York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 31st July 2024
Time: 9:30am – 12:30pm
Venue: Boardroom, 2nd Floor Admin Block, York 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**	Chair	Verbal	-	9:30
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 26 June 2024** To be agreed as an accurate record.	Chair	Report	5	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log. 5.1 Children and Young People Community Waiting List	Chair Chief Operating Officer	Report Report	13	
6.	**Chair's Report** To receive the report.	Chair	Report	22	9:35
7.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	25	9:45
8.	**Quality Committee Report** To receive the July meeting summary report.	Chair of the Quality Committee	Report	52	10:00

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Resources Committee Report** To receive the June meeting summary report.	Chair of the Resources Committee	Report	54	10:10
10.	**Trust Priorities Report (TPR)** May 2024-25 Trust Priorities Report Performance Summary:		Report		10:20
	• Operational Activity and Performance	Chief Operating Officer		60	
	• Urgent and Emergency Care Performance Summary	Chief Operating Officer		Verbal	
	• Quality & Safety	Chief Nurse		97	
	• Workforce	Director of Workforce & OD		119	
	• Digital and Information Services	Chief Digital Information Officer		129	
	• Finance	Finance Director		135	
Break 11:15					
11.	**Staff Survey Improvement Action Plan** To consider the report.	Director of Workforce & OD	Report	146	11:25
12.	**Annual Inpatient Staffing Review** To consider the report.	Chief Nurse	Report	156	11.35
13.	**Annual Complaints Report** To consider the report.	Chief Nurse	Report	171	11:45
14.	**CQC Compliance Update Report including Journey to Excellence** To consider the report.	Chief Nurse	Report	182	11:55

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Maternity and Neonatal Reports (including CQC Section 31 Update)** To consider the report.	Chief Nurse	Report	**195**	12:05
16.	**Emergency Preparedness Resilience and Response (EPRR) Core Standards Assurance - Quarterly Action Plan Update** To consider the report.	Chief Operating Officer	Report	**208**	12:15
Governance					
17.	**Board Assurance Framework Q1 Report** To approve the report.	Associate Director of Corporate Governance	Report	**225**	12:20
18.	**Fit & Proper Persons Test Annual Report** To consider the report.	Associate Director of Corporate Governance	Report	**241**	12:25
19.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
20.	**Time and Date of next meeting** The next meeting held in public will be on 25 September 2024 at 10am at Scarborough Hospital.				
21.	**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.				
22.	**Close**				12:30

Minutes
Board of Directors Meeting (Public)
18 June 2024

Minutes of the Public Board of Directors meeting held on Wednesday 26 June 2024 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 10.00am and concluded at 11.50am.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (& Maternity Safety Champion)
- Mrs Lynne Mellor
- Dr Stephen Holmberg *(via Teams)*
- Prof. Matt Morgan
- Ms Julie Charge
- Ms Helen Grantham (Associate)

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

Corporate Directors
- Mrs Lucy Brown, Director of Communications

In Attendance:
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 12)
- Mr Mike Taylor, Associate Director of Corporate Governance
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Two members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting, with a particular welcome to members of the public, Julie Charge (new Non-Executive Director) and Sarah Barrow, new Deputy Finance Director.

2 Apologies for absence

Apologies for absence were received from:

Mrs Jenny McAleese, Non-Executive Director
Mr Jim Dillon, Non-Executive Director
Mr Andrew Bertram, Finance Director

Professor Matt Morgan had indicated that he would join the meeting late.

3 Declaration of Interests

There were no declarations of interest to note.

4 Minutes of the meeting held on 22 May 2024

The Board approved the minutes of the meeting held on 22 May 2024 as an accurate record.

5 Matters arising/Action Log

The Board noted the outstanding actions which were on track or in progress. The following updates were provided:

BoD Pub 08 - *Investigate options for strengthening the telephony infrastructure.*
Mr Hawkins advised that he had sent an email to the Board detailing his response to this action. In summary, his team were working closely with the Patient Access Team to prepare call queues in readiness for call back request functionality, to add trigger numbers to existing call queues to help manage call flow and potentially to provide an option for an online cancellation form. Once the Patient Access Team were content with the implementation of these measures, the next phase would be to more accurately assess how any call back feature should be configured. However, the strategic intent was not to evaluate alternative platforms, but to enhance and utilise existing infrastructure to leverage evolving technologies across the current infrastructure. The timescale for this had not yet been determined. It was agreed that the action could be closed.

6 Chair's Report

The Board received the report. Mr Barkley reflected that the dominant theme arising from his visits and meetings in the last month had been the gap between demand for the Trust's services and its capacity to meet them, and the resulting impact on staff morale in key areas.

7 Chief Executive's Report

The Board received the report. Mr Morritt agreed with Mr Barkley that operational pressures were considerable and the impact on staff morale and overall performance was significant. This was a subject of ongoing meetings with the ICB and the wider system. On a more positive note, the Trust was making good progress on elective recovery.

Mr Morritt reminded the Board that industrial action by junior doctors would recommence on Thursday 27 June until Tuesday 2 July; the usual mitigation plans were in place but the impact on services was unavoidable.

Mr Morritt reported that he had met with the Change Makers at an event in Malton to mark the end of the Discovery phase of the Our Voice Our Future programme. This had been a very successful meeting, and it was hoped that the Change Makers would present the outcomes of the feedback they had collated to the Board.

Mr Morritt summarised the other sections of his report, which included the visit of Dame Cally Palmer to the Trust, the Achievement Awards event to be held in September, the success of the Digital team in reaching the finals of this year's HSJ Digital Awards. Mr Morritt highlighted the contribution of volunteers to the Trust, which was recognised during National Volunteers' Week, and the award of an OBE to Sally Light, Public Governor.

In terms of the work of the York Poverty Truth Commission, which was discussed at the last meeting, Mr Morritt underlined the importance of the Trust signing up to the four standards outlined in the charter, as part of the city-wide initiative. He recommended that the Board support the adoption of the Charter.

Mr Barkley observed that the aims of the Charter were admirable, but he remained cautious about any extra burden for staff in fulfilling the standards. Mr Morritt responded that the Charter reflected and reinforced the Trust's values and would not present any addition to workload. Mrs Parkes suggested that the standards could be embedded in Quality Impact Assessments which would help to focus senior leaders on the working practices which needed to be embedded.

The Board formally pledged its support for adopting the York Poverty Truth Commission Charter and integrating it into the Trust's working practices.

8 Quality Committee Report

Dr Holmberg briefed the Board on the escalations from the meeting of the Quality Committee on 18 June, which included:

- cultural barriers to improvement remained:
    - investigations into two never events had identified lack of adherence to protocols, which more junior staff had felt unable to escalate;
    - basic infection prevention and control practices were still not being followed in some areas;
- incidences of ambulance waits breaching 8 hours were under investigation: both the causes and mitigation of harms would be reviewed;
- it was agreed that, where appropriate, the Committee should be sighted on recommendations from internal audit reports, in order to monitor progress against the actions;
- the Family Health Care Group Senior Leadership Team had presented to the Committee; discussions around paediatric services had included the pressures on the Speech and Language Therapy and autism services; the Committee had been impressed by the innovative strategies used to address the demand but expressed concern that vulnerable children might not be afforded equitable access to the services; further assurance was sought;
- the number of complaints was increasing; the themes were mainly around long waiting times; the re-opening of the complaints process when patients were dissatisfied with the response was an additional time consuming task;
- the Volunteering Service was at risk from a lack of recurrent funding for, currently fixed-term, coordinator roles.

Mr Barkley noted that the substantial increase in demand for paediatric community services, particularly Speech and Language Therapy and autism, was recognised by NHS England.

With regard to the re-opening of complaints, Mr Barkley asked if the level was above normal. Mrs Parkes advised that the number was not higher than normal; the reason that most complaints were re-opened was because the initial response raised more questions from the complainant.

9 Resources Committee Report

Mrs Mellor highlighted the key escalations from the meeting of the Resources Committee on 18 June:

- there was concern at the pressures on the Emergency Departments, particularly the continuing high number of Category 4 patients arriving; discussions to mitigate the level of attendances were taking place at system level;
- the Committee received the Workforce Plan; concern was expressed at the mandated slowdown in workforce growth and the associated strategic risk of the increasing gap between supply and demand; it was agreed that a Board discussion on this issue would be valuable;
- the Committee expressed disappointment with the level of response to the Staff Pulse survey and discussed what more could be done to encourage engagement;
- a quarterly deep dive on risk was planned; the Committee discussed risk appetite and it was agreed that this should be revisited when the new Board Assurance Framework was in place.

Mr Barkley queried the reference to paediatric and cancer patients waiting over two years. Ms Hansen advised that these were waits for follow up appointments and that, on review, a significant number had been found to be errors.

Mr Barkley asked what action was in place to increase the response rate to the Staff Pulse survey. Miss McMeekin advised that the survey would feature in the next Staff Brief, amongst other strategies. The data in the Pulse survey could now be analysed at a more granular level and the survey would therefore be more useful in gauging the impact of improvements. Miss McMeekin confirmed that a “you said, we did” approach was being implemented to evidence improvements and increase staff engagement. Anecdotal evidence demonstrated that staff were not completing the Pulse survey due to time constraints and also due to concerns about anonymity. Work would be undertaken to ensure that the questionnaire was short and focussed and that those in leadership roles were encouraging their staff to engage with it.

Dr Boyd queried whether the headroom figure of 22% was an ambition for all clinical areas. Mrs Parkes explained that there was a programme of work in place to scope clinical areas and decisions would be made on the level of headroom, as this would vary depending on the area.

10 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen advised that, whilst there was a small decline in the 28-day Faster Diagnosis Standard in March 2024, the Trust was still ahead of the trajectory submitted to NHS England for the end of April 2024.

Referring to the Acute Flow scorecard, Mr Barkley questioned why the figures for the number of Type 1 attendances and the other types of attendances did not match the total number of Emergency Care attendances. Ms Hansen agreed to check whether the total number of Emergency Care attendances included those for the Urgent Treatment Centres.

Action: Ms Hansen

Dr Boyd asked whether the ambition for the Optimal Care Service (OCS) of seeing 95% of patients within 2 hours was mandatory. Ms Hansen responded that it was a guideline for the service. Dr Boyd expressed some concern that meeting this metric might lead staff to treat more straightforward cases first. Dr Stone explained that it would lead to a more effective use of resources as patients needing a lower level of care could be discharged more quickly, freeing up the unit for more serious cases. She advised that some staff on duty would only deal with cases of higher acuity. Ms Hansen advised that the OCS would have a Senior Decision Maker to stream patients on their arrival at the Emergency Department.

Mr Barkley noted that the Same Day Emergency Care (SDEC) service was underused at the York site compared with Scarborough. Ms Hansen agreed and outlined the actions to be taken to improve the process.

The Board noted the 25% increase in ambulance arrivals since the same period last year. Ms Hansen advised that this figure had been externally validated.

Mr Bannister confirmed that the internal infrastructure works at Selby Hospital would be completed by early September.

Mr Barkley queried the delays in the purchase of IT equipment which had been recorded as a factor impacting performance in diagnostic activity. Ms Hansen agreed to investigate.

Action: Ms Hansen

The rise in delays to discharge, which was linked to the demand on community resource, was highlighted. Ms Hansen advised that a discharge improvement plan was built into the new Urgent and Emergency Care plan. Local Authorities and community teams were also involved, and further capacity and efficiencies were being identified. She confirmed that Primary Care Networks were linking into other discussions: a number of GPs were interested in working with the Trust. Mr Barkley commented on the increase in referrals to Community Response Teams. Ms Hansen advised that demand on resources was challenging, despite improvements in the process.

Quality and Safety

The Board was pleased to note the reduction in inpatient acquired pressure ulcers.

Workforce

Referring to the Workforce scorecard, Mr Barkley observed that figures for the use of agency and bank staff were still an issue for the Trust. Miss McMeekin responded that there had been a significant reduction in the last three months and the Trust was on track to reduce nursing staff agency spend to zero by September. Progress was also being

made on reducing dental and medical agency spend. Dr Stone added that Care Groups were challenged on their agency spend.

Mr Barkley asked that future information on responses to the quarterly Staff Pulse be more detailed, specifically to the two key questions around recommending the Trust as a place to work and a place to received treatment. It was noted that the metrics for these questions in the report were taken from the Staff Pulse survey.

Digital and Information Services

A question was raised about the number of Freedom of Information requests received by the Trust. Mr Hawkins advised that the number had been increasing; the reason for this was not clear.

Finance

Ms Barrow reported that the operational plan showed an adjusted deficit for 2024/25 of £16.6m, after income of £4.2m had been received from the ICB. This latest income would not impact on the Cost Improvement Programme (CIP). Ms Barrow noted that the Month 2 position still showed an adjusted deficit of £20.8m; this would be updated for Month 3. The variance to plan in Month 2 was £3.3m of which £1.3m related to the CIP. Ms Barrow noted specifically the variance relating to high-cost drugs.

Ms Barrow reminded the Board of the 2024/25 efficiency target of £53.3m of which £24.9m had been identified in the Corporate Programme and £20m in the Core Programme, the latter being 100% of the required target. Ms Barrow cautioned that some of the cost saving schemes identified were high risk. Mrs Mellor advised that the Resources Committee had asked for a 12 month plan for the CIP.

Mr Morritt noted that the financial plan for Humber and North Yorkshire had not been received and the Trust was still awaiting a response to its formal submission.

Mr Barkley surmised from the figures in the report that the run rate had improved from Month 1 to Month 2. Ms Barrow explained that position had been improved by the Elective Recovery Fund (ERF) income rather than a decrease in the run rate, but she was expecting improvements to the run rate from the work to reduce the use of bank and agency staff. Mr Morritt confirmed that the ERF position was very positive, and services were being encouraged both to increase activity and to code accurately, to maximise income. He observed that further benefits would be seen as work being completed on more efficient rostering was implemented.

The meeting was adjourned at 11.10am and reconvened at 11.22am.

11 CQC Compliance Update Report

Mrs Parkes presented the report and highlighted the following:

- performance against the Journey to Excellence framework was progressing well; the remaining actions were more challenging, and it was important to ensure that they were embedded and sustained before being closed; as a result, it was likely to that extensions to deadlines may become more frequent;
- 37 CQC actions were closed as of 31 May 2024;
- the Mental Health Risk Assessment protocols were embedded and working well at Scarborough and had now been implemented in York; engagement was being

monitored and the Trust was now looking to evidence that it met the conditions of registration placed on it in January 2020.

In response to a question, Mrs Parkes advised that an extended deadline would be added to Action 38 for the next report. She added that there had been a number of actions with deadlines extended by six months to ensure that there was sufficient time for them to be embedded.

It was noted that closure of actions was agreed by the senior leadership team at Journey to Excellence meetings and reported to the Quality Committee. A report was also shared with the Quality Improvement Board so that it was sighted on the process and the reasons for extensions. Mrs Parkes also provided monthly updates to the CQC.

12 Maternity and Neonatal Reports

Ms Wells-Munro was welcomed to the meeting.

Maternity and Neonatal Quality and Safety Update

Ms Wells-Munro referred to her report and began by reporting that there had sadly been two stillbirths and three neonatal deaths in April 2024; these were being reviewed under the standard processes which now included input from the families affected. The cases had also been reported to the coroner and feedback was awaited. Ms Wells-Munro advised that there were no immediate safety concerns to report, pending the outcomes of the reviews.

Ms Wells-Munro reported that the number of Post-Partum Haemorrhages (PPH) over 1500mls had reduced again in April 2024 but was still above the national recommended target. The rate was still subject to variation month on month, and it had been agreed that a full review of all cases since November 2023 should be undertaken. There had been 49 cases in total but no themes in terms of the profile of the mothers or the mode of birth had been identified, although a substantial percentage of the women had been induced. Ms Wells-Munro was of the view that the risk of PPH associated with induction could be reduced. Other reasons for PPH had been identified and the results of the review would be carefully analysed. In response to a question, Ms Wells-Munro observed that the national measures put in place via the Savings Babies Lives Care Bundle resulted in more and earlier inductions, which may result in a higher risk of PPH, but the method of induction also needed to be reviewed, with changes to clinical practice implemented.

Ms Wells-Munro returned to her report and highlighted the following:

- there had positive work done around Workstream 1 *Listening to service users and families with compassion*: service information boards had been co-produced and key information for women was now available in nine languages;
- a neonatal lead for the Maternity and Neonatal Voices Partnership had been appointed;
- a report from the Culture Score survey was expected in July at which time actions would be taken to address any issues raised;
- a new process was in place which would provide more rigour around access to professional development opportunities;
- there was a significant number of vacancies on the Scarborough site; Ms Wells-Munro was pleased to report that some of the recent cohort of trainee midwives had been successfully encouraged to apply;

- the recent recruitment process for a Deputy Director of Midwifery had been unsuccessful and would be repeated;
- NHS Resolution had undertaken a thematic review of early notification cases received from the York and Scarborough service between 1 April 2017 and 21 October 2023; there had been no cases requiring to be reported by the Trust from late 2022 to date; the findings of the cases had been reviewed, along with the recommendation made by NHS Resolution, and a full response would be provided in July.

CQC Section 31 Update

The Board approved the Section 31 Update.

Maternity and Neonatal Staffing Review

Ms Wells-Munro presented the paper and invited questions. In response to a query, she explained that some midwives were trained to complete newborn examinations (NIPE) but it was currently not possible to establish a midwife led clinic due to capacity and this was hindering flow out of units and using paediatrician time.

13 Infection and Prevention Control Annual Report

Mrs Parkes presented the report and began by highlighting staffing changes in the Infection Prevention and Control (IPC) team in 2023/24. The paper set out in detail the IPC position within the Trust and included actions in place to reduce the level of Healthcare Associated Infections. Mrs Parkes drew attention to the steps being taken to move towards the National Standards for Healthcare Cleanliness 2021. Mr Bannister noted that cleaning standards were rated “green” across all areas for the second successive month which demonstrated excellent progress.

14 Q4 2023/24 Mortality Report – Learning from deaths report

Dr Stone presented the report, which had been recently presented to the Quality Committee. She highlighted the sharper focus on themes from Structured Judgement Reviews.

Mr Barkley referred to the Summary Hospital-level Mortality Indicator (SHMI) data in the report which was distributed by diagnostic group and asked if deaths from strokes should be included. Dr Stone explained that the graph showed only the groups which affected the SHMI. She would send the relevant stroke figures to Mr Barkley.

Action: Dr Stone

15 Questions from the public received in advance of the meeting

No questions had been received.

16 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 31 July 2024 at 9.30am at York Hospital.

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 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 (from Feb 24)	Amber
BoD Pub 06	24-Apr-24	10	Trust Priorities Report	Investigate and address incomplete data on pathways with an ethnicity code.	Chief Digital & Information Officer	Update 22.05.2024: Mr Hawkins advised that the Patient Administration group were looking at procedures to increase the level of information provided by patients and their families. The action was ongoing. It was agreed to amend the target date to July.	Jul 24 (from May 24)	Amber
BoD Pub 07	24-Apr-24	10	Trust Priorities Report	Provide further information about children and young people on community waiting lists.	Chief Operating Officer	Update 22.05.24: Ms Hansen advised that she was working with DIS to collate this information which would first be presented to the Children's Board before coming to the Board. The target date was amended to July.	Jul 24 (from May 24)	Amber
BoD Pub 09	22-May-24	7	Chief Executive's Report	Prepare brief paper summarising the implications of the Trust adopting the York Poverty Truth Commission Charter	Chief of Allied Health Professionals		Jul-24	Green
BoD Pub 10	22-May-24	11	Trust Priorities Report	Remove the metric on "waits over 78 weeks"	Chief Digital & Information Officer		Jul-24	Green
BoD Pub 11	22-May-24	11	Trust Priorities Report	Investigate whether children and young people waiting for Speech and Language Therapy can be categorised in a way which attracts specific funding	Finance Director		Jul-24	Green
BoD Pub 12	22-May-24	11	Trust Priorities Report	Add phasing information to the next Finance report, and a year-end forecast based on trends to date and other known factors	Finance Director		Jul-24	Green
BoD Pub 13	26-Jun-24	10	Trust Priorities Report	Check whether the total number of Emergency Care attendances recorded in the Acute Flow Scorecard includes those for the Urgent Treatment Centres.	Chief Operating Officer		Jul-24	Green
BoD Pub 14	26-Jun-24	10	Trust Priorities Report	Investigate the reason for the delays in the purchase of IT equipment as a factor impacting performance in diagnostic activity.	Chief Operating Officer		Jul-24	Green
BoD Pub 15	26-Jun-24	14	Mortality Report	Send statistics on deaths from strokes to Mr Barkley	Medical Director		Jul-24	Green

Report to:	Trust Board
Date of Meeting:	31 July 2024
Subject:	Children and Young People Community Waiting LIst
Director Sponsor:	Claire Hansen, Chief Operating Officer
Author:	Kim Hinton, Deputy Chief Operating Officer

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

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

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

Summary of Report and Key Points to highlight:

The report outlines the national context and York and Scarborough's position of children and young people community waiting lists. We also have children and young people waiting on both RTT waiting list (open clocks) and non RTT acute waiting lists. Patients on an open RTT waiting list are monitored through the weekly elective recovery meeting. We are currently developing the reporting around the non RTT waiting list (waiting for 1st outpatient appointment, follow up partial booking waiting lists and patients on an elective waiting list) so that we can report children and young people waits.

As at the 28th of June 2024 there were 2,038 patients on the Trust's CYP Community Waiting List. It includes patients waiting for the following services:

- Physiotherapy (MSK and Neurology).
- Occupational Therapy.
- Speech and Language Therapy.
- Eating and Drinking.
- Request for Helpline.

It describes the current actions the Family Health Care Group are taking to reduce this length of waiting time that children and young people are experiencing for these community service.

It also highlights some of the challenges to this improvement and the oversight and governance arrangements.

Recommendation:

The Board is requested to note the current community children and young people waiting lists and the actions the Family Health Care Group are leading on to improve the waiting times for children and young people.

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
Resources Committee	21 May 2024	

Children and Young People Community Waiting List

1. Context of Children and Young People Community Waiting lists

NHS Providers and NHS Confederation published a report *'Community Network Survey on waiting times in children and young people's services'* (May 2023) which outlined that children and young people community waiting list nationally is growing three times faster than adult community services, with a 10.2% increase since October 2022. The greatest area of growth has been seen in the waiting list for children's speech and language therapy with a 14% rise. Community providers estimate an average waiting time for community paediatrics appointment of 33 weeks with some services reporting an average wait of 104 weeks.

The reported highlighted that children and young people are being put at risk as community services struggle to keep pace with demand noting that children at risk of poorer outcomes if development windows are misses.

There is a growing incidence of school age children requiring additional support and special education needs (SEN) Information from the Department for Education reveals 390,000 nationally have an Education, Health, and Care Plan (EHCP), a rise of around 150,000 over the last decade, while there are just over a million pupils with SEN support, an increase of around 200,000 over the same period. In part, this is related to a growing awareness and diagnosis of, for example, neurodivergent conditions.

At a recent ICB Children and Young People workshop it was evident that our Trust were more advanced in our innovations to address the waiting list issues, other providers are interested in adopting some of the approaches we have developed. Following the recent Special Educational Needs and Disabilities (SEND) inspection, inspectors fed back that they particularly like the Request for Helpline model (RFHL). RFHL is a move from written referral forms to a helpline system with specific age groups. The commissioners are currently drawing up a position statement which we will be contributing to.

The service has ~~also~~ recently submitted data to the National Benchmarking (Children's Therapies) Project, and the impending outputs will allow additional comparative data to be considered going forward.

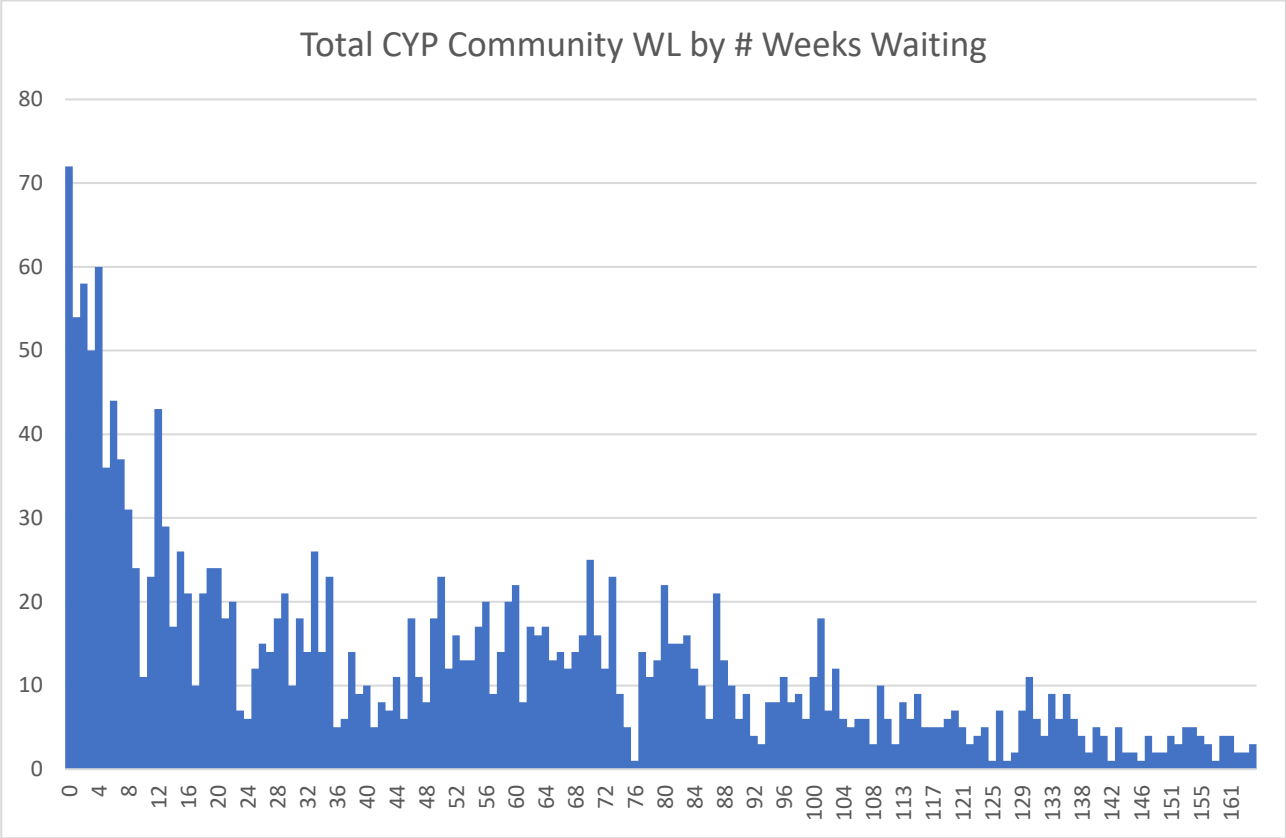
2. The current waiting list position

As at the 28th of June 2024 there were 2,038 patients on the Trust's CYP Community Waiting List. It includes patients waiting for the following services:

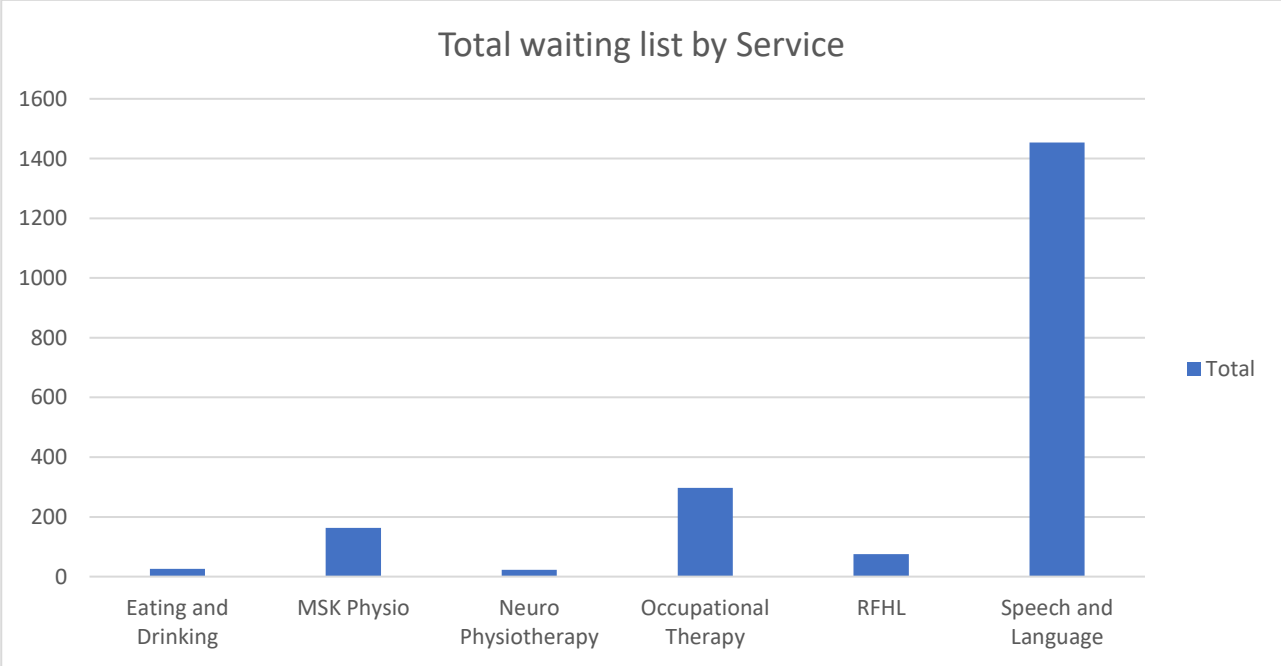
- Physiotherapy (MSK and Neurology).
- Occupational Therapy.
- Speech and Language Therapy.
- Eating and Drinking.
- Request for Helpline.

There are 842 patients waiting more than 52 weeks (41% of the total waiting list) and 256 patients waiting 104 weeks or more, 214 of these are waiting for York Speech and Language Therapy. These patients are not referred in under the referral to treat (RTT)

clock start rules so are not subject to the same external reporting as the RTT waiting list. The profile of the waiting list is shown below.

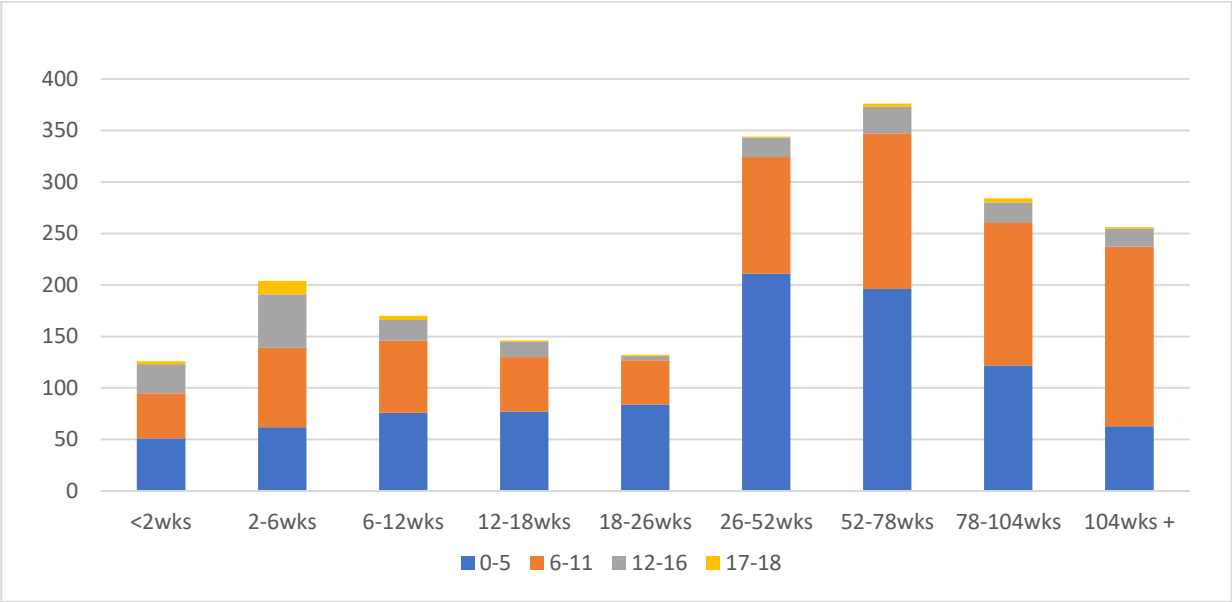


The proportion of the total waiting list by service highlights that the largest number of patients waiting are waiting for speech and language with 64% of the waiting list.



Of the speech and language waiting list, 70% are waiting under the York service (1,016 patients) and 30% under the Scarborough / Whitby Service (438 patients).

The age group(s) with the largest waiting lists are under 12s with approximate even split between age 5 and under (942 patients) and 6 to 11yrs (863 patients).



3. Children and Young People Community waiting time recovery actions

The Speech and Language Therapy (SaLT) waiting list issue is a key focus for the Family Health Care Group and the ICB. The therapy leads have developed and implemented various initiatives to address the longest waiters to reduce the overall waiting times.

3.1. YSTHFT SaLT access improvement plan:

- Development of a Request for Helpline (RFHL) by SaLT service that can be accessed by schools/parents/other partners.

RFHL involves scheduling a call between a speech therapist and the 'Bothered Person', often the patient's parent or guardian, but potentially a healthcare professional or teacher. During the call, concerns are addressed, impacts assessed, guidance provided, and resources offered. This approach provides a clearer understanding of the patient's needs, informing decisions about waiting list placement and triage prioritisation. It also promotes open communication and collaboration between the SLT service, schools, parents, and other healthcare professionals. Since this change in November 223, the services has received 1,062 referral calls and the percentage of accepted referrals has decreased from 98% to 73%. This has been delivered through existing capacity and therefore has not reduced new patient capacity.

The initial qualitative feedback from key stakeholders being very positive and example of some feedback from a nursery teacher in York '*Thank you for changing the system. The telephone system is so easy, so accessible for referrals and I applaud whoever changed that. It was so much more personal, I could give so much more information about the children and talk about their individual issues. It is going to have so much more impact on their outcomes. The change is superb!*"'.

- Review of all long waiters and re-triage where appropriate.

- Needs assessment of training requirements for education/early years staff in relation to supporting CYP with SLCN and development of a training offer to meet these needs.
- Development of website and resources for parents/carers/education staff to support.
- Staff wellbeing and support needs including increased clinical supervision to review caseloads.
- Episode of Care model introduced based on an enablement model of care as opposed to the previous impairment focused model of service delivery.
- Opt-in initiative.
- Group Interventions: singing speech.
- Group interventions: moderate language difficulties (parent and setting intervention)
- Sensory Feeding pilot group starting in Scarborough.
- Dysfluency Project: reviewing RFHL process.
- Beyond diagnosis: creating training for early years settings.
- SLT paperwork being updated, to ask service users for feedback.
- Joint working between CYC, YSTHFT and Quality lead to develop information and resources to support parent/carers and professionals working with 0–5-year-olds to know what is available in the city to support SLC development.

3.2. Early Talk for York in City of York funded by York Schools and Academies Board (YSAB)

- **Early Talk for York (**ETFY) approach trains staff in early years settings and primary schools to identify any issues with children's speech, language, and communication for the 0-5 age range. It also delivers training to setting/school staff to provide interventions to children and young people who they have identified as having speech and language and communication needs.
- In a pilot project working with schools and early years providers in the west of York, children in the pilot group showed significantly improved speech and communication skills at age 5, compared to children who did not receive the same programme of support through the ETFY approach. The approach is now being rolled out across York to more early years providers and primary schools but resource to support the roll out is limited and funding for project is not recurrent and not enough to cover all need in the city.
- More Talk for York is in its early development stages, but the aim is to assess the impact of the ETFY approach with children who are primary school age.
- ETFY is example of system wide approach that involves NHS, public health (HCS), education and early years, University of York, and CVS partners.
- Learning Support Hub developed where schools/settings can get advice and request specialist support from specialist teaching team, educational psychologist, specialist settings/enhanced resource provision.

4. Challenges / Issues

4.1. Commissioning arrangements

Commissioning arrangements for Children and Young People and those with SEND are complex and this has been reflected in uneven and patchy service provision, both in terms of geography and need. There is a diversity of service offerings across the ICS and that

partly comes historically from the way services have been commissioned in the past - by CCGs that were separate and have since amalgamated over the years and although there are statutory responsibilities in relation to EHCPs the legislative framework is vague.

In part, this variation in service design might be seen to legitimately reflect differences in the service needs of different areas. Indeed, a population needs based approach to commissioning is predicated on the assumption that services should to reflective of local demographics. Every locality is different so, the commissioning needs to be different and the ways of working need to be different. However, the design features of therapy services for CYP often emerge from an incremental, sometimes time-bound, fragmented approach to commissioning, unfolding over several years, rather than being rooted in an ordered and a considered population needs analysis leading to pockets of different approaches to provision existing with differing outcomes.

Service specifications do not exist under the block contracts so there is a lack of service specificity and monitoring arrangements with no KPIs or other monitoring parameters or data requirement under them.

Outdated contracts are progressively disconnected from the increasing demand and thus misaligned with staffing requirements.

4.2. Workforce

In York and Scarborough, the SaLT teams are fully recruited to establishment with no vacancies or maternity leaves. There is an imminent retirement, but a succession plan has been progressed to address this.

Recent capacity and demand modelling indicated that investment would be required for an additional 13 WTE therapists to address the current level of demand and reduce the service waiting times. Given that there is no additional resource pending, the shortfalls are being addressed through innovation and service improvement. However, due to the continuing high rates of referrals, these projects are not impacting significantly.

Job planning is being rolled out to allied health professions, yet the staffing establishments have not been fully calibrated with the NHSE job planning process. This process is designed to build in time for non-clinical activities, yet most posts were running on 100% direct or indirect patient contact, with no headroom for SPA time factored in, impacting negatively on staff wellbeing and burnout.

There is a national shortage of SaLTs so there would be no guarantee of recruiting to additional posts. In addition, east coast vacancies have proven difficult to recruit to. With this cohort of patients, it is important to be able to offer the robust clinical supervision and emotional support for the more junior members of the workforce. Nationally within all therapies, between 5% and 10% of the workforce in are lost in the first five years, but realistically, it is in the first two years. Stressful situations with parents and children with complex needs can impact on mental health and resilience.

5. Monitoring and oversight

The SaLT waiting list is on the risk register scoring a 15. It is reviewed monthly by AHP Senior Manager and Associate Chief AHP and reported through the Child Health

Directorate Meeting to Care Group Board and then onto the performance review and improvement meeting (PRIM).

The elective recovery programme also has a children and young people's workstream and the reporting of the impact of the recovery actions are reported through this to the elective recovery board.

Regular meetings are held with commissioners to discuss performance position and improvement initiatives.

A Children's and Young People Board has also been established and is chaired by the medical director.

6. Recommendation

The Board is requested to note the current community children and young people waiting lists and the actions the Family Health Care Group are leading on to improve the waiting times for children and young people.

Report to:	Board of Directors
Date of Meeting:	31 July 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	31 July 2024	

Chair's Report to the Board – July 2024

1. I had the pleasure of welcoming and thanking donors who attended the preview event of the planned opening of the new Urgent and Emergency Care Centre at Scarborough General Hospital. The wonderful new facility is planned to be fully operational early October. The public fundraising appeal of £400,000 has been exceeded by £28,000. A huge thank you to everyone who donated and organised fundraising activities. The generous response by the public has been truly magnificent.

2. My end of year appraisal was completed at the end of June by our Senior Independent Director and Lead Governor, and the necessary paperwork was submitted to NHS England in the first week of July.

3. I was given a very informative 75 minute guided tour and briefing of the emergency dept. at York Hospital by the Clinical Director Dr Amjad. It was the first time I had met with Dr Amjad, who had been invited to be the first Clinical Director to brief the Board and take questions at our meeting in July.

4. Similarly, Dr Marcus Nicholls gave me a guided tour of the Radiology service at York Hospital – my first tour around the dept. but the second time I have had a briefing from Dr Nicholls. The scale and range of diagnostic and treatment service is extensive and of course is expanding with the creation of community diagnostic centres. Recruitment of radiographers and sonographers is a very real challenge and equally concerning is a falling number of school leavers applying to University to become a radiographer despite the very good career prospects.

5. I met with a consultant histopathologist to listen to their serious concerns about the lack of space which impedes on their work and that whilst the number of specimens that need to be reported on has increased significantly there has been no commensurate increase in in-house reporting capacity.

6. I had an introductory meeting with Iain Mitchell, Yorkshire & Humber Senior Engagement Manager, Thomas Pocklington Trust, Sight Loss Councils, who was accompanied by a colleague. They want to work with the Trust to help us improve the experience of patients who have sight loss, for example difficulties in reading correspondence, flagging patients on our database who have sight loss, advice on wayfinding around the hospital (black writing on yellow background is best), offering advice when new buildings or upgrades are being designed. They would be willing to brief the Board.

7. I met with the Chair of the Friends of York Hospital, who raised a couple of concerns with me which I will follow-up with the relevant Director/s.

8. With the Chief Executive I attended a meeting of the Collaborative Acute Trusts Committee in Common. The main issues discussed were: finances, ICB wide projects that followed from the report by Grant Thornton, opportunities for Trusts to save money through some of the elective efficiency/repatriation possibilities, a review of the CAP programmes of work and approval of the “Fair Shares” method and amount to be paid by each Trust to fund CAP. A more detailed briefing will be given at the Board meeting.

Martin Barkley

Trust Chair

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	31 July 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: Operational pressures, industrial action, Scarborough Urgent and Emergency Care Centre update, Improving engagement with our staff, Humber and North Yorkshire Collaboration of Acute Providers annual report, 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	31 July 2024	

Chief Executive's Report

1. Operational pressures

Our challenges in urgent and emergency care continue, with no indication that demand is reducing, and acuity remaining high.

This mirrors the national position, with NHS England reporting that last month emergency departments nationwide saw more attendances than in any other June. Nationally attendances were up 3.1% on the previous year and emergency admissions were up 7.2% on the preceding 12-month period.

To help to relieve some of this pressure and to ensure patients are seen by the most appropriate clinician we have introduced some changes to the way patients are initially streamed as soon as they arrive in either of our emergency departments.

Senior clinical staff working as clinical navigators are working alongside receptionists at the front door, navigating patients with 'red flag' presentations to the emergency department (majors) or the Optimal Care Service (OCS) for any other presentations.

Alongside the nurse-led minor injuries and GP minor illness services, there is a new ringfenced service where a senior clinician will see patients who do not need to be kept in 'majors'. Collectively, these services make up the OCS. This enables patients who do not need to be in the main department to quickly be seen by a clinician, who will give them the advice and treatment they need to get back on their way.

The aim is to reduce the pressure in the emergency department, providing a better experience for patients and reducing delays.

2. Industrial action

The latest round of the BMA's industrial action for junior doctors went ahead as planned for five days from 27 June. My thanks once again to all of our staff who supported our patients and other colleagues during this period.

There are reports that talks are once again underway between the BMA and the Government in a bid to bring the action to an end, at the time of writing there have been no updates as to the outcome of these discussions.

Meanwhile, the BMA's GP Committee is currently balloting its GP contractor/partner members in England, and this is due to conclude on 29 July. The BMA has indicated that they will encourage participating practices to take part in action at scale from 1 August. Unlike with the industrial action carried out by other staff groups, no defined timeframe for the action has been announced, with the suggestion that it may continue in some form for an extended period of time.

If this action goes ahead it will have a considerable system-wide impact, and is likely to cause greater pressure on our already busy emergency and acute services.

3. Scarborough Urgent and Emergency Care Centre update

Work is continuing at pace to prepare our teams and services to move in to the new Urgent and Emergency Care Centre in Scarborough in the coming months.

Familiarisation tours have been running for staff during June, and a number of public tours have also taken place. Clinicians are reviewing the clinical pathways and simulations of the clinical and operational pathways for the new model of care have taken place.

It is hugely rewarding to see this project nearing its completion, which mark the achievement of a truly significant milestone in the history of Scarborough Hospital. My thanks to all involved, and I would also like to give a special mention to our Capital Projects Team who were named regional winners in the Integration and Collaborative Working category at this year's Constructing Excellence Yorkshire and Humber Awards, in partnership with the UECC's principal contractor Integrated Health Projects (IHP).

4. Improving engagement with our staff

We have made some changes in recent months to support how we engage and communicate with our staff. We have replaced our face-to-face monthly staff brief with a live virtual briefing led by myself and the wider executive team, and open to all staff. The session is also recorded and made available on the intranet for a short period after the briefing so that people can watch it back at a time to suit them. This has enabled us to reach a far greater number of people than the previous in-person approach. We are now looking at how we can use the technology to make the sessions more interactive, however the feedback so far is that this has a been a positive step forward in keeping staff up to date.

Earlier this month we also held our first senior leadership forum. These are half day events, every other month, where our senior leadership team from across the trust can meet together as a group and have the opportunity to influence how we are addressing the key issues we are facing as leaders in the organisation, and to consider particular challenges or areas for our collective development in more depth. The focus will vary from session to session, and we are seeking feedback from the group as to what they would like to cover at future events.

The group who attended the first session were positively engaged in the discussions and particularly valued the opportunity to meet up with other colleagues face-to-face. I look forward this forum's development in the months ahead.

5. Humber and North Yorkshire Collaboration of Acute Providers annual report

The Humber and North Yorkshire Collaboration of Acute Providers (CAP) has published its 2023/24 annual report, detailing its activities and achievements in its first full year as a resourced provider collaborative.

CAP is part of the Humber and North Yorkshire Health and Care Partnership, bringing together the four Humber and North Yorkshire NHS acute trusts.

You can read the report here.

6. Star Award nominations

Our monthly Star Awards are an opportunity for patients or colleagues to recognise individuals or teams who have made a difference by demonstrating our values of kindness, openness, and excellence through their actions. It is fantastic to see the nominations coming in every month in such high numbers, and I know that staff are always appreciative when someone takes the time to nominate them.

July's nominees are in Appendix 1.

Date: 31 July 2024

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

July 2024

Sonia English, Advanced Clinical Specialist **York** **Nominated by colleague**

Sonia has made an immeasurable difference to the quality of life of a community patient living with Alzheimer's. This patient was not compliant with therapy assessment on initial contact at home by the community therapy OT and physiotherapist and could not engage in conversation. She was cared for in bed and did not wish to engage in therapy assessment to assess sitting out. Sonia's advice and input was sought and she came out on a joint visit with me. Sonia's communication style and the use of the PAC approach supported this lady to engage in therapy. Ongoing joint sessions enabled this lady to be sat out in a care chair and referred for a specialist wheelchair and ramps to access the community.

Sonia also provided training for the patient's husband so he can care for his wife and gave information on community support he could access. In his words: "Sonia showed me that our situation was not the end of the world and gave me the skills to live with our situation positively."

We are very fortunate to have Sonia's skill base within our Trust and I feel very fortunate that I was able to draw on her expertise to produce this positive outcome for one of our community patients.

Jenna Raby, Deputy Sister	**White Cross Court**	**Nominated by colleague**

Jenna has recently worked tirelessly to put together a training package to train the whole team on the deterioration policy and NEWS. It was recognised that many of our support workers and therapists were not competent with NEWS, and this was affecting appropriate escalation of deteriorating patients. This has been a huge piece of work which has been essential in making sure all staff within the team are appropriately trained and competent in NEWS.

As a result, there has been the positive feedback that staff now feel competent in using NEWS and empowered to escalate patients that they are concerned about. This has been a huge undertaking which Jenna has managed alongside the other responsibilities of her role. Jenna is a committed nurse who is passionate about service improvement and her work on this project has and will improve patient safety.

Catherine Williamson, Advanced Specialist Practitioner	**Community Stadium**	**Nominated by colleague**

At the community stadium, we give eye injections and see 80-100 patients a day. One day we were short-staffed, and, instead of doing her scheduled office work, Cath put herself forward and worked hard, juggling and filling the gaps of three different roles, which enabled all the patients to have treatment on time. Cath has shown excellent leadership, teamwork, and dedication to her role on many occasions, this is just one example.

Kate Ruddock, Nursing Band 7 **York** **Nominated by relative**

My son has autism and had badly damaged his finger. Dr Ruddock (and a colleague whose name I did not get) did a fantastic job medically as well as dealing brilliantly with Sam's additional needs. Sam is used to only dealing with staff he knows and in situations he is comfortable with. To be able to complete an awkward repair involving nine stitches without causing Sam undue stress as an exceptional piece of work.

Binumon Varghese, Endoscopy Technician **York** **Nominated by patient**

I was coming in for a routine procedure, but my condition had been fluctuating and I was silently anxious about it. I want to nominate Binu because from my first interaction with him, he was calming and put me at ease. He was clear and I felt like he cared, he was there to comfort me and keep me safe during my procedure and I felt reassured. Even though I had no intention of needing medication, I was struggling, and Binu made sure to give me a reassuring nudge that I do not have to struggle. He dealt with me efficiently and gracefully and, even though it was very routine, to me it was exactly what I needed. We need more like Binu; I appreciated him greatly.

Laura Wilson, Sister **Scarborough** **Nominated by colleague**

Laura has always supported me and helped me build my knowledge and skills as a newly qualified nurse, and she has helped me feel comfortable within the team and my role. She is a very knowledgeable nurse who cares for her patients with compassion and is a very good advocate for her patients. She goes above and beyond when providing care for her patients and, if there is something she is not competent in, she will always find someone who is to help her out.

