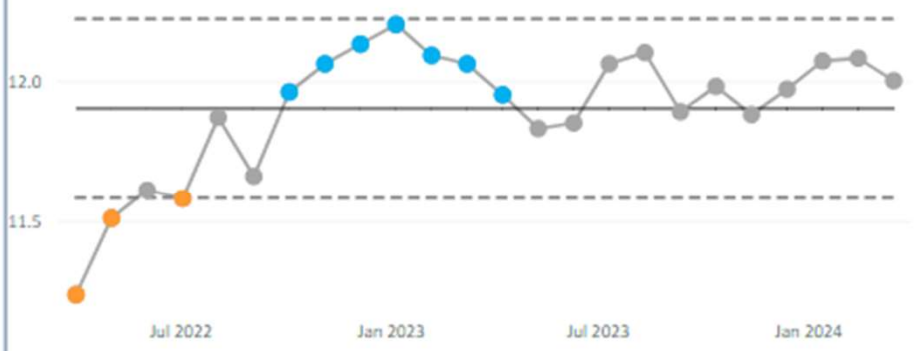
1.8%

The indicator is **below the baseline** for the latest month and **is not** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **0.1**.

Variation Assurance

Proportion of most deprived quintile pathways on RTT PTL (S056a)



Latest Month

2024-03

Value

12%

Baseline

12%

The indicator is **equal to the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **0.1**.

A health inequalities group has been established as part of the 2024/25 Elective Programme with representatives from across the Trust including the Health Inequalities Clinical Fellow and Place representatives.

A learning disability task and finish group has been formed, with operational, business intelligence and clinical colleagues to develop an eight-week surgical pathway by the end of quarter one 2024/25. Initial meeting has taken place with three core workstreams:

1. Process for identifying patients with a learning disability on the elective waiting list.
2. Pathways for the Complex Needs Team to identify reasonable adjustments to be made.
3. Pre-assessment/on the day process to maximise the opportunity for appointment/procedure to take place.

Scoping continues for both the East Coast CYP dental extraction patients and for patients who have caring responsibilities on the elective waiting list.

Health Inequalities

York and Scarborough Teaching Hospitals NHS Foundation Trust

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile

At end of: **March 2024**

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	20	5465	12.13%	8.88%
2	21	6422	14.25%	13.59%
3	20	9553	21.20%	20.94%
4	20	9871	21.91%	20.68%
5	20	13742	30.50%	35.90%
Unknown	21	991		
Total	**20**	**46044**		

Highlights For Board To Note

As per 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 Trust has established a Health Inequalities and Population Health Steering Group; the primary aim is to develop a plan that encompasses the overall Trust Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. This will align to the refreshed Trust Strategy 2024. A number of Task and Finish Groups will be established to facilitate focused and efficient implementation of specific aspects of the strategy. The overarching goal is to foster a healthcare environment that prioritises equity, inclusivity, and improved health outcomes for all individuals, considering socio-economic, demographic, or other determinants.

RTT PTL by Ethnic Group

At end of: **March 2024**

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	20	30058	98.34%	94.34%
Black, Black British, Caribbean or African	20	53	0.17%	0.94%
Mixed or multiple ethnic groups	17	120	0.39%	1.26%
Asian or Asian British	20	232	0.76%	2.97%
Other ethnic group	22	103	0.34%	0.49%
Unknown	20	12358		
Not Stated	21	3120		
Total	**20**	**46044**		

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

Children & Young Persons Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Children & Young Persons: ED - Patients waiting over 12 hours in department	2024-03			0	5
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2024-03			76.2%	79.2%
Children & Young Persons: Cancer 2 week wait (all cancers)	2024-02			88.9%	100%
Children & Young Persons: RTT - Total Waiting List	2024-03			4363.1	3720
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024-03			92%	64.8%
Children & Young Persons: RTT Waits over 65 weeks for incomplete pathways	2024-03			0	5

KPIs - Operational Activity and Performance

Children and Young Persons (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Children & Young Persons: RTT Waits over 65 weeks for incomplete pathways

Variation Assurance

Latest Month

2024-03

Value

5

Target

0

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

The latest months value has **improved** from the previous month, with a difference of **1.0**.

Children & Young Persons: ED - Emergency Care Standard (Type 1 only)

Variation Assurance

Latest Month

2024-03

Value

79.2%

Target

76.2%

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

The latest months value has **deteriorated** from the previous month, with a difference of **4.7**.

An Improvement trajectory to meet the internal ambition to deliver zero RTT52 week patients aged 0-17 at the end of March 2024 was not met. As at the end of March 2024 the Trust had 38 patients aged 0-17 waiting 52+ weeks across ENT, Maxillo-Facial Surgery and Ophthalmology.

As part of 2024/25 activity and performance planning the Trust is signalling that zero 52+ week waiters aged 0-17 will be achieved by the end of quarter one.

Development work from the Trust's BI Team is ongoing to put in place a CYP community waiting list dashboard to provide increased visibility across the Family Health Care Group. This will form a key workstream within the 2024/25 elective programme.

KPIs - Operational Activity and Performance

Children and Young Persons (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Children & Young Persons: ED - Patients waiting over 12 hours in department

Variation Assurance

Latest Month

2024-03

Value

5

Target

0

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

The latest months value has **improved** from the previous month, with a difference of **1.0**.

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See Acute Flow section commentary.

Community Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
2-hour Urgent Community Response (UCR) care Referrals	2024-03	H	?	80.1	112
% Community Therapy Team Patients Seen within 6 weeks of Referral	2024-03		?	68.2%	72.7%
2-hour Urgent Community Response (UCR) Compliancy %	2024-03		P	70%	90.2%
Number of Adults (18+ years) on community waiting lists per system	2024-03	L	?	826.4	800
% of End of Life Patients Dying in Preferred Place of Death	2024-03	L	?	76%	72.7%
Community Inpatient Units Average Length of Stay (Days)	2024-03		?	22.1	22.6
Number of District Nursing Contacts	2024-03		?	21160.5	21692
Number of Selby CRT Contacts	2024-03	H	?	2578.6	2893
Number of York CRT Contacts	2024-03		?	4810.7	4408
Referrals to District Nursing Team	2024-03		?	2219.2	2222
Virtual Ward Capacity	2024-03	H	F	33	40
Number of CYP (0-17 years) on community waiting lists per system	2024-03	L	F	726	2022

KPIs - Operational Activity and Performance

Community (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

2-hour Urgent Community Response (UCR) Compliancy %

Variation Assurance

Latest Month

2024-03

Value

90.2%

Target

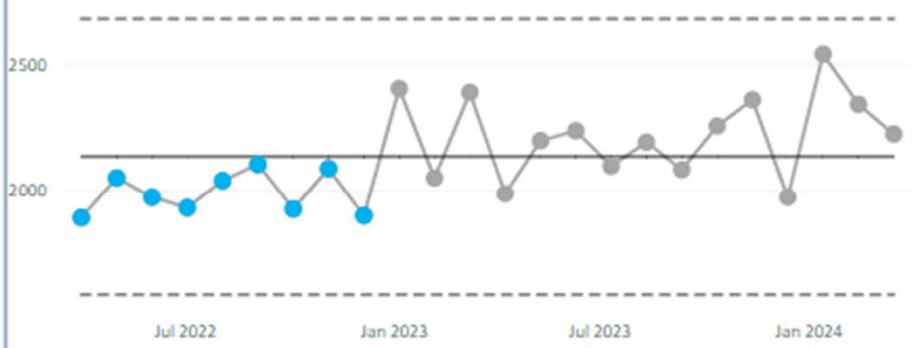
70%

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

The latest months value has **improved** from the previous month, with a difference of **1.3**.

Referrals to District Nursing Team

Variation Assurance



Latest Month

2024-03

Value

2222

Baseline

2219.2

The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **118.0**.

2-hour Urgent Community Response (UCR)

2 UCR Covers all areas; York, Selby and South Hambleton and Ryedale (SHaR) and has achieved the 70% target for each month of 2023/24.

Numbers of patients has been growing and is predicted to continue to grow as the service develops. We have seen some efficiency for the team, as they are able to access the Frailty hub GP for advice and guidance and reduce the time wasted waiting for call backs from home GP teams.

Data has shown on average there are 9 referrals per month the service is unable to accept due to capacity, the full MDT is not available at a weekend and with the geography the paramedic element is unable to respond to all calls in the time required. From this we need to target areas for development and opportunities for expansion.

Virtual Ward

Ambition for 2023/24 to increase to 33 virtual Hospital beds in York was achieved at the end of March 2024.

We now have capacity for 40 patients on our virtual wards:

- Frailty (10 with a view to increase in April).
- Heart Failure (reporting capacity for 10 but trialling 15 and testing sustainability of this before increasing).
- Vascular (10 and no need to increase).
- Cystic Fibrosis (10 and in early days of virtual hospital but finding benefits already).

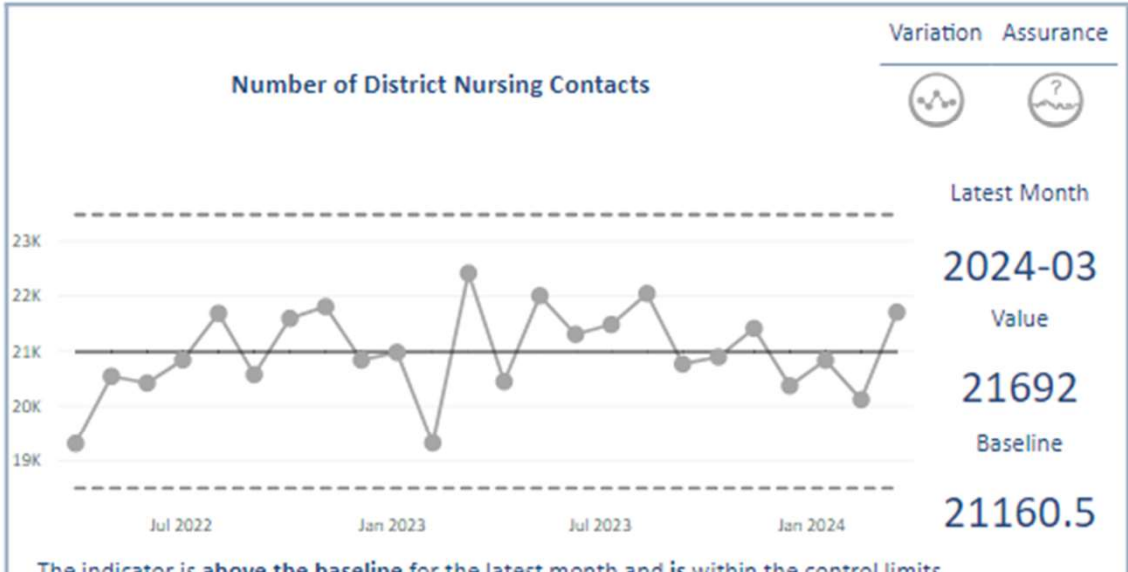
District Nursing

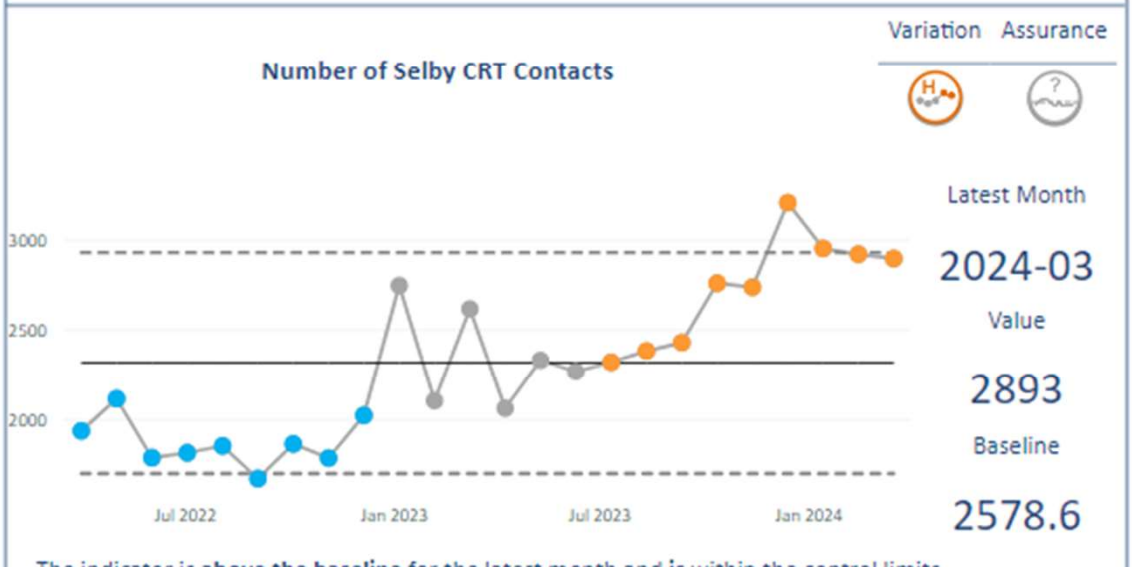
We saw a spike in January 2024 and referrals remain higher than average in February 2024, there is a slight decrease in March bringing the number closer to the average line. Referrals in the 12 months to February 2024 averaged at around 2,225 a month circa 10% above the previous 12 months, where referrals averaged at 2,033 a month.

District Nursing caseloads have seen an increase due to the growing age and frailty of the population. In addition, the changes in the care home market can have a direct impact on the demand for community nursing. District Nursing Teams have completed 3 rounds of data collection for the Community Nursing Safer Staffing Tool (CNSST), this will be used to support the workforce review. The District Nursing team triage all referrals and undertake regular case load reviews to ensure the case load is appropriate.

KPIs - Operational Activity and Performance

Community (2)





District Nursing

Sickness has been high within the District Nursing service and Community Services at the start of 2024 and continues to be above the Trust Average. Data investigation has shown that the Community Service Age profile is different to the Trust with the highest age demographic in community being 51-55 years old (17.5%) whilst the highest demographic across the rest of the trust is those aged 31-35 years old (13.5%). The workforce data shows we have an older workforce and with this we see an increase in absence and specifically in MSK absences.

Increase in referrals to York and Selby Community Response Team (CRT) is driven by both the implementation of Urgent Community Response pathway and the additional demand for none 2-hour referrals for additional support for patients in the community (step up) and additional demand for patients leaving hospital (step down).

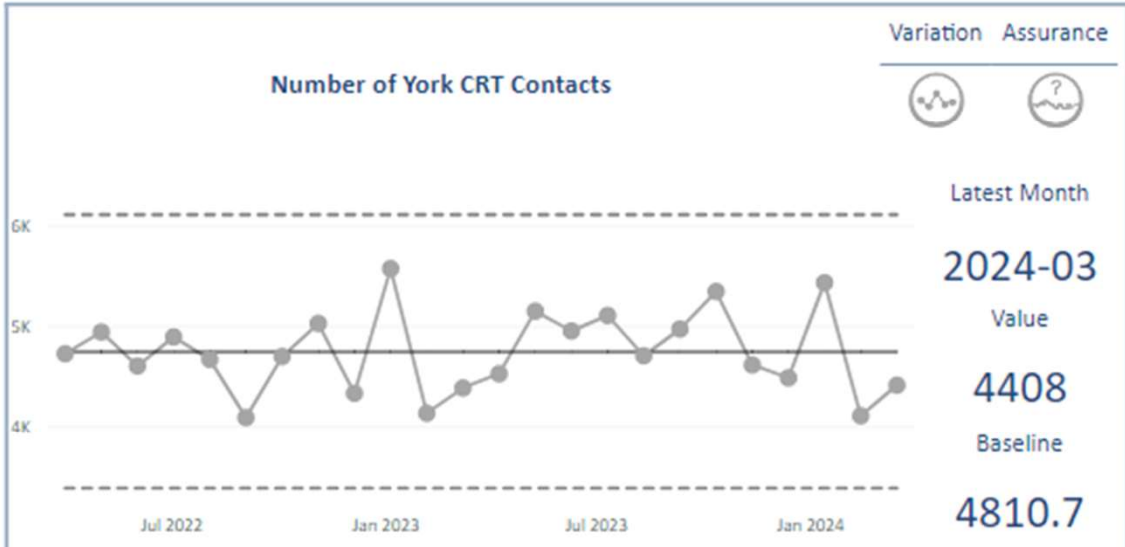
The increased demand is more than the available capacity and pulls on the wider resource within community at times of escalation.

Investigation work to look at how contacts are being recorded and attributed when supporting the York CRT is being analysed. Data is pulled via contacts not number of visits, further investigation required to ensure that double up visits are being recorded accurately.

In addition, in q4 Selby CRT/CTT were commissioned to support the North Yorkshire place intermediate care beds at Osbourne and Carentan House. This is likely to continue into 2024/25.

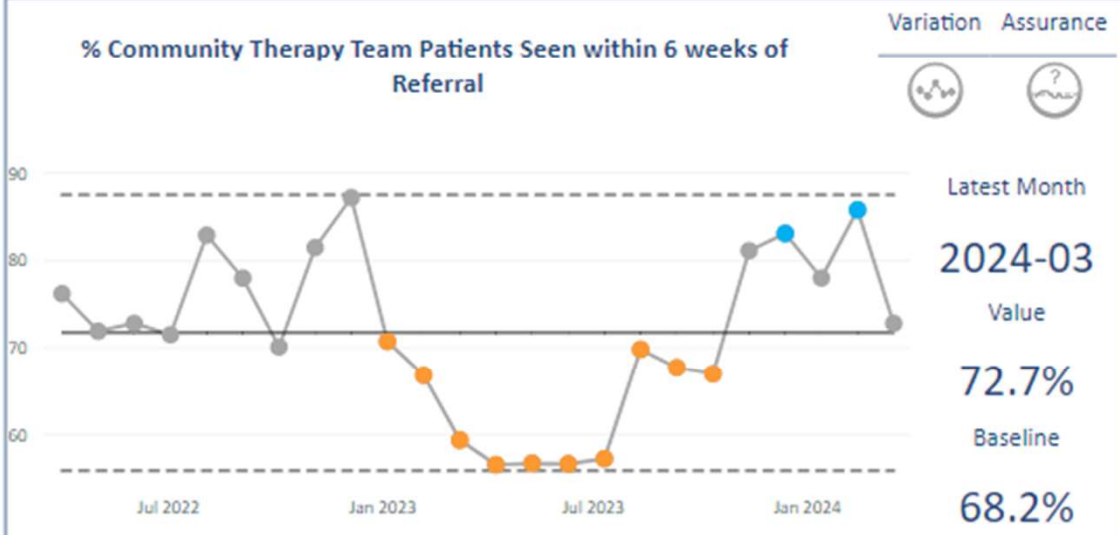
KPIs - Operational Activity and Performance

Community (3)



The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **305.0**.



The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **13.0**.

Community Therapy Team

The percentage of routine referrals seen within 6 weeks increased in February to 85.7% - the highest level attained since December 2022 however, March has seen a decrease to 72.7% .

Community Therapy waiting list slight increase from 467 (February 2024) to 507.

District Nursing waiting list down from 278 (February 2024) to 244.

Specialist Nursing waiting list down from 67 (February 2024) to 49.

Community Waiting List

The Community waiting lists saw a reduction in March 2024.

We continue to target the waiting list to ensure the data is accurate and implement our recovery plans. There was a small increase in February due to the level of sickness and vacancies within the teams. As staff have returned the waiting list has reduced as expected.

KPIs - Operational Activity and Performance

Community (4)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

% of End of Life Patients Dying in Preferred Place of Death

Latest Month

2024-03

Value

72.7%

Baseline

76%

The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **4.5**.

Variation Assurance

Community Inpatient Units Average Length of Stay (Days)

Latest Month

2024-03

Value

22.6

Baseline

22.1

The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **2.2**.

The community units support both Acute flow and Community admission avoidance.

Acuity and dependence has increased over time which has seen an increase in the restricted weightbearing pathway and bariatric rehabilitation, both pathways have an expected extended length of stay.

Rehabilitation audits identified that the therapy workforce is below the required level.

The Selby service have seen the difference that increasing the therapy workforce to have a consistent team has a direct impact in reducing length of stay and improving admission numbers. Unfortunately, this additional resource was unfunded so will be lost at the end of the financial Year, we are exploring with the North Yorkshire place potential funding to continue this model to maintain their improved LOS.

We continue to drive the SAFER board round principles, the MADE+ event identified that we need to have an equal escalation for the LA delays within our community units and reduce the NCTR.

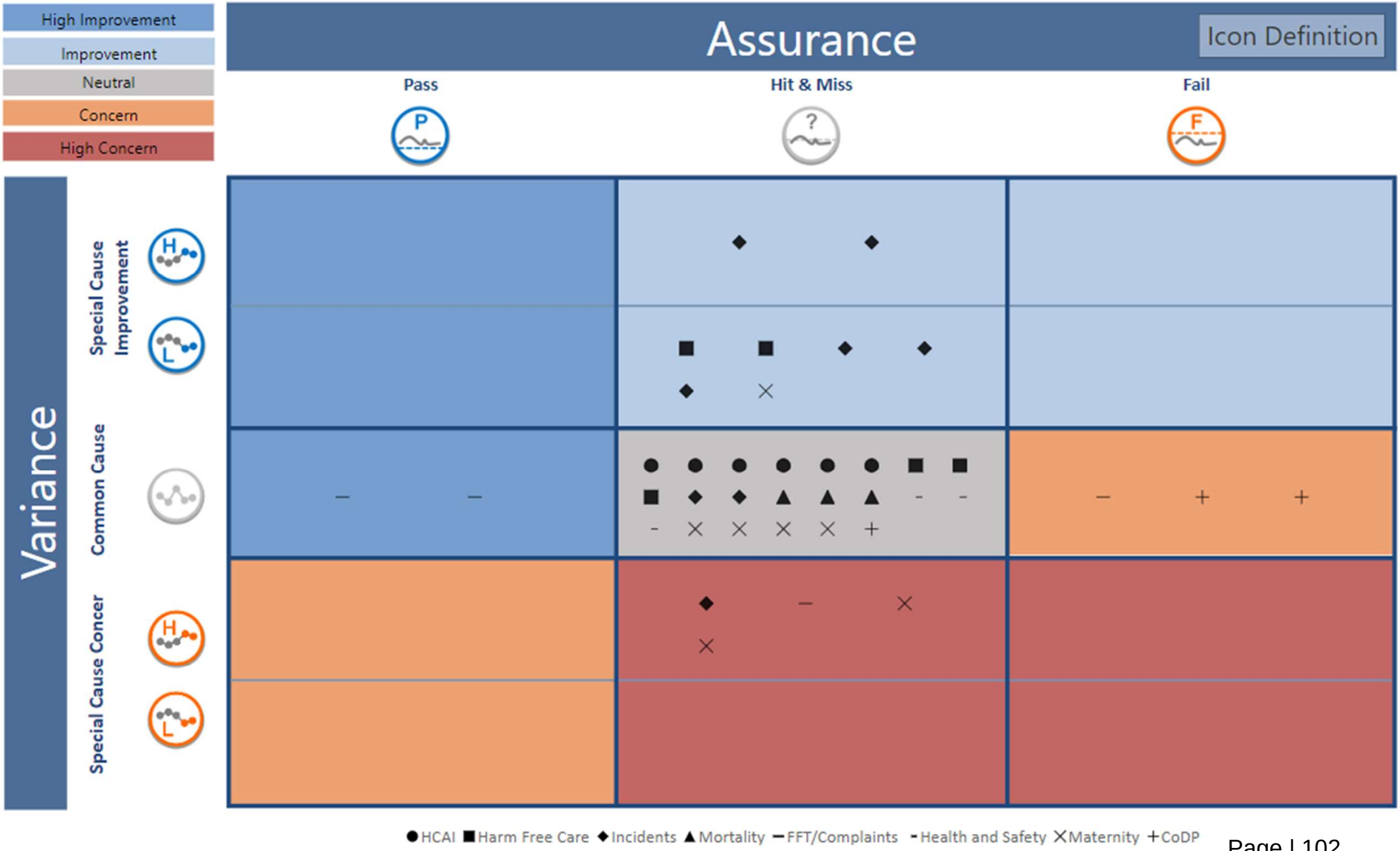
QUALITY AND SAFETY

April 2024

Summary Matrix - Quality and Safety

The table below provides an overview for all quality and safety metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

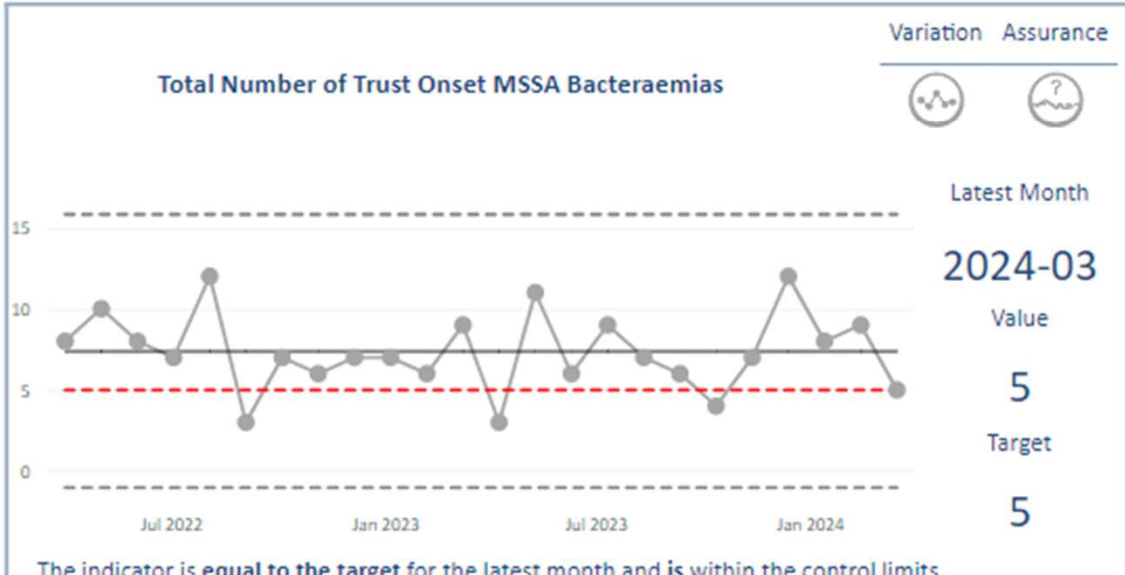


Quality and Safety (1) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Total Number of Trust Onset MSSA Bacteraemias	2024-03			5	5
Total Number of Trust Onset MRSA Bacteraemias	2024-03			0	1
Total Number of Trust Onset C. difficile Infections	2024-03			10	11
Total Number of Trust Onset E. coli Bacteraemias	2024-03			15	6
Total Number of Trust Onset Klebsiella Bacteraemias	2024-03			6	5
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2024-03			1	0
Inpatient Acquired Pressure Ulcers	2024-03			151	153
Pressure Ulcers per thousand Bed Days	2024-03			4	4.9
All Patient Falls	2024-03			256	271
Patient Falls per thousand Bed Days	2024-03			9	8.8
Medication incidents per thousand bed days	2024-03			6	5

KPIs - Quality and Safety (1)

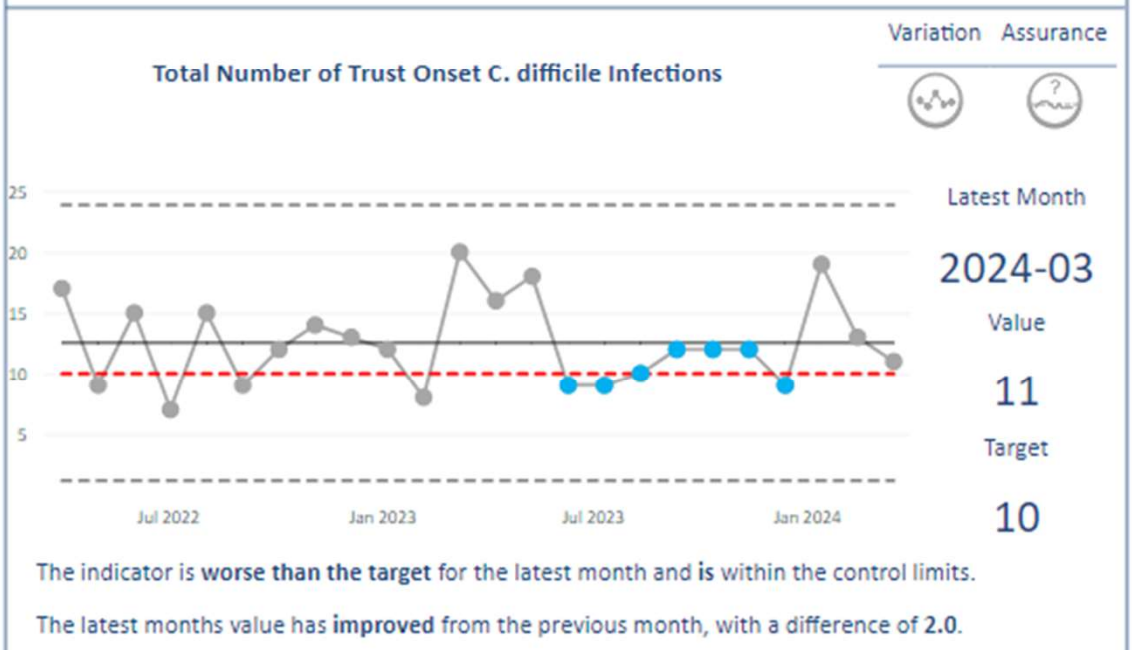


There have been 5 Trust attributed Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia in March 2023, 3 in Medicine and 1 in surgery and 1 in CSCS. The trust has breached its annual objective of 59 cases having a total of 87 cases year to date.

The PSIRF findings of the cases will be presented at the Staphylococcus aureus bacteraemia reduction group.

There has been 1 Methicillin resistant Staphylococcus aureus (MRSA) in March in Medicine, which takes the Trust to 4 cases against a zero objective. A PSIRF has been completed and lessons identified which are being actioned.

Th Trust Internal Audit report on cannula management has been received and improvement work is required which will be overseen by the Infection Prevention Steering and Assurance Group (IPSAG)



There have been 11 Trust attributed Clostridiodes difficile (C.difficile) cases in February 2024 which is an improved position from January and February 2024. 8 cases occurred in Medicine and 1 in Surgery and 2 in CSCS. Of the 11 cases in March 5 occurred on the York Hospital site, 5 occurred on the Scarborugh site and 1 occurred in a community unit. The Trust annual C.difficile objective is 116 cases, with 150 cases reported at the end of March 2024.

PSIRF is being completed on all the cases in March and will be reported via the C.difficile reduction group and Infection Prevention and Strategic Assurance Group (IPSAG).

We are awaiting the annual HCAI thresholds for 2024/25. UKHSA have announced changes to the definitions and allocation of C.difficile from 1st April. This will likely increase the numbers of hospital attributed cases.

Quality and Safety (2) Scorecard

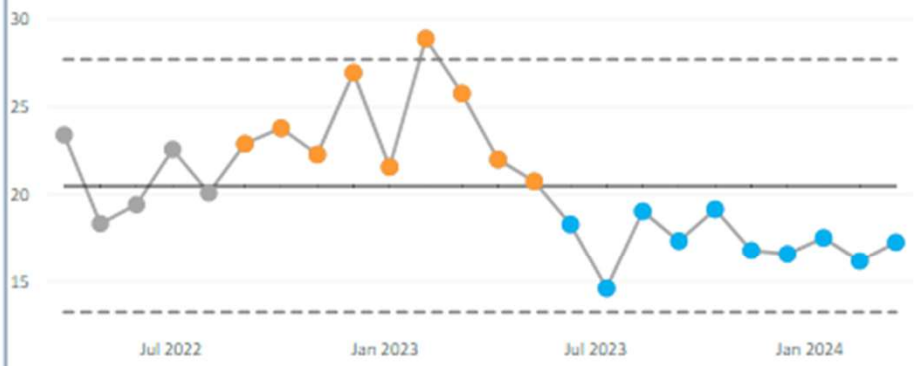
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Patient Safety Incidents per thousand Bed Days	2024-03			54	47.4
Harmful Incidents per thousand bed days	2024-03			19	17.2
Percentage of Patient Safety Incidents with Moderate or Above Harm	2024-03			2%	5.9%
Trust Duty of Candour (Stage 1)	2024-03			93%	93.9%
Trust Duty of Candour (Stage 2)	2024-03			91%	91.2%
Trust Duty of Candour (Stage 3)	2024-03			89%	88.4%
Number of Serious Incidents Reported	2024-03			11	2
Total Number of Never Events Reported	2024-03			0	0
In-Hospital Deaths	2024-03			200	195
Quarterly SHMI	2023-09			100	96.3
Monthly SHMI	2023-10			100	94.1
Quarterly HSMR	2023-12			100	108.2
Monthly HSMR	2023-12			100	108.8

KPIs - Quality and Safety (2)

Variation Assurance

Harmful Incidents per thousand bed days



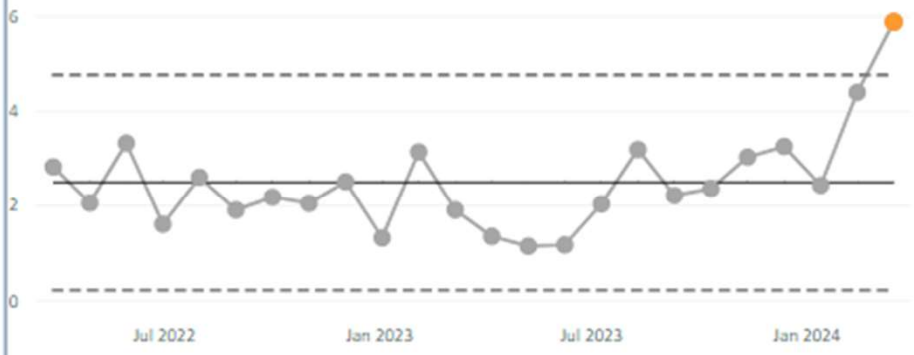
Latest Month
2024-03
Value
17.2
Baseline
19

The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **1.1**.

Variation Assurance

Percentage of Patient Safety Incidents with Moderate or Above Harm



Latest Month
2024-03
Value
5.9%
Baseline
2%

The indicator is **above the baseline** for the latest month and **is not** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **1.5**.

There has been a reduction in incident reporting throughout the trust. This variation occurred at the same time we transitioned between the Datix Web and DCIQ the trust updated incident management system. Incident reporting has been impacted further in November and December through the introduction of the mandatory module Learning From Patient Safety Events (LFPSE) from NHSE resulting in an additional 20 questions when a patient is involved in an incident. Care groups have reported this is impacting on staff having time to report the initial incident. The incident reporting appears to be levelling and becoming consistent but below the levels previously seen on Datix Web.

