York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 23rd October 2024
Time: 9:30am – 12:45pm
Venue: Boardroom, 2nd Floor Administration 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 25 September 2024** To be agreed as an accurate record.	Chair	Report	**6**	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	**17**	
6.	**Chair's Report** To receive the report.	Chair	Report	**18**	9:35
7.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	**21**	9:40
8.	**Quality Committee Report** To receive the October meeting summary report.	Chair of the Quality Committee	Report	**105**	9:55

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Resources Committee Report** To receive the October meeting summary report.	Chair of the Resources Committee	Report	107	10:05
10.	**Trust Priorities Report (TPR)** September 2024 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Chief Operating Officer Chief Nurse Director of Workforce & OD Chief Digital Information Officer Finance Director	Report	109 112 149 171 182 188	10:15
Break 10:55					
11.	**Maternity and Neonatal Reports (including CQC Section 31 Update)** To consider the report.	Chief Nurse	Report	201	11:05
12.	**CQC Compliance and Journey to Excellence Update Report** To consider the report.	Chief Nurse	Report	212	11:15
13.	**Safeguarding Annual Report** To consider the report.	Chief Nurse	Report	239	11:25
14.	**Pay Gap Report** To consider the report.	Director of Workforce & OD	Report	256	11:35

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Learning from Deaths Report** To consider the report.	Medical Director	Report	263	11:45
16.	**Medical Education Annual Report** To consider the report.	Medical Director	Report	280	11:50
17.	**Research and Development Strategy** To approve the strategy.	Medical Director	Report	299	12:00
18.	**Emergency Preparedness Resilience & Response (EPRR) Action Plan Update** To consider the report.	Chief Operating Officer	Report	320	12:15
Governance					
19.	**York Teaching Hospital Facilities Management (YTHFM) - Management Group Terms of Reference** To approve the terms of reference.	YTHFM Chair	Report	342	12:20
20.	**Update and Restatement of Approval for the VIU, TIF2 and Targeted Lung Health Check Business Cases** To approve the Business Cases.	Finance Director	Report	350 358	12:25
21.	**Q2 Board Assurance Framework** To approve the report.	Associate Director of Corporate Governance	Report	397	12:35
22.	**Schedule of Board Meetings 2025/26** To consider the meeting dates.	Chair	Report	415	12:40
23.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-

Item	Subject	Lead	Report/ Verbal	Page No	Time
24.	**Time and Date of next meeting** The next meeting held in public will be on 27 November 2024 at 10am at Scarborough Hospital.				
25.	**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.				
26.	**Close**				12:45

Minutes
Board of Directors Meeting (Public)
25 September 2024

Minutes of the Public Board of Directors meeting held on Wednesday 25 September 2024 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 10.00am and concluded at 12.45pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (& Maternity Safety Champion)
- Ms Julie Charge
- Mr Jim Dillon
- Dr Stephen Holmberg *(Via Teams)*
- Mrs Jenny McAleese
- Mrs Lynne Mellor
- Prof. Matt Morgan

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

Corporate Directors
- Mrs Lucy Brown, Director of Communications

In Attendance:
- Mr Mike Taylor, Associate Director of Corporate Governance
- Ms Stefanie Greenwood, Freedom to Speak Up Guardian (For Item 12)
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 13)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- One member of the public and one member of Trust staff.

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

2 Apologies for absence

Apologies for absence were received from:

- Ms Helen Grantham, Associate Non-Executive Director
- Ms Paula Gardner, Insight Programme

3 Declaration of Interests

The following new interests were declared:
- Mr Bertram had joined the Board of St Leonard's Hospice as a co-opted trustee
- Mrs Mellor was now a co-owner/director of The Human Digital Collaborative Ltd.

These interests had been added to the register of potential conflicts of interest for the Board of Directors 2024/25 which was published on the Trust's website.

4 Minutes of the meeting held on 31 July 2024

The Board approved the minutes of the meeting held on 31 July 2024 as an accurate record of the meeting.