Lisa Allen, Deputy Sister | **Scarborough** | **Nominated by colleague**

Lisa is such a good advocate for all her patients and cares for them with compassion. If she needs to, she will fight for her patients by escalating to senior staff or paediatric doctors, especially when it comes down to the patients care. She is a very knowledgeable and skilled nurse who always work well in the team and is there to support her colleagues.

Jess Lagana, Ophthalmic Clinical Educator | **York** | **Nominated by colleague**

Jess joined us in a new role as Ophthalmic Clinical Educator in April and has taken to her new role fantastically. She has taken time to listen to the staff and has got to grips with the role very quickly, from both a clinical and education viewpoint. She is committed to the team and the service, and often spends time outside of work producing training packs for the team, as well as throwing all her energy into professional development. Jess's energy and skills have been a breath of fresh air, and she is already a great asset to the department.

Suzi Greening, Midwife | **Scarborough** | **Nominated by patient**

Suzi was my midwife from the very beginning of my pregnancy, and I was fortunate to have her consistent support all the way until I gave birth. Suzi was incredibly kind and compassionate. When I had to cancel my appointment because my daughter arrived three weeks early, she even came to the labour ward that morning to meet my newborn and check on us both. Words cannot express how much that meant to me. All the midwives were lovely, but Suzi's care went above and beyond.

I am sixteen months postpartum now, and amidst the whirlwind, I completely forgot to nominate Suzi. I hope she knows what an incredible midwife she is and how much her kindness helps during such a vulnerable time. Keep being you, Suzi, you are amazing!

Irene Bunag, Specialist Nurse **York** **Nominated by patient**

I was recently told my kidney disease had worsened. I was shocked and devastated. Irene is my main point of contact and she has dealt with my frantic communications, always having a solution. She goes above and beyond what I expected, making sure I am ok and keeping me informed. Going through something like this can make you feel like the loneliest person in the world, and yet Irene is always just an email or phone call away to reassure me and remind me the whole team are doing everything they can to keep me stable and well for as long as possible. The Trust's values of kindness, openness, and excellence are shown by Irene every time I contact her, and I am sure everybody else under her care has the same experience. The NHS is an incredible service because of people like Irene, thank you!

Lucy Griffin, Medical Secretary **York** **Nominated by patient**

Lucy is completely patient-focused and listens, understands, and goes above and beyond her role to help. Even when she is the only one in her team, covering the work of four people, she still is responsive, making things happen. Juggling many different demands, she follows up requests with consultants to speed up scans and advice.

Debbie Bayes, Deputy Lead Nurse **York** **Nominated by colleague**

Debbie has led the Dying Matters focus for our Year of Quality in an exemplary manner. She has demonstrated effective leadership, engaging with senior nurses and AHPs, providing education and equipping teams to learn about good practice at end-of-life care. She has presented at senior leader meetings with professionalism, passion, and sensitivity and has made herself available to provide support where needed. She has flourished and grown in confidence since taking up post and is really helping front-line staff, supported by her teams, to make a difference.

Jade Mackenzie, ODP, Liz Moody, ODP, Fiona Wainwright, Healthcare Assistant, Raymund Cosi, Deputy Team Leader, and Weiguang Li, ST3-ST8

Scarborough

Nominated by colleague

At shift change over, part of this team came onto the management of a cardiac arrest in the Critical Care Unit of a young lady. Unfortunately, despite the best efforts of all involved, the resuscitation attempt was unsuccessful. This was obviously devastating for the woman's partner, who was left in an unfamiliar area, with young children and no immediate family support, struggling to cope with what was happening. These team members, without ask, took it upon themselves to take care of both the children, ensuring they were entertained in a safe and more comforting environment (away from the Critical Care Unit), whilst members of the critical care team supported the recently bereaved partner and helped him contact other family members.

Whilst almost every member of this team would deny this was "above and beyond" their roles, none of us expect to come into work to suddenly find ourselves caring for young children, whilst still providing an exceptional level of service associated with their roles. For this reason, I feel that this team performed well above what would be routinely expected and did so with exceptional kindness and compassion to ensure the effects of such a traumatic experience were minimised. This was echoed by the extended family of the children on arrival to the hospital several hours later.

Tracy Keyter, Ward Clerk **York** **Nominated by colleague**

Tracy always goes above and beyond when at work. She helped me when I was working on Switchboard by taking a message to Ward 21 and making sure a patient got a message from a relative. It is lovely to work alongside someone who cares and shows empathy and humility all the time. Thank you.

Alex Kenyon, AHP Team Manager **York** **Nominated by colleague**

Access to data pertaining to AHP services is severely limited and there is no dedicated BI resource. As a Team Manager, Alex goes over and above to improve access and availability of service data and performance information. This allows for effectiveness to be demonstrated and services to be robustly planned and improved. Much of the work is done in Alex's own time which is outside of expectation but nonetheless does not go unnoticed. Thank you, Alex, you are a star!

Ellie Freer, Associate Audiologist **Scarborough** **Nominated by colleague**

Ellie's day began with sorting the best possible care for an end-of-life care patient, liaising with multiple staff to make sure the patient would be seen in a time sensitive manner and that they would be given access to sound. This was followed a patient with dementia struggling to get on with wearing their hearing aid. They openly admitted they could not cope after losing their partner and did not see the point in wearing the hearing aid. Their family member who attended with them became upset after to hearing this and due to the lack of communication between them and the patient when they did not wear the hearing aid. Ellie handled this difficult and emotional situation with such compassion, empathy, and care. Not only for the patient, but the family member who attended. After a long chat, the appointment positive ended on a positive note with the patient leaving wearing the hearing aid and a much better outlook. Ellie has not worked in our department long, but on witnessing these situations I am very glad she joined our team!

Surgical Assessment Unit	**York**	**Nominated by relative**

The team on this ward work so hard. After spending three days here with my daughter, I saw first-hand how compassionate and caring they are. They are run off their feet and do not stop. I cannot name an individual, but everyone working in the unit is superb. They do not get the recognition they deserve. They have empathy, put you at ease, keep you informed, and go above and beyond to help. Thank you.

Kath Garry, Clinical Skills Facilitator	**York**	**Nominated by colleague**

Kath has worked conscientiously and diligently towards the implementation of the ReSPECT process. She is an active member of the ReSPECT and Treatment Escalation Plan Group. She has been involved in writing policies, TORs, and training packages. She has been key to the implementation and roll out of the ReSPECT folders for all clinical areas. This has included the ordering and organisation of the folder content. She has often worked to tight deadlines and some of this work she has done in her own time. Her values and commitment are to be commended.

Martina Rogers, Deputy Unit Manager, and Abigail Hutchinson, Healthcare Assistant	**Scarborough**	**Nominated by colleague**

I was choking on my lunch and needed help. I managed to get the attention of Martina Rogers and Abi Hutchinson and they came to my assistance. Martina began applying back slaps while Abi held my hand and supported my back as by this time I had had to lower to the floor. The food eventually dislodged and I was extremely emotional. I was fully supported and reassured and I cannot thank them enough for possibly saving my life. Thank you; you not only go above and beyond for patients, but also for other colleagues.

Georgy George, Healthcare Assistant | **Bridlington** | **Nominated by colleague**

Georgy is new to the Trust and is an asset to the team. He is kind, courteous, and helpful towards all patients. Georgy is always positive and walks around the ward with a smile on his face. He is hard working and will support his team when needed.

Helen Archibold, Staff Nurse | **Community** | **Nominated by colleague**

A patient was palliative and had been bed-bound for some time and their last wish was to go outside. Helen went the extra mile to work with the occupational therapist and physiotherapist who supported the patient to help the patient gain strength and install equipment to make transfers possible. Eventually it was possible to assist the patient outside where she was able to see her beautiful garden. Thank you to Helen and her allied healthcare colleagues for a good job well done. This has had a positive effect on the patient. Helen is a credit to our team and the community she serves.

Rinku Mathew, Staff Nurse | **Scarborough** | **Nominated by patient**

I was cared for by many different nurses during my stay on Maple Ward. Rachel was my nominated nurse on the second day of my stay. Immediately she came over to speak with me I felt at ease. She exudes warmth and compassion. She has a very reassuring calmness about her. I am very grateful that I was in her care.

Thanks Rachel, happy gardening.

Dawn Carr, Maternity Support Worker | **Community** | **Nominated by colleague**

Dawn has been an essential member of South West Community team as a maternity support worker for many years now and has deserved many Star Awards for all her hard work and kindness over the years. I would like to nominate her in this instance for all the support she has given to one of the women on my caseload, who needed additional support. Dawn went above and beyond to help her transition to parenthood. While she was pregnant, she provided home visits to demonstrate how to safely make up feeds, bathe baby, and how to keep her baby safe whilst sleeping. Dawn also visited her while she was in hospital and contacted her and visited regularly with me and independently in the postnatal period to ensure she was emotionally and physically well.

Dawn is a fabulous member of our team, she is diligent, kind, has a lovely way with colleagues and families and we would not be able to do our jobs without her, she is a real star!

Vicki Fenton, Radiology Scanning Administrator

Community

Nominated by a colleague

Vicki today has gone over and above her role to help an extremely anxious patient and myself. A patient had travelled on three buses from York early morning to Selby for a Fast Track CT scan. The patient arrived late, and then went to the wrong department. This patient has been calling the department several times a day for this appointment and celled me saying she was extremely sorry for being late but despite this had been told she would not be scanned today.

I phoned Vicki to see if she could help me in any way to see if another slot was free - which there was not. She then went over to the mobile scanner to speak to the patient, reassured her that we would do our best to have her seen today. Vicki arranged with the team doing the scans to have her scanned that morning and the patient was seen and very grateful for all her help.

This patient is a FT patient for suspected cancer and there is no doubt that Vicki speaking to the scanning department to persuade her to be seen, has kept this ladies pathway moving forward. I am so grateful for her help today.

Communications Team | **Trust-wide** | **Nominated by colleague**

I would like to nomination the communications team, a small, committed, and efficient team who do some very public work, but mostly hidden work, quietly and diligently behind the scenes. The team covers a very large remit for a small team; as well as websites and digital communication channels, our portfolio includes all internal and external communications, media handling, stakeholder management and all corporate events. Each member brings a unique set of skills and talents to the table, creating a dynamic and cohesive team that is ready to tackle any challenge that comes our way.

Despite being a relatively new team, we are pushing boundaries and pushing each other to reach new heights. In the last 12 months, alongside business-as-usual work, which is challenging enough, we have delivered a new Intranet solution, providing seamless communication, streamlined processes, access to resources, and updates in real-time. Our new intranet fosters collaboration in our workplace and offers a single source of truth for our people. Since its launch 1 February, there have been 2.25m views on homepage so far. The search has been used nearly 150,000 times, which is testament to the work which goes on in the back end of the intranet to ensure it works efficiently and is fully searchable – ensuring it is easier for our people to find what they need, when they need it. We have also introduced Teams Town Hall as an effective tool for keeping staff informed and engaged. The platform allows for seamless communication and collaboration, hopefully leading to increased transparency and satisfaction among our people. In the first three sessions we have managed to reach 100s of staff rather than just a handful, so that everyone hears about Trust priorities first hand and at the same time. We are also responsible for events, such as long service and our annual Celebration of Achievement awards night. This extra workload is quietly absorbed into the everyday workload, and delivered to an exceptional standard, knowing that this work is integral to boosting morale and motivation, leading to a positive work environment. The evaluations for both events evidence speak for themselves about the difference this works makes.

Comms team - you should all be rightly proud of everything to continue to deliver. Thank you, I hope I say it often and I hope you know that I mean it.

Sharon Mortimer, Imaging Support Worker | **York** | **Nominated by colleague**

I just wanted to pass on that Sharon has been of fantastic help today. We were extremely short staffed in main department, and she was proactive and helpful, getting patients changed, prepared and into the correct waiting areas. As well as asking how she could help. This really aided in workflow and allowed us to image more patients. It was a great help in a difficult time, and I wanted to pass on our appreciation.

East Coast Community Midwives | **Community** | **Nominated by colleague**

I am nominating the wonderful East Coast Community Maternity team for their hard work and commitment to providing an excellent service to their service users. Working in community is very challenging and yet the team strive to go above and beyond to ensure the care given is excellent and continuity is provided where possible. I am so proud to be a part of the team. The midwives, support workers, admin staff, and student midwives should be recognised for their professionalism, passion, and commitment that they demonstrate daily, providing fantastic care to the families they serve. Thank you to every one of you.

Rebecca Deighton, Outpatient Services Administrator | **York** | **Nominated by colleague**

Bex not only makes time to answer my questions whatever time of the day, but she also offers caring support to me. I am lucky to have someone like Bex in my team to learn from and who is ready to listen and asks after my and others' wellbeing. This is especially appreciated when returning to work after a break. Thank you again to Bex, she deserves to be celebrated.

Jackie Snowden, Medical Secretary **York** **Nominated by colleague**

Jackie is the backbone of Acute Medicine. She is one of the hardest working people, while also taking the time to help others who need it. She has mentored me and I look up to her. She does not receive enough recognition and has so much expected on her. She is a great asset for the Trust.

Rebekah McKeown, Student Midwife **York** **Nominated by colleague on behalf of a relative**

This feedback was received from a family Rebekah cared for, making a positive impact on their birthing journey. She took her role above and beyond what she needed to do and demonstrated our Trust values.

“I would like to start by saying that the care, compassion, and pastoral support we received from most of the staff was exceptional. Rebekah moved her shift so she was available when my wife went in labour and even made sure she was back the next day to help deliver the baby. Rebekah was our student midwife throughout pregnancy and she had excellent bedside manner and built an excellent relationship with us. Rebekah had a genuine professional interest in us, remembering little things we had said at other appointments, pet names for the baby, etc. My wife had a difficult labour and Rebekah returned an hour or two before baby was born which was perfect timing to help with putting us at ease and for supporting my wife through labour. Rebekah was exceptional and a huge credit to the maternity team.”

Thomas Edwards, Clerical Officer **York** **Nominated by colleague**

Tom is always willing to help anyone. He is calm and shows great empathy and understanding. Tom is a very good, confident, and he will never offer his opinion unless asked. Tom supports the admin team daily. He is kind, open, and approachable. Tom never asks for or expects anything in return for the support he gives and thinks nothing of staying on into his own time to help others.

Mohamad Kajouj, Speciality Doctor | **York** | **Nominated by relative**

My daughter was seen by Dr Mo as an emergency admission. He was gentle and compassionate when we were admitted. On discovering she was still in on Monday, he organised an CT scan to find out what was going on. He personally followed up on how she was doing, and she went from feeling lost in the system to well on the way to recovery. Thanks Dr Mo, we will not forget you.

Jodie Clarke, Security Officer | **York** | **Nominated by colleague**

Jodie was exceptional during a difficult situation. There was a patient who had a mental illness and needed constant care. Jodie was emotionally understanding to the patient, listening to them, and talking to them on a level that was kind and genuinely concerned. Jodie made the patient's stay little easier. She put feelings of the patient first, helping them feel settled, calm, and comfortable enough know Jodie on a first name basis.

I would also like to mention, Josh Allenby and Lamin Tamba for their amazing support. I was very proud of the team and how they handled it. They put the patient's needs first. This is a much-deserved nomination. Jodie and the team were exceptional.

Fiona Whalley, Directorate Secretary | **York** | **Nominated by colleague**

Fiona goes above and beyond for the ED team. As well as doing her day-to-day duties, Fiona regularly acts outside of her normal role to help all staff. She helps new starters through recruitment processes, helps existing staff with various issues, almost always has a solution to resolve a problem, and much more. I am sure that I will not be alone in saying she is the font of all knowledge. Being hidden in the office, I imagine Fiona might think her work goes unnoticed, but it does not. Thank you.

Children's Clinic Admin Team	**Scarborough**	**Nominated by colleague**

The admin team in Scarborough children's clinic is a new team, so, when their manager had to go on leave, all three team members stepped up. They demonstrated confidence and professionalism and dealt with everything that came their way, all while showing care and kindness towards their manager. Support was in place for them, but they rarely needed this and all three did a superb job of keeping everything running smoothly. They absolutely all embraced every Trust value.

Amanda Marshall, Discharge Liaison Officer	**York**	**Nominated by colleague**

Mandy is always a pleasure to work with, but today she was particularly kind to a patient who had been declining personal cares. Mandy took the time to sit with her and talk to her. She then helped her to clean her nails and hands and have a change of clothes. The patient settled while Mandy was talking to her and appreciated the time and care she put into her personal care.

Outpatients Reception Team	**Community Stadium**	**Nominated by relative**

While waiting for a blood test I heard the reception staff helping a patient find a COVID vaccine centre. I have had a problem finding a local vaccine centre for my Mum so spoke to them about this. The reception team got an appointment sorted for my Mum close to my house and which met her accessibility issues. I do not think this is part of their job description, but they did it willingly, were lovely, and removed the stress this had been causing me. Thank you so much.

Daniella Purce, Community Staff Nurse	**Community**	**Nominated by patient (1) and colleague on behalf of a patient (2)**

(1) Danielle has been wonderful with me. I cannot fault her. She takes her time when she visits and is not just focused on the job she has come to do, asking how I am and if there is anything else she can do to help. She is an absolute gem. The whole team have been really good.

(2) A patient would like to nominate Daniella due to the consistently excellent care she provides and would like to pass on her thanks. Daniella continuously demonstrates commitment to her patients, supporting her colleagues and being a passionate advocate for district nursing.

Bhavesh Patel, Consultant	**Bridlington**	**Nominated by colleagues**

Bhavesh Patel has an exceptional level of commitment to safe, woman-centred, and evidence-based care to our women and their families who access maternity services. Mr Patel strives to ensure all our patients leave hospital feeling reassured and advocated for and with a full understanding of their plan of care. He has a kind and caring bedside manner, which in turn makes our women feel safe and empowered in their care and personal choices.

As a colleague, Mr Patel is a pleasure to work with and is looked upon with great respect in Bridlington. He is willing to hear feedback about clinics and how we can improve patient care, as well as always being available for clinical advice and care planning if maternity staff have any concerns.

April Kirk, Healthcare Assistant | **Bridlington** | **Nominated by colleague**

April has been banking at Bridlington Care Unit (BCU) for some time now and is part of the team. She is hard working, kind, and caring and promotes the Trust values. Recently we had a night shift where a patient needed advanced support. If it had not been for April finding the patient and following protocol, the patient's outcome could have been very different. April dealt with the situation, despite it being her first crash call. She is a valued member of the BCU family!

Laura Kemsley, Admin and Clerical Manager | **York** | **Nominated by colleague**

Laura has made a difference by using her artistic talents and thinking outside of the box. She has visually presented feedback from the staff survey to engage with staff and pictorially demonstrate the areas where the team were doing well and areas where the team can improve. This is much improved from traditional ways that the staff survey has been fed back to teams in the past. This presentation was shared across the CSCS care group and then to other areas of the organisation as a template and is a brilliant example of shared learning across the organisation.

Bhavesh Patel, Consultant, Jacqueline Tang, Consultant, Joann Newby, Consultant, and Joanne Davey, Consultant	**Bridlington**	**Nominated by colleague**

Bhavesh, Jackie, Joann, and Joanne went above and beyond in providing care for a family. All appointments were extended to suit the family and SCBU accommodation was made available for the immediate family due to them having no support with childcare. Staff also travelled to peripheral units to ensure continuity of care and transport arrangements for the patient and family were made. The care plan was tailored to meet the individual, complex needs of the family. All of this was put in place to mitigate barriers to accessing care. This demonstrated the Trust's values and was the epitome of gold standard maternity care.

Rebecca Hurrell, Senior Healthcare Assistant	**Community**	**Nominated by colleague**

Rebecca goes above and beyond for her patients; always advocating for them, raising concerns, and learning how to rectify the problems as quickly as possible to achieve the best outcome for the patients.

Chris Littlewood, Catering Assistant	**York**	**Nominated by colleague**

Chris is a new member of our team. Recently the supervisors have been short-staffed, so Chris offered to step up into a supervisor position and he has been smashing it. He has always gone above and beyond for his work colleagues, patients, and visitors. I feel that his efforts should be shown some well-deserved appreciation and gratitude.

Ena Nyong, Staff Nurse	**Scarborough**	**Nominated by colleague**

Ena has been a fantastic nurse since joining the Trust three years ago. I am nominating Ena for her speediness, brilliant thinking, compassion, and cleverness. We had an emergency on a night shift where a patient self-harmed. Even though this patient was not assigned to Ena, she showed teamwork, compassion for all patients on the ward, and leadership. The Trust needs what a good, kind, brilliant, and compassionate nurse she is.

Fritha Tennant, Midwife, and Emily Riley, Student Midwife	**York**	**Nominated by patient**

I want to nominate these two lovely ladies for helping me throughout my labour and sticking by me and my partner. Their moral support and genuineness were out of this world. I want to say thank you so much for not only helping me through one of the hardest days of my life, but also for helping me bring one of the most precious things into this world. Any lady would be lucky to have you as part of their journey.

Hugo Lambert, Advanced Clinical Specialist Physiotherapist | **York** | **Nominated by patient**

I had an appointment with Hugo was for physiotherapy. He was prompt and prepared, having read my notes beforehand. He listened and was kind and caring whilst being professional and realistic. He explained my back problem to me with visual aids and thoroughly explained a potential procedure I could have. He made me feel cared about and I felt very positive and encouraged when I left the consultation. On the way home he rang me to update on progress he had already made and then followed through with sending me additional information he had promised to send me by the next day.

I cannot praise Hugo enough, and to add to all his personal and professional qualities, he was also extremely efficient! He is a credit to the hospital.

Emergency Department Team | **York** | **Nominated by colleague**

This weekend sees the new York Emergency Department celebrate one year since it was opened. The past year has seen them provide outstanding care to the people of York and North Yorkshire. The Emergency Department team are real heroes and, despite how busy the department is, I have seen amazing teamwork. They are a lifeline for the hospital and I always see staff from the department with a smile on their face. Thank you, Fiona Sharp, and the team at York Emergency Department, for reaching one year of amazing care. Well done York Emergency Department.

Lisa Wright, Sister **York** **Nominated by colleague**

Since Lisa took over as manager of our unit, the changes and improvements she has brought about have been nothing short of amazing. She has taken on the role of our advocate and champion and demonstrated wonderful leadership. She has thrown herself into the role with great passion and enthusiasm. Many changes have been implemented since she joined us, all of which have been positive for the unit. She has brought about changes to our working practices, improved the ward environment, and has been working hard to improve both staff and patients' experiences. She is approachable, fair, caring, and supportive and has been a breath of fresh air. Thank you, Lisa.

Jessica Savage, Midwife **York** **Nominated by colleague**

Jess not only supports our women with mental health issues as a perinatal mental health midwife, but, as a clinical midwife, she often volunteers to go into theatre with them for elective c-sections. This helps the women enormously as they have a familiar face who knows their story with them as they have their baby. Jess has supported one of our more complex women during a medically challenging c-section. Her baby needed to go to Special Care following delivery and Jess supported the woman's husband with this. The woman told me what a difference it made to her having met Jess before and seeing Jess's familiar face during the c-section. Jess is one of the most caring midwives I know and goes above and beyond every single day to support our most vulnerable women. I am proud to work with her in my team.

Committee Report

Report from:	Quality Committee
Date of meeting:	23rd July 2024
Chair:	Steve Holmberg

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

ALERT
Principal Risks – Committee confirmed that the 3 principal risks to Quality & Safety were: • Stalling of improvement work in Maternity • Risks associated with ambulance handover and other delays in urgent care • Care on in-patient wards These themes are discussed further below **Violence/Aggression against staff –** Rates show increase of concern **Patient self-harm –** Increased incidence reported as cause for concern
ASSURE
Audiology Service – Achieved IQUIPS accreditation for adult service **Volunteering Service** – Time-limited funding had been obtained from charitable sources to support the programme **PLACE –** Improvements noted in scores especially notable was substantial increase in ratings for food **Nuclear Medicine –** Delays in commissioning of new camera (probably until October) in part due to identification of asbestos in clinical area. Committee received assurance that service was continuing with aid from neighbouring Trusts and pro-active communication strategy had avoided patient complaints

ADVISE
Maternity – Metrics were stable or improving in month. Committee again alerted to risk of lack of sustainability without additional funding **ICU –** Committee advised regarding legacy funding shortfall for AHP provision and that options were being worked through **CQC –** Committee continues to receive assurance that CQC is responding positively to Trust plans and progress which is nearing completion. Moving forward, Committee agreed that the focus of reporting should move to a quality framework approach to ensure that there were real and sustainable benefits to patient care from the improvement work. Chief Nurse advised the

Committee that she was confident that the nursing leadership had a better understanding of their own quality metrics that was a fundamental step to drive further improvement

Quality Account – Final version to be signed off by Committee next week

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Maternity – Committee discussed the £4M+ funding gap associated with required quality and safety improvements. Committee derived some assurance from multi-stranded work to ensure optimal usage of run-rate funding with focus on bank/agency spend, cessation of non-essential and non-contracted activity, other cross-directorate working and prioritisation of areas of most urgent funding that would together mitigate the total funding shortfall

UEC – Committee had detailed discussion in response to presentation from COO and follow-up information on patients with very prolonged ambulance handover times. Committee were pleased to learn of creation of UEC Board to be chaired by Chief Nurse and sought assurance that this would have scope to drive safety improvements with all internal and external stakeholders. It was agreed that Committee would receive regular updates on progress

In-patient Care – Committee received a presentation from the Surgery CG and heard major concerns about specific and general issues related to patients outlying on wards. Committee were advised that improvement work within the CG was on-going and urged that this was extended Trust-wide to ensure that medical and nursing responsibility for all in-patients was clearly understood and mandated with robust escalation protocols in place to which all would be held accountable. Improvements were also encouraged, at pace, from workstreams including Right Sizing, Job Planning and LoS

IPC – Number of C. diff and MSSA infections remained high in-month. Focussed work on Ward 11 has now had positive impact on C. diff rates. HAIs noted to be a particular problem on wards with additional capacity (on-boarding) that may be creating challenges for effective cleaning

Complaints – Committee received annual report. Long waits, staff attitudes and poor communication remain dominant themes but complaint numbers show concerning increase. Committee noted report but recommended that it should have more focus on actions to reduce complaints rather than just reporting numbers. Committee also agreed that a triangulated report encompassing other aspects of patient experience would be more useful rather than the current arrangement

Committee Reportŷ

Report from:	Resources Committee
Date of meeting:	16th July 2024
Chair:	Jim Dillon

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

ALERT

Operational Performance

- Emergency Care Standard of 68.1% was not achieved but was 67.5%
- Ambulance arrivals up 11% from May with acute categories(1&2) up 10% adding to significant pressures in ED
- NCTR remains high with 924 lost bed days
- The June average ambulance handover target of 23 minutes and 57 seconds was not achieved. However the achieved average if 50 minutes and 38 seconds was an improvement on the average of 57 minutes and 47 seconds the previous month.
- Rise of 22% in paediatric in ED from June 2023
- Waiting times for Children and Young People in community care becoming concerning with 41% of the 2,038 on the list waiting more than 52 weeks with particular issues in Speech and Language Therapy.

Finance

- CIP behind plan by £1.9m
- Spend on Agency, Bank and WLI is ahead of plan.

ASSURE

- OCS(Optimal Care Service) launched on 3rd July aimed at improving the flow through ED and ensuring patients are directed to the appropriate pathways. This will operate from 8am to midnight in York and 8am to 6.30 in Scarborough.

- Ambulance “pit-stops” introduced in York to assist in reducing the impact of ambulance congestion

- Progress in eRostering having a significant impact managing resources and creating £1.3m in savings since March.

- Good progress made in nursing and HCSW recruitment

- Successfully moved all general nursing agency use to within NHS England agency price caps

- Efficiency savings of £14m banked in the last 3 months with around £13m recurring efficiencies

ADVISE

- A programme of initiates aimed at improving performance in Cancer care progressing, focussing on:

    - Earlier and faster diagnosis
    - Improvements in treatment Personalised Care
    - Refurbishment of the York Cancer Care facility
    - Targeted Lung checks
    - Breast pain clinics
    - Research & Development
    - Improvement in informing patients of the outcome of diagnosis.

- Change Makers progressing with writing a report regarding the feedback from the Discovery Phase.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Ongoing concern over the challenging situation in ED's however new initiatives will hopefully have a positive impact.
- Importance of maintaining a focus on the delivery of efficiency targets
- Uncertainty over the impact the new government will have on the threat of continued industrial action.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

TRUST PRIORITIES REPORT

July 2024

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York and Scarborough Teaching Hospitals
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Executive Summary

Priority Metrics

NHS
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Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
ED - Proportion of all attendances having an initial assessment within 15 mins	2024-06		F	66%	Target	53.9%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024-06		F	7.5%	Target	16.6%
ED - Emergency Care Standard (Trust level)	2024-06	L	?	68.1%	Target	67.3%
ED - Median Time to Initial Assessment (Minutes)	2024-06	L	?	18	Target	10
ED - Proportion of Ambulance handovers waiting > 60 mins	2024-06		F	10%	Target	26.3%
Cancer - Faster Diagnosis Standard	2024-05	H	?	69%	Target	70.5%
Cancer - 62 Day First Definitive Treatment Standard	2024-05	H	?	60%	Target	71.8%
RTT - Total Waiting List	2024-06	L	F	45877	Target	45568
RTT - Waits over 78 weeks for incomplete pathways	2024-06	L	F	0	Target	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024-06	L	F	102	Target	132

Executive Summary:

The June 2024 Emergency Care Standard (ECS) position was 67.3%, against the trajectory of 68.1%. Median wait time to initial assessment in ED remained unchanged at ten minutes in June 2024.

Please note; in line with national reporting deadlines cancer reporting runs one month behind. The Cancer performance figures for May 2024 saw an improvement in the 28-day Faster Diagnosis standard (FDS) to 70.5% (compared to 68.6% in April 2024). This was ahead of the trajectory submitted to NHSE for the end of May 2024 (69.05%). 62 Day waits for first treatment May 2024 performance was 71.8% an improvement on the 66.8% seen in April 2024. The Trust has, as part of the 2024 Operational Planning, submitted trajectories to achieve the national ambition of 77% for FDS and 70% for 62 Day waits for first treatment by March 2025.

There were zero RTT 78-week waiters at the end of June 2024.

At the end of June 2024, the Trust had 132 RTT patients waiting over sixty-five weeks, three above the end of month trajectory of 102. The Trust is working to achieve the national ambition to have zero RTT65 week waits by the end of September 2024. There are currently 1,482 patients who if not treated will breach 65 weeks by the end of September 2024 (a reduction of 1,259 on the end of April 2024 position; 2,741).

OPERATIONAL ACTIVITY AND PERFORMANCE

July 2024

Summary MATRIX 1

Acute Flow

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	• % of SDEC admissions transferred to downstream acute wards	• ED - Median Time to Initial Assessment (Minutes) • Number of SDEC attendances • Number of RAFA attendances (York Only)	
COMMON CAUSE / NATURAL VARIATION		• ED - Emergency Care Attendances • ED - Emergency Care Standard (Type 1 level) • ED - A&E attendances – Other type attendances • Percentage of SDEC attendances transferred from ED • Percentage of SDEC attendances transferred from GP • % ED attendances streamed to SDEC Within 60 mins • Number of attendances at SAU (York & Scarborough)	• ED - Proportion of all attendances having an initial assessment within 15 mins • ED - Proportion of all attendances seen by a Doctor within 60 mins • ED - Total waiting 12+ hours - Proportion of all Type 1 attendances • ED - 12 hour trolley waits • ED - Proportion of Ambulance handovers waiting > 30 mins • ED - Proportion of Ambulance handovers waiting > 60 mins • ED - Ambulance average handover time (number of seconds)
SPECIAL CAUSE CONCERN		• ED - Total waiting 12+ hours - Actual number of all Type 1 attendances • ED - Emergency Care Standard (Trust level) • ED - A&E attendances – Type 1 • ED - Number of ambulance arrivals	• ED - Proportion of Ambulance handovers within 15 mins

Acute Flow (1)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

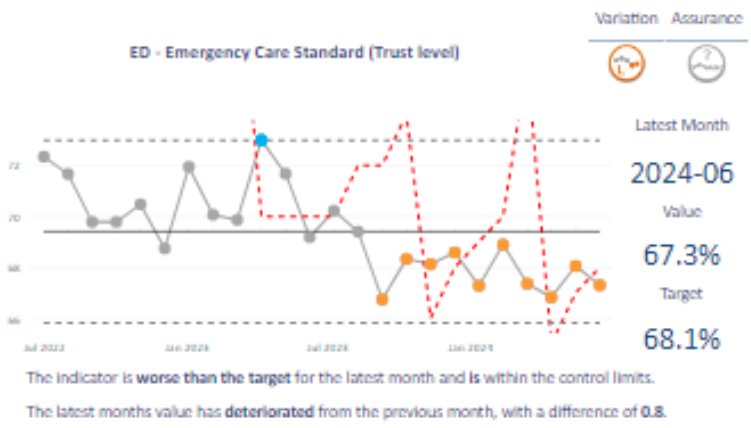
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
ED - Proportion of all attendances having an initial assessment within 15 mins	2024-06		F	66%	Target	53.9%
ED - Proportion of all attendances seen by a Doctor within 60 mins	2024-06		F	55%	Target	26.4%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024-06		F	7.5%	Target	16.6%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2024-06	H	?	1917.3	Baseline	1866
ED - 12 hour trolley waits	2024-06		F	0	Target	557
ED - Emergency Care Attendances	2024-06		?	19861.4	Baseline	20080
ED - Emergency Care Standard (Trust level)	2024-06	L	?	68.1%	Target	67.3%
ED - A&E attendances – Type 1	2024-06	H	?	10089	Target	11429
ED - Emergency Care Standard (Type 1 level)	2024-06		?	49%	Target	46.1%
ED - A&E attendances – Other type attendances	2024-06		?	7144	Target	6748
ED - Median Time to Initial Assessment (Minutes)	2024-06	L	?	18	Target	10

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor waiting times in A&E and Urgent Care Centres.
Target: NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025.



Factors impacting performance:

- The Trust did not achieve the 2024/25 improvement trajectory of 68.1% for the Emergency Care Standard with performance of 67.3%.
- Ambulances arrivals at our Emergency Departments continue to rise (June 2024 average of 144 per day against the May 2023 average of 128, a rise of 11%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) saw a rise from a daily average of 107 in June 2023 to a daily average of 117 in June 2024 putting significant pressure on our EDs (10% increase).
- In-month reduction from 19.3% to 16.2% of patients who have LoS 21+ days.
- 924 lost bed days due to patients with No Criteria To Reside (NCTR). This level equates to a thirty-one bedded ward being occupied for every day of June.

Actions:

The Optimal Care Service (OCS) was launched on both acute sites on Wednesday 3rd of July. At York Hospital OCS is in operation 8am to midnight seven days a week and at Scarborough Hospital it is running 8am to 6:30pm also seven days a week.

This service is a change to our front-door model whereby only patients meeting set criteria are sent to ED (Majors) and other patients are seen in the Optimal Care Service, which incorporates minor injuries and minor illnesses.

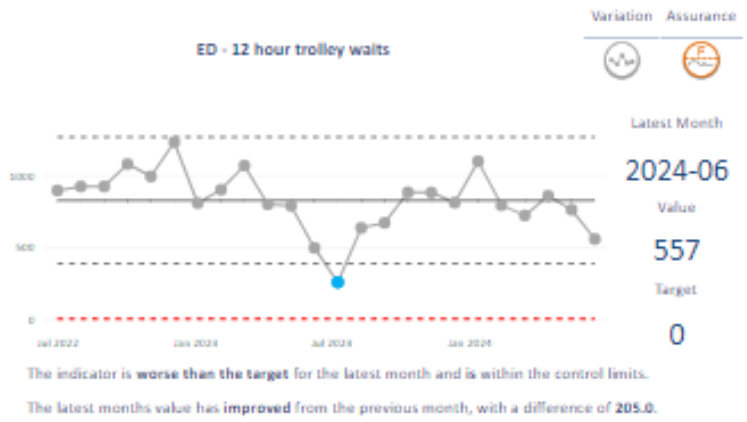
Once fully embedded, this service should result in a less crowded ED waiting room, better patient and staff experiences, and increased ECS% performance.

- Feedback from the Clinical Navigators on the front-door is positive.
- We are planning for regular audits to ensure patients are being seen by the right service and as soon as clinically appropriate.
- As part of regular monitoring clinical leads will ensure that development is provided so that patients the right disposition.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor long waits in A&E.
Target: SPC1: Zero patients to wait over 12 hours from decision to admit to being admitted. **SPC2:** Less than 7.5% of patients should wait more than 12 hours.



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- 924 lost bed days due to patients with No Criteria To Reside (NCTR).

Actions:

- Alongside the implementation of the Optimal Care Service on 3rd July 2024, focused work is underway to strengthen our response to long waits in ED, namely; review of harm and themes for long waiters to outline remedial actions to pathways and improved inter-specialty working to expedite time to be seen/timely onward patient management from ED.
- Soft breaches/4-hour Breach validation: new SOP has been drafted to support the process. A further SOP is in draft to support 12-hour breaches too. These are going through internal approval routes in July/August 2024.
- Operational management restructure within York ED is being worked up. Opportunities to review fixed term recruitment of Flow coordinators available.
- Resolving these issues and making improvements in this area will lead to better flow and fewer patients waiting over 12 hours for an acute bed after the decision to admit.
- Planning for the integrated assessment units (IAU) is underway, which will result in an improved same day and short stay provision for patients via increased assessment capacity. To achieve IAUs we need acute physicians; we appointed two substantive Acute Physician Consultants in June 2024, to start in Q3.

Acute Flow (2)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

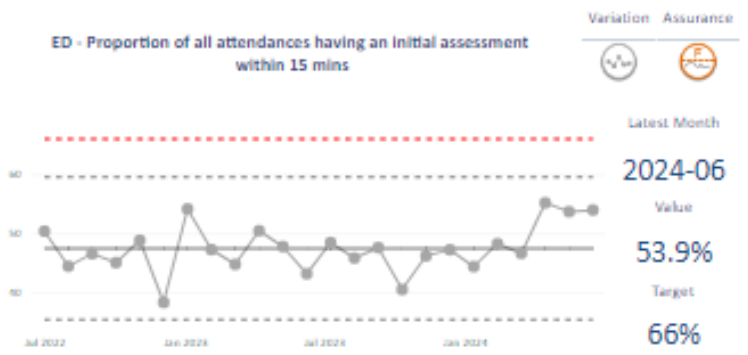
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Number of SDEC attendances	2024-06			2303.9	Baseline	2371
Percentage of SDEC attendances transferred from ED	2024-06			64.7%	Baseline	64%
Percentage of SDEC attendances transferred from GP	2024-06			22.9%	Baseline	25.4%
% ED attendances streamed to SDEC Within 60 mins	2024-06			41.4%	Baseline	41.1%
% of SDEC admissions transferred to downstream acute wards	2024-06			20%	Target	13.2%
Number of RAFA attendances (York Only)	2024-06			117.3	Baseline	149
Number of attendances at SAU (York & Scarborough)	2024-06			831.8	Baseline	800
ED - Proportion of Ambulance handovers within 15 mins	2024-06			65%	Target	20.1%
ED - Proportion of Ambulance handovers waiting > 30 mins	2024-06			5%	Target	53.5%
ED - Proportion of Ambulance handovers waiting > 60 mins	2024-06			10%	Target	26.3%
ED - Number of ambulance arrivals	2024-06			4128	Baseline	4311
ED - Ambulance average handover time (number of seconds)	2024-06			1437	Target	3038

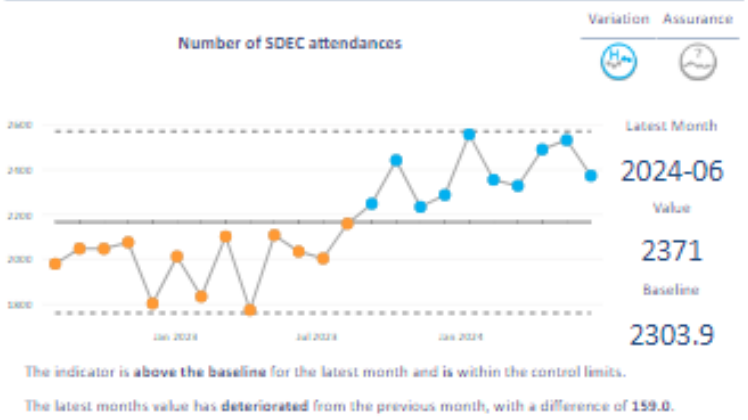
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: SPC1: To monitor waiting times in A&E. Patients should be assessed promptly by within 15 minutes of arrival based on chief complaint or suspected diagnosis and acuity. **SPC2:** SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.

Target: SPC1: 66% assessed within 15 mins. **SPC2:** No target.





Factors impacting performance:

- Ambulances arrivals at our Emergency Departments continue to rise (June 2024 average of 144 per day against the May 2023 average of 128, a rise of 11%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) saw a rise from a daily average of 107 in June 2023 to a daily average of 117 in June 2024 putting significant pressure on our EDs (10% increase).
- Demand increasing for beds, the daily average admissions via ED in June 2024 was 156 patients compared to 134 in June 2023. A rise of 16%.
- Reduction in the number of patients who have LoS 21+ days.
- 942 lost bed days due to patients with No Criteria To Reside (NCTR).
- SDEC attendance numbers remain above the baseline.

Actions:

- 'Ambulance pit-stop +' model at York remains in use; using dedicated cubicle capacity to support with ambulance handover has improved handover times. Work still ongoing to ensure these cubicles are ring-fenced and not reverted for general use when the department is under pressure.

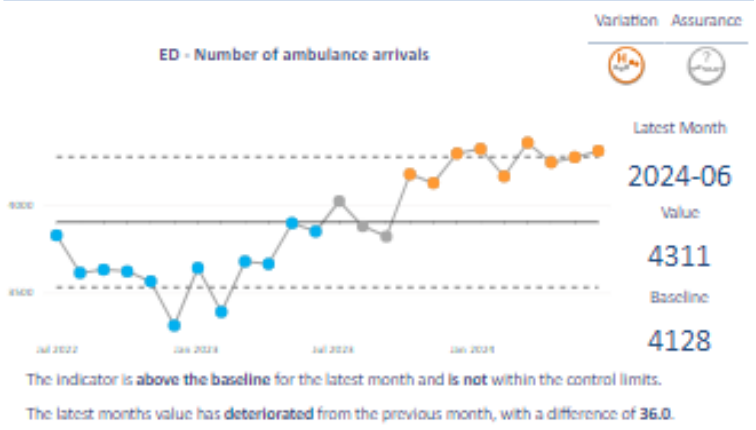
- In collaboration with system partners, we are working to improve alternative pathway and dispositions away from EDs. This includes direct admission to SDEC.

- Planning for the integrated assessment units (IAU) is underway, which will result in an improved same day and short stay provision for patients via increased assessment capacity. To help achieve IAUs we appointed two substantive Acute Physician Consultants in June 2024, to start in Q3.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: SPC1: To monitor Ambulance demand in A&E. **SPC2:** Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.
Target: SPC1: No target. **SPC2:** Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival. Less than 10% should wait over 60 minutes to handover.



Factors impacting performance:

- Ambulances arrivals at our Emergency Departments continue to rise (June 2024 average of 144 per day against the June 2023 average of 128, a rise of 11%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) saw a rise from a daily average of 107 in June 2023 to a daily average of 117 in June 2024 putting significant pressure on our EDs (10% increase).

- The Trust did not achieve the June 2024 average ambulance handover time target of 23 minutes and 57 seconds. However, the June performance of 50 minutes and 38 seconds was a marked improvement on the previous month (57 minutes 47 seconds). Average ambulance handover time is calculated by taking the total combined handover times divided by the number of ambulances that attended the Trust's EDs.

Actions:

- ECIST is supporting our senior nursing team to develop the Nurse In Charge (NIC) role so there is a consistent approach. A staff questionnaire is currently underway to gather further views.

- The introduction of the Optimal Care Service (detailed earlier in this report) will positively impact ambulance handovers.

- Alongside that work, the Deputy Chief Operating Officer is working closely with colleagues at YAS to consider CAT3 and CAT5 triage, to ensure that people are only conveyed to hospital when required.

- Monthly operational meeting with YAS is in place with ED colleagues cross-site. The meeting is focused on facilitating improvements in partnership working, unblocking operational challenges, communication of optimal patient pathways and learning from incidents. There is a sub-group – Ambulance steering group that focuses on shared learning opportunities. This meeting has recently been evaluated and actions have been disseminated to improve timeliness of feedback and preparation of data.

Summary MATRIX 2

Acute Flow

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Number of zero day length of stay non-elective admitted patients	• Inpatients - Proportion of patients discharged before 5pm
COMMON CAUSE / NATURAL VARIATION	• Community bed occupancy/availability	• Patients with Senior Review completed at 23:59 • Inpatients - Percentage of adult G&A beds occupied by patients not meeting the criteria to reside • Inpatients - Super Stranded Patients, 21+ LoS (Adult) • Overnight general and acute beds open • Of those overnight general and acute beds open, percentage occupied	• Patients receiving clinical Post Take within 14 hours of admission
SPECIAL CAUSE CONCERN	• Number of non-elective admissions	• Inpatients - Lost bed days for patients with no criteria to reside	

Acute Flow (3)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Patients receiving clinical Post Take within 14 hours of admission	2024-06		F	90%	Target	78.2%
Patients with Senior Review completed at 23:59	2024-06		?	48.5%	Baseline	46.6%
Inpatients - Proportion of patients discharged before 5pm	2024-06	H	F	70%	Target	64.2%
Inpatients - Lost bed days for patients with no criteria to reside	2024-06	H	?	949.1	Baseline	924
Inpatients - Percentage of adult G&A beds occupied by patients not meeting the criteria to reside	2024-06		?	17.9%	Target	18.9%
Number of non-elective admissions	2024-06	H	P	6837	Target	6161
Number of zero day length of stay non-elective admitted patients	2024-06	H	?	2010	Target	2350
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2024-06		?	124	Target	137
Overnight general and acute beds open	2024-06		?	838	Target	856
Of those overnight general and acute beds open, percentage occupied	2024-06		?	92%	Target	93.2%
Community bed occupancy/availability	2024-06		P	100%	Target	93.1%

Executive Owner: Karen Stone

Operational Lead: Abolfazl Abdi

Rationale: Patient safety.
Target: **SPC1:** 90% of patients receiving clinical Post Take within 14 hours of admission. **SPC2:** No target.

Factors impacting performance:

- Demand and acuity.
- Workforce challenges.

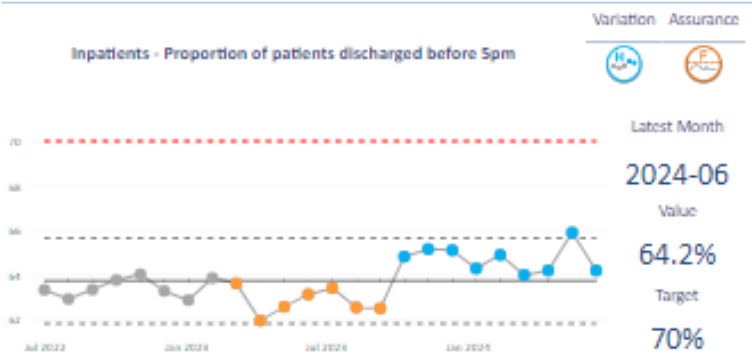
Actions:

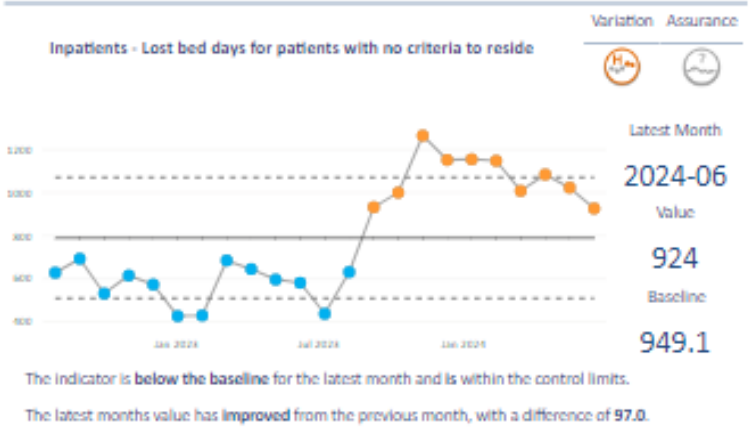
- As part of the Integrated Assessment Unit (IAU) programme the Trust is planning to strategically move towards real-time post take. This means patients will receive a senior review by a physician in real-time within the operating hours of the IAU (8am to 8pm).
- In the interim we are aiming to appoint an increased number of Acute Physicians to strengthen our daily senior review of patients in line with our strategy.
- In the short-term the Trust is developing capacity for and mentoring for senior clinicians to ensure patients receive timely post take.
- The Internal Professional Standards project (which was paused at the end of the financial year) is being aligned to UCIP and being restarted with support from the Quality Improvement team. This will support improvements in both post-take and senior daily review compliance.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: Understand flow in the acute bed base.
Target: Internal target of 70%.





Factors impacting performance:

- Demand and acuity.
- Timing of Ward Rounds and Senior Review.
- Community capacity in particular social provision.
- Infection Prevention Control (IPC) outbreaks.
- Workforce challenges.

Actions:

- The Discharge Improvement Group is supporting improvement both in-hospital and across community partners. The group leads the coordination and completion of tasks to achieve alignment with the national discharge policy.