There has been challenges facing reporting due to connectivity issues to the incident management system, particularly during December. The cause for these problems is yet to be confirmed with connectivity problems resulting in incidents not being reports or duplication of work with multiple submissions. Resulting reluctance to either submit a datix or repetition of the same incidents means that there is a risk that in the short term the numbers of incidents is distorted until duplicates are deleted.

Due to the intermittent nature of these problems and failure to solve the issues the organisations Deputy Chief Digital Information Officer has taken responsibility for liaising directly with DCIQ. DCIQ has visited York Hospital at the beginning of February 2024 to see first-hand the problems we are experiencing and to ensure a better understanding of our concerns is understood and addressed.

DCIQ are no in direct contact with systems and networks to resolve any new issues. An email sent to the patient safety team from systems and networks does allude to the fact the hospitals WIFI struggles to load the fields on DCIQ rather than a problem with DCIQ itself.

Quality and Safety (3) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Friends and Family Test - Trust ED Recommend %	2024-02		F	90%	75.6%
Friends and Family Test - Trust Inpatient Recommend %	2024-02		P	90%	97.2%
Friends and Family Test - Trust Maternity Recommend %	2024-02		P	90%	95.7%
Trust Complaints	2024-03	H	?	67	67
Needlestick Injury or Sharps Incident	2024-03		?	14	13
Staff Slips, Trips and Falls	2024-03		?	3	5
RIDDOR	2024-03		?	2	1

KPIs - Quality and Safety (3)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

Friends and Family Test - Trust ED Recommend %

Latest Month

2024-02

Value

75.6%

Target

90%

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

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

The FFT continues to be a focus of work in the Scarborough department. Engagement has been challenging due to the footfall of patients through the department through recent months.

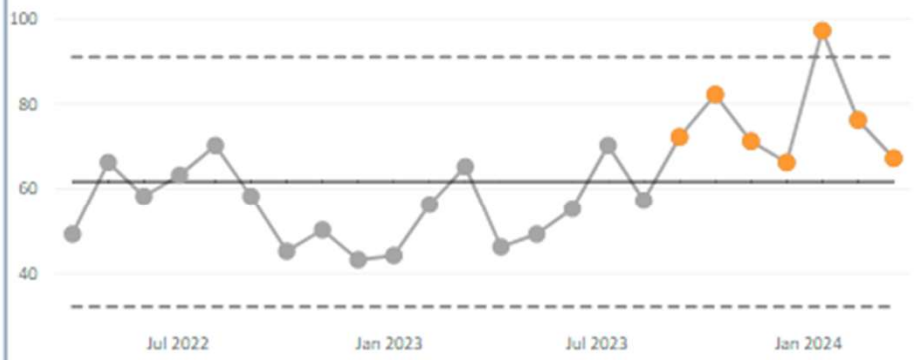
FFT Posters are in the department and patient with a mobile phone will receive text messages to encourage participation and feedback.

Over 82% of the feedback in December rated very good/good

The main feedback is related to waiting times which continues to be an ongoing challenge

Variation Assurance

Trust Complaints



Latest Month

2024-03

Value

67

Baseline

67

The indicator is **equal to the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **9.0**.

The number of new complaints for February 2024 was 76.

Main complaint themes:

- Delay or failure in treatment or procedure
- Communication with patient
- Attitude of nursing staff/midwives
- Arranging/undertaking diagnostics
- Attitude of medical staff

18 cases over 50 working days were closed in February – care groups are prioritising complaint management with a focus on overdue cases.

There were 4 new re-opened complaints.

As at 7 March there were 17 open cases over 50 working days. Extensions for some of these cases have been agreed with complainants and not all cases will be expected to be concluded within 30 working days.

Quality and Safety (4) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

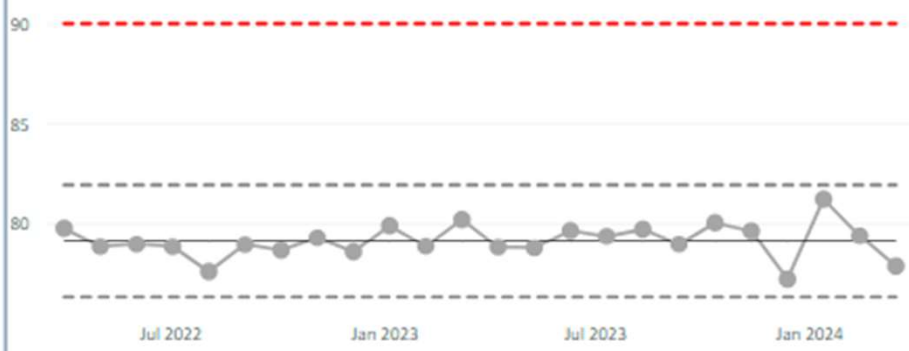
Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Antepartum Stillbirths	2024-02			0.7	0
Intrapartum Stillbirths	2024-02	L		0	0
Early neonatal deaths (0-7 days)	2024-02			0.5	0
PPH > 1.5L as % of all women - York	2024-02			4.5%	5.2%
PPH > 1.5L as % of all women - Scarborough	2024-02			2.5%	1.1%
Obstetrics and Gynaecology: Serious Incidents	2024-03	H		0.1	2
Obstetrics and Gynaecology: Moderate Incidents	2024-03	H		8.2	15
14 Hour Post Take	2024-03		F	90%	77.8%
Senior Review	2024-03			49%	45.7%
Discharges by 5pm	2024-03		F	70%	64%

KPIs - Quality and Safety (4)

York and Scarborough Teaching Hospitals NHS Foundation Trust

14 Hour Post Take

Variation | Assurance



Latest Month

2024-03

Value

77.8%

Target

90%

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

The latest months value has **deteriorated** from the previous month, with a difference of **1.5**.

Senior Review

Variation | Assurance

Latest Month

2024-03

Value

45.7%

Baseline

49%

The indicator is **below the baseline** for the latest month and **is** within the control limits.

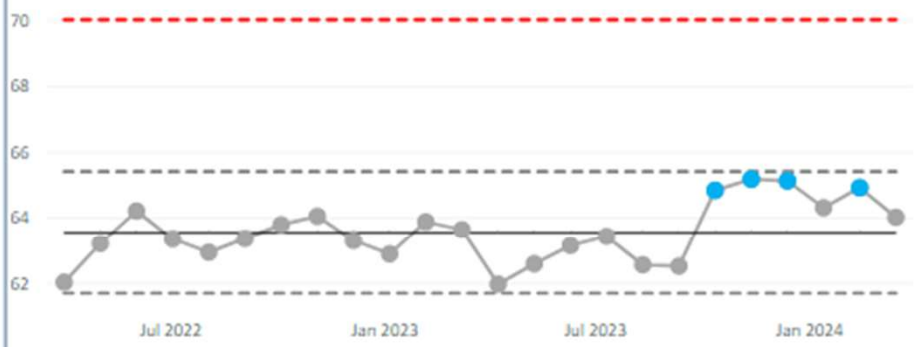
The latest months value has **deteriorated** from the previous month, with a difference of **2.8**.

KPIs - Quality and Safety (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variation Assurance

Discharges by 5pm



Latest Month

2024-03

Value

64%

Target

70%

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

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

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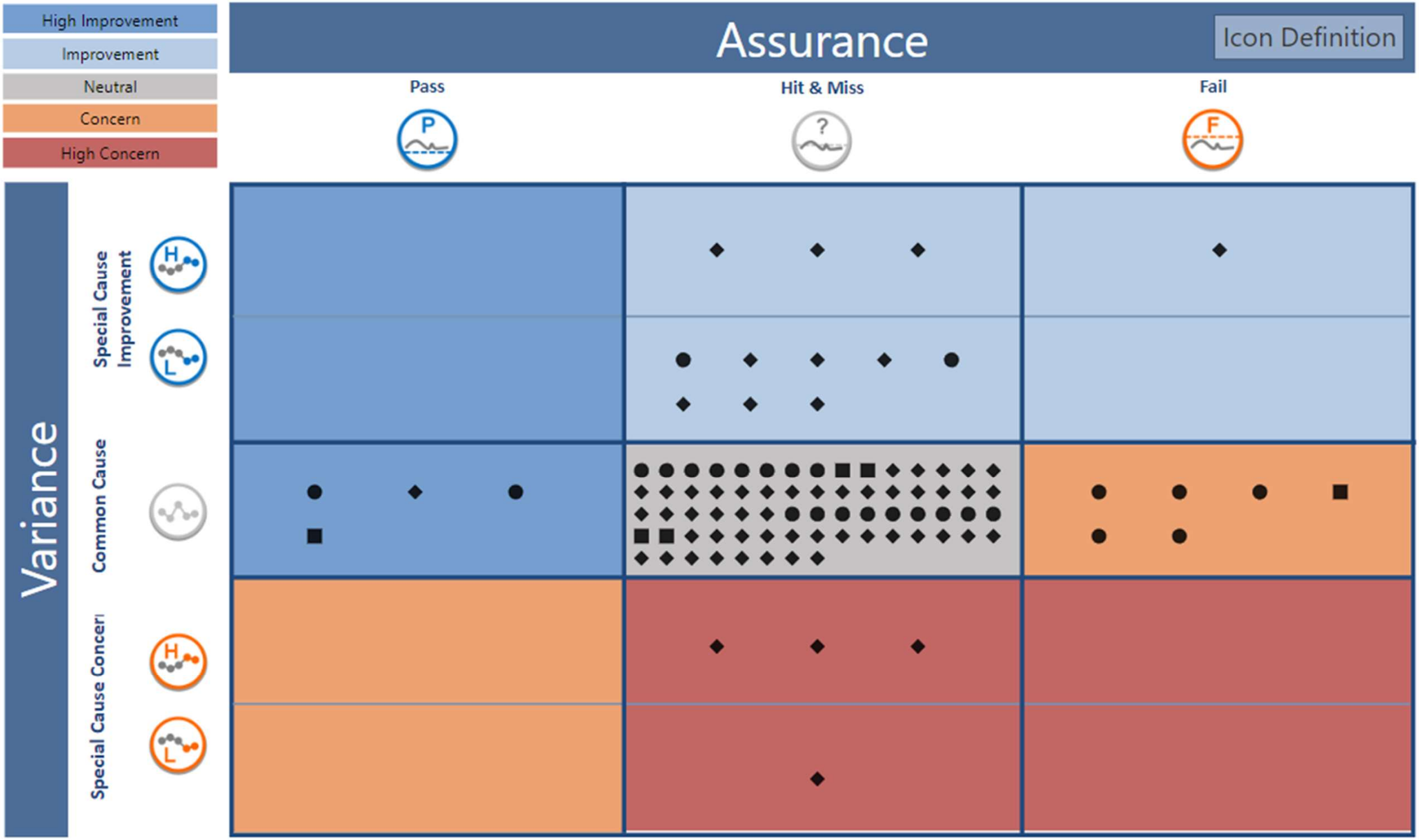
MATERNITY

April 2024

Summary Matrix - Maternity

The table below provides an overview for all maternity metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust



Maternity Scarborough (1) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Bookings - Scarborough	2024-02			169	116
Bookings <10 weeks - Scarborough	2024-02		F	90%	56.9%
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2024-02			10%	8.6%
Births - Scarborough	2024-02			113	95
No. of women delivered - Scarborough	2024-02			112	95
Planned homebirths - Scarborough	2024-02		F	2.1%	0%
Homebirth service suspended - Scarborough	2024-02		F	3	26
Women affected by suspension - Scarborough	2024-02			0	1
Community midwife called in to unit - Scarborough	2024-02	L		3	0
Maternity Unit Closure - Scarborough	2024-02			0	1
SCBU at capacity - Scarborough	2024-02			0	0
SCBU at capacity of intensive care cots - Scarborough	2024-02			0	3
SCBU no of babies affected - Scarborough	2024-02		P	0	0
1 to 1 care in Labour - Scarborough	2024-02			100%	100%
L/W Co-ordinator supernumerary % - Scarborough	2024-02			100%	96.6%
Anaesthetic cover on L/W - Scarborough	2024-02		F	10	5

Maternity Scarborough (2) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Normal Births - Scarborough	2024-02			57%	56.8%
Assisted Vaginal Births - Scarborough	2024-02			12.4%	7.4%
C/S Births - Scarborough	2024-02			40.9%	35.8%
Elective caesarean - Scarborough	2024-02			18.4%	16.8%
Emergency caesarean - Scarborough	2024-02			22.4%	19%
Induction of labour - Scarborough	2024-02			41.3%	44.2%
HDU on L/W - Scarborough	2024-02			5	3
BBA - Scarborough	2024-02			2	0
HSIB cases - Scarborough	2024-02	L		0	0
Neonatal Death - Scarborough	2024-02			0	0
Antepartum Stillbirth - Scarborough	2024-02			0	0
Intrapartum Stillbirths - Scarborough	2024-02		P	0	0
Cold babies - Scarborough	2024-02			1	0
Preterm birth rate <37 weeks - Scarborough	2024-02			6%	2.1%
Preterm birth rate <34 weeks - Scarborough	2024-02			1%	0%
Preterm birth rate <28 weeks - Scarborough	2024-02			0.5%	0%

Maternity Scarborough (3) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Low birthweight rate at term (2.2kg) - Scarborough	2024-02			0%	0%
Breastfeeding Initiation rate - Scarborough	2024-02			75%	82.1%
Breastfeeding rate at discharge - Scarborough	2024-02			65%	64.2%
Smoking at booking - Scarborough	2024-02			6%	16.4%
Smoking at 36 weeks - Scarborough	2024-02			6%	0%
Smoking at time of delivery - Scarborough	2024-02			6%	13.7%
Carbon monoxide monitoring at booking - Scarborough	2024-02			95%	70.7%
Carbon monoxide monitoring at 36 weeks - Scarborough	2024-02			95%	68.4%
SI's - Scarborough	2023-10			0	1
PPH > 1.5L as % of all women - Scarborough	2024-02			2.5%	1.1%
Shoulder Dystocia - Scarborough	2024-02			2	0
3rd/4th Degree Tear - normal births - Scarborough	2024-02			2.8%	1.1%
3rd/4th Degree Tear - assisted birth - Scarborough	2024-02			6.1%	0%
Informal Complaints - Scarborough	2024-02			0	0
Formal Complaints - Scarborough	2024-02			0	0

Maternity York (1) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Bookings - York	2024-02			295	291
Bookings <10 weeks - York	2024-02			90%	79.4%
Bookings ≥13 weeks (exc transfers etc.) - York	2024-02		P	10%	2.1%
Births - York	2024-02			245	217
No. of women delivered - York	2024-02			242	211
Planned homebirths - York	2024-02		F	2.1%	0%
Homebirth service suspended - York	2024-02		F	3	17
Women affected by suspension - York	2024-02			0	1
Community midwife called in to unit - York	2024-02	L		3	1
Maternity Unit Closure - York	2024-02			0	0
SCBU at capacity - York	2024-02			0	0
SCBU at capacity of intensive care cots - York	2024-02			0	6
SCBU no of babies affected - York	2024-02			0	0
1 to 1 care in Labour - York	2024-02			100%	99.5%
L/W Co-ordinator supernumerary % - York	2024-02			100%	100%
Anaesthetic cover on L/W - York	2024-02		P	10	10

Maternity York (2) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Normal Births - York	2024-02	L	?	57%	50.7%
Assisted Vaginal Births - York	2024-02		?	12.4%	12%
C/S Births - York	2024-02	H	?	36%	37.3%
Elective caesarean - York	2024-02		?	15.1%	15.7%
Emergency caesarean - York	2024-02	H	?	21%	20.7%
Induction of labour - York	2024-02	H	?	44.4%	45%
HDU on L/W - York	2023-10		?	5	8
BBA - York	2024-02		?	2	0
HSIB cases - York	2024-02	L	?	0	0
Neonatal Death - York	2024-02		?	0	0
Antepartum Stillbirth - York	2024-02		?	0	0
Intrapartum Stillbirths - York	2024-02	L	?	0	0
Cold babies - York	2024-02	L	?	1	0
Preterm birth rate <37 weeks - York	2024-02		?	6%	11.1%
Preterm birth rate <34 weeks - York	2024-02		?	2%	2.8%
Preterm birth rate <28 weeks - York	2024-02		?	0.5%	0.5%

Maternity York (3) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Low birthweight rate at term (2.2kg) - York	2024-02			0%	0%
Breastfeeding Initiation rate - York	2024-02	H		75%	83.9%
Breastfeeding rate at discharge - York	2024-02	H		65%	69%
Smoking at booking - York	2024-02			6%	7.6%
Smoking at 36 weeks - York	2024-02			6%	3%
Smoking at time of delivery - York	2024-02			6%	5.1%
Carbon monoxide monitoring at booking - York	2024-02			95%	87.3%
Carbon monoxide monitoring at 36 weeks - York	2024-02	H	F	95%	80.7%
SI's - York	2023-10			0	2
PPH > 1.5L as % of all women - York	2024-02			4.5%	5.2%
Shoulder Dystocia - York	2024-02			2	0
3rd/4th Degree Tear - normal births - York	2024-02			2.8%	1%
3rd/4th Degree Tear - assisted birth - York	2024-02			6.1%	4.7%
Informal Complaints - York	2024-02			0	0
Formal Complaints - York	2024-02			0	4

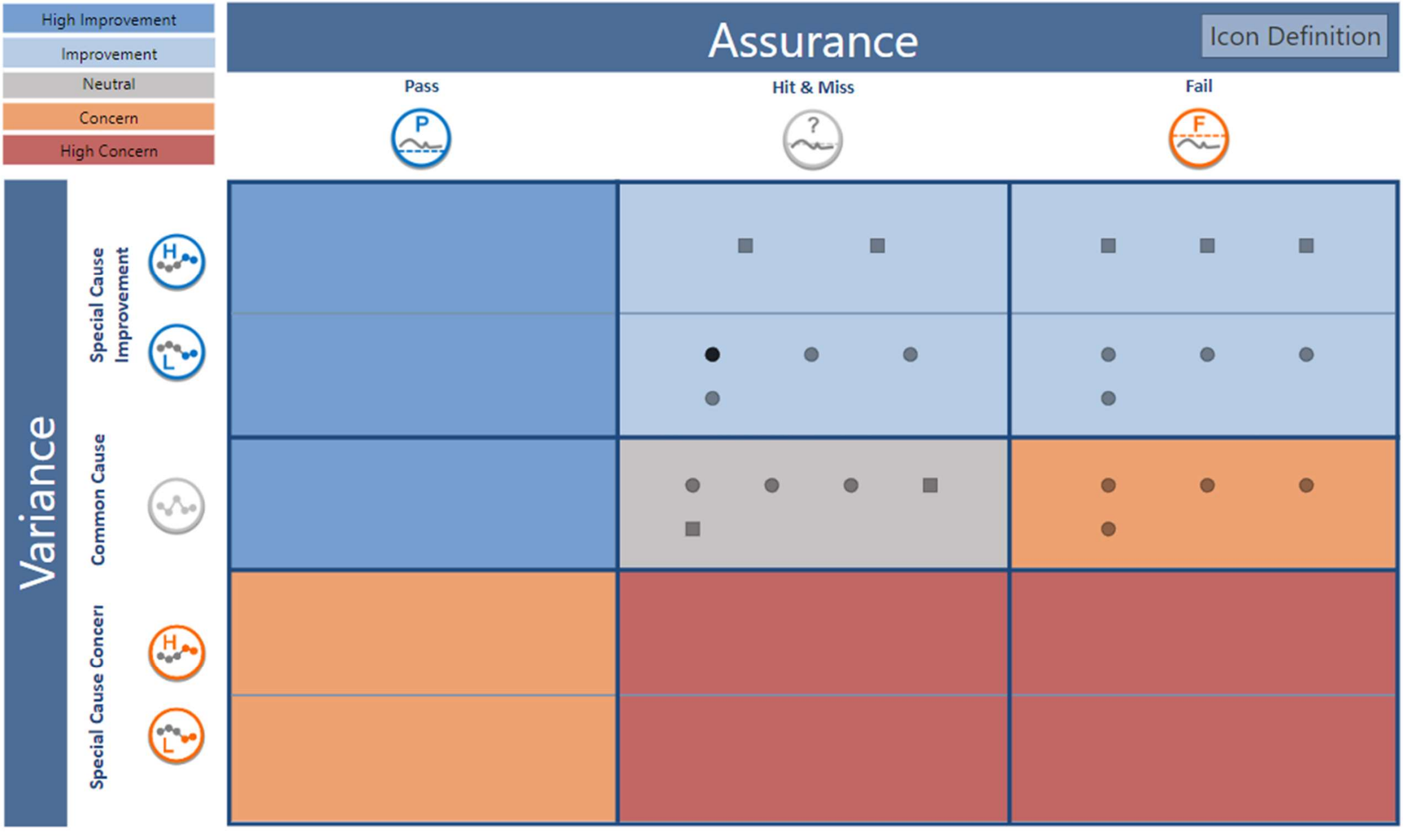
WORKFORCE

April 2024

Summary Matrix - Workforce

The table below provides an overview for all workforce metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

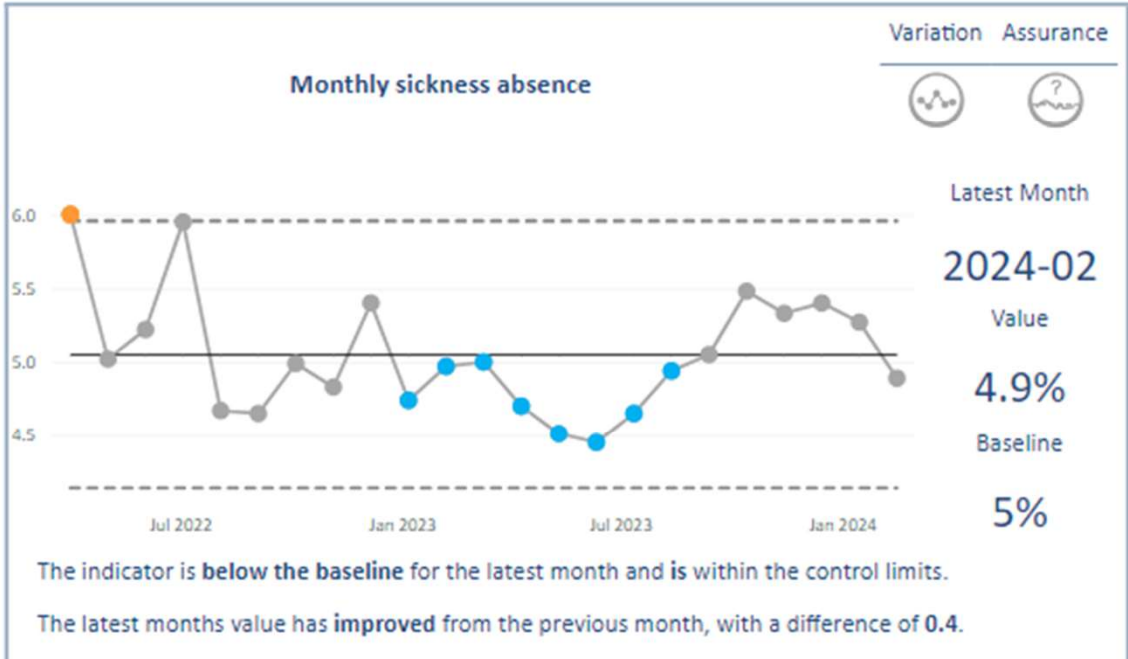


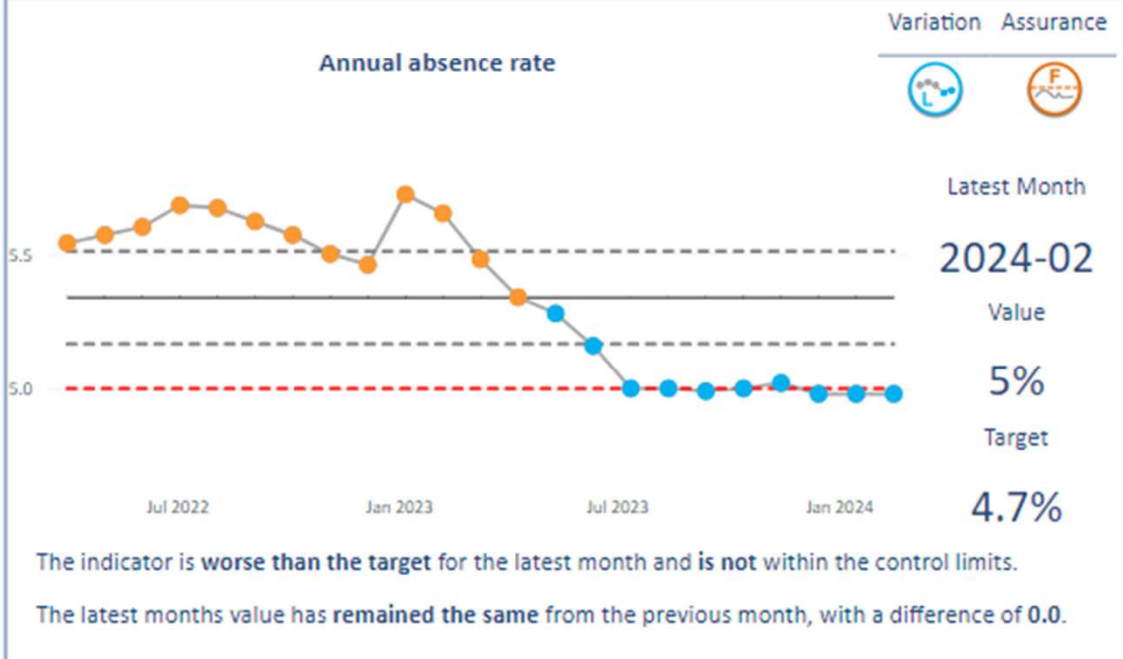
Workforce (1) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Monthly sickness absence	2024-02		?	5%	4.9%
Annual absence rate	2024-02	L	F	4.7%	5%
12 month rolling turnover rate Trust (FTE)	2024-03	L	?	10%	9%
Overall vacancy rate	2024-03	L	F	3.7%	6%
HCSW vacancy rate in adult inpatient wards	2024-03		F	1%	12.8%
RN vacancy rate in adult inpatient wards	2024-03	L	F	7.5%	3%
HCSW vacancy rate	2024-03		F	9.1%	11.1%
Midwifery vacancy rate	2024-03	L	?	0%	-6.1%
Medical and dental vacancy rate	2024-03		?	10%	5.9%
Registered Nursing vacancy rate	2024-03	L	?	5%	4%
AHP vacancy rate	2024-03	L	?	8.5%	5.6%
Total nursing (registered and nursing support) temporary staffing requests (total hours requested)	2024-03		F	80388.1	114000
% unfilled nursing temporary staffing requests	2024-03	L	F	0%	23%
Total medical and dental temporary staffing requests (total hours requested)	2024-02		?	23592.2	28000
% unfilled medical & dental temporary staffing requests	2024-02		F	0%	14.6%

KPIs - Workforce (1)





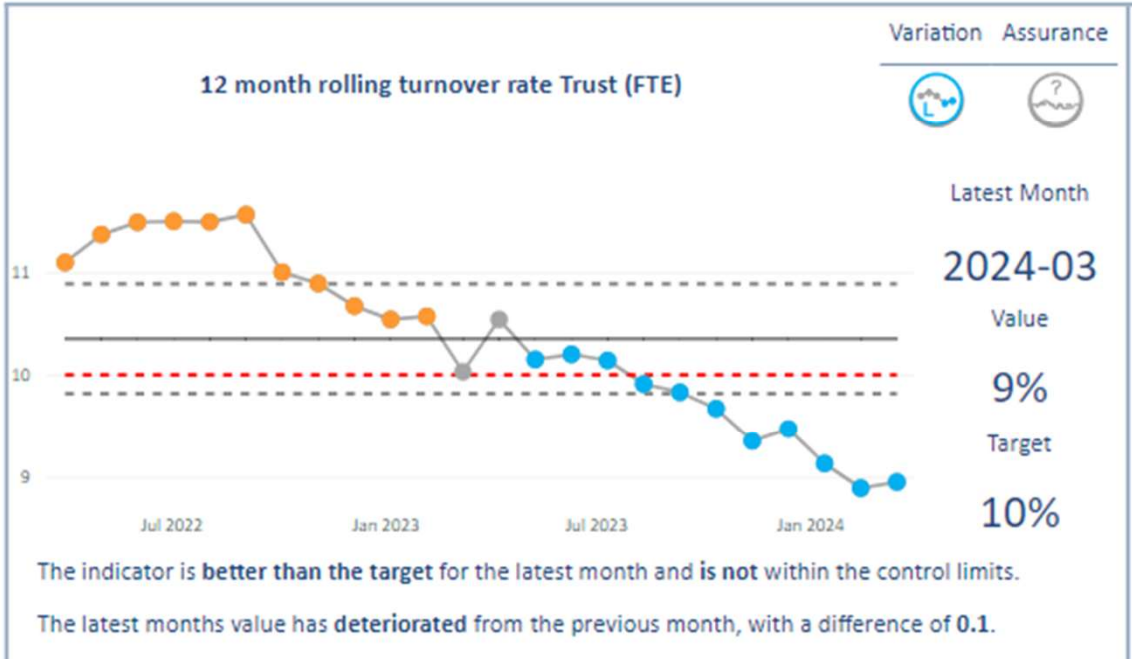
In February we saw a total absence of 435.27 WTE out of 8902.94 WTE leading to a 4.89% sickness rate for February. The calculation used to produce this figure takes the total number of WTE days lost and number of WTE days available and divides them by the number of days in the month.

The Top 3 sickness reasons for February were: Anxiety/Stress (99. 47 WTE), Cold/ Flu (49.58 WTE) and Musculoskeletal problems (41.86 WTE).

Following the recent Staff Survey Results plans are being developed at Trust, Care Group and Directorate level to make improvements across all elements of the People Promise, staff engagement and morale. Evidence shows that an increase in staff engagement can have a positive impact on rates of sickness absence.

The Our Voice Our Future Programme is continuing in the Trust and the Change Makers continue to receive informal feedback from staff members, with over 500 comments received. The Change Makers have held Culture Focus Groups in York, Scarborough and Bridlington with mixed attendance. Over the next 30 days the Change Makers will be holding a further five Culture Focus Groups, these will be delivered as two virtual sessions and three in the Community at Nelson Court, St Monica's and Selby War Memorial Hospital.

KPIs - Workforce (2)



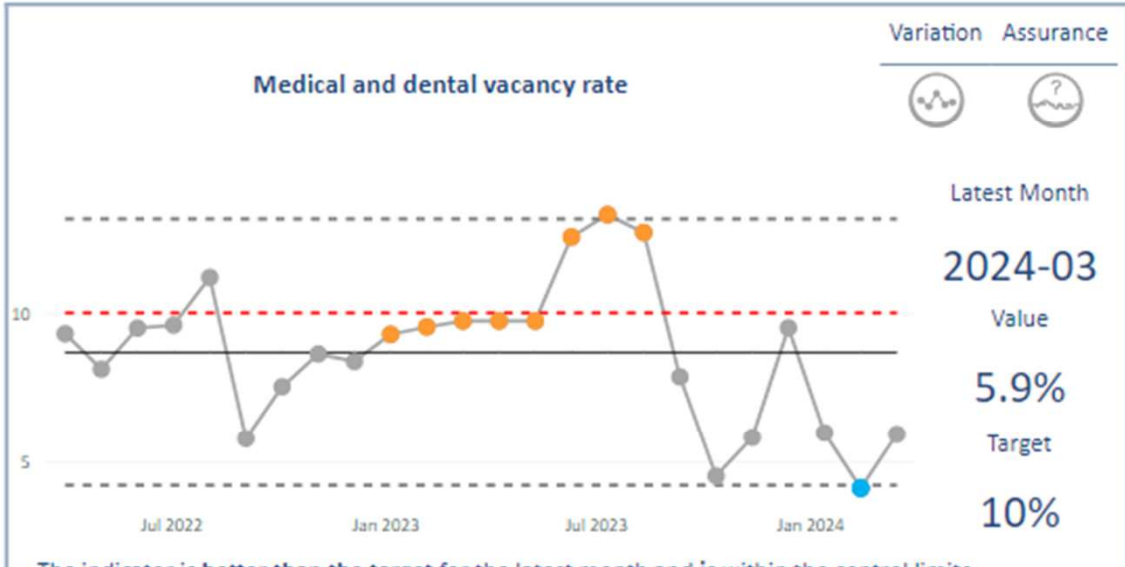
The Trust successfully recruited 113 international nurses in 2023/24. Our first international nursing cohort of 2024/25 arrived in the UK at the end of March, with 12 international nurses commencing their induction with the organisation during the first week of April. The Trust has committed to recruiting 55 international nurses this year and is already well underway with filling future cohorts.

11 registered nurses are currently undertaking pre-employment checks to join the Trust, with plans to interview further candidates for Community, ED York and ICU Scarborough in the coming weeks.

To date the Trust has made offers to 62 pre-registered nurses, ahead of qualifying in September. An advert for the Apprentice Nursing Associate post received 69 applications, with shortlisting in progress. Interviews are scheduled for 15th April followed by interviews at University of York in June.

Recruitment to support York ED has been taking place, with offers made to 4 x Band 7 Sister/Charge Nurses, 7 x Band 6 Deputy Sister/Charge Nurses and 5 x Band 3 Senior HCSWs.

KPIs - Workforce (3)



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

The latest months value has **deteriorated** from the previous month, with a difference of **1.8**.

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

The latest months value has **deteriorated** from the previous month, with a difference of **0.3**.

The Trust made 10 offers for medical posts in March, including 3 consultant posts for Paediatrics, Medicine and Surgery. 5 Trust Grades commenced in post during March, along with 1 Speciality Doctor. The new starters will be working across CSCS and Surgery.

The Trust continues to target hard to fill posts through our existing recruitment pathways while exploring new international pipelines in conjunction with the ICB.