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 10 – *Remove the metric on "waits over 78 weeks".*
Mr Hawkins advised that the metric had been removed except for one line: "RTT – waits over 78 weeks for incomplete pathways" which needed to remain to meet national requirements. The action was declared closed.

BoD Pub 12 – *Add phasing information to the next Finance report, and a year-end forecast based on trends to date and other known factors.*
Mr Bertram advised that this information had been provided in Finance section of the Trust Priorities Report (TPR). The action was therefore complete.

BoD Pub 17 – *Add SPC charts for emergency care attendance and Type 1 attendances to the TPR.*
This would be discussed under Item 11. The due date for the action was extended to October.

BoD Pub 18 – *Statistical Process Control (SPC) chart to be added to the TPR for non-elective admissions data.*
Mr Hawkins advised that information on Same Day Emergency Care admissions was published in the TPR; further clarification was needed on the data to be provided. This would be discussed under Item 11. The due date for the action was extended to October.

BoD Pub 19 – *Investigate anomaly in data on operations cancelled on or after the day of admission.*
Mr Hawkins advised that the data was not anomalous in referring to March rather than June in the last TPR: the data was declared quarterly and would be unvalidated if presented more frequently. It was agreed that the unvalidated monthly data should be included in the TPR.

Action: Mr Hawkins

BoD Pub 21 – *Update the Board by email on the implementation date for the new automated process which would ensure that Patient Initiated Follow Ups (PIFU) were correctly added to the PIFU list.*
The implementation had taken place in the week commencing 22 July; this date had been communicated to Board members on 6 August and the action was therefore closed.

BoD Pub 22 – *Review use of the terms "baseline" and "target" in the TPR.*
Mr Hawkins advised that the use of these terms had been reviewed. It was noted that some inconsistencies remained which would be raised under Item 11. The due date for the action was extended.

BoD Pub 23 – *Include information on the development of the new Electronic Patient Record (EPR) in the TPR.*
Following a brief debate, it was agreed that data on the use of the new EPR and down times would be included in the TPR once the system had been implemented. The development and implementation of the EPR would be monitored by the Digital Sub-Committee. On this basis, the action was closed.

BoD Pub 24 – *Dr Stone to ensure that Care Groups are advised of Trust practice re: letters from clinicians detailing ongoing treatment plans.*
Dr Stone had completed this action.

BoD Pub 25 – *Make amendments to Fit & Proper Persons report as discussed.*
Mr Taylor had made the amendments, and the revised report had been presented to the Council of Governors.

6 Chair's Report

The Board received the report.

Mr Barkley referred to his attendance at the penultimate session of the Leadership Development programme that the Trust had commissioned for Black and Minority Ethnic (BME) colleagues. He had subsequently contacted the previous chair of the Board to commend him on the decision to commission the programme which was proving so valuable to those undertaking it.

Mr Barkley reported that the meeting held with members of the Bridlington Health Forum had been very constructive. Mr Barkley also reported that the York Public Constituency Meeting had been a very worthwhile exercise, with good engagement from those attending. The decision to hold the meeting in the evening had resulted in better attendance and a similar event would be scheduled for Hambleton, Ryedale and East Coast constituencies.

7 Chief Executive's Report

The Board received the report.

Mr Morritt referred first to the key findings of Lord Darzi's report of the independent investigation of the NHS in England published on 12 September, noting that the work to address these findings would begin now.

Mr Morritt advised that, whilst the junior doctors' industrial action had been brought to an end by the offer of an improved pay award, the Royal College of Nursing had rejected a 5.5% pay award.

Mr Morritt also highlighted:

- the Trust's "No Excuse for Abuse" campaign;
- the accreditation by the Joint Advisory Group (JAG) for the Trust's endoscopy services which was a significant achievement;
- the campaign to raise awareness of organ donation;
- information on Star Award winners appended to his report;
- the Celebration of Achievement event held at York Racecourse.