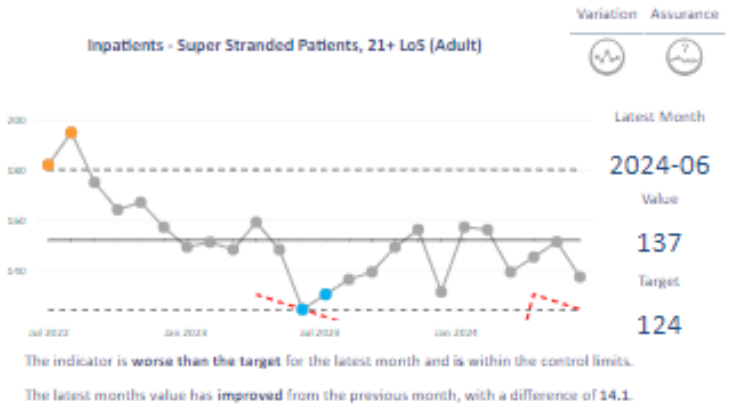
- Adoption of the OPTICA application which is a digital discharge management tool that is integrated with all other partner's systems, so all partners can see the status of a patient and can allocate actions to progress discharge. Implementation is being scoped and likely to be delivered in Q3 of 2024/25.

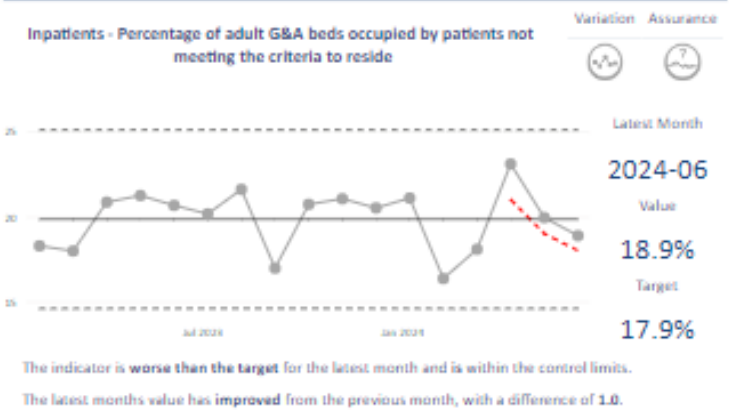
- Super discharge teams are being stood up at both sites each week, with senior members from a multidisciplinary team adding challenge into board rounds to ensure there is a focus on 'why not home? why not today?'

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: Less than 15% as per activity plan (March 2025).





Factors impacting performance:

- Demand increasing for beds, the daily average admissions via ED in June 2024 was 156 patients compared to 134 in June 2023. A rise of 16%.
- Reduction in number of patients who have LoS 21+ days.
- 924 lost bed days due to patients with No Criteria To Reside (NCTR). Although the Trust did achieve the target to have less than 18.8% of beds occupied by NCTR patients with performance of 17.9%. As part of 2024/25 planning the Trust is aiming to have less than 15% occupied by NCTR patients by March 2025.

Actions:

- As per the previous slides, a discharge programme is underway and will support improvements to NCTR occupancy rates.
- As part of this, we continue to implement super discharge teams where possible to expedite and encourage safe discharges. Super discharge teams should include a senior nurse, medic, AHP and ops lead; together they can add professional challenge into board rounds and keep a focus on 'why not home, why not today?'.
- Adoption of OPTICA (see previous slide).

Summary MATRIX
CANCER

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Cancer - Faster Diagnosis Standard • Cancer - 62 Day First Definitive Treatment Standard • Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL • Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result	
COMMON CAUSE / NATURAL VARIATION		• % of patients waiting 63 or more days after referral from cancer PTL • Cancer 31 day wait from diagnosis to first treatment • Total Cancer PTL size	
SPECIAL CAUSE CONCERN			

CANCER
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Cancer - Faster Diagnosis Standard	2024-05			69%	Target	70.5%
Cancer - 62 Day First Definitive Treatment Standard	2024-05			60%	Target	71.8%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2024-06			143	Target	156
% of patients waiting 63 or more days after referral from cancer PTL	2024-06			12%	Target	7.7%
Cancer 31 day wait from diagnosis to first treatment	2024-05			96%	Target	99.3%
Total Cancer PTL size	2024-06			2611.1	Baseline	2084
Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result	2024-06			80%	Target	72.9%

KPIs – Operational Activity and Performance

Cancer (1)

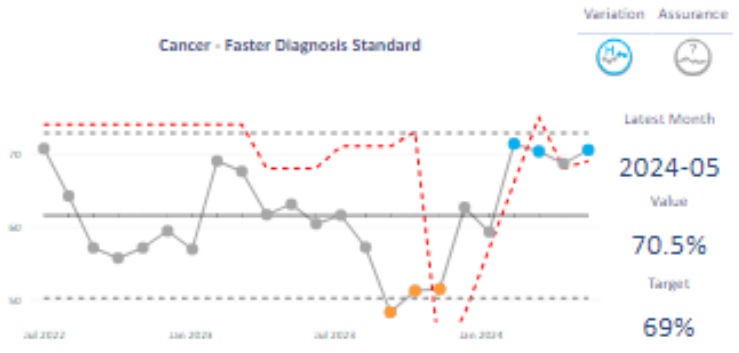
York and Scarborough Teaching Hospitals NHS Foundation Trust

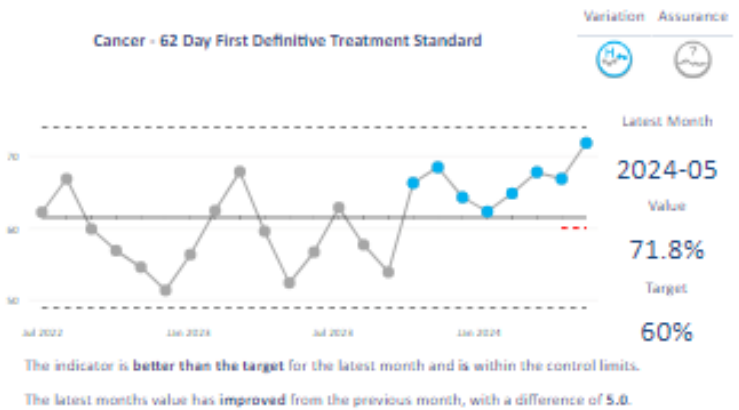
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: SPC1: Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. **SPC2:** National focus for 2024/25 is to improve performance against the headline 62-day standard**.** Rationale to be inserted by Corporate Ops Teams.

Target: SPC1: 77% by March 2024. **SPC2:** 70% by March 2025.





Factors impacting performance (please note; in line with national reporting deadlines cancer reporting runs one month behind):

- May 2024 saw similar referral volumes across all sites (2,815 total). Skin saw the highest monthly total since June 2023, suggesting seasonal variation has commenced.
- The following cancer sites exceeded 75% FDS in May: Breast, Haematology, Head and Neck, Skin and Upper GI. Urology achieved the internal trajectory but is still not achieving FDS. Colorectal and Gynaecology remain below FDS and internal trajectory, with recovery plans around additional WLI's and insourcing to recover the position.
- The following cancer sites exceeded 70% 62-day performance in May: Breast, Head and Neck, Upper GI and Skin. Similarly to FDS, Urology achieved the internal trajectory but did not achieve the national 62-day target.
- Diagnostic turnaround times remain challenged in CT reporting and pathology sample reporting. Recovery plans are in place and utilisation of cancer alliance and NHSE performance recovery funding once received by Trust.
- The proportion of patients waiting over 104+ days continues to equate to 1% of the PTL size. Colorectal and Urology remain the areas with the highest volume of patients past 62 days with/without a decision to treat but are yet to be treated or removed from the PTL.

Actions:

- Use of pathway IST analyser to review cancer site pathways against Best Practice Timed Pathways (BPTP) to achieve FDS. Specific improvement workstream set up to support Urology and mapping underway with Skin and Head and Neck to review streamlining opportunities.
- Cancer site operational teams are reviewing summer plans to maintain capacity.
- Awaiting SLA and receipt of circa £1.2million 2024-25 system development funding (SDF) via cancer alliance, including schemes that directly impacting performance by providing additional capacity and those directly impacting patient experience and treatment. Further funding bid for as part of NHSE national cancer performance recovery fund (£250k allocated to the trust from regional funding). Some funding approved but awaiting transaction and detail.
- SACT demand and capacity modelling commenced in June 2024 and being lead in partnership with the cancer alliance using nationally approved tool, to inform future treatment planning.
- BI development of IPT dashboard to give improved visibility of patient moves and timescales, which is now available on SIGNAL during Q1 2024/25. This is anticipated to aid planning for actions around site specific improvements for 62-day performance.

Summary MATRIX
Referral to Treatment (RTT)

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Proportion of most deprived quintile pathways on RTT PTL (S056a)	• RTT - Total Waiting List • RTT - Waits over 78 weeks for incomplete pathways • RTT - Waits over 65 weeks for Incomplete Pathways • RTT - Waits over 52 weeks for Incomplete Pathways • RTT - Proportion of incomplete pathways waiting less than 18 weeks • RTT - Mean Week Waiting Time - Incomplete Pathways
COMMON CAUSE / NATURAL VARIATION		• Proportion of BAME pathways on RTT PTL (S056a)	
SPECIAL CAUSE CONCERN	• Proportion of pathways with an ethnicity code on RTT PTL (S058a)		

Referral to Treatment (RTT)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
RTT - Total Waiting List	2024-06			45877	Target	45568
RTT - Waits over 78 weeks for incomplete pathways	2024-06			0	Target	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024-06			102	Target	132
RTT - Waits over 52 weeks for Incomplete Pathways	2024-06			1755	Target	1539
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024-06			92%	Target	55.4%
RTT - Mean Week Waiting Time - Incomplete Pathways	2024-06			9	Target	18.8
Proportion of BAME pathways on RTT PTL (S056a)	2024-06			1.8%	Baseline	1.7%
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2024-06			12%	Baseline	12.3%
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2024-06			67.2%	Baseline	66.4%

KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

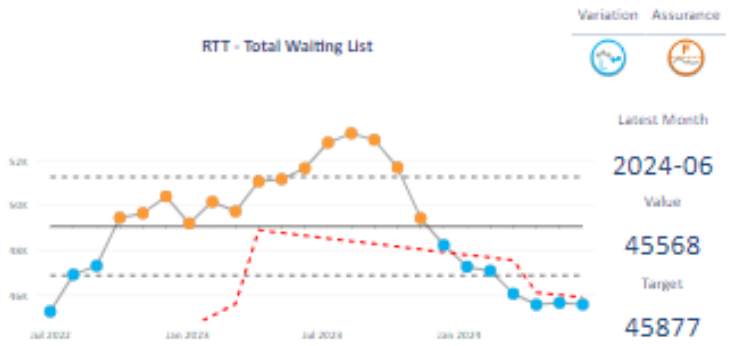
York and Scarborough Teaching Hospitals NHS Foundation Trust

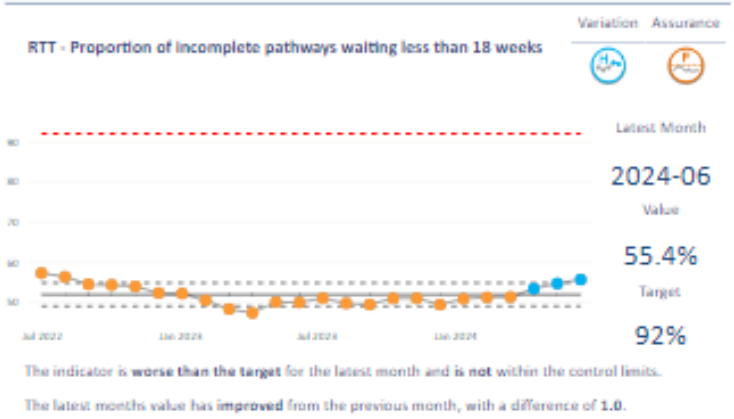
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: SPC1: To measure the size of the Referral to Treatment (RTT) incomplete pathways waiting list. **SPC2:** To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.

Target: SPC1: Aim to have less than 44,663 patients waiting by March 2025 as per activity plan. **SPC2:** No target.





Factors impacting performance:

- The Trust's RTT Waiting list position continues to be ahead of the trajectory submitted to NHSE as part of the 2024/25, 45,568 against the trajectory of 45,877.
- The NHS Constitution established that patients "have the right to access certain services commissioned by NHS bodies within maximum waiting times". The RTT standard is a key performance standard indicating how trusts are delivering on a patient's right to receive treatment within 18 weeks of being referred to a consultant-led service. The proportion of the waiting list **waiting under 18 weeks** improved from 54.4% at the end of May 2024 to 55.4% at the end of June 2024. The target for this is 92% which was last achieved nationally in February 2016.

Actions:

- Implementation of new Power business intelligence (BI) RTT patient tracklog list (PTL) tool for Operational Managers continues with the significant progress made in May continued in June. Testing is underway with plans for training dates with Operational Managers set to be finalised in July.
- The Trust's RTT Waiting List has a data quality RTT PTL Confidence Rating of 99.7% as awarded by the LUNA National data quality (DQ) RTT Benchmarking tool. The Trust is in the top 25 Trusts in the country for this metric and signals that our RTT waiting list is 'clean', accurate and the patients are legitimate waiters.
- The Trust is part of cohort 2 of the national Further Faster Programme, several specialties perform well against the key metrics including the did not attend (DNA) rate, pre-referral triage and advice and guidance. Next steps are to focus on further patient initiated follow up (PIFU) roll out, Rapid Expert Input (REI) roll out, clinic slot utilisation and new to follow up ratios.
- 24/25 Elective Recovery plan has been developed with Trust and Place colleagues and includes the following workstreams:
    - Outpatient improvement.
    - Theatre improvement.
    - Diagnostic improvement.
    - Cancer.
    - Children and Young People.
    - Productivity and Efficiency.
    - Health inequalities.

KPIs – Operational Activity and Performance

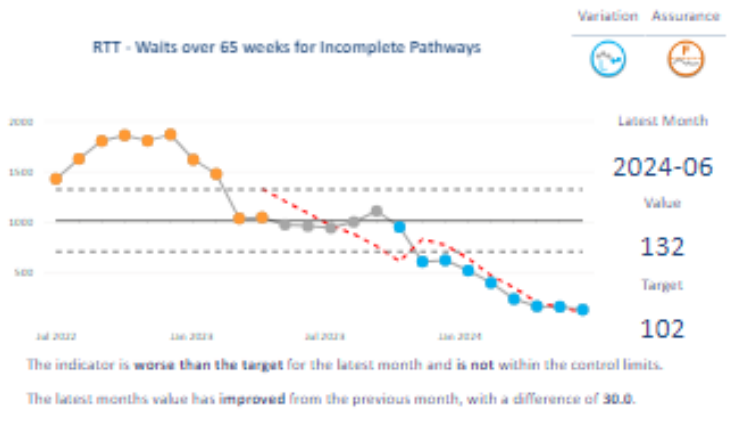
Referral to Treatment RTT (2)

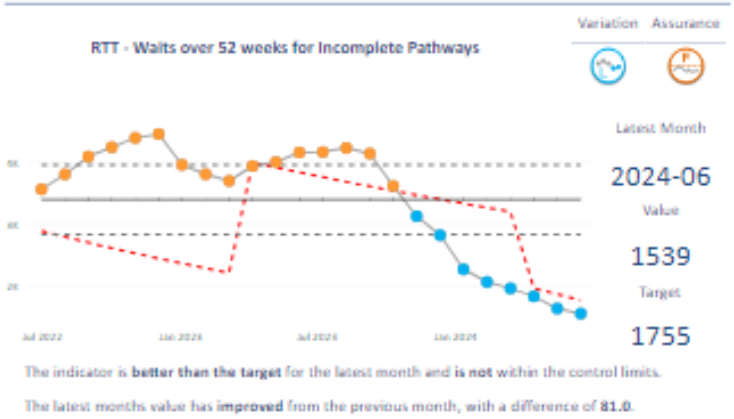
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients. **Target: SPC2:** Aim to have 0 patients waiting more than 65 weeks by September 2024. **SPC2:** Aim to have less than 923 patients waiting more than 52 weeks by March 2025 as per activity plan.





Factors impacting performance:

- The Trust maintained the position of having zero RTT78 week waits at the end of June 2024 and had 132 patients waiting 65 weeks or more, above the trajectory of 102 submitted as part of the 2024/25 Activity Plan.
- The Trust delivered the trajectory for RTT52 weeks; 1,539 against the trajectory of 1,755.
- RTT52 week waits reduced by 81 compared to the end of May 2024 (1,620).
- Performance against Further, Faster cohorts. The latest Further, Faster data released by the GIRFT Team in June shows the Trust as having the second highest reduction (-56%, -2140 patients) compared to all Trusts included in Further, Faster cohorts one and two over the last twelve months.

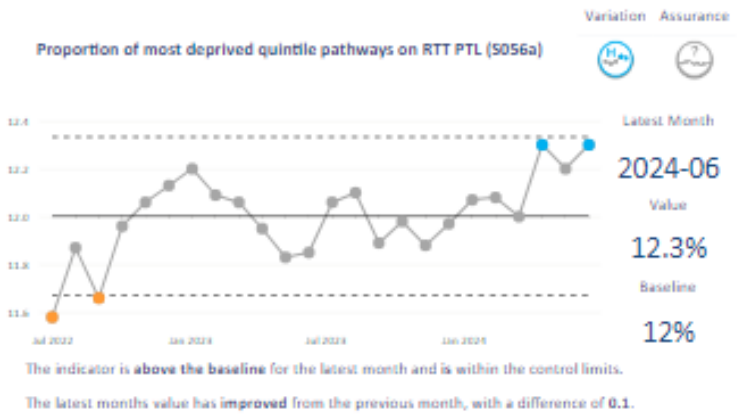
Actions:

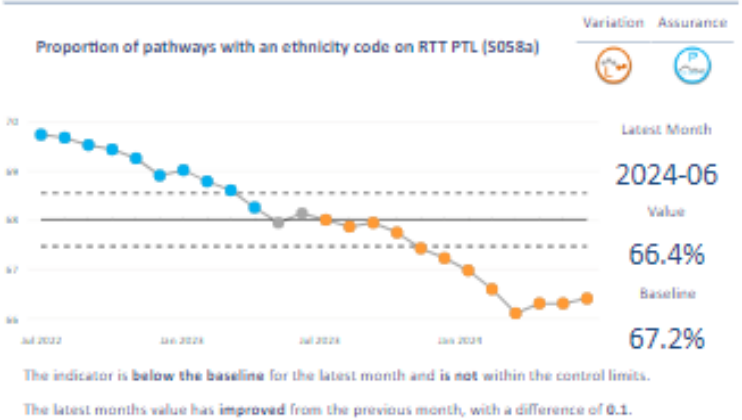
- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 and RTT65 weeks.
- The Trust's activity plan that is aligned to improvement trajectories; delivering zero RTT65 week waits by the end of September 2024 and an improvement to no more than 923 RTT52 week waits by the end of March 2025, was submitted to the national team on the 2nd of May 2024. To achieve this trajectory our Care Groups will need to make a collective net monthly reduction of between 80 to 110 patients per month throughout 2024-25. This was achieved in June 2024.
- Delivery of the 2024/25 elective recovery plan. Initial analysis shows that at the end of June 2024 the Trust is ahead of the 2024/25 activity plan with a provisional performance of 103% of the Weighted Value Trust Activity Plan submitted to NHSE. From a financial point of view this equates to a provisional performance of 112% against the submitted plan, this is linked to the value of the casemix that has been seen during quarter one.
- Elective Health inequalities group in place, reporting into elective recovery board and Trust Health Inequalities Steering Group.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: To identify any health inequalities.
Target: No target.





Factors impacting performance:

- Removal of the question regarding ethnicity from the inpatient admission form has impacted performance.
- Consistency of outpatient reception staff asking patients at the point of booking in.

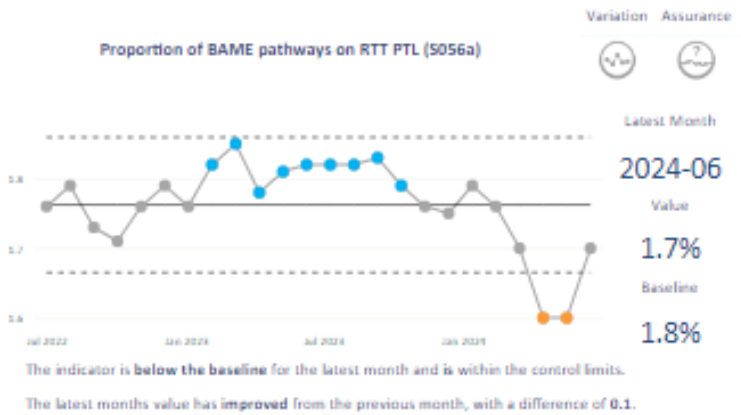
Actions:

- Elective Health inequalities group established, reporting into elective recovery board and Trust Health Inequalities Steering Group.
- 8-week surgical pathway for patients with learning disabilities on an elective waiting list task and finish group established and piloted new pathway in May and June 2024 with SOP and full implementation to go live in July 2024. Baseline position for median waiting time is 17.5 weeks.
- Q2 2024/25 focus will be a review of DNAs and correlation with deprivation index.
- Professional Lead for Patient Access has developed a laminated sheet for all outpatient receptions to provide patients with information on why we collect this information.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: To identify any health inequalities.
Target: No target.



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Factors impacting performance:

See previous slide.

Actions:

See previous slide.

Executive Owner: Dawn Parkes **Operational Lead:** Melanie Liley

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile

At end of: **June 2024**

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	19	5511	12.36%	8.88%
2	19	6206	13.92%	13.59%
3	19	9367	21.02%	20.94%
4	19	9815	22.02%	20.68%
5	19	13672	30.67%	35.90%
Unknown	19	997		
Total	**19**	**45568**		

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: **June 2024**

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	19	29890	98.30%	94.34%
Black, Black British, Caribbean or African	16	53	0.17%	0.94%
Mixed or multiple ethnic groups	18	118	0.39%	1.26%
Asian or Asian British	17	249	0.82%	2.97%
Other ethnic group	18	97	0.32%	0.49%
Unknown	19	12112		
Not Stated	20	3049		
Total	**18**	**45568**		

Data source for trust catchment area: Public Health England NHS Acute Catchment Areas.

*Proportion on waiting list excluding not stated and unknown.

Summary MATRIX
Outpatients & Elective

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			• Outpatients: 1st Attendances (Activity vs Plan) • Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)
COMMON CAUSE / NATURAL VARIATION	• Outpatient procedures • Percentage of elective admissions which are day case	• Outpatients - DNA rates • 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* • Day Cases (based on Activity v Plan) • Electives (based on Activity v Plan)	• Outpatients - Proportion of appointments delivered virtually (S017a)
SPECIAL CAUSE CONCERN		• Outpatients: Follow Up Attendances (Activity vs Plan)	• Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) • Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)

Outpatients & Elective Care
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

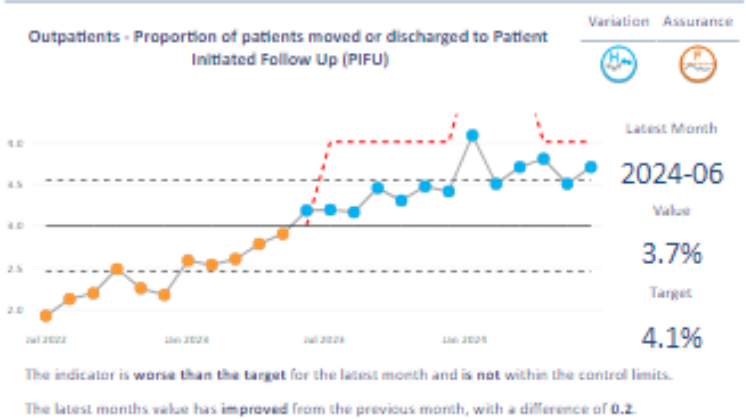
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Outpatients - Proportion of appointments delivered virtually (S017a)	2024-06		F	25%	Target	20.4%
Outpatients - DNA rates	2024-06		?	5%	Target	5.2%
Outpatients: 1st Attendances (Activity vs Plan)	2024-06	H	F	18730	Target	16922
Outpatients: Follow Up Attendances (Activity vs Plan)	2024-06	H	?	45043	Target	42093
Outpatient procedures	2024-06		P	7766	Target	12713
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2024-06	H	F	0	Target	27415
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2024-06	H	F	4.1%	Target	3.7%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2024-06	L	F	99%	Target	19.1%
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*	2024-03		?	0	Target	11
Day Cases (based on Activity v Plan)	2024-06		?	6505	Target	7167
Electives (based on Activity v Plan)	2024-06		?	549	Target	664
Percentage of elective admissions which are day case	2024-06		P	85%	Target	91.5%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: SPC1: Need to reduce instances where people miss their outpatient appointments ('did not attends' or 'DNAs') to improve patient experience, free up capacity to treat long-waiting patients and support the delivery of the NHS's plan for tackling the elective care backlog. **SPC2:** Helps empower patients to manage their own condition and plays a key role in enabling shared decision making and supported self-management in line with the personalised care agenda.
Target: SPC1: Internal target of less than 5%. **SPC2:** Above 5% by March 2025.



Factors impacting performance:

- Outpatient bi-directional text messaging positively impacting DNA rates.
- PIFU roll out is paused awaiting an automated solution to add patients to PIFU list and lack of call handling capacity.
- Increasing demand on the Rapid Access Chest Pain service has been seen, service are undertaking capacity and demand work before options appraisal developed.

Actions:

- DIS Development team developing an automated process to ensure PIFU patients are correctly added to PIFU list. Go live is planned for July 2024.
- Review of call handling solutions to ensure we have capability to respond to additional patient contacts.
- Development of PIFU pathways across specialities as part of elective recovery plan and further faster workstream.

Summary MATRIX
Diagnostics

MATRIX KEY
- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI • Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy • Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	• Diagnostics - Proportion of patients waiting <6 weeks from referral • Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies
COMMON CAUSE / NATURAL VARIATION		• Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema • Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology • Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography • Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral • Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	• Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound • Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan
SPECIAL CAUSE CONCERN		• Diagnostics - Proportion of patients waiting <6 weeks from referral - CT • Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics • Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	

DIAGNOSTICS – National Target: 95%

Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Diagnostics - Proportion of patients waiting <6 weeks from referral	2024-06	H	F	68.3%	Target	63.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2024-06	H	?	64.4%	Target	75.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2024-06	L	?	70.4%	Target	48.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2024-06	-	F	83.1%	Target	71.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2024-06	-	?	77.5%	Target	82.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2024-06	-	F	65%	Target	55.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2024-06	-	?	84.8%	Target	57.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2024-06	-	?	31.1%	Target	43.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2024-06	-	?	95.5%	Target	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2024-06	H	F	95%	Target	89.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2024-06	L	?	30.8%	Target	36.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2024-06	H	?	49%	Target	74.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2024-06	H	?	39.4%	Target	64.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2024-06	-	?	76.3%	Target	69.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2024-06	L	?	74%	Target	80.1%

KPIs – Operational Activity and Performance

Diagnostics (1)

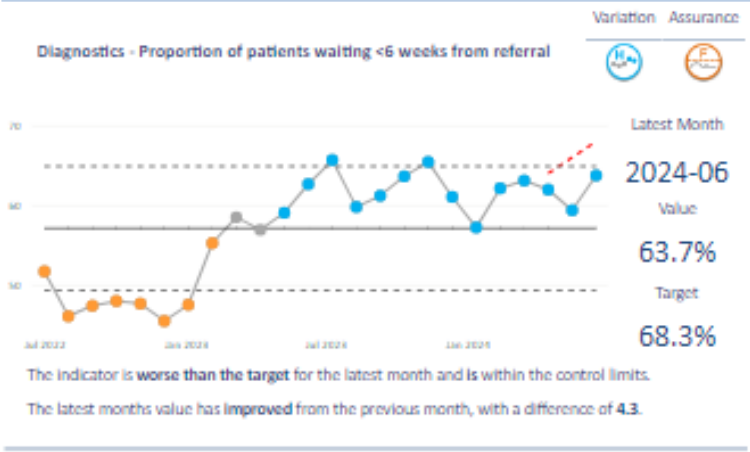
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: Maximise diagnostic activity focused on patients of highest clinical priority.

Target: Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%.



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Factors impacting performance:

- Complexity of CDC programme delivery.
- Workforce challenges across most imaging modalities and consequence of higher banding for CDC mobile so seeing increased attrition of staff.
- Acute and cancer demand for CT and MRI.
- Aging equipment (MRI at York and SGH, CT3 at York) causing increased downtime.
- Complex booking and administrative processes which adds to delays.
- Workforce challenges within Gastroenterology but recent recruitment successful.
- Development of non-consultant workforce.
- Age-extension of bowel cancer screening programme demand.
- Increase in outsourced work leading to longer reporting times due to lack of in-house reporting capacity.

Actions:

- All services now operational at Askham Bar CDC (CT, MRI, DEXA scans, Cardiorespiratory and Phlebotomy).
- Go live of new Selby CDC activity with completion of onboarding of all services by August 2024 (NOUS and Cardiorespiratory).
- 3rd MRI scanner at York received external funding approval and business case approved at Executive Committee.
- ECHO at York has completed demand and capacity and forecast that with additional 45 extra patients per week delivered through the CDC, the backlog will be cleared by the end of August 2024. Improvement plans for Scarborough being developed.
- Demand and Capacity work for all DM01 diagnostics tests being completed during Q1&Q2 2024/25 as part of elective recovery plan.
- Urodynamics have developed a recovery plan to deliver by Q2 2024/25 including additional extra contractual activity attracting ERF through the outpatient procedure tariff.
- Endoscopy insourcing continues with additional 10 lists per week to end of Q2 2024/25. They are currently ahead of the improvement trajectory.
- HNY Diagnostic board presented productive partner report which indicates further area for productivity improvements.

Summary MATRIX
Children & Young Persons

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT		• Children & Young Persons: RTT - Total Waiting List	• Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks • Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways
COMMON CAUSE / NATURAL VARIATION		• Children & Young Persons: ED - Patients waiting over 12 hours in department	• Children & Young Persons: ED - Emergency Care Standard (Type 1 only)
SPECIAL CAUSE CONCERN			

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Children & Young Persons: ED - Patients waiting over 12 hours in department	2024-06			0	Target	3
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2024-06		F	95%	Target	84%
Children & Young Persons: RTT - Total Waiting List	2024-06	L		4106.8	Baseline	3797
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024-06	H	F	92%	Target	70.6%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2024-06	L	F	0	Target	37

KPIs – Operational Activity and Performance

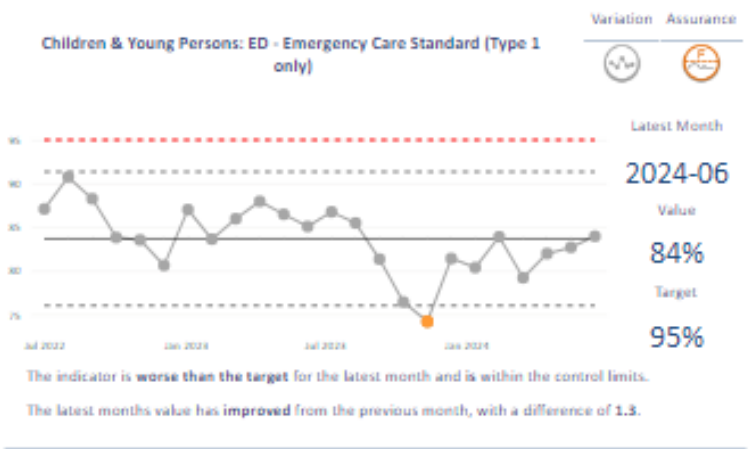
Children & Young Persons (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: SPC1: To monitor waiting times in A&E**. SPC2:** To monitor long waits in A&E.
Target: SPC1: NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025.
SPC2: No paediatric patients should wait more than 12 hours.



Factors impacting performance:

- Increased paediatric attendances across both of our Emergency Departments (EDs) compared to June 2023, The Trust saw an average of 15 more paediatric attendances per day throughout the month of June 2024, a rise of 22%.

- The children and young people waiting longer than 12 hours in the department were all aged 16-17 years old and are being managed through an adult pathway with one patient who was admitted having their wait impacted by the wait for an adult ward.

Actions:

- Scoping improvement actions for children and young people with Family Health Care Group.

KPIs – Operational Activity and Performance

Children & Young Persons (2)

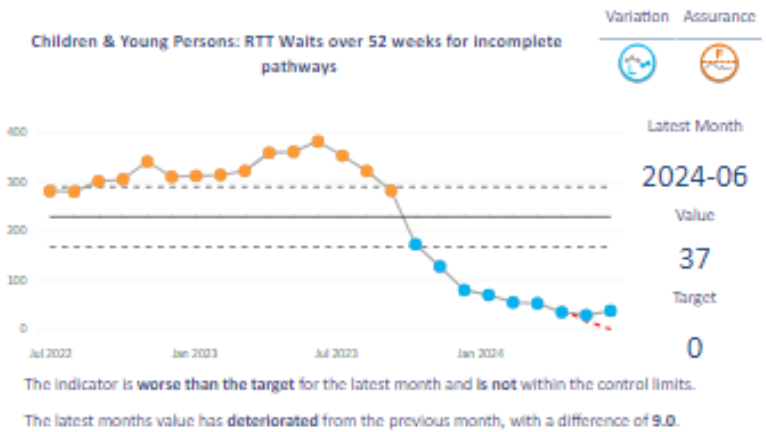
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.

Target: Aim to have 0 patients waiting more than 52 weeks by July 2024 (internal target).



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Factors impacting performance:

- The Trust did not deliver the trajectory for RTT52 weeks wait for patients aged under eighteen with 37 against a revised internal trajectory of 29. The Trust is now seeking to deliver zero CYP patients waiting over 52 weeks by the end of September 2024.

- Performance against Further, Faster cohorts. The latest Further, Faster data released by the GIRFT Team in June shows the Trust as having the highest reduction (-90%, -342 patients) in CYP RTT52 week waiters compared to all Trusts included in the Further, Faster cohorts one and two over the last twelve months.

Actions:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 weeks wait for patients aged under eighteen.

- Reviewing option to run paediatric super Saturday Ear, Nose and Throat lists at the end of July 2024 to support the reduction in a long waiters because of patient choice because of school / exam periods.

- Children and Young People are a workstream within the 2024/25 elective recovery plan with a focus on the following improvements:
    - Increase outpatient capacity at Scarborough through the Scarborough right sizing priorities.
    - Strategy for day case surgery for children.
    - Going further for children waiting times for surgery
    - Stabilise community waiting lists.

Summary MATRIX
Community

MATRIX KEY

HIGH IMPROVEMENT
IMPROVEMENT
NEUTRAL
CONCERN
HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Total Urgent Community Response (UCR) referrals • 2-hour Urgent Community Response (UCR) care Referrals • Number of Adults (18+ years) on community waiting lists per system	• Number of open Virtual Ward beds • Number of CYP (0-17 years) on community waiting lists per system
COMMON CAUSE / NATURAL VARIATION	• 2-hour Urgent Community Response (UCR) Compliancy %	• Percentage of Virtual Ward beds occupied • Number of District Nursing Contacts • Number of Selby CRT Contacts • Number of York CRT Contacts • Referrals to District Nursing Team • Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	
SPECIAL CAUSE CONCERN		• Community Response Team (CRT) Referrals	

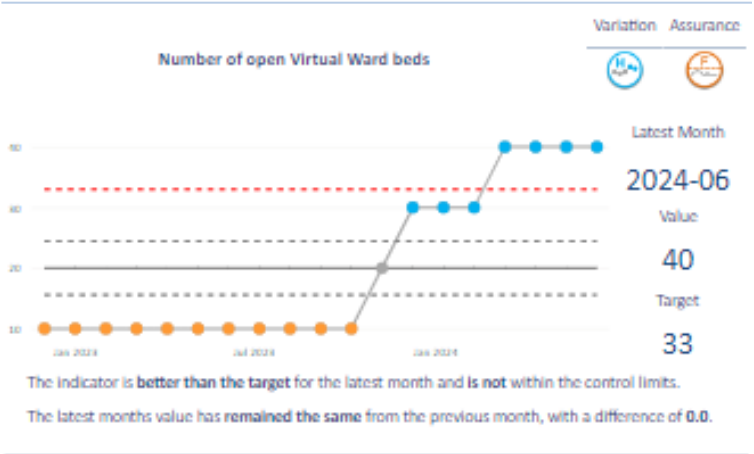
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Number of open Virtual Ward beds	2024-06			33	Target	40
Percentage of Virtual Ward beds occupied	2024-06			80%	Target	50%
Community Response Team (CRT) Referrals	2024-06			437.9	Baseline	500
Total Urgent Community Response (UCR) referrals	2024-06			218	Baseline	493
2-hour Urgent Community Response (UCR) care Referrals	2024-06			88.3	Baseline	108
2-hour Urgent Community Response (UCR) Compliancy %	2024-06			70%	Target	87.8%
Number of Adults (18+ years) on community waiting lists per system	2024-06			786.2	Baseline	813
Number of CYP (0-17 years) on community waiting lists per system	2024-06			726	Baseline	2052
Number of District Nursing Contacts	2024-06			21176.2	Baseline	19686
Number of Selby CRT Contacts	2024-06			2788.8	Baseline	2354
Number of York CRT Contacts	2024-06			4744.3	Baseline	4584
Referrals to District Nursing Team	2024-06			2238	Baseline	2253
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2024-06			972	Target	917

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor demand on Community services.
Target: No Target.



Factors impacting performance:
- Workforce challenges.
- Acute pressures.

Actions:
The trajectory for March 2024 was capacity for 33 patients on virtual wards, which we met. That target is not changing in 2024-25, though there are ongoing discussions about whether this number should be reduced to 28 because of the removal of 5 care home beds from the original plan.

Our York Frailty virtual ward expanded last month and in July it will be fully technology-enabled through the new system Inhealthcare which we procured with externally awarded funds at the end of last financial year.

Our Heart Failure virtual ward is considering how it could expand its remit and support an in-reach service into Emergency Departments; any recommendations that come from this planning work would likely require additional investment.

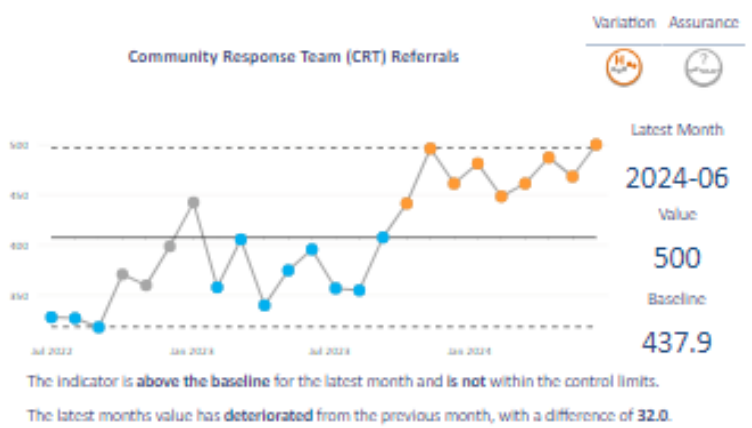
Vascular Virtual Ward remains open for suitable patients who are awaiting callback for scans who can wait at home. Utilisation varies based on the number of patients meeting the criteria. A new vascular imaging unit is due to open over winter; it may be the case that this additional capacity reduces the length of stay for patients on the vascular virtual ward and therefore reduces the requirement for capacity and/or utilisation.

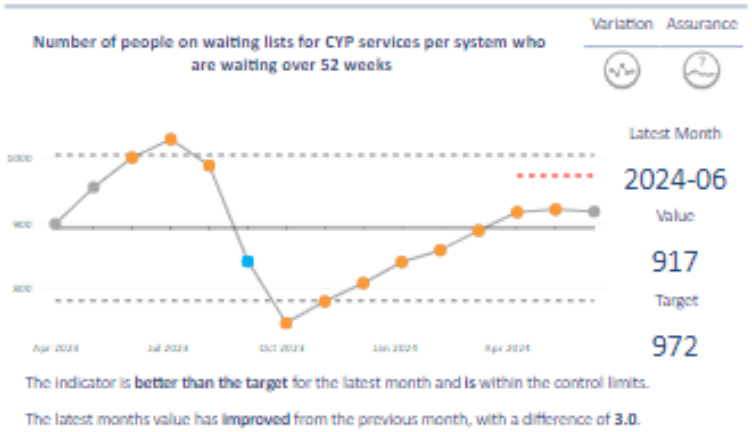
Cystic Fibrosis: This is the newest of the virtual wards to open on CPD and after a trial period there is evidence to reduce capacity. The team are seeing benefits to using the virtual ward, however there are very rarely more than 2-3 patients with Cystic Fibrosis in our acute care at any one time, so the capacity on the virtual ward should reflect that.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor demand on Community services.
Target: SPC1: No target. **SPC2:** no more than 1,056 by end of March 2025 as per activity planning submission.





Factors impacting performance:

- **SPC1:** Referrals to York Community Response Team and Urgent Community Response was consistent with previous months in May 2024 remaining near the upper control limit. The continued development of the Frailty Crisis Hub will likely have further impact on referrals with the YAS pathway developments. There is continued demand for hospital discharge support approx. 60 % of all referrals. The additional resource for York Place Discharge to Assess bridging will provide little impact on type and complexity of the rehab and reablement referrals. To manage the competing demands community teams flex capacity to provide a responsive service where they can, however with continued growth and no further investment to meet this demand it will become challenging.

- **SPC2:** Continuing increase in demand and static funded current capacity resulting in increasing waiting times.

Actions:

- **SPC1:** There is ongoing conversations with the South Hambleton and Ryedale and Selby Primary Care Networks re the UCR model and creating better integration with primary care to ensure better equity of service.

- Additional therapy resource has been funded by NYCC place to support step down beds and IPU flow in the Selby area only.

- **SPC1:** Continue to monitor the demand and capacity of both the Selby and the York teams.

- **SPC2:** Community Children and Young People Speech and Language Therapy have a detailed improvement plan including the implementation of a Request for Helpline Service, re-triage of long waiters, development of training and resources and group interventions.

- **SPC2:** Community Children and Young People Occupational Therapy service are implementing a 'let's make sense together' project with several support resources for children with sensory needs which equates to 50% of longest waiters.

QUALITY AND SAFETY

July 2024

Summary MATRIX 1 of 2

Quality and Safety

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Inpatient Acquired Pressure Ulcers • Medication incidents per thousand bed days • Patient Safety Incidents per thousand Bed Days • Harmful Incidents per thousand bed days • Number of Serious Incidents Reported	
COMMON CAUSE / NATURAL VARIATION		• Total Number of Trust Onset MSSA Bacteraemias • Total Number of Trust Onset MRSA Bacteraemias • Total Number of Trust Onset C. difficile Infections • Total Number of Trust Onset E. coli Bacteraemias • Total Number of Trust Onset Klebsiella Bacteraemias • Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias • Pressure Ulcers per thousand Bed Days • All Patient Falls • Patient Falls per thousand Bed Days • Percentage of Patient Safety Incidents with Moderate or Above Harm • Trust Duty of Candour (Stage 1) • Trust Duty of Candour (Stage 2) • Trust Duty of Candour (Stage 3) • Total Number of Never Events Reported • In-Hospital Deaths • Monthly SHMI • Monthly HSMR	
SPECIAL CAUSE CONCERN			

Quality & Safety
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

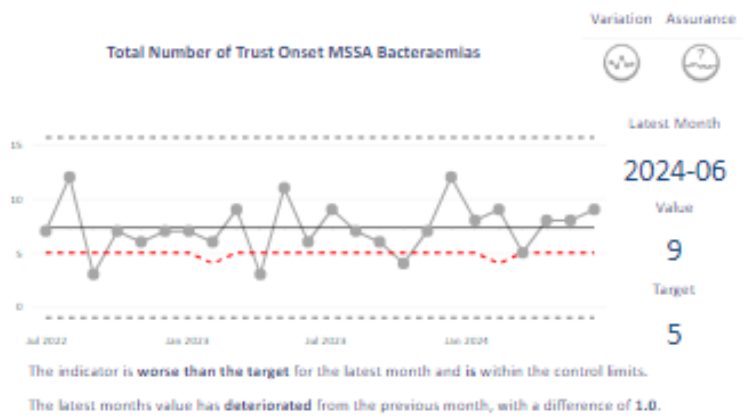
Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

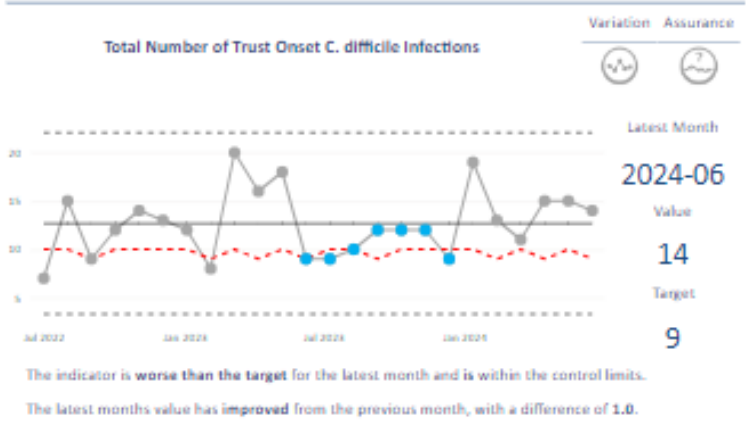
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Total Number of Trust Onset MSSA Bacteraemias	2024-06			5	Target	9
Total Number of Trust Onset MRSA Bacteraemias	2024-06			0	Target	1
Total Number of Trust Onset C. difficile Infections	2024-06			9	Target	14
Total Number of Trust Onset E. coli Bacteraemias	2024-06			12	Target	20
Total Number of Trust Onset Klebsiella Bacteraemias	2024-06			4	Target	5
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2024-06			2	Target	5
Inpatient Acquired Pressure Ulcers	2024-06			139	Baseline	122
Pressure Ulcers per thousand Bed Days	2024-06			4	Baseline	3.8
All Patient Falls	2024-06			247	Baseline	253
Patient Falls per thousand Bed Days	2024-06			9	Target	8.7
Medication incidents per thousand bed days	2024-06			6	Baseline	4.6

Executive Owner: Dawn Parkes

Operational Lead: Sue Peckitt

Rationale: To drive reduction in avoidable health care associated infection, facilitate patient safety and improve patient outcomes
Target: National targets for 2024/25 not yet set, working on 2023/24 threshold – 1 for all mandatory surveillance organisms.





Factors impacting performance:

- MSSA bacteraemia breached the internally set target of 5 cases with 9 cases recorded in June, 5 cases attributed to York Hospital, 4 attributed to Scarborough Hospital. The Trust is 9 cases over the year to date target.
- 1 MRSA bacteraemia reported in June against a zero target. This takes the Trust to 3 MRSA cases for 2024/25
- Clostridioides difficile breached the monthly target in June by 6 cases. Of the 15 cases 7 were attributed to York Hospital, 6 attributed to Scarborough Hospital, 2 attributed to community hospital sites. The Trust is 18 cases over the year to date target.
- Whilst not directly related to performance Scarborough Hospital saw significant impact from outbreaks of Norovirus in May/June with 6 wards affected which were either fully closed or partially closed as a control measure. A daily outbreak meeting was held during the outbreak and clear management plan was in place

Actions:

- A post infection review of the June MRSA case has been undertaken, whilst the source of infection cannot be determined improvement lessons have been identifies and being implemented by the care group.
- All MSSA bacteraemia undergo a review using a PSIRF approach, learning identified improvement needed with hand hygiene compliance, IV cannula documentation, ANTT compliance
- Internal audit of Cannula Management Action plan in progress which addresses ANTT and IV cannula documentation, peripheral intravenous cannula devices guideline has been updated and approved via IPSAG, to be uploaded on staff room.
- Clostridioides difficile cases are reviewed using PSIRF approach, learning identified inappropriate antibiotic prescribing, delay in isolation, need for improved communication during handover and with Microbiology regarding treatment advice, improvements required for Hand Hygiene, commode cleanliness and completion of Bristol Stool Chat. Learning being addressed via the Care Group.
- Working with Care Groups to introduce Care Group Infection Prevention and Control Groups from July. Term of reference have been drafted and presented to IPSAG for approval

Quality & Safety
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Adele Coulthard **Operational Lead:** Dan Palmer

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Patient Safety Incidents per thousand Bed Days	2024-06			50	Baseline	40.7
Harmful Incidents per thousand bed days	2024-06			17	Baseline	14.8
Percentage of Patient Safety Incidents with Moderate or Above Harm	2024-06			3%	Baseline	4.2%
Trust Duty of Candour (Stage 1)	2024-06			93%	Baseline	89.9%
Trust Duty of Candour (Stage 2)	2024-06			91%	Baseline	89.9%
Trust Duty of Candour (Stage 3)	2024-06			91%	Baseline	94.4%
Number of Serious Incidents Reported	2024-06			8	Baseline	1
Total Number of Never Events Reported	2024-06			0	Target	0
In-Hospital Deaths	2024-06			201	Baseline	183
Quarterly SHMI	2023-12			100	Target	98.8
Monthly SHMI	2024-01			100	Target	90.6
Quarterly HSMR	2024-03			100	Target	112.6
Monthly HSMR	2024-03			100	Target	103

Executive Owner: Adele Coulthard

Operational Lead: Dan Palmer

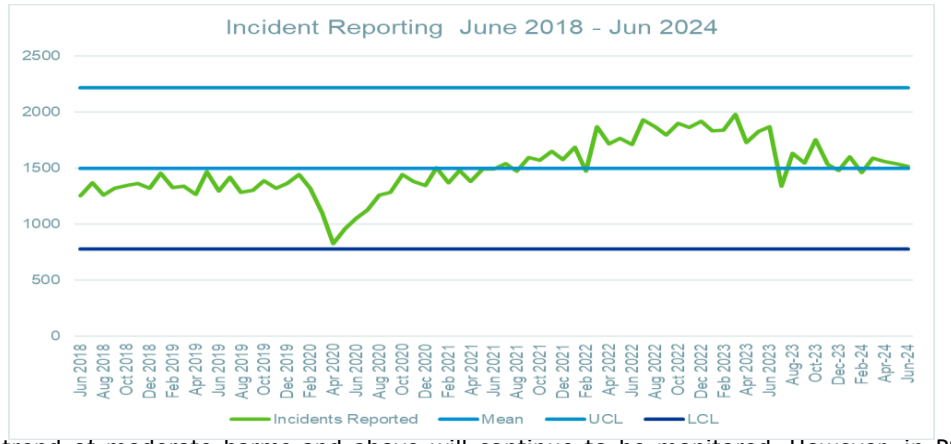
Rationale: Rationale to be inserted by leads
Target: Target to be inserted by leads

Factors impacting performance:

With the move to DCIQ, there have been issues with the new system bedding into business as usual. These issues are known about and are addressed through regular discussions with the system provider and with staff using the system. The previous figures show that even with concerns being raised across the organisation, the completion of incidents has not dropped as a result and has been consistent for 8 months.