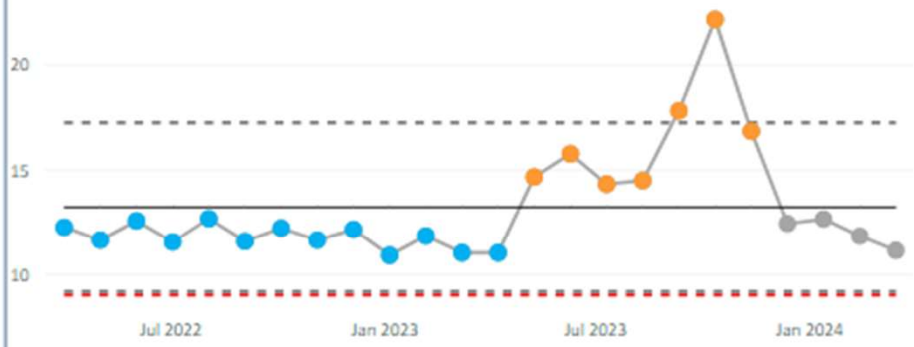
Planning for August's doctor's changeover is underway. Discussions are taking place with Care Groups about Trust Grades currently in post and their plans to stay with the organisation beyond August.

The Trust has successfully recruited 2 hard to fill AHP Team Managers posts within Medicine. We also welcomed 3 internationally recruited Radiographers and an Audiologist who is the Trust's first internationally recruited member of staff to be based in Ripon, working in the Community Hospital.

KPIs - Workforce (4)

Variation Assurance

HCSW vacancy rate



Latest Month

2024-03

Value

11.1%

Target

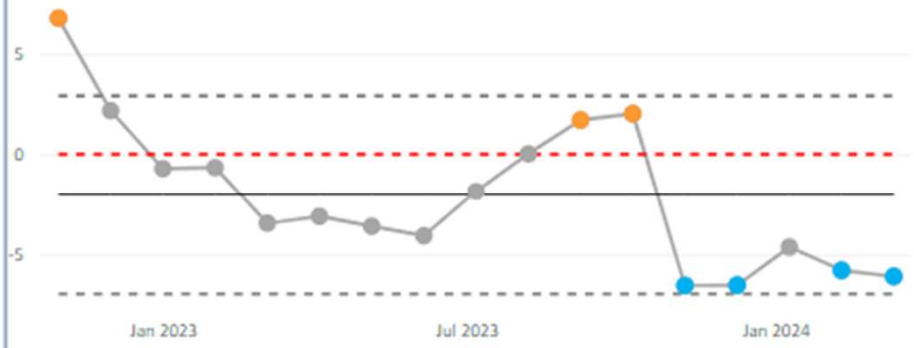
9.1%

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

The latest months value has **improved** from the previous month, with a difference of **0.7**.

Variation Assurance

Midwifery vacancy rate



Latest Month

2024-03

Value

-6.1%

Target

0%

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

The latest months value has **improved** from the previous month, with a difference of **0.3**.

There are 77 HCSWs currently undertaking pre-employment checks. In addition, 46 individuals were offered HCSW posts having attended an interview session at the Community Stadium on the 3rd April. 40 new starters are booked onto the HCSW Academy in April, with 10 already booked into May's Academy. These appointments will be reflected in the HCSW vacancy position in the coming months once they have started in post.

Since September 2023, 174 new HCSWs have started in post. The Trust has made offers to 301 HCSW candidates, 147 of these have been in the last 2 months.

The Trust welcomed 23 3rd year midwifery students to the Maternity Open Day held on Saturday 16th March at York Hospital. An advert will be released mid-April for students to apply to join the organisation.

As part of the ongoing monitoring of Nursing Associates it was agreed to include the number of Nursing Associates employed by the Trust in the TPR. There has been a slight change between February and March with the number increasing from 54 to 55 and the WTE increasing to 51.53.

KPIs - Workforce (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Total nursing (registered and nursing support) temporary staffing requests (total hours requested)

Variation Assurance

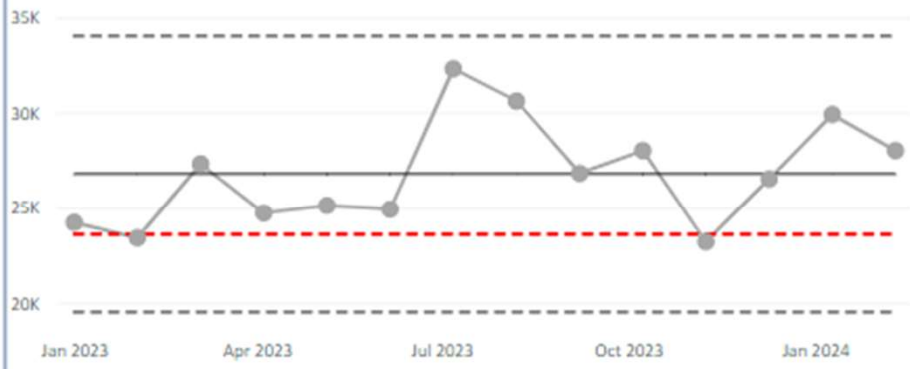
Latest Month
2024-03
Value
114000
Target
80388.1

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

The latest months value has **deteriorated** from the previous month, with a difference of **4200.0**.

Total medical and dental temporary staffing requests (total hours requested)

Variation Assurance



Latest Month
2024-02
Value
28000
Target
23592.2

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

The latest months value has **improved** from the previous month, with a difference of **1900.0**.

The Allocation On Arrival (AOA) incentive ended on 7th April. The volume of use has been closely monitored, with an average of 89 RN/RM shifts per week and 87 HCSW shifts per week covered in March. This is an increase from the previous month, after approval was given for additional AOA shifts to be added on to support York ED. This requirement has since been approved as a separate incentive.

March saw a significant reduction in agency use for nursing due to the measures introduced in February to reduce temporary staffing costs. This included the introduction of additional scrutiny of agency requests and an aim to no longer release agency shifts for Saturday nights and Sundays which are charged at the highest rates. Bank and agency day shifts were reduced from the standard shift length of 7.5 hours to 6 hours. A review is being undertaken to consider a permanent reduction in shift times. The Trust has also successfully negotiated with a number of agency suppliers to reduce rates, enabling better value for money on future bookings.

The organisation has just one non-clinical agency booking in place at the start of April. This is for a domestic role, with the individual due to move onto a bank contract on 11th April.

The Trust has successfully removed off framework agency and is now focusing on high-cost long term agency bookings. Progress to date includes the contract for the organisations highest paid medical locum coming to an end on 19th April. Three medical locums have agreed to move to direct engagement (DE) contracts which is at a lower rate for the Trust, and another doctor has requested to join the Trust bank. The organisation has also ended a long-term medical bank locum in Family Health due to successful substantive recruitment.

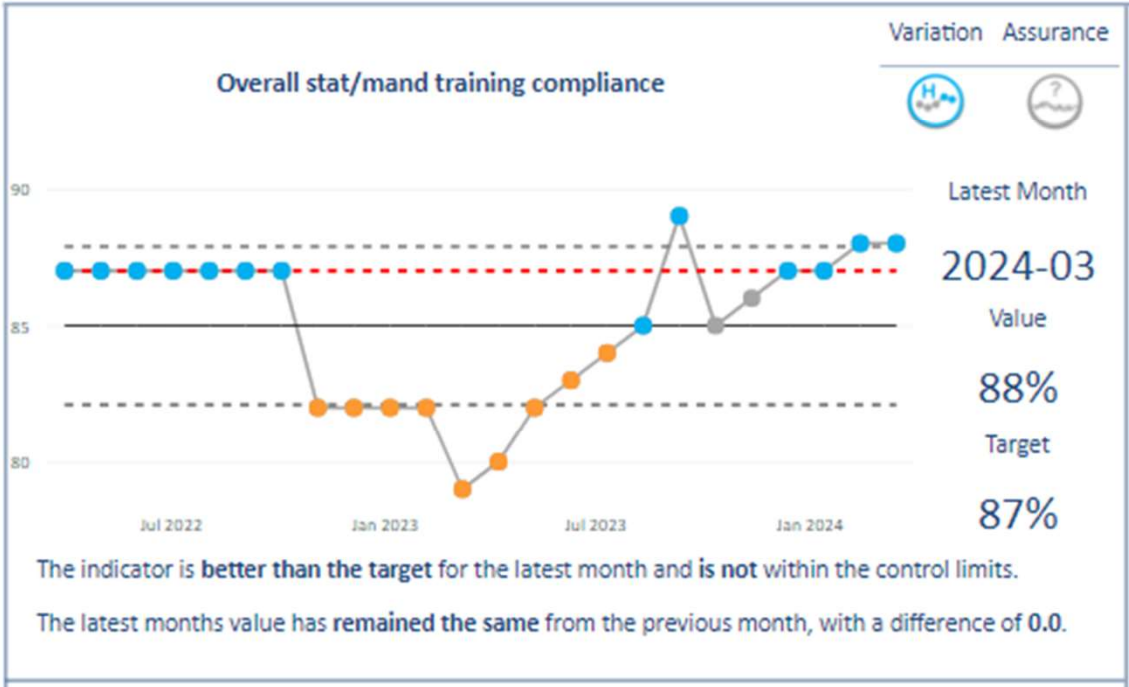
The eRostering Improvement programme is a key piece of work to support a reduction in temporary staffing across all staffing groups. An eRostering efficiency group is being established for nursing to monitor KPIs and ensure temporary staffing use is being managed effectively across the organisation.

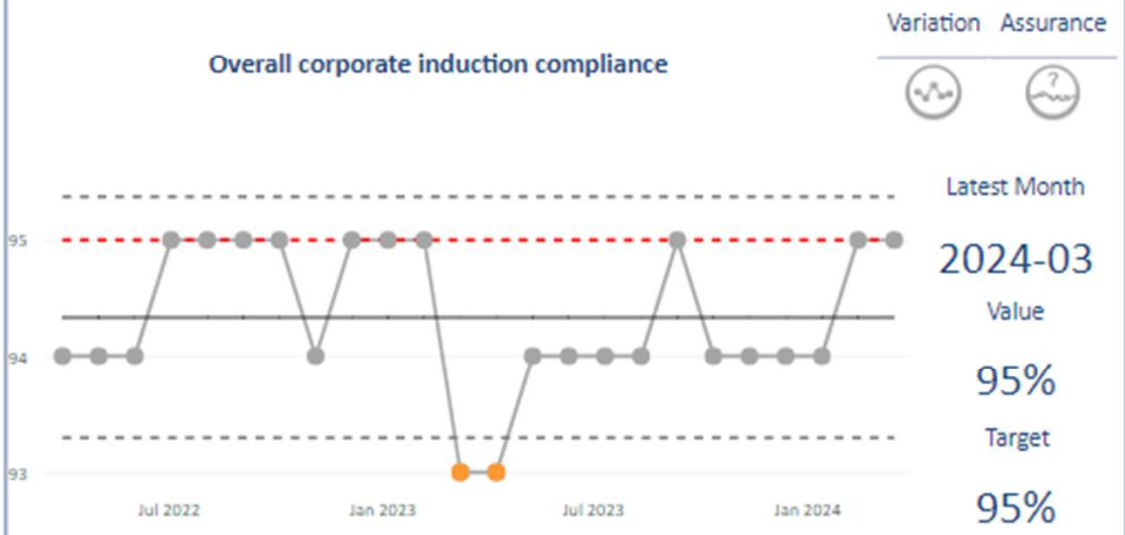
Workforce (2) Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Overall stat/mand training compliance	2024-03	H	?	87%	88%
Overall corporate induction compliance	2024-03		?	95%	95%
A4C staff stat/mand training compliance	2024-03	H	?	87%	89%
A4C staff corporate induction compliance	2024-03		?	95%	95%
Medical & dental staff stat/mand training compliance	2024-03	H	F	87%	76%
Medical & dental staff corporate induction compliance	2024-03	H	F	95%	94%
Appraisal Activity	2023-12	H	F	90%	92.3%
Staff engagement staff survey score	2023			6.9	6.4
Staff morale staff survey score	2023			5.9	5.5

KPIs - Workforce (6)





In March, compliance for corporate induction and mandatory training has maintained at 95% and 88% respectively. At Staff Group level, improvement in mandatory training compliance for Medical and Dental (76%) and Estates and Ancillary (81%) staff continues to be a focus. Actions include ensuring sufficient time is built into rotas to accommodate training requirements and working to make e-learning more accessible to staff who don't use the Trust's IT Network directly.

At subject level, 13/25 programmes continue to achieve the 87% compliance target. Of the 12 subjects which are not at this level, five have increased completion rates since February, while one has deteriorated. Compliance amongst the 12 subjects ranges from 55% (Paediatric Advanced Life Support) to 85% (Information Governance, Deprivation of Liberty Safeguards). Both Adult Life Support (77%) and Mental Capacity Act higher level training (76%) which form part of the Trust's CQC Improvement Action Plan remain below target.

The Care Group Development programme (Leading our Journey to Excellence) continues with the commencement of Phase 2. 52 of the 61 delegates attended the 'Know your business' session on 29th February. Feedback on the session was positive. Phase 2 will conclude at the end of April following two further sessions. Meanwhile delegates from Phase 1 will be brought back together as one team with an opportunity to reconnect for ½ day on 2nd May 2024 using a creative thinking approach to future planning.

Phase 3 which commences from 30th May 2024 will bring together Senior Ops Managers, Matrons, Lead AHPs and Clinical Leads.

Corporate Services and YTHFM will subsequently benefit from similar development with dates currently being identified.

Meanwhile progress is being made with the recruitment of a line manager trainer with interviews being conducted on 24th April. Three candidates have been invited to interview.

DIGITAL AND INFORMATION SERVICES

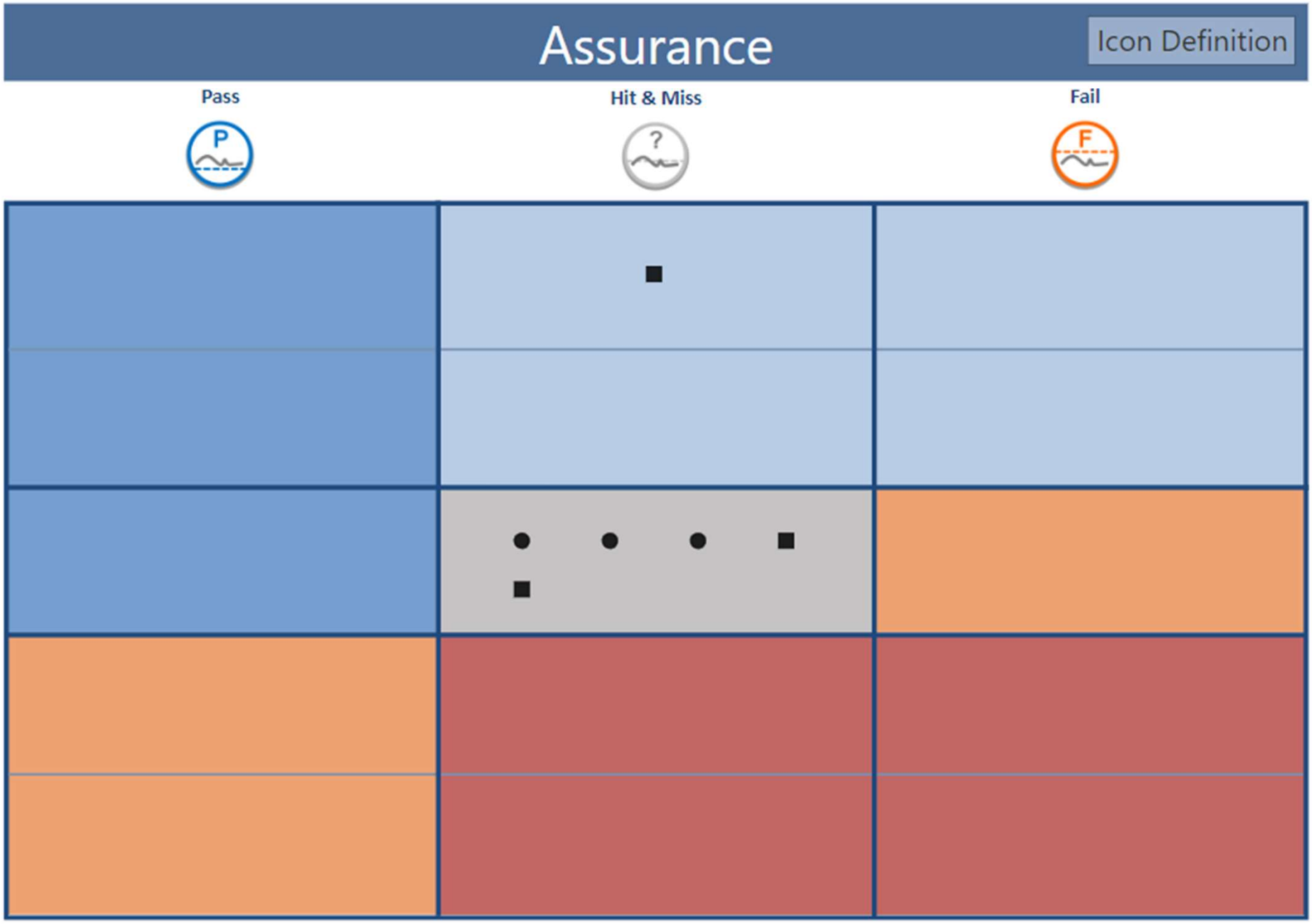
April 2024

Summary Matrix - Digital and Information Services

The table below provides an overview for all digital and information services metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

High Improvement
Improvement
Neutral
Concern
High Concern

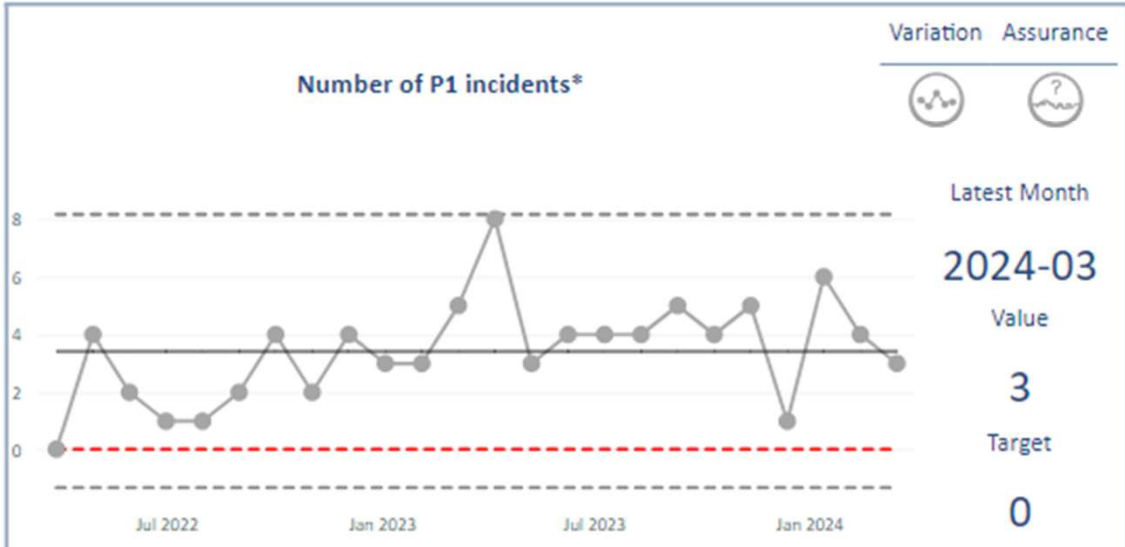


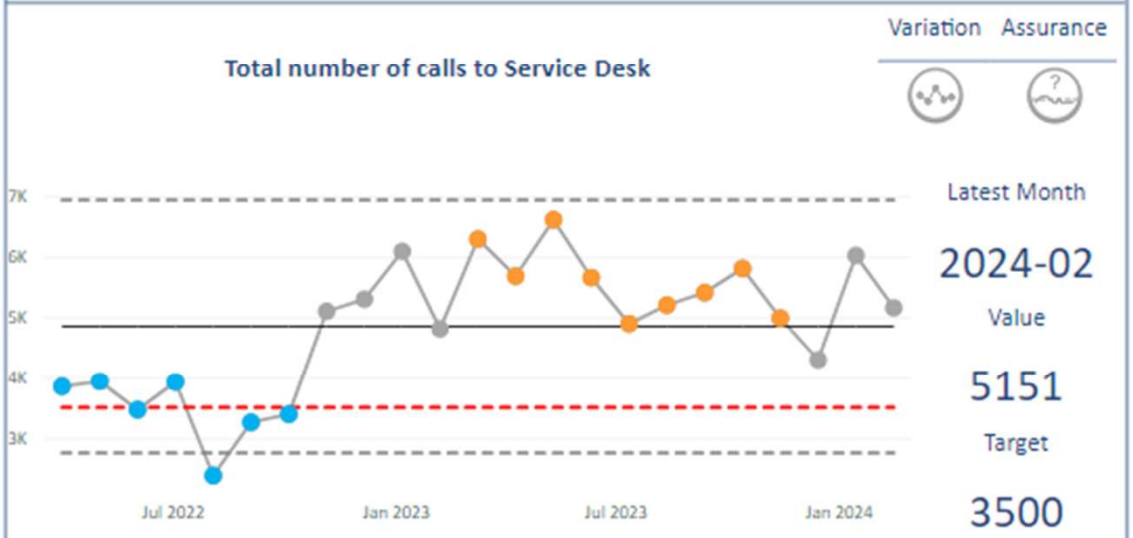
Digital and Information Services Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline	Value
Number of P1 incidents*	2024-03			0	3
Total number of calls to Service Desk	2024-02			3500	5151
Total number of calls abandoned	2024-02			500	1316
Number of information security incidents reported and investigated	2024-03			43	44
Number of Patient Subject Access Requests (SARs)	2024-03			401	408
Percentage of Patient Subject Access Requests (SARs) processed within one calendar month	2024-03	H		100%	100%
Number of Freedom Of Information requests (FOIs) received (quarterly)	2024-03				284
Percentage of Freedom Of Information requests (FOIs) responded to within 20 working days (quarterly)	2024-03			100%	90%

KPIs - Digital and Information Services (1)





P1 incidents

A P1 incident is classed as a loss or degradation of service being experienced by a group of users which is having a significant impact on the operating efficiency of the Trust and/or its employees and no immediate workaround exists.

17/3 Vcenter virtual server system problems affecting backups and snapshots of systems. No disruption to systems or availability, but a period of 2 days when backups had not completed over a weekend until this was resolved.

19/3 Remote Access Always On VPN service disruption affected new connections for a period of 3 hours. Existing connections prior to 0900 were unaffected

19/3 Telephone call queue systems unavailable for several services (IT Service Desk, Patient Access, Community Single Point of Access, Audiology, Sexual Health.) Workarounds implemented with a “hunt group”, services restored on new servers for high impact/volume queues by 2/4 and fully resolved by 4/4/24 when Audiology was successfully transferred to new server.

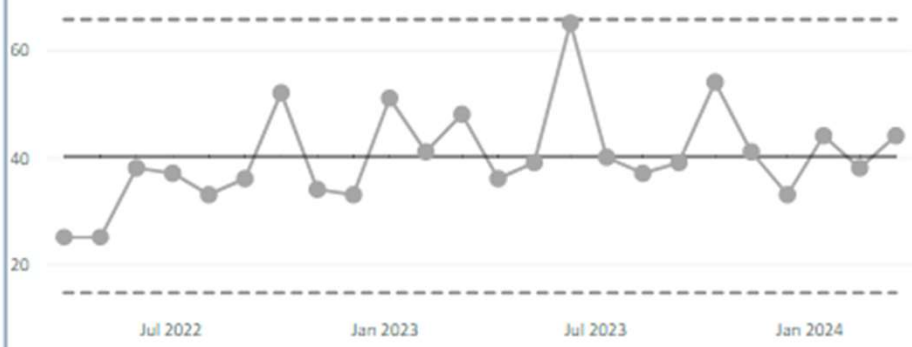
Total number of calls to Service Desk

Telephone call statistics are not available for the March period due to the call queue system fault from 19/3

KPIs - Digital and Information Services (2)

Variation Assurance

Number of information security incidents reported and investigated



Latest Month

2024-03

Value

44

Baseline

43

The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **6.0**.

Variation Assurance

Number of Patient Subject Access Requests (SARs)

Latest Month

2024-03

Value

408

Baseline

401

The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **107.0**.

Number of information security incidents reported and investigated

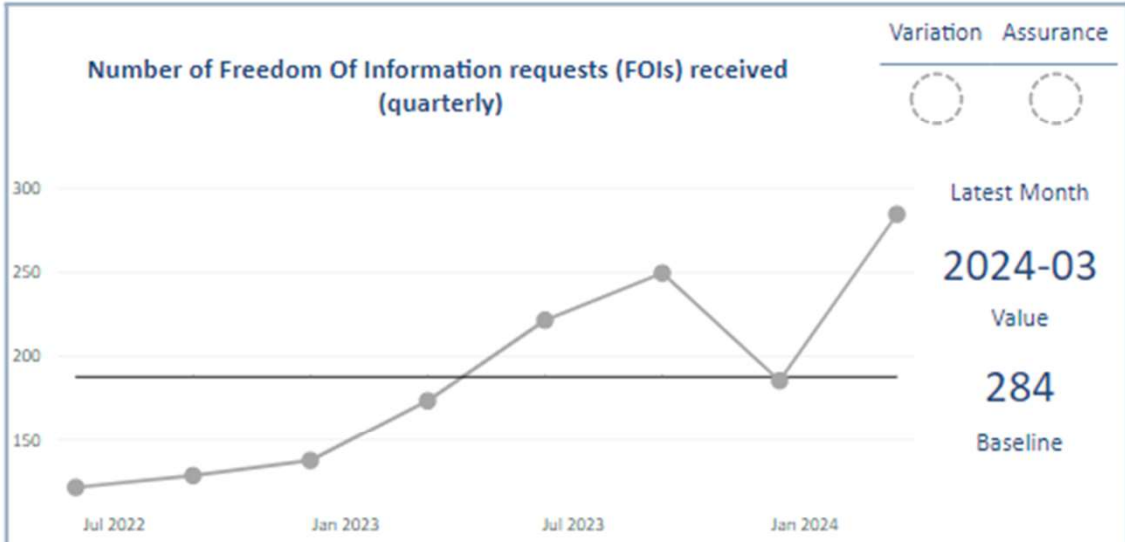
There was a peak of information security incidents in July, due to an audit undertaken which led to an increase of reporting of misfiled information.

The other recent increase in the Autumn was due to an increase in data disclosed in error which the majority of were related to the introduction of NHSMail and the adoption of the global address list. Targeted communication has helped reduce this trend.

Number of Patient Subject Access Requests

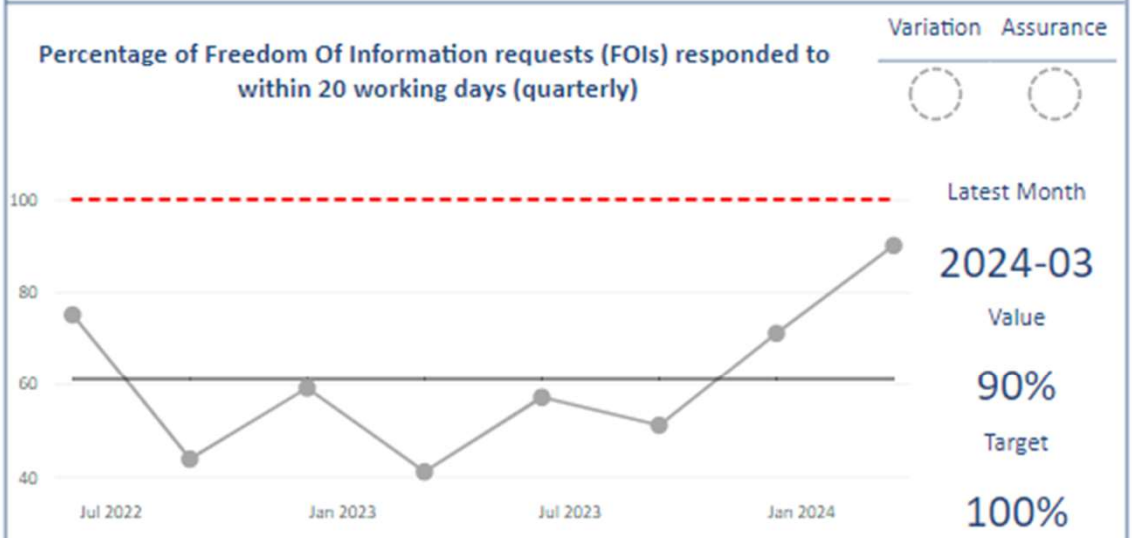
The recent reduction trend in SARs continued through the Autumn. The team reviewed the increase in SARs in the previous periods against the Trust's complaints data and found no correlation. The Team are seeing an increase in requests where patients need their notes as they have chosen to access private healthcare.

KPIs - Digital and Information Services (3)



The indicator is **above the baseline** for the latest month and **is not** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **284.0**.



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

The latest months value has **improved** from the previous month, with a difference of **90.0**.

Number of FOIs Received

The Information Governance team has experienced a significant increase in the volume of FOIs received. This was partly due to the way that FOIs were logged and reported.

This increase has been challenging given the limited resources available to manage the increase in FoIs alongside other IG priorities.

Percentage of FOIs responded to within 20 working days

We can see that comparatively to last year the team is responding to more requests in line with legislation even with the increase in those received, and the team are working to continue this improvement.

FINANCE

April 2024

Summary Dashboard and Income & Expenditure

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	£3.8m adverse	£0.0m	↑	Improving
Forecast Outturn I&E Variance to Plan	£0.0m	£0.0m		Static
Core CIP Delivery Variance to Plan	£5.5m Adverse	£0.0m	↑	Improving
Core CIP Planning (£21.4m Target) Value Identified	£17.8m identified	£21.5m identified	↑	Improving
ICB Cost Reduction Ask (£17.5m target) Value Identified	£10.4m Identified	£10.4m Identified		Static
Variance to NHSE Agency Cap (3.7% of pay)	£5.0m Above	£8.0m Above	↓	Deteriorating
Month End Cash Position	£27.3m	£47.5m	↑	Improving
Capital Programme Variance to Plan	£1.5m behind plan	£0.3m ahead of plan	↑	Improving

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	666,594	666,594	735,351	68,756
Other Income	59,917	59,917	74,370	14,453
Total Income	726,511	726,511	809,721	83,209
Pay Expenditure	-485,963	-485,963	-531,907	-45,944
Drugs	-58,005	-58,005	-72,893	-14,888
Supplies & Services	-72,530	-72,530	-82,020	-9,490
Other Expenditure	-98,989	-98,989	-129,794	-30,804
Outstanding CIP	-77	-77	0	77
Total Expenditure	-715,565	-715,565	-816,614	-101,050
Operating Surplus/(Deficit)	10,947	10,947	-6,894	-17,840
Other Finance Costs	-10,926	-10,926	-8,832	2,093
Surplus/(Deficit)	21	21	-15,726	-15,747
NHSE Normalisation Adj	-21	-21	15823.31	15844.31
Adjusted Surplus/(Deficit)	0	0	97	97

The I&E table confirms that the Trust has delivered its 2023/24 plan by delivering a small I&E surplus against a balanced I&E plan.

Following the receipt of additional funding from the ICB in February as reported last month, the Trust received an additional allocation from the ICB in March of £1.8m. This additional allocation, plus increased ERF income from extra elective activity during March, together with actions to contain spend in the latter months of the year have collectively enabled the Trust to deliver its I&E plan.

Corporate Overview of Key Drivers

York and Scarborough Teaching Hospitals NHS Foundation Trust

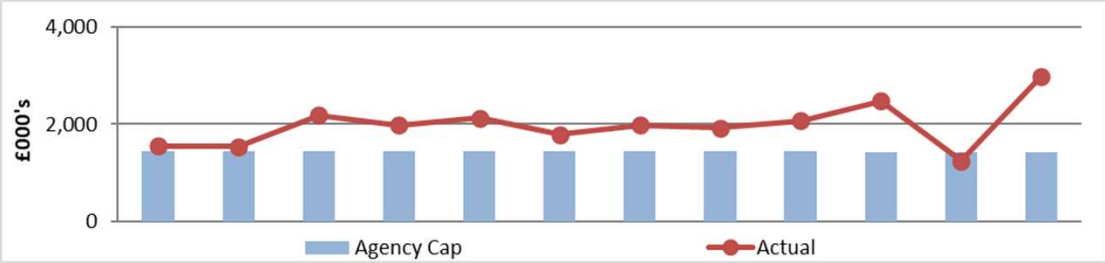
Variance	Favourable/ (adverse) £000	Commentary
Net Overall Strike Impact	4,587	Assessed reduced elective activity and income against plan due to cancellation of operations and outpatient appointments due to strike action, but for which the costs are in the system, is £3.68m. The assessed net increase 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 £4.02m. Total adverse impact is £7.7m. The total impact is offset by the decision of NHSE to reduce the national ERF target by 4% to acknowledge the cost of all strikes for the year to date has been assessed to increase ERF income to the Trust by £5.0m. In addition, specific additional allocations of £2.5m and £4.8m have been made to offset the impact of the strikes. Total strike support is £12.3m. This leaves a net favourable impact of £4.6m.
ERF Funding Position	6,672	Underlying elective activity has significantly increased in March. The assessed increased ERF payable to the Trust at M12 is £11.67m of which £5m is linked to the 4% reduction in the ERF target and offset against the strike costs incurred above.
CIP Surplus	77	Included within the reported position. See CIP section below.
Stretch Target Shortfall	-7,118	Included within the reported position.
Agency and Bank covering vacancies	-8,748	Relates to covering vacancies, with minimal levels relating to the cost of covering strike action included above. Operational pressures experienced over the winter period has resulted in increased bed capacity driving increased staff costs. The Chief Nurses and Operational teams are reviewing staff levels.
Covid test costs	-114	Formerly a pass-through cost to NHSE, but now transferred to the ICB with a fixed allocation.
Plan adjustment including further allocations	19,926	Following NHSEs allocation of £30m to the ICB to cover its planned deficit, the ICB and Providers plans are to be adjusted to breakeven I&E positions, a net pressure of £15.4m for the Trust. To compensate this and to assist deliver a breakeven position the Trust has received additional reserve and other allocations from the ICB of £25.5m in February and March; in addition to earlier year generic allocation of £4.5m, and £5m for Advice & Guidance, in full year terms.
Other I&E variances	-4,768	Various other miscellaneous variances
Drugs, devices, unbundled OP Radiology, and Pathology direct access	-10,417	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, £4.9m is an increase over the M12 22/23 outturn spend levels.