Finally, Mr Morritt reported that he and Mr Hawkins had just received confirmation that the full Electronic Patient Record Business Case had been approved by NHS England with no conditions applied. The committee making this decision had been very complimentary on the work completed thus far.

The Board offered its congratulations to the teams involved in both the JAG accreditation and the development of the EPR Business Case.

8 Quality Committee Report

Dr Holmberg briefed the Board on the key discussion points from the meeting of the Quality Committee held on 17 September. He reported that improvements in Maternity Services were evident, despite the increase this month in Post-Partum Haemorrhages over 1500mls. There were no specific concerns raised by the cases. Dr Holmberg advised that lack of further funding to increase staffing levels was the main obstacle to further rapid improvement. Members of the Quality Committee would continue to monitor and seek assurance on the quality and safety of the Trust's Maternity Services.

Dr Holmberg noted that the backlog of coding of patients attending Emergencies Departments (ED) had again been reported to the Committee. The non-allocation of a code to patients attending ED resulted in poor communication with primary care and the potential for safeguarding risks.

Dr Holmberg reported that the Cancer Specialist and Clinical Support Services Care Group leaders had presented to the Committee. They had highlighted:

- improvements to the ophthalmology booking system;
- concerns with infection prevention and control (IPC); the Care Group had established an IPC monitoring group;
- JAG accreditation for endoscopy services;
- the increase in the number of complaints; themes included staff attitude and waiting times for appointments;
- unauthorised access to the mortuary at York Hospital and to the body store at Scarborough Hospital; access was not with malicious intent but in ignorance of protocols; the Mortuary Policy had been updated and training delivered.

Finally, Dr Holmberg highlighted the clear evidence of a positive, collaborative relationship between Corporate and Care Group teams, the former offering challenge but also support to improve.

9 Resources Committee Report

Mrs Mellor updated the Board on the main discussion points from the meeting of the Resources Committee on 17 September. She observed that, whilst there were signs of improvement in operational key metrics, the Committee had expressed concern regarding the continuing rise in the number of ambulance arrivals and patient flow in Urgent and Emergency Care settings. Visibility of Yorkshire Ambulance Service and Primary Care plans would support discussions. The Committee had welcomed improvements in Referral To Treatment (RTT) metrics, particularly relating to patients waiting over 65 weeks, which had reduced significantly. Mrs Mellor reported that there had also been improvement in diagnostic waiting times across a number of specialties, particularly echocardiography.

In terms of the financial position, the Trust was expecting a cash injection of £17m, this being its share of the £50m ICB deficit which NHS England had agreed. Mrs Mellor advised that the Committee had received a presentation from the Director of Procurement, from the HNY Procurement Collaborative, and had congratulated him and the Finance Team on the level of savings being delivered. This was an example of positive collaboration between the Trust and the Integrated Care System.

In response to a question, Ms Hansen outlined plans to accelerate discharge to improve patient flow; she noted that these depended in large part on work being done by partner organisations.

10 Group Audit Committee Report

Mrs McAleese provided an update on the main points discussed at the meeting of the Group Audit Committee on 10 September. These included:

- a report from the Freedom To Speak Up Guardian; escalations from this report would be raised under Item 12;
- overdue audit recommendations; the Committee heard that the process for supplying evidence for closure had been tightened and Committee members had requested that Executives work to improve the reporting process;
- the appointment of external auditors; Mrs McAleese noted that the Council of Governors had approved the process recommended by the Committee.

11 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Mr Barkley congratulated all those involved in the significant reduction in 12-hour trolley waits in ED. He queried the data for attendances at ED which was divided into *Type 1* and *Others* and noted that further sub-divisions would be useful for the Board to track the impact of the Optimal Care Service (OCS) and the use of the Urgent Treatment Centres (UTCs). Ms Hansen would ensure that this data was added to the TPR.