- The numbers of reported incidents remain within levels of normal variation.
- Work is now completed on improving the Datix reporting form to make this easier for staff to complete and load.
- Use of the system is constantly monitored and any operational issues are discussed with the system provider.

It unclear as to where this data is pulled from. The below data pulled from Datix shows reporting is along the mean with natural peaks and troughs dependant on A/L, Sickness, season etc.



The trend of moderate harms and above will continue to be monitored. However, in PSIRF the low and no harms have equal importance as these will reduce potential future serious harm

Summary MATRIX 2 of 2

Quality and Safety

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Intrapartum Stillbirths	
COMMON CAUSE / NATURAL VARIATION	• Friends and Family Test - Trust Maternity Recommend %	• Trust Complaints • Needlestick Injury or Sharps Incident • Staff Slips, Trips and Falls • RIDDOR • Antepartum Stillbirths • Early neonatal deaths (0-7 days) • PPH > 1.5L as % of all women - York • PPH > 1.5L as % of all women - Scarborough	• Friends and Family Test - Trust ED Recommend %
SPECIAL CAUSE CONCERN	• Friends and Family Test - Trust Inpatient Recommend %	• Obstetrics and Gynaecology: Serious Incidents • Obstetrics and Gynaecology: Moderate Incidents	

Quality & Safety
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Tara Filby/ Sacha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Friends and Family Test - Trust ED Recommend %	2024-05		F	90%	Target	71.7%
Friends and Family Test - Trust Inpatient Recommend %	2024-05	L	P	90%	Target	91.8%
Friends and Family Test - Trust Maternity Recommend %	2024-05		P	90%	Target	99%
Trust Complaints	2024-06			78	Baseline	92
Needlestick Injury or Sharps Incident	2024-06			15	Baseline	20
Staff Slips, Trips and Falls	2024-06			4	Baseline	4
RIDDOR	2024-06			2	Baseline	3
Antepartum Stillbirths	2024-05			0.8	Baseline	0
Intrapartum Stillbirths	2024-05	L		0	Baseline	0
Early neonatal deaths (0-7 days)	2024-05			0.9	Baseline	1
PPH > 1.5L as % of all women - York	2024-05			5.2%	Baseline	3.2%
PPH > 1.5L as % of all women - Scarborough	2024-05			2.3%	Baseline	3.2%
Obstetrics and Gynaecology: Serious Incidents	2024-06	H		0	Baseline	1
Obstetrics and Gynaecology: Moderate Incidents	2024-06	H		10.6	Baseline	7

Executive Owner: Dawn Parkes/Karen Stone **Operational Lead:** Tara Filby

Rationale: Rationale to be inserted by leads.
Target: Target to be inserted by leads.

Factors impacting performance: The number of new complaints remains high and is almost three times the average pre pandemic. In the month of May, 12% new complaints related to the Emergency Department at York Hospital. Unsurprisingly the majority of complaints relate to delayed treatment across services but complaints about staff attitude and poor communication also remain high.
As at 04/06/24 194 complaints remain open, of which 57 are overdue and 28 due in the next 10 days.

Actions: the majority of complaints within the Emergency Department at York Hospital are themed around long waits, with some featuring lack of access to food and drink. The Launch of the OCS in July is streaming a high proportion of patients away from ED, the effect of this is the waiting times reducing and hopefully this will really help to reduce complaints and concerns. Staff are allocated to the waiting room to ensure drinks and light refreshment are offered safely. Catering staff have met with the ED Matron and hot meals are also provided to patients being cared for in cubicles where appropriate at lunchtime and in the evening. Drinks stations are available near the waiting room and majors cubicles for ease of access.

In terms of the numbers open and overdue, because of the increased number of complaints, it means Investigating Officers have multiple complaints to handle and coupled with the operational demand are struggling to meet deadlines- the governance team are trying to provide as much support as possible and in medicine specifically the formal response times remain at 71% in target timeframe. In terms of PALS very poor performance at 41%, the medicine care group are actively pursuing ways of changing concern management, reviewing the allocation of the concerns and working in collaboration with the Patient Experience Team.

The Head of Patient Experience is working with the Head of Nursing for Urgent and Emergency Care to explore how to promote increased uptake of FFT within the Emergency Departments, including the potential use of volunteers.

MATERNITY

July 2024

Summary MATRIX 1 of 3

Maternity Scarborough

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	• Bookings - Scarborough		
COMMON CAUSE / NATURAL VARIATION		• Bookings ≥13 weeks (exc transfers etc.) - Scarborough • Births - Scarborough • No. of women delivered - Scarborough • Women affected by suspension - Scarborough • Community midwife called in to unit - Scarborough • Maternity Unit Closure - Scarborough • SCBU at capacity - Scarborough • SCBU at capacity of intensive care cots - Scarborough • SCBU no of babies affected - Scarborough • 1 to 1 care in Labour - Scarborough • L/W Co-ordinator supernumerary % - Scarborough	• Bookings <10 weeks - Scarborough • Planned homebirths - Scarborough • Homebirth service suspended - Scarborough • Anaesthetic cover on L/W - Scarborough
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Bookings - Scarborough	2024-05			169	Target	109
Bookings <10 weeks - Scarborough	2024-05			90%	Target	62.4%
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2024-05			10%	Target	11%
Births - Scarborough	2024-05			113	Target	108
No. of women delivered - Scarborough	2024-05			112	Target	107
Planned homebirths - Scarborough	2024-05			2.1%	Target	0.9%
Homebirth service suspended - Scarborough	2024-05			3	Target	17
Women affected by suspension - Scarborough	2024-05			0	Target	0
Community midwife called in to unit - Scarborough	2024-05			3	Target	0
Maternity Unit Closure - Scarborough	2024-04			0	Target	0
SCBU at capacity - Scarborough	2024-04			1.2	Baseline	0
SCBU at capacity of intensive care cots - Scarborough	2024-04			5.4	Baseline	1
SCBU no of babies affected - Scarborough	2024-04			0	Target	0
1 to 1 care in Labour - Scarborough	2024-05			100%	Target	100%
L/W Co-ordinator supernumerary % - Scarborough	2024-04			100%	Target	96.6%
Anaesthetic cover on L/W - Scarborough	2024-05			10	Target	5

Summary MATRIX 2 of 3

Maternity Scarborough

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• HSIB cases - Scarborough	
COMMON CAUSE / NATURAL VARIATION	• Assisted Vaginal Births - Scarborough • Intrapartum Stillbirths - Scarborough	• Normal Births - Scarborough • C/S Births - Scarborough • Elective caesarean - Scarborough • Emergency caesarean - Scarborough • Induction of labour - Scarborough • HDU on L/W - Scarborough • BBA - Scarborough • Neonatal Death - Scarborough • Antepartum Stillbirth - Scarborough • Cold babies - Scarborough • Preterm birth rate <37 weeks - Scarborough • Preterm birth rate <34 weeks - Scarborough • Preterm birth rate <28 weeks - Scarborough	
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Normal Births - Scarborough	2024-05			57%	Target	50%
Assisted Vaginal Births - Scarborough	2024-05		P	12.4%	Target	8.3%
C/S Births - Scarborough	2024-05			40.9%	Baseline	41.7%
Elective caesarean - Scarborough	2024-05			19.4%	Baseline	19.4%
Emergency caesarean - Scarborough	2024-05			21.4%	Baseline	22.2%
Induction of labour - Scarborough	2024-05			43.2%	Baseline	42.5%
HDU on L/W - Scarborough	2024-04			5	Target	0
BBA - Scarborough	2024-05			2	Target	1
HSIB cases - Scarborough	2024-04	L		0	Target	0
Neonatal Death - Scarborough	2024-05			0	Target	0
Antepartum Stillbirth - Scarborough	2024-05			0	Target	0
Intrapartum Stillbirths - Scarborough	2024-05		P	0	Target	0
Cold babies - Scarborough	2024-04			1	Target	0
Preterm birth rate <37 weeks - Scarborough	2024-05			6%	Target	5.6%
Preterm birth rate <34 weeks - Scarborough	2024-05			1%	Target	0.9%
Preterm birth rate <28 weeks - Scarborough	2024-05			0.5%	Target	0%

Summary MATRIX 3 of 3

Maternity Scarborough

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Breastfeeding Initiation rate - Scarborough • 3rd/4th Degree Tear - assisted birth - Scarborough	
COMMON CAUSE / NATURAL VARIATION		• Low birthweight rate at term (2.2kg) - Scarborough • Breastfeeding rate at discharge - Scarborough • Smoking at booking - Scarborough • Smoking at 36 weeks - Scarborough • Smoking at time of delivery - Scarborough • Carbon monoxide monitoring at booking - Scarborough • Carbon monoxide monitoring at 36 weeks - Scarborough • SI's - Scarborough • PPH > 1.5L as % of all women - Scarborough • Shoulder Dystocia - Scarborough • 3rd/4th Degree Tear - normal births - Scarborough • Informal Complaints - Scarborough • Formal Complaints - Scarborough	
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Low birthweight rate at term (2.2kg) - Scarborough	2024-05			0%	Target	0%
Breastfeeding Initiation rate - Scarborough	2024-05	H		75%	Target	81.5%
Breastfeeding rate at discharge - Scarborough	2024-05			65%	Target	56.3%
Smoking at booking - Scarborough	2024-05			6%	Target	11.9%
Smoking at 36 weeks - Scarborough	2024-03			6%	Target	14.4%
Smoking at time of delivery - Scarborough	2024-05			6%	Target	13.1%
Carbon monoxide monitoring at booking - Scarborough	2024-05			95%	Target	84.4%
Carbon monoxide monitoring at 36 weeks - Scarborough	2024-05			95%	Target	80.4%
SI's - Scarborough	2023-10			0	Target	1
PPH > 1.5L as % of all women - Scarborough	2024-05			2.3%	Baseline	2.8%
Shoulder Dystocia - Scarborough	2024-05			2	Target	1
3rd/4th Degree Tear - normal births - Scarborough	2024-04			2.8%	Target	0%
3rd/4th Degree Tear - assisted birth - Scarborough	2024-05	L		6.1%	Target	0%
Informal Complaints - Scarborough	2024-05			0	Target	1
Formal Complaints - Scarborough	2024-05			0	Target	2

Summary MATRIX 1 of 3

Maternity York

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Community midwife called in to unit - York • Maternity Unit Closure - York • L/W Co-ordinator supernumerary % - York	
COMMON CAUSE / NATURAL VARIATION	• Bookings ≥13 weeks (exc transfers etc.) - York • Anaesthetic cover on L/W - York	• Bookings - York • Bookings <10 weeks - York • Births - York • No. of women delivered - York • Women affected by suspension - York • SCBU at capacity - York • SCBU at capacity of intensive care cots - York • SCBU no of babies affected - York • 1 to 1 care in Labour - York	• Planned homebirths - York • Homebirth service suspended - York
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Bookings - York	2024-05			295	Target	282
Bookings <10 weeks - York	2024-05			90%	Target	77%
Bookings ≥13 weeks (exc transfers etc.) - York	2024-05		P	10%	Target	2.5%
Births - York	2024-05			245	Target	223
No. of women delivered - York	2024-05			242	Target	219
Planned homebirths - York	2024-05		F	2.1%	Target	0%
Homebirth service suspended - York	2024-05		F	3	Target	9
Women affected by suspension - York	2024-05			0	Target	0
Community midwife called in to unit - York	2024-05	L		3	Target	0
Maternity Unit Closure - York	2024-04	L		0	Target	1
SCBU at capacity - York	2024-04			0.8	Baseline	0
SCBU at capacity of intensive care cots - York	2024-04			19.5	Baseline	29
SCBU no of babies affected - York	2024-04			0	Target	0
1 to 1 care in Labour - York	2024-05			100%	Target	100%
L/W Co-ordinator supernumerary % - York	2024-04	H		100%	Target	98%
Anaesthetic cover on L/W - York	2024-05		P	10	Target	10

Summary MATRIX 2 of 3

Maternity York

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• HSIB cases - York • Intrapartum Stillbirths - York • Cold babies - York	
COMMON CAUSE / NATURAL VARIATION		• Normal Births - York • Assisted Vaginal Births - York • C/S Births - York • Elective caesarean - York • Emergency caesarean - York • HDU on L/W - York • BBA - York • Neonatal Death - York • Antepartum Stillbirth - York • Preterm birth rate <37 weeks - York • Preterm birth rate <34 weeks - York • Preterm birth rate <28 weeks - York	
SPECIAL CAUSE CONCERN		• Induction of labour - York	

Maternity York
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Normal Births - York	2024-05			57%	Target	52.4%
Assisted Vaginal Births - York	2024-05			12.4%	Target	13.5%
C/S Births - York	2024-05			36.1%	Baseline	34.1%
Elective caesarean - York	2024-05			14.9%	Baseline	13.5%
Emergency caesarean - York	2024-05			21.2%	Baseline	20.6%
Induction of labour - York	2024-05			45.9%	Baseline	46.6%
HDU on L/W - York	2023-10			5	Target	8
BBA - York	2024-05			2	Target	0
HSIB cases - York	2024-04			0	Target	0
Neonatal Death - York	2024-05			0	Target	1
Antepartum Stillbirth - York	2024-05			0	Target	0
Intrapartum Stillbirths - York	2024-05			0	Target	0
Cold babies - York	2024-04			1	Target	1
Preterm birth rate <37 weeks - York	2024-05			6%	Target	11.2%
Preterm birth rate <34 weeks - York	2024-05			2%	Target	3.1%
Preterm birth rate <28 weeks - York	2024-05			0.5%	Target	0%

Summary MATRIX 3 of 3

Maternity York

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Breastfeeding Initiation rate - York • Breastfeeding rate at discharge - York	• Carbon monoxide monitoring at 36 weeks - York
COMMON CAUSE / NATURAL VARIATION	• 3rd/4th Degree Tear - assisted birth - York	• Low birthweight rate at term (2.2kg) - York • Smoking at booking - York • Smoking at 36 weeks - York • Smoking at time of delivery - York • Carbon monoxide monitoring at booking - York • SI's - York • PPH > 1.5L as % of all women - York • Shoulder Dystocia - York • 3rd/4th Degree Tear - normal births - York • Informal Complaints - York • Formal Complaints - York	
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Low birthweight rate at term (2.2kg) - York	2024-05			0%	Target	0.9%
Breastfeeding Initiation rate - York	2024-05			75%	Target	89.7%
Breastfeeding rate at discharge - York	2024-05			65%	Target	72%
Smoking at booking - York	2024-05			6%	Target	8.5%
Smoking at 36 weeks - York	2024-05			6%	Target	1.6%
Smoking at time of delivery - York	2024-05			6%	Target	5.9%
Carbon monoxide monitoring at booking - York	2024-05			95%	Target	88.7%
Carbon monoxide monitoring at 36 weeks - York	2024-05			95%	Target	79.9%
SI's - York	2023-10			0	Target	2
PPH > 1.5L as % of all women - York	2024-05			5.2%	Baseline	3.2%
Shoulder Dystocia - York	2024-05			2	Target	5
3rd/4th Degree Tear - normal births - York	2024-05			2.8%	Target	0.9%
3rd/4th Degree Tear - assisted birth - York	2024-05			6.1%	Target	0.5%
Informal Complaints - York	2024-05			0	Target	3
Formal Complaints - York	2024-05			0	Target	5

WORKFORCE

July 2024

Summary MATRIX
Workforce

MATRIX KEY
- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• 12 month rolling turnover rate Trust (FTE) • Overall vacancy rate • Registered Nursing vacancy rate • AHP vacancy rate • Overall stat/mand training compliance • Overall corporate induction compliance • A4C staff stat/mand training compliance • A4C staff corporate induction compliance	• Annual absence rate • HCSW vacancy rate • Medical & dental staff stat/mand training compliance • Medical & dental staff corporate induction compliance
COMMON CAUSE / NATURAL VARIATION		• Monthly sickness absence • Midwifery vacancy rate • Medical and dental vacancy rate • Total Agency Whole Time Equivalent Filled • Total Bank Whole Time Equivalent Filled • Appraisal Activity	
SPECIAL CAUSE CONCERN			

Workforce
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

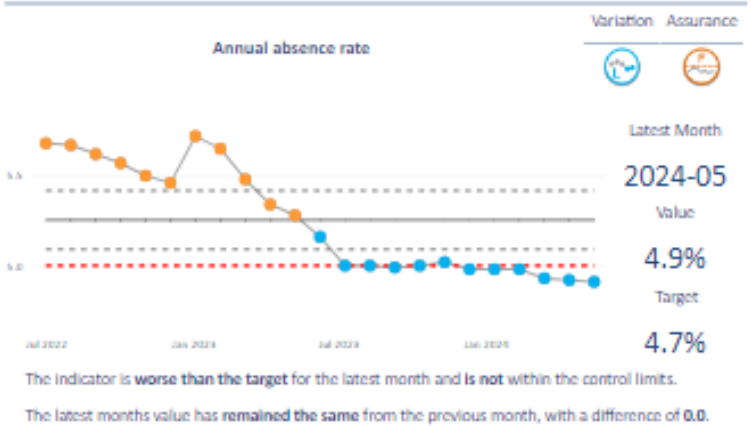
Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Monthly sickness absence	2024-05			4.9%	Baseline	4.8%
Annual absence rate	2024-05			4.7%	Target	4.9%
12 month rolling turnover rate Trust (FTE)	2024-06			10%	Target	8.5%
Overall vacancy rate	2024-06			6%	Target	7.1%
HCSW vacancy rate	2024-06			5%	Target	7.6%
Midwifery vacancy rate	2024-06			0%	Target	-1.5%
Medical and dental vacancy rate	2024-06			6%	Target	7.6%
Registered Nursing vacancy rate	2024-06			5%	Target	6.1%
AHP vacancy rate	2024-06			8.5%	Target	5.6%
Total Agency Whole Time Equivalent Filled	2024-05			151	Target	161.8
Total Bank Whole Time Equivalent Filled	2024-05			557	Target	655.6

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.7%



Factors impacting performance and actions:

The Trust is continuing with the Our Voice Our Future programme with an aim of making the organisation a place where people want to come to work. The Change Makers are writing their report with feedback from the Discovery Phase and engaging with the workforce. The new People Promise Manager is also meeting with key stakeholders and setting out a work plan for the next 12 months.

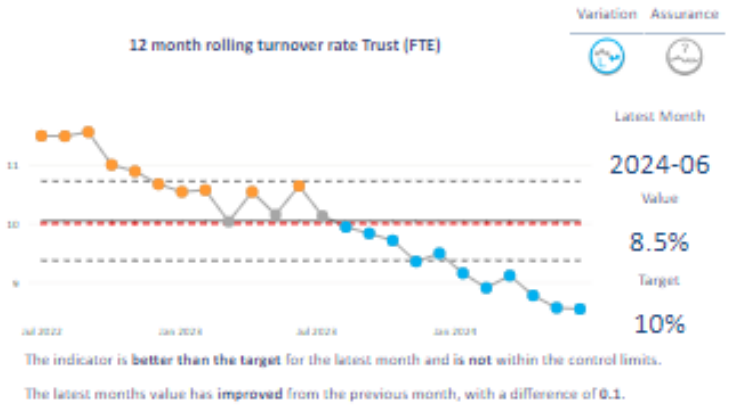
Junior Doctors took further industrial action from 27th June to 2nd July. The Trust had a strike rate of 52% over the period.

On 8th July the Trust will launch a Mutually Agreed Resignation Scheme (MARS). Employees within the Trust will be able to apply to resign from the Trust via mutual agreement. The scheme will be open for applications between 8th July and 18th August. Applications will be considered against a set of strict criteria by Care Group/Corporate Service management teams and then an Executive Panel prior to final authorisation from NHS England. Those with successful applications will leave the Trust by 30th September with a severance payment based on years of completed service.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 10% Vacancy Rate 6%



Factors impacting performance and actions:

The Trust is holding its annual Staff Benefits Fairs across our sites throughout July. The fairs are an opportunity for staff to come together, find out more about the benefits available, learn about the Staff Networks, enjoy some food and collect samples from our partners. The fairs are always well attended by staff and remain a highlight event in the Trust's calendar.

The organisation is due to welcome 10 internationally recruited nurses from Kerala on 15th July as part of our plans to recruit 55 international nurses in the year 2024/25. The most recent cohort of nurses that started their OSCE training (Objective Structured Clinical Examination) in June have just received their results, achieving a 75% first time pass rate which is significantly higher than our usual rate of between 50-60%.

There are currently 20.59 WTE Registered Nurses undertaking pre-employment checks with the Trust, and a further 11 nurses ready to commence with their start dates booked in. The organisation is planning to move away from generic recruitment for nursing vacancies to bespoke adverts. This is intended to improve the recruitment experience for both applicants and recruiting managers.

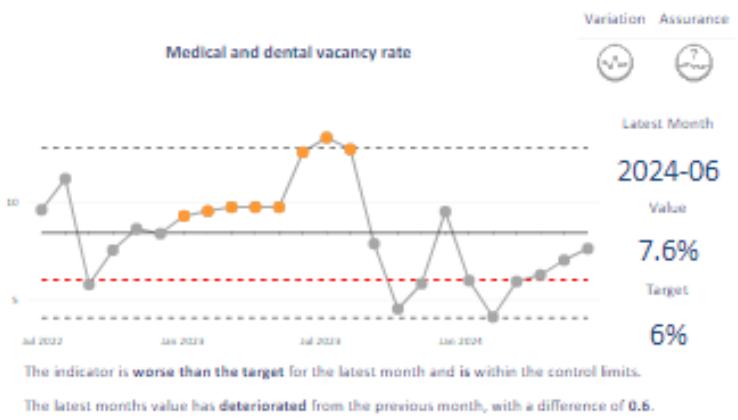
The Trust has recruited a healthy number of Pre-registered Nurses from local universities, contributing to a current pipeline of 102 Pre-registered Nurses. Welcome Days will be held for our Pre-registered Nurses in July and August across both sites, giving new recruits the opportunity to meet their teams, have a tour of the hospitals and fill in any outstanding onboarding information before they embark on their preceptorship in Autumn. The days are always well-received by new starters and help build a positive on-boarding experience and reduce instances of attrition prior to the beginning of employment.

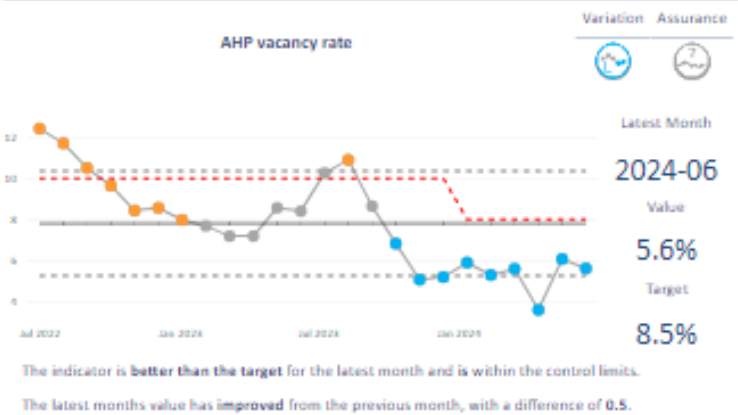
Registered Nurse establishments increased by 26.35 WTE between June and July resulting in a 1% increase to vacancy rates (from 5.1% to 6.1%).

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 8.5%





Factors impacting performance and actions:

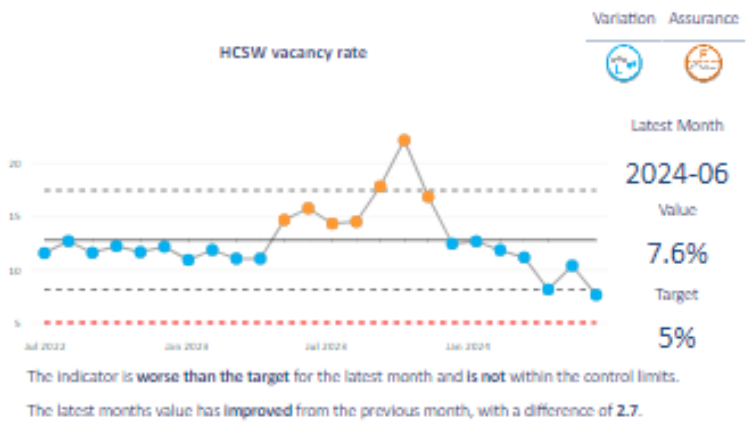
Over the last month, the Trust has made five offers for Consultant posts within Medicine, Renal, Paediatrics and Anaesthetics. Recruitment to the posts will contribute to the organisation's efforts to reduce its agency spend as there are agency locums covering three of the vacancies.

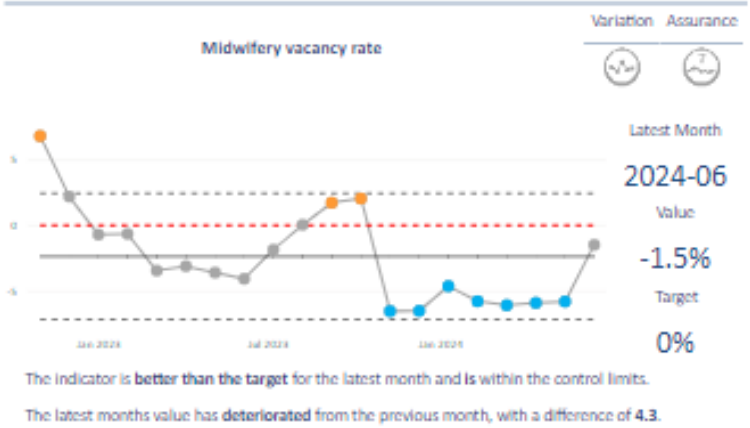
The Trust continues to prepare for Doctors changeover in August. There are currently 35 vacant posts (an improved position on last year) that the organisation is actively seeking to fill through parallel recruitment, with most gaps (20) based within Medicine. It is anticipated that some start dates will be after changeover, so departments are working to mitigate rota gaps. Pre-employment checks for our new trainee doctors are progressing well, with improved engagement with doctors this year.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 5%, Midwifery vacancy rate 0%





Factors impacting performance and actions:

There are 36.43 WTE Healthcare Support Workers undertaking pre-employment checks with the Trust, and an additional 49 HCSWs (43.43 WTE) have been allocated places on the next three HCSW Academy dates.

Meanwhile recruitment continues. The Trust's next HCSW interview day is scheduled on the 1st August.

10 candidates were appointed at the end of June as the next cohort of HCSW apprentices.

The Trust is on course to meet the 5% vacancy target for HCSWs by August 2024. 5% equates to 63 WTE posts based on the current establishment. Recruitment levels have remained high over a three-month period while retention has improved, and figures show that the number of substantive HCSWs in the Trust has increased by 79 WTE since February.

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 nominal decrease in terms of WTE in June compared to May. The WTE decreased from 51.01 to 50.01 and the headcount has reduced by 1 from 55 to 54. The next cohort of Apprentice Nursing Associates (14.20 WTE) are due to graduate in September.

There have been several applications from Pre-registered Midwives but only a small number of vacancies available in the Trust. The Trust plans to recruit many of the students on to the bank pending the availability of substantive positions.

Workforce Table

Workforce (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

	WTE Funded Establishment	WTE Vacancy	WTE Sickness	WTE Temporary Staffing Requested	WTE Variance between Requested and Vacancy & Sickness	WTE Filled by Bank	WTE Filled by Agency	WTE Variance between Total Filled and Vacancy & Sickness
Nursing								
Mar-24	2462.43	79.92	107.45	356.16	168.79	189.31	85.24	87.18
Apr-24	2461.99	64.51	105.94	275.13	104.68	147.02	77.17	53.74
May-24	2493.09	97.12	114.05	285.48	74.31	141.88	82.12	12.82
HCA								
Mar-24	1244.59	138.39	51.53	343.91	153.99	264.50	0.00	74.58
Apr-24	1219.59	98.89	49.40	296.18	147.89	228.50	0.00	80.21
May-24	1267.98	131.11	54.55	283.18	97.51	229.48	0.00	43.82
M&D								
Mar-24	1032.73	61.03	42.71	116.58	12.84	63.79	51.76	11.81
Apr-24	1021.48	63.89	42.56	141.25	34.80	82.59	41.29	17.43
May-24	1024.33	71.81	45.34	153.66	36.51	88.33	45.69	16.87

Factors impacting performance and actions:

The Nursing eRostering Efficiency Group continues to monitor KPIs and ensure temporary staffing use is being managed effectively. The group is driving efficiencies within temporary staffing usage, with key areas of focus including; reducing day shift times for bank and agency, removing bank incentives and ensuring nights and weekends are rostered effectively, to reduce requirements for bank and agency at these peak cost times.

The Trust has successfully moved all general nursing agency use to within the NHS England agency price caps, a major milestone for the organisation. Work continues to negotiate rates with suppliers to reduce the 'critical' nursing rates (as defined by agencies, relating to designated specialities).

Positively, the Trust has converted a long-standing ED doctor from agency to bank. The bank rates agreed present a marginal saving and are a positive step in reducing agency reliance. The organisation has also recruited a Histopathologist to the bank which has removed the need for an agency locum. The Trust continues to work with our agency Master Vendor to increase the percentage of Direct Engagement (DE) bookings for medical shifts as this provides a direct saving for the organisation. DE has increased to 83% with a small number of non-DE bookings remaining. The target is to achieve 100% DE for all medical agency bookings, in line with the current position for AHP agency bookings.

BankStaff+ along with the Loop app are launching in the Trust from 8th July 2024 to support the organisation's medical bank, allowing departments to release shifts from their electronic rosters and individuals to book their bank work via the Loop app. By moving to new software, the Trust will benefit from interoperability between its workforce system and bank shifts which will increase visibility of shifts and reduce duplication of work and risk of errors. The new solution replaces incumbent software and provides significant savings for the Trust.

Workforce
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Overall stat/mand training compliance	2024-06			87%	Target	88%
Overall corporate induction compliance	2024-06			95%	Target	96%
A4C staff stat/mand training compliance	2024-06			87%	Target	89%
A4C staff corporate induction compliance	2024-06			95%	Target	96%
Medical & dental staff stat/mand training compliance	2024-06			87%	Target	78%
Medical & dental staff corporate induction compliance	2024-06			95%	Target	95%
Appraisal Activity	2024-06			2.7%	Target	5.4%
Staff engagement staff survey score	2024-06			6.9	Target	6.4
Staff morale staff survey score	2024-06			5.9	Target	5.5
Percentage recommending the Trust as a place to work (quarterly)	2024-04			31.7%	Baseline	27.9%
Percentage recommending the Trust as a place to receive treatment (quarterly)	2024-04			34.6%	Baseline	31.4%

Executive Owner: Polly McMeekin

Operational Lead: Will Thornton

Rationale: Trained workforce delivering consistently safe care
Target: Mandatory Training 87% and Corporate Induction 95%

Factors impacting performance and actions:

Compliance with corporate induction and mandatory training continues to be strong, maintaining at 96% and 88%. When compared with the previous month, rates of mandatory training compliance amongst the eight staff groups were largely static and ranged from 78% for Medical & Dental staff to 94% for Health Care Scientists.

The mandatory training programme consists of 14 subjects prescribed by the Core Skills Training Framework. A review is underway nationally to consider the future composition of the Framework. A likely addition is the Oliver McGowan training on Learning Disabilities and Autism which has been made a requirement for CQC registered service providers. The Trust is working with Humber and North Yorkshire ICB to plan for the full roll-out of the Oliver McGowan training (an eLearning package has already been completed by 70% of patient-facing staff in the Trust). The training requires all clinical staff to attend a full-day classroom session co-delivered by the Autism Liaison Service and experts by experience. Non-clinical staff will need to attend a webinar. The Trust has noted on its Risk Register the difficulty it will face releasing an additional 62,000 hours of staff time over three-years to enable receipt of training.

The line manager development programme launches this month in the form of a pilot phase. It will consist of a one-day workshop to complement and raise awareness of the Line Manager's Toolkit. It aims to set the standard the Trust expects from its line managers, as well as bringing managers together to support and learn from each other and to enable them to support their staff to deliver the best patient care. The workshop will be required learning for all staff with responsibility for line management, at all levels, with no banding requirement/restriction and multi-disciplinary, to promote a 'One Team' consistent approach to line manager development. Sessions will be released for general booking via Learning Hub from September.

Leading Our Journey to Excellence; Our Care Group Leadership Development Programme -'One Team'
Phase 3 began on 25th June with 75 attendees from across the four Care Groups. 43 individuals did not or were not able to attend. The second workshop of this phase is due on 9th July. The third session of this phase 'Know Our Business' is currently being planned, with the content and structure of the day adapting to the size of the group.

DIGITAL AND INFORMATION SERVICES

July 2024

Summary MATRIX

Digital

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		• Percentage of Patient Subject Access Requests (SARs) processed within one calendar month	
COMMON CAUSE / NATURAL VARIATION		• Number of P1 incidents* • Total number of calls to Service Desk • Total number of calls abandoned • Number of information security incidents reported and investigated • Number of Patient Subject Access Requests (SARs)	
SPECIAL CAUSE CONCERN			

Digital & Information Services (DIS)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: James Hawkins **Operational Lead:** Steve Lawrie/Rebecca Bradley

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Number of P1 incidents*	2024-06			0	Target	3
Total number of calls to Service Desk	2024-06			3500	Target	6262
Total number of calls abandoned	2024-06			500	Target	1305
Number of information security incidents reported and investigated	2024-06			43	Baseline	28
Number of Patient Subject Access Requests (SARs)	2024-06			406	Baseline	376
Percentage of Patient Subject Access Requests (SARs) processed within one calendar month	2024-06			100%	Target	100%
Number of Freedom Of Information requests (FOIs) received (quarterly)	2024-06			93.9	Baseline	219
Percentage of Freedom Of Information requests (FOIs) responded to within 20 working days (quarterly)	2024-06			100%	Target	88%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy

Rationale: Reduction in P1 Incidents and Service Desk Calls are a proxy for better digital service
Target: 0 P1 Incidents 3500 Calls to Service Desk

Factors impacting performance:

3x P1 incidents occurred
11/6 Springhill house network offline – hardware related issue with supplier equipment at site.
14/6 G2 dictation system unavailable - restart required, investigating recurring incident with supplier
24/6-25/6 network incidents (power issue affecting equipment at Scarborough Hospital) caused several issues due to resilient traffic flows not working in expected ways. Affecting wifi, some remote access to certain services (G drive, Telecare), Cisco call-queues, and 1-way voice traffic
- workarounds used and 1 way voice resolved 2/7 after making configuration changes

Actions:

Telephone demand management steps include promoting the use of Self Service using the 4Me platform. This can provide support information for staff 24/7, and provide alternate routes to raise a support request and get support.

- A small change has been made in early June to provide callers with feedback on their queue position, and an "overflow" process to distribute calls to additional support staff when waiting times reach a threshold.
- This is expected to result in changes to abandoned call levels as staff are better informed about their likely wait to speak with support staff, and long waits are responded to in a more automated way.

Problem management reviews of common support incidents focus on fixing underlying causes, to minimise disruption and support demand.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate
Target: to identify and minimise incidents

Number of information security incidents reported and investigated

Factors impacting performance:

There was a peak of information security incidents in July 2023, due to an audit undertaken which led to an increase of reporting of misfiled information.

More recently, there has been a reduction in IG incidents, it is unclear if this is due to less incidents or less reporting. Targeted communications regarding frequently seen incidents have been in the staff bulletin over the last 2 months.

Actions: Continue targeted communication to continue this trend.

Number of information security incidents reported and investigated

Factors impacting performance:

This month saw a reduction in SARs.

Actions:

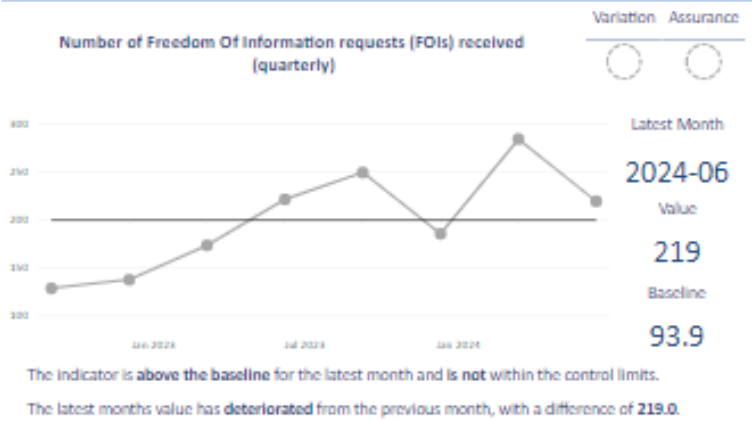
The team reviewed the increase in SARs in the previous periods against the Trust's complaints data and found no correlation. The Team are seeing an increase in requests where patients need their notes as they have chosen to access private healthcare.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Rationale: Ensuring the Trust responds to FOI in line with legislation

Target: FOIs responded to within 20 days



Factors impacting performance:.

Number of FOIs Received

FoI requests have decreased but are still above the baseline.

Actions:

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. We are seeing that only specific requests are being delayed before release which is bringing the percentage down. This is due to staff not fully understanding exemption policy.

FINANCE

July 2024

- The Trust has resubmitted its Operational Financial Plan to NHSE on 12 June 2024, which presented an adjusted I&E deficit of £16.6m as per the table opposite.
- The Trust's I&E deficit forms part of a wider HNY ICB I&E deficit plan of £50.0m.
- The Trust's actual operational I&E deficit is £33.7m, but for the purposes of assessing financial performance NHSE allow certain technical adjustments to arrive at underlying financial performance. The most notable of these is the removal of impairments relating to the revaluation of capital assets.
- It should be noted that the Trust's projected deficit is after the planned delivery of a significant efficiency programme of £53.3m (6.4%), more of which is discussed under cost improvement programme below.
- The plan is designed to assist the Trust meet all the required performance targets in 2024/25.

OPERATIONAL FINANCE PLAN 2024/25
SUMMARY INCOME & EXPENDITURE POSITION

	£000
INCOME	
Operating Income from Patient Care Activities	
NHS England	79,591
Integrated Care Boards	589,043
Other including Local Authorities, PPI, etc.	7,142
	675,776
Other Operating Income	
R&D, Education & Training, SHYPS, etc.	76,547
Total Income	**752,323**
EXPENDITURE	
Gross Operating Expenditure	-827,158
Less: CIP	53,266
Total Expenditure	**-773,891**
OPERATING SURPLUS/ (DEFICIT)	**-21,568**
Finance Costs (Interest Receivable/Payable, PDC Dividend)	-12,152
SURPLUS/ (DEFICIT) FOR THE YEAR	**-33,720**
ADJUSTED FINANCIAL PERFORMANCE	
Add Back	
I&E Impairments	16,734
Remove capital donations/grants net I&E impact	435
ADJUSTED FINANCIAL SURPLUS/(DEFICIT)	**-16,551**

Summary Dashboard and Income & Expenditure

Finance (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£3.3m	-£2.0m	↑	Improving
Forecast Outturn I&E Variance to Plan	£0.0m	£0.0m	-	Static
Core CIP Delivery Variance to Plan (£20.0m Target)	-£0.6m	-£0.1m	↑	Improving
Corporate CIP Delivery Variance to Plan (£33.3m Target)	-£1.3m	-£1.9m	↓	Deteriorating
Variance to Agency Cap	£0.8m Above	£1.2m Above	↓	Deteriorating
Month End Cash Position	£3.4m ahead of plan	£3.9m ahead of plan	↑	Improving
Capital Programme Variance to Plan	£1.7m ahead of plan	£0.4m behind plan	↓	Deteriorating

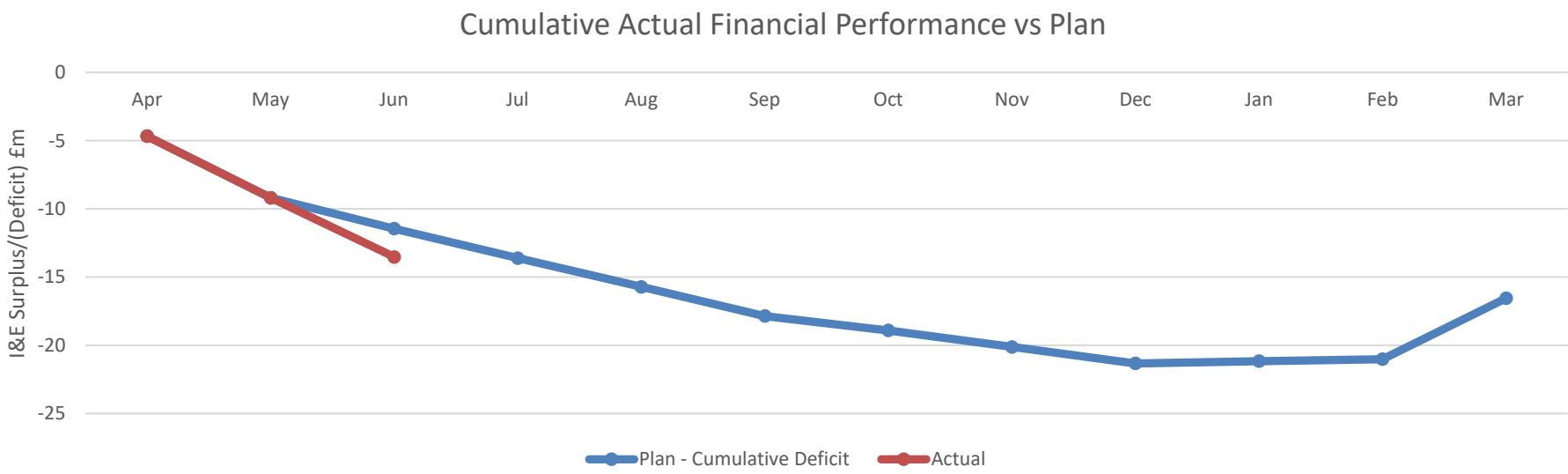
	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	676,548	168,330	177,566	9,235
Other Income	78,421	18,585	18,860	275
Total Income	754,969	186,915	196,425	9,510
Pay Expenditure	-499,787	-129,070	-133,550	-4,481
Drugs	-65,238	-16,317	-18,665	-2,348
Supplies & Services	-84,885	-21,166	-23,457	-2,291
Other Expenditure	-166,123	-30,819	-31,828	-1,009
Outstanding CIP	39,568	1,980	0	-1,980
Total Expenditure	-776,465	-195,391	-207,501	-12,109
Operating Surplus/(Deficit)	-21,496	-8,476	-11,076	-2,600
Other Finance Costs	-12,225	-3,080	-2,590	490
Surplus/(Deficit)	-33,720	-11,556	-13,666	-2,110
NHSE Normalisation Adj	17169	109	148	39
Adjusted Surplus/(Deficit)	-16,551	-11,447	-13,518	-2,070

The I&E table confirms an actual adjusted deficit of £13.5m against a planned deficit of £11.4m for June (Month 3), leaving the Trust with an adverse variance to plan of £2.07m. For M3 reporting the M1 & M2 plan have been adjusted to match expenditure, therefore the £2m adverse variance represents the M3 in month position. The annual plan has now been updated for the revised plan with a deficit position of £16.5m.

Whereas based on the position at month 3 mitigating actions will need to be applied, we will continue to review and update our I&E forecast tool to assess our likely year end outcome, but at this early stage of the financial year the working assumption is that actions applied will be successful, so the forecast is that the Trust will deliver its plan. This position will be kept under review as we progress through the financial year.

Cumulative Actual Financial Performance vs Plan

Finance (3)



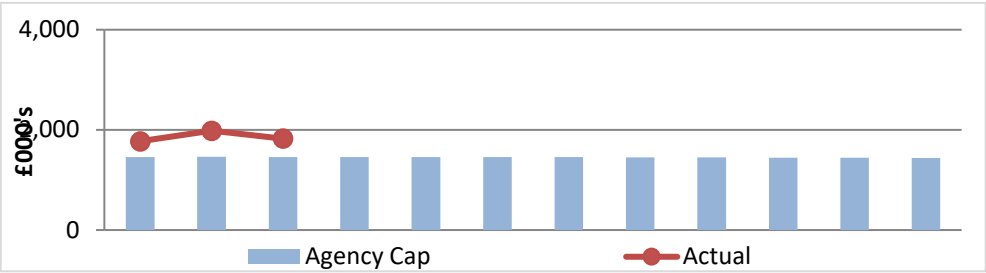
On the 12th June the Trust resubmitted it's plans which aligned April & May to actual expenditure. June shows expenditure of £13.5m YTD deficit against a plan of £11.4m.

Month 12 assumes the £4.2m the Trust expects to receive as a proportion of the £24m identified to reduce the overall ICB deficit from £74m to £50m, thereby improving the planned cumulative deficit from £21m in February to £16.5m in March.

Key Subjective Variances
Finance (4)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	635	Primarily linked to the usage of high-cost drugs and devices being slightly ahead of plan, for which income is earned on a pass-through basis and matched by expenditure; partially offset by ERF being slightly behind plan.	No mitigation or action required.
ICB Income	8,652	Primarily linked to ERF being significantly ahead of plan and accrued additional income from HNY ICB regarding the Integrated Urgent Care service, which is matched by expenditure, and subject to an in-year contract variation.	Contract variation for the Integrated Urgent Care service to be completed.
Employee Expenses	-4,481	Agency, bank and WLI spending is ahead of plan to cover vacancies, and delivery increased elective activity.	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). Vacancy control measures now in place.
Drug expenses	-2,348	Relates primarily 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, plus out of tariff drugs & devices costs covered by NHSE contracts for which additional income is earned.	To continue discussions with HNY ICB regarding additional income in recognition of the constraints that the block contract is placing on the Trust.
Clinical Supplies & Services	-2,291	Increased spending linked to increased elective activity for which additional ERF income is expected to compensate. Also includes overspending on pathology direct access and devices, which was previously covered by a variable tariff, but is now included in the block contract with the ICB.	To continue discussions with HNY ICB regarding additional income in recognition of the constraints that the block contract is placing on the Trust.
CIP	-1,980	CIP behind plan. M3 savings delivered per plan. £1.9m delivery gap in relation to M1 & 2.	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.
Other Costs	-1,009	Primarily linked to increased spending on insourcing/ outsourcing services particularly within diagnostic services, and within SHYPS and the contract with Ramsey mainly linked to increased elective activity for which additional income through ERF income is expected to compensate. Some other smaller adverse variances to be investigated.	Investigation of other variances not linked to increased elective activity.



	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,501.47	2,363.50	137.97	33,404	34,553	-1,149
Scientific, Therapeutic and Technical	1,254.10	1,195.44	58.66	16,519	16,625	-106
Support To Clinical Staff	1,899.15	1,720.44	178.71	15,754	16,030	-276
Medical and Dental	1,046.79	970.7	76.09	32,741	38,160	-5,419
Non-Medical - Non-Clinical	3,114.68	2,879.26	235.42	27,667	27,650	16
Reserves				2,488	0	2,488
Other				496	532	-36
TOTAL	9,816.19	9,129.34	686.85	129,070	133,550	-4,481

Trust Performance Summary vs ERF Target Performance

Commissioner	24-25 Target % vs 19/20	ERF Confirmed Targets Weighted Value at 24/25 prices	ERF Month 3 Phase (Av %)	Activity to Month 3 Actual	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	104.00%	£128,452,102	£31,344,882	£35,771,824	£4,426,942	118.7%
West Yorkshire	103.00%	£1,347,881	£328,910	£312,809	-£16,101	98.0%
Cumbria and North East	115.00%	£170,165	£41,524	£54,753	£13,230	151.6%
South Yorkshire	121.00%	£150,189	£36,649	£44,488	£7,839	146.9%
Other ICBs - LVA / NCA	-				*£0*	-
All ICBs	***104.02%***	***£130,120,337***	***£31,751,965***	***£36,183,875***	***£4,431,910***	**118.5%**
NHSE Specialist Commissioning	113.38%	£4,514,034	£1,101,515	£1,202,260	£100,745	123.7%
Other NHSE	104.13%	£287,288	£70,104	£68,280	-£1,824	101.4%
All Commissioners Total	**104.31%**	**£134,921,659**	**£32,923,583**	**£37,454,414**	**£4,530,831**	**118.7%**

Agency Controls

Controls around agency spending, which recommenced in 2023/24 have continued into 2024/25. The Trust's has assumed agency is capped at 3.7% of its overall pay spend in its plan. At the end of June expenditure on agency staffing was £1.2m ahead of plan.