Treatment area	£	Drug or Device	Comments
Drugs			
Wet AMD	-1,844,159	Aflibercept, Ranibizumab, Faricimab	
Crohn's Disease or Ulcerative Colitis (IBD)	-1,424,337	Ustekinumab, Vedolizumab, Infliximab, Certolizumab Pegol	
Rheumatoid Arthritis	-452,699	Baricitinib, Abatacept, Tofacitinib	
Plaque Psoriasis, Psoriatic Arthritis, and Ankylosing Spondylitis	-995,774	Risankizumab, SECUKINUMAB	
Auto Immune, Rhumatoid Arthritis	223,624	Etanercept, adulimumab	
Other	-1,944,230		Following further analysis, the key driver for these increases in costs have been established as volume driven, with minimal price impact.
	-6,437,575		
Devices			
Sleep Apnoea	-445,399	CPAP machines	
Diabetic Pumps	-1,702,379	Insulin Pumps and Consumables, Continuous Glucose Monitoring Systems, Insulin I-Ports	
Other	-2,287		
	-2,150,065		
Unbundled Radiology	-1,013,078		
Pathology Direct Access	-816,000		
	-10,416,718		

Key Subjective Variances

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	6,031	Primarily increased usage of high-cost drugs and devices for which income is earned on a pass-through basis and matched by increased expenditure.	No mitigation or action required.
ICB Income	43,457	Predominantly linked to (a) ERF being ahead of plan boosted by NHSEs 4% reduction in the ERF baseline to compensate for the impact of strikes over the year; (b) the additional allocations received by HNY ICB from NHSE and passed onto the Trust to further compensate for strike action and other pressures, and (c) the additional allocations received in February and March from the ICB linked to release of reserves and additional income received from NHSE.	No mitigation or action required.
Other income	10,383	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	-26,876	Agency, bank and WLI spending is ahead of plan to cover vacancies and in part to provide 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 additional funding received from HNY ICB referred to above, plus vacancies, and by planned investments in nursing and response to the CQC progressing behind plan.	To control agency spending within the cap into 2024/25. 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.
Drug expenses	-14,888	Relates to high-cost drugs and devices, 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 continue discussions with HNY ICB regarding a change in contract methodology for 2024/25.
Clinical Supplies & Services	-9,490	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 continue discussions with HNY ICB regarding a change in contract methodology for 2024/25.
CIP	77	CIP finished the slightly ahead of plan.	Continued focus on delivery of the CIP into 2024/25.
Other Costs	-29,971	Primarily driven by the non-pay related unachieved stretch target, and the Ramsey contracted activity being ahead of plan. Also included is a £15.1m impairment, which is a technical adjustment and discounted by NHSE for the purposes of assessing the Trust's financial performance.	

Agency, Workforce, Elective Recovery Fund



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 March expenditure on agency staffing was £8.0m ahead of the cap.

	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,462.23	2,382.31	79.92	128,707	133,533	-4,827
Scientific, Therapeutic and Technical	1,230.25	1,195.35	34.9	63,952	63,493	459
Support To Clinical Staff	1,880.52	1,646.61	233.91	59,837	61,892	-2,055
Medical and Dental	1,032.73	971.7	61.03	127,381	147,682	-20,301
Non-Medical - Non-Clinical	3,056.99	2,859.53	197.46	102,762	104,321	-1,559
Reserves				1,337	0	1,337
Other				1,987	1,918	69
TOTAL	9,662.72	9,055.50	607.22	485,963	512,839	-26,876

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. The reserves primarily relate to agreed but 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.

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) v9 baseline inc strike 4% red	ERF Month 12 Phase (Av 100%)	Activity to Month 12 Actual	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	99.63%	£120,427,976	£120,427,976	£132,345,412	£11,917,436	109.5%
West Yorkshire	99.00%	£1,266,898	£1,266,898	£1,099,531	-£167,367	85.9%
Cumbria and North East	111.00%	£159,999	£159,999	£254,185	£94,186	176.3%
South Yorkshire	118.00%	£143,586	£143,586	£150,001	£6,415	123.3%
Other ICBs - LVA / NCA	-	£573,948	£573,948	£480,802	-£93,146	-
All ICBs	***99.76%***	***£122,572,408***	***£122,572,408***	***£134,329,931***	***£11,757,524***	**109.3%**
NHSE Specialist Commissioning	108.00%	£4,416,219	£4,416,219	£4,356,472	-£59,747	106.5%
Other NHSE	100.20%	£266,864	£266,864	£240,529	-£26,335	90.3%
					£0	
All Commissioners Total	**100.12%**	**£127,255,491**	**£127,255,491**	**£138,926,931**	**£11,671,441**	**109.3%**

Elective Recovery Fund

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 £11.7m surplus for the year.

This position includes the 4% total reduction for the year on the Trust's elective target as confirmed by NHSE to further acknowledge the impact the strikes have had on elective activity for the year to date.

ICB activity finished ahead of the revised 100% target value, whereas NHSE Specialist Commissioned activity finished slightly behind plan.

Cost Improvement Programme

York and Scarborough Teaching Hospitals NHS Foundation Trust

2023/24 Cost Improvement Programme - March									
	Full Year CIP Target	March Position			Planning Position		Planning Risk		
		Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Technical CIP									
ICB Stretch Target	17,533	17,533	10,415	7,119	10,415	7,119	10,415	0	0
Productivity	5,025	5,025	5,025	0	5,025	0	5,025	0	0
Surge/Ann Leave accrual	5,500	5,500	5,500	0	5,500	0	5,500	0	0
	28,059	**28,059**	**20,940**	**7,119**	**20,941**	**7,119**	**20,941**	**0**	**0**
Core CIP									
Medicine	7,164	7,164	3,054	4,110	3,054	4,110	3,054	0	0
Surgery	5,475	5,475	3,092	2,383	3,092	2,383	3,092	0	0
CSCS	3,995	3,995	4,487	-492	4,487	-492	4,487	0	0
Family Health	2,073	2,073	2,269	-196	2,269	-196	2,269	0	0
CEO	105	105	343	-238	343	-238	343	0	0
Chief Nurses Team	295	295	964	-669	964	-669	964	0	0
Finance	92	92	1,014	-922	1,014	-922	1,014	0	0
Medical Governance	83	83	421	-339	421	-339	421	0	0
Ops Management	303	303	40	264	40	264	40	0	0
Corporate CIP	0	0	3,311	-3,311	3,311	-3,311	3,311	0	0
DIS	260	260	270	-10	270	-10	270	0	0
Workforce & OD	145	145	746	-601	746	-601	746	0	0
YTHFM LLP	1,400	1,400	1,456	-55	1,456	-55	1,456	0	0
	21,389	**21,389**	**21,466**	**-77**	**21,466**	**-77**	**21,466**	**0**	**0**
Total Programme	**49,448**	**49,448**	**42,407**	**7,041**	**42,407**	**7,041**	**42,407**	**0**	**0**

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 Cost Improvements. 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.

Delivery of the core efficiency programme at month 12 is £21.5m against a plan of £21.4m giving an over delivery £0.1m. Recurrent delivery at month 12 is £5.9m (27.4%) of the Core programme target.

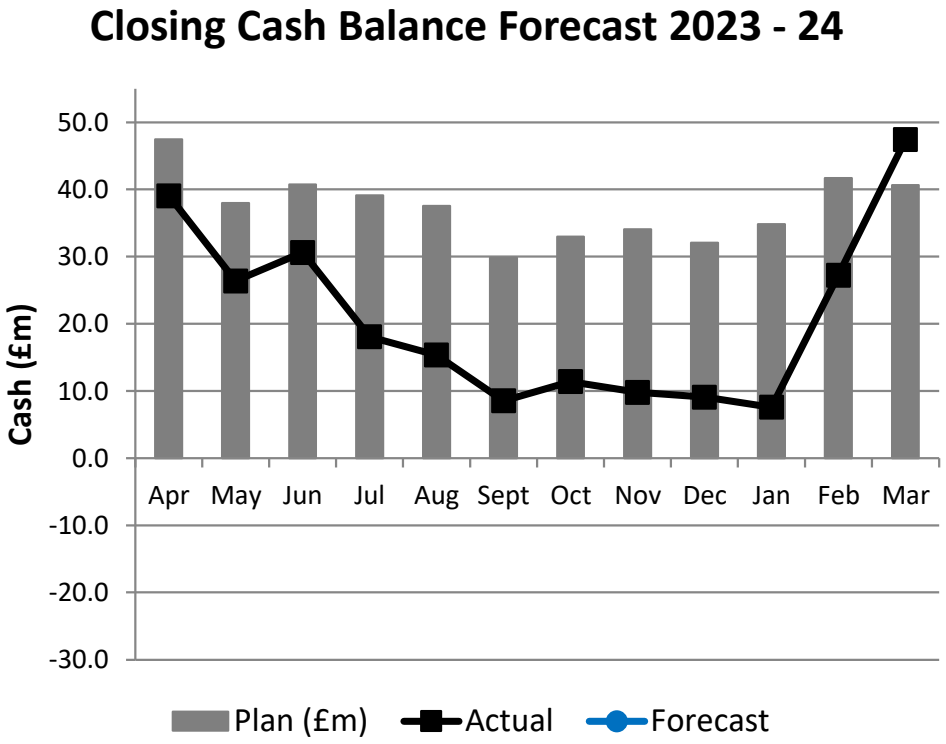
Current Cash Position

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. The cash balance for March was £6.8m favourable to plan.

Debtors and accrued income are above plan (£12m), which is offset by the positive impact of payables and accruals below plan (£7m) and accessing revenue support (£12m).

The table below summarises the planned and actual 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	9,813	9,099	7,629	27,256	47,475



An application to NHSE for cash support was made during September to access £15m of cash support during Q3. Of this £12.2m was drawn (£5m in November and £7.2m in December).

The cash forecast graph illustrates the cash position based on the actual cash balance at the end of March and reflects the significant income receipts from the ICB during March.

Capital PDC & capital loan allocations were drawn in line with national year end deadlines during March. This expenditure was incurred during March with cash timing of invoice payments expected to fall in April / May. As a result, the cash balance is artificially increased by approx. £18m.

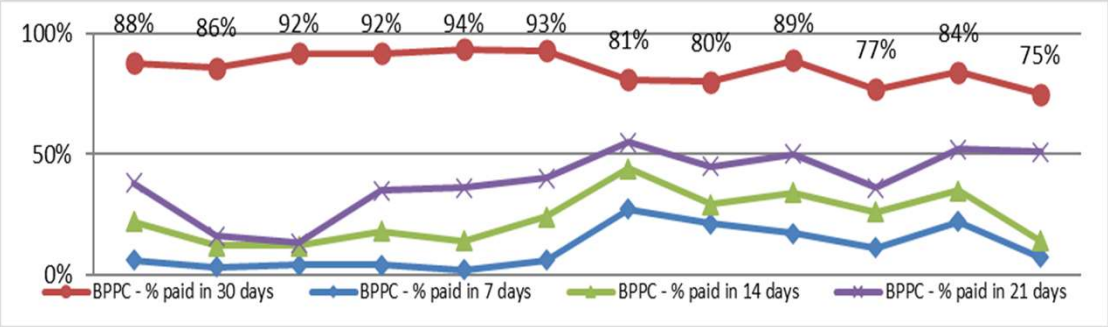
At this stage, we are not expecting a requirement for cash support in 24/25 Q1, however this will be closely monitored alongside development of the 24/25 financial plan.

Current Capital Position and Better Payment Practice Code (BPPC)

Capital Plan 2023-24 £000s	Capital FOT 2023-24 £000s	Mth 12 Planned Spend £000s	Mth 12 Actual Spend £000s	Variance to Plan £000s	Variance to FOT £000s
45,852	58,707	45,852	59,052	13,200	345

The capital programme outturn at the year-end was £58.7m; £13m above the original plan. This is due to additional PDC schemes added throughout the year, mainly the Community Diagnostic Schemes at Scarborough and Selby. The final year end position was £345k ahead of the revised funding position.

Expenditure relating to IFRS 16 leases is £37k above the outturn position due to recognition of leases completed by the year end. If we remove the impact of IFRS 16 the capital programme is £308k above the outturn position. This is mainly due to the vast number of projects that had to be delivered by the year end, alongside the final review of the capital year end position including capitalisation of staff delivering capital projects.



Better Payment Practice Code

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 received increased focus from NHSE, with Julian Kelly (NHSE Finance Director) championing its delivery.

The table illustrates that in March the Trust managed to pay 75% of its suppliers within 30 days. As the Trust did not apply for cash support in Q4, cash balances were managed accordingly.

Annex - Key

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key

Are we improving, declining or staying the same

Blue = significant improvement or low pressure

Can we reliably hit target

Grey = no significant change

Orange = change required to hit target

Variation				Assurance		
No Change	Concerning		Improving	Random	Passing	Failing
Common cause - no significant change	Special cause of concerning nature or higher pressure due to higher values	Special cause of concerning nature or higher pressure due to lower values	Special cause of improving nature or higher pressure due to higher values	Special cause of improving nature or higher pressure due to lower values	Variation indicates inconsistently hitting passing and failing short of the target	Variation indicates consistently passing the target	Variation indicates consistently failing the target

Orange = significant concern or high pressure

Grey = Hit and miss target

Blue = will reliably hit target

SPC Key

The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3 are near the upper or lower control limit. The target can be either static or moving.

Annex - Icon Descriptions

			
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 April 2024
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 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:

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 22 March 2024.

Implementation of the Urgent and Emergency Care Screening Tool is due to commence from 22 April 2024. The screening tool includes the mental health risk assessment. Once embedded, the trust will be looking to evidence that the current conditions on the registration are complied with.

There are 17 open enquiries with the CQC.

Recommendations:
The Board of Directors is asked to:

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

Report History

Meeting	**Date**	**Outcome/Recommendation**
Patient Safety and Clinical Effectiveness Sub Committee	10 April 2024	Presented and accepted.
Quality Committee	16 April 2024	*Not presented at the time of submitting the paper.*

1. CQC Inspection Update

The Trust invited the CQC to visit the York Emergency Department and this was scheduled for 26 March 2024. The visit was cancelled by the CQC due to absence of a key member of the team.

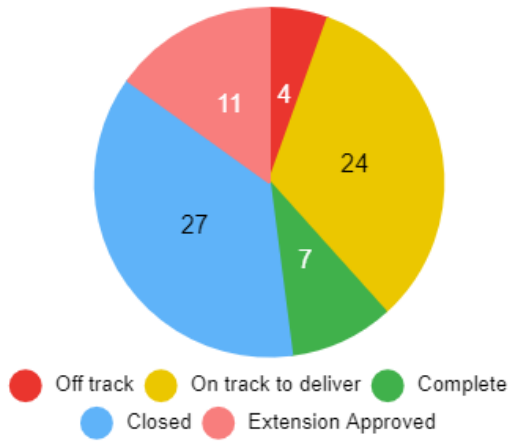
The Board of Directors has agreed seven improvement workstreams providing a framework for the Trust's 12-month quality recovery programme; Journey to Excellence. Each of the workstreams will include actions to deliver each of the CQC Must and Should actions.

The workstreams are as follows:

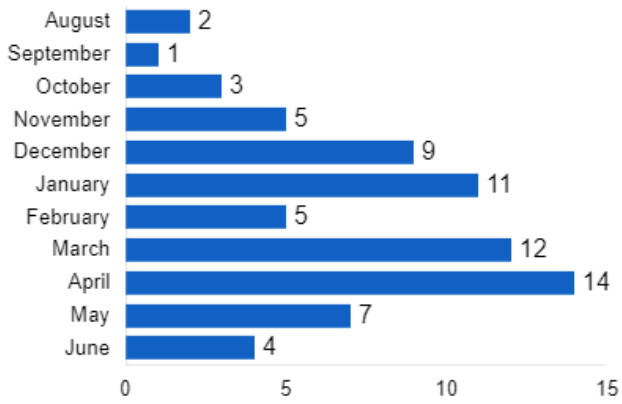
- Maternity Services
- Governance; Corporate / Quality
- Urgent Care
- Elective Care
- Leadership and Culture
- Safe Staffing
- Fundamentals of Care

Progress with the CQC Improvement Plan, as of 28 March 2024, can be seen in the charts below:

Overall Progress with CQC Actions



Action Due Dates for Completion 2023/24



2. Achievements

Since the last report was written, a further two actions have been approved for closure at the Journey to Excellence meetings (see below). A total of 27 actions have now been closed.

Ref	Must / Should	Action
31	Should	The trust should ensure that monitoring and action plans are in place should water checks and legionella checks fail.
58	Should	The trust should ensure they achieve joint advisory group (JAG) on gastrointestinal endoscopy accreditation.

Seven actions are considered complete with the closure form being drafted or awaiting approval at the next Journey to Excellence meeting.

The Trust response to the CQC actions has resulted the following improvements:

- ✓ Positive feedback was given as part of the recent JAG accreditation visit and the Trust is progressing with the required actions to gain accreditation.
- ✓ The Trust has commissioned an external review of Water Safety, completed by Capita, and is addressing the recommendations raised within the report.

3. Actions Off Track and Extensions

Four actions are considered off track meaning the original target date for delivery has not been met. These are detailed in **Appendix A**.

There are 11 actions which have had extensions approved by the Executive Leads and through the Journey to Excellence meetings.

4. 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 22 March 2024.

5. Mental Health Risk Assessment Section 31

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

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

The Urgent and Emergency Care assessment, Mental Health triage, mental health care plan and Emergency Department comfort checks have been live in Scarborough ED since 6 February 2024. Since that date, improvements have been made to the assessment tool following feedback from the Scarborough team. Two significant ones to mention, a dashboard where staff can see at a glance any overdue assessments or tasks over the whole department and a filter so that the ED patient list can be shortened according to the area where staff are working (majors, resus, etc).

Planned date for York ED to go live is 22 April 2024. This date has been requested by the senior nursing team. Challenges remain with the requirement to comply with the assessment timescales i.e. delivering within 1 hour of a patient being streamed.

Training material has been supplied and an offer of enhanced training has been made for any staff who are interested and would be able to support other staff.

The Trust is looking to evidence that it now meets the conditions of registration placed on the Trust in January 2020 once the screening assessment is embedded at both the York and Scarborough hospital sites.

6. 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.

There has been a significant increase in the number of cases received during February 2024. This could be partly attributed to the introduction of the single assessment framework and a more centralised approach adopted by the CQC to assessing and distributing concerns from January 2024.

There have been 11 CQC cases received since the last report was written (6 March 2024).

- **Four** cases were raised from safeguarding concerns reported to the local authority. Investigations were already underway for four at the time of receiving the information from the CQC as the notification had been received from the local authority. The investigation reports will be shared with the CQC once complete.
- **Three** were linked to patient complaints.
- **Four** were linked to concerns raised by staff to the CQC.

At the time of writing, the Trust had 17 open cases / enquiries. The enquiry dashboard can be viewed in **Appendix B**.

7. CQC Updates

Update from Ian Trenholm, Chief Executive
The CQC's Chief Executive, Ian Trenholm, talks about the feedback the CQC have received about the roll out of the new regulatory approach and what is being done with the feedback.

Ian shares an update on the number of quality statements the CQC look at in their assessments. Updating that when carrying out an assessment of a service that is either inadequate or requires improvement, all quality statements under the key question that are rated inadequate or requires improvement will be reviewed.

The blog can be read in full here.

8. Recommendations

The Board of Directors is asked to:

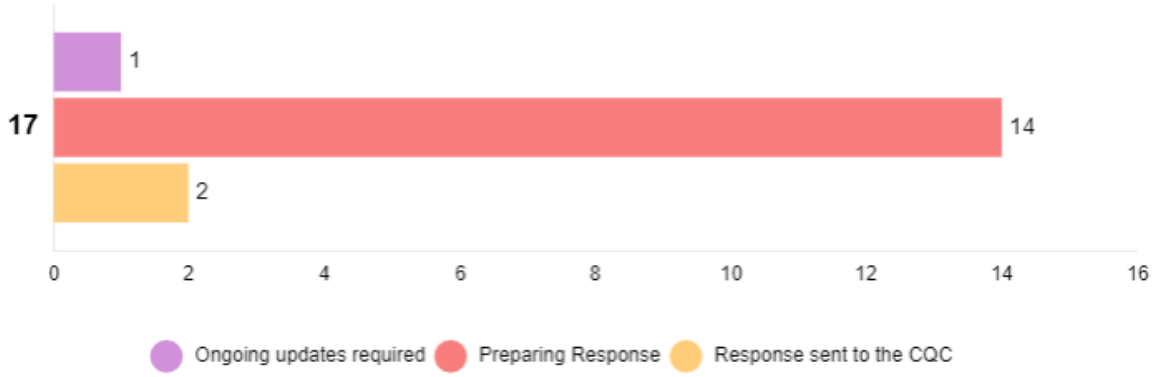
- Note the current position regarding the recent CQC inspection activity.
- Note the current position of the open CQC enquires.

Appendix A
CQC Actions 'Off Track'

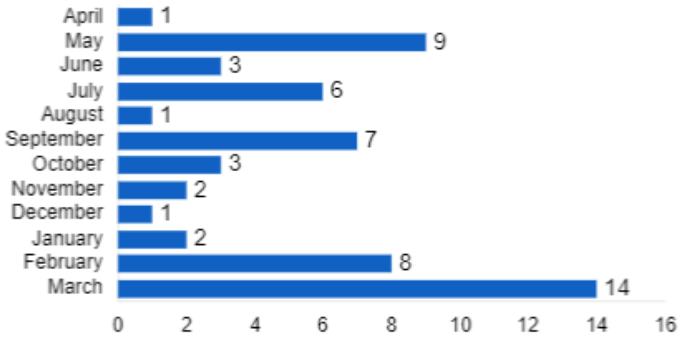
Ref	Action	BRAG rating	Target Date to Complete	Current Position	Workstream Lead
33	The trust should ensure that resuscitation trollies in Maternity and Urgent and Emergency Care are checked in line with trust policy and records are available to evidence completion.	Off track	29/02/24	Assurance on the resus trolley checks in Urgent and Emergency Care have been provided. An update has been provided by Maternity and an extension request is scheduled to be presented at J2E 15 April 2024.	Dawn Parkes
53	The trust should ensure that cleaning records are completed for all clinical areas in Medical Care at York.	Off track	31/01/24	A closure form has been drafted however further assurance has been requested in regard to the completion of all cleaning records.	Dawn Parkes
64	The service must implement a robust governance process and risk management strategy. For example, they must ensure they instigate a process to effectively triage women in a safe environment. They must ensure they have effective risk management processes in place to manage and mitigate all risks.	Off track	31/01/24	A closure form has been drafted however further assurance and documentation has been requested in regard to the risk management process. The closure form is scheduled for J2E 15 April 2024.	Karen Stone
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	Off track	29/12/23	There have been delays in completing the closure documentation. Evidence has been provided by the IPC Team and the closure form is scheduled to be presented at J2E on 15 April 2024.	Karen Stone

Appendix B
CQC Cases / Enquiries (1 April 2023 to 28 March 2024)

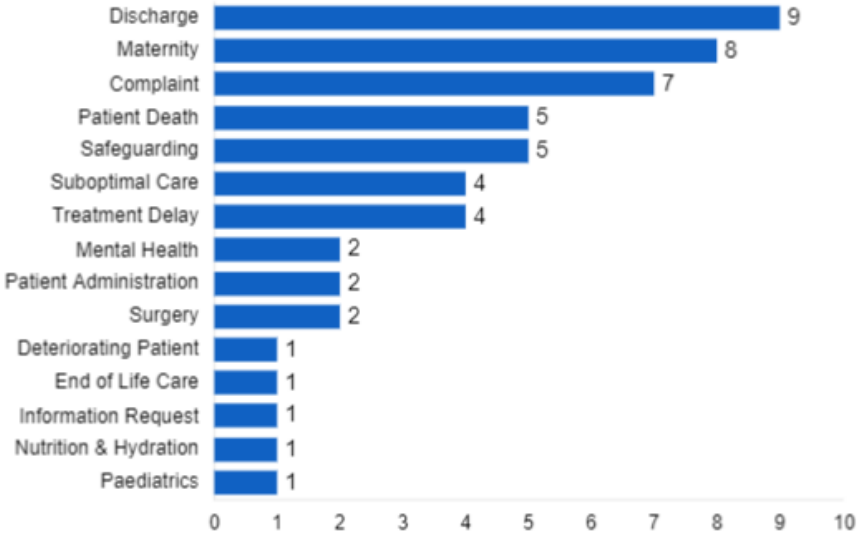
Number of Open CQC Enquiries / Cases



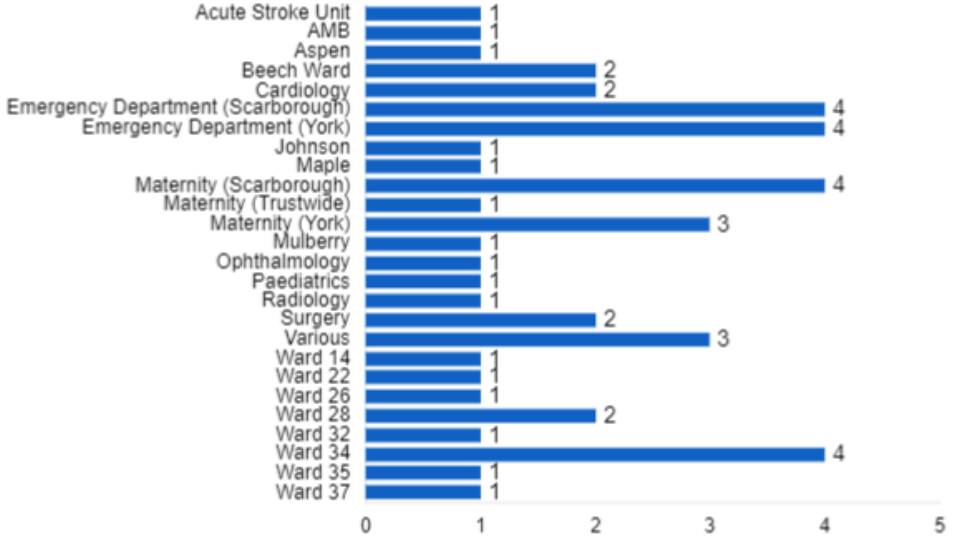
Number of Enquiries Received



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Report to:	Trust Board
Date of Meeting:	24th April 2024
Subject:	Maternity Neonatal Safety Report
Director Sponsor:	Dawn Parkes Interim Executive Chief Nurse (Maternity Safety Champion)
Author:	Sascha Wells-Munro, Director of Midiwfery

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 progress of improvements in the maternity and neonatal service as well as provide monthly key quality and safety metrics for the services for the month of February 2024.

Recommendation:
The Board is asked to receive the updates from the maternity and neonatal service for January and approve the CQC section 31 report before submission to the CQC.

Report History
The Quality and Safety Committee 20/02/2024

Meeting	Date	Outcome/Recommendation
Quality & Safety Assurance Committee	16/04/24	1/ To note the progress with the safety actions and improvement work in maternity and neonatal services. 2/ To formally receive and approve the CQC Section 31 monthly report.

Report to Trust Board

The maternity and neonatal services continue to demonstrate improvements in key quality and safety metrics. The maternity and neonatal service dashboard remains under development to support greater understanding of the services performance.

Annex 1 provides the current delivery position for the service against the core national safety metrics. In February 2024 there were no stillbirths or Neonatal deaths. Unexpected admissions to the Neonatal Unit have remained the same as last month. Further work on improving this position further is articulated in the single improvement plan and links through to the work required for the delivery of transitional care across both sites and safety action 3(Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies) within the maternity incentive scheme.

There has been a further decrease in the % of postpartum haemorrhage over 1500mls to 3.9 % from the previous month (4.4%). This however remains above the national target of 2.9% per 1000 births. The QI project continues to identify and take positive action.

There are no other escalations to Trust Board in relation to these metrics.

Annex 2 provides the January 2024 monthly update to CQC on the service progress against the Section 31 concerns and key improvement workstreams in place in the maternity and neonatal improvement programme.

Annex 3 is the Local Maternity and Neonatal System Assurance visit report. The visit took place on the 9th February 2024 and was conducted at the Scarborough site. The report recognises the improvements underway and areas of good practice. It also identifies areas for further improvement that are already or have been added to the maternity and neonatal single improvement plan since receipt of the report.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

The maternity and neonatal single maternity improvement plan will be shared in its final form at the engagement event on the 23rd of April. All staff attending the event will be encouraged to sign up to one of the workstreams and support delivery of the milestone and high-level actions. The day will give all participants the opportunity to go to all four workstream stations and understand the work required before they make the commitment.

Workstream 1: Listening to service users and families with compassion.

As a result of feedback form services users, the development of discharge videos for women has now commenced. These are being developed in collaboration with women and families through the MNVP to ensure all service users receive the same important information prior to discharge in the community. These will also be translated in to the top 10 languages used in our communities but will also be able to be adapted to meet specific individual needs outside of those 10.

The work around the process for Induction of Labour continues which is led by AQUA on behalf of the ICB/LMNS with service user involvement. In addition, the hot topic sessions have started to focus on what pain relief is available for women in labour and their choices as a result of feedback from the Picker survey from February 2023 and on-going feedback from the MNVP.

A task and finish group with the LMNS on Birth Afterthoughts/Reflections commences in March with the aim of reviewing the current service provision, scoping ideas for collaborating and developing a standardised pathway which includes early triage and a self-referral form. This service is not specifically funded and is absorbed by all maternity services and as such the LMNS are looking how to address this as part of the group.

Workstream 2: Growing and Retaining our Workforce.

The culture score survey closes on the 24th of April, which will enable staff to complete the survey when they attend the engagement day, using IPads. At the time of this report the return rate was 31% and the breakdown can be seen in image 1 below. Those areas showing lower return rates are being supported by champions and the IPads to complete and refreshment trollies are being used in areas to support the conversation.

Work Setting	Responses	Total Eligible Respondents	Response Rate
SGH-Community	12	34	35%
SGH-Delivery Suite	23	45	51%
SGH-Hawthorn Ward	5	31	16%
SGH-Maternity Theatres	3	13	23%
SGH-Operational/Admin	1	8	13%
SGH-SCBU	7	44	16%
SGH-Specialist/Sr MWs	4	20	20%
SGH-Womens Unit/ANC	5	35	14%
YK-ANC/Triage	19	103	18%
YK-Community	30	61	49%
YK-Del Suite/Labour Wd	25	109	23%
YK-G2	17	61	28%
YK-Maternity Theatres	10	22	45%
YK-NNU	17	82	21%
YK-Operational/Admin	11	18	61%
YK-Specialist/Sr MWs	20	30	67%
All York and Scarborough Teaching Hospitals NHS FT Survey Work Settings	221	716	31%

The Recruitment and Retention lead midwives are working with the workforce lead to develop a workforce strategy, looking at the demographics of our staff to be able to determine attrition and potential leaver rate. This will assist the overall workforce strategy to be able to identify the number of new recruits required to ensure minimum safe staffing level are maintained against demand and acuity.

The adverts for newly qualified midwives and the Deputy Director of Midwifery will be in the recruitment process at the time of this report.

Workstream 3: Developing and sustaining a culture of safety, learning and support.

The finalisation and testing of the new Quality and Safety Governance Framework continues, although there will be a pause in implementation due to challenges extending the contract of the independent consultant undertaking and leading this work. There is no capacity in the existing team to absorb this work currently.

Workstream 4: Standards and structures that support and underpin safer and more personalised and equitable care.

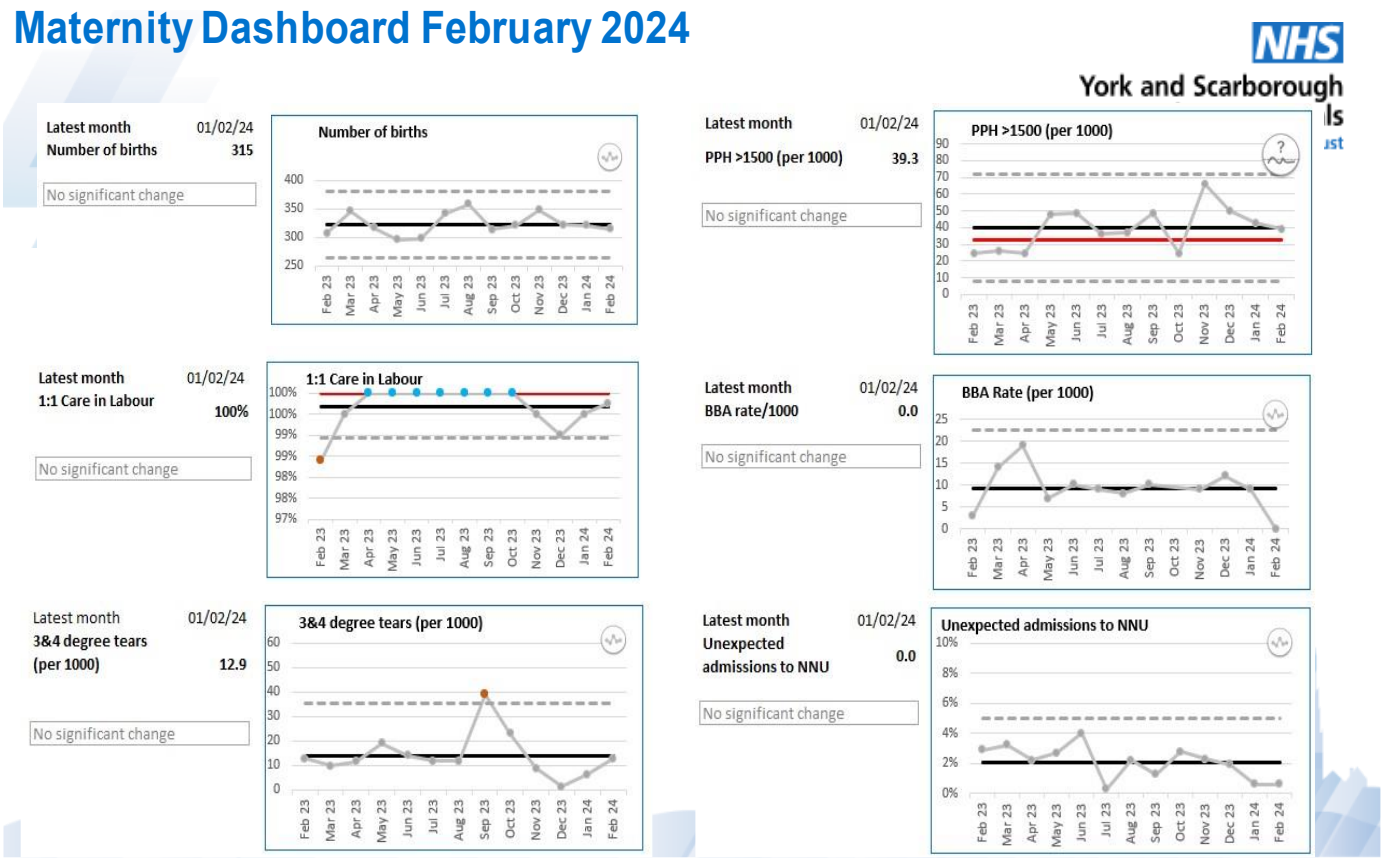
The additional funding asks for maternity services to continue of the journey of sustained improvement have been shared with the LMNS and ICB. Outcome of this is awaited. By receiving the additional funding, the service will be able to meet the national standards and recommendations for minimum safe staffing, Quality, safety and governance requirements and also the caesarean section and scanning provision required to support safe care and reduce delays in care for service users.