Action: Ms Hansen

Ms Hansen noted that the number of patients seen by the OCS was lower than she would have expected and, as a result, further work was taking place with ED staff on streaming patients to the correct pathways. Dr Boyd asked how patients were categorised when arriving at ED and whether the Board could be assured that this process was effective. Ms Hansen explained that patients arriving by ambulance were categorised at the time of the call by the Ambulance Service according to a nationally set algorithm. She was unsure how patients who did not arrive by ambulance were categorised, but she would provide this information to the Board.

Action: Ms Hansen

Ms Hansen explained that there was a higher number of admissions to inpatient wards than was actually required as the assessment units were not large enough. The clinical estates work currently in progress would address this. She also clarified the terminology "soft breach" in respect of waiting times in ED: a soft breach was a waiting time between four and five hours, where the four-hour breach could have been avoided. A new internal process should reduce the number of soft breaches.

In response to a question about attendances at the Same Day Emergency Care (SDEC) service, Ms Hansen explained that patients were being treated in SDEC who had been asked to re-attend for follow-up treatment which was not the purpose of the service. This was being addressed by the development of more appropriate clinical pathways.

Dr Holmberg observed that the acute flow metrics reported delays at different stages of the process; the Board needed to be assured that the whole patient journey was safe. Ms Hansen emphasised that patient safety underpinned the development of pathways, and a new governance structure had been put in place as oversight. Other measures included the Urgent and Emergency Care (UEC) risk on the Corporate Risk Register, additional staffing in UEC and increased support from regional experts in clinical decision making. Mrs Parkes added that the UEC assurance group would report to the Quality Committee.

Professor Morgan noted that the number of ambulance arrivals was still increasing and questioned when the impact of the new strategies implemented by the Yorkshire Ambulance Service (YAS) might begin to take effect. Ms Hansen did not envisage any significant decrease in ambulance arrivals as demand overall continued to rise. However, strategies to ensure that patients were streamed into correct pathways was in place. An audit on "avoidable attendance" had been undertaken which would feed into discussions with YAS and Place partners. Mr Barkley advised that the CEO of YAS had indicated that arrivals may be impacted by out of hours availability of alternatives to EDs. Ms Hansen responded that discussions were already in progress with Place partners around maximising the use of the workforce to effect economies of scale at peak times of demand.

In response to a question, Ms Hansen confirmed that the Trust was learning from best practice in high-performing Trusts with regards to managing ambulance arrivals; she provided examples.

Dr Boyd highlighted the reference to the Community Improvement Group and queried where the clinical accountability sat. Ms Hansen responded that this was with the Unplanned Care Improvement Programme (UCIP), which reported to Executive Committee, and also with the UEC Place Board. There were different clinical leads for different areas, but the identification of an overarching clinical lead still needed to be resolved. Ms Hansen suggested that a Non-Executive sponsor for the Unplanned Care Improvement Programme would be valuable.

It was noted that some of the targets in the TPR metrics represented rolling monthly targets, based on an identified trajectory. Ms Hansen and Mr Hawkins would discuss how these might be better described, such that the Board could gain assurance that progress was being made towards defined targets.

There was some discussion on the value of the metrics in the TPR for the Board and a view was expressed that there was too much operational detail which was difficult for the Board to interpret to gain assurance that improvement was being made.

Mr Morritt asked if the target of zero RTT patients waiting more than 65 weeks at the end of September would be met. Ms Hansen responded that it was assumed now that 25 patients would breach this deadline as they would not be treated until October. For some, this had been a matter of choice. Whilst this was disappointing, it compared well with figures in other Trusts. Ms Hansen reported that the work undertaken on children's and young people's elective waiting lists had been shared with regional colleagues as best practice.

Mr Barkley noted that the ethnicity data on patients waiting for Referral to Treatment was still lacking. Ms Hansen advised that the importance of collecting this data had been emphasised to staff and training had been delivered. Processes to collect this data formed part of the elective care improvement programme. Ms Hansen agreed to provide further information on the deadlines for this work to be complete.