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 relate to agreed but at this point undrawn activity and cost pressures, and nursing investments linked to the YCU, BCU , and IUC services.

The table illustrates that a key driver for the pay position (other than reserves) is spend against Medical and Dental staff, although establishment is under plan. The key driver for the residual adverse variance is agency cover for vacant posts across the Care Groups.

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 £4.5m surplus for the period.

With both ICB activity and NHSE Specialist Commissioned ahead of plan.

Cost Improvement Programme
Finance (6)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

The Trust' efficiency programme comprises the following:	
- Prior Year programme (non-recurrent)	£15.5m
- ICB Prior year Stretch Target (non-recurrent)	£8.5m
- New year base ask (1.1%)	£6.7m
- New year additional convergence ask	£5.0m
- New year covid reduction (testing)	£1.4m
- Further stretch target for 2024/25	£16.2m
- TOTAL REQUIREMENT	£53.3m

2024/25 Cost Improvement Programme - June Position

	Full Year CIP Target	June Position			Full Year Position		Planning Position		Planning Risk		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Corporate Programme	33,326	3,715	1,838	1,877	7,356	25,970	23,865	9,461	8,706	4,065	11,094
	33,326	**3,715**	**1,838**	**1,877**	**7,356**	**25,970**	**23,865**	**9,461**	**8,706**	**4,065**	**11,094**
Core Programme											
Medicine	4,152	463	268	195	445	3,707	1,093	3,058	1,043	0	50
Surgery	4,120	459	245	215	1,024	3,096	3,666	455	2,476	1,190	0
CSCS	6,290	701	743	-43	2,629	3,660	3,902	2,387	3,815	0	87
Family Health	1,797	200	378	-178	941	856	2,158	-361	1,481	637	40
CEO	104	12	10	1	41	63	41	63	41	0	0
Chief Nurses Team	207	23	7	16	28	179	126	81	126	0	0
Finance	382	43	184	-141	225	157	225	157	225	0	0
Medical Governance	23	3	3	-1	13	10	58	-36	58	0	0
Ops Management	233	26	89	-63	227	6	232	1	232	0	0
DIS	427	48	51	-3	203	223	280	146	280	0	0
Workforce & OD	361	40	9	32	39	322	88	273	88	0	0
YTHFM LLP	1,840	205	131	74	527	1,314	1,437	403	931	82	424
Central	0	0	0	0	0	0	7,166	-7,166	7,040	120	6
	19,936	**2,222**	**2,119**	**104**	**6,342**	**13,594**	**20,472**	**-536**	**17,838**	**2,028**	**607**
Total Programme	**53,262**	**5,937**	**3,957**	**1,980**	**13,698**	**39,564**	**44,337**	**8,925**	**26,543**	**6,093**	**11,701**

2024/25 Efficiency Target

The 2024/25 efficiency target is £53.3m. This allocation of the target to the Care Groups, Directorates, and YTHFM has been based on variable percentage rates for different cost pools but capped at 3% in any one cost pool. This result is £20.0m (Core) of the target being directly allocated to Care Groups, Directorates, and YTHFM; with the remaining £33.3m (Corporate) held centrally with corporate plans being developed to meet this. The governance for the overall delivery of the target is through the Efficiency Delivery Group.

Corporate Efficiency Programme

The Corporate efficiency programme currently consists of 27 schemes which, following an initial risk assessment, give planned savings of £23.8m towards the £33.3m target.

In June £7.4m of the target was delivered in full year terms, all of which are recurrent savings. The YTD position shows delivery of £1.8m against target of £3.7m, £1.9m behind plan.

Core Efficiency Programme

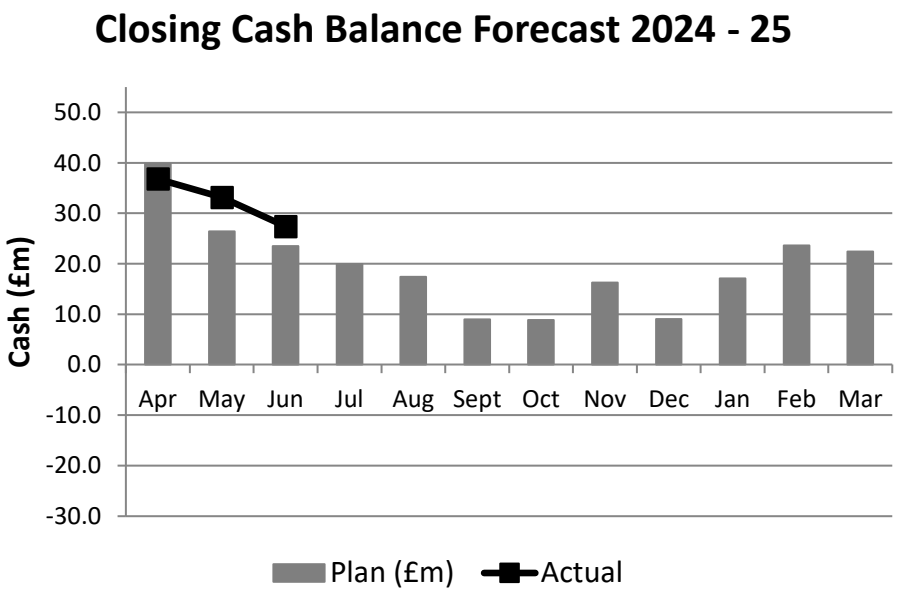
The core efficiency programme currently has plans totalling £20.5m towards the required £20m target.

In June £6.3m of the target was delivered in full year terms £5m of which was recurrent. The YTD position shows delivery of £2.1m against target of £2.2m, £0.1m behind plan.

The Group's cash plan for 2024/25 is for the cash balance to reduce from £47.5m at the end of March 2024 to £22.4m at the end of March 2025, with the planned I&E deficit being a key driver in the reduced balance. The cash balance for June was £3.9m favourable to plan.

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	39,790	26,407	23,541	19,964	17,437	9,006	8,886	16,306	9,059	17,101	23,624	22,454
Actual	36,793	33,128	27,407									



The cash forecast graph illustrates the cash position based on the actual cash balance at the end of June at £27.4m against a plan balance of £23.5m.

At this stage, we are not expecting a requirement for cash support in 2024/25, however this will be closely monitored alongside the delivery of the Trust's efficiency programme as any slippage will impact cash reserves and a cash support application may have to be made.

Current Capital Position and Better Payment Practice Code (BPPC)

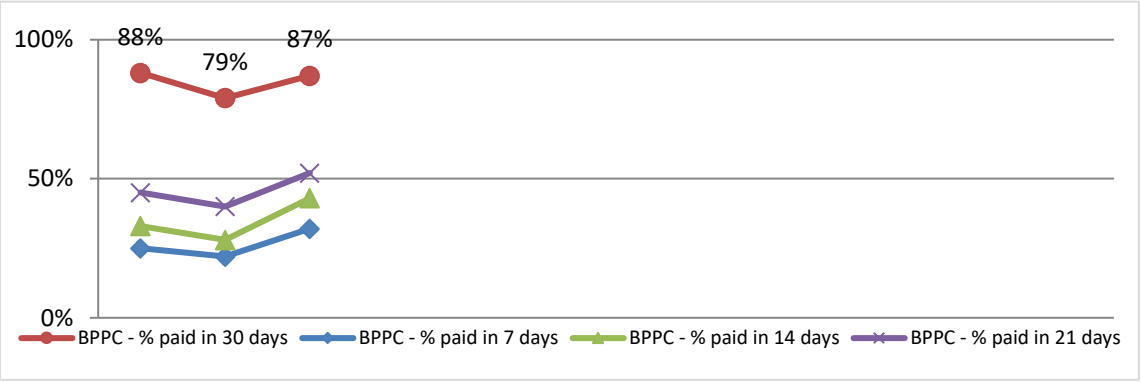
Finance (8)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Capital Plan 2024-25 £000s	Capital FOT 2024-25 £000s	M3 Planned Spend £000s	M3 Actual Spend £000s	Variance to Plan £000s	Variance to FOT £000s
51,870	51,870	3,769	3,401	(368)	0

For 2024/25 the main schemes are the completion of SGH UECC and SGH CDC and the commencement of the construction phase of VIU / PACU plus the start of the implementation of the EPR scheme.

The capital programme at month 3 is £368k behind plan. The main driver of the variance is IFRS 16 leases running behind plan due to timing and expected to return to plan during future months.



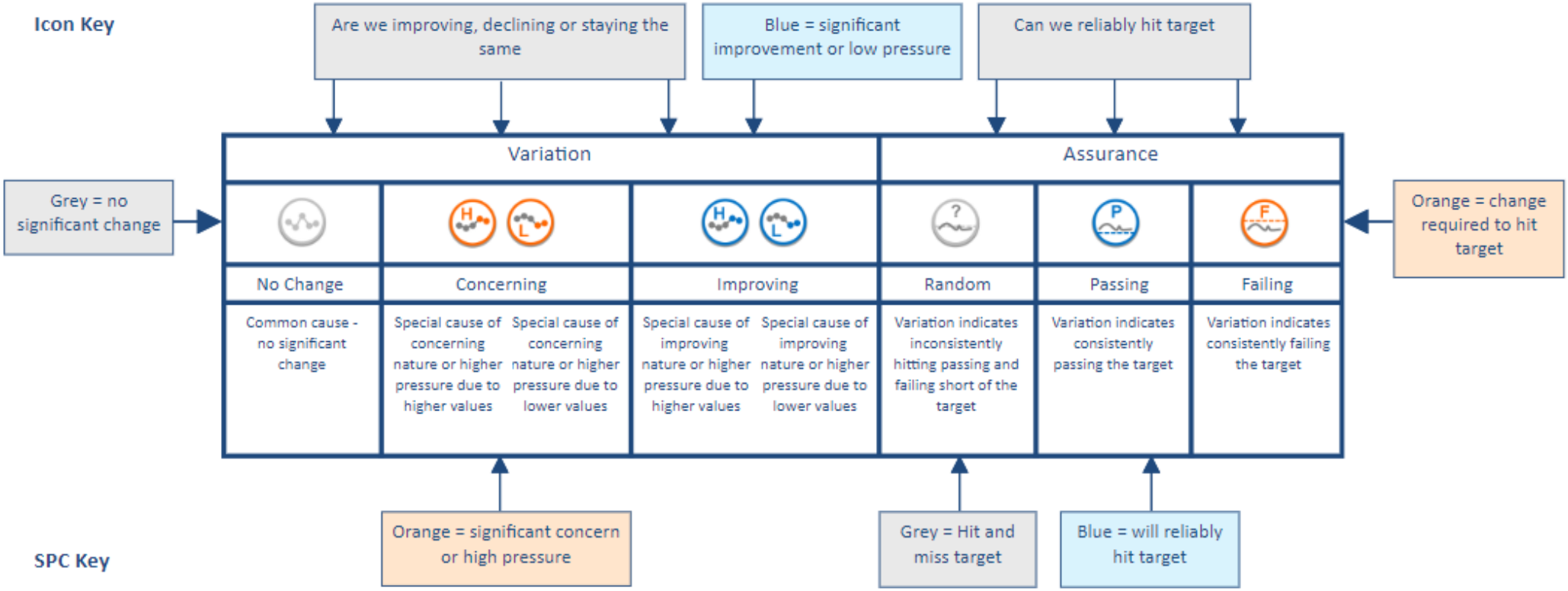
Better Payment Practice Code

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.

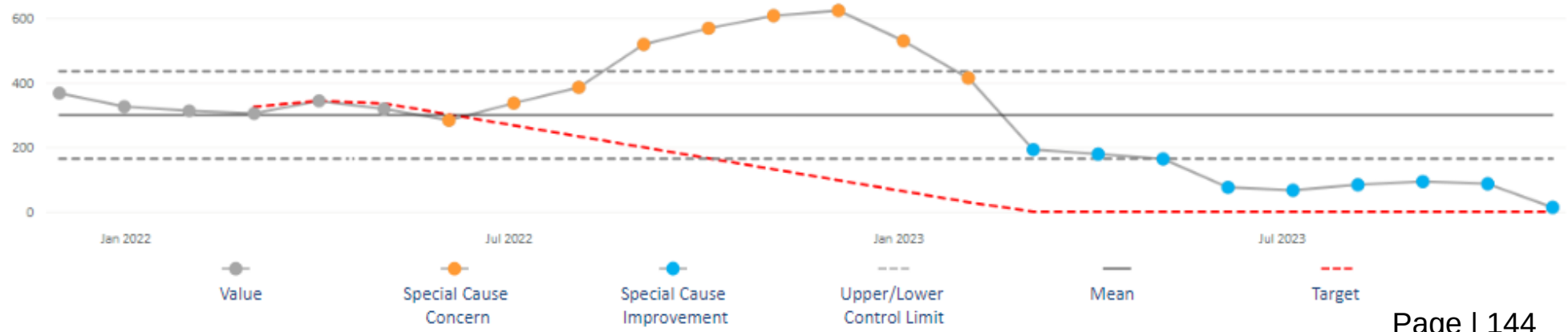
The table illustrates that in June the Trust managed to pay 87% of its suppliers within 30 days.

Keys

Icon Key



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

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:	Trust Board
Date of Meeting:	31 July 2024
Subject:	Staff Survey 2023 – Improvement Plan
Director Sponsor:	Polly McMeekin, Director of Workforce and OD
Author:	Vicki Mallows, Workforce Lead Jenny Flinton, Head of Employee Relations & Engagement

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

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

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

Summary of Report and Key Points to highlight:

- The 2023 Staff Survey results were shared at Resources Committee, Executive Committee and Board of Directors in March this year.
- The Trust was below our national peer group average for each of the seven elements of the NHS People Promise and the themes of 'Staff Engagement' and 'Morale'.
- This improvement plan includes existing ongoing and planned work and suggestions from the Our Voice Our Future change makers who have analysed the staff survey results and comments in detail.

Recommendation:

- Trust Board are asked to review this plan and support future actions for improvement.

Report Exempt from Public Disclosure

No ☒ Yes ☐

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Trust Board	27 March 2024	Nationally benchmarked results were shared. This paper responds to the results.

Staff Survey Improvement Plan 2023

1. Introduction and Background

The national NHS Staff Survey measures how engaged staff are and provides insight into how colleague experiences and ultimately retention can be improved. Evidence shows that more engaged staff result in better patient experiences and outcomes.

The Trust results (including YTHFM) are benchmarked against our national peer group of all Acute/Acute & Community Trusts.

- Our response rates deteriorated in 2023 and remain under the peer group average.
- Our scores were below our peer group average for every People Promise element and theme in 2023.
- Over 900 colleagues made 'free text comments' about working for the Trust.

The results have been analysed both within Workforce & OD, and by a sub-group of change makers from the Our Voice Our Future programme – their suggested responses to the results are included in the attached improvement plan (Appendix 1).

2. Improvement Plan

The results reflect that there is still much to do to ensure that all colleagues feel safe and confident to speak up, and that we take the time to really listen to understand. They also mirror feedback from change makers about the ongoing challenge to achieve effective communication with all colleagues at all sites, particularly those that have irregular / no access to electronic communications.

Our improvement plan going forward will continue to focus on Our Voice Our Future, our long term cultural engagement work to develop a compassionate and inclusive culture. This programme has now reached the end of the discovery phase so the feedback from colleagues and patients will be used to develop the improvements needed for the future.

The staff survey results demonstrate our need to invest in the development of our line managers to grow management and leadership capability. In January 2024 we launched our line managers toolkit. A one day development session aligned to this toolkit will be rolled out in the summer of 2024 and delivered to all line managers over an 18 month period.

We will continue to develop an environment where staff feel safe and healthy through the reintroduction of Schwartz rounds, development of wellbeing rooms and taking our wellbeing offer directly to staff. We have identified that staff are not aware of the number of resources available to them.

To support staff to be safe and healthy and to develop flexible working opportunities for all the Trust has commenced the Erostering improvement plan with NHSE support. This will improve roster management to increase staff availability.

The EDI workstream will continue to focus on the educational work that is needed within the Trust regarding equality, diversity and inclusion. Training will continue to be offered and work with the care groups will be developed. The staff survey improvement plan will run alongside our other equality, diversity and inclusion plans such as WRES and WDES.

We will focus on creating a great place to learn by building effective understanding of career development opportunities, running workforce development fairs and publishing strategic educational goals for the group.

With funding from NHSE, the Trust has recruited a People Promise Manager for 12 months, as part of the People Promise Exemplar programme. A programme designed with the aim of increasing retention and engagement across Trusts.

3. Next Steps

The corporate action plan is attached (Appendix 1). In terms of agreeing targets for increasing the response rate in each Care Group / Corporate Directorate / YTHFM it is proposed that for those areas currently below the Trust average of 39% - their target should be to match / exceed the Trust average (with an improvement on their current rate of at least 10%); for those areas currently between 40-69%, a 10% improvement; and for those areas currently at 70%+, a 5% improvement. Care Groups will be asked to share local staff survey results and improvement plans through the PRIM programme to provide assurance regarding local actions. Learning from other Trusts demonstrates when staff see action from the survey they are more likely to complete it going forward.

A Retention Steering group is being established following discussions with nursing and AHP leads. The aim of the group will be to share best practice across the organisation, utilising resources through the People Promise Exemplar programme with a focus on increasing the response rates to the quarterly people pulse surveys and national staff survey. This group will also provide the opportunity to review the results against ongoing programmes of work improving patient experience, quality and safety.

Trust Board is asked to support the corporate improvement plan and continue to support to the Our Voice Our Future programme. Executive Committee approved the request to continue the protected time for Change Makers, subject to line management approval; a number of the individuals would like to continue with the programme through to the design phase.

Once ratified by Trust Board the improvement plan will be published and shared with Care Groups and Corporate Services.

Date: 18th June 2024

Staff Survey Improvement Plan - Listening to Employee Voice: Our Voice Our Future

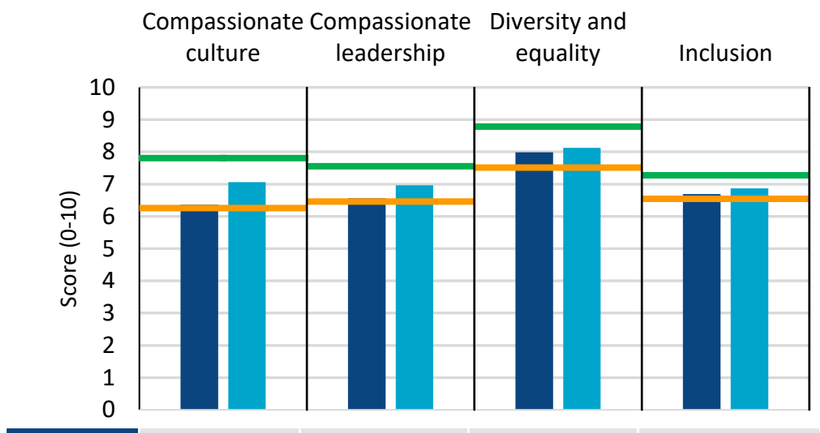
The People Promise is the single, unifying framework for understanding, measuring, and improving Employee Experience in the NHS. Those best placed to say when progress has been made towards achieving improved experience in the workplace are our NHS people.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

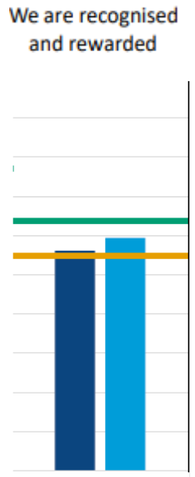
<table>
<tr><th>PROMISE ELEMENT</th><th>2023 ELEMENT SCORE</th><th>PROMISE ELEMENT</th><th>2023 ELEMENT SCORE</th></tr>
<tr>
<td> 
We are compassionate and inclusive

We do not tolerate any form of discrimination, bullying or violence.

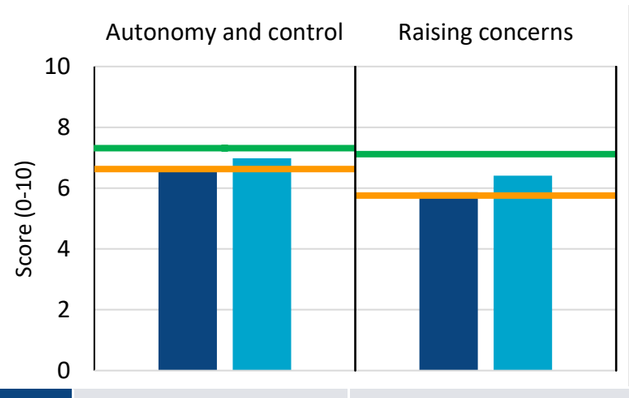
We are open and inclusive.

We make the NHS a place where we all feel we belong.</td>
<td> 

<table>
<tr><td>Your org</td><td>6.36</td><td>6.56</td><td>7.98</td><td>6.69</td></tr>
<tr><td>Best result</td><td>7.81</td><td>7.55</td><td>8.78</td><td>7.27</td></tr>
<tr><td>Average result</td><td>7.06</td><td>6.96</td><td>8.12</td><td>6.86</td></tr>
<tr><td>Worst result</td><td>6.26</td><td>6.46</td><td>7.51</td><td>6.54</td></tr>
<tr><td>Responses</td><td>3839</td><td>3851</td><td>3851</td><td>3848</td></tr>
</table>
</td>
<td> 
We are recognised and rewarded

A simple thank you for our day to day work, formal recognition for our dedication, and fair salary for our contribution.</td>
<td> 

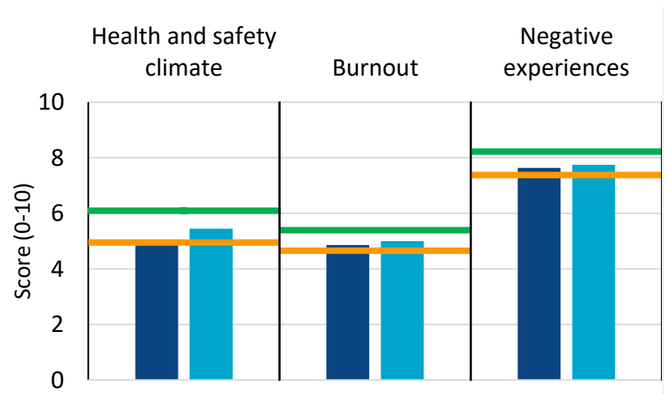
<table>
<tr><td>Your org</td><td>5.61</td></tr>
<tr><td>Best result</td><td>6.37</td></tr>
<tr><td>Average result</td><td>5.94</td></tr>
<tr><td>Worst result</td><td>5.50</td></tr>
<tr><td>Responses</td><td>3853</td></tr>
</table>
</td>
</tr>
<tr>
<td> 
We each have a voice that counts

We all feel safe and confident to speak up. And we take time to really listen – to understand the hopes and fears that lie behind the words.</td>
<td> 

<table>
<tr><td>Your org</td><td>6.69</td><td>5.87</td></tr>
<tr><td>Best result</td><td>7.31</td><td>7.12</td></tr>
<tr><td>Average result</td><td>6.99</td><td>6.41</td></tr>
<tr><td>Worst result</td><td>6.63</td><td>5.76</td></tr>
<tr><td>Responses</td><td>3859</td><td>3822</td></tr>
</table>
</td>
<td> 
We are safe and healthy

We look after ourselves and each other.

Wellbeing is our business and our priority – and if we are unwell, we are supported to get the help we need.

We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.</td>
<td> 

<table>
<tr><td>Your org</td><td>5.03</td><td>4.86</td><td>7.75</td></tr>
<tr><td>Best result</td><td>6.12</td><td>5.39</td><td>8.24</td></tr>
<tr><td>Average result</td><td>5.46</td><td>5.00</td><td>7.83</td></tr>
<tr><td>Worst result</td><td>4.95</td><td>4.65</td><td>7.39</td></tr>
<tr><td>Responses</td><td>3663</td><td>3857</td><td>3651</td></tr>
</table>
</td>
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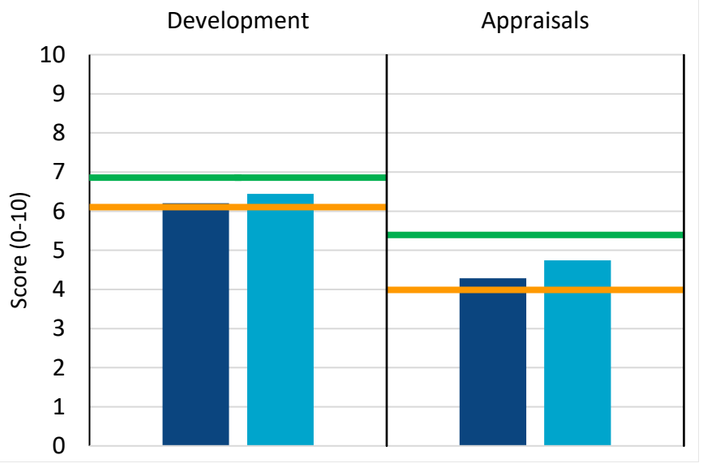
</table>

We are always learning

Opportunities to learn and develop are plentiful, and we are all supported to reach our potential.

We have equal access to opportunities.

We attract, develop and retain talented people from all backgrounds.

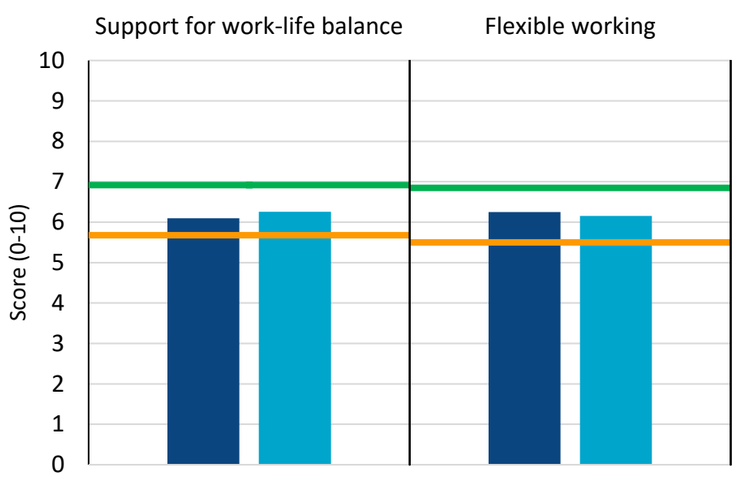


Your org	6.20	4.29
Best result	6.86	5.39
Average result	6.44	4.74
Worst result	6.10	3.99
Responses	3846	3687

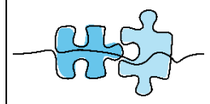
We work flexibly

We do not have to sacrifice our family, our friends or our interests for work.

We have predictable and flexible working patterns and if we do need to take time off, we are supported to do so



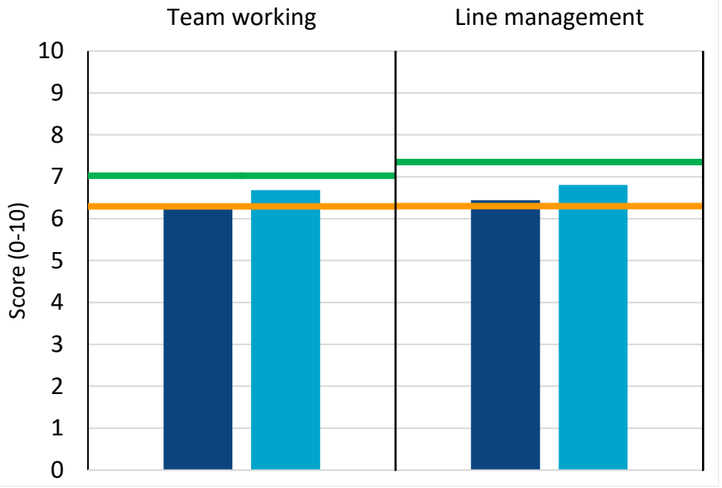
Your org	6.10	6.25
Best result	6.92	6.85
Average result	6.25	6.15
Worst result	5.68	5.50
Responses	3846	3843



We are a team

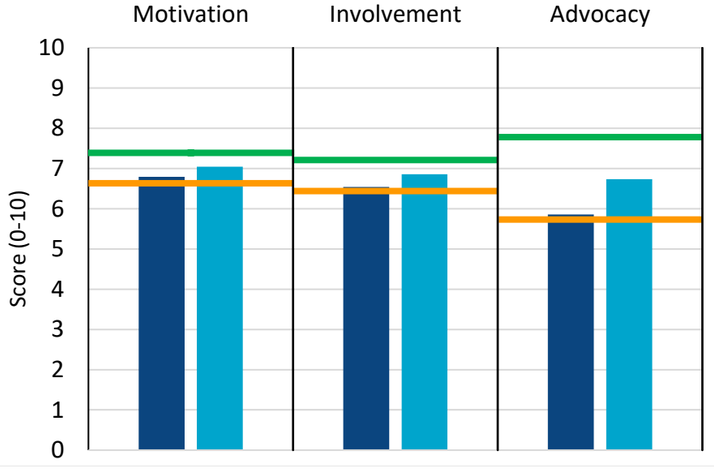
First and foremost, we are one huge, diverse and growing team, united by a desire to provide the very best care.

We learn from each other, support each other and take time to celebrate success.



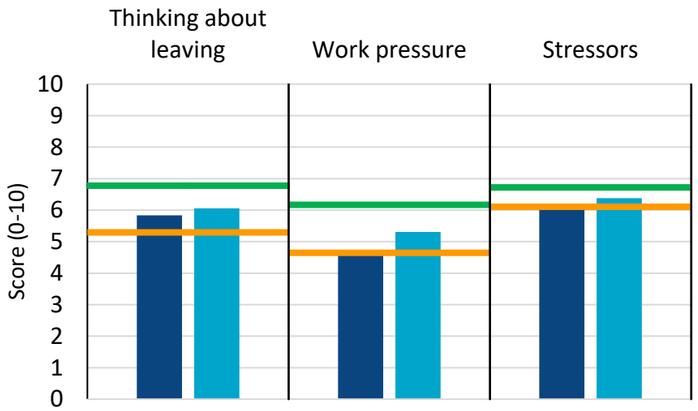
Your org	6.29	6.44
Best result	7.03	7.35
Average result	6.68	6.80
Worst result	6.29	6.30
Responses	3853	3853

Staff Engagement

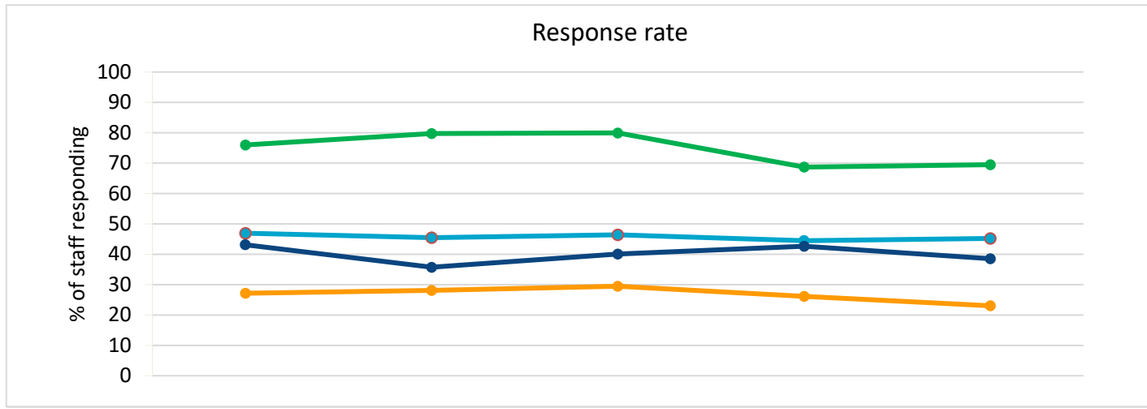


Your org	6.79	6.54	5.86
Best result	7.39	7.21	7.78
Average result	7.04	6.86	6.74
Worst result	6.63	6.44	5.73
Responses	3834	3859	3839

Morale



	Thinking about leaving	Work pressure	Stressors
Your org	5.83	4.71	6.11
Best result	6.78	6.17	6.72
Average result	6.06	5.31	6.38
Worst result	5.29	4.65	6.11
Responses	3842	3857	3854



	2019	2020	2021	2022	2023
Your org	43.11%	35.73%	40.05%	42.62%	38.54%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	3203	2831	3250	3635	3863

PROMISE ELEMENT	ACTION	EXECUTIVE SPONSOR	OPERATIONAL LEAD(S)	MEASURES	TIMESCALES	PROGRESS
• Compassionate & inclusive • Rewarded & recognised • Voice that counts • Safe & healthy • Always learning • Work flexibly • We are a team • Engagement • Morale	Create a compassionate and inclusive culture where people want to come to work. Continue with Our Voice Our Future, the NHSE Cultural and Leadership Programme running within the Trust and YTHFM. Complete the discovery phase of the programme and use the stakeholder feedback to design changes to develop our future culture.	Simon Morritt, Polly McMeekin	Jenny Flinton, Gail Dunning, & Hattie Myers	To improve the staff survey scores in 2025: 'We are compassionate and inclusive' to increase to 7.4 and 'Staff Engagement' to increase to 7.0. To increase the response to 'I would recommend my organisation as a place to work' from 46.2% in 2022 to 50% in 2025 and 56% in 2026.	Two year programme for completion summer 2025	The discovery phase of the project commenced in December 2023, 50 internal Change Makers were 'recruited' to join the programme.
• Compassionate & inclusive • Always learning • We are a team • Engagement • Morale	Embed a Just and Learning Culture ensuring that learning is taken from any incidents within the workplace.	Polly McMeekin, Dawn Parkes, Melanie Liley, Karen Stone	Jenny Flinton Adele Coulthard	New Conduct and Disciplinary policy launched within Group	June 2024	July 2023 new policy ratified by JNCC, awaiting ratification by LNC. Investigation training available via Learning Hub

				Embed the new Patient Safety Incident Response Framework (PSIRF)	Ongoing	PSIRF launched December 2023
• Compassionate & inclusive • Voice that counts • Safe & healthy • Always learning • We are a team • Engagement • Morale	Strive for continuous improvement within the workplace. Systematically embed QI methodology	Dawn Parkes	Adele Coulthard	Continuous delivery of QSIR Training Every team to have quality improvement as a goal	Ongoing 2024/25	Four cohorts of QSIR training delivered – June 2024
• Always learning • Morale	• Improve our recruitment outputs • Widening access through creating bridges for new entrants including school, college and university leavers • Simplify and standardise job descriptions – increase visibility and accessibility*	Polly McMeekin	Will Thornton Amy Messenger	Creation of local graduate scheme Recruit at least 10 apprentices externally	July 2024 September 2024	Implementation of local graduate scheme paused for consultation with Care Groups in light of vacancy freeze External recruitment introduced for HCSW and NA apprenticeships (16 apprentices recruited with more in pipeline) Job description project plan developed
• Compassionate & inclusive • Voice that counts • Safe & healthy • We are a team	Create an environment where staff are safe and healthy	Polly McMeekin	Alex Cowman	Continuous review of wellbeing offers across the Group to assess gaps in provision Reduction in sickness absence rates to 4.4% Take the wellbeing offer directly to staff, rather than waiting for them to engage Staff Wellbeing Rooms to be implemented at York, Scarborough and Bridlington Hospitals	Ongoing throughout 2024-25 March 2025 Ongoing throughout 2024-25 Completion by August 2025	Ongoing work with HR teams supporting line managers with sickness absence cases. Training being delivered to line management groups Ward visits currently being planned with the wellbeing team, FTSU Guardian and relevant stakeholders Suitable space identified at Bridlington, with work due to start in the second quarter of 2024. Spaces identified at SGH & YH not freed up yet – charitable funds have to be used within 24 months.
• Safe & healthy • Compassionate & inclusive	Increase resilience support within teams and the system	Polly McMeekin	Dr Yvonne Doherty (Veronica Oliver-Jenkins for Schwartz Rounds)	Reintroduce Schwartz Rounds	3 rounds to be completed 2024/25	Two-year Schwartz Round licence re-procured. Steering group established. Funds secured for training, awaiting outcome of charitable funds application for other aspects

				Reintroduce support following traumatic incidents Introduce short 'Healthy Headspace' workshops Revisit multi-disciplinary support provided to teams upon death of a colleague	Ongoing May 2024 March 2025	Post event pathway and hot debrief training piloted in April with ED & Maternity (both sites). A series of psychological wellbeing workshops piloted Jan-April; open access from May Working group established to implement the Owens model
• Safe & healthy • Work flexibly	Improve roster management to increase staff availability and promote flexible working.	Dawn Parkes	Associate Chief Nurses /Amy Messenger	Reduction in net hours owed Increase percentage of shifts locked down Self rostering pilots to commence	March 2025	Commenced eRoster Improvement Plan with NHSE support
• Rewarded & recognised • Work flexibly	Increase in number of completed job plans	Karen Stone	Care Group Leadership Teams	100% of job plans completed	June 2024	System has been updated to focus on 2024 job plans increases are being reported.
• Compasionate & inclusive • Rewarded & recognised • Safe & healthy • Always learning • We are a team • Engagement	Offer further support and development for all line managers to grow management and leadership capability developing teams – 'no change about me without me'	Polly McMeekin	Lydia Larcum Gail Dunning	Ongoing development and refinement of the line manager toolkit Delivery of line management training to new and existing managers Leaders to look at areas with good staff survey results, go and identify good practice to then apply in other teams.* Encourage regular appreciation to be shown to staff, not just monthly Star Awards / annual awards etc e.g. the power of a meaningful 'thank you'; use of appreciation station cards etc.* Delivery of 'One Team' development programme for Care Group Management teams following launch of new Care Groups Embedding the Trust's Leadership Framework as a tool for development	Ongoing December 2025 March 2025 Ongoing September 2024 Ongoing	Latest toolkit published First & second cohorts complete, third cohort to commence June 2024 Used for Executive 360 Feedback
• Compassionate & inclusive • Always learning • We are a team • Engagement	Create a great place to learn: • Build effective understanding of career development opportunities amongst staff • Workforce Development Fairs • Develop and publish strategic education goals for the Group • Work with the Interim Chief Nurse to develop a Trust-led programme of training to support organisational priorities for nurses and AHPs	Polly McMeekin, Karen Stone, Dawn Parkes, Melanie Liley	Will Thornton Rachael Snelgrove Emma George Heather Neary	Development score in Staff Survey increased to 6.5	March 2025	Published apprenticeship career pathways in LM Toolkit Held WF Development Fairs in York & Scarborough with further celebration events planned for 24-25

	• Demonstrate how we invest in staff development – publicise what is being done / stats etc*					Partially delivered against Nursing/AHP LNA for 24-25 LEaD formed and working towards development of Strategy – to be published in 2024
• Compassionate & inclusive • Voice that counts • Always learning • We are a team • Engagement • Morale	Address staff feedback that 'nothing changes'. Improve team working and formation across the organisation via effective communication of shared vision, purpose and strategy.* Continue to increase leadership visibility at all levels	All directors	All team managers	Finalise new Trust vision, purpose and strategy. Share widely and ensure each team has clear shared goals and objectives, each person is clear on the purpose of their role.* Ensure each team knows the available and relevant forums for escalating barriers to change (and ensure those forums take action)* Continuous 'We listened and responded' / 'You Said & Together We Are Doing' communication in response to staff feedback / ideas* Ensure all staff know how to suggest improvements and ensure they are heard / considered by the appropriate people* Recommend every team has a monthly meeting to talk about issues relevant to the team, changes being considered, praise given for good work etc.* Recommend that each team reviews and agrees how best to communicate effectively (with each other and two-way between manager and staff)* Review effective methods for ensuring the offline workforce can access updates Leadership visibility at all levels – walking around / popping in to say hello should be routine – not just formal booked visits* CG leadership teams to provide improvement plan updates at PRIMs	Ongoing 2024/5	
• Compassionate & inclusive • Voice that counts • Engagement	Improve the response rate to ensure the results are more representative of the workforce. Set 'stretch' targets for each Care Group, Corporate Directorate, and YTHFM. Executive support for low performing areas.	All directors	Leadership teams in Care Groups, Corporate Directorates, and YTHFM	For those areas currently below the Trust average of 39% - their target should be to match / exceed the Trust average (with an improvement on their current rate of at least 10%); For those areas currently between 40-69%, a 10% improvement;	September 2024 ongoing	

				For those areas currently at 70%+, a 5% improvement		
• Rewarded & recognised	Raise awareness of the parameters of the national terms and conditions i.e. what is nationally agreed / mandated so that staff understand what is outside the remit of the Trust in terms of reward and recognition.	Polly McMeekin	Lydia Larcum	Education to be provided via regular communication routes including Staff Brief, JNCC, LNC.	Ongoing	
• Compassionate & inclusive • Voice that counts • Always learning • We are a team • Engagement • Morale	The free text comments reflect that further educational work is required around equality, diversity and inclusion. Equality and inclusion improvements for patients and staff members through the EDI improvement plans such as WRES, WDES and EDS	Polly McMeekin	Virginia Golding		Ongoing	Ongoing EDI plans and workstream – needs renewed commitment from Care Groups, Corporate Directorates and YTHFM
• Compassionate & inclusive • Safe & healthy • Always learning • Work flexibly • We are a team • Engagement	Retention Steering Group to be established to work with professional leads across the organisation to share best practice internally and communicate positive action focused on improving staff experience.	Polly McMeekin	Jenny Flinton Anna Goode	Increase in quarterly Pulse survey response rates.	Ongoing	Initial discussions taking place to establish the group.

We acknowledge that improving staff experience and delivering a sustainable workforce for our patients' needs will take more than one year and it is a core part of our multi-year Trust strategy. We aim to have made significant improvements by March 2025.

*** Improvement from Change Makers**

Last updated: 18.06.2024.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	31 July 2024
Subject:	Annual In-Patient Nurse Staffing Review
Director Sponsor:	Dawn Parkes, Chief Nurse
Author:	Emma George, Assistant Chief Nurse

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

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

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

Summary of Report and Key Points to highlight:
This paper summarises the nursing workforce review for adult and paediatric inpatient services, based on the quality metrics, professional judgement and staff required to meet the needs of patients. This review is consistent with the established requirements of the National Quality Board (NQB, 2016) and the NHS Improvement (NHSI 2018) Workforce Safeguards to ensure that Trust Boards are cited on the assessed and recommended nurse staffing workforce required to care for inpatients.

Key points to highlight are:
The data is indicating a need to review current nursing workforce models of care and modernise these in line with the changing needs of our population.
The service capacity and use of specific guidance for Acute Stroke, Respiratory and Acute Medicine needs further capacity and demand completing, to inform the staffing guidance application.
Further Safer Nursing Care Audits (SNCT) are required to offer full evidence-based acuity and dependency in Care Hours Per Patient Day (CHPPD).

Recommendation:
To receive this first nurse staffing Inpatient report.
To note the need for further nursing data assurance and analysis.

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

Meeting	Date	Outcome/Recommendation
Resources Committee	21 May 2024	

Bi - Annual In-Patient Nurse Staffing Review April 2024

1. Introduction and Background

The purpose of this paper is to report on the outcomes of the review of the first 6 monthly adult and paediatric ward nurse staffing establishments undertaken between September 2023 to February 2024. These 6 monthly reviews form part of the Trusts approach to the systematic review of staffing resources to ensure safe staffing levels effectively meet patient care needs and is a new process.

This paper focuses specifically on a review of nursing levels for the Trusts funded inpatient beds and does not include the nurse staffing required for additional bed capacity used in escalation and areas such as maternity, critical care, outpatients, theatres and the emergency which will be reviewed separately.

This review is consistent with the established requirements of the National Quality Board (NQB, 2016) and the NHS Improvement (NHSI 2018) Workforce Safeguards to ensure that Trust Boards are cited on the assessed and recommended nurse staffing workforce required to care for inpatients. In 2013 Sir Robert Francis QC published his final report of the inquiry into the failings at Mid Staffordshire NHS Foundation Trust. Following this report, a clear governance and oversight framework alongside recommended evidence-based tools, resources, and examples of good practice to support NHS providers in delivering safe patient care and the best possible outcomes for patients was developed.

Through the review process, Ward Managers, Matrons and Care Group Associate Chief Nurses are supported to review their workforce establishments and staffing models, taking account of measured and validated patient acuity and dependency, patient quality metrics and professional nursing judgement. The outcomes are considered and approved by the senior Care Group Leadership Team. The process is detailed in Appendix 1. An assessment or re-setting of the nursing/midwifery establishment and skill mix, based on acuity and dependency data using an evidence-based toolkit must be reported to the Trust Board via internal Clinical Governance processes by ward or service twice a year.

The interim Chief Nurse has established a formal approach to completing and presenting establishment reviews, taking a more robust approach to assure the Board of the safety of nurse staffing and to make any recommendations to nursing establishment changes. This must be linked to professional judgement and patient outcomes. Recognising any redesign or introduction of new roles, including but not limited to Nursing Associates, would be considered a service change, and must have a full Quality Impact Assessment (QIA) and go through the Trust formal business case process. As part of the safe staffing review, the Chief Nurse must confirm in a statement to the board that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable.

2. Current Position

The Trust currently has approximately 1000 general beds in use (including paediatrics) there are also at times additional beds open as unplanned escalation spaces which equate when fully open to 60 additional beds. The review of nursing and midwifery establishments is complex and any method of determining staffing levels has limitations. There is no one solution to determining safe staffing and therefore triangulation of methods is essential.

Using a combined approach provides greater confidence in the decisions taken. The setting of establishments has been based on triangulation of:

1) Workload and patient information of acuity, dependency and activity using a validated tool Safer Nursing Care Tool.
2) Professional judgement.
3) Professional consultation and review of patient safety metrics.
4) Design and layout of ward

The process has been elongated due to this being new for Care Groups and the complexities within them. The Safer Nursing Care Tool Audit (SNCT) whilst becoming embedded and having undertaken 3 full audits still requires further assurance around the accuracy of the data inputted through peer review. There is a continual training programme for nursing staff which is specifically aimed at Band 6 and Band 7 senior nurses as per NHSE guidance.

Therefore, the SNCT data, whilst taken into consideration has not offered full assurance on its outcome for this review.

Safer Nursing Care Tool Audit (SNCT)

The audit provides organisational level metrics to monitor impact on the quality of patient care and outcomes and gives a defined measure of patient acuity and dependency. It supports all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE/I 'Safe, sustainable and productive staffing' resources. Included are staffing multipliers to support professional judgement and it provides accurate data collection methodology. As an organisation we undertake this audit twice a year across all the adult inpatient wards, this has supported the decision making in this review. The SNCT is run in summer (June) and winter (February) to offer a rounded result of acuity and dependency due to seasonal changes. Band 6 and Band 7 are trained to input this data, and this is peer reviewed to ensure accuracy.

Patient acuity and dependency is also assessed and entered into the SafeCare Live module within Healthroster, twice a day using the evidence based Safer Nursing Care Tool. This calculates the care hours per patient day (CHPPD) required based on acuity and dependency needs to determine if the funded staffing levels meet the needs of the patients in our care. Whilst we monitor this data 24/7, 12 months a year, for the purpose of this review, as per national guidance, we use the twice-yearly audit to determine the staffing levels required.

The required CHPPD is determined by the level of acuity and dependency needs of the patients, as per the Safer Nursing Care Tool categorisation:

> **Level 0**: Needs met by provision of normal ward cares.
> **Level 1a**: Acutely ill patient requiring intervention (unstable or potential to deteriorate).
> **Level 1b:** Stable patients who are dependent on nursing care to meet most or all the activities of daily living.
> **Level 2**: Require designated beds with expertise resource/staffing level or transfer to Level 2 facility.

Currently our CHPPD reliability is not robust, and we are receiving support from the national NHSE team in educating ward leaders to ensure that we are reporting accurately

so whilst this data is available, it has not been utilised as an evidence-based tool for this review but will be in the subsequent staffing reviews.

As CHPPD does not consider the geographical layout and design of the ward, the number of side rooms, the requirement to provide enhanced care, skill mix, staff competency, or minimum registrant numbers, this metric must be used in triangulation with other quality metrics and professional judgement.

Safe Care Red Flags

Based on the NICE Safe Staffing guidelines released in July 2014, there are several 'Red Flag' events which need to be raised should they occur. SafeCare allows red flags to be raised in real time providing visibility to staff and senior management of potential risk. This live incident mapping helps identify when staffing levels do not meet the needs of the patients and may indicate that the quality of care has declined, and patients are vulnerable. The use of red flags, process of raising them and ensuring they are mitigated or not is still an ongoing process within the organisation and therefore has not offered enough assurance to use for this review.

The current red flags that are used within the organisation are in line with the NICE guidelines.

Table 1 indicates the current NICE recommended red flags:

NICE recommended red flags	
FOC1: Delay in painrelief	
FOC2: Delay in Intentional Rounding	
FOC3: Unplanned omission of medication	
FOC4: Vital Signs not assessed or recorded	
Staff1: Less than 2 RN on shift	
Staff2: Sortfall RN/HCSW hours	

The main theme for red flags that has been identified is 'delay in intentional rounding' and this will be collated monthly and shared within Care Groups. Again, there is clearly more work to be undertaken to ensure all wards are submitting red flags, mitigating where they can and ensuring there is narrative to support the decision making so an informed decision can be made to increase establishments where required.