The refurbishment work for the York delivery suite theatres continues and completion has been delayed by a further week. The female changing rooms on delivery suite has now concluded. Work can now start of the condemned birthing pool room that needs significant repair and refurbishment.

National Maternity and Neonatal Service Estates Survey

The national survey was submitted by the required date of the 8th of April. This took a significance amount of work from colleagues across the organisation, but a comprehensive submission was made detailing all the areas of non-compliance and poor condition across the estate.

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery February 2024.



Humber and North Yorkshire
Health and Care Partnership

HNY Local Maternity & Neonatal System

YSTHFT Assurance Support Visit

Scarborough - 29th February 2024

Introduction

The Humber and North Yorkshire (HNY) Local Maternity and Neonatal System (LMNS) are running a series of Trust visits during the 23/24 financial year. These are as a successor to an original set of visits, designed to test adherence to the Ockenden recommendations (2020 and 2022) for safe and high quality care in our maternity and neonatal care units. The original visits were run by the regional North East and Yorkshire NHS England (NHSE) team in 2022 and output a report on progress against those recommendations and performance against a set of standard reporting metrics by Trust and LMNS. Since July 2022 the LMNS has been working to take on the portfolio of oversight and assurance from the regional team, including regular assessment of key workstreams such as the Saving Babies Lives Care Bundle, described below. Taking on these review visits is part of that assurance process.

The visit to Scarborough General Hospital, covering the scope of York & Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) in February 2024 was coordinated by the LMNS with the support of the NHSE regional team and other local and regional stakeholders. We would like to thank Trust colleagues present on the day for their warm welcome and for hosting the proceedings.

With the release of the East Kent: Reading the Signals report and the national 3-year strategic plan for maternity and neonatal care, the visit had a slightly different focus from the previous year but still aimed to investigate aspects of the quality of care throughout the hospital and wider Trust. Those present also sought to gain overall assurance that the maternity and neonatal units were well run and that organisational culture and knowledge was sound.

Other current LMNS priorities include the provision of data describing how Trusts are meeting the Saving Babies Lives Care Bundle v3 (SBLv3) standards and the overall performance against the Clinical Negligence Scheme for Trusts (CNST) Year 5 requirements. Both schemes have a robust and timely set of evidence review processes already underway and so it was agreed that there would not be an additional data requirement from Trusts for these visits.

This report summarises the aims and objectives of the visit, collates the pertinent points noted, acknowledges good practice where it was seen or described, and makes recommendations for improvement and further development.

Aims of the visit

The visit aimed to talk with executive, managerial, specialist leads and unit staff to understand their knowledge of and adherence to different aspects of maternity and neonatal care. We did this to ensure there was a clear line of sight for governance, escalation, and learning across the units.

An outline set of open questions was developed and coproduced with core LMNS team members, Maternity and Neonatal Voices Partnership (MNVP) colleagues and based on the original questions asked at Ockenden review meetings. The ambition was to have a more appreciative inquiry approach with additional questions around specific aspects of care or clinical areas to be asked on the day as relevant.

The outline question set is appended at the end of this report.

Stakeholders from the local and regional organisations involved in maternity and neonatal care were invited to participate; both to provide a more independent and objective overview of the work done and aspects of the team, but also to ensure they could understand where their projects best fitted with the needs of each Trust and where additional support might be offered.

Feedback was requested from all the members of the review group and is incorporated in this report and accompanying slide deck.

Structure

The day commenced with introductory presentations from the LMNS and the leadership team at YSTHFT. The LMNS overview outlined the ambition of the visit, described the intention to gather information and how this would be analysed, assessed, and fed back to the teams.

Please see the slides appended at the end of this report.

The YSTHFT team were represented by their interim Chief Nurse, Dawn Parkes and interim Director of Midwifery Sascha Wells-Munroe. Additional slides were presented by their Transformation Lead Midwife, Lucy Flatley; Deputy Head of Midwifery, Bev Waterhouse and Governance Lead, Sarah Gallagher. Jointly they welcomed the LMNS team and stakeholders, outlined key issues and priorities using data metrics and staff and service user feedback and then described their current improvement plans. Service users were represented by the local MNVP Engagement Lead, Ilayda Gill.

Slides for this section are appended at the end of this report.

Stakeholders then split into two different working groups and went on accompanied visits of all main maternity and neonatal areas in Scarborough General Hospital.

Clinical areas visited in the morning included:

- Antenatal Day Unit
- SCBU
- Labour Ward
- Antenatal and Postnatal Ward (Hawthorn Ward)

The site tours were led by Deputy Head of Midwifery, Bev Waterhouse and Transformation Lead Midwife, Lucy Flatley.

Specialist/other midwives Q&A in the afternoon included:

- Lorraine Dodd, PNMH Specialist Midwife
- Lynda Fairclough, Safeguarding Midwife
- Jolene Boyce, Antenatal Screening Co-ordinator
- Roseann Pease, Labour Ward Manager

Key Findings

Areas of good practice across YSTHFT – for wider sharing by the LMNS

- Senior team cohesiveness – focus on delivering co-produced Maternity and Neonatal Single Improvement Plan developed during November 2023 engagement day and themed in line with the national 3-year Delivery Plan.
- The 'Pebbles in Your Shoes' – quick win approach identifying and solving issues.
- Weekly 'Hot Topics' sessions linking service user feedback and CQC maternity survey themes to inform QI work.
- Cross site learning promoted through joint maternity incident reviews.
- PLF role supporting workforce efficiencies and effectiveness.
- Good visibility of posters/information and great to have 'Whose Shoes' and '15 steps' events planned soon.
- Long term agency staff were considered and felt well integrated.

Other positive observations noted by the visiting team across YSTHFT:

- All staff feel the positive difference now that Sascha is in post and providing leadership.
- Lorraine Boyd as Non-Executive Director and Safety Champion is seen to be very engaged and involved.
- Service user engagement is now felt to be strong.
- There is a good understanding of 'the ask' – what the structure needs to be to make the required changes for improvement.
- Relief that there is the space to make the changes needed.
- Pride in the recently implemented triage system.
- Staff on shop floor feel that they can raise concerns and voiced relief that there was now recognition of the unsafe staffing levels and that action was being taken.
- Good feedback from a Newly Qualified Midwife (NQM) re the local preceptorship programme – she felt heard. Time out day once a month across sites is beneficial. Sascha attends. This is finite though with only 18 months allocated to the project.
- The NQM also cited the friendliness of the unit and the ability to give one to one personalised care as the best aspects of working at Scarborough with challenges stemming from staff morale and perceived levels of staff sickness.
- Ward walk around: all ward areas noted to be clean, free from clutter and well organised.

Observations noted by the visiting team in different service areas at the Scarborough Site:

Antenatal Day Unit/Antenatal Clinic

- Separation of planned and unplanned activity to aid appropriate management; this can often be challenging for small units but is largely achieved in Scarborough.
- Triage looked to be working well, with two staff supporting activity and aiming for a 24/7 service. The area is however sometimes closed due to staffing capacity but there is cross site support offered where possible.
- The teams recognised the requirement for a Continuity of Carer team to be placed in local areas of deprivation – but acknowledged the staffing issues impacting this.

- There was a discussion with Victoria Clark (Community Team Leader) around parent education and after the visit information was shared with her from previous surveys carried out in the LMNS to support her local work.
- There was an antenatal Clinical Quality Improvement poster with MNVP contact details obviously displayed on the wall of the waiting area.
- The triage area had displays and patient information leaflets explaining the clinical prioritisation processes for service users.

Special Care Baby Unit (SCBU)

- It was a welcoming environment with good communal facilities for parents.
- Clear and up to date governance board seen.
- There is an excellent family area with plenty of service user information and QR codes linking to the Neonatal Operational Delivery Network (ODN) support via their website.
- We noted that there was only one parent room available at present as the bed in the other has been broken for some time. We suggest action to remedy this is undertaken immediately.
- A stakeholder asked a question around the timeliness of medication for mothers visiting babies on SCBU from the postnatal ward and their access to meals. The response was that mothers may have late or missed medications and mothers who had been discharged from the postnatal ward were not entitled to meals. This has been picked up as part of the 'Whose shoes' project and a nutrition and hydration group has been set up to address this.
  Suggested further action: Address access to medication for mothers visiting SCBU who are still inpatients – eg. can they be supported to self-administer medication? Can midwives visit them on SCBU during medication round?
- A member of staff stated that neonatal ward rounds were irregular and this meant sometimes parents weren't always present. It was felt that a structured ward round would enable inclusion of parents.
- No transitional care provision is available at present. Term babies on antibiotics need to be brought to SCBU for their administration. Term babies may be admitted to SCBU for observation such as respiratory distress syndrome etc. requiring separation from parents if they are unable to go with them. It was unclear as to whether data about those babies receiving transitional care are captured correctly for activity and funding calculations.
- The visiting team thought that the unit would benefit from formal transitional care arrangements, this would potentially improve their ATAIN performance (Avoiding Term Admissions into Neonatal Units).
- Monthly ATAIN meetings have been held for the last 12 months, but staff described a struggle to get consistent obstetric engagement.
- A good example was given by staff of how ATAIN audits had led to improvement work to reduce cases of hypoglycaemia.
- It was noted that babies requiring readmission from the community are admitted to SCBU rather than the paediatric ward due to bed capacity, including those outside of the early neonatal period. Potentially this raises infection risk and the practice should be reviewed.
- A staff member described that they were not aware of safety champions in the Trust.
- A staff member noted ongoing issues with maintaining clinical skills due to the small numbers of neonates passing through the unit.

Labour Ward

- The visiting team noted that the staff room door was open and staff personal belongings were on view. No lockers or secure storage for staff was apparent.
- The governance board here contained minimal information and that presented was not up to date. The governance lead was alerted to this while the team were present.
- A conversation with a newly qualified midwife had been held with some of the visiting team; she was very positive about her preceptorship programme and felt connected to colleagues in York. Monthly cross site meetings are held for them with the Director of Midwifery in attendance.
- Conversely a conversation was held with a senior midwife who had very different views; she felt communication with leaders could be difficult at times, with reference made to slow or absent responses to emails/phone calls. She described that no regular Band 7 meetings were held and felt disconnected from York.
- Staff said they did not feel confident to lead on active birth and water birth and would appreciate some support or training in this.
- Staff also mentioned the need to get consultant buy in to projects that they felt improved the quality and/or safety of the service; culturally this felt hard sometimes.
- One Labour Ward Co-ordinator advised that she had no awareness of the new national framework.
- A new mother spoken to reported that informed choice and consent discussions had taken place throughout her care.

Postnatal Ward

- A service user reported good support with bottle feeding and that timely pain relief had been offered.
- Within a relatively short visit the visiting team noted a calm, pleasant environment, with a good level of information for staff, and perceived good communication across the ward team.

Additional areas for consideration/improvement/information sharing across YSTHFT and the LMNS

We note that many of the actions described both in the positive aspects and in this area are part of the ongoing internal planning process; and appreciate that as we're still in Year 1 of the national 3-year plan delivery some of these actions need continued progress. We commit to continuing to observe, assess and support the YSTHFT team in their current strategy and in production of targeted deliverables.

- Obstetricians not visible to the visiting team – limited coming together/alignment with midwives. Some staff described a 'battle' to get buy in around new measures such a BSOTS. Improvement work appears to be midwifery led with staff expressing that they have to then go to the consultants 'to get them on board'.
- In SCBU, the use of cots for paediatric re-admissions from the community – will require further discussion.
- Disconnect between midwifery and obstetric leadership noted in several conversations; for example the change process was described as being very midwifery led with challenge/barriers to change from the obstetric team described.
  Suggested further action: more obstetric engagement in change management would be beneficial in order to embed the transformation required.

- Different perceptions of Band 7 midwives (clinical managers and specialist MWs) around culture/communication/feeling heard suggesting inequity of support. One cited "feeling like a nuisance" when asking for help.
- Some staff expressed continued uncertainty around the stability of the senior management team and how this affected their trust and confidence in achieving the aims of the single improvement plan.
- Reliance on communicating by email – this was not always felt to be effective as staff haven't time to access emails. Staff described that they value being able to speak directly to their managers. **Suggested further action:** protected time for regular one to one check-ins with line managers.
- Recognition that BadgerNet requires further investment to use optimally – Trust to note plans for the current LMNS MITS Steering Group to become a Co-ordinating Group in due course to allow for joint working on areas that require development.
- Translation and interpretation services need significant improvement (a YSTHFT identified issue); and there needs to be more consideration of measures to support women, birthing people and their families with learning disabilities. After the visit the LMNS shared information on the Together Project and the link to the Easy Read Guides to Pregnancy on the LMNS website: https://www.humberandnorthyorkshirematernity.org.uk/support1/easy-read-guide-to-pregnancy/
- Following a discussion re challenges of digital exclusion, YSTHFT to consider involvement in The Digital Maternity Leaders Community project for 2024: #FixingTheDigitalDivide in Maternity.
  Email: England.DigitalMaternityLeaders@nhs.net
- In the specialist midwife discussion session, succession planning for safeguarding role was described as requiring consideration.
- Staff also described that Datix (incident reporting system) could be better used to highlight themes and trends and support the evidencing of clinical project priorities.
- It was suggested that to support transitional care an outreach service could be created with potential invest to save opportunities.
- Staff suggested a 'red phone' could be made available for triage to enable urgent access for community staff/ambulance services

Areas for the LMNS/ICB and stakeholders to jointly pick up

- There could be more promotion of work done within the LMNS to support some of the Equity & Equality need highlighted at YSTHFT; the LMNS now have some comms & engagement support on a regular basis from the ICB so can review previous documents and guidance drawn up and re-publicise as appropriate.
- More regional mutual aid and robust escalation process; YSTHFT to continue to support the exploration and implementation of new ways of working with system partners.

Areas where further information is required for follow up (Summer 24)

Key themes for action are:

- All team members need to be well communicated with about service improvement and ongoing issues from the service leads and Trust senior teams on a regular basis so that they feel part of the improvement journey.
- The units need to continue to communicate issues and seek help from other LMNS partners and regional stakeholders about any aspects of their work; and equally share their learning and successes.

Outputs:

- Initial on the day feedback given. Please see in appended documents.
- This report – provides presentations, information and updates from the day and clear recommendations as to actions.

Next steps

We want to use the information gathered on this day to best effect; and build on these annual visits to provide assurance around the different aspects of maternity and neonatal care. Please encourage staff to read this report and highlight any things they agree with, any they don't or any other suggestions to improve these visits. Please comment yourselves on any aspects of the day and process.

Actions to progress, to work with the YSTHFT team to prioritise and support;

- Review period; to arrange a follow up meeting in the summer of 2024 and understand what progress has further been made.
- Collation of lessons learnt across the Trust during these visits.
- Celebration event: learning and sharing of good practice – all contributors to the visit days and stakeholders to be invited.

Questions to be addressed by the wider LMNS;

- Should we develop these visits to echo more of the requirements of the 3-year maternity and neonatal plan?
- Suggestions as to the future role of similar visits – is there a review cycle that we could fit in with better?
- Comments on the usefulness and format of the visit – would a peer review approach be useful to Trust leaders?

Many thanks again to all staff for their input and support during the visit and this process; we look forward to setting up a follow-up meeting and progressing the recommendations included.

Appended documents:

Question Set	 Combined prompts 2022 Updated 28022
YSTHFT Presentation – commencement	

	LMNS Assurance Visit YSTHFT Team P
LMNS Presentation – commencement	LMNS Review Visits YSTHFT Feb 24 - Intr
LMNS Presentation – completion	LMNS Review Visits YSTHFT Feb 24 - Init

Becky Case
LMNS Programme Lead
March 2024

Report to:	Quality Committee
Date of Meeting:	16 April 2024
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 March 2024 monthly submission to the CQC which provides assurance on progress and impact on outcomes in February 2024.

Report History

Meeting	Date	Outcome/Recommendation
Maternity Assurance Group	3 April 2024	Approved

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.2 Fetal Monitoring

A.2.2 Fetal Monitoring Training

Current Fetal Monitoring compliance figures, by site, at the end of February 2024 are outlined below.

Staff Group	York	Scarborough
Midwives	92% (171/185)	87% (66/76)
Consultants	87% (13/15)	63% (5/8)
Obstetric medical staff	87% (14/16)	38% (5/13)

Three members of the medical staff and one Consultant have been booked onto training sessions during March which increase to 61% for medical staff and 87% for Consultants at Scarborough. Training compliance is overseen by the Maternity Assurance Group and the Clinical Lead for Education.

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.

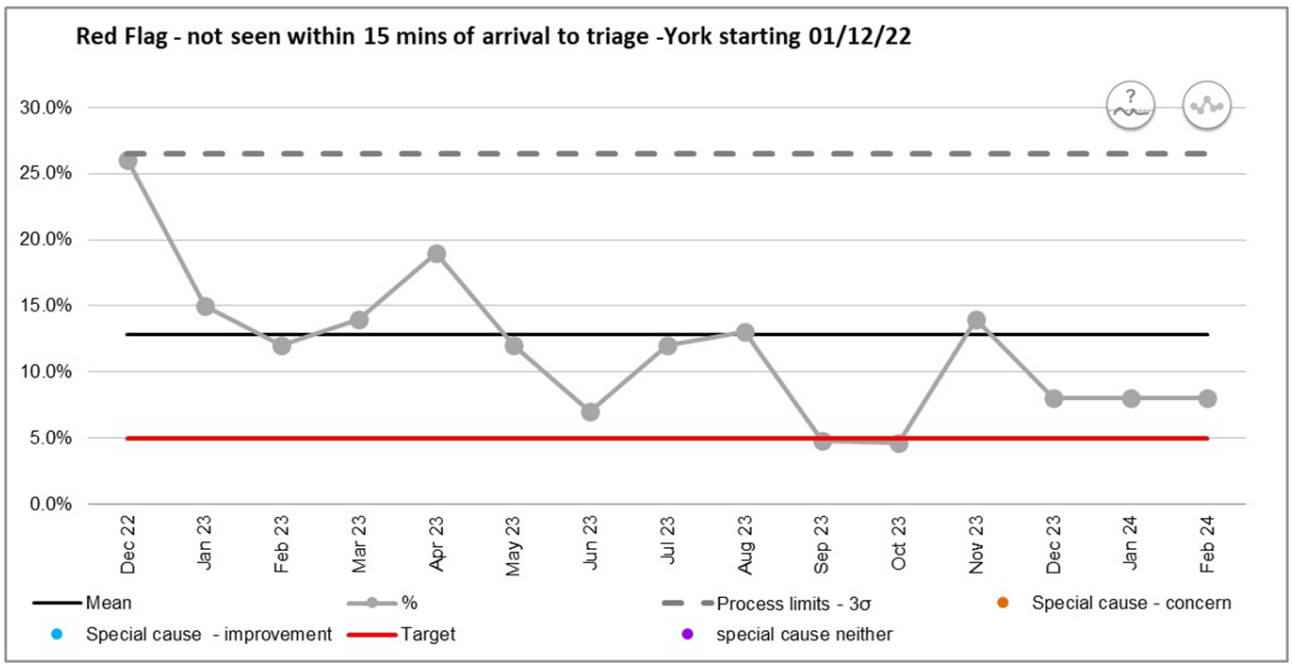
The Digital Midwives undertook a review of all antenatal risk assessments which were identified on BadgerNet as not completed in December 2023 and January 2024. The review discovered a training need with a small group of staff members, which addressed by the Digital Midwives in March 2024. A further review will be undertaken in April 2024 and reported on in May 2023.

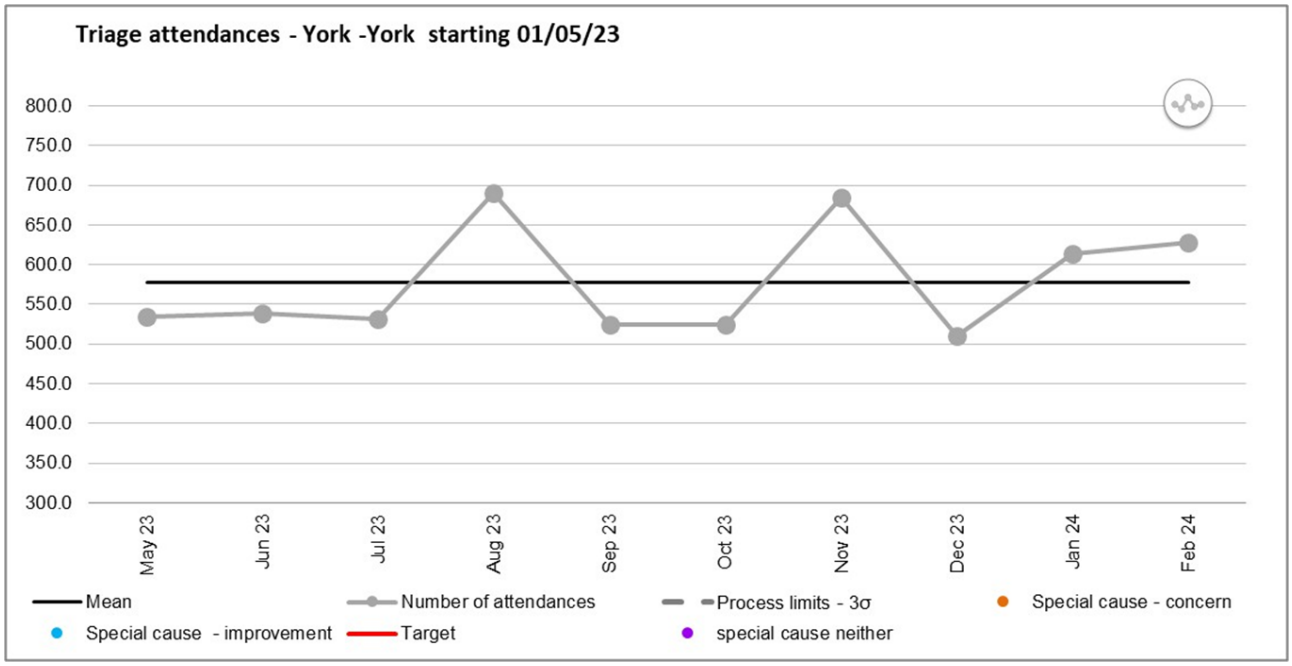
A.4 Assessment and Triage

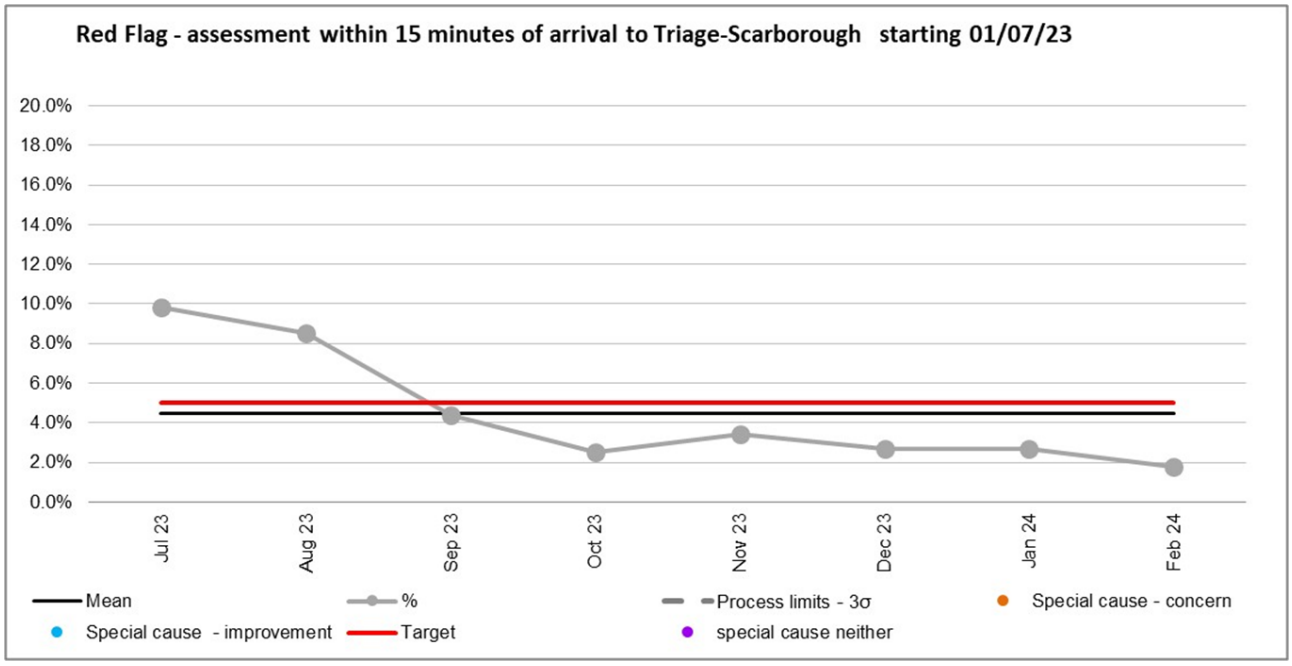
On the 12 May 2023, the Birmingham Symptom Specific Obstetric Triage System (BSOTS) Triage system went live at York Hospital and partially from 3 July 2023 at Scarborough. The triage system is part of the Badgernet software, the system facilitates the prioritisation of women based on needs.

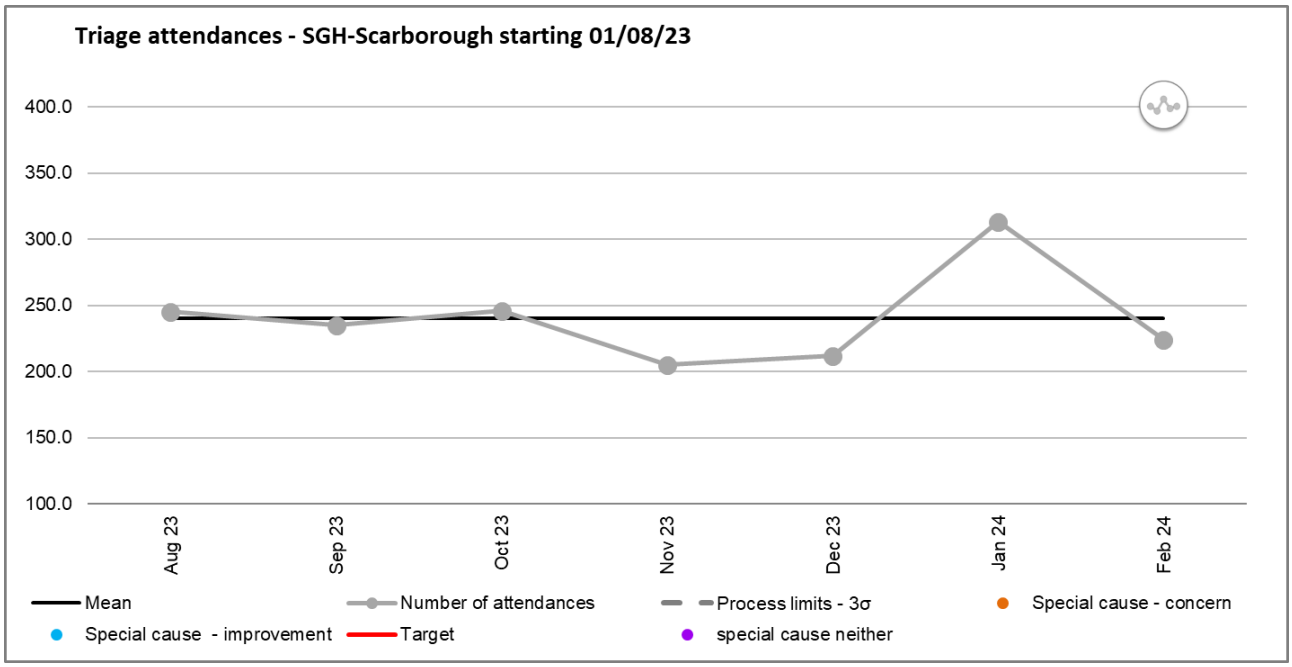
The introduction of BSOTS in January 2023 is demonstrating a steady reduction in the number of red flags reported which are outlined in the NICE safe midwifery staffing for maternity settings (2015). These will continue to be monitored as a key safety metric for our service in demonstrating safe staffing.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

Telephone audit information has been requested and will be reported on in the April update. The team continue to work with the MatNeo SIP looking at national metrics and reporting.









A dedicated triage area next to the maternity ward at Scarborough has been identified to support the full implementation of BSOTS. Recruitment has not been as successful as anticipated, however with the use of agency midwives has supported this rollout. The HCA/MSW vacancy has been filled and we anticipate our 5 new team members will commence in March 2024.

In February 10.3% of RM shifts and 32.8% of MSW/HCA shifts were unfilled. Staffing remains a challenge across the whole unit which has resulted in Triage closing on numerous occasions. From March, the team were asked to complete a Datix for each closure to allow us to audit and review the impact of this.

B. Governance and Oversight of Maternity Services

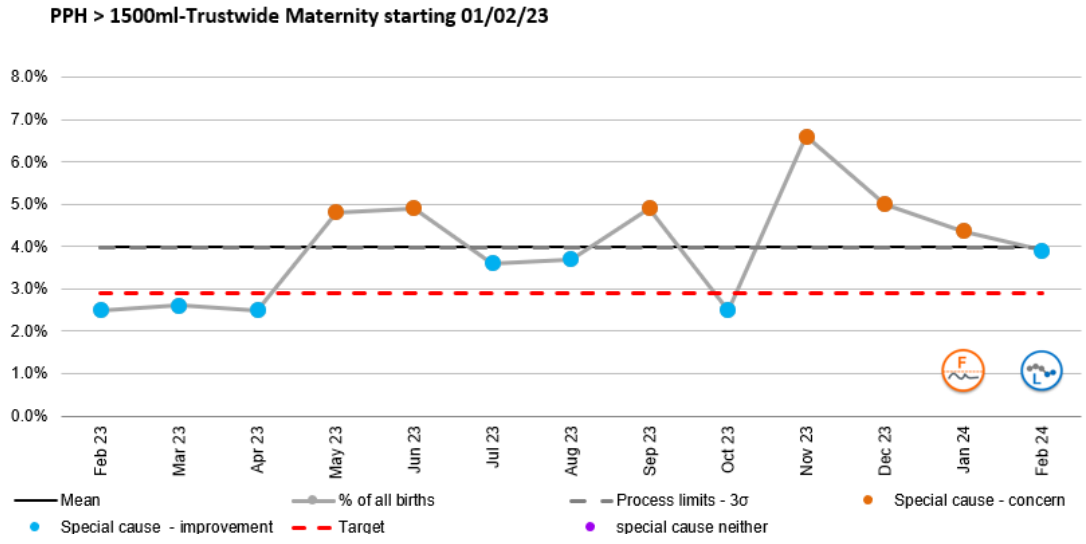
B.1 Post-Partum Haemorrhage

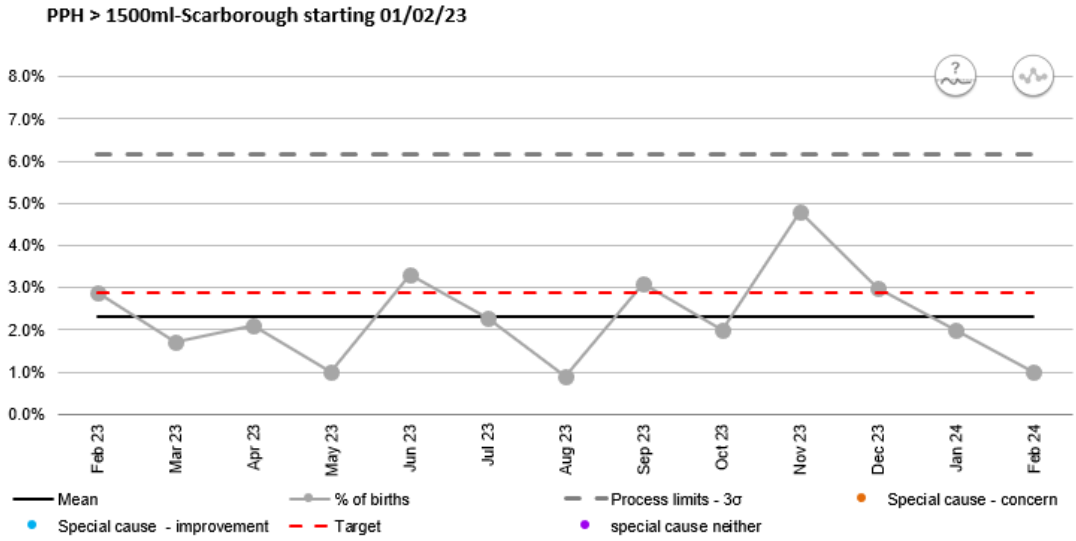
PPH over 1.5 litres

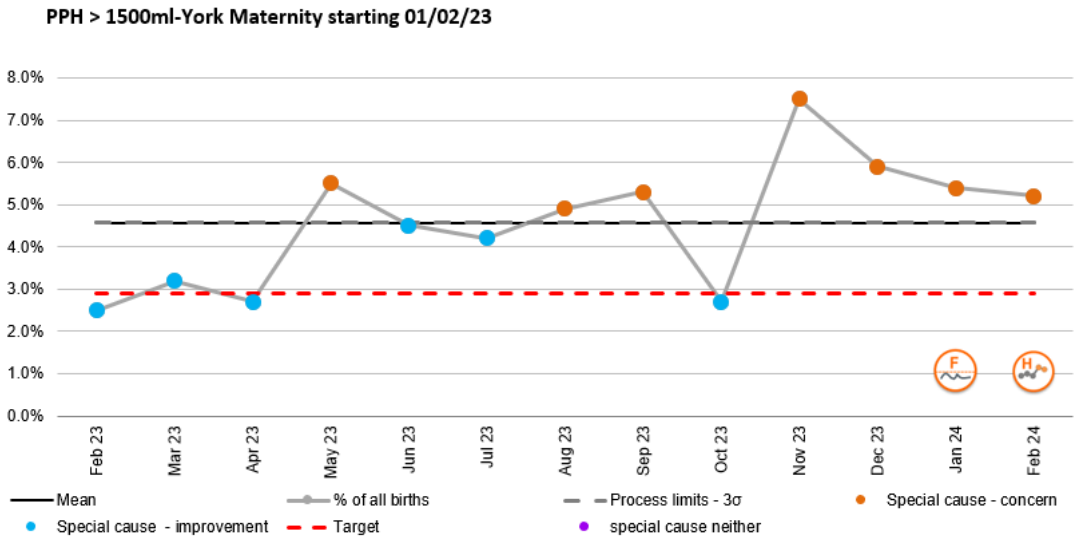
PPH is included as one of the key priority areas in the Trust Patient Safety Incident Review Plan launched in December 2023.