Action: Ms Hansen

Quality and Safety

Mrs Parkes highlighted efforts to improve infection prevention and control using learning from cases. The establishment of Care Group Infection Prevention and Control Groups was further assurance that issues were being addressed.

It was noted that the target rate for the Trust's Duty of Candour at all three stages should be 100%. Mrs Parkes would investigate this anomaly.

Action: Mrs Parkes

Mr Hawkins undertook to ensure that the metric relating to Serious Incidents was removed from the TPR as these were now managed under the Patient Safety and Incident Response Framework (PSIRF).

Action: Mr Hawkins

The Board noted that data from the Friends and Family Test showed that 99.2% of those responding would recommend the Maternity Service to others. Mrs Parkes would check the figure of two antepartum stillbirths one of which she was unsure of.

Action: Mrs Parkes

Maternity

Mr Barkley referred to the increase in formal complaints made to the Maternity Service at York Hospital. Mrs Parkes advised that Ms Wells-Munro and her team were working on strategies to address the level of complaints.

Workforce

Board members were pleased to note the significant improvement in the vacancy rate for Health Care Support Workers, which stood at 3.6% in August. Mrs Parkes advised that the Healthcare Academy had been nominated for a Nursing Times award.

Digital and Information Services

Mr Barkley suggested that the reduced IT Service Desk capacity due to more colleagues than usual not being at work, relative to demand which was flagged in the report should be explained to staff via the Staff Bulletin.

Action: Mr Hawkins/Ms Brown

Mr Hawkins explained that a key issue behind the increase in calls to the Service Desk was the reduced level of IT training time allocated for new junior doctors. He would discuss learning points from the induction programme with Dr Stone.

Action: Mr Hawkins/Dr Stone

Finance

Mr Bertram advised that an ICB-led summit was due to take place on 27 September to review the 2024/25 financial plan and to discuss system-wide action to manage the second half of the financial year.

Referring to the report, Mr Bertram advised that the Month 5 position showed the Trust to be £700k adrift of plan, this amount relating entirely to the costs of the junior doctors' industrial action. Mr Bertram expected that resource would be released to the ICB to cover these costs.

Mr Bertram drew attention to the chart in the report which tracked cumulative actual financial performance versus plan and cautioned that it would become more challenging to maintain parity between them. He highlighted the likely, best and worst case scenarios detailed in the report which would be discussed at the ICB summit as they had implications for the system's status and the likelihood of intervention.

Mr Bertram reported that £9.2m of elective income had been earned in addition to the plan as at the end of Month 5. In respect of this, £9.5m had now been paid into the Trust's account which had significantly improved the cash position.

Mr Bertram advised that NHS England had agreed the HNY ICB Income and Expenditure Plan for 2024/25 which forecast a deficit of £50m and had agreed to release the funds to cover the deficit. He expected that the Trust's share of this, £16.5m, would be paid by the end of September which would support the Trust's cash position until the end of the financial year. Mr Bertram cautioned that whilst the cash position had improved the Income and Expenditure position remained challenging.

In terms of the Cost Improvement Programme, £20.2m of savings had been delivered at Month 5 which was significant, but this level of saving would be challenging to maintain. A gap remained in the efficiency programme and £9.8m of plans were considered at high risk of not being delivered.

There was some discussion on the worst-case scenario presented in the report. Mr Bertram was confident that the planned savings could be achieved under the worst-case scenario. He confirmed that budget assumptions were revised as the year progressed.

Board members congratulated Care Group and Corporate teams on the level of cost savings already achieved.

12 Freedom to Speak Up Annual Report

Ms Greenwood presented the report and highlighted increasing engagement with clinical staff which was positive. Mrs McAleese advised that the following issues had been raised when Ms Greenwood had presented to the Group Audit Committee:

- cover for