Patient Quality Indicators

The patient quality metrics available in the Trust are provided through the nursing dashboard on Signal and provides additional evidence to triangulate the sustained demand on our staff, and the increased acuity and dependency of in-patients to measure the impact on avoidable patient harm and poor outcomes and support the decision making in this review. The quality indicators that are measured in the reviews are detailed in Appendix 3.

As part of the review other factors have been considered as detailed below:

Career Development

The organisation has an ambition to 'grow our own' nursing teams to ensure that the nursing workforce reflects the needs of the patient in ensuring that future roles are accessible. This means that we will increase all our apprenticeships particularly the Health Care Support Worker (HCSW) and Nursing Associate (NA) apprenticeships. This review has shown an increased requirement for the Band 4 NA role of 26.03 WTE, from redefining the required workforce model and changing Registered Nurses to Nursing Associates (Table 2).

Table 2: Number of Nursing Associates, current, proposed and variance:

Current budget WTE	Proposed budget WTE	Variance WTE
45.09	71.12	+26.03

There is much more to be done to address the gaps in our workforce across various roles, professional groups, and geographies, and develop appropriate multidisciplinary patient care workforce models. But if we are to address the pressures of workload and deliver the care patients need, we need to focus now on what we can do to grow our workforce in the coming months. Growing for the future particularly the need to build on renewed interest in NHS careers, to expand and develop our workforce, as well as taking steps to retain colleagues for longer.

Band 2 -3 Review

The NHS Agenda for Change Job Evaluation Scheme has always recognised the clear and very distinct differences between band 2 and band 3 Healthcare Support Worker roles in the delivery of personal care and clinical care.

Most jobs change over time but if changes in roles have not been captured and properly reflected in updated job descriptions that have gone through a job evaluation process, it is possible that they are not banded correctly. Currently the organisation is in the process of recognising the differences in the roles and there is a separate workstream to consider this across the whole organisation. Within this review there is a recommended requirement to establish 260.18 WTE Band 3 WTE Healthcare Support Worker roles from the current Band 2 workforce, this information will inform the ongoing project across the organisation as this only considers the inpatient wards.

The review has indicated that there is a requirement for a total of 275.5 WTE Band 3 roles within adult and paediatric inpatients (see Table 3). There is a specific review being undertaken in relation the National Job Profile across all departments and this data will feed into this to then determine the actual WTE requirement. Currently there are 742.76 WTE Band 2 Health Care Support Workers in the adult inpatient wards and paediatrics.

Table 3: Current Band 3 WTE, proposed and variance.

Current budget WTE	Proposed budget WTE	Variance WTE
15.34	275.52	260.18

Staffing Review Outcome

National Guidance

As part of the review there has been consideration given to specific National Clinical Guidelines, the main ones considered in this review are Stroke services, Respiratory and Acute Medicine.

Acute Stroke Unit (ASU) including Hyperacute Stroke Unit (HASU)

The National Clinical Guidelines for Stroke were updated in April 2023 providing authoritative, evidence-based practice guidance to improve the quality of care delivered to every adult who has a stroke in the United Kingdom. The recommendations are:

• People with stroke should be treated in a specialist stroke unit throughout their hospital stay unless the stroke is not the predominant clinical problem.
• A hyperacute, acute and rehabilitation service should provide specialist nurse staffing levels matching the following recommendations:

- 1.35 WTE registered nurses per bed (7 days) for Acute Stroke Care
- 2.9 WTE registered nurses per bed (7 days) for Hyper Acute Stroke Care

The National Stroke Service Model is the first 72 hours for every patient admitted with acute stroke and classified as a level 2 patient within Safecare and SNCT.

York and Scarborough Hospitals has 1 Acute Stroke Centre for all sites which is the Acute Stroke Unit (ASU) a 25 bedded unit incorporating 8 HASU beds with the nurse staffing model running over the standard 3 shift pattern – early, late and night shift. There is also a HASU service pathway to receive a pre alert by Yorkshire Ambulance Services to meet the patient in the Emergency Department to prevent delays to Thrombolysis.

The table (4) below indicates there is an overall requirement to increase the WTE by 37.43 to achieve the National Clinical Guidelines for Stroke based on direct calculation of registered nurses required. There is further work to be completed to understand the 8 hyperacute stroke beds utilisation with patients meeting the definition of hyperacute stroke level care requirements to refine the required nurse staffing capacity required.

Table 4: Stroke Services (Acute/HASU) required WTE: Registered and Non-Registered

	Band 2	Band 3	Nursing Associates	Registered Nurses
Current	19.52	0.00	3.00	25.51
Proposed	32.46	0.00	4.76	48.24
Variance	+ 12.94	0.00	+ 1.76	+ 22.73

Respiratory

The British Thoracic Society (BTS) in line with the National Institute for Health and Clinical Excellence (NICE) produced set standards for acute non-invasive ventilation (NIV) in adults in 2018.These standards include a nursing ratio of 1 Registered Nurse to 2 NIV patients and is in line with Safecare and SNCT standards. This guidance is relevant to Ward 34 (York) and Beech Ward (Scarborough) which are both respiratory wards. Ward 34 currently accepts 2 acute NIV patients at any one time and does so using the Nurse in Charge to care for these patients. There is a reliance on ICU for any patient attending with a Type 2 Respiratory failure above this number to be cared for in that environment which increases critical care bed occupancy pressures and increases length of stay. The current establishment also removes the nurse in charge being able to effectively manage the ward environment. Beech Ward has the capacity to accept up to 4 acute NIV patients within the current nurse staffing envelope.

Tables 5 and 6 below indicates there is a requirement for an increase of 18.14 WTE registrants to achieve the National standard for respiratory. This is a requirement for further review to understand the type and number of respiratory patients, numbers of acute NIV patients there are on these wards and analyse the workforce required in further detail.

Table 5: Ward 34 Respiratory Ward WTE requirement according to National Guidance

Ward 34	Band 2	Band 3	Nursing Associates	Registered Nurses
Current	25.09	0.00	0.00	20.42
Proposed	12.37	14.28	4.76	28.42
Variance	-12.72	+14.28	+4.76	+8.00

Table 6: Beech Ward Respiratory Ward WTE requirement according to National Guidance

Beech Ward	Band 2	Band 3	Nursing Associates	Registered Nurses
Current	18.73	0.00	2.30	25.05
Proposed	7.90	9.52	2.80	30.38
Variance	-10.83	+9.52	+0.50	+4.88

Acute Medical Admission Units

The Society for Acute Medicine (SAM, 2023) highlights using evidence-based decision support tools such as the SNCT to review acuity and dependency and seasonal variations however recommends the minimum registered nurse to patient ratio is 1:6 for direct clinical care on the acute medical admission units (AMU/AMB/Lilac).

Having a co-ordinator who can liaise with emergency departments to support the reduction in overcrowding and timely transfers, support clinical decision making and ensure there is an overview of patients at risk of deteriorating in their acute phase of illness is extremely beneficial and recommended to ensure an optimal quality of care is being delivered.

The tables below indicate there is a requirement for an increase across the nursing roles to achieve the National Standard for Acute Medicine if applied as recommended, this includes the increase in Band 2 to 3 roles. To accurately assess the definition of an acute assessment patient within our assessment units there will be further analysis of the type of patients

attending the Acute Assessment Units. Currently the model of care delivered is not reflective of an assessment unit with patients staying on the assessment units for several days.

Table 7: Acute Medicine Unit (AMU) WTE requirement against Acute Medicine Standards per band

Acute Medical Unit	Band 2	Band 3	Nursing Associates	Registered Nurses
Current	21.18	0.00	1.00	23.90
Proposed	13.42	19.04	0.00	30.00
Variance	-7.76	+19.04	-1.00	+6.10

Table 8: AMB Acute Frailty Unit per band

Acute Frailty Unit (AMB)	Band 2	Band 3	Nursing Associates	Registered Nurses
Current	19.86	2.80	2.00	22.45
Proposed	10.32	31.36	0.00	29.77
Variance	-9.54	+ 28.56	-2.00	+7.32

Table 9: Lilac Ward Acute Medical Unit per band

Lilac Ward	Band 2	Band 3	Nursing Associates	Registered Nurses
Current	16.65	4.81	4.25	24.77
Proposed	8.95	31.36	4.76	30.82
Variance	- 7.70	+9.44	+0.51	+6.05

Family Health (paediatric services)

Whilst a review has been undertaken in paediatrics, this is mainly related to professional judgement due to the SNCT not yet being fully embedded and therefore there is not enough evidence to support workforce change recommendations, and this audit will be undertaken again in June 2024 and presented back to panel chaired by the Chief Nurse.

Paediatrics have access to the Trust generic dashboard but there is work ongoing to look at specific quality indicators related to paediatrics to consider these in future reviews.

Outcome of the Establishment Review

As a result of the safe nurse staffing workforce review process the outcome for all the Care Groups is described below. The table below describes the WTE requirement for all adult and paediatric inpatient wards which equates to 290.57 WTE. Each ward nursing workforce model is detailed in Appendix 2.

Each registered and non-registered WTE is detailed below in Table 10 identifying each band including the increase to Band 3 Healthcare Support Workers and Nursing Associate roles (noted as unqualified Band 4 nurses). This indicates that our models of care are not appropriate for the changing needs of our population and nor are they within our current resource profile. This requires a further detailed review of our nursing workforce models and alignment to multidisciplinary working.

Table 10: Overall Care Group WTE for Registered and Non-Registered

	Current Budget					Proposed Budget					Variance				
Care Group	B2 HCA/ Support Staff PSOs	B3 HCA / Unqualified Nurse	B4 HCA / Unqualified Nurse	Qualified Nurse	Total	B2 HCA / Support Staff /	B3 HCA / Unqualified Nurse	B4 HCA / Unqualified Nurse	Qualified Nurse	Total	B2 HCA / Support Staff / PSOs	B3 HCA / Unqualified Nurse	B4 HCA / Unqualified Nurse	Qualified Nurse	Total
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Cancer Specialist	8.77	0.00	0.00	22.00	30.77	0.00	8.77	0.00	22.00	30.77	-8.77	8.77	0.00	0.00	0.00
Medicine	544.26	15.34	45.09	521.93	1,126.62	367.23	275.52	71.12	635.56	1349.43	-177.03	260.18	26.03	113.63	222.81
Surgery	159.05	6.76	15.15	218.09	399.05	146.62	72.09	16.95	216.19	451.85	-12.43	65.33	1.80	-1.90	52.80
Family Health Ca	20.56	1.20	0.60	55.72	78.08	2.00	22.74	3.83	64.47	93.04	-18.56	21.54	3.23	8.75	14.96
	732.64	**23.30**	**60.84**	**817.74**	**1,634.52**	**515.85**	**379.12**	**91.90**	**938.22**	**1925.09**	**-216.79**	**355.82**	**31.06**	**120.48**	**290.57**

Annual Governance Statement

As noted within this paper, the methodology and governance adopted in this review is compliant with both the NQB (2016) and NHSE guidance and pays due consideration to the RCN Workforce Standards (2021). The Care Groups have triangulated the evidence from the Nursing Quality Assurance Framework, patient and staff experience, alongside professional judgement; to provide assurance that the proposed required workforce models are safe, sustainable, and effective. This will be signed by the Chief Executive in June 2024.

Summary

This review has determined that there has been a requirement to review the nursing workforce for both registered and non-registered nurses across the organisation but specifically against current National Guidance in Acute Stroke, Respiratory and Acute Medicine. It is evident that there is a requirement to ensure the work recommended by NHSE is effective, including E roster Efficiency and ensuring the SNCT is embedded and reliable as evidence to support these reviews. It is important to ensure that the data is accurate and currently there is poor assurance in relation to this, a more detailed review of acuity and dependency within the acute areas needs further analysis.

The data is indicating a need to review current nursing workforce models of care and modernise these in line with the changing needs of our population.
The service capacity and use of specific guidance for Acute Stroke, Respiratory and Acute Medicine needs further capacity and demand completing, to inform the staffing guidance application.

Further Safer Nursing Care Audits (SNCT) are required to offer full evidence-based acuity and dependency in Care Hours Per Patient Day (CHPPD).

The review will be ongoing and repeated every 6 months and where there is a requirement for an increase in the nursing workforce aligning to National Guidance, the Care Groups will be required to submit a business case to support these recommendations.

Recommendations

Acknowledge the report and new process within the organisation for completing the required six-monthly nurse safe staffing reviews and support the planned further refinement, analysis against the National Staffing Guidance for Stroke, Respiratory and Society for Acute Medicine.

Support the next 6 months safe staffing review to commence August 2024, to align with the remodelling of our estate, care models and operating plan requirements, and to be presented to the Trust Board.

Appendix 1 Establishment review process

Stage 1	Accountability	Timeline
Nurse/Midwifery staffing review starts Email notification sent to Care Group Senior Quadrumvirate team and copied to Finance Manager	**Chief Nurse**	**Week 1 28/8/23**
Nurse Staffing Review Toolkit and Standard Operating Procedure, timeline of actions and Care Group Quality Metrics summary paper sent to Care Group Associate Chief Nurses (ACN) /Director of Midwifery (DoM). Copied to Associate Chief Operating Officer (ACOO) for Care Group	**ACN workforce**	**Week 3 13/9/23**
Care Group/DoM in collaboration with Heads of Nursing/ Matrons / Ward Manager to review current nursing/midwifery workforce models and develop recommended reviewed nursing workforce models.	**Care Group ACNs**	**Week 3 – 8 max. By 21/10/23**
ACN to discuss recommendations and gain initial support from quadrumvirate team	**Care Group ACN**	**By Latest Week 9 28/10/23**
Care Group ACN/DoM submit completed toolkit and workforce model to Assistant Chief Nurse Workforce & Education and lead nurse for	**Care Group ACN/DoM**	**Week 10 30/10/23**
ACN or DoM presents and agrees proposed Nursing/Midwifery Workforce Model with Care Group Senior Quadrumvirate team and Finance Manager. Care Group ACN/DoM confirms via email to the ACN Workforce Development & Education and the Care Group Senior Quad support for the recommended workforce staffing model.	**Care Group ACN /DoM**	**Week 11 6/11/23**
Stage 2		
Care Group Senior Quadrumvirate approved revised workforce model to be presented to the Chief Nurse for professional agreement.	**Care Group ACN**	**Week 12 27/11/23**
Professionally approved final Staffing Review Paper of quality metrics and recommended staffing model shared with Senior Quadrumvirate Care Group and agreed. Care Group ACN/DoM co –authors paper with ACN for Nursing Workforce Development and Education.	**ACN Workforce Development & Education and** **ACN/DoM**	**Week 13** **4/12/23 approx**
Paper with quality metrics and recommended workforce model roles and WTE shared with Senior Care Group Triumvirate for information.	**ACN Workforce Development & Education and ACN/DoM**	**Week 13/14** **11/12/23**
Annual Staffing Review Paper shared at executive team by the Chief Nurse	**Chief Nurse**	**Week 14**
Stage 3		
Chief Nurse presents the Annual staffing review paper to TBC – Exec Committee?	**Chief Nurse**	**Next scheduled meeting following above**
Divisional business cases for additional workforce capacity funding written	**Care Group Finance Manager**	**Week 15**

Appendix 2 Nursing Review Care Group Detail 2024

Care Group – Cancer Specialist & Clinical Support Services Group			
Ward	Current budget WTE	Proposed budget WTE	Variance WTE
	Total	Total	Total
Ward 31 - Haematology/Oncology	30.77	**30.77**	**0.00**
TOTAL	**30.77**	**30.77**	**0.00**

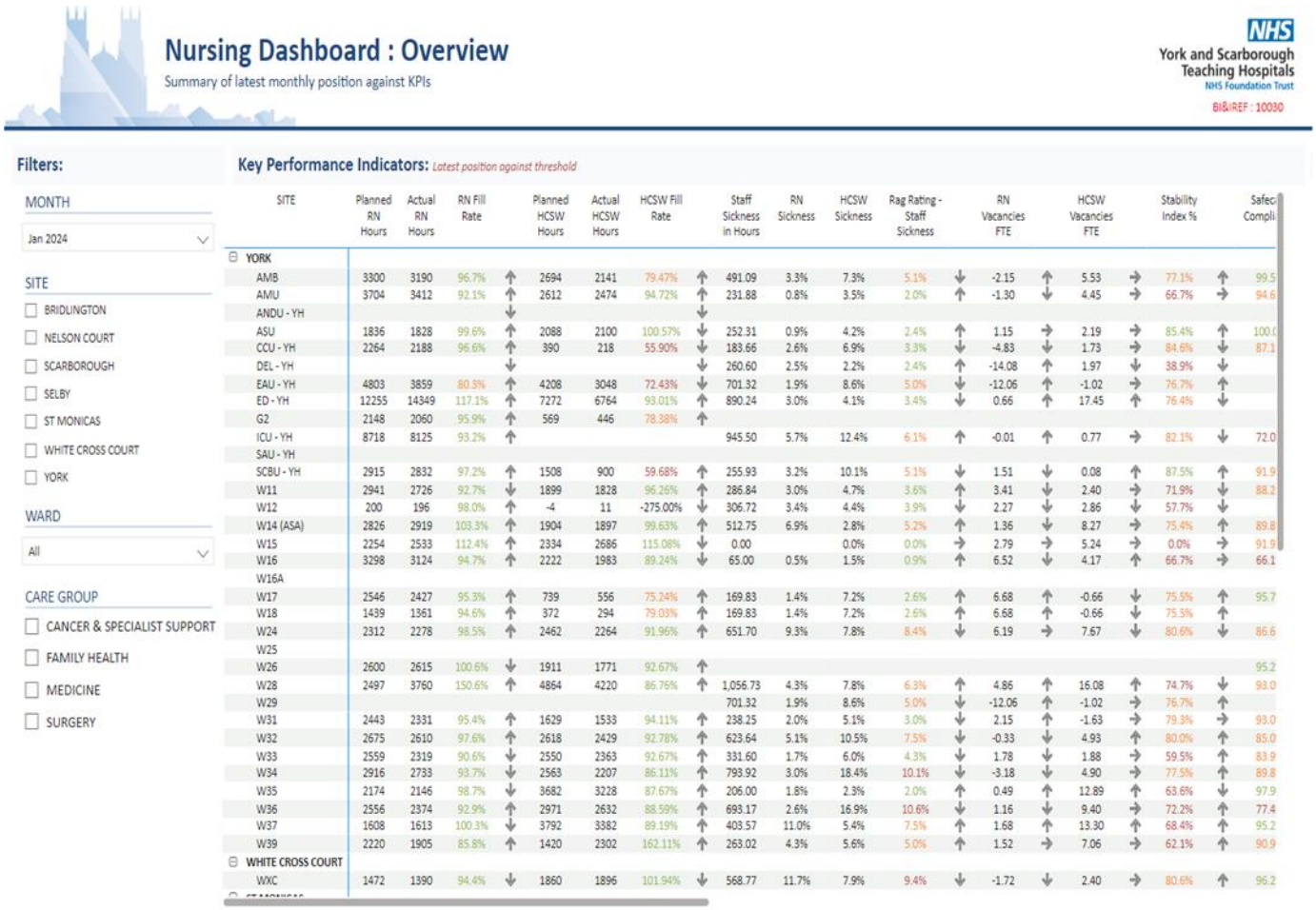
Care Group – Medicine			
Ward	Current budget WTE	Proposed budget WTE	Variance WTE
	Total	Total	Total
Acute Medical Unit / SDEC	46.08	62.46	16.38
General Medical Ward 33 (Renal)	41.74	49.01	7.27
General Medical Ward 34 (Respiratory)	45.51	59.83	14.32
General Medical Ward 32 (Cardio/Neuro)	42.33	52.43	10.10
Coronary Care Unit	20.82	33.75	12.93
Acute Frailty Unit (AMB)	47.11	71.45	24.34
General Medical Ward 36 (Gastro)	51.62	52.42	0.80
Elderly Whitecross Court (Stroke Rehab)	34.13	40.70	6.57
Elderly Ward 24 (Elderly Short Stay)	55.05	55.05	0.00
Elderly Ward 28 (Elderly Acute)	54.87	59.84	4.97
Elderly Ward 37 (Dementia)	42.60	54.02	11.42
Nelson's Court Ward 1 Community	24.39	25.48	1.09
Nelson's Court Ward 2 Community	24.37	25.48	1.11
Acute Stroke Unit Ward 23	48.03	85.46	37.43
Elderly Ward 35	55.37	59.84	4.47
St Monica's Inpatient Unit	17.30	21.58	4.28
Selby Inpatient Unit	26.75	25.48	-1.27
SDEC/EAU Nursing SGH	38.45	40.28	1.83
Beech Ward (respiratory)	47.08	51.60	4.52
Oak Ward (medicine)	50.45	54.45	4.00
Aspen Ward (medicine)	16.40	18.67	2.27
Cherry Ward (elderly)	48.42	55.02	6.60
Ash Ward (gastro)	27.15	31.59	4.44
Juniper Ward (medicine)	22.26	27.24	4.98
CCU SGH	40.83	48.15	7.32
Mulberry Ward (medicine)	26.52	31.79	5.27
Amu- Lilac Ward	51.48	59.81	8.33
Chestnut Ward (elderly)	45.62	55.02	9.40
Johnson Ward (Rehab)	33.89	41.51	7.62

TOTAL	**1126.62**	**1349.43**	**222.81**

Care Group - Surgery			
Ward	Current budget WTE	Proposed budget WTE	Variance WTE
	Total	Total	Total
Surgery Ward 14 Surgical Acute	57.20	63.82	6.62
Surgery Ward 11 Vascular	39.26	46.16	6.90
Surgery Ward 16 Colorectal	44.10	47.40	3.30
Ward 26 Head/neck and gynae	35.95	41.67	5.72
Ward 15 Orthopaedics	40.02	49.03	9.01
Ward 39 ~NOF	34.30	39.25	4.95
Day Unit	15.67	15.90	0.23
ESA Ward 12 Urology	29.60	34.54	4.94
Maple Ward Gen Surgery	52.85	50.93	-1.92
Holly Ward Orthopaedics	30.79	39.70	8.91
Kent Ward Elective Ortho	19.31	23.45	4.14
TOTAL	**399.05**	**451.85**	**52.80**

Care Group – Family Health (paediatrics)			
Ward	Current budget WTE	Proposed budget WTE	Variance WTE
	Total	Total	Total
The Childrens Ward & Assess Unit	48.82	54.69	5.87
Rainbow Ward	29.26	38.35	9.09
TOTAL	**78.08**	**93.04**	**14.96**

Appendix 3 Quality Indicators used to triangulate nurse staffing review



Nursing Dashboard : Overview

Summary of latest monthly position against KPIs

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10030

Filters:

MONTH: Jan 2024

SITE: BRIDLINGTON; NELSON COURT; SCARBOROUGH; SELBY; ST MONICAS; WHITE CROSS COURT; YORK

WARD: All

CARE GROUP: CANCER & SPECIALIST SUPPORT; FAMILY HEALTH; MEDICINE; SURGERY

Key Performance Indicators: *Latest position against threshold*

SITE	Planned RN Hours	Actual RN Hours	RN Fill Rate	Planned HCSW Hours	Actual HCSW Hours	HCSW Fill Rate	Staff Sickness in Hours	RN Sickness	HCSW Sickness	Rag Rating - Staff Sickness	RN Vacancies FTE	HCSW Vacancies FTE	Stability Index %	Safec Compli
YORK														
AMB	3300	3190	96.7%	2694	2141	79.47%	491.09	3.3%	7.3%	5.1%	-2.15	5.53	77.1%	99.5
AMU	3704	3412	92.1%	2612	2474	94.72%	231.88	0.8%	3.5%	2.0%	-1.30	4.45	66.7%	94.6
ANDU - YH														
ASU	1836	1828	99.6%	2088	2100	100.57%	252.31	0.9%	4.2%	2.4%	1.15	2.19	85.4%	100.0
CCU - YH	2264	2188	96.6%	390	218	55.90%	183.66	2.6%	6.9%	3.3%	-4.83	1.73	84.6%	87.1
DEL - YH							260.60	2.5%	2.2%	2.4%	-14.08	1.97	38.9%	
EAU - YH	4803	3859	80.3%	4208	3048	72.43%	701.32	1.9%	8.6%	5.0%	-12.06	-1.02	76.7%	
ED - YH	12255	14349	117.1%	7272	6764	93.01%	890.24	3.0%	4.1%	3.4%	0.66	17.45	76.4%	
G2	2148	2060	95.9%	569	446	78.38%								
ICU - YH	8718	8125	93.2%				945.50	5.7%	12.4%	6.1%	-0.01	0.77	82.1%	72.0
SAU - YH														
SCBU - YH	2915	2832	97.2%	1508	900	59.68%	255.93	3.2%	10.1%	5.1%	1.51	0.08	87.5%	91.9
W11	2941	2726	92.7%	1899	1828	96.26%	286.84	3.0%	4.7%	3.6%	3.41	2.40	71.9%	88.2
W12	200	196	98.0%	-4	11	-275.00%	306.72	3.4%	4.4%	3.9%	2.27	2.86	57.7%	
W14 (ASA)	2826	2919	103.3%	1904	1897	99.63%	512.75	6.9%	2.8%	5.2%	1.36	8.27	75.4%	89.8
W15	2254	2533	112.4%	2334	2686	115.08%	0.00		0.0%	0.0%	2.79	5.24	0.0%	91.9
W16	3298	3124	94.7%	2222	1983	89.24%	65.00	0.5%	1.5%	0.9%	6.52	4.17	66.7%	66.1
W16A														
W17	2546	2427	95.3%	739	556	75.24%	169.83	1.4%	7.2%	2.6%	6.68	-0.66	75.5%	95.7
W18	1439	1361	94.6%	372	294	79.03%	169.83	1.4%	7.2%	2.6%	6.68	-0.66	75.5%	
W24	2312	2278	98.5%	2462	2264	91.96%	651.70	9.3%	7.8%	8.4%	6.19	7.67	80.6%	86.6
W25														
W26	2600	2615	100.6%	1911	1771	92.67%								95.2
W28	2497	3760	150.6%	4864	4220	86.76%	1,056.73	4.3%	7.8%	6.3%	4.86	16.08	74.7%	93.0
W29							701.32	1.9%	8.6%	5.0%	-12.06	-1.02	76.7%	
W31	2443	2331	95.4%	1629	1533	94.11%	238.25	2.0%	5.1%	3.0%	2.15	-1.63	79.3%	93.0
W32	2675	2610	97.6%	2618	2429	92.78%	623.64	5.1%	10.5%	7.5%	-0.33	4.93	80.0%	85.0
W33	2559	2319	90.6%	2550	2363	92.67%	331.60	1.7%	6.0%	4.3%	1.78	1.88	59.5%	83.9
W34	2916	2733	93.7%	2563	2207	86.11%	793.92	3.0%	18.4%	10.1%	-3.18	4.90	77.5%	89.8
W35	2174	2146	98.7%	3682	3228	87.67%	206.00	1.8%	2.3%	2.0%	0.49	12.89	63.6%	97.9
W36	2556	2374	92.9%	2971	2632	88.59%	693.17	2.6%	16.9%	10.6%	1.16	9.40	72.2%	77.4
W37	1608	1613	100.3%	3792	3382	89.19%	403.57	11.0%	5.4%	7.5%	1.68	13.30	68.4%	95.2
W39	2220	1905	85.8%	1420	2302	162.11%	263.02	4.3%	5.6%	5.0%	1.52	7.06	62.1%	90.9
WHITE CROSS COURT														
WXC	1472	1390	94.4%	1860	1896	101.94%	568.77	11.7%	7.9%	9.4%	-1.72	2.40	80.6%	96.2

Nucleus: Nursing Assessments

Summary of nursing assessment performance

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10072

Filters:

Admission Month: 2024-01

Site: All

Ward Code: All

Assessment Type: All

Schedule Type: All

How to Export Data

Assessment Compliance : *compliance performance against a 95% target by admission month*

Total Assessments: 64,554

Total Compliant: 44,916

Total non-compliant: 19,638

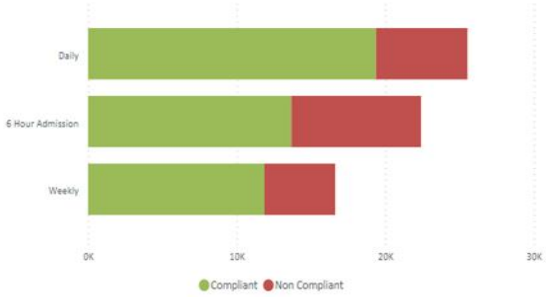
Compliance Rate: 69.6%

Compliance by Admission Month:

Admission Month	Assessments	Compliance %
2024-04	34,242	75.2%
2024-03	62,388	73.0%
2024-02	58,602	71.6%
2024-01	64,554	69.6%
2023-12	63,744	70.2%
2023-11	63,037	73.7%
2023-10	62,356	71.8%
2023-09	61,675	73.1%
2023-08	60,421	74.0%
2023-07	58,257	74.4%
2023-06	55,231	72.1%
2023-05	52,720	69.8%
2023-04	46,065	69.5%
2023-03	32,322	67.8%
Total	775,624	71.9%

Compliance by Assessment Type: *Number of assessments by compliance*

Compliance by Schedule Type: *Number of assessments by compliance*



Tendable: Matrons Monthly Assurance Compliance

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10063

Filters:

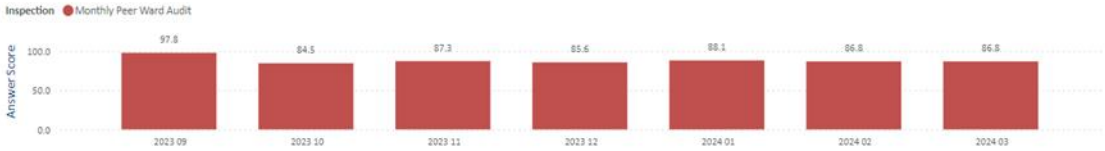
INSPECTION NAME: Monthly Peer Ward Audit

AREA NAME: All

CARE GROUP: All

CATEGORY NAME: All

Tendable: *Metrics showing average answer score by month*



Inspection	2023 09	2023 10	2023 11	2023 12	2024 01	2024 02	2024 03	2024 04
Monthly Peer Ward Audit	97.8	84.5	87.3	85.6	88.1	86.8	86.8	87.2

Inspection	2023 09	2023 10	2023 11	2023 12	2024 01	2024 02	2024 03	2024 04
⊟ Monthly Peer Ward Audit								
⊞ Administration of Medicines	100.0	77.1	78.3	82.0	84.9	91.0	92.2	97.2
⊞ Cannulation/Line	100.0	82.7	81.0	82.9	90.2	84.6	79.7	74.2
⊞ Clinical Area Safety	100.0	86.5	89.1	87.4	88.5	88.9	86.8	84.8
⊞ Continence		79.6	87.7	85.4	81.1	78.1	82.6	85.2
⊞ Enhanced Supervision		91.0	87.2	92.0	90.0	94.8	87.9	94.5
⊞ Falls	100.0	81.1	82.3	79.6	82.1	78.9	79.6	76.6
⊞ Fundemtals of Care	100.0	90.9	93.5	88.9	92.1	90.2	92.5	93.7
⊞ IPC Questions	100.0	95.3	94.8	92.5	95.8	96.2	94.7	96.2
⊟ MCA, DOLS & Cognitive Impairment								
Does the patient have a fully completed DoIs in place?		87.5	93.9	93.8	94.3	96.3	98.0	83.3
If this document is available, is there evidence that care is being delivered as per this document?		68.3	77.1	88.9	88.9	81.7	87.3	100.0
Is a hospital passport or "what matters to me" document completed and available?		48.7	41.1	56.3	68.1	60.9	75.3	70.0
⊞ Medicine Management	91.7	79.0	84.7	79.9	83.8	82.0	83.3	78.8
⊞ Nutrition and Hydration	100.0	84.5	89.6	85.8	88.1	89.2	88.5	95.1
⊞ Observations	100.0	84.6	84.7	90.7	91.0	92.4	95.7	90.0
⊞ Patient/Carer question	100.0	91.3	92.5	91.0	96.2	90.5	85.7	91.4
⊞ Pressure Ulcers	100.0	88.1	90.0	88.8	93.1	87.1	89.7	97.4
⊞ Wound Care		86.4	88.5	90.7	91.6	83.5	85.6	92.4

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	31 July 2024
Subject:	Complaints Annual Report 2023-24
Director Sponsor:	Dawn Parkes, Chief Nurse
Author:	Justine Harle, Lead for Complaints and Concerns

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

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

Summary of Report and Key Points to highlight:

The report contains details of complaint performance and actions taken in response to feedback.

Key points:

- 816 complaints were received compared to 663 in 2022/23, an increase of 23%.
- The top five subjects related to attitude of nursing staff/midwives, communication with patient, delay or failure in treatment or procedure, attitude of medical staff and delay or failure to diagnose.
- Overall performance in responding to complaints was 49%, compared to 55% in 2022/23.

Feedback from Quality Committee (23 July 2024) – the report was received, and performance noted. A robust discussion was held regarding persistent themes, specifically in relation to communication and staff attitudes. Strategic next steps include:

- Co-production of an experience & engagement framework with key stakeholders, to include targeted focus on communication and staff attitudes – workshop to progress the framework and improvement actions is planned for 5 August 2024.
- Strategic commitment to co-design of compassionate leadership, with associated 'compassionate accountability' to drive down complaints in relation to staff attitude – this was identified as a key priority at a strategic leadership event held 19 July 2024.
- Chief Nurse Designate has requested assurance from Care Groups regarding local actions around addressing complaint themes.
- Future reports to include information regarding % identified theme per patient contact.

Progress updates against these actions will be provided in future quarterly patient experience reports, which will provide triangulation of feedback and updates in relation to agreed improvement work and associated impact on patient experience.

Recommendation:

The committee is asked to note the contents of the report, and the work that is being undertaken to improve services as a result of feedback.

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

Meeting	**Date**	**Outcome/Recommendation**
Patient Experience Sub Committee	12 June 2024	Approved
Quality Committee	23 July 2024	Approved for Board of Directors with additional information regarding strategic actions identified within executive summary above

1. Background

York and Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) is an acute and community provider delivering a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale.

The Trust manages eight hospital sites and has a workforce of around 10,000 staff working across our hospitals and in the community.

In 2023/24, the Trust had 115,414 A&E attendances, 100,613 attendances in Urgent Care Centres on our sites, 779,908 outpatient attendances (also including telephone and video appointments), 160,808 inpatients (adults, including maternity), 9,921 inpatients (children), 121,700 operations or procedures as an inpatient and 3,916 babies delivered.

Every point of contact and interaction has an impact on an individual's experience, from the moment they receive an appointment letter to the point of their discharge. An approachable welcome at reception, an introduction that starts with a name, a system that saves patients needing to repeat their story – every role and every employee has a part to play in creating a positive experience for our patients, their families and loved ones.

2. Introduction

This is the complaints annual report for the period 1 April 2023 to 31 March 2024. It includes details of numbers of complaints received during this period, performance in relation to responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations and examples of actions the Trust has taken in response to complaints.

In managing complaints, the Trust is required to adhere to The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Receiving and acting on complaints.

The Board has corporate responsibility for the management and monitoring of complaints received by the Trust and the Chief Executive has delegated the responsibility for the management of complaints to the Chief Nurse. Monthly care group reports are produced for each Care Group as well as quarterly reports for the Quality Committee including details of number of complaints received, number of complaints closed by working day response time and compliance with performance targets and complaint themes. Complaint handling is now monitored at care group Performance Risk Improvement Management (PRIM) meetings and there is a focus on improving response times.

3. The number of complaints which the responsible body received and the number of complaints which the responsible body decided were well-founded

3.1 New complaints

816 formal complaints were received during 2023/24 compared to 663 in 2022/23, an increase of 23%. This equates to a monthly average of 68 complaints. As in the previous year, patients remain particularly unhappy about the long waits in ED and for elective surgery, scans and follow up appointments.

New complaints 2023/24	Q1	Q2	Q3	Q4	Total
York Hospital (including Community)	119	143	149	172	583
Scarborough Hospital	37	53	62	61	213
Bridlington Hospital	5	4	5	6	20
Total	161	200	216	239	816

New complaints by care group	Q1	Q2	Q3	Q4	Total
Cancer, Specialist and Clinical Support Services (CSCS)	22	26	17	28	93
Corporate Services	3	5	0	4	12
Family Health	16	34	32	29	111
Medicine (Scarborough)	21	31	33	35	120
Medicine (York)	56	55	72	71	254
Surgery	43	49	62	72	226
Total	161	200	216	239	816

3.2 Reopened Complaints

The Trust always seeks to apologise for failings in care and applies the duty of candour principles to the complaints process. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in their absence, the Chief Nurse or an Executive Director designated signatory.

In 2023/24 805 complaint investigations were concluded, of which 6% (46) were reopened at the request of the complainant and further investigations undertaken. These figures are a reduction on 2022/23 (11%). Complainants are encouraged to contact us if they have any further questions and almost half of complainants took the opportunity to raise additional questions.

3.3 Outcome data

The Trust is required under the complaints legislation to record whether the issues were substantiated following investigation. Of the 805 complaints closed this financial year, 776 had an outcome code provided by the investigating officer at the time of this report. Of the 776 cases, 18% were upheld, 45% were partially upheld and 37% were not upheld. These figures are comparable to previous years.

Outcomes 2023-24	Not upheld	Partially Upheld	Upheld	Total
Cancer, Specialist & Clinical Support Services	41	26	31	98
Corporate Services	6	4	4	14
Family Health	36	64	28	128
Medicine Scarborough	25	67	18	110
Medicine York	88	131	30	249
Surgery	90	55	32	177
Total	286	347	143	776

3.4 Parliamentary and Health Service Ombudsman (PHSO)

Complainants are advised of their right to apply to the PHSO for independent review if they are dissatisfied with the Trust's efforts to resolve their concerns. In 2023/24 the PHSO undertook an initial inspection of twelve complaints and concluded no further action was required. No PHSO full investigations were registered in 2023/24 and we are currently awaiting the outcome of two full investigations that the PHSO registered in 2021/22 and 2022/23.

Five cases registered in previous years were concluded this year; four were partially upheld and one was upheld.

19957 related to care under the elderly medicine team at Scarborough Hospital in 2020. The investigation concluded that ward staff failed to provide the district nursing service accurate information about the patient's catheter. However, the error did not have an impact on the patient's overall care and the PHSO did not recommend any further actions.

22860 related to paediatric care at York Hospital in 2022. The investigation concluded that there was a significant delay in treating a child's undescended testicle. His parents were understandably worried about the long-term impact of the delay and felt their only option was to pay for treatment themselves. This case was discussed at the Child Health Paediatric Clinical Governance meeting in October 2023. It was agreed that any child aged three months or over, presenting with an undescended testicle, would be referred to the Urology Service, to comply with new NICE guidance that these infants should be seen by a urologist by the age of six months. This learning was shared with all medical staff performing baby checks and with our urology consultant team. The PHSO also asked the Trust to pay the family £3,450 in recognition of the costs they incurred for private surgery and the distress they suffered as a result of failings.

20779 related to delays in the Medicine Care Group management of the complaint during the Covid-19 pandemic. There was a delay in sending the complaint response and the investigating officer did not always keep the complainant up to date during this period. During the pandemic we faced challenges that affected our ability to respond to all complaints in a timely way but on balance we thought it was right not to suspend investigations as some NHS trusts did.

In the case of 18915 the PHSO found that appropriate investigations were not carried out when it was first suspected that the patient was suffering from infective endocarditis in February 2020. The Medicine Care Group created a safety briefing which was shared with all clinical staff to remind them of the importance of looking for this condition. Our cardiologists follow the European Society of Cardiology guidelines for the investigation and treatment of endocarditis and have a weekly endocarditis multi-disciplinary meeting involving our microbiologists. The details of this case and the Ombudsman findings were presented at a cardiology meeting.

22987 was upheld because follow-up imaging should have been recommended at the time of the original CT and that due to this error staff did not provide the patient with the correct follow up care she required. In addition, her rheumatoid pain was not managed effectively in the last months of her life. This case was anonymously reviewed at a Radiology Events and Learning Meeting (REALM) in October 2021. It was agreed that practice would be changed regarding cases such as this with immediate effect. Since October 2021, when a haematoma is identified in an atypical location, staff recommend a short interval follow-up study to ensure this is resolving and that there is no underlying tumour or vascular abnormality. It was recognised that the communication between oncology and other specialities, such as rheumatology was not as consistent as it should have been. Since this case communication has improved and the Oncology Team communicates to other specialties when specialist drugs have been stopped so that the specialities are aware they may have to consider other treatment options. They also provide clearer plans to the other specialities in terms of the safe treatment options that can be provided if necessary.

4. The subject matter of complaints that the responsible body received

The top five themes in 2023/24 were attitude of nursing staff/midwives, communication with patient, delay or failure in treatment or procedure, attitude of medical staff and delay or failure to diagnose. Staff attitude and communication have been identified as priorities in the Trust Experience and Engagement Framework.

It should be noted that complainant's comments are opinions and not always statements of fact and failings were not identified in 37% cases concluded in 2023/24. However, emerging trends or themes are monitored regularly as complaints are received, and any areas of concern are highlighted to the Care Group management teams.

Top themes 2023-24	Q1	Q2	Q3	Q4	Total
Attitude of nursing staff/midwives	29	36	35	41	141
Communication with patient	19	42	34	42	137
Delay or failure in treatment or procedure	20	25	40	49	134
Attitude of medical staff	22	38	39	33	132
Delay or failure to diagnose	20	27	22	22	91
Total	**110**	**168**	**170**	**187**	**635**

NB: There are often multiple subjects within a single complaint, reflecting the complexity of many complaints.

Whilst the number of complaints relating to communication has gone up, the data alone doesn't tell us the reason behind this increase. It could be due to growing problems in the way services communicate with patients, or it could be because people feel better able to speak up. In addition, some patients make requests that are beyond what the NHS can provide. Often through little fault of their own, staff are stalled by unavoidable hurdles, such as staffing levels, or lack of resources. Working under these extreme pressures inevitably means that staff cannot always provide the instant answers and results that some expect and managing expectations is important from the outset.

As well as communication being the main issue for some complainants, it is more often part of a complaint about something else. The communication issue can be a trigger for a complaint or part of other errors and can also arise during the complaints process such as when a patient gets access to their medical records. Often issues can overlap and there can be a combination of communication issues and contributory factors in one complaint, particular around complaints about discharge arrangements.

Issues included lack of clear oral and written communication, misunderstandings and patient not being kept up to date, test results not being communicated to patients and consent issues. Some patients told us they felt rushed in their consultation and did not have an opportunity to discuss everything they wanted to during the time allotted for their appointment, which in some cases they had waited a long time for. Some told us the doctor failed to effectively communicate their diagnosis or treatment options and did not involve the patient in decisions. We have also seen a steep increase this year in the number of people complaining about the difficulties getting through on the phone to wards and departments across the Trust.

Issues about staff attitudes and behaviour included abruptness, rude arrogant or dismissive attitude. In addition, confrontation, inappropriate comments, insensitive to patient needs and lack of support were cited by complainants.

It may not always be clear exactly what has taken place and what might have caused a communication breakdown – this can be because the individuals have a different recollection of events or because it hasn't been possible to identify through the case investigation. However, even if a member of staff disagrees with the complainant's version of events there is a perception by the patient that there was a communication issue.

Communication: Accessible Information Standard

All NHS organisations are legally required to follow the Accessible Information Standard.

The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

No formal complaints were received in 2023/24 relating to the Accessible Information Standard.

5. Any matters of general importance arising out of those complaints, or the way in which the complaints were handled.

The national regulations, together with guidance from the Parliamentary and Health Service Ombudsman, indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the investigating officer informs the complainant of the reason for the delay and a new date is agreed by which the response will be sent.

On average 49% of closed cases met the Trust's 30-day response target. However, the figures alone do not reflect the care group recent focus on addressing longstanding cases and as at 22/04/24 there were 6 cases over 30 working days and 3 over 50 working days.

2023/24	2022/23	2021/22	2020/21	2019-2020	2018-19
49%	55%	57%	57%	41%	36%

Percentage performance per month (working days)

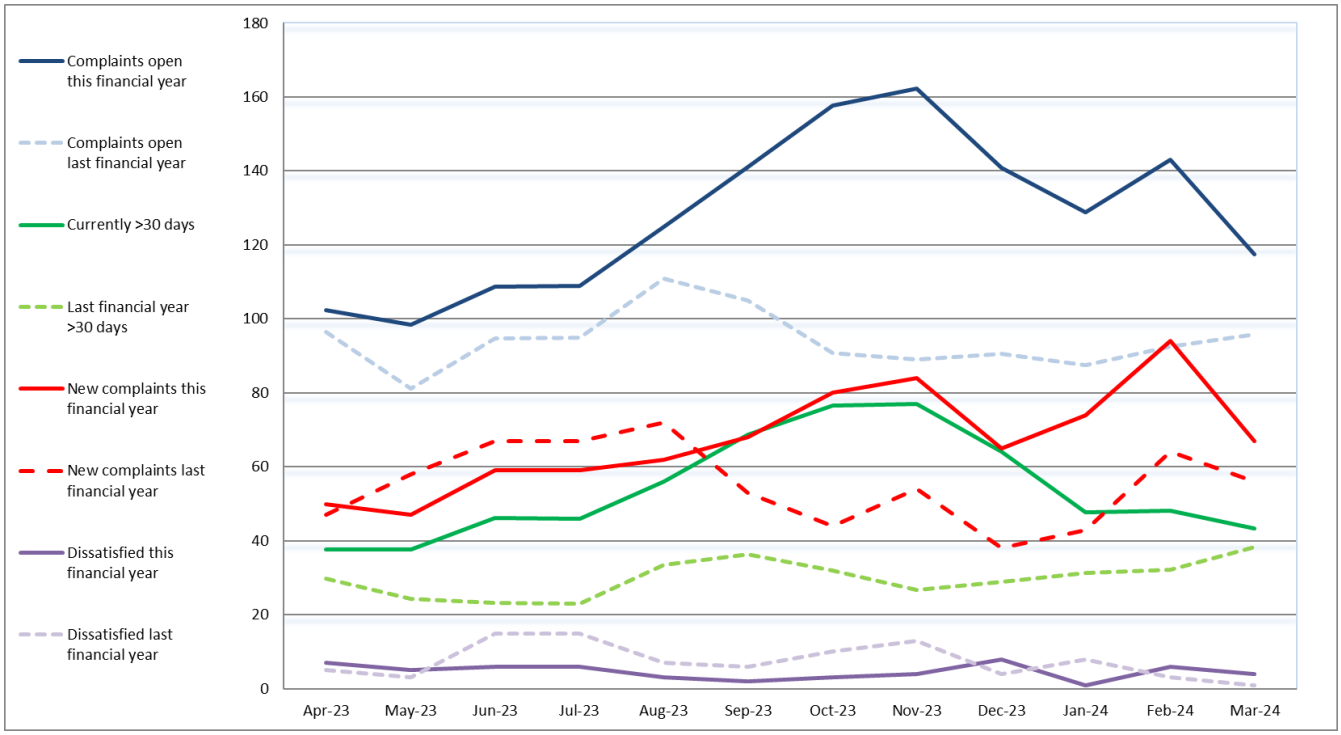
2023-34	<30		30-50		51-100		>100		Total Closed	Total Average no days	% Within Target
	Closed	Average no days	Closed	Average no days	Closed	Average no days	Closed	Average no days			
April	26	14	10	40	6	72	0	0	42	28	62%
May	23	19	12	39	9	71	3	127	47	41	49%
June	35	14	10	37	5	74	1	107	51	26	69%
July	21	16	18	40	13	66	0	0	52	37	40%
August	29	16	20	37	14	64	6	138	69	42	42%
September	23	12	13	38	7	59	3	123	46	34	50%
October	29	14	17	40	27	67	5	163	78	48	37%
November	30	12	18	39	14	75	5	131	67	41	45%
December	40	14	29	39	26	66	14	159	109	51	37%
January	48	13	22	37	13	69	6	132	89	35	54%
February	37	13	20	38	14	69	4	148	75	38	49%
March	48	17	34	37	14	68	5	117	101	36	48%
Total	**389**	**15**	**223**	**38**	**162**	**68**	**52**	**112**	**826**	**38**	**49%**

Responses within target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of cases closed	42	47	51	52	69	46	78	67	109	89	75	101
Closed within 30 days	26	23	35	21	29	23	29	30	40	48	37	48
Trust %	**62%**	**49%**	**69%**	**40%**	**42%**	**50%**	**37%**	**45%**	**37%**	**54%**	**49%**	**48%**
Quarterly average	**60%**			**44%**			**40%**			**50%**		

Care Group average compliance with 30-day response target

Responses within target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Av
CSCS	63%	25%	50%	59%	54%	65%	38%	57%	30%	45%	83%	71%	53%
Family Health	33%	0%	38%	50%	44%	40%	25%	13%	28%	37%	43%	45%	33%
Medicine (av CG1 & 2)	90%	78%	85%	40%	48%	46%	50%	62%	47%	73%	56%	43%	60%
Surgery	57%	63%	77%	29%	42%	50%	22%	43%	28%	33%	32%	45%	43%

Complaint Performance 2023/24



Care Group Actions to improve performance

Cancer, Specialist and Clinical Services Care Group

CSCS hold a weekly complaints meeting which is chaired by the Associate Chief Nurse or Associate Chief Operating Officer. When they are available, they both attend to ensure the team is aware that complaints are a high priority. All complaint leads attend the meeting and if they are not available their line manager reports on progress.