Blood Loss	Number in February 2024
1.5l – 1.9l	7 (range 1.5l – 1.9l)
2l – 2.4l	4 (range 2l – 2.3l)
> 2.5l	1 (2.5l)

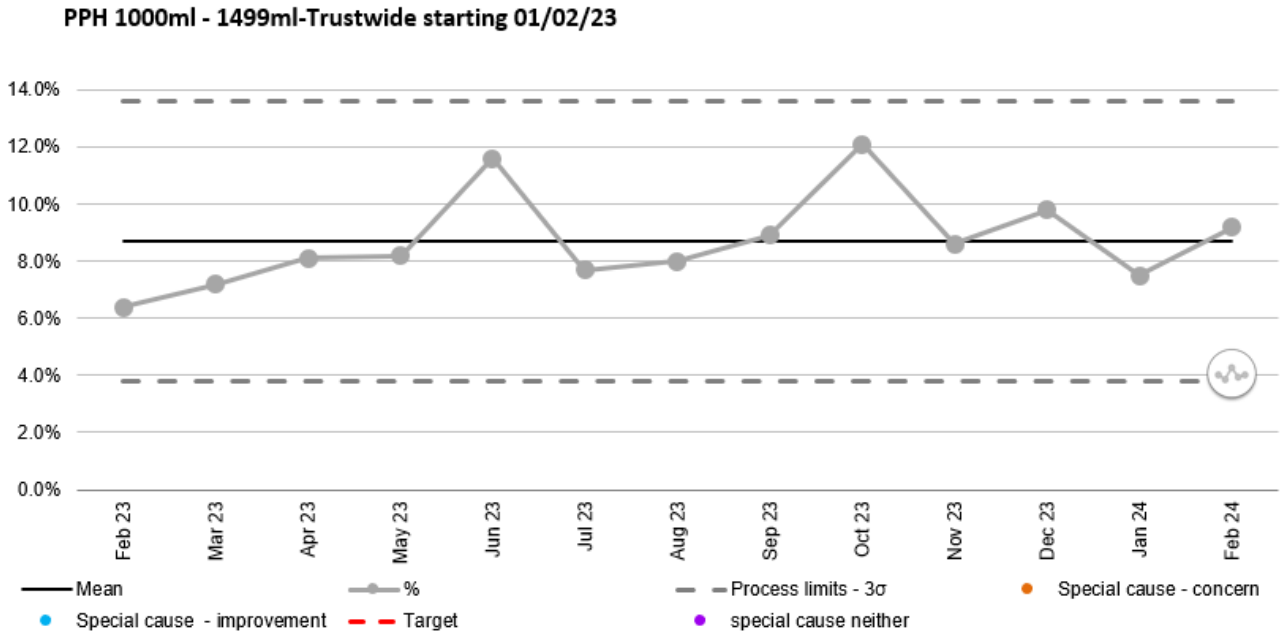
There has been a decrease in the PPH rate at both sites since a peak in November 2023. All PPH over 1.5 litres are reviewed at the Maternity Case Review meetings and a cluster review will be started in April 2024 which will inform the Quality Improvement project.







PPH between 1000ml – 1499ml



The rate of PPH between 1000ml and 1499ml has decreased since October 2023. This rate is also monitored by the PPH Improvement Group.

B.2 Incident Reporting

There were twenty moderate harm incidents reported in January 2024.

Datix Number	Incident Category	Outcome/Learning/Actions	Outcome
13748 12331 12009 12335 12208 12276 12370 12513 12604 12772 12874	PPH >1500ml	Cluster review to be commenced in April 2024, this will inform QI project	Awaiting the outcome of the review to inform QI projects
11717 12273 13110	Maternal or Baby Readmission	Reviewed at the Maternity Case Review meeting	Local actions identified
12368 12332 12876 13029	3rd or 4th degree perineal tear	To be included in the perineal tear cluster review	Audit to be presented to Clinical Governance
12225	Injury caused to baby at birth	Reviewed at the Maternity Case Review meeting	For PSII
12483	Medication Issue	Reviewed at the Maternity Case Review meeting	Local actions identified

B.4 Management of Risks

B.4.1.1 Project Updates York

The renovation of the maternity theatres at York started on 12 February 2024, works were expected to take 12 weeks extended by 3 weeks.

There is a daily audit of baby tags by the ward managers on both sites. The estates team undertake monthly testing of the baby tagging equipment to ensure it is working as it should.

B.4.1.2 Project Updates Scarborough

The infrastructure is in place at Scarborough for the implementation of x-tags. The use of Hugs tags continues to be effective at Scarborough. Video intercoms have been updated and installed at the ward entrances.

B.4.2 Scrub and Recovery Roles

The recruitment of scrub and recovery roles for maternity theatres continues. There is a rolling recruitment advert targeting experienced theatre staff to work in maternity theatres and a rotational programme giving practitioners experience in maternity following placements in vascular, urology, gynaecology, and general surgery.

Scrub and recovery shifts continue to be offered as overtime and bank to midwives and theatre staff with a system in place to allow all staff to identify vacant shifts and book onto them.

Report to:	Board of Directors Public
Date of Meeting:	24 April 2024
Subject:	Emergency Planning Resilience and Response (EPRR) – Core Standards Action Plan Progress Report
Director Sponsor:	Accountable Emergency Officer – Claire 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
	☒ Sustainability

Summary of Report and Key Points to highlight:

The Board of Directors are asked to:

- Note the progress made in addressing the actions to achieve a greater level of compliance with EPRR Core Standards since Dec 23.
- Note the residual risks to a) completion of the action plan and b) to the preparedness of the Trust to respond to emergency and business continuity incidents.

Recommendation:

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**

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS – ACTION PLAN PROGRESS REPORT

1. Introduction

NHSE conduct an annual assurance of the EPRR Core Standards. There are 62 core standards that are grouped into the 10 domains of: Governance, Duty to Risk Assess, Duty to Maintain Plans, Command and Control, Training and Exercising, Response, Warning and Informing, Cooperation, Business Continuity and CBRN. The overall assurance grading is determined as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Historically the assurance process has been a self-assessment that is then subjected to check and challenge by the Local Healthcare Resilience Partnership (now chaired by the ICB Accountable Emergency Officer). 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 was clear that the assurance process was not fit for purpose. NHSE conducted a new process for 2023-2024 with evidence of compliance with each standard having to be uploaded for NHSE to review and adjust gradings accordingly. This resulted in all Acute Trusts, all ICBs and all NHSE Regional EPRR in England being downgraded to a NON-COMPLIANT rating.

The post assurance debrief determined that it is important to note that this reduction in grading does not signal a material change or deterioration in preparedness but is considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

The NON-COMPLIANCE grading attracts the requirement to produce an action plan and for the review of the progress of that plan to be reported to the Board of Directors.

2. EPRR Assurance Rating 2023/2024. The Trust final rating by domain was as follows:

Domain	Core Standards			Total
	Fully Compliant	Partially Compliant	Non-Compliant	
Governance	1	5	0	**6**
Risk Assessment	0	2	0	**2**
Duty to Maintain Plans	1	10	0	**11**
Command & Control	0	2	0	**2**
Training & Exercising	0	3	1	**4**
Response	3	4	0	**7**
Warning & Informing	1	3	0	**4**
Cooperation	1	3	0	**4**
Business Continuity	3	7	0	**10**
CBRN	4	8	0	**12**
Total	**14**	**47**	**1**	**62**

3. EPRR Core Standards Action Plan & Progress

The action plan to address partial or non-compliance was developed from the advice and feedback provided by the NHSE EPRR Regional Team. It is expected that completion of all 62 actions[1] will take in the region of 48 months i.e. completion by Dec 25. The action plan is attached for information and actions are RAG rated in terms of completion and a summary for this and past quarters is as follows:

Domain	RAG	Dec 23	Mar 24	Jun 24	Sep 24	Dec 24	Mar 25	Jun 25
Governance	(G)		6					
	(A)		1					
	(R)	10	3					
Risk Assessment	(G)		1					
	(A)							
	(R)	3	2					
Duty to Maintain Plans	(G)		4					
	(A)		3					
	(R)	14	7					
Command & Control	(G)		3	**Completed**				
	(A)		0					
	(R)	3	0					
Training & Exercising	(G)		2					
	(A)		2					
	(R)	4						
Response	(G)		2					
	(A)		2					
	(R)	5	1					
Warning & Informing	(G)							
	(A)							
	(R)	2	2					
Cooperation	(G)		2					
	(A)							
	(R)	4	2					
Business Continuity	(G)		3					
	(A)		3					

[1] Note that the number of standards in each domain do not relate to the number of actions required in each domain although by coincidence there are 62 standards and 62 actions!

	(R)	11	5					
CBRN	(G)		2					
	(A)							
	(R)	6	4					

4. Residual Risks

The residual risks to the completion of the action plan are as follows:

- **EPRR Team Resources.** The EPRR Team consist of 3 staff members. Competing priorities for the team include responding to incidents such as industrial action, conducting training and exercising to comply with core standards, managing the annual work schedule and running the EPRR governance and assurance processes. To complete the action plan is a significant task that will take time.
- **Staff Availability.** The development and implementation of plans and then the testing of them through training and exercising of them relies on the availability of clinical and nursing staff. Operational pressures limit the ability of the EPRR Team to engage with subject matter experts and then when it is possible, timelines for completion of tasks are protracted.

The main residual risk to the preparedness of the Trust to respond to emergency and business continuity incidents is as follows:

- **Duty to Maintain Plans.** One of the largest domains of EPRR Core Standards is Duty to Maintain Plans. The portfolio comprises of: 3 Policies, 15 Plans, 8 Aide Memoires and 2 contingency plans. The NHSE guidance and advice has commented on the format of these documents and in a very few cases suggested amendments. The review of all these documents is currently underway however whilst this will take time the original document will have to be used in the event of an incident.

Appendix:

1. EPRR Core Standards Assurance – Action Plan 2023-2024.

Date: 04 April 2024

Appendix 1 – EPRR Core Standards Assurance – Action Plan 2023/24

Ref	Domain	Standard name	Standard Detail	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.	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. (A) 2 - Cross check that EPRR Policy includes accountability, authority and responsibilities as per the JS and then publish EPRR Policy update. (G)	CR RC	Q3 - 23 Q3 - 23	1 - (12/01/2024) JD drafted and requires HR approval. 1 - (03/04/2024) CR to discuss with CH
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.	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			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. (R)	RC	Q2 - 24	3 - (03/04/2024) This will not change until Board report is submitted.
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.	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. (G) 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. (G) 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. (G)	AB AB AB AB RC RC / AB	Q3 - 23 Q3 - 23 Q3 - 23 Q3 - 23 Q3 - 23 Q3 - 23	4 - (12/01/2024) EPRR schedule can be found in EPRR MS teams channel. 5/6 - (12/01/2024) TOR's & agendas ammended, requires EPSG and exec sign off. (07/02/2024) Exec Committee signed off 07/02/2024.
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.	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. (R)	RC	Q3 - 24	7 - (03/04/2024) - CR to track down a format to use.
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.	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. (G) 9 - Include in 24/25 Executive Committee and Board of Directors reports a section on lessons from incidents and exercises. (R) 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	8/10 - (12/01/2024) EPRR policy ammended, requires EPSG and exec sign off. (07/02/2024) Exec Committee signed off.

Ref	Domain	Standard name	Standard Detail	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.	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. (G) 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. (R) 13 - Check that EPRR Risk escalation process is included in the Trust Risk Framework specifically. (R)	RC RC / CR CR	Q3 -23 Q3 - 24 Q4 - 23	12 (19/12/2023) - Accept that all risk assessment forms will take 2024 to complete therefore EPRR Core Standards likely to remain AMBER with evidence of progress. 11 (07/02/2024) - Exec Committee signed off. 12 (03/04/2024) - RC / CR to conduct initial risk assessment on RACC and then review what the target completion against dates should be.
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	A	Please see comments for core standard 7	Please see evidence requested for core standard 7					

Ref	Domain	Standard name	Standard Detail	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.	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. (G) 15 - Add section on collaborative planning to the EPRR Policy. (G)	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				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. (A)	RC	Q3 - 24	16 (19/12/2023) - RC to contact ST to discuss the rationale of the seperation of information and to confirm the provenance of the guidance. (12/01/2024) RC confirmed with ST that plans are to be broken out into aide memoirs, to cover immediate acitons.
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			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. (G)	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.	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. (G) 19 - Ratify and publish the HCID SOP and test. (A)	RC RC	Q3 - 23 Q4 - 23	18 - (19/12/2023) RC to speak with ST to clarify the requirements of Infectious Disease, Outbreak, HCID and Pandemic Flu. (12/01/2024) RC confirmed with ST requirement for the above seperation of plans. 19 - (12/01/2024) HCID SOP in draft and on the ID working agenda on 17/01/2024.

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	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. (A)	RC	Q3 - 24	20 (03/04/2024) - RC obtained best practice New and Emerging Pandemic Plan and is amending for Trust use and will then authorise through ID WG.
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	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. (R) 22 - Write a new policy to consider mass vaccination and issue of prophylaxis. (R)	CR 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				23 - Publish the Mass Casualty Plan. (R)	RC	Q4 - 23	23 - (12/01/2024) this plan is on the MI working group agenda on 24/01/2024.
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				24 - Publish the Evacuation & Shelter Plan. (R)	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.	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. (R)	CR	Q2 - 24	25 - (07/02/2024) Included on EPM work schedule. Query - delay SGH exercise to conduct in new ED
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.	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. (R)	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.	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. (R)	RC	Q4 - 24	

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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.	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. (G) 28A - Ensure CONFIRMER Tests are captured as a Lessons Template. (G)	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	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. (G)	RC	Q4 - 23	

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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				30 - Develop and publish Trust Training Needs Analysis. (A)	RC / CR	Q2 - 24	30 - (19/12/2023) 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. 30 - (07/02/2024) Incuded in EPM work schedule 30 - (03/04/2024) Date set for TNA develoment
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				31 - Capture all training into central log / register. (G)	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				32 - Develop Trust MS Teams Channel to manage responder training for On Call Staff. (G)	RC / CR	Q4 - 24	32 - (19/12/2023) 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. 32 - (03/04/2024) Due for publication next week.
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.	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. (A)	RC / CR	Q4 - 24	33 - (04/04/2024) EPRR Team to develop TNA and then CR understands the requirement for platform access.

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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			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. (G) 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. (A)	RC AB	Q3 - 23 Q3 - 23	35 - (07/02/2024) ICC audit document completed and BC contingency boxes audit implemented. Now need to determine what else requires documentation audit.
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.	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. (G)	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							

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	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. (A)	RC / CR	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			**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. (R)	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.	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)	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.	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. (R)	CR	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				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. (R)	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							
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							

Ref	Domain	Standard name	Standard Detail	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 / Update
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.	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. (G)	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	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 required) of information after which determination of any actions can be made. (G)	AB	Q3 - 23	42 - (19/12/2023) Barrier to completion is that responsibility for clarification resides 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.	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. (R)	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.	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 - CR 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. (R)	CR	Q2 - 23	44 - (03/04/2024) CR to contact LC-P to determine the deadlines for the ICB led work on a common ISA.

Ref	Domain	Standard name	Standard Detail	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 / Update
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			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. (G)	CR	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			**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).	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. (A) 46A - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 47 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (R)	CR CR CR	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				48 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 49 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (R)	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.	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								
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.	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. (G) 51 - Include in TNA & BCP - Testing and Audit section (R) and annual report through Executive Committee and Board of Directors to describe BC activity, compliance and KPIs. (G)	AB CR	Q2 - 24 Q2 - 24	50 - (07/02/2024) - Include AB Exec Report Jan 24 as evidence of KPIs.
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.	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 & BCP Testing & Audit section. (A)	CR	Q2 - 24	52 - (12/01/2024) meeting with internal auditors on 18/01/2024.
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				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. (R)	RC / CR	Q2 - 24	53 - Link to Action 8. (07/02/2024) - Action tracking process is requirted for inclusion in EPRR Policy (possible 0.1 amendment).
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.	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. (G)	AB	Q2 - 24	54 - (07/02/2024) List of approved suppliers already in evidence folder. Needs annual review.

Ref	Domain	Standard name	Standard Detail	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
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			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	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							
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	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 Plan. (R)	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.	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 Plan post development of TNA to determine if capability can be sustained for 24/7 and develop a methodology to evidence for core standards. (R)	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	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 Plan to include equipment husbandry to include registers, audits and fault finding flow charts. (R) 58 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (R)	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	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							
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	National requirement is for organisations to have adequate training resource to deliver Hazmat/CBRN training aligned to the organisational Hazmat/CBRN plan. The Trust has provided a copy of their CBRN self-assessment responses however outside of identifying the Trust has two trainers (one of which was trained 6 years ago, and one who appears to have been trained by another Trust which is outside the formal PRPSi requirement) the standard requires evidence of all supporting information in order to rate full compliance. This includes - **identified minimum training standards within the organisations Hazmat/CBRN plan** (which has not been provided), a staff training needs analysis and documented evidence of training records for both staff that have undertaken training and for those staff delivering training to evidence their attendance at an appropriate train the trainer session with dates provided - these latter elements have not been provided	**Evidence to be provided of identified minimum training standards withing the organisations Hazmat/CBRN plan (which has not been provided), a staff training needs analysis and documented evidence of training records for both staff that have undertaken training and for those staff delivering training to evidence their attendance at an appropriate train the trainer session with dates provided**					Note: Concern resolved in Action 30.

64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	A	National requirement is for organisation to undertake training for ALL staff who are most likely to come into contact with potentially contaminated patients and those requiring decontamination. T**his should include a risk assessment to consider areas where patients may self present - not just ED and UTC staff, and should be evidenced by Trust training slides and evidence of training records**. No evidence provided which outlines training to wider staffing groups which covers "staff that may make contact with a potentially contaminated patient, whether in person or over the phone" and which should include IOR principles. **No evidence of IOR training or traiining competency records provided.**	Evidence to be provided that supports compliance with standard details, supporting information and compliance requirements					Note: Concerns resolved in TNA - Action 30 and Risk Assessment Action 12.
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	A	National requirement is for organisations to ensure staff who come into contact with patients requiring wet decontamination, and patients with confirmed respiratory illnesses, have access to - **and are trained to use appropriate PPE**. The requirement is that this needs **to include evidence of equipment inventories. fit testing schedules and a requirement to maintain 24 operational PRPS suits. There is a requirement for an associated TNA which identifies which staff require what training, and provides clear instructions on use.** No evidence has been provided in relation to equipment inventories or fit testing schedules and records.	Evidence to be provided which includes evidence of equipment inventories. fit testing schedules and percentage compliance	Supplementary commentary and evidence provided by the Trust refers to the CBRNE equipment list which whilst it indicates "PRPS - Y" does not confirm that the Trust has 24 operational suits, and **we cannot see evidence of this being submitted as evidence. This standard also refers to a requirement for FFP3 testing which the Trust has provided commentary on for standard 12 but has not provided evidence that they have sufficient FFP3 trained staff.** Based on this we would advise a rating of partial compliance on their final submission	59 - Clarify with EPRR the confusion over 24 versus 12 suits. (G) 60.- Clarify EPRR responsibility for FFP3 trained staff. (G)	RC RC	Q3 - 23 Q3 - 23	Note: Concerns resolved in TNA - Action 30 and Risk Assessment Action 12. (07/02/2024) - Confirmed there are 12 x PRPS suits on each site.
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	National requirement is for organisations to ensure that exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR testing and exercising programme. The Trust identifies their CBRN self-assessment as evidence for this standard, however this suggests only 1 member of staff has been trained in the last 12 months, and no exercises have been undertaken.	**Evidence to be provided on inclusion of Hazmat/CBRN in the Trusts training, testing and exercising schedule, alongside evidence of their ability to provide a safe system of working**					Note: Concerns are reso+O13:O15lved with TNA - Action 30 and Lessons Identifed 8.

Report to:	Board of Directors
Date of Meeting:	24 April 2024
Subject:	3rd Static MRI York Hospital
Director Sponsor:	Claire Hansen
Author:	Karen Priestman

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:

- Successful Bid to fund a state-of-the-art static MRI scanner including funding of the building to host the new scanner
- Current capacity does not meet demand even with CDC sites mobilised
- Reduce use of contracted mobile MRI unit to off set funding of clinical staff required to run the 3rd Scanner
- 3rd Scanner will provide a contingency plan to support the eventual replacement of the 2 aging current MRI machines
- 3rd Scanner will support our ambition to deliver MpMRI for all prostate cancer patients
-

Recommendation:

Approval to proceed with the capital scheme to house and purchase a 3rd Static MRI scanner at York Hospital

Report Exempt from Public Disclosure

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**
Executive Committee	17 April 2024	Approved

3rd Static MRI Scanner York Hospital Business Case

1. Introduction and Background

MRI service delivery on the York Hospital site is currently provided by two aging (12 and 14 years old) static MRI scanners (which have no acceleration software), supported by costly third party scanning provision.

Current independent sector capacity for MRI is provided at 7 days per week on a mobile scanner and the equivalent of 2 days per week on a static scanner at a private hospital in York.

Recent completion of the NHSE core capacity and demand model demonstrates that even with the capacity due to be provided by the CDC mobile scanners across the region, there will still be a significant reliance on the independent sector to support the capacity deficit in MRI scanning in the York area.

A successful bid has been approved to fund via the NHSE national programme a capital scheme including the purchase of a state-of-the-art 3rd MRI scanner with acceleration software. The funding allocation is £2,215,747.

2. Considerations

Approval is being requested to proceed with the capital scheme and purchase of a 3rd static MRI Scanner for the York Hospital site. This will significantly reduce the reliance on the independent and private sector to support MRI imaging.

The reduction in the use of the contracted mobile unit will fund the staffing required to run the MRI machine 7 days per week.

3. Current Position/Issues

Elective and acute MRI service provision is provided by two static scanners on the York site. One scanner is dedicated fully to delivery of acute imaging leaving one scanner to carry out all elective imaging. The number of patients requiring complex imaging, have implanted devices or require a GA to conduct the scan, has been increasing. Given this type of imaging cannot be done on third party scanners the remaining static scanner capacity available to the York area is severely limited. As a result, the MRI team at York are unable to flex capacity to support any sudden rise in demand for complex imaging creating backlogs and delays on diagnostic cancer and elective pathways.

During a period of servicing or machine breakdown there is very little opportunity to re-provide the lost capacity due to the limits of what can be done on each scanner and the need to continue always running an acute list.

There is no capacity currently to deliver national best practice guidelines for all eligible patients to have a Multiparametric MRI scan for prostate cancer.

The current 2 aging scanners frequently breakdown with minimal contingency available.

4. Summary

National funding has been secured to purchase a new static MRI scanner including the capital build to address the capacity gap we currently have in providing timely access within 6 weeks.

The new machine will provide the service with the ability to be more efficient and innovative in the service provision which would include providing MpMRI service for all eligible patients.

The new MRI will provide a contingency plan for any failures of the aging 2 scanners and will aid the eventual replacement scheme of these aging scanners.

A reduction in the reliance on independent and private services will be realised.

5. Next Steps

Commence capital programme to deliver 3rd MRI machine to deliver timely imaging for our patients.

Date: 17 April 2024

APPENDIX Ai

Business Case Approvals

- Potential cases should be outlined at Annual Planning
- Business Case Completed (Revenue and/or Capital)
- Care Group Board - Revenue Approval <£50k
- CPMG - Capital Approval <£50k
- Chief Executive, usually through the Executive Committee (Revenue) / CPEG (Capital) - Approval £50k - £500k
- Executive Committee - Revenue & Capital Approval £500k - £1m
- Board of Directors - Revenue & Capital Approval >£1m
- CAP Board / ICB Review of all cases that impact / benefit the wider ICS
- Post Project Evaluation - 12 months after implementation

Stakeholder Considerations

YTHFM LLP	•Is accommodation required? •Is cleaning / maintenance of accomodation required? •Are porters / catering / laundry & linen required? •Is maintenance of medical equipment required?
Digital Information Services (DIS)	•Does the change require a system change? •Does the change require new digital functionality? •Does the change require a new digital solution? •Has the DIS Change Request Process been followed?
Care Groups	•Consider the impact of your business case on other Care Groups - have they been engaged where required? •Mandatory consultation for stakeholder groups is included in section 8 of the business case summary
Sustainability	•Does the business case impact on the Trust's sustainability programme?
Commissioners	•Where additional funding is required this should be discussed with commissioners (i.e the ICB)
Other Providers within the ICS	•Does the business case have an impact or provide a benefit to other provider organisations within the ICS?

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2024/25-06

2. Business Case Title

3rd MRI Static Scanner York Hospital

3. Sponsorship, Management Responsibilities & Key Contact Point

The Business Case 'Owner' should be the appropriate Care Group or Corporate Director, or where appropriate an alternative lead Clinician nominated by the respective Care Group Director. The 'Author' will be the named manager supporting the owner of the Business Case, who will have responsibility for the development and writing of the Business Case, and will be the key contact point for enquiries.

3.1 Sponsorship Confirmation (where neither are the Owner or Author of the Business Case)

	Name	Date of Agreement
Care Group/ Corporate Director	Mark Quinn/Claire Hansen	15/04/2024

	Name	Date of Agreement
Associate Chief Operating Officer	Karen Priestman	15/04/2024

3.2 Management Responsibilities & Key Contact Point

Business Case Owner:	Karen Priestman

Business Case Author:	Lisa Shelbourn/ Karen Priestman
Contact Number:	01904 721345

STRATEGIC CASE

The purpose of the strategic section of the business case is to make the case for change and to demonstrate how it provides strategic fit.

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change.

MRI service delivery on the York Hospital site is currently provided by two aging (12 and 14 years old) static MRI scanners (which have no acceleration software), supported by costly third party scanning provision.

Current independent sector capacity for MRI is provided at 7 days per week on a mobile scanner and the equivalent of 2 days per week on a static scanner at a private hospital in York.

Recent completion of the NHSE core capacity and demand model demonstrates that even with the capacity due to be provided by the CDC mobile scanners across the region, there will still be a significant reliance on the independent sector to support the capacity deficit in MRI scanning in the York area (see capacity and demand section)

Elective and acute MRI service provision is provided by two static scanners on the York site. One scanner is dedicated fully to delivery of acute imaging leaving one scanner to carry out all elective imaging. The number of patients requiring complex imaging, have implanted devices or require a GA to conduct the scan, has been increasing. Given this type of imaging cannot be done on third party scanners the remaining static scanner capacity available to the York area is severely limited. As a result, the MRI team at York are unable to flex capacity to support any sudden rise in demand for complex imaging creating backlogs and delays on diagnostic cancer and elective pathways.

During a period of servicing or machine breakdown there is very little opportunity to re-provide the lost capacity due to the limits of what can be done on each scanner and the need to continue running an acute list at all times.

A new MRI scanner which incorporates technological advances including AI enabled imaging applications will facilitate an increased patient throughput and improved image quality, offering improved efficiency and an enhanced patient experience. New model MRI scanners have a 13% efficiency rate.

By having a third scanner available to the York site, the potential to roll out extended working hours on internal available capacity would support the expansion of the multiparametric MRI service to ALL suspected prostate cancer patients rather than the current model which rationalises the service to a smaller cohort of patients where this type of imaging is of most benefit. The limitations of other available complex imaging capacity across York prevents us from being able to offer this type of scan to ALL indicated patients without severely compromising the turnaround of other imaging pathways. Provision of this service aligns to NHS England mandated KPIs.

<u>Planned Implementation of Scheme</u>

The Acute Trust has committed to replacing the 2 existing static scanners and upgrading them as part of the capital replacement programme.

In order to continue providing an acute MRI service during this replacement work, a new acute MRI scanner would be installed closer to the main radiology department on the York hospital site. This new scanner will go live and take on the acute patient throughput. The replacement of the old scanners in their existing location would then commence. Both of these old scanners would be replaced in the existing MRI unit at York and would then become the 2 scanners dedicated to delivering elective capacity.

This case therefore looks for support to purchase of a new 1.5 T MRI scanner plus the additional capital revenue cost to relocate the acute MRI service to the main radiology site.

The MRI scheme has been funded via a successful bid for National allocated money to support diagnostic delivery and recovery. The Trust has been awarded £2,215,747 to fund the machine and capital build to accommodate this.

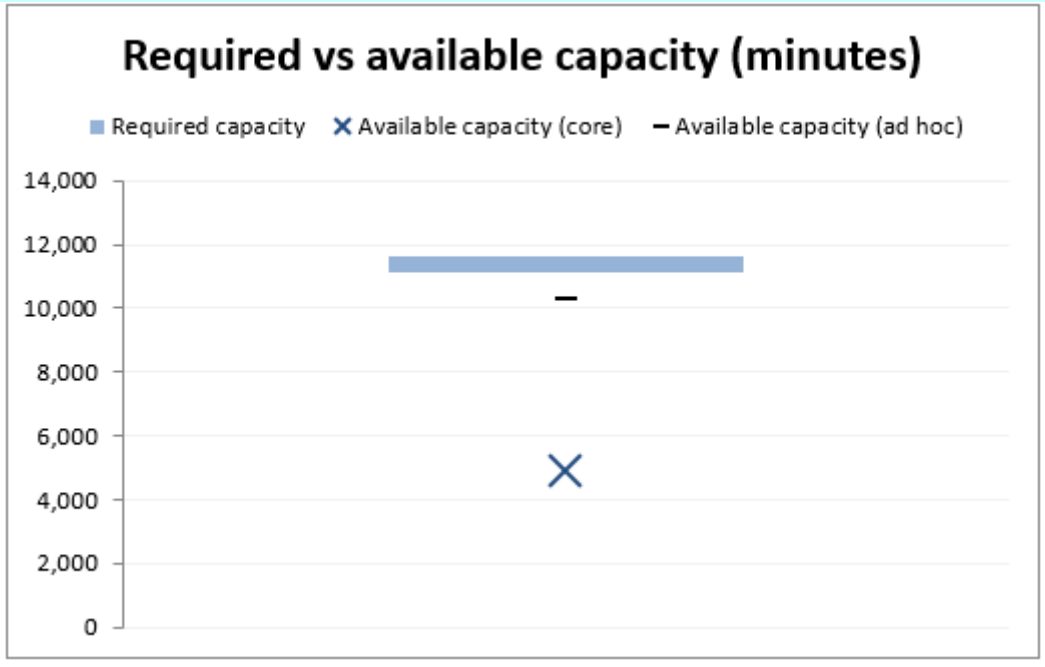
Revenue Funding

The revenue requirement of this bid is cost neutral, the funding for the staffing of this new scanner will be provided by reducing the usage of Mobile/Independent Sector as shown in the financial statements below.

5. Capacity & Demand Analysis

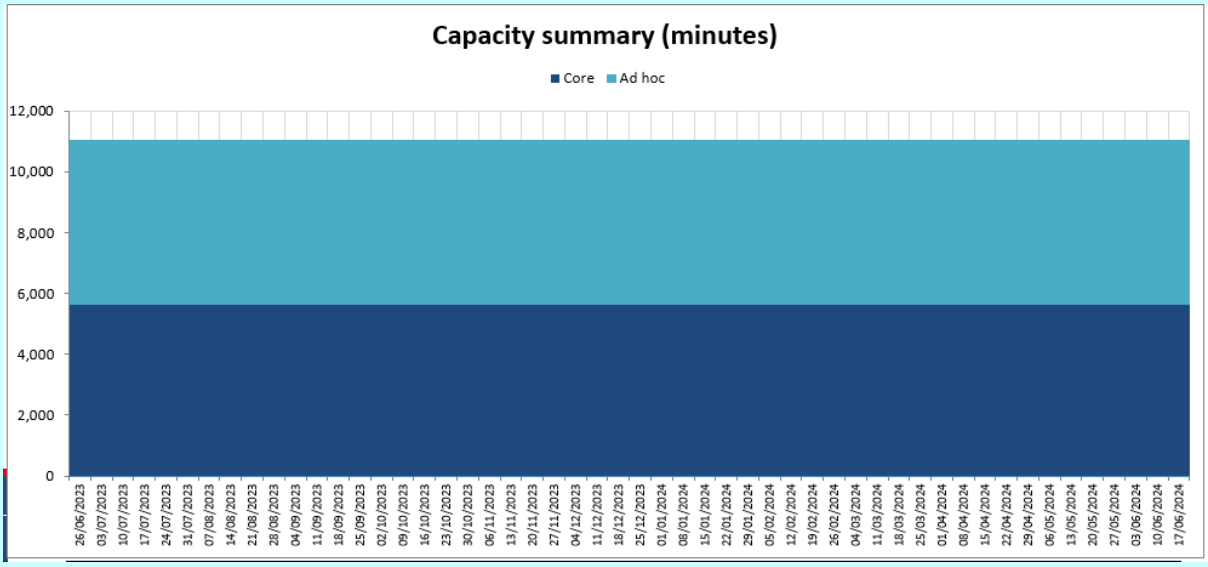
Where a key issue raised concerns of the availability of sufficient capacity to meet anticipated demand on the service, it must be supported by a Capacity and Demand analysis to clearly demonstrate the gap in capacity, with the results presented below. Please refer to the Business Case guidance document for the guidance and access to the preferred capacity and demand model. If required, support in completing the model is available through the Corporate Operations team (contact Andrew Hurren on extension 5639).

Capacity and Demand - Current Position as of end of 2023/24



An additional 1300 minutes per week is required to meet demand, in addition to the capacity currently being provided by the independent sector, for MRI at York.

Capacity and demand modelling shows almost half of the total capacity for MRI at York is provided by the independent sector



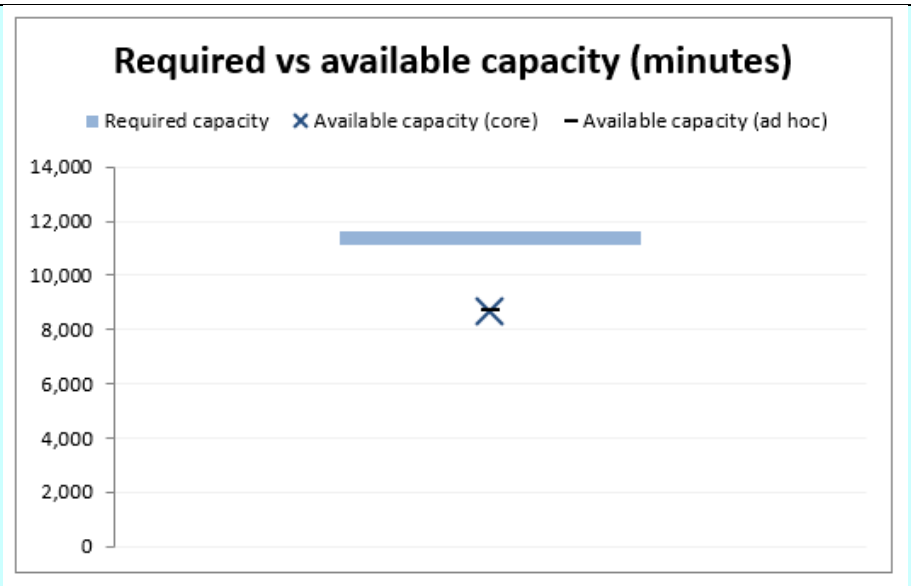
Impact of Capacity and Demand Forecast by Installing a 3rd MRI Scanner

Introducing a 3rd MRI scanner at York which runs 7 days per week will provide capacity for an additional 7700 patients per year if running 12 hours a day.

- 09:00 – 17:00 – Mon – Fri = annual capacity of 4500 patients
- 09:00 – 17:00 – Mon-Sun = annual capacity of 6300 patients
- 08:00 – 20:00 – Mon – Fri = annual capacity of 5500 patients
- 08:00 – 20:00 – Mon-Sun = annual capacity of 7700 patients

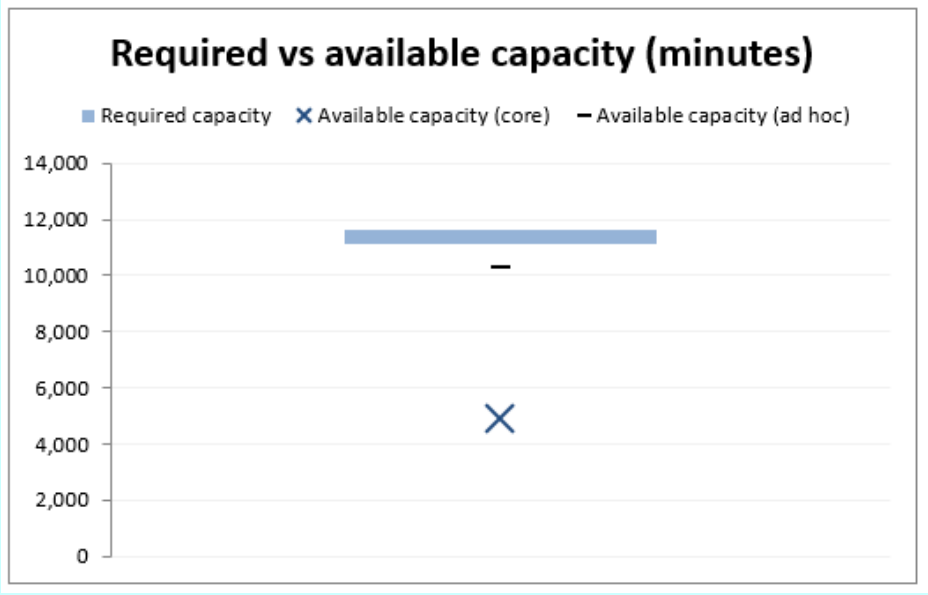
The MRI strategy to be delivered by installing a third scanner at the York site would be to reduce down the high cost independent sector outsourcing and replace this with internally provided NHS capacity.

Using the Core model we have forecasted that by removing all existing independent sector capacity currently provided at York and replacing it with 7 day working on a 3rd MRI scanner, there would be a deficit of 2168 minutes of scanning per week; the equivalent of approximately 3.5 x 12 hour days per week of mobile scanning.

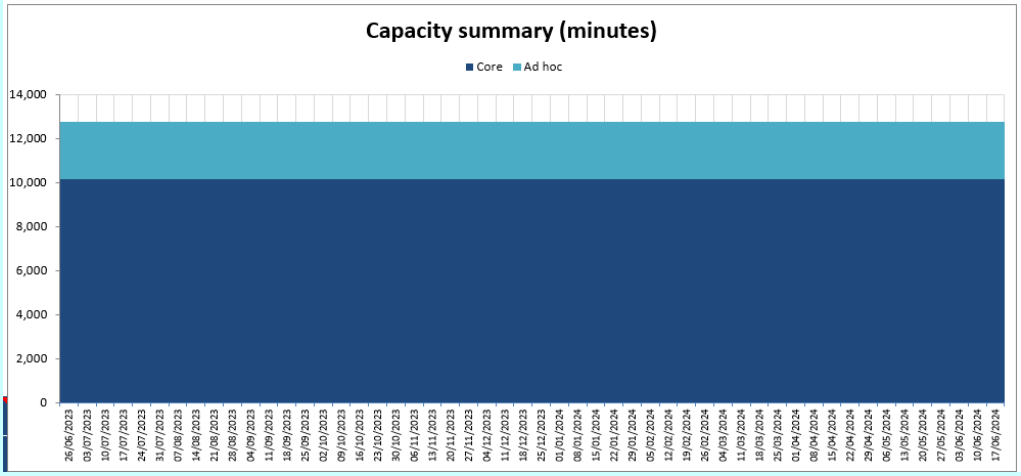


We therefore would reduce our independent sector capacity by removing approx. 4 days per week to offset the cost of the increased revenue costs for the 3rd scanner.

Maintaining access to 4 days per week of mobile imaging alongside opening the 3rd static MRI scanner at York provides sufficient capacity to manage current demand as demonstrated below, which provides some additional capacity to reduce down the existing backlog of long waiters.



The proportion of NHS capacity increases as a result of the 3rd MRI scanner and shows a much reduced reliance on the independent sector capacity.



Long Term Plan for MRI Capacity in York

Further scope to remove the remaining high cost mobile capacity comes from the following options. These would require further business case approval to expand workforce to provide this extra capacity:

- open the remaining static scanner at York 7 days per week (3 scanners at 7 days per week rather than 2)
- partnership working with York St John University in the development of their imaging training hub and the offer of MRI capacity staffed by the Trust

6. Alignment with the Trust's Strategic priorities

The Trust has identified four strategic priorities that ensure there is a focus for its emerging priorities and objectives, and assists in the communication to staff, patients and other stakeholders.

Indicate using the table below, to what extent the preferred option is aligned with these strategic priorities. It is expected that the preferred option will align with at least one of the strategic priorities.

Strategic Priority	Describe how the case is aligned to the Strategic Theme
Priority 1 – Our People	Upgraded MRI equipment with the latest software makes training and scanning easier and more efficient. Leads to better recruitment and retention
Priority 2 – Quality & Safety	Reduced time to wait for an MRI scan which in turn will assist in quicker diagnosis and treatment for patients. Reduction in the likelihood of complaints or incidents relating to delayed diagnosis
Priority 3 – Elective Recovery	Reduce length of time to wait for a scan for RTT and Cancer pathways. Increased availability of complex MRI capacity which is a growth area for cancer imaging
Priority 4 – Acute Flow	Having a 3rd MRI scanner provides the scope to flex capacity for periods of increased demand without impacting on the turnaround of elective fast track patients

7. Business Case Objectives

Setting robust spending or investment objectives is essential in making a coherent case for change; the case should identify SMART (Specific, Measurable, Achievable, Relevant, Time bound) to address one or more of the following generic drivers, see page 23 of the guidance for full description of drivers. List the business case objectives and the metrics and measures below:

Description of objective	Metric	Quantity Before	Quantity After
Reduced reliance on high-cost independent sector capacity	Percentage of total capacity provided by independent sector	49%	20%
Provision of modern imaging equipment with up-to-date software	Average age of MRI scanners across the Trust (years)	11.5 years	8.5 yrs (reduces to 2.5 years once 2 existing static scanners upgraded as well)
Provision of more efficient scanning from use of acceleration technology on modern imaging software. Estimated 10% - 12% efficiency.	Average length of scan per patient (mins)	35 mins	30 min
Increased access to complex imaging capacity in the York region	Mins per week that are provided on scanners capable of undertaking complex imaging (mins per wk)	6150	9504

How will information be collected to demonstrate that the benefit has been achieved?

Independent sector vs NHS capacity – collected as part of ongoing capacity and demand modelling in ops team in radiology

Current Position

Independent sector	49%
NHS	51%

3rd Scanner Position

Independent sector	20%
NHS	80%

Equipment age – from radiology equipment register data

Efficiency of scanning – data from soliton RIS about number of patients scanned per list and average length of scan per patient calculated by capacity and demand model

Complex capacity – data from core model C&D data

8. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the Business Case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above.

Where external stakeholder support is vital to the success of the Business Case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment. If the Business Case spans more than one Care Group or Directorate the expected/required close collaboration in such circumstances must be evidenced.

Examples of stakeholders include lead clinicians, support services (e.g. Digital Information Services (DIS), Capital Planning re: accommodation, YTHFM LLP re Estates & Facilities support services), Commissioners (e.g. HCV ICB, NHSE, etc.), patients & public, etc.

See page 24 of the guidance for a checklist of potential questions that should be considered when assessing stakeholder involvement.

A 'Not-Applicable' (N/A) response is not acceptable in this section of the case unless accompanied by the name of the relevant stakeholder that has confirmed there is no applicable involvement in the case.

Stakeholder	Confirmation of Stakeholder Support
Mandatory Consultation	
Radiology	Yes – author of case
Laboratory Medicine (SHYPS)	Yes – via CSCS care group consultation
Pharmacy	Yes – via CSCS care group consultation
AHP & Psychological Medicine	Yes – AHP professional lead feedback
Theatres, Anaesthetics and Critical Care	Yes – TIF 2 Bid and this case is intrinsically linked to the TIF 2 BC
Community Services	N/A
Digital Information Systems (DIS)	Yes – requirement for networking of new scanner
Sustainability	Yes
YTHFM LLP	Yes – project management and installation costs via capital team. Support for scheme approved via CPEG
Clinical Coding Team	Yes – via Care Group Consultation

ECONOMIC CASE

The purpose of the economic case is to identify the proposal that delivers the best value for money.

The economic case should identify the preferred option when measured against the issues identified in section 4 of the strategic case, how it closes the capacity gaps identified, how it meets the business case objectives outlined in section 7 and how it meets the Trust's strategic priorities.

9. Options Considered

List, and describe briefly below the alternative options considered to resolve the issue(s) presented in Section 4 above. This should just be a factual description of the option, without at this stage, any comments on the pros and cons of the option. The inclusion of alternative workforce and clinical models should be considered when generating the list of options. Option 1 should always be Business as Usual (BAU) as a comparison to the options considered

Description of Options Considered
Option 1: Do nothing maintain status quo
Option 2: Install 3rd Static MRI scanner

10. Benefit and Cost Analysis

All identified options must be subject to a Benefit and Cost analysis, using the 'Investment Appraisal Scoring Sheet' (Appendix Aiii) and summarised below:

Summary Benefit Cost Analysis						
	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Objectives Score	0	0	0	0	0	0
	£000	£000	£000	£000	£000	£000
Net Income & Expenditure	0	0	0	0	0	0
Net Present Value	0	0	0	0	0	0
Net Present Value Per Objective Point Scored (£000)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Overall Ranking (manually enter)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

11. The Preferred Option

Detail the preferred option together with the reasons for its selection over the other options. This must be supported with appropriate description and data in demonstrating how it will address the issue(s) described in Section 4 above.

The case for the preferred option should include how the option closes any capacity gaps identified in section 5, with the results of the closed gap after using the preferred capacity and demand model. This section should also confirm that the preferred option meets the business case objectives identified in section 7.

The preferred option should be cross referenced to key attributes identified in the Benefit and Cost Analysis in section 10.

Confirm the preferred option
Option 2 - Install 3rd Static MRI Scanner
Describe how the preferred option addresses any capacity gaps identified in section 5
Opening a third scanner 7 days per week provides NHS capacity for 7700 patients per year reducing the reliance on high-cost independent sector capacity to support demand in imaging. The up-to-date technology and acceleration software provided on upgraded scanners is estimated to provide approximately 10% efficiency on current scan times allowing scan capacity to be better utilised
Describe how the preferred option meets the Trust's strategic priorities in section 6
• Our people – up to date imaging technology provides easier applications to train new radiographers on and promotes recruitment and retention by having up to date imaging equipment to work on • Quality and safety – efficiencies from more up to date scan technology mean an increased number of patients can be scanned in the same number of scan minutes. This supports reduction of long waiting patients and reduced the risk of delayed diagnoses. Better imaging quality technology reduces the risk of missed diagnoses from poor quality images obtained by old equipment. • Elective Recovery – efficiencies from up-to-date imaging equipment provide an opportunity to scan faster and therefore see more patients in the same scan sessions. This supports more patients being scanned within the required timescales and reduces waste on 18 week and cancer pathways. Opening a scanner 7 days per week also creates capacity for additional patients to be scanned. Increased access to complex imaging.

• Acute flow – having access to a 3rd static scanner means elective capacity is less likely to be compromised during busy acute periods where the imaging department is required to flex capacity. Acute access to MRI imaging will be provided for a longer period on the new scanner.
Describe how the preferred option meets the Business Case Objectives identified in section 7
The proportion of capacity provided via high-cost independent sector services will reduce significantly by converting this capacity to in-house static scanner resource. Reduction in average age of MRI equipment across the Trust by installing a new scanner which then facilitates the replacement of the other 2 static scanners at York Up to date imaging software on new scanners provides acceleration technology and AI which reduces the number of mins per scan for certain patients. This frees capacity to scan other patients in the same length of scan session Increasingly patients are needing access to complex MRI imaging. This cannot be provided by a lot of independent sector providers and remains a pressured waiting list area. Having access to another static scanner on site at York provides a significant increase in the available capacity to scan complex patients.
Describe how the outcome of the IASS in section 10 supports the preferred option?

12. Consultant, and other Non-Training Grade Doctor Impact

*(Only to be completed where the preferred option **increases** the level of Consultant / non-Training Grade input)*

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the Business Case.

	Before	After
Average number of PAs	9.0	9.1
On-call frequency (1 in)	18	19

Working Weeks v 41 Week Requirement		PA Commitment	
Before	**After**	**Before**	**After**
41	41	10	10
41	41	10	10
41	41	10	10
41	41	12	12
41	41	7	7
41	41	10	10
41	41	10	10
41	41	6.5	6.5
41	41	9.5	9.5
41	41	10	10
41	41	10	10
41	41	3	3
41	41	7	7
41	41	10	10
41	41	10	10
41	41	10	10
41	41	10	10
41	41	6.5	6.5
41	41	10	10
41	41	8	8
41	41	10	10
41	41	11	11
41	41	10	10
41	41	10	10
41	41	10.5	10.5
41	41	5	5
41	41	10	10
41	41	10	10
41	41	10	10
41	41	8.5	8.5
41	41	10	10
41	41	5.25	5.25
41	41	11	11
41	41	7	7
41	41	10	10
		317.75	317.75

12.2 Job Plan Approval:

The Medical Director or Deputy, along with the Medical Workforce Manager must review all proposed Job Plans for new Consultant posts, as well as any Job Plans of existing Consultants where the proposed new post would have an impact on current working practices. The date that the Job Plans were approved must be provided below.

Date of Approval	17 April 2024
Comments by either the Medical Director or Deputy, or the Medical Workforce Manager	

13. Accommodation

If the delivery of this Business Case is reliant on the Care Group or Directorate submitting the case being allocated additional space (e.g. to accommodate new staff or to expand its services) the availability of this additional space should be established prior to the submission of the Business Case for approval.

If assistance is required in assessing the space requirements / availability of space to support this Business Case then help is available from Tony Burns (01904) 721856 or tony.burns@york.nhs.uk).

Does the implementation of the Business Case require additional space to be found and allocated?	**Yes**	**No**
	x	
Has the space identified been confirmed available?	**Yes**	**No**
	x	
Have the costs associated with maintaining the space been included in the financial analysis?	**Yes**	**No**
	x	

Please tick

14. Benefits of the Preferred Option

The identification of the benefit(s) that are expected to arise from the Business Case is crucial to ensuring that a robust evaluation of the progress and delivery of the Business Case objectives is possible during any post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will arise from implementing the preferred option below. The benefits identified must be aligned to the business case objectives in section 7 and be tangible and capable of being evidenced through some form of measurement. The timings of when the benefits will materialise should be realistic.*

It is acknowledged that some benefits may not materialise until at least 6m, dependent on the purpose of the Business Case and, as the Guidance Manual indicates, in a small number of

instances there may be a need to consider adjusting the timings of the reviews, dependent on the forecast timeframe for benefit delivery.

						(* from Estimated Implementation date)
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m***	**At 6m***	**At 12m***
Reduced reliance on high-cost independent sector capacity	TBC					
Provision of modern imaging equipment with up-to-date software	TBC					
Provision of more efficient scanning from use of acceleration technology on modern imaging software. Estimated 10% - 12% efficiency.	TBC					
Increased access to complex imaging capacity in the York region	TBC					
How will information be collected to demonstrate that the benefits have been achieved?						

15. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

In light of the difficulties being experienced both locally and nationally in successfully recruiting across a broad range of staff groups, the author should pay particular attention to the risks associated with fully recruiting to any new posts identified in the business case, supported by current market intelligence. Such risks need to be considered in the context of the likelihood (and timeframe) of the need to use agency or locum staff incurring premium costs for the Trust.

*The likelihood of any additional costs of risk **after** mitigation should be acknowledged in this section, and its impact recognised in the financial assessment of the case.*

Identified Risk	Proposed Mitigation	Value of Risk £'000
Insufficient qualified trained MRI radiographers to staff an additional scanner	Increased frequency of advertising of MRI vacancies. Promote development of imaging technology upgrades in job adverts to encourage people to apply. Explore use of locum/insourcing in the event of too few staff at go live. Explore increasing numbers of training radiographers with support from clinical education team and VR training.	

COMMERCIAL CASE

The commercial case should demonstrate that the preferred option has considered additional approval routes required for the purchase of equipment or that a viable procurement route has been identified where required.

16. Is there a requirement to apply for funding via the Medical Equipment Resources Group (MERG), linked to this Business Case?

If 'yes', the completed and approved MERG form must feature as an attachment to the Business Case document.

Yes	x
No	

Please tick

If 'Yes' please state below what proportion of the overall Capital costs associated with the Business Case (see the Financial Pro-forma), relate specifically to equipment

Overall Capital Costs for the Business Case	
State the value of the Equipment within the above	

17. Is there a requirement to involve or liaise with the Procurement Department with regard to any aspects associated with this Business Case?

Yes	x
No	

Please tick

If 'Yes' please provide a brief summary to evidence the involvement and the outcome.

We require support to purchase the 1.5T MRI scanner including maintenance contract.

FINANCE CASE

The finance case should demonstrate that the business case is affordable and the relevant source of funding is identified.

18. Financial Summary

18.1 Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the Care Group or Directorate as a result of this Business Case. The figures should summarise the more detailed analysis on the accompanying 'Financial Pro Forma'.

Capital Expenditure		-2019	-2019
Income		0	0
Direct Operational Expenditure	-9,757	-9,757	0
EBITDA	9,757	9,757	0
Other Expenditure		-150	-150
I&E Surplus/ (Deficit)	9,757	9,907	-150
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	9,757	9,907	-150
Contribution (%)	#DIV/0!	#DIV/0!	#DIV/0!
Non-recurring Expenditure	n/a		0

Supporting Financial Commentary:

The total Capital Costs of this case are £2,019k this is broken down as £895 (Ex VAT) for 3rd MRI Scanner, £1,124k (Ex VAT) for all associated works. This project has been subject to a successful bid through SR21 Year 3 – 2024/25 Financial Year Imaging Transformation Additional Acute Assets. We have been notified that we have been successful in securing £1,966k through this nationally funded route, and the trust capital programme will need to fund the remaining £53k in 2024/25.

The only revenue cost pressure that will be incurred through this Business Case is the Capital charges.

Staff Costs - Radiographers (6wte B6 1 wte B7), ISWs (5wte B3), Admin (1 wte B3), Medical Physics (B8a 0.2wte), Consultant (1wte) all start from 1st October 2024.

Non Pay - The reduction in non-pay costs is driven by the reduced requirement for Mobile provision and offsets the revenue impact of the case.

18.2 Estimated Impact on Run Rate

Summarise the impact on current monthly income and expenditure run rate as a result of this Business Case. The current run rate should reference the average monthly income and expenditure over the last six months. Demonstrate how the run rate will change as a result of this business case in full, and at 6 months and 12 months following approval of the case. Show income as positive figures and expenditure as negative.

	Current Run rate	Revised Run Rate	Change	Change at 6 months	Change at 12 months	Change in later years
	£000	£000	£000	£000	£000	£000
Income (+ve)						
Clinical Income			0			
Non Clinical Income			0			
Expenditure (-ve)						
Pay	-651	-707	-56			
Non Pay	-162	-106	56			
Non Operational expenditure		-13	-13	-13	-13	-13
Total	-813	-826	-13	-13	-13	-13

Run Rate Supporting Commentary:

The only run rate consequences of this case are the capital charges

MANAGEMENT CASE

The management case should demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the preferred option.

19. Delivery

Describe the process put in place for successful delivery of the preferred solution, this should include the management of any potential risks, delivery of benefits, recruitment timescales and budgetary changes.

The scheme will be managed with project management support with a full programme brief, risk and issue logs supported by a project delivery group meeting. Delivery of benefits, recruitment, budgets etc. will be monitored through Diagnostic Delivery Group and Care Group Board. Any escalation will be managed through Elective Recovery Board and PRIM

20. Post Implementation Review (PIR)

Provide a self-assessment of the risk score and summarise below to determine whether a PIR is required, this will be validated at the time of approval of the business case, by the approving authority, see section 20 of the business case guidance:

Self-assessment score	Level of Risk	Outcome
4 (2x2) – if the business case isn't delivered the MRI service will continue to run using high cost independent sector capacity. Due to the lack of available complex capacity and reliance on other companies to consistently provide this capacity there is a risk that current waiting lists cannot be reduced and pose a risk to a delay in diagnosis	Low	No PIR required

21. Estimated Implementation Date

State the estimated implementation date. This will be used as the start point of the review period where the Business Case is selected for Post Implementation Review (PIR).

Estimated Implementation Date	**Feb 2025**

22. Date of Completion:

Note: This date should be kept current on each occasion that the documentation is refreshed/ updated.

The use of version control is recommended to aid the auditing and tracking of current documentation, particularly if the Case spans more than one Care Group or Directorate with multiple contributors. The 'Final' version must be clearly indicated as such.

Date	12/04/2024
Version No.	1

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	
TITLE:	**3rd MRI Static Scanner York Hospital**
OWNER:	**Dr Mark Quinn**
AUTHOR:	**Karen Priestman**

Capital

		Total £'000	Planned Profile of Change 2023/24 £'000	2024/25 £'000	2025/26 £'000	Later Years £'000
Capital Investment	(-ve)	0				
Equipment	(-ve)	-2,019		-2,019		
Property Transactions (Leases)	(-ve)	0				

Capital Notes *(including reference to the funding source)* :

The total Capital Costs of this case are £2,019k this is broken down as £895k (Exc VAT) for 3rd MRI Scanner, £1,124k (Exc VAT) for all associated works. This project has been subject to a successful bid through SR21 Year 3 – 2024/25 Financial Year Imaging Transformation Additional Acute Assets. We have been notified that we have been successful in securing £1,966k through this nationally funded route, and the trust capital programme will need to fund the remaining £53k in 2024/25.

Revenue

		Total Change Current £'000	Revised £'000	Change £'000	WTE	Planned Profile of Change 2023/24 £'000	2024/25 £'000	2025/26 £'000	Later Years £'000
(a) Non-recurring set up costs	(-ve)								
(b) Recurring									
Income									
Income from Patient Care Activities:	(+ve)	0	0	0		0	0	0	0
Other Operating Income	(+ve)	0	0	0		0	0	0	0
Total Income		**0**	**0**	**0**		**0**	**0**	**0**	**0**
Operating Costs:									
Pay									
Medical	(-ve)	-5,056	-5,191	-135	1.00	-68	-135	-135	-135
Nursing	(-ve)			0					
Other (please list):									
Medical Physics	(-ve)	0	-14	-14	0.20	-6	-14	-14	-14
Support Staff	(-ve)	-944	-974	-30	1.00	-15	-30	-30	-30
ISW	(-ve)	-891	-1,040	-149	5.00	-75	-149	-149	-149
Radiographers	(-ve)	-926	-1,264	-338	7.00	-169	-338	-338	-338
Total Pay Costs		**-7,817**	**-8,483**	**-666**	**14.20**	**-333**	**-666**	**-666**	**-666**
Non-Pay									
Purchase of Healthcare from NHS Bodies	(-ve)			0					
Purchase of Healthcare from non NHS Bodies	(-ve)	-1,940	-1,274	666		333	666	666	666
Clinical Supplies & Services	(-ve)			0					
General Supplies & Services	(-ve)			0					
Drugs	(-ve)			0					
Establishment	(-ve)			0					
Premises - (incl Business rates)	(-ve)			0					
Transport	(-ve)			0					
LLP Costs (Facilities Mgmt & Estates)	(-ve)			0					
Other (please list):									
	(-ve)			0					
	(-ve)			0					
Total Non Pay Costs		**-1,940**	**-1,274**	**666**		**333**	**666**	**666**	**666**
Total Operational Expenditure		**-9,757**	**-9,757**	**0**		**0**	**0**	**0**	**0**
Impact on EBITDA		**-9,757**	**-9,757**	**0**	**14.20**	**0**	**0**	**0**	**0**
Capital Charges Total Provided for Bid	(-ve)		-150	-150		-37	-150	-150	-150
Rate of Return	(-ve)			0					
Lease Ammortisation	(-ve)			0					
Overall impact on I&E		**-9,757**	**-9,907**	**-150**	**14.20**	**-37**	**-150**	**-150**	**-150**
									+ favourable (-) adverse
Less: Existing Provisions	(+ve)	**n/a**		**0**					
Net impact on I&E		**-9,757**	**-9,907**	**-150**		**-37**	**-150**	**-150**	**-150**
									+ favourable (-) adverse

Revenue Notes *(including reference to the funding source)* :

The only revenue cost pressure that will be incurred through this Business Case is the Capital charges.

Staff Costs - Radiographers (6wte B6 1 wte B7), ISWs (5wte B3), Admin (1 wte B3), Medical Physics (B8a 0.2wte), Consultant (1wte) all start from 1st October 2024.

Non Pay - The reduction in non-pay costs is driven by the reduced requirement for Mobile provision and offsets the revenue impact of the case.

			Board of Directors Only
	Owner	Finance Manager	Director of Finance
Signed	Dr Mark Quinn	Neil Barrett	
Dated	10.4.24	10.4.24	

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2023/24	2024/25	2025/26	Later Years
Fixed Contract Element							
Non-elective admissions			0				
Outpatient Follow Ups			0				
A&E			0				
High Cost Drugs			0				
Other (please list):							
			0				
Variable Contract Element							
Elective Inpatients			0				
Elective Day Cases			0				
Outpatient First Attendances			0				
Outpatient Procedures			0				
High Cost Drugs			0				

Income (*+ve*)

		Total Change			Planned Profile of Change			
		Current £'000	Revised £'000	Change £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	Later Years £'000
Fixed Contract Element								
Non-elective admissions	(+ve)			0				
Outpatient Follow Ups	(+ve)			0				
A&E	(+ve)			0				
High Cost Drugs	(+ve)			0				
Community Services	(+ve)			0				
Other (please list):								
				0				
Variable								
Elective Inpatients	(+ve)			0				
Elective Day Cases	(+ve)			0				
Outpatient First Attendances	(+ve)			0				
Outpatient Procedures	(+ve)			0				
High Cost Drugs	(+ve)							
Other NHS Clinical Income								
	(+ve)			0				
	(+ve)			0				
Non NHS Clinical Income								
Private patient income	(+ve)			0				
Other non-protected clinical income	(+ve)			0				
Total Income from patient care activities		0	0	0	0	0	0	0
Other income								
Research and Development	(+ve)			0				
Education and Training	(+ve)			0				
Other (please list):								
	(+ve)							
	(+ve)			0				
Total other income		0	0	0	0	0	0	0

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE RUN RATE SUMMARY

		Total Change				Planned Profile of Change		
		Current £'000	Revised £'000	Change £'000		6 months £'000	12 months £'000	Later Years £'000
Income								
Income from Patient Care Activities:	(+ve)			0				
Other Operating Income	(+ve)			0				
Total Income		**0**	**0**	**0**		**0**	**0**	**0**
Operating Costs:								
Pay								
Medical	(-ve)	-421	-433	-11		-11	-11	-11
Nursing	(-ve)			0				
Other (please list):								
Medical Physics	(-ve)	0	-1	-1		-1	-1	-1
Support Staff	(-ve)	-79	-81	-3		-3	-3	-3
ISW	(-ve)	-74	-87	-12		-12	-12	-12
Radiographers		-77	-105	-28		-28	-28	-28
Total Pay Costs		**-651**	**-707**	**-56**	**0.00**	**-55**	**-55**	**-55**
Non-Pay								
Purchase of Healthcare from NHS Bodies	(-ve)			0				
Purchase of Healthcare from non NHS Bodies	(-ve)	-162	-106	56		55	55	55
Clinical Supplies & Services	(-ve)			0				
General Supplies & Services	(-ve)			0				
Drugs	(-ve)			0				
Establishment	(-ve)			0				
Premises - (incl Business rates)	(-ve)			0				
Transport	(-ve)			0				
LLP Costs (Facilities Mgmt & Estates)	(-ve)			0				
Other (please list):								
	(-ve)			0				
	(-ve)			0				
Total Non Pay Costs		**-162**	**-106**	**56**		**55**	**55**	**55**
Total Operational Expenditure		**-813**	**-813**	**0**		**0**	**0**	**0**
Impact on EBITDA		**-813**	**-813**	**0**	**0.00**	**0**	**0**	**0**
Depreciation	(-ve)		-13	-13		-13	-13	-13
Rate of Return	(-ve)			0				
Lease Ammortisation	(-ve)			0				
Overall impact on I&E		**-813**	**-826**	**-13**	**0.00**	**-13**	**-13**	**-13**
Less: Existing Provisions	(+ve)	**n/a**		**0**				
Net impact on I&E		**-813**	**-826**	**-13**		**-13**	**-13**	**-13**

Run rate notes:

The only run rate consequences of this case are the capital charges.

Report to:	Board of Directors
Date of Meeting:	24 April 2024
Subject:	Board of Directors Public Meeting Work Plan
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

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

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

Summary of Report and Key Points to highlight:

To note and approve the 2024/25 Board of Directors Public Meeting Work Plan.

Recommendation:

The Board of Directors is asked to approve the 2024/25 Board of Directors Public Meeting Work Plan.

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

Meeting	Date	Outcome/Recommendation
N/a		

Board of Directors Public Meeting Work Plan 2024/25

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Governance Standing Items													
Apologies	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Declarations of Interest	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Approval of previous meeting's minutes	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Matters Arising	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chair's Report	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chief Executive's Report	Chief Exec	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Items													
Trist Priorities Report (TPR): - Performance - Quality & Safety - Workforce - Digital - Finance	Each Exec Director	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Maternity: - Maternity & Neonatal Quality & Safety Report - CQC Section 31 Update	Chief Nurse	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
CQC Compliance Update Report	Chief Nurse	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Summary Reports of Assurance Committees	Comm Chairs	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Quarterly Items													
Risk Management report - Board Assurance Framework	Asso Dir CG	✓			✓			✓			✓		

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mortality Review (Learning from Deaths) Report	Medical Director		✓				✓		✓				✓
Emergency Preparedness Resilience and Response (EPRR) Action Plan Update	Chief Operating Officer	✓			✓			✓			✓		
Journey to Excellence Report	Chief Nurse	✓			✓			✓			✓		
Annual Items													
Annual Operational and Finance Plan (final)	Dir Fin/ COO/Dir Work & OD		✓										
Infection, Prevention and Control Annual Report	Chief Nurse			✓									
Safeguarding Annual Report	Chief Nurse						✓						
Freedom to Speak Up Report	FTSU Guardian						✓						
Annual Complaints Report	Chief Nurse		✓										
Responsible Officer Annual Report	Medical Director						✓						
Medical Education Report	Medical Director						✓						
Guardian of Safe Working Hours Annual Report	Medical Director												✓
Staff Survey Annual Report	Dir Work & OD												✓
Staff Survey Improvement Plan	Dir Work & OD			✓									
WRES & WDES Annual Report	Dir Work & OD		✓										
WRES & WDES Action Plan Report	Dir Work & OD						✓						

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Gender Pay Gap Report	Dir Work & OD							✓					
Equality, Diversity and Inclusion Annual Report	Dir Work & OD			✓									
Winter Plan	Chief Operating Officer						✓						
EPRR Annual Report	Chief Operating Officer								✓				
Governance Framework Review: - Constitution - Standing Orders - Scheme of Reservation and Delegation - Standing Financial Instructions	Asso Dir CG										✓		
Fit & Proper Persons Annual Report	Asso Dir CG		✓										
Modern Slavery Act Statement approval	Asso Dir CG												✓
Assurance Committees Annual Reports approval (ToR as required)	Asso Dir CG												✓
Board Register of Interests	Asso Dir CG	✓											
Research and Development Strategy	Medical Director							✓					
Research and Development Annual Report	Medical Director		✓										

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Premises Assurance Model (PAM)	YTHFM Managing Director						✓						
Trust Planning Items													
Trust Strategy Approval	Chief Exec/ CDIO						✓						

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 April 2024
Subject:	Risk Management Update – Board Assurance Framework
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

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

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

Summary of Report and Key Points to highlight:

To approve the Q4 2023/24 Board Assurance Framework.