During the weekly complaints meeting the Care Group identifies what support is needed for the lead and ensures they have contacted the complainant within 72 hours of the Care Group receiving the complaint and that this is captured within Datix. The complaints dashboard is reviewed ahead of the meeting with support from the governance team to ensure that the Care Group is meeting timescales. This allows them to challenge in the meeting. The Complaints and Concerns Team is represented at the weekly meeting and this has really helped to ensure the care group has clear points of contact in the team.

The aim of the Care Group is to better represent patient experience within their governance structure to better evidence learning and celebrate how they have improved care for patients.

Family Health Care Group: Gynaecology and Paediatrics

Individuals are contacted as soon as possible to acknowledge their complaint/concerns and efforts are made to resolve these over the phone where possible. Associate Chief Nurse led weekly Gynaecology MDT meetings were introduced in October 2023 to clear the backlog of complaints and concerns and new investigating officers are being identified and will undertake complaint investigation training to further support the Care Group in the year ahead.

The Clinical Governance Team produces a weekly Datix report of open Gynaecology and Paediatric complaints and concerns and these are circulated to investigating officers as a reminder. The team also undertakes a daily review of the Datix dashboard to ensure investigating officers have been allocated, check approaching deadlines and identify where an extension may be required.

Concerns, complaints, and incidents are reviewed at the weekly Paediatric incident review meetings and immediate learning identified. Complaints and concerns are also discussed at the weekly Gynaecology Senior Leadership Team meetings and immediate learning. Identified.

Medicine Care Group

Weekly complaints meetings are in place to review progress and offer support and guidance to investigating officers and a training needs analysis has been completed to identify skills gaps.

The Care Group is promoting proactive responses to complaints as soon as possible after consent and encouraging investigating officers to contact the complainant directly and have a verbal conversation. The number of complaints that have been closed as a result has been significant.

Surgery Care Group

The frequency of complaint meetings has been increased to weekly to improve response times and ensure support is available from senior colleagues to investigating officers. This led to a marked decline in overdue responses by the latter end of 2023.

Each Directorate General Manager has also added complaints to the weekly catch-ups to manage response times and any extension to the original timeframe has to be submitted to the General Manager for approval.

6. Examples of actions that have been taken to improve services as a result of complaints

Cancer, Specialist and Clinical Services Care Group

- MySight York now has a room at the Community Stadium site to support closer working between the Trust and the charity to promote patient experience and more integrated working.
- The Macmillan Cancer Health and Wellbeing Support Service responded to a need highlighted by patients and undertook patient engagement work with the redesign of the existing Cancer Care Centre starting in autumn 2024. It is planned the development will be completed in 2025 and the centre will be open to people affected by cancer across the region.

- Patient concerns and feedback following previous moves was taken into consideration during the relocation of the York Medical Elective Service and this has gone smoothly and benefitted both patients and staff.
- A glaucoma patient group had been developed by the ophthalmology consultants in response to patient requests for more information and support.
- Endoscopy concerns have been addressed as part of the work to achieve Joint Advisory Group on GI Endoscopy (JAG) accreditation for the Trust.
- The Community Diagnostics Centres have been developed to provide more rapid access to diagnostics which is often a theme within concerns, providing access to services closer to home.

Family Health Care Group: Gynaecology and Paediatrics

- Gynaecology and Paediatric complaints and concerns regarding medical care and attitude of medical staff are now copied into the Clinical Directors for awareness and feedback to the individuals concerned.
- Clinic letters are copied to patients in Gynaecology to improve communication by confirming follow-up arrangements which was identified as a complaint theme.
- There is now parent involvement on Matron interview panels in Paediatrics.
- The parents' room on Ward 17 has been renovated with parental input regarding design.
- Fundraising is continuing for a new bathroom on ward 17 and the Care Group plans to seek feedback from patients and families when developing the design.
- Special Schools, parents and teens with complex needs have requested outreach training to youth groups, attended evening sessions covering public and personal health.
- Special Schools: new bowel and bladder training for new starters as requested in Hobmoor Oaks School.
- Child Development Centre: going forward all appointment letters will include a note about waiting times to get into hospital and advice on parking to reduce late appointments.

Medicine Care Group

- Because of the high number of complaints regarding staff attitude and communication, learning regarding this is being shared at Care Group meetings with all disciplines and the ward sisters have been asked to share with their teams. The ward sisters and Matrons have been asked to walk around the ward during visiting times introducing themselves and asking patients and visitors how their experience has been and if there is anything we can do to improve this.
- Scarborough site has been successful in obtaining a further 12 months charitable funding to support a Family Liaison Officer as this demonstrated a reduction in concerns previously. There is a desire to replicate this for York site, accepting that communication is core to everyone's role and should be of a high standard. This role can however help with the more complex cases.
- Another theme is regarding delay in appointments and treatment. The operational team is focusing on medical recruitment to increase capacity and try to reduce waiting times.
- The work around themes for the year of quality is also being used to raise awareness of the critical importance of basic cares.
- Within the community sites the teams have enabled Pets as Therapy dog visits to wards and the Autumn rooms at Selby and St Monica's Hospitals have been refurbished. Within Community, ward doors have also been upgraded to promote patient safety and dining rooms have been reconfigured to enable patients to socialise.

Surgery Care Group

- The Trauma and Orthopaedic Service moved to the Surgery Care Group in October 2023. Several of their complaints related to patients not being clear about ongoing treatment and management plans. To help rectify this, it was agreed that clinic letters from appointments will be sent to patients as well as their GP or referrer as this had been stopped a few years ago.
- Several complaints related to patients not having appropriate over the counter pain relief medications at home on discharge and this has been added to the information given to patients at pre-assessment about preparing for their operation.

7. Looking Ahead: Quality Priorities 2023/24

- Continue with support and training for investigating officers.
- Explore reinstating the complainants survey when Trust retenders for the third party survey services for Friends and Family Test and national patient surveys in Q3 of 2024/25
- Care groups to continue focus on improving response times.

8. Conclusion and request for the committee

The complaints procedure is entirely necessary and can prevent negligence and promote transparency of care. Patients should always retain the right to make a complaint, and to highlight situations where something has gone wrong. Being open and honest about learning from complaints gives more people the confidence that the process will result in positive change and complaints must be seen not as a measure of poor performance, but as an opportunity for learning.

The committee is asked to note the contents of the report and continue to support the work being undertaken to improve patient experience.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 14

Report to:	Board of Directors
Date of Meeting:	31 July 2024
Subject:	CQC Update Report including Journey to Excellence
Director Sponsor:	Dawn Parkes, Chief Nurse Designate Adele Coulthard, Director of Quality, Improvement and Patient Safety
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 20 June 2024.

There are 12 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 July 2024	Presented and accepted
Quality Committee	23 July 2024	*Not presented at the time of submitting the paper.*

1. CQC Inspection Update

The CQC have been invited onsite to visit the York Hospital Emergency Department on 29 July 2024.

The Board of Directors has agreed seven improvement workstreams providing a framework for the Trust's 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

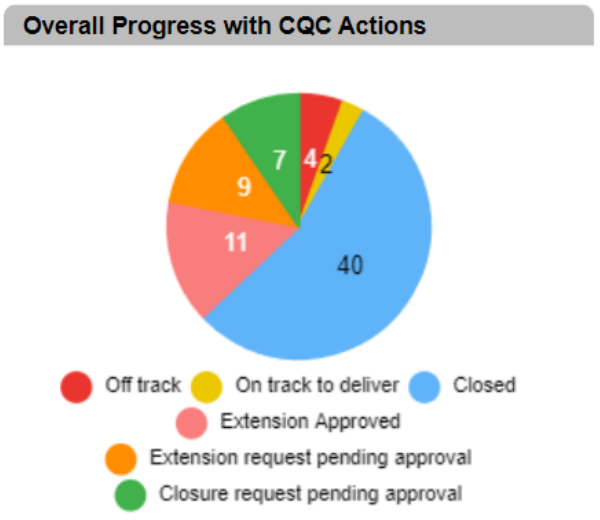
Journey to Excellence receives requests for closure of the CQC Must/Should do actions and reviews the evidence provided to approve closure. The group also considers and approves any requests to extend CQC Improvement plan action timescales.

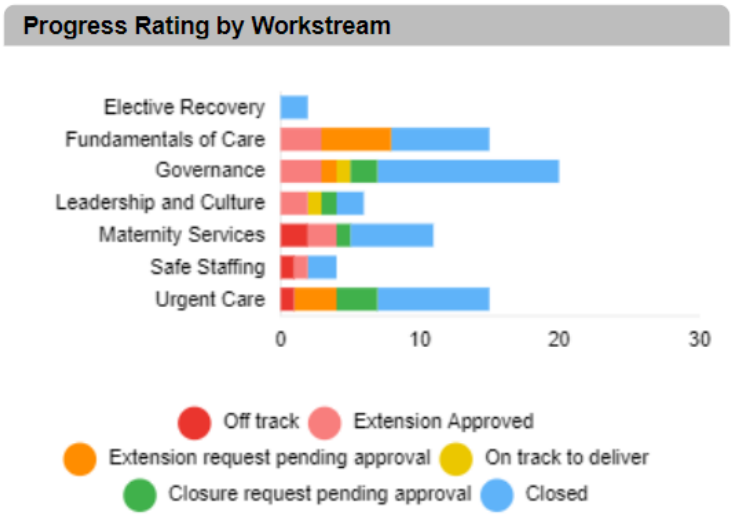
The Care Group delivery of the CQC action plan and workstream actions are monitored though the Trusts monthly Performance Review and Improvement Meeting (PRIM).

The Journey to Excellence Programme Board is held fortnightly, chaired by the Chief Executive. Each workstream lead presents an updated monthly highlight report. One week will be a verbal update on progress, risks and mitigations and the following week will be a formal written progress report for assurance and challenge. The group holds workstreams leads to account for delivery of the key milestones aligned to each workstream.

A highlight report for six workstreams were presented at meetings held on 24 June 2024 and 8 July 2024 respectively. An update on Elective Care workstream is now presented quarterly as all CQC actions in this workstream are complete.

Progress with the CQC Improvement Plan, as of 28 June 2024, can be seen in the charts below. All open actions are also included in the appendices:





2. Actions Off Track and Extensions

A comprehensive update on actions is included in the appendices of this paper this month.

Four actions are considered off track meaning the original target date for delivery has not been met and an extension request has either yet to be made or approved (see Appendix B).

There are 11 actions which remain open and have had extensions approved by the Executive Leads and through the Journey to Excellence meetings (Appendix C). There are also nine actions for which an extension is needed, and an application made, but this is awaiting approval (see Appendix D).

3. Achievements

Since the last report was written, a further three actions have been approved for closure. A total of 40 actions have now been closed.

Ref	Must / Should	Action
21	Must	The trust should ensure it meets the criteria for accessible information standard (AIS)
57	Should	The trust should ensure that psychology services are made available for patients.
65	Must	The trust must ensure that in Maternity, key environmental and clinical audits are completed and monitored with action plans. For example, audits on fresh eyes assessments and WHO safety checklists.

A multidisciplinary task and finish group, led by the Assistant Chief Nurse, was established in June 2024 to oversee the delivery of improvements with accessible information. Progress is reported through the Patient Experience Sub-Committee.

Maternity Services has also developed a comprehensive audit and assurance programme, with oversight of delivery reported through the Guideline and Audit Group. The three year programme is driven by regulatory requirements, procedural compliance and NICE guidance.

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

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 20 June 2024.

The Interim Chief Nurse has invited the CQC to re-visit the Maternity Service with a view of assessing the progress made with the conditions of registration. A date for the on-site visit is being arranged for September 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. The electronic assessment tool went live at York Emergency Department on 30 April 2024.

The Trust is looking to evidence that it now meets the conditions of registration placed on the Trust in January 2020 once the use of 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 have been five CQC cases received since the last report was written (31 May 2024) one concern regarding patient discharge, two regarding patient safety and two regarding safeguarding.

At the time of writing, the Trust had 12 open cases / enquiries. The enquiry dashboard can be viewed in Appendix F.

7. CQC Updates

Ian Trenholm to step down as CQC's Chief Executive

Ian Trenholm, CQC's Chief Executive, has announced that he will step down from his role at the end of the month. Kate Terroni, CQC's Deputy Chief Executive, will assume the role of Interim Chief Executive until a permanent replacement is appointed. Click here for more information.

Guidance on the CQC scoring methodology

In a new masterclass video, led by the Head of Analytic Content at the CQC, talks through how scoring features in the new assessment model. Click here to watch.

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 – Off Track

Ref	Action	Target Date to Complete	Summary	Workstream Lead
29	The trust must ensure that there are sufficient allied healthcare professional, nursing, midwives and medical staff in Medical Care and Maternity to keep people safe.	29/03/24	Position statement is being drafted by the Patient Safety Team - Medical Workforce meeting held and AHP evidence and nursing evidence received.	Dawn Parkes
38	The trust must ensure the Urgent and Emergency service continues to work to improve the following performance standards at Scarborough hospital; - the median time from arrival to treatment. - the percentage of patients admitted, transferred, or discharged within four hours. - the monthly percentage of patients that left before being seen.	30/04/24	Closure form has started to be drafted by the Patient Safety Team but not complete. The action lead has been absent from work. To be presented at J2E on 24 July 2024.	Claire Hansen
63	The trust must ensure that in Maternity, fire risk assessments are up to date, thoroughly assessed and documented to meet best practice guidance. For example, they must ensure fire exits are clearly marked and have safe exit routes. They must ensure fire drills are completed regularly and audited.	29/03/24	Further assurance is needed for this action. Meetings in June have been held with the EPRR Lead for planned evacuation scenarios. Tabletop reviews are being scheduled with the Director of Midwifery.	Karen Stone
67	The trust should ensure midwifery staff complete their mentorship training to provide them the skills to facilitate preceptorship programmes to new students and newly qualified midwifes	30/04/24	Family Health Care Group has confirmed that the actions are complete. Awaiting for submission of the action closure form.	Karen Stone

Appendix B – Extensions Approved

Ref	Action	Target Date to Complete	Summary	Workstream Lead
3	The trust must ensure that the guidance within all policies is up to date, accurate and relevant to the service. This includes, but is not limited to: - The guidance within the workforce and equality diversity, and inclusion (EDI) - Freedom to speak up - Policies for transgender and non-binary people - Unacceptable behaviours from patients - Maternity Services	30/08/24	Original target date 29.12.23, extended 8.1.24 and 29.4.24 FTSU policy is in draft - this is the national policy but received comments at JNCC. Trans and Gender Policy is to be presented at Executive Committee 1.5.24 The exclusion guidance within the Violence and Aggression Policy (reference as unacceptable behaviours) is under review by the Director of Quality, Improvement and Patient Safety.	Dawn Parkes
4	The trust must demonstrate it supports its staff by challenging unacceptable behaviours and language. This includes, but is not limited to, racism and discrimination.	30/08/24	Original target date 29.12.23 The exclusion guidance within the Violence and Aggression Policy (reference as unacceptable behaviours) is under review by the Director of Quality, Improvement and Patient Safety.	Polly McMeekin
13	The trust must ensure that complaints are responded to in a timely way, result in further investigation if indicated and where possible involve family in the investigation.	28/06/24	Original target date 30.4.24 Whilst we have seen improvement especially in the complaints outstanding over 50 days over the last few months, looking at the analysis, we cannot demonstrate that complaints responses have significantly improved over the financial year. Another extension form is needed	Dawn Parkes
22	The trust should ensure disabled staff are protected in line with the Equality Act 2010 and have meaningful personal adaptation plans to ensure they are treated fairly; with dignity and respect they deserve.	30/08/24	Original target date 31.05.24 - Reasonable Adjustment policy drafted and awaiting approval. Assurance	Polly McMeekin
23	The trust must ensure that in Maternity and Medical Care, all staff are aware of and consistently follow the trust policy to safely store medicines including controlled drugs and controlled substances hazardous to health (COSHH). The trust must also ensure adequate action is taken following audits which identify medication storage issues.	29/03/24	Original target date 29.12.23 Discussed at J2E in June 2024 and lack of assurance around medicines management. Limited Assurance Internal Audit report in maternity and Tendable results not supporting closure.	Dawn Parkes

Ref	Action	Target Date to Complete	Summary	Workstream Lead
25	The trust must ensure that all staff groups in Medical Care, Maternity and Urgent and Emergency Services complete designated mandatory training sessions. Including: - Safeguarding, PREVENT, Adult Life Support and Advanced Life Support (MC York and Scarborough) - Theatre recovery training, practical obstetric multi-professional training and saving babies lives version 2 (Mat York and Scarborough) - ED Medical Staff, esp. Safeguarding, learning disabilities and dementia (Scarborough)	28/06/24	Original target date 31.1.24 For the areas and subjects listed, the Trust is on track to achieve the 85% compliance except in the following: • Adult Life Support (MC York and Scarborough) • Learning Disabilities and Dementia (ED Medical Scarborough) • Saving Babies Lives version 2 (Mat York and Scarborough) As a multi-stranded action, the subjects which are outstanding are all at different stages; but the one which will take longest to reach its target and then sustain compliance for three-months is Adult Life Support in Medicine (119 further completions needed + maintain existing level) – the requested deadline has been selected on that basis	Dawn Parkes
27	The trust must continue to ensure patients nutritional and hydration needs are met and this is confirmed through the Malnutrition universal screening tool (MUST) auditing process. The Urgent and Emergency Care services must ensure ED and SDEC staff fully and accurately complete patients' fluid and nutrition charts and offer patients drinks, especially long waiters, and those in recovery.	29/11/24	Original target date 30.04.24 Impact measure not achieved for compliance with MUST. Ongoing action led through the Nutrition and Hydration Improvement Group and the Quality Assurance Framework.	Dawn Parkes
56	The trust should ensure that patients on the acute stroke ward 23 received their daily 45 minutes of rehabilitation.	30/08/24	Original target date 31.01.24 The refurb of ward 23 has been delayed - rehab facilities are within the ward plans	Dawn Parkes
61	The trust should consider identifying dedicated rehabilitation and kitchen areas for use when undertaking patient assessments on the acute stroke ward.	30/08/24	Original target date 30.04.24 The refurb of ward 23 has been delayed - rehab facilities are within the ward plans	Dawn Parkes
69	The trust must ensure that in Maternity, persons employed receive such appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform.	29/11/24	Original target date 29.12.23 Training plan agreed and underway. Assurance on delivery needed, including appraisal rates.	Karen Stone

Ref	Action	Target Date to Complete	Summary	Workstream Lead
71	The service must implement an effective system to assess and monitor compliance to ensure the baby tagging process is adhered to in line with trust policy.	28/06/24	Original target date 31.1.24 X tag in place at York and Hugs at Scarborough. Incidents have been raised which include babies not having a tag in place. Daily assurance checks are being undertaken within maternity and will be added once compliance can be evidenced.	Karen Stone

Appendix C - Extensions Awaiting Approval

Ref	Must / Should	Action	Original Target Date to Complete	Summary	Workstream Lead
10	Must	The trust must ensure there is full clinical engagement to support operational performance and that challenges are resolved with a focus upon patient safety across the organisation.	30/04/24	Closure form presented at J2E on 24 June 2024 but not approved for closure. Requested that an extension form be completed. Further six months needed.	Claire Hansen
12	Must	The trust must ensure ongoing patient safety concerns such as falls, pressure ulcers and healthcare care acquired infections are addressed in a timely way and all possible actions are taken to address concerns.	29/03/24	Original target date 29.3.24 Part A of the form relating to fundamentals of care was approved for closure. Part B linked to IPC performance was not due to performance. Awaiting IPC update for extension form.	Dawn Parkes
14	Must	The trust must ensure that attendance to patient 'fundamental care needs' are met, including getting enough help to wash or keep clean and to eat meals, as well as being able to get help from staff when needed.	29/03/24	Closure form was not approved at J2E 24 June 2024. Agreed that an extension form will be needed for impact measures - six month extension requested.	Dawn Parkes
28	Must	The trust must ensure that patients records are maintained securely (including records for patients on trolleys waiting in the Scarborough ambulance arrival corridor), are accurate, complete, and contemporaneous records maintained in respect of each service user in Medical Care and Urgent and Emergency Services.	31/01/24	Closure form presented at J2E on 24 June 2024 for closure but not approved until the issue with ED coding is resolved. Another extension is needed.	Dawn Parkes
30	Must	The trust must ensure that effective systems are in place In Medical Care and Urgent and Emergency Services to ensure staff adhered to the Mental Capacity Act, including the completion of Mental Capacity Act and DoLS training.	31/05/24	Original target date 31.05.24 and extension form has been drafted as the audit result are not giving assurance and MCA training for medical staff is not at 85%.	Dawn Parkes
33	Should	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.	31/05/24	Original target date 29.2.24 Assurance provided for the resus trolley checks in Medicine, but performance not at 100% in Maternity. Compliance checks are now being led by the Deputy Head of Midwifery	Dawn Parkes

Ref	Must / Should	Action	Original Target Date to Complete	Summary	Workstream Lead
35	Must	The trust must ensure that the urgent and emergency service improves compliance in sepsis screening, especially for patients receiving antibiotics within an hour. They must also ensure ED medical staff improve their overall training compliance rate in sepsis screening and all ED staff complete screening for patients at risk of sepsis (to better recognise and respond to warning signs of deterioration).	31/05/24	An extension request has been drafted and awaiting approval. The Sepsis screening rates have improved but other metrics, such as time for antibiotics, have not.	Claire Hansen
55	Should	The trust should ensure that in Medical Care at York, patients have venous thromboembolism (VTE) checks and risk assessments are completed and documented within the current trust protocol within 14 hours.	30/04/24	Original target date 30.11.23 Extension form drafted for review at J2E 8 July 2024. Trust compliance is at 45% for VTE assessment within 14 hours	Dawn Parkes
60	Should	The trust should ensure that patients discharge plans in medical care at York are commenced on admission to the service so that support is in place where needed on the patients discharge.	30/04/24	Extension form has been drafted and awaiting approval. Discharge Improvement Group overseeing programme with involvement from system partners.	Claire Hansen

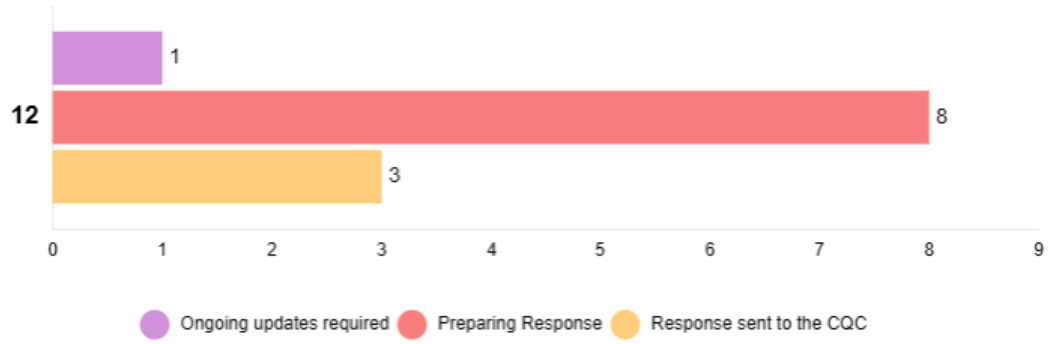
Appendix D – Closure Request Pending Approval

Ref	Must / Should	Action	Original Target Date to Complete	Summary	Workstream Lead
15	Must	The trust must gain assurance that learning from incidents and risks are shared within the organisation to prevent the risk of reoccurrence.	31/01/24	Additional assurance requested in the closure form by the Director of Quality, Improvement and Patient Safety. This is under review and scheduled to be presented on 22 July 2024.	Dawn Parkes
18	Should	The trust should ensure clear levels of responsibility and accountability for management of staff not employed by the trust for example York Teaching Hospital Facilities Management (YTHFM) staff.	30/04/24	Discussed at J2E on 24 June 2024. Agreed that action can be closed. Closure form scheduled for 22 July 2024.	Polly McMeekin
24	Must	The trust must ensure that in Maternity and Medical Care, an effective system is implemented to assess, monitor, and drive improvement in the quality and safety of the services provided. They must demonstrate improvements in patient outcomes to be in line with national guidance and benchmark against a similar sized service.	30/04/24	Closure form drafted and awaiting approval. Scheduled for 22 July 2024.	Dawn Parkes
37	Must	The trust must ensure Urgent and Emergency Care service leads take action to improve their performance in the royal college of emergency medicine (RCEM) standards and develop a robust action plan from the 2020-21 results.	29/02/24	The EAU Governance & Quality Improvement Lead, Scarborough Hospital is meeting with the Director of Quality, Improvement and Patient Safety 8 July 2024 to review assurance paper.	Claire Hansen
39	Should	The trust should ensure the urgent and emergency service at Scarborough does not contravene their SOP for the care and treatment of patients whilst in an ambulance.	31/05/24	Associate Chief Nurse has provided evidence for the closure form and is being collated by the Patient Safety Team.	Claire Hansen
40	Should	The trust should ensure ED staff recognise or make reasonable adjustments to meet patient needs such as those with mental health issues or anxiety. ED staff must complete all sections of risk assessments for patients who show signs of mental ill health. They should consider revising this documentation's length to improve staff compliance	28/06/24	Original target date 29.12.23 The UEC electronic screening tool is in place at Scarborough ED and went live in York 30 April 2024. Dashboard to be produced to show compliance with the assessment and the care plans. Closure form drafted.	Claire Hansen

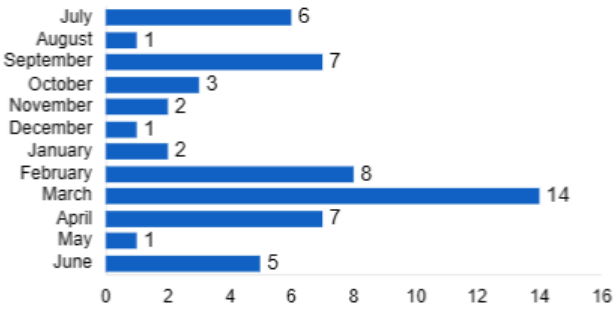
Ref	Must / Should	Action	Original Target Date to Complete	Summary	Workstream Lead
73	Must	The trust must ensure both Maternity theatres are serviced, maintained, and fit for purpose in line with best practice guidance.	31/07/24	Original target date 29.2.24 Theatre one complete and closure form approved by the Medical Director and due at J2E 4 July 2024.	Karen Stone

Appendix E
CQC Cases / Enquiries (1 July 2023 to 30 June 2024)

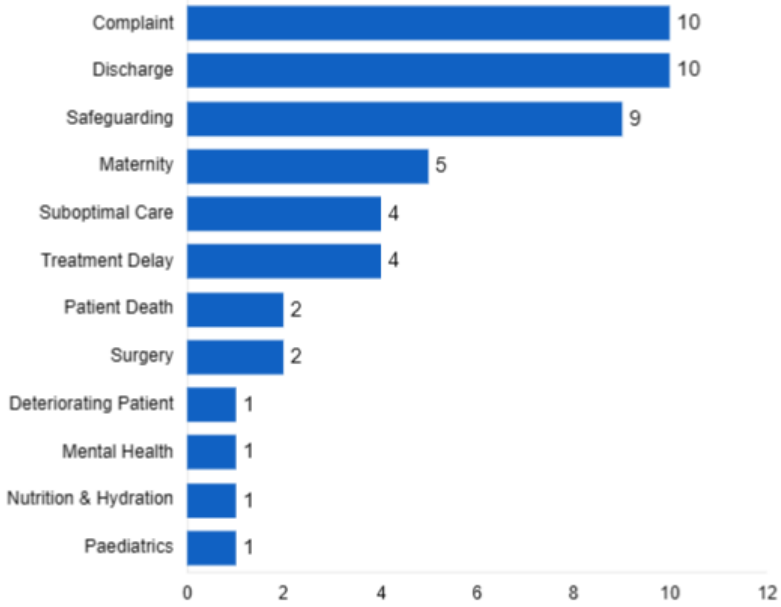
Number of Open CQC Enquiries / Cases



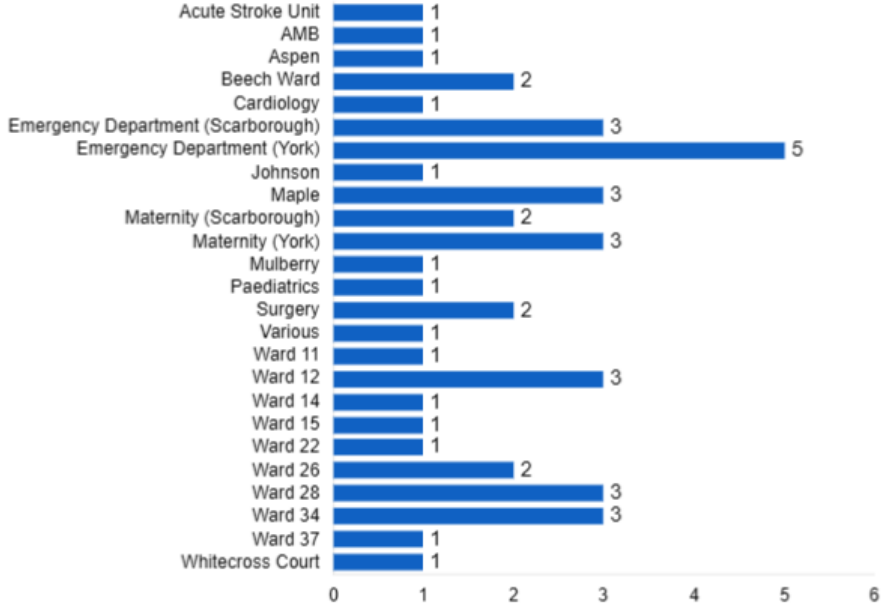
Number of Enquiries Received



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Report to:	Trust Board
Date of Meeting:	31 July 2024
Subject:	Maternity Neonatal Safety Report
Director Sponsor:	Dawn Parkes, Chief Nurse (Maternity Safety Champion)
Author:	Sascha Wells-Munro, Director of Midwifery and Strategic Clinical Lead for Family Health

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 a monthly update on key quality and safety metrics for the services for the month of May 2024.

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

Report History
The Quality Committee

Meeting	Date	Outcome/Recommendation
Quality Committee	23/07/24	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 review and monitor improvements in key quality and safety metrics.

Annex 1, provides the current delivery position for the service against the core national safety metrics. In May 2024 there was one neonatal death at 18 weeks gestation, and this will be reviewed using the National Perinatal Mortality review tool.

There was a maternal death that sadly occurred nine weeks into the postnatal period. The woman was visiting Scarborough on holiday and due to this a full investigation is being undertaken across specialties and maternity units involved in her care, to ensure all aspects of care are reviewed and all learning opportunities are identified and shared with the family if they should wish to receive them.

There has been a decrease in the percentage of postpartum haemorrhage over 1500mls to 3.0% (10 cases) from the previous month of 3.6 % (11 cases). This remains above the national target of 2.9% per 1000 births. A multi-professional focus group continues and a thematic review of 49 cases from November 2023 to the end of April 2024 has been undertaken. The findings of this review have been presented to an MDT cluster review meeting and the following actions and themes have been identified and therefore further supports the Quality improvement work being undertaken.

- Ensure all women have a week 28 full blood count taken and is recorded and acted upon where needed if the haemoglobin is not within normal limits
- Review of the postpartum haemorrhage proforma to aide clinical action in appropriate sequential order
- Review of the clinical guideline for the timing of the use of Oxytocin infusion for induction of labour
- Review the timeliness of suturing of the perineum post-delivery and the skills of midwives to undertake the procedure.
- Undertake a documentation audit to ensure all elements of care are recorded contemporaneously.

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

Annex 2, provides the May 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.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

An initial review of the maternity and neonatal single maternity improvement plan has been undertaken to identify those improvements that can be progressed within existing resources and where support can be provided by Operational and Project Management Teams as well as other specialities and departments in the organisation. A fuller review is underway to prioritise improvements in order of clinical quality and safety. This will be presented in full to the Trust Board in September along with the outcomes of the actions agreed at the trust board in June.
These were.

1. Review efficiencies for mandatory and statutory training across the total workforce to release funded hours to contribute to the financial requirement for increasing workforce.
2. Review the overspend in Maternity for 2023/24.
3. Review the run rate for bank and agency usage in Maternity for 2023/24, and consider conversion to substantive posts.

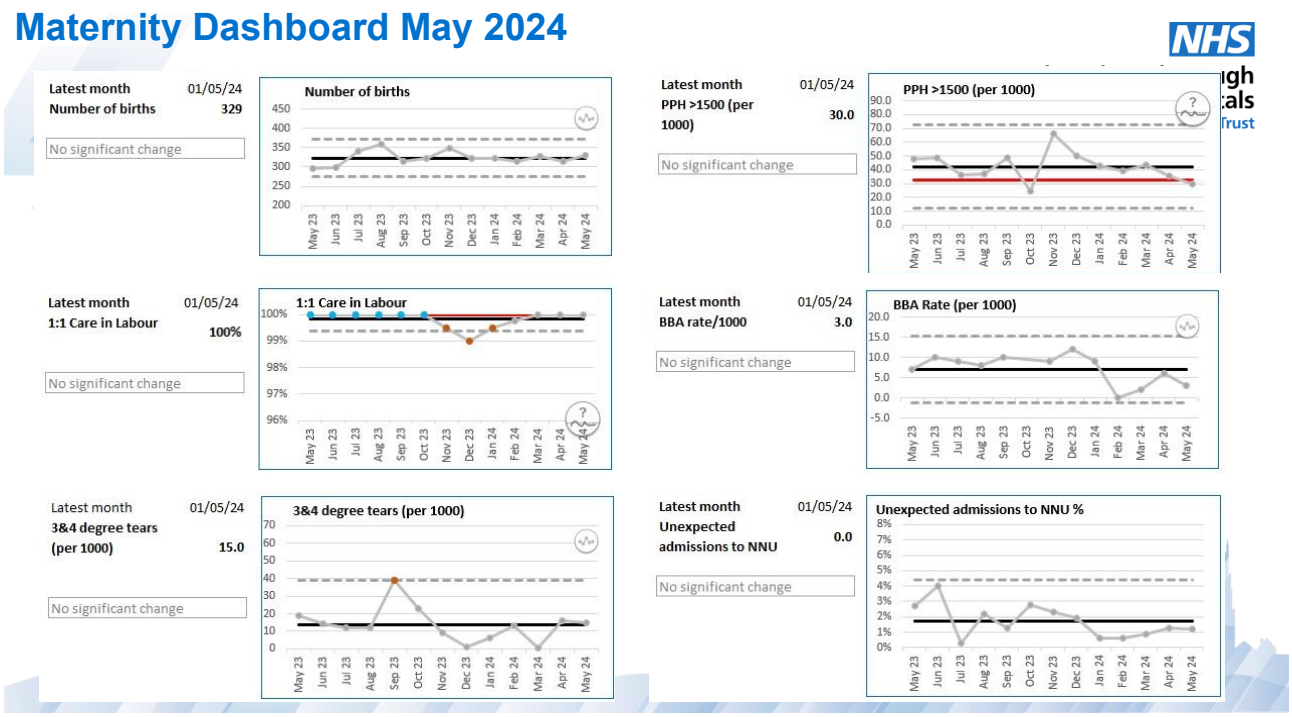
4. Ensure all new specialist midwife roles recommended by NHSE are reviewed for a system-wide approach.
5. Update the corporate risk register for Maternity service's risks.
6. Add each element of the maternity and neonatal equality and quality impact assessment to the speciality risk register.
7. Review the provision of theatre scrub nurses for caesarean sections against recommended national best practice standards and scope opportunities for releasing of previously funded posts to ward-based midwives.

The ability to undertake key actions is becoming more difficult due to the lack of capacity in the teams both clinically and non-clinically, due to operational challenges and the need to apply mitigations daily to ensure the safety of services and care provided to women and families.

Recommendations to Trust Board

To note the contents of this report and agree the CQC section 31 submission in addendum 2

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



Report to:	Quality Committee/Trust Board
Date of Meeting:	23 July 2024
Subject:	CQC Section 31 Update
Director Sponsor:	Dawn Parkes - 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 July 2024 monthly submission to the CQC which provides assurance on progress and impact on outcomes in May 2024.

Report History

Meeting	Date	Outcome/Recommendation

CQC Section 31 Progress Update: July 2024

Maternity Services at York and Scarborough NHS Teaching Hospitals 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 May 2024 are outlined below.

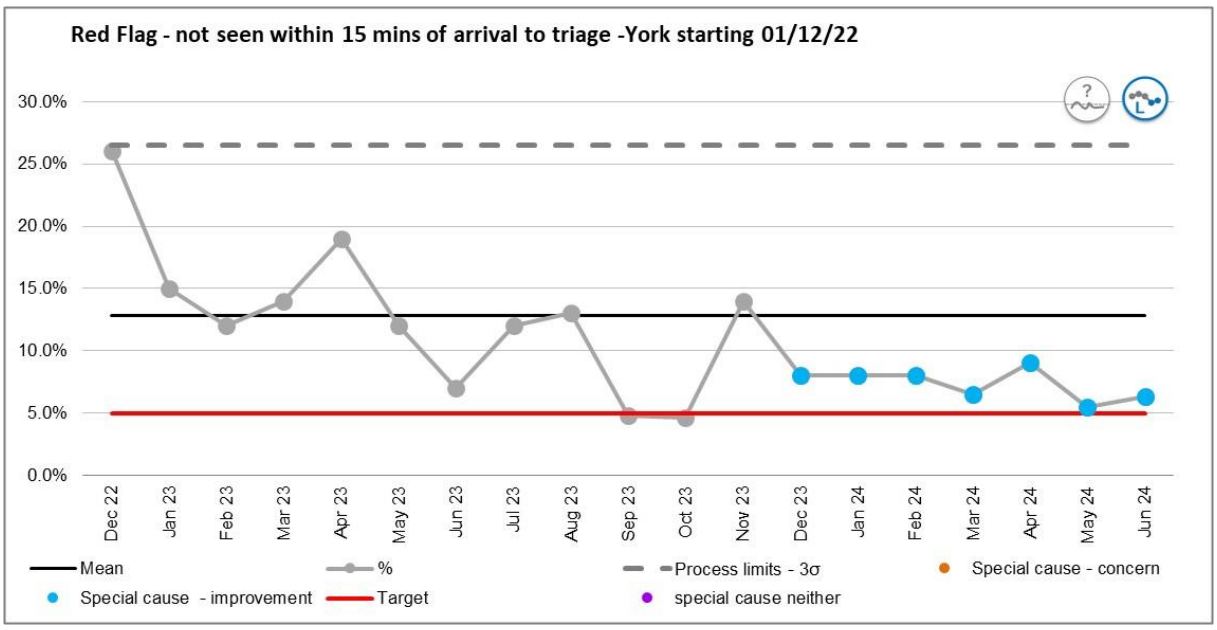
Staff Group	York	Scarborough
Midwives	95% (176/186)	89% (63/71)
Consultants	93% (14/15)	88% (7/8)
Obstetric medical staff	88% (14/16)	83% (10/12)

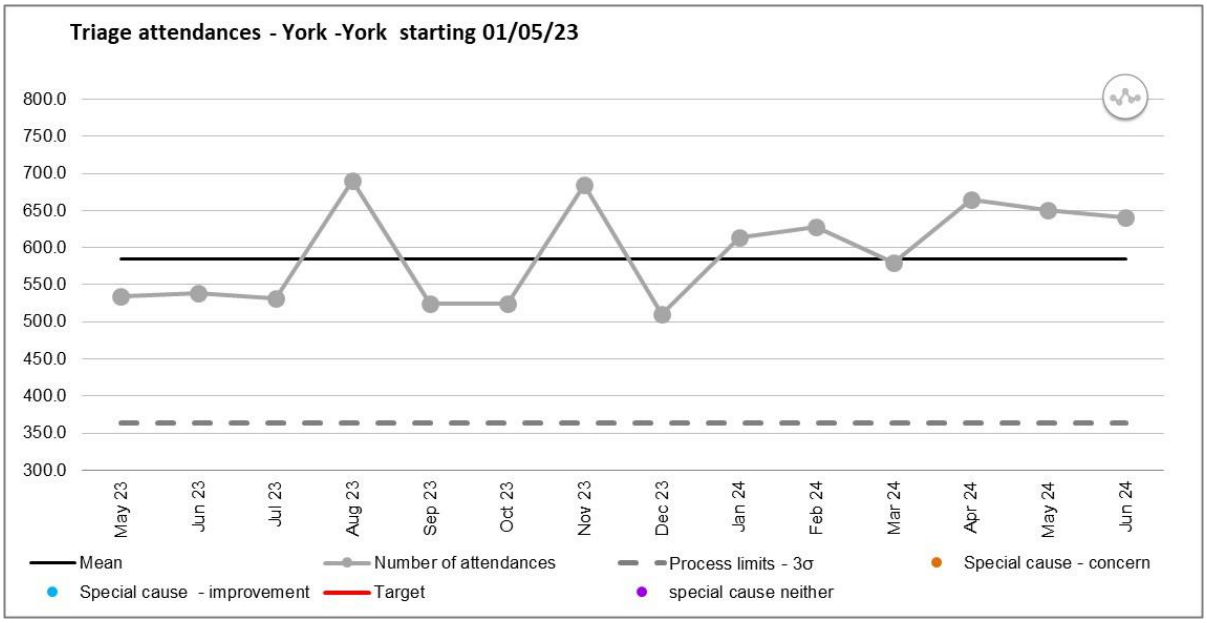
Members of the obstetric medical team are booked onto sessions in May and June 2024 and projections indicate the required compliance of 85% will be maintained into Q2 of 2024.

A.4 Assessment and Triage

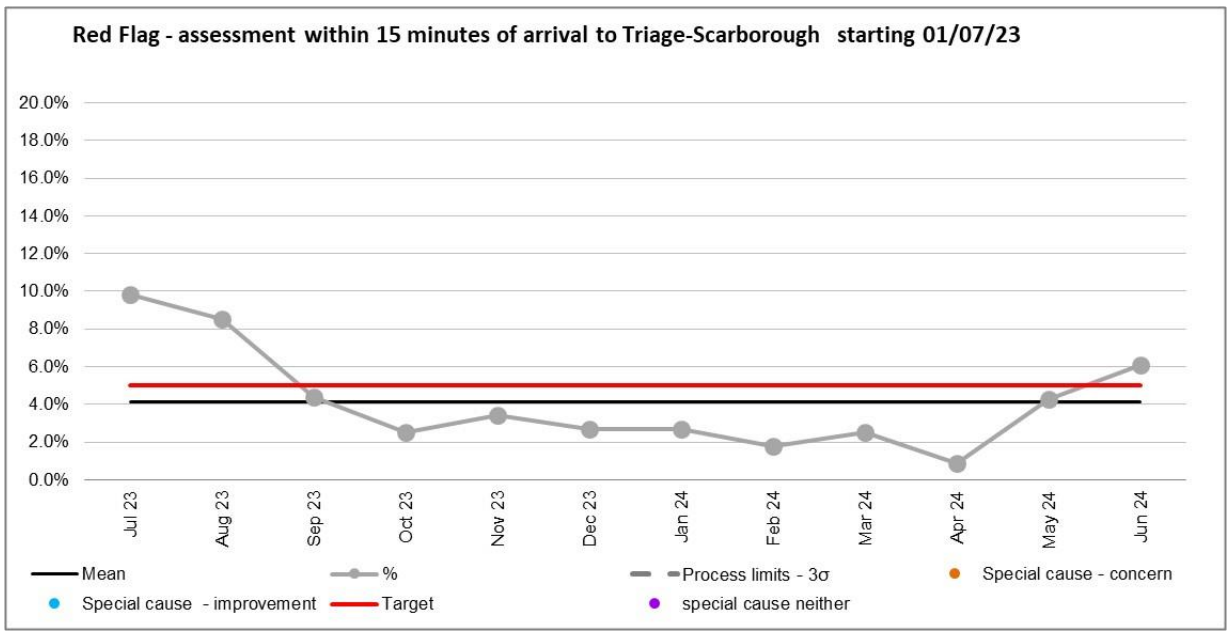
On the 12 May 2023, the Birmingham Symptom Specific Obstetric Triage System (BSOTS) Triage system went live at York Hospital and partially from 3 July 2023 at Scarborough. The triage system is part of the BadgerNet software, the system facilitates the prioritisation of women based on needs.

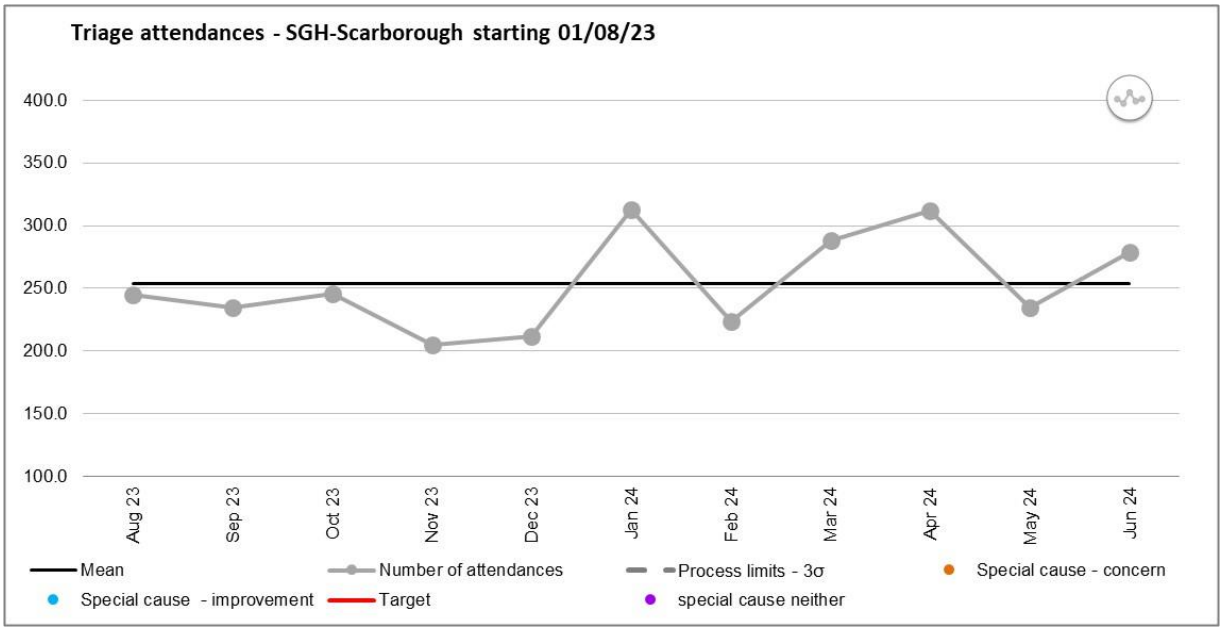
Collaboration has commenced with the communications team in relation to Telecoms. This is a phone system that tracks and provides a call queue to ensure women are getting through to triage as opposed to other clinical areas. This will ensure that all other non-urgent calls do not block triage line for women. Due to absence in the telecoms team, this has not made as much progress due to other priorities across the trust This has been escalated to Deputy Chief Digital Information Officer.





Doctor wait times were unable to be calculated due to the lack of information available on Badgernet.

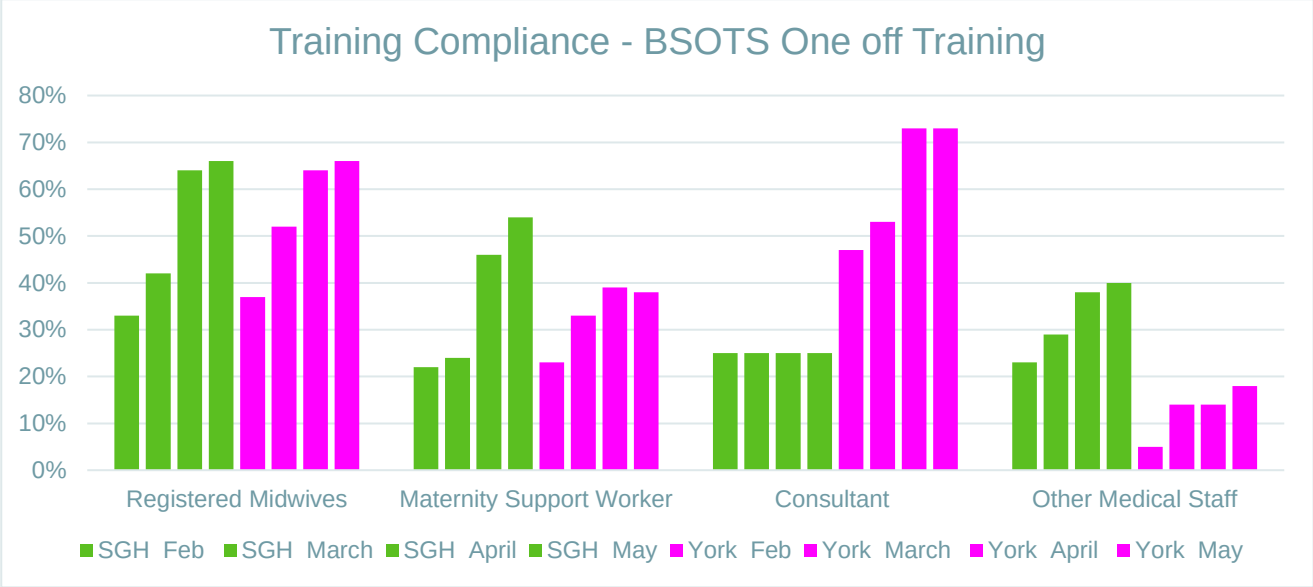




On 15th January 2024, Scarborough commenced the use of a dedicated triage area next to the Maternity Ward to support the full implementation of BSOTS. Recruitment has not been as successful as anticipated. The HCA/MSW vacancy has been filled and we are awaiting start dates for these staff.