Recommendation:

The Board of Directors is asked to approve the Q4 2023/24 Board Assurance Framework.

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

Meeting	Date	Outcome/Recommendation
Risk Committee	Quarterly	Approved

Risk Management Update – Board Assurance Framework

1. Introduction and Background

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

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

2. Board Assurance Framework (BAF)

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

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

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

3. Risk updates

The BAF has been updated for Q4 2023/24 following review by the Executive Director owners.

The BAF will subsequently be reviewed for 2024/25 with the Executive Risk owners at the forthcoming May Risk Committee, ahead or a full evaluation in line with the review of the Trust's strategy.

4. Next Steps

The BAF will next be reported at the July Board of Directors meeting.

Trust Priorities; Quality and Safety

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

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Quality Committee**	
Likelihood	4	4	3	**Risk Appetite: Exceeding**		
Impact	5	4	2	**Date to achieve target score: Year-End Review**	**Risk Owner:**	**Chief Nurse**
Overall risk rating	20	16	6		**Links to CRR:**	**6, 16, 17, 4, 7, 18, 14, 24, 20, 8, 2, 3, 12, 21, 5, 19, 15, 22**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Internal effectiveness reviews against national standards	None identified	-Clinical effectiveness team -Internal Audit -Internal Accreditation Process to be launched Q2	- Clinical Effectiveness reports - Internal Audit reports - Accreditation status reports	None identified
Review of data from national surveys e.g. NICE, NSF	None identified	-Healthcare Evaulation Data (HED) -Clinical Effectiveness Audits -NICE - Clinical Outcomes Effectiveness Group - Patient Safety and Clinical Effectiveness Sub-Committee	- HED reports - National Survey results - Minutes of the monthly Clinical Outcomes Effectiveness group - Minutes of the monthly Patient Safety and Clinical Effectiveness Group	None identified
Implementation of Clinical standards	None identified	- Board of Directors - Quality Committee -Development Programme for Matron and Senior Nursing and AHP staff.	- TPR reported and discussed at every Board of Directors and Quality & Safety Assurance Committee (re-named Quality Committee from December 2023) - Minutes and actions of papers April- June, July-December Board of Directors , Executive Committee and Quality & Safety Assurance Committee inc Nurse Staffing, Ockenden, CQC, IPC. -Feedback from the development programme for Matrons and senior Nursing and AHP staff.	None identified

Revalidation of professional standards for doctors	None identified	-Trust internal appraisal and revalidation process/system	- Annual Revalidation Report to Sept 2023 Board	- Revalidation requirements and links to appraisal
Oversight of performance	None identified	- Oversight & Assurance meetings (Performance Review & Improvement Meetings (PRIM) from Q3) and other governance forums	- TPR reported to April-December Board of Directors and April-December Quality & Safety Assurance Committee (re-named Quality Committee from December 2023) - Minutes and actions of papers TPR April-December Board of Directors , Executive Committee and Quality & Safety Assurance Committee (re-named Quality Committee from December 2023) - KPIs in Care Group dashboards - Q1 & Q2 Minutes of Oversight & Assurance meetings - Performance Review & Improvement Meetings (PRIM) from Q3	None identified
Implementation of the Performance Management Framework	None identified	- Oversight & Assurance meetings (Performance Review & Improvement Meetings (PRIM) from Q3) and other governance forums	- Q1 & Q2 Minutes of Oversight & Assurance meetings - Performance Review & Improvement Meetings (PRIM) from Q3 and other governance forums e.g. Quality Committee, Care Group Board meetings.	None identified
Ongoing Implement Workforce & OD Strategy (Being Renewed)	Poor diversity in leadership positions (gender pay, race equality)	- Board, Executive and Digital, Performance and Finance Assurance Committee (renamed Resources Committee from Jan '24)	- Board/Committee papers - Oct Board Equality, diversity and inclusion data reporting	None identified
Ongoing monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	-TPR reported to April-December Board of Directors and May, July and Dec People & Culture Assurance Committee - Executive Committee Agency Usage Report	None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	-Limited visibility to investments required but not progressed.
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports Bank only training for non-medical is at 83.1% and Medical is at 67.2%.	-Training deferred/delayed due to operational pressures.
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
Monitoring the effectiveness of waiting lists	None identified	Clinical Risk stratification, validation and monitoring of waiting lists	- Risk stratified elective waiting lists.	None identified
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT. -Business Planning process	- Schedules detailing capital investment needs. -Business Planning schedules	None identified

Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	- April & May Executive Committee and Board of Directors approved plan - Capital planning process underway for 2024/25	None identified
Routine monitoring and reporting against capital programme	None identified	-Financial Services	- Agenda, papers, minutes and action logs for internal governance meetings (CPEG), Digital, Performance and Finance Committee, Executive Committee, Board of Directors) - Reports to external bodies (the ICS and NHSE/I)	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Recruitment	55 target (including 15 specialist roles for adult inpatient areas) to be recruited Apprenterships initiatives underway Fully supporting staff using national CPD funds	Polly McMeekin	**Mar-25**
Culture change (Retention)	Implement E,D & I gap analysis Our Voice Our Future programme commenced June 23 Visibility Programme launched July 23	Simon Morritt	**Jun-25**
Wellbeing space development	Utilisation of charity funds to implement	Polly McMeekin	**Mar-25**

Trust Priorities; Quality and Safety

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

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Quality Committee**	
Likelihood	5	4	3	**Risk Appetite: Exceeding**		
Impact	5	5	4	**Date to achieve target score: Review at Year End**	**Risk Owner:**	**Medical Director**
Overall risk rating	25	20	12		**Links to CRR:**	**16, 17, 4, 7, 18, 14, 24, 20, 8, 2, 3, 12, 21, 5, 19, 15, 22**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implementation of Clinical standards	None identified	-Board of Directors -Quality & Safety Assurance Committee (now Quality Committee and sub structure) --PRIM - Review of clinical harm process - Internal and External Audit - Monitoring of incidents via Datix enbling identification of gaps	- TPR Committee reporting of learning from Patient Safety Incidents - Minutes and actions of papers (Board, Executive, Quality Committee) - National Audit Clinical Standards - GIRFT Reviews - External reviews; JAG, RCP-IQUILS, Structure Judgement Reviews, LEDER Reviews national audits	Sustained clinical demand resulting in over occupancy of beds, crowding of acute and emergency areas leads to challenges of delivering safe and effective care. The montoring of incidents via Datix will provide the idenfication of potential gaps in assurance for further investigation.
Revalidation of doctors	None identified	-Annual Board Report and peer review	- Annual Organisational Audit Report to Sept Board	None identified

Conduct Incident Reporting and learning from Safety incidents Implementation of PSIRF December 2023	None identified	- Datix - Care Group Boards - Oversight & Assurance meetings - CPD - PSIRF implementation plan completed	- Action plans following investigation of incidents on a case by case basis - Datix incident reports - Monthly SI/Never Event reports presented to Quality & Safety Committee, Operational Quality Group (Patient Safety and Clinical Effectiveness from Jan 24), Care Group Boards and Oversight & Assurance meetings April-July 2023/24 - Performance Review and Improvement Meeting (PRIM) from Q3) - Learning from deaths and 6 monthly Cancer Harm report to QPaS - Patient experience report Q1-Q3 reported to Quality & Safety Assurance Committee - Medical Legal report - Escalations recorded on CPD - Medical Examiner Report - From January 2023 new Quality Assurance Structure in place	Overarching analysis and triangulation of all information. Clinical pressures divert Clinical Staff from Audit Assurance work. Ward to Board Quality data.		
What actions will further mitigate the causes and consequences of the risk to its identified target rating?			*What is the current progress to date in achieving the action identified?*		*Owner of action*	*When action takes affect?*
Actions for further control			**Progress to date / Status**		**Lead action owner**	**Due Date**

Trust Priorities; Elective Recovery - Acute Care Flow

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

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Resources Committee**	
Likelihood	4	4	4	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: Year End**	**Risk Owner:**	**Chief Operating Officer**
Overall risk rating	20	16	12		**Links to CRR:**	**6, 16, 17, 4, 7, 18, 14, 24, 20, 8, 9, 2, 3, 12, 21, 5, 19, 15, 22**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
1. Oversight of performance	None identified	Board and DPF Committee (Resources Committee from Jan '24) Oversight & Assurance meetings and other governance forums - Performance Review & Improvement Meetings (PRIM) from Q3. Executive attendance at the Integrated Quality Improvement Group (IQIG).	TPR reported and discussed at every Board, Digital, Performance and Finance Assurance Committee (Resources Committee from Jan '24) - Minutes and actions of papers Apr- Dec (TPR), Apr-Dec (Board, Executive, Digital, Performance and Finance Assurance Committee - Resources Committee from Jan '24) - KPIs in Care Group dashboards - Minutes of Q1 & Q2 Oversight & Assurance meetings and Care Groups - Performance Review & Improvement Meetings (PRIM) from Q3 -IQIG Presentations from Q3 23/24	Speciality level dashboards not not fully established with all metrics available.

A. Implementation of the Performance Management Framework	None identified	Board and DPF Committee (Resources Committee from Jan '24) Oversight & Assurance meetings and other governance forums - Performance Review & Improvement Meetings (PRIM) from Q3.	- Minutes of Q1&2 Oversight & Assurance meetings - Performance Review & Improvement Meetings (PRIM) from Q3 - Minutes and actions of papers TPR April-Dec (Board, Executive Committee , Digital, Performance and Finance Assurance Committee - Resources Committee from Jan '24) EY review of performance Management Framework as part of Tier 1 actions	Speciality level dashboards not not fully established with all metrics available.
B. Implementation of surge plans	None identified	- Scenario testing of surge plans (Winter resilience) Lessons learned paper to Exec Committee and Board - Silver and Gold Command standard operating procedures -23/24 OPEL framework implemented in Q3 23/24	- Results of scenario testing. Minutes of March Board & March Exec Committee were lessons learnt were presented - OPEL 4 daily calls assurance to YAS and NHSEI on Ambulance turnaround when required - Bronze/Silver/Gold Command enacted for exeptional pressures with documented actions when required	None identified
C. Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
D. Implementation of winter plans, resilience plans and surge plans	None identified	- Winter and resilience plans discussed at governance meetings (Executive, Board, Quality Committee)	- Minutes of Sept Board and Sept Executive Committee where winter and resilience plans were discussed.	None identified
E. Delivery of Building Better Care programme. Established as Elective Recovery Board UEC Board, Maternity Transformation Board People & Culture Committee	None identified	Programme structure established Transitioned to BAU project management office approach suporting 5 main programmes including maternity and neonatal, elective recovery, urgent and emergency care, community diagnostic centres and culture and leadership.	- April-Sept Transformation Committee reports and minutes inc KPIs Closing report to Execuive Committee May2023 -Journey to execllence monthly highlight reports for all programmes	- None identified

F. Monitoring the effectiveness of waiting list management	None identified	- Elective recovery planning and monitoring of waiting list management - ERB - weekly elective recovery meetings reviewing all speciality RTT waiting lists. - weekly Cancer patient tracking meetings revieiwng all tumour site waiting lists.	- Reporting on progress of meeting waiting lists, via Tier 1 meetings and DPF Committee & Board - Operational Performance discussed at monthly care group performance review and improvement meetings (PRIM)	Monitoring of non RTT waiting lists remains in development
G. Urgent Care working at place	None identified	- Collaboration of Acute Providers '- HNY ICB UEC Board	- Engagement and participation at Collaboration of Acute Providers ~~for elective recovery~~ '- systemwide UEC transformational programmes	- None identified
H. Deployment of health inequality assessment to inform waiting list management	None identified	- Board and Executive Committee - Trust inequalities working group now established from Jan 2024	- Oct Executive Committee York City Council reporting of Health Inequalities across Trust area - Terms of reference and minutes of Trust Health Inequalities Working Group	- Development of gaps for prioritisation of health inequalities on waiting lists

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Deliver the 2024/25 Plan on activity	Oversight provided through the Executive Committee as a Committee of Board. Assurance provided through the Digital, Performance and Finance Assurance Committee (resources committee from Jan 24).	Claire Hansen	**Mar-25**
Integrated Quality Implementation Group delivery	Attendance by the Trust on an ongoing basis	Claire Hansen	**Mar-24**

Trust Priorities; Our People

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

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Resources Committee**	
Likelihood	5	4	4	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: Year End**	**Risk Owner:**	**Director of Workforce and OD**
Overall risk rating	25	20	12		**Links to CRR:**	**6, 4, 7, 18, 24, 8, 3**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implement Workforce Strategy and People Recovery Plan	- Poor diversity in leadership positions (gender pay, race equality) - Lack of resources to fund intiatives	- Board, Executive and People and Culture Committee (Resources Committee from Jan '24)	- Board/Committee papers June 2019 approval - Equality, diversity and inclusion data reporting of WRES/WDES Oct Board of Directors report	None identified
Deliver Board development sessions	None identified	-Board meetings	- Board development independent review	None identified
Conduct Talent Management Framework	None identified	-Trust intranet - Board of Directors papers	- Learning Hub - PREP	None identified
Design and Deliver Internal Leadership Programmes	None identified	-Trust intranet - Shadow Board development with NHS Elect	- List of programmes on Learning Hub	None identified
Line Management Toolkit and training implementation	None identified	- Line Management Toolkit rollout	- Developed Line Management Tookit	- Evidence of implementation
Leadership succession plans	None identified	- Board, REMCOM, Executive Committee - Shadow Board development with NHS Elect	- Remuneration Committee papers (Oct agenda, minutes, action log)	None identified

Implement ICS initiatives e.g. Ambassador Scheme	Poor diversity in leadership positions (gender pay, race equality)	- Board (reporting on Equality, diversity and inclusion)	-Board papers (agenda, minutes, action log) -REMCOM papers (agenda, minutes, action log)	None identified
Implement Workforce models and planning on a case by case basis	National contract limitations National training programmes	-Director of Workforce & OD	-Board approved Workforce models and plans	None identified
Target overseas qualified staff	None identified	- Overseas AHP and medical recruitment programme	- QIA for new nurse roles - CHPPD - ICS international recruitment programme (Kerala)	None identified
Incentivise recruitment & reintroduced recruitment open days. Launched careers website.	None identified	-Reduced vacancy rates in TPR	- TPR and workforce reporting at May-Dec People and Culture Workforce Committee (Resources Committee from Jan '24)	None identified
Monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	- Minutes and actions of papers TPR April-Dec (Board, Executive Committee , People & Culture Assurance Committee - Resources Committee from Jan '24 - Executive Committee Monthly Agency Usage Report	None identified
Oversight of rotas - e-Rostering	Approximately 50% of AHP rotas remain manual	- Internal Audit	- Internal Audit reports on E-Rostering - CHPPD - Erostering Business Case - New Erostering Policy	None identified
Oversight of Establishments and establishment reviews (nursing and AHP)	None identified	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	None identified
~~Monitor performance against the People Plan~~	~~None identified~~	~~-Resource Committee updates against the People Plan~~	~~- Sept 22 Minutes People and Culture Committee~~	~~None identified~~
Implement Workforce & OD Strategy	None identified	- Reporting on performance against the Workforce & OD Strategy to Board, Executive and Resources Committee.	- People & Culture Assurance Committee updates July-Dec (Resources Committee from 'Jan 24)	None identified
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%) - May-Dec People and Culture Committee reporting, action plan and minutes	None identified
Workforce resilience model	Estate limitations - lack of staff rest areas	Executive Committee	- Executive Committee approval October 2021	Limited visibility to investments required but not progressed.
Communicate guidance for Managers for remote working	None identified	- Trust intranet	- Agile Working Policy	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*

Actions for further control	Progress to date / Status	Lead action owner	Due Date
Culture change (Retention)	Implement E,D & I gap analysis Our Voice Our Future programme commenced June 23 Visibility Programme launched July 23.	Simon Morritt	**Jun-25**
Leadership Framework roll-out	Roll out continues with Phase 2 of Care Group Leadership Development due to complete April 24. Phase 3 which commences from 30th May 2024 will bring together Senior Ops Managers, Matrons, Lead AHPs and Clinical Leads.Following this Corporate areas and YTHFM will be invited to join with adapted agenda.	Polly McMeekin	**Oct-24**
Recruitment	International recruitment paper to go to Exec Committee (April 24) 55 target (including 15 specialist roles for adult inpatient areas) to be recruited Apprenterships initiatives underway Fully supporting staff using national CPD funds Persuing international medical recruitment with the ICB	Polly McMeekin	**Mar-25**
Workforce Plan	Clinical Establishment review continues (Nursing complete - AHP being finalised); Develop further alternative roles ; Increase Apprenticeship levy spend	Polly McMeekin	**Oct-24**

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

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

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Resources Committee**	
Likelihood	5	4	2	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: Oct 2024**	**Risk Owner:**	**Director of Finance**
Overall risk rating	25	16	6		**Links to CRR:**	**6, 4, 7, 18, 14, 24, 8, 9, 5**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Annual Business Planning process including Trust Strategy	None identified	- Business Planning process - Internal Audit - ICB plan triangulation	- Business planning schedules. - Internal audit reports on effectiveness of controls around the Business Planning process.	None identified
Preparation and sign off of annual Income and Expenditure plan, balance sheet and cash flow	None identified	- Executive Committee and Board of Directors. - Board Development Session deep dive into plan work	Plan approved at March with update at April Board.	None identified
Full triangulation with ICB and wider system partners	None identified	- Executive Committee and Board of Directors. - Board Development Session deep dive into plan work	Plan feedback shared with Executive Committee and Board of Directors including full ICB overview. ICB FD group reviewing planning for consistency and triangulation. ICB feedback sessions involving CEO and Chair.	None identified

Routine monitoring and reporting against I&E plan	None identified	- Monthly updates to Care Group PRIMs, Resources Committee, Financial Review Meetings, Executive Committee, Board of Directors, the ICS and NHSE.	- Minutes and actions of papers TPR (Board, Executive Committee , Resources Committee) - Reports provided to external bodies (PFR monthly to NHSE)	None identified
Expenditure control; scheme of delegation and standing financial instructions.	None identified	- Board of Directors	- Board approved scheme of delegation - System enforced delegation and approval management. - Written confirmation by prime budget holders or responsibilities - Care Groups finance risk planning documentation - Further intervention opportunities considered	None identified
Expenditure control; business case approval process	Unplanned and unforeseen expenditure commitments.	- Internal audit - Financial Management team - Non-Pay Prime Budget Holder acceptance and sign-off	- Business Case Register - Internal audit reports on effectiveness of controls around the Business Planning process. - Reports produced by the Financial Management team on variance analysis - Vacancy control process - Development and deployment of a new budet holder dashborard (REACH reporting)	None identified
Expenditure control; segregation of duties	None identified	-Finance systems	-System enforced approvals. -No Purchase Order No Payment policy.	None identified
Expenditure control; staff leaver process	Management failing to notify Payroll in a timely way of staff leavers	-Contract change notification process. -Routine reporting of staff in post (i.e. paid) to budget holders.	-Salary overpayment recovery policy. -Reports from Finance to budget holders on their staff in post	Limited visibility to issue
Income control; income contract variation process	Unforeseen and unplanned in-year reduction in income.	-Financial Management Team	Income Adjustment form register.	None identified
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	-April/May Executive Committee and Board of Directors approved plan	None identified

Routine monitoring and reporting against capital programme	None identified	-Financial Services	- Minutes and actions of papers TPR (Board, Executive Committee , Resources Committee and CPEG - Ad hoc reports to external bodies (the ICS and NHSE)	None identified
Overspend against approved scheme sums	None identified	-Financial Services	-Scheme sum variation process. -Scheme expenditure monitoring reports to CPEG.	None identified
Routine monitoring against cash flow	None identified	- Board of Directors - Finance team	- Minutes and actions of papers TPR (Board, Executive Committee , Resources Committee) - PFR monthly to NHSE	None identified
Cash flow management through debtors and creditors	None identified	-Financial Management Team -Government	-Monthly debtor and creditor dashboard to Finance Managers and Care Groups. -Trend data reported to Executive Committee, Resources Committee and Board of Directors. -Better Payment Practice Code (BPPC) - monthly report	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
System wide medium-term financial planning te be revised later in the year	Guidance for 2024/25 now released. Focus currently on 24/25 planning but expectation that work later this summer will move to production of a medium term system financial plan.	Andrew Bertram	Autumn-24

Trust Priorities; Quality and Safety

Risk description	PR 6 - Failure to deliver safe, secure and reliable digital services required to meet staff and patients needs.	**Causes** *What has to happen for the risk to occur?*	- Succesful cyber attack through a computer virus or malware, malicious user behaviour, unauthorised access, phishing or unsecure data flows. - Failure of the core technology estate (e.g. CPD, clinical or administrative systems or network infrastructure) due to single points of weakness, loss of power/premises, out of data infrastructure or poor data storage/sharing processes.
		Consequences *If the risk occurs, what is its impact?*	- Potential patient harm. - Regulatory attention (ICO). - Reputational damage. - Financial costs.

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Digital Sub-Committee**	
Likelihood	4	3	3	**Risk Appetite: Exceeding**		
Impact	4	4	3	**Date to achieve target score: July 2024**	**Risk Owner:**	**Chief Digital and Information Officer**
Overall risk rating	16	12	9		**Links to CRR:**	**6, 4, 5**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Information Governance Policies and Procedures The trust have policies and staff guidance in place communicating the organisations principles and procedures for data protection. The following policies are in place: Data protection Record Management Data Security Registration Authority Subject Access Requests Freedom of Information Network Security	The Data Quality Policy is currently under review. The Network Security Policy requires updating. The draft Registration Auhority Policy requires approval. Limited monitoring of policy implementation and adherance.	Yearly internal Data Security Protection Toolkit (DSPT) audit report. Bi-annual Data Security Protection Toolkit submission to NHS England. DSPT improvement plan. Policies are available to all staff through the Information Goverance pages on Staff Room. Information Governance Executive Group minutes and actions (now forms part of Digital Sub-Committee).	DSPT Internal Audit report highlights 'Medium' assurance. IGEG meeting minutes highlight policies being reviewed. Proactively follow IG breach management and report to the ICO as appropriate. Regular trusts wide communications regarding new policies and procedures. Audit of procurement processes.	Levels of compliance with the Trust Data Protection/Confidentiality Policies should proactively be undertaken on an annual basis through unannounced IG walks. Commision audit against the principles set out in the Shadow IT Policy.

Data Security and Protection Training All staff should undertake their mandatory Information Governance Training All Board members should complete their Core Statutory and Mandatory IG and Data Security training on an annual basis. Continuous campain to raise staff awareness of cyber threats.	Awareness training should be continuous.	KPIs highlighting number of staff undertaking IG training	SIRO Completed Manadatory Training. Majority of IAOs completed relvenat training. Majority of staff completing IG training. All staff must have initial IT induction training before they are granted access to the Trust network.	Provide specialised cyber security training to all members of the Board of Directors. ** Cyber Security Officer assessing potential training options. **
User Access Controls Processes for dealing with joiners, movers and leavers that identify/change appropriate user access as necessary. Wherever possible, the Trust should use Multi Factor Authentication (MFA) for end user and end point devices.	Lack of access management policy, or similar, that documents how access is removed from user accounts that are no longer required and whether payroll systems or other means, such as manual processes, are involved in triggering the revocation of access.	Regular audits of access to the Active Directory as part of the leavers process.	MFA enrollment (for users) across the Trust completed in Mar 24 (noting that this is a national requirement and compliance for the DSPT).	MFA for users of CPD (and other applications) with elevated acess rights. Despite NHSE policy, this will be prohibitive and challenging to implement. ** Cyber Security Officer engaging with NHSE on next steps. **
Business Continuity and Resiliance Data security incident response and management plan. Penetration Testing of key systems Backup policy and Testing.	A wide vareity of policies require review and updating (currently in progress at 14 Apr 24); this is inclusive of a raft of cyber protocols that need to be redesignated as formal policies.	Business Continuity exercise conducted in September 2022 and results presented to DPF Committee; and BC activity was considered appropriate as part of the CPD outages of Nov 23 and Jan 24 respectively (agreed with Internal Audit). A full backup review has been undertaken. Cyber Incident Response plan finalised and approved.	Exercise outputs indicated staff perfomed well. A test restore has been undertaken on minor system as proof of concept, and schedule of quarterly restores planned.	Trust wide participation in business continuity exercise; regular CPD downtime (via scheduled maintenance windows) should be considered to (help) facilitate this. Penetration testing of CPD has been undertaken, but there needs to be a rolling schedule of penetration testing implemented. ** Cyber Security Officer assessing options. ** Recovery Time Objectives (RTOs) and Recovery Point Objectives (RPOs) need to be more clearly defined for the Trust's key systems.

Software Patching Patch management procedure that enables security patches to be applied at the operating system, database, application and infrastructure levels. This procedure should be set out in a patch management procedure and/or strategy/policy.	The Patch Management Process needs to be reviewed and updated to reflect the procedures in place for the management of security patches to mitigate high and critical vulnerabilities, and to include procedures for escalating patching; exceptions to the SIRO, in line with best practice guidance contained in the DSPT. ** The patch management process has been updated (see actions list below) and this gap in control will be closed on the next reporting cycle. **	All IT assets are currently recorded in the IT Health system, which can be monitored in real time.	Benchmarking with regards to the cyber exposure score continues to demonstrate a robust posture with positive results yielded.	There are a number of servers and endpoint devices that are not currently in support and require investment (noting upgrades for part of our Capital Plan for FY24/25). ** Upgrade plan in development to mitigate risk. **
Supply Chain Management The Trust should have an up to date list of its suppliers, which enables it to identify suppliers that could potentially pose a data security or data protection risk to the organisation.	The Trust does not currently possess a comprehensive central register of the processors that the Trust engages with, and a Supplier Management Policy/Process is not yet in place. A Supplier Management Policy or Process is required which provides guidance and standards for the procurement of IT services and products, supplier maintenance, network segmentation and whether 3rd party access is allowed or managed.	The Record of Data Processing Activity (ROPA) identifies the IT systems being used to process personal data.		The Trust does not currently possess a comprehensive central register of the processors that the Trust engages with and a Supplier Management Policy/Process is not yet in place. ** A work in progress; Head of IT and Service Ops is currently developing a register. **

Software Development Methodology The Trust should have a secure software development lifecycle (SSDLC) or equivalent software and code security approach in place, aligned to industry good practice such as OWASP, to reduce the risk of code vulnerabilities or web application vulnerabilities being exploited.	The Development Team should be provided with training on secure website design principles to ensure that suitably qualified staff are available as necessary in the future. The Development Team should also agree to a specified framework for software development process.			Assurances that third party website developers have used secure design principles, and that their web applications are protected against common security vulnerabilities. Penetration Test requires completion. ** Ref Business Continuity and Resilience; Cyber Security Officer is assessing potential options. **

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

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

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

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Executive Committee**	
Likelihood	3	3	3	**Risk Appetite: Inside Tolerance**		
Impact	3	2	2	**Date to achieve target score: Achieved**	**Risk Owner:**	**Chief Executive**
Overall risk rating	9	6	6		**Links to CRR:**	**6, 7, 18, 24, 9, 22**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Integration with ICS on system wide planning	None identifed	- Attendance of members of Trust Executive Team across H&NY ICS governance structure	- CEO engagement in senior leadership forums across ICS - Trust Executive membership of ICS Place governance arrangements - Chief Executive update reports on Board of Directors Minutes and actions of papers April-Dec - Trust Chief Executive the SRO for ICB Cancer Performance and Chair for the Cancer Alliance	None identified
Operational and Finance Plans 2023/24	None identified	- Board of Directors approval processes and sub-committee assurances of delivery	- Approval at May Board of Directors and submission to NHSE&I	None identified
Trust involvement in the Collaborative of Acute Providers	None identified	Acute providers governance in decision making across 5 strategic themed transformation programmes; cancer, diagnostics, electives, maternity and paediatrics, urgent and emergency care	- Chief Executive and Executive Directors fully engaged with the developing infrastructure supporting CAP - Board agreed CAP terms of reference and joint working agreement (June 2023) - Board approved Committee in Common to manage CAP business	None identified

Trust Chief Exective and Executive team engagement in collaboration	None identified	Executive Team engagement and involvement in collaboration across executive porfolios	- Collaboration meetings: Chief Operating Officer, Chief Nursing Officer, Medical Director, Dir of Workforce & OD, Finance Director	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Finance and activity delivery for 2023/24 as part of H&NY system delivery	Year-End performance for 23/24 in April TPR	Exec Team	**Apr-24**

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

Risk description	PR 8 - Failure to achieve net zero targets, air quality targets and changing climate adaptation requirements from the Health and Care Act 2022 and Humber & North Yorkshire ICS Green Plan	**Causes** *What has to happen for the risk to occur?*	- Failure to reduce greenhouse gas emissions from the Provider's Premises in line with targets in 'Delivering a 'Net Zero' National Health Service' (targets are 80% carbon reduction by 2032 and Net Zero by 2040). - Not achieving NHS Standard Contract Service Condition 18: Requirement to provide detailed plans as to how the Trust will contribute to a Net Zero NHS in relation to: (a)reducing air pollution from fleet vehicles, offering more sustainable travel choices - and increase their use - for Service Users, staff and visitors, in accordance with the NHS Net Zero Travel & Transport Strategy; (b)phasing out fossil fuels for primary heating and replacing them with less polluting alternatives; (c)reducing the carbon impacts of environmentally damaging gases used as anaesthetic agents and as propellants in inhalers, including reduction of piped nitrous oxide waste; and (d)adapting premises to reduce risks associated with climate change and severe weather.
		Consequences *If the risk occurs, what is its impact?*	- Reputational risk in not achieving targets - Potential NHS England action

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

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Sustainable Design Guide.	Internal Audit identified need to review the Sustainable Design Guide and its role to strengthen its contribution to the delivery of Net Zero.	Design Guide being implemented for Scarborough new emergency department (UECC) to reduce carbon emissions.	UECC designed with reference to Sustainable Design Guide.	None identified
York Hospital part of Carbon Reduction Pathway Modern Energy Partners Programme which estimated the cost to get York Hospital on track. Trust signed up to NHS Living Labs Innovation Programme to investigate new and developing technologies for achieving carbon reduction.	None identified	Modern Energy Partners (MEP) concept design report received for York Hospital 18/01/21. NHSE Living Labs - MoU signed following Executive Committee approval 20/04/22.	MEP Concept Design used as a basis for grant applications for Public Sector Decarbonisation Scheme (PSDS) projects, and subsequently for NHS National Energy Efficiency Fund (NEEF). NHSE Living Labs - NHS England lead left and projects not progressed.	None identified

PSDS Phase 3 grant applications approved for £4.7million for Bridlington Hospital to achieve Net Zero, and £4.3million scheme for York Hospital to start the decarbonisation process.	None identified	Planning applications approved in 2022. Business case approved. Signed contracts agreed and signed with Vital Energi for the delivery of grant aided works and to help develop plans to achieve net zero by 2040.	PSDS Grant work delivered in 2022/23. Works undertaken at York and Bridlington.	None identified
Feasibility funding awarded (Community Renewal Fund) for reviewing carbon reduction potential at Scarborough and Selby Hospitals.	None identified	Feasibility work to identify funding needs and practical implementation issues for Scarborough and Selby completed.	Several capital funding grant applications submitted that were unsuccessful until recent award from NEEF for low energy LED lighting at Scarborough, Bridlington, York, Malton and White Cross Court.	None identified
Green Plan published setting out the overall Trust approach and latest carbon footprint	Internal Audit identified need to review the Trust Green Plan and its role to more closely align its plans, projects and business cases with contributions to the delivery of Net Zero.	Trust Green Plan. Trust Travel Plan. Energy Saving Trust (EST) undertook a review of Trust's fleet and provided a Transport Decarbonisation Report in April 2022.	EST Transport Decarbonisation Report. Sustainability progress update in Trust Annual Report. Green Plan updated 2023/24 in line with latest guidance. Trust Travel Plan currently being updated to align with NHS Net Zero Travel and Transport Strategy.	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
New procurement exercise to commenced with Carbon & Energy Fund (CEF) to take advantage of next round of grant funding and develop a plan for achieving reductions in line with Net Zero 2040 target.	Procurement exercise completed. £9million grant funded works at York and Bridlington established through this procurement exercise nearing completion with some snagging matters currently being addressed at both York and Bridlington. Works due to be completed by end Feb 2024. Both projects have had best practice case studies published on the national Salix Finance website (grant managers on behalf of government's Department for Energy Security & Net Zero). Further PSDS grant applications for Scarborough hospital were unsuccessful.	Head of Sustainability	**Completed**
Contract negotiations on going for a contract which develops plans for York, Scarborough and Bridlington to 2040.	New contracts established for York , Scarborough and Bridlington hospitals with 6 monthly review of proposals to help the Trust get to net zero by 2040 through grant applications and business case proposals at these three sites. York, Scarborough and Bridlington contracts signing completed after gaining Board approval.	Head of Sustainability	**Completed**
Trust Travel Plan to be updated to incorporate plans to achieve carbon emissions	Previous focus of work in 2022 and 2023 was developing business case to support staff commute	Head of	**Jul-24**

reductions in line with NHS requirements.	options and facilities for York and Scarborough Hospitals which was approved and went live in June 2023. The Trust's Travel Plan is now being updated in line with the recently released NHS Net Zero Travel and Transport Strategy and will be released by July 2024. Key targets include reducing staff commuting emissions by 50% by 2033 and transitioning the entire Trust fleet to zero emissions vehicles by 2035.	Sustainability	
Improve internal temperature monitoring and control for vulnerable groups within the hospital estate to develop a plan in response to the changing climate.	Funding agreed and used during the summer of 2023 for a representative sample of inpatient ward temperature monitoring for York and Scarborough Hospitals. Temperatures recorded to be reviewed by Estates Team and Emergency Planning Manager to establish where improved temperature control and other operational and capital measures could assist with adapting to the changing climate whilst reducing carbon emissions. Consideration to be given to installing automated temperature monitoring at other sites with inpatient beds.	Head of Sustainability	**Oct-24**
Sustainable Design Guide to be reviewed when NHS Net Zero Building Standard published.	Net Zero Building Standard currently only applies to large Capital projects which require the Treasury Business Case approval so currently doesn't apply. Head of Capital Projects will review requirements when time permits or a new project dictates its's inclusion.	Head of Capital Projects	**Oct-24**
Green Plan to be reviewed.	Green Plan review now complete. Some amendments required by the Trust Board. Document to be brought again for approval by Trust Executive Committee in May before being published on the Trust website.	Head of Sustainability	**May-24**