Staffing capacity remains a challenge across the Scarborough site due to a vacancy factor of circa 8 WTE which has resulted in Triage closing on numerous occasions and being moved to delivery suite. The service contniue to work wth the national leads for BSOTS for advice and guidance.

The Yorkshire Audit into Maternity Triage showed limited compliance with training and varied documentation on BadgerNet. Compliance to date is demonstrated below and is reported through the Maternity Assurance Group.



Documentation Audit - May 2024	
DR Specialist review	Documented in the correct place
York	100%
SGH	0%
	50%

B. Governance and Oversight of Maternity Services

B.1 Post-Partum Haemorrhage (PPH)

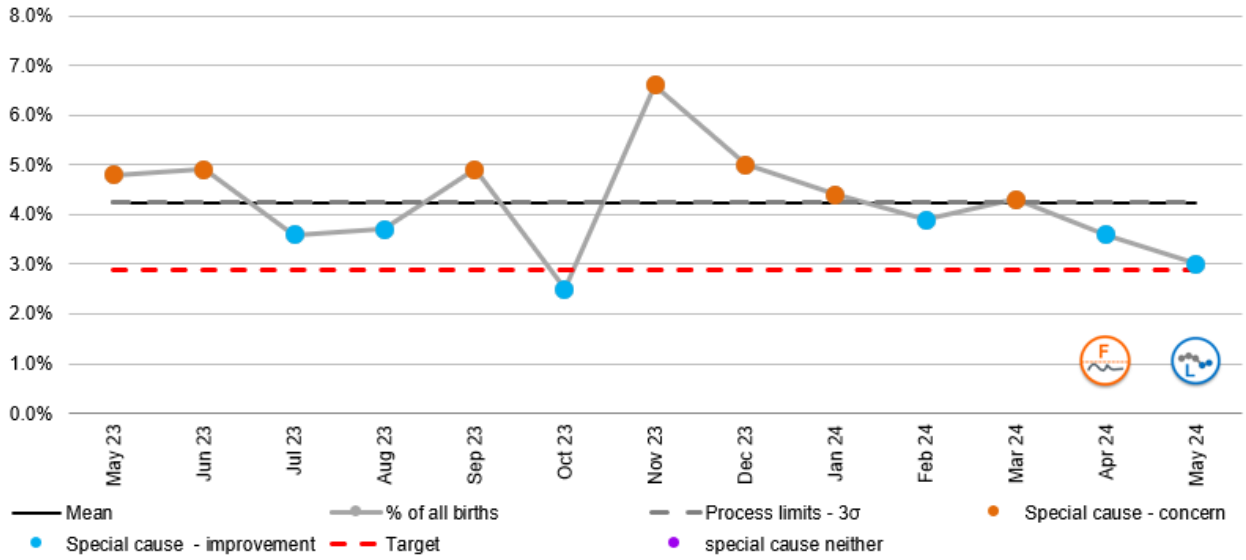
PPH over 1.5 litres

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

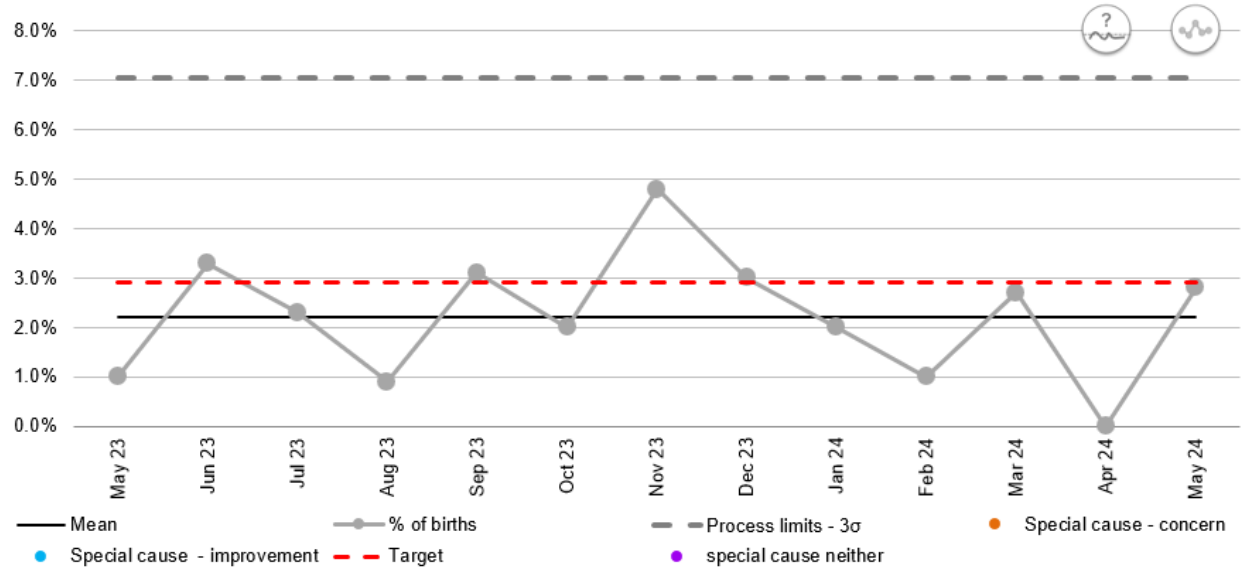
Blood Loss	Number in April 2024
1.5l – 1.9l	4 (range 1.5l – 1.9l)
2l – 2.4l	2 (range 2l – 2.4l)
> 2.5l	4 (2.6l – 4l)

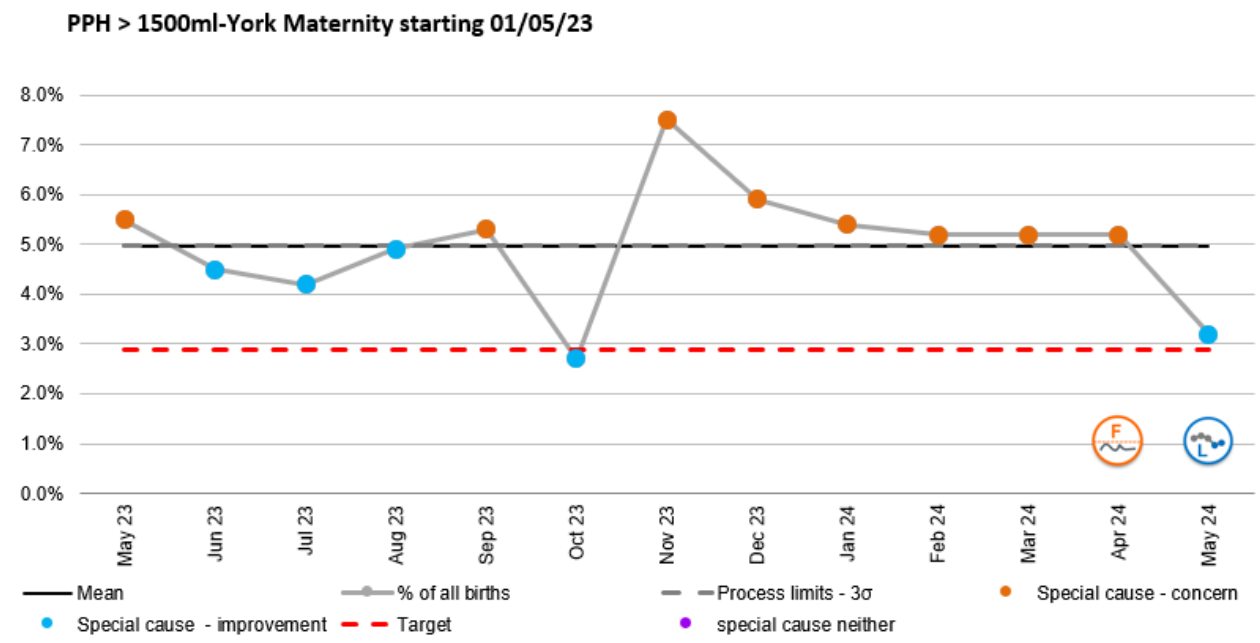
There has been a steady decrease in the PPH rate across both sites since November 2023. There has been detailed analysis into all PPH over 1500ml that occurred between January and April 2024, the outcome of this will be included in further reports.

PPH > 1500ml-Trustwide Maternity starting 01/05/23

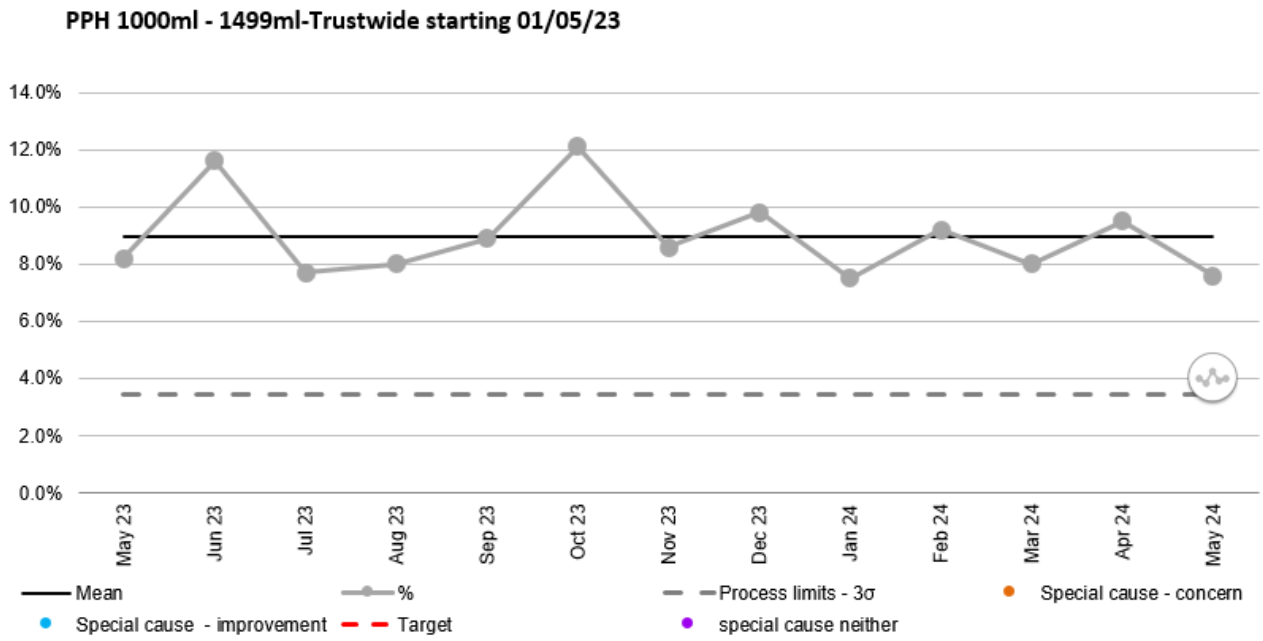


PPH > 1500ml-Scarborough starting 01/05/23





PPH between 1000ml – 1499ml



Following the thematic cluster review of 49 cases from November 2023 to April 2024 and the following MDT roundtable to review the findings the following actions have been agreed.

- Ensure all women have a week 28 full blood count taken and is recorded and acted upon where needed if the haemoglobin is not within normal limits
- Review of the postpartum haemorrhage proforma to aide clinical action in appropriate sequential order
- Review of the clinical guideline for the timing of use of Oxytocin infusion for induction of labour

- Review the timeliness of suturing of the perineum post-delivery and the skills of midwives to undertake the procedure.
- Undertake a documentation audit to ensure all elements of care are recorded contemporaneously.

B.2 Incident Reporting

There were 18 moderate harm incidents reported in May 2024.

Datix Number	Incident Category	Outcome/Learning/Actions	Outcome
16782 16778 16973 17243 17364 17362 17711 17766 17894	PPH >1500ml	Cluster review to be completed in July 2024, this will link with the PPH QI project	Awaiting the outcome of the review to inform QI projects
16906 17858	Postnatal readmission	Reviewed at the Maternity Case Review meeting	Learning identified and shared
16519 17150 17760	3rd degree tear	To be included in the quarterly perineal tear audit	Audit to be shared in Guideline and Audit meeting in Q2
16864 17349 17669	Care issues identified	Reviewed at the Maternity Case Review meeting	Learning included in the weekly safety brief
17875	Maternal Death	Reported to MRRACE-UK	Awaiting cross LMNS review meeting

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. The renovation of theatre 1 was completed in May 2024 with work starting on theatre 2 at the beginning of June 2024, work is expected to be completed in six weeks.

There is a daily audit of baby tags by the Ward Managers on both sites and forms part of the weekly and monthly tendable audits. Where there is no compliance and tags are not used due to parental request this is followed up with each individual midwife. The estates team undertake monthly testing of the baby tagging equipment to ensure the system 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 Capital Project team will be working with the operational and security teams during June to complete this project. Until this work is completed, the use of Hugs tags continues to be effective at Scarborough.

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. There have been three new practitioners join the team in May and June and 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. A full review of the remaining vacancy factor and opportunities to review the scrub nurse provision as outlined in national best practice standards versus the ongoing risk and pressures in maternity services, will be undertaken collaboratively across both surgery and maternity services.

Report to:	Board of Directors
Date of Meeting:	31 July 2024
Subject:	Emergency Planning Resilience and Response (EPRR) – Core Standards Action Plan Progress Report
Director Sponsor:	Claire Hansen
Author:	Richard Chadwick – Head of EPRR

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

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

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

Summary of Report and Key Points to highlight:

The Board is asked to:

- Note the progress made in addressing the actions to achieve a greater level of compliance with EPRR Core Standards since Mar 24.
- 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:

The Board is requested to:

- To note the progress of the EPRR Core Standards Action Plan for this quarter.

Report History

Resource Committee – 16 Jul 24

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board of Directors
Date of Meeting:	24 July 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

Summary of Report and Key Points to highlight:

The Board is asked to:

- Note the progress made in addressing the actions to achieve a greater level of compliance with EPRR Core Standards since Mar 24.
- 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:

The Board is requested to:

- To note the progress of the EPRR Core Standards action plan for this quarter.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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 63 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	7				
	(A)		1					
	(R)	10	3	3				
Risk Assessment	(G)		1	2				
	(A)							
	(R)	3 (4)	2	2				
Duty to Maintain Plans	(G)		4	6				
	(A)		3	2				
	(R)	14	7	6				
Command & Control	(G)		3	**Completed**				
	(A)		0					
	(R)	3	0					
Training & Exercising	(G)		2	2				
	(A)		2	2				
	(R)	4						
Response	(G)		2	2				
	(A)		2	2				
	(R)	5	1	1				
Warning & Informing	(G)			1				
	(A)							
	(R)	2	2	1				
Cooperation	(G)		2	2				
	(A)			1				
	(R)	4	2	1				
Business Continuity	(G)		3	4				
	(A)		3	4				
	(R)	11	5	3				

[1] Note that the number of standards in each domain do not relate to the number of actions required in each domain. Since the Mar 24 report one further action has been added to the action plan (Risk Assessment) on the direction of the EPSG.

CBRN	(G)		2	3				
	(A)			3				
	(R)	6	4					

4. Points to Note From the Last 3 Months

Since the last report the committee should note:

- **New Task.** The Emergency Planning Steering Group (EPSG) has agreed that the EPSG Risk Register is to be hosted on the Corporate Operations Risk area on DATIX to align risk management with the Trust. Work is underway to migrate the register.
- **Training Needs Analysis (TNA).** The TNA has been written and is currently on circulation for comment. The TNA has identified recommended learning for staff cohorts and what training can be hosted on Learning Hub. The EPRR Team are now in consultation with Learning Hub to develop the EPRR training site.
- **Health Commander Personal Development Portfolios (PDP).** Health Commander PDPs have been issued to On Call staff with direction on what competency requirements are applicable to each cohort.
- **Information Sharing Agreement (ISA).** An ISA has been drafted for implementation with the ICB and other Healthcare partners in the event of a critical or major incident declaration. The ISA is due to be signed off at the next Local Healthcare Resilience Partnership meeting.
- **Business Continuity.** The Emergency Planning Manager (EPM) has recently completed a Business Continuity Course at the National Emergency Planning College.

5. 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. Mitigation measures for this risk include:
    - A QIA has been prepared relating to a Band 7 EPRR Training Manager being established to deliver the training articulated in the Training Needs Analysis and also for a Band 4/5 Emergency Planning Officer to assist with CBRN and departmental training on the York site.
    - Pending the consideration of the QIA the EPRR Team are re-prioritising work schedules to ensure critical training does take place. The EPSG routinely oversee the EPRR work schedule priorities on a quarterly basis.
- **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. Mitigation measures for this risk include:
    - Training and exercising is targeted at senior managers and clinicians to minimise disruption on the shop floor. Where operation procedures are required to be tested then longer lead in times to roster staff to activity are considered.

- Work is ongoing to develop training packages that can be delivered on Learning Hub maximise the time staff can take to conduct online training and prevent disruption to services.
- Activity conducted when responding to incidents is being recorded on logs to minimise the need for training and exercising events.

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. Mitigation measures for this risk include:
  - The EPSG oversee the EPRR work schedule as a standing agenda item on a quarterly basis.
  - The Lessons Identified process is extensively used to learn from incidents, share improvement plans and to audit allocated actions.
- **Business Continuity.** The Emergency Planning Manager (EPM) has identified that the delivery of Business Impact Analyses and Business Continuity Plans to departmental level will require a bespoke project that may take 12-24 months to complete. Mitigation measures for this risk include:
  - The EPM has been tasked with writing a project plan for approval at the Emergency Planning Steering Group (EPSG). The plan will include the governance and assurance required to complete the project whilst providing regular progress reports to the EPSG.

Appendix:

1. EPRR Core Standards Assurance – Action Plan 2023-2024.

Date: 09 Jul 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. (G) 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 inclded 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. (G)	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.

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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. (G) 12A - EPSG decision made to transition EPRR Risk Register to DATIX as part of the Corporate Risk area. CR to speak with KH to determine methodolgy for migrating the risks to DATIX. Target completion Dec 24. (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 Q3 - 24	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. 12A (03/07/24) - New task as directed by EPSG.
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. (G)	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. 16 (03/07/24) - Plans and A-Ms now established. Only missing documents are those that will requiring drafting in the future.
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. (G)	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. 19 - (03/07/24) HCID SOP enacted at SGH - see leassons learnt report. HCID High Fidelity training taking place on 15/07/24).

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. (A)	CR RC	Q3 - 24 Q4 - 24	22 - 03/07/24) - RC initiated consultation at York Integrated Emergency Planning Gro
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 - 24	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 - 24	
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 - 25	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 individual 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 CR	Q3 - 23 Q3 - 24	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 **this 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 - 24	37 (03/07/24) - CONFIRMER Test scheduled for Sep 24. Loggist testing will be incorporated off the back of this test.
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. (G)	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 comms 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							

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37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	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. (A)	CR	Q3 - 24	44 - (03/04/2024) CR to contact LC-P to determine the deadlines for the ICB led work on a common ISA.

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44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G			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 Annex, 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	46 / 46A / 47 (03/07/24) - Standalone Project required to deliver BIA / BCP framework from Trust to Dept. CR to write project delivery strategy. Timelines agreed as follows: Trust / BRONZE BIAs by Dec 24, BCPs by Mar 25. Dept BIAs by Mar 26, BCPs by Oct 26.
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 / 49 (03/07/24) - See above.

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 resolve 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. (A)	RC / CR	Q2 - 24	53 - Link to Action 8. (07/02/2024) - Action tracking process is required 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)	CR	Q2 - 24	54 - (07/02/2024) List of approved suppliers already in evidence folder. Needs annual review.

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55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G			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. (A)	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. (G)	RC	Q4 - 24	56 (03/07/24) - EM-S conducted dip audit of rotas and confirmed availability of trained staff. Include work in Core Standards.
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. (A) 58 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (A)	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. **This 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.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	31 July 2024
Subject:	Board Assurance Framework Q1 Report
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 Q1 2024/25 Board Assurance Framework.

Recommendation:

The Board of Directors is asked to approve the Q1 2024/25 Board Assurance Framework.

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

Meeting	Date	Outcome/Recommendation

Board Assurance Framework Q1 Report

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 Q1 2024/25 following review by the Executive Director owners.

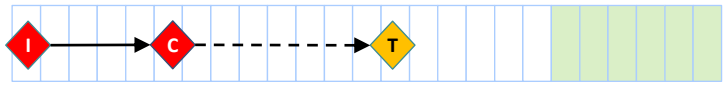
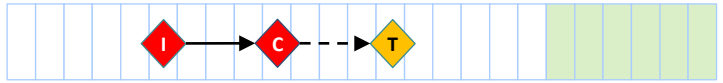
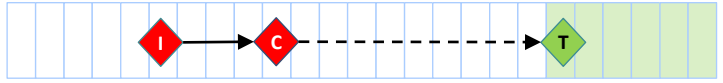
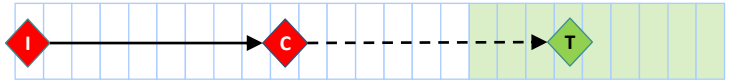
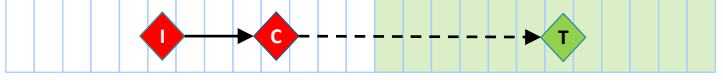
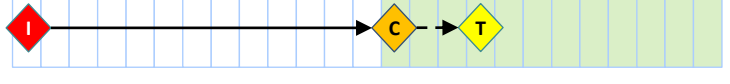
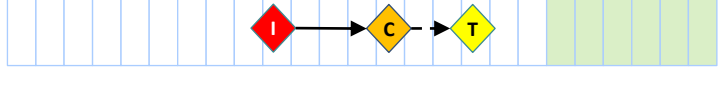
The BAF will subsequently be reviewed during 2024/25 via the Risk Committee and reported to the Board Committees for deep dive assurance.

4. Next Steps

The BAF will next be reported at the October Board of Directors meeting.

2024/25 Board Assurance Framework

York and Scarborough Teaching Hospitals NHS Foundation Trust

Rank/Move		High Level Risk Description	Risk Assessment (Catastrophic / Major / Moderate / Minor / None)	Risk Rating	Actions	Owner	Oversight
1	N	PR2 – Inability to provide safe and effective care		20	0 0 1	Medical Director	Quality Committee
2=	N	PR3 - Failure to deliver constitutional/regulatory performance and waiting time targets		16	0 0 1	Chief Operating Officer	Resources Committee
2=	N	PR1 – Unable to deliver treatment and are to the required standard		16	0 0 3	Chief Nurse	Quality Committee
2=	N	PR5 – Financial risk associated with delivery of Trust and System strategies		16	0 0 1	Director of Finance	Resources Committee
2=	N	PR8 – Failure to achieve net zero targets, air quality targets and changing climate adaptation requirements from the Health and Care Act 2022 and Humber and North Yorkshire ICS Green Plan		16	0 0 3	Director of Finance	Resources Committee
3=	N	PR4 – Inability to manage vacancy rates and develop existing staff predominately due to insufficient domestic workforce supply to meet demand		12	0 0 3	Director of Workforce & OD	Resources Committee
3=	N	PR6 – Failure to deliver safe, secure and reliable digital services required to meet staff and patients needs		12	0 0 1	Chief Digital & Information Officer	Digital Sub-Committee
4	N	PR7 – Trust unable to meet ICS expectations as an acute collaborative partner		6	0 0 1	Chief Executive	Executive Committee

Key

N New Risk

Increase in Rank

Decrease in Rank

No movement in Rank

I Inherent Risk - The measure of risk before controls are considered

C Current Risk - The measure of risk after controls are considered

T Target Risk - The measure of risk once actions have been completed

Reliance on controls

Planned mitigations

1 Action on track

1 Action delayed by 1-2mths

1 Action delayed by 3mths+

Risk Appetite

Minimal - 6
Cautious - 9
Open - 12
Hungry - 20

Summary of Risks by objective

Strategic Objective: Quality of Care – To provide timely, responsive, safe accessible, effective care at all times

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR1	Unable to deliver treatment and care to the required standard	Chief Nurse	Quality Committee	5	4	20	4	4	16	6 LOW	OUT	2	3	6	New Risk 2024/25

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR2	Inability to provide safe and effective care	Medical Director	Quality Committee	5	5	25	5	4	20	6 LOW	OUT	4	3	12	New Risk 2024/25

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR3	Failure to deliver constitutional/regulatory performance and waiting time targets	Chief Operating Officer	Resources Committee	5	4	20	4	4	16	6 LOW	OUT	4	3	12	New Risk 2024/25

Strategic Objective: Our People – To create a great place for our people to work, learn and thrive

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR4	Inability to manage vacancy rates and develop existing staff predominately due to insufficient domestic workforce supply to meet demand	Director of Workforce & OD	Resources Committee	5	5	25	3	4	12	12 OPEN	IN	3	3	9	New Risk 2024/25

Summary of Risks by objective

Strategic Objective: Research, Innovation and Transformation – Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6	Failure to deliver safe, secure and reliable digital services required to meet staff and patient needs	Chief Digital information Officer	Digital Sub-Committee	4	4	16	4	3	12	6 LOW	OUT	3	3	9	New Risk 2024/25

Strategic Objective: Sustainability – To use the resources to deliver healthcare today without compromising the health of future generations

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR8	Failure to achieve net zero targets, air quality targets and changing climate adaptation requirements from the Health and Care Act 2022 and Humber and North Yorkshire ICS Green Plan	Director of Finance	Resources Committee	5	4	20	4	4	16	12 OPEN	OUT	2	3	6	New Risk 2024/25

Strategic Objective: Governance and Finance – To be well led with effective governance and sound finance

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR5	Finance risk associated with delivery of Trust and System strategies	Director of Finance	Resources Committee	5	5	25	4	4	16	10 CAUTIOUS	OUT	3	2	6	New Risk 2024/25

Strategic Objective: Our Partnerships – To work together with partners to improve the health and wellbeing of the communities we serve

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR7	Trust unable to meet ICS expectations as an acute collaborative partner	Chief Executive	Executive Committee	3	3	9	2	3	6	12 OPEN	IN	2	3	6	New Risk 2024/25

Ref PR1 Board Assurance Framework (BAF)

Ref: PR1	Strategic Objective: Quality of Care	**PRINCIPAL RISK 1:** Unable to deliver treatment and care to the required standards.	Risk Score: 16

Causes – What must 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

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	5	20	4	4	16	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	16	TBD	TBD	TBD
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
Internal effectiveness reviews against national standards	- Clinical Effectiveness Reports - Accreditation Status Reports	Oversight of establishments	Schedules detailing capital investment needs	Annual Capital Programme Approval	April 2024 Board approved plan
Review of data from national surveys e.g. NICE, NSF	Monthly minutes of: Clinical Outcomes Effectiveness Group & Patient Safety Clinical Effectiveness Group	Monitoring of staffing levels (temp/perm)	- Q1 TPR Board and Committee reporting - Q1 Monthly Agency Usage reporting to Executive Committee	Monitoring and reporting against the capital programme	- Q1 CPEG, Resources Committee reporting and minutes - Q1 TPR Board and Committee reporting
Implementation of Clinical Standards	Q1 24/25 Board and Quality Committee reporting; Maternity, Nurse Staffing, IPC	Monitor Bank Training Compliance	Q1 Bank Training Compliance Care Group Reports; Non-Medical X, Medical Y		
Professional Standards Doctors Revalidation	Annual Board Revalidation Report Sept 2023 *Gap – Revalidation links to appraisal*	Operational Plan Implementation	Q1 Care Group weekly operational meeting minutes		
Performance Management Framework	- Q1 TPR Board and Committee reporting - Q1 PRIMs for each Care Group	Effectiveness of waiting lists monitoring	Risk Stratified elective waiting lists implementation		
Implementation of Workforce & OD Strategy	- Q1 TPR Nurse Staffing reporting *Gap - Poor diversity in leadership positions*	Capital planning process (Trust and Estates Strategy)	- Q1 Capital Programme Executive Group (CPEG) monitoring minutes - Q1 Business Planning schedules		

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Recruitment	55 target (including 15 specialist roles for adult inpatient areas) , Apprenticeships initiatives underway and fully supporting staff using national CPD funds	Polly McMeekin	March 2025
Culture Change (Retention)	Implement Equality, Diversity and Inclusion Gap Analysis, Our Voice Our Future programme commenced June 2023 and Visibility Programme launched July 2023	Simon Morritt	June 2025
Wellbeing space development	Utilisation of charity funds to implement	Polly McMeekin	March 2025

Target Risk (After Actions Implemented)

I	L	Rating I x L
2	3	6

Next Review
Q2 - Sept 2024

Ref PR2 Board Assurance Framework (BAF)

Ref: PR2	Strategic Objective: Quality of Care	**PRINCIPAL RISK 2:** Inability to provide safe and effective care	Risk Score: 20

Causes – What must happen for the risk to occur?
- Increased waiting times
- Insufficient bed capacity
- failure to transform patient pathways
- Insufficiencies 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's reputation
- Regulatory attention
- Increased financial costs

Executive Risk Owner: Medical Director | **Assurance Committee:** Quality Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	5	4	20	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	20	TBD	TBD	TBD
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
Implementation of clinical standards	- Q1 TPR reporting in learning from incidents - National Audit Clinical Standards - GRIFT reviews External reviews conducted: JAG, RCP-IQUILS, structure judgement reviews, LEDER reviews	Conduct Incident Reporting, Learning from Safety Incidents and Never Events	- Datix Incident reports - Q1 Patient Safety and Clinical Effectiveness Sub-Committee reporting - Q1 PRIM meetings - Q1 Learning From Deaths June Board and Quality Committee reporting - Q1 Patient Safety and Clinical Effectiveness escalation reporting to Quality Committee - Q1 Patient Experience Sub-Committee escalation reporting to Quality Committee - Elective and Cancer Care Tier review May reporting to Quality Committee and Board - Q1 Reportable Issues Log Board reporting *Gaps – Overarching analysis and triangulation of all information. Clinical pressures divert clinical staff from Audit Assurance work. Ward to Board quality data.*	Patient Safety Incident Response Framework (PSIRF)	- Staff training Trust wide - Quality and Safety Group reporting - Communication of learning
Professional Standards Doctors Revalidation	Annual Board Revalidation Report Sept 2023 *Gap – Revalidation links to appraisal*			Quality and Safety Governance Framework reporting into Quality Committee	- Q1 Patient Safety and Clinical Effectiveness Sub-Committee reporting and Quality Committee escalation - Q1 Patient Experience Sub-Committee reporting and Quality Committee escalation

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Implementation of PSIRF	Embedding of PSII investigation	Adele Coulthard	September 2024 (review)

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	3	12

Next Review
Q2 - Sept 2024

Ref PR3 Board Assurance Framework (BAF)

Ref: PR3	Strategic Objective: Quality of Care	**PRINCIPAL RISK 3:** Unable to deliver treatment and care to the required standards.	Risk Score: 16

Causes – What must happen for the risk to occur?
- Increased demand and waiting times
- Insufficient bed capacity
- Insufficient patient pathways
- Nursing and speciality workforce recruitment challenges

Consequences – If the risk occurs, what is its impact?
- Patient harm
- Reputational damage
- Regulatory attention
- Financial costs

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Resources Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	4	20	4	4	16	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	16	TBD	TBD	TBD
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
Oversight of Performance	- Q1 Board and Resources Committee TPR reporting - Q1 PRIMs with all Care Groups reporting - Q1 Integrated Quality Improvement Group reporting *Gap – Specialty level dashboards not fully established with all metrics available*	Monitoring the effectiveness of waiting list management	- Q1 Board and Resources Committee reporting on performance - Q1 PRIM operational performance oversight *Gap – Monitoring of RTT waiting lists remains in development*	Urgent Care working at Place	- Collaboration of Acute Provider delivery of plans - Systemwide UEC transformational programmes
Performance Management Framework	- Q1 TPR Board and Committee reporting - Q1 PRIMs for each Care Group	Implementation of operational, winter, resilience and surge planning	- Q1 Operational planning meeting minutes - Scenario testing of surge plans - Silver and Gold Command enacted for exceptional pressures - OPEL regional and national assurance calls	Deployment of health inequality assessment to inform waiting list management	- Terms of reference and minutes of the Trust Health Inequalities Working Group Gap – Development for prioritisation of health inequalities on waiting lists

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Deliver the 2024/25 Plan on Activity	Oversight provided through Executive Committee. Assurance provided through the Resources Committee.	Claire Hansen	March 2025

Target Risk (After Actions Implemented)

I	L	Rating I x L
3	4	12

Next Review
Q2 - Sept 2024

Ref PR4 Board Assurance Framework (BAF)

Ref: PR4	Strategic Objective: Our People	**PRINCIPAL RISK 4:** Inability to manage vacancy rates and develop existing staff predominately due to insufficient domestic workforce supply to meet demand	Risk Score: 12

Causes – What must happen for the risk to occur?
- Insufficient supply of workforce
- Lack of succession planning
- Limited career opportunities
- Operational Pressures
- 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

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	3	4	12	OPEN (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	12	TBD	TBD	TBD
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
Implement Workforce Strategy and People Recovery Plan	WRES/WDES Board and Resources Committee reporting May 2024	Target oversees qualified staff	- Quality Impact Assessments for new nurse roles and ICS international recruitment programme (Kerala)	Monitor Bank Training Compliance	Q1 Bank Training Compliance Care Group Reports
Conduct Talent Management Framework	Learning Hub development, PREP	Revised Medical Recruitment Process	Q1 TPR Board and Resources Committee workforce reporting reduced vacancy rates	Communicate guidance for Managers for remote working	Agile Working Policy
Delivery of Internal Leadership Programmes in line with Leadership Framework	- Care Group Leadership Development Programme Cohorts - List of programmes on Learning Hub	Monitoring of staffing levels (temp/perm)	- Q1 TPR Board and Committee reporting - Q1 Monthly Agency Usage reporting to Executive Committee		
Line Management Toolkit and Training	Toolkit rollout to all Line Managers and training implementation records	Oversight of rotas - E-rostering *Gap – 50% of AHP rotas remain manual*	- Executive Committee approval of E-rostering and implementation plan - Care Hours Per Patient Day (CHPPD) data		
Leadership Succession Plans	Remuneration Committee Oct 2023 reporting	Oversight of establishments and establishment reviews (Nursing and AHP)	Schedules detailing Capital Investment needs		
Our Voice Our Future Programme	Discovery and Design phase – change makers implementation and Q1 Board reporting	Implement Workforce and OD Strategy	- Q1 TPR Workforce Board and Resources Committee reporting		

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Culture Change	Implement Equality, Diversity and Inclusion Gap Analysis, Our Voice Our Future Design Phase Q2 2024/25, Visibility Programme launched	Simon Morritt	June 2025
Recruitment	55 target (including 15 specialist roles for adult inpatient areas) , Apprenticeships initiatives underway and fully supporting staff using national CPD funds	Polly McMeekin	March 2025
Leadership Framework	Phase 2 and 3 cohort rollout of Care Group Leadership Development programme, Senior Leaders Forum engagement	Polly McMeekin	December 2024

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	3	9

Next Review
Q2 - Sept 2024

Ref PR5 Board Assurance Framework (BAF)

Ref: PR5	Strategic Objective: Governance & Finance	**PRINCIPAL RISK 5:** Financial risk associated with delivery of Trust and System strategies	Risk Score: 16

Causes – What must 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 cashflow to support operations
- Net carbon zero objectives addressing environmental hazards not achieved
- Inadequate capital funding to meet infrastructure investment needs at the Trust
- Imposition of financial special measures or licence conditions

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	4	16	CAUTIOUS (8-9)	OUT OF APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	16	TBD	TBD	TBD
Risk Appetite	CAUTIOUS (8-9)	CAUTIOUS (8-9)	CAUTIOUS (8-9)	CAUTIOUS (8-9)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
Annual business planning process including Trust Strategy	- Business planning schedules - Internal Audit Reports of the business planning process	Capital planning process	- Capital Investment needs schedules - Business Planning schedules	Expenditure control - scheme of delegation and standing financial instructions	- January 2024 Board approved - Written prime budget holders' approval - Care groups finance risk planning
Preparation and sign-off of annual Income & Expenditure plan, balance sheet and cash flow, triangulation with ICB & system partners	- April 2024 Board approval - ICB overview, Finance Group and feedback sessions with Chair & CEO	Preparation and sign-off of annual capital programme	- Executive endorsement April 2024 - Board approval April 2024	Expenditure control - business case approval process *Gap – Unplanned and unforeseen expenditure commitments*	- Business Case register - Variance analysis reporting - Vacancy control process - Budget holders Reach reporting
Monitoring and reporting of I&E plan	- Q1 TPR Board and Committee reporting - PFR monthly to NHSE	Routine monitoring and reporting against capital programme	- Q1 TPR Board and Committee reporting - CPEG reporting - ICS/NHSE ad hoc reports	Expenditure control - segregation of duties	- System enforced approvals - No purchase order no payment policy
Income control - income contract variation process *Gap – unplanned income reduction*	Income adjustment form register	Overspend against approved scheme sums	- Scheme sum variation process - Scheme expenditure CPEG reports	Expenditure control - staff leaver process *Gaps – payroll untimely informed of leavers*	- Salary overpayment recovery policy - Staff Reports, Finance to budget holders
Cash flow monitoring through debtors and creditors	- Monthly debtor and creditor dashboard to Finance Managers and Care Groups - Trend data debtor reported to Resources, Executive Committees and Board - Better Payment Practice Code reports				
Routine monitoring against cash flow	- Q1 TPR Board and Committee reporting - PFR monthly to NHSE				

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
System wide medium-term financial planning to be revised later in the year	Guidance for 2024/25 now released. Expectation that work later this year will move to production of a medium term system financial plan.	Andrew Bertram	October 2024

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6

Next Review
Q2 - Sept 2024

Ref PR6 Board Assurance Framework (BAF)

Ref: PR6	Strategic Objective: Research, Innovation and Transformation	**PRINCIPAL RISK 6:** Failure to deliver safe, secure and reliable digital services required to meet staff and patients needs	Risk Score: 12

Causes – What must happen for the risk to occur?
- Successful cyber-attack through a computer virus or malware, malicious user behaviour, unauthorised access, phishing or unsecure data flows
- Failure of the core technology estate (eg CPD, clinical or administration 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 patient harm
- Reputational damage
- Financial costs

Executive Risk Owner: Chief Digital and Information Officer | **Assurance Committee:** Digital Sub-Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	16	TBD	TBD	TBD
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
IG Policies: Data Protection, Record Management, Data Security, Registration Authority, SARs, FoI, Network Security *Gap – Limited monitoring of policy adherence*	- 2024 DPST audit report 'medium assurance' - Q1 Digital Sub-Committee reporting - IG breach management, ICO reporting - Trust wide new policy communications *Gaps – Level of compliance, unannounced IG walk inspections, audits of shadow IT policy*	Business Continuity and Resilience Data security incident response and management plan. Penetration testing of key systems, back up policy and testing. *Gap – wide variety of policies requiring review and update inc cyber protocols.*	Exercise outputs indicated staff performed well. A test restore has been undertaken on minor system as proof of concept and schedule of quarterly restores planned. *Gaps – Trust business continuity exercise, regular CPD scheduling, RTO/RPO defined.*	Software Development Methodology *Gaps – Secure design development principles training for Development staff to ensure qualified staff are available. Software Development Process framework.*	*Gaps – Assurances that third party website developers have used secure design principles and that web applications are protected against common security vulnerabilities. Penetration Test requires completion.*
Data Security and Protection Training for staff, Board Members statutory and mandatory annual. Staff cyber threat awareness campaign.	- SIRO completed mandatory training - Majority IAOs completed required training - Majority staff completed IG training - IT induction training for all staff *Gap – specialised Board cyber-security training*	Software patching procedure enabling security patching to be applied at the operating system, database, application and infrastructure levels.	Benchmarking of the cyber exposure score demonstrating a robust posture with positive results yielded. *Gap – Services and endpoint devices not currently supported and need investment.*		
User Access Controls – processes for leavers, joiners, movers user access requirements. Multi Factor Authentication (MFA) *Gap – Lack of access management policy, how access is removed, manual processes revocation of access.*	March 2024 MFA enrolment across the Trust compliance with the DPST *Gap – MFA users of CPD (and other applications) with elevated access rights challenging to implement.*	Supply Chain Management *Gaps – Central register of the Trust's processors and Supplier Management Policy.*	A central register of the Trust's processors is in development.		

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Action plan arising from Compliance Inspection visits should be logged and shared with the Digital Sub-Committee, together with examples of good and bad practice.	Inspection reports to be presented to the Digital Sub-Committee	Rebecca Bradley	September 2024 (review)

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	3	9

Next Review
Q2 - Sept 2024

Ref PR7 Board Assurance Framework (BAF)

Ref: PR7	Strategic Objective: Our Partnerships	**PRINCIPAL RISK 7:** Trust enable to meet ICS expectations as an acute collaborative partner	Risk Score: 6

Causes – What must happen for the risk to occur?
- Insufficient supply of workforce
- Lack of succession planning
- Limited career opportunities
- Operational Pressures
- 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

Executive Risk Owner: Chief Executive | **Assurance Committee:** Executive Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
3	3	9	2	3	6	OPEN (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	6	TBD	TBD	TBD
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
Integration with ICS on system wide planning	- CEO engagement in senior leadership forums across ICS - Trust Executive membership of ICS Place governance arrangements - Q1 CEO update reports to Board - Trust CEO the SIRO for ICB Cancer Performance and Chair for the Cancer Alliance	Trust involvement in the Collaboration of Acute Providers (CAP)	- Chief Executive and Executive Directors fully engaged with the developing infrastructure supporting CAP - Board approved Committee in Common to manage CAP business - June 2023 Board agreed terms of reference and joint working agreement - Q1 CAP meeting minutes	Trust Chief Executive and Executive Team engagement in collaboration	Collaboration meetings across Executive Portfolios: Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce and OD, Finance Director
2024/25 Operational and Financial Plans	Board of Directors approval processes and Sub-Committee assurances of delivery				

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Finance and Activity delivery for 2024/25 as part of the H&NY system delivery	Quarterly and Year-end performance for 2024/25	Executive Team	September 2024 (review)

Target Risk (After Actions Implemented)		
I	L	Rating I x L
2	3	6

Next Review
Q2 - Sept 2024

Ref PR8 Board Assurance Framework (BAF)

Ref: PR8	Strategic Objective: Sustainability	**PRINCIPAL RISK 8:** Failure to achieve net zero targets, air quality targets and changing climate adaptation requirements from the Health and Care Act 2022 and Humber and North Yorkshire ICS Green Plan	Risk Score: 16

Causes – What must 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' NHS' (target 80% reduction by 2032 and Net Zero by 2042)
- Not achieving NHS Standard Contract Service Condition 18: (a) reducing air pollution (b) phasing out fossil fuels, (c) reducing the carbon impacts of environmentally damaging gases 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

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to 2024/25 BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	4	20	4	4	16	OPEN (10-12)	OUT OF APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	16	TBD	TBD	TBD
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances	ii) Controls	ii) Assurances	iii) Controls	iii) Assurances
Sustainable Design Guide *Gap – Internal Audit review and the need to strengthen contribution to delivery of Net Zero.*	Scarborough UECC designed in reference to the Sustainable Design Guide	York Hospital part of Carbon Reduction Pathway Modern Energy Partners Programme. NHS Living Labs Innovation Programme.	- Modern Energy Partners (MEP) concept design report on the Trust - NHS Living Labs MoU signed April 2022	PSDS Phase 3 grant applications approved for £4.7m for Bridlington Hospital for Net Zero and £4.3m for York Hospital decarbonisation process	- PSDS Grant work delivered in 2022/23 - Works undertaken at York and Bridlington 2023/24
Feasibility funding awarded (Community Renewal Fund) for reviewing carbon reduction potential at Scarborough and Selby Hospitals	Several capital funding grant applications submitted that were unsuccessful until recent award for NEEF for low energy LED lighting at Scarborough, Bridlington, York, Malton and White Cross Court.	Trust Green Plan	- Energy Saving Trust Transport Decarbonisation Report 2022 - March 2024 Board Approved Green Plan - Trust Travel Plan (currently being updated to align with NHS Net Zero Travel and Transport Strategy)		

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Trust Travel Plan to be updated to incorporate plans to achieve carbon emissions reductions in line with NHS requirements	The Trust's Travel Plan is now being updated in line with the recently released NHS Net Zero Travel and Transport Strategy. Key Targets include reducing staff commuting emissions by 50% by 2033 and transitioning the entire Trust fleet to zero emissions vehicles by 2035.	Graham Titchener	September 2024
Improve internal temperature monitoring and control for vulnerable groups within the hospital estate and develop a plan in response to the changing climate	Funding agreed and used during the summer of 2023 for a representative sample of in-patient 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 in-patient beds.	Graham Titchener	October 2024
Sustainable Design Guide to be reviewed when Net Zero Carbon Guide 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.	Andrew Bennett	October 2024

Target Risk (After Actions Implemented)		
I	L	Rating I x L
2	3	6

Next Review
Q2 - Sept 2024

Severity/Impact Descriptors

Severity score (severity levels) and examples of descriptors - this is not an exhaustive list					
Domains	**1 No Harm**	**2 Minor Harm**	**3 Moderate Harm**	**4 Severe Harm**	**5 Catastrophic Harm**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days. Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death(s) Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint /inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis

Severity/Impact Descriptors (cont'd)

Severity score (severity levels) and examples of descriptors - this is not an exhaustive list					
Domains	**1 No Harm**	**2 Minor Harm**	**3 Moderate Harm**	**4 Severe Harm**	**5 Catastrophic Harm**
Statutory duty / inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating, critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Cost increase /schedule slippage <1% over project budget /plan	Cost increase /schedule slippage >1<5% over project budget /plan	Cost increase/schedule slippage >5<10 % over project budget /plan	Cost increase/schedule slippage >10<25 % over project budget /plan Key objectives not met	Cost increase /schedule slippage >25% over project budget /plan Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results , Claim(s) >£1 million
Service / business interruption Environmental impact	Loss or interruption of >1 hour Minimal or no impact on the environment	Loss or interruption of >4 hours Minor impact on environment	Loss or interruption of >1 day Moderate impact on environment	Loss or interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood Descriptors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	31 July 2024
Subject:	Fit and Proper Persons Test Annual Report
Director Sponsor:	Martin Barkley, Chair
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:
The purpose of the report is to highlight the assurance of the Board of Directors members adherence to the Trust's Fit and Proper Persons Test Policy (FPPT).

Specifically to note and discuss:
Assurance provided to the Trust's Fit and Proper Persons Policy in line with the NHS England Fit and Proper Person Test Framework for Board members.

Recommendation:
The Board of Directors is asked to note the assurance provided in compliance with the NHS England Fit and Proper Person Test Framework for Board members.

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

Meeting	Date	Outcome/Recommendation
Board of Directors	31 January 2024	Fit & Proper Persons Policy - Approved

Fit and Proper Persons Annual Assurance 2023/24

1. Introduction

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'.

2. Background

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations in the Kark Review, NHS England developed a FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. This FPPT framework came into effect from 30 September 2023.

The Framework applies to the board members of NHS organisations, irrespective of voting rights or contractual terms.

3. FPPT Process

The Board of Directors members have each completed a FPPT self-attestation and subsequently the test has been applied in line with the NHS guidance and the Trust Policy approved in January 2024.

The test has been completed both for annual checks and for those board members joining since January 2024 as recruitment checks. The outcome of the FPPT have been saved in respective personnel files and uploaded onto ESR. A summary of this is provided in appendix 1.

The Annual NHSE FPPT submission has been concluded and provided to NHSE as required by the FPPT framework.

Between FPPT checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Director of Workforce and OD or the Trust Chair.

4. Recommendation

The Board of Directors is asked to note the assurance provided in compliance with the NHS England Fit and Proper Person Test Framework for Board members.

Appendix 1 - Fit and Proper Persons Register 2023/24

Name, Title / Role	Annual/ Recruitment Checks Complete	DBS Check	Registering Professional Body	Annual Appraisal Conducted	Annual Self Declaration Signed	Disqualified Director Check	Insolvency Service Bankruptcy Register	Charity Trustees Register	Public Domain Search
Non-executive Directors (NEDs)									
Martin Barkley (Chair)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Jenny McAleese (NED)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Jim Dillon (NED)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Lorraine Boyd (NED)(SID)	Yes	Yes	GMC Not currently registered	✓	✓	✓	✓	✓	✓
Lynne Mellor (NED)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Matthew Morgan (NED)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Stephen Holmberg (NED)	Yes	Yes	GMC Not currently registered	✓	✓	✓	✓	✓	✓
Helen Grantham (ANED)	Yes	Yes	N/A	N/A	✓	✓	✓	✓	✓
Julie Charge (NED)	Yes	Yes	N/A	N/A	✓	✓	✓	✓	✓
Trust Executive Group									

Simon Morritt, Chief Executive	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Andrew Bertram, Finance Director and Deputy Chief Executive	Yes	Yes	Yes Current CIPFA registration	✓	✓	✓	✓	✓	✓
Claire Hansen, Chief Operating Officer	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Dawn Parkes, Interim Chief Nurse	Yes	Yes	Yes Current NMC registration	✓	✓	✓	✓	✓	✓
James Hawkins, Chief Digital & Information Officer	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Karen Stone, Medical Director	Yes	Yes	Yes Current GMC Registration	✓	✓	✓	✓	✓	✓
Lucy Brown, Director of Communications	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Polly McMeekin, Director of Workforce and Organisational Development	Yes	Yes	Yes Current CIPD Membership	✓	✓	✓	✓	✓	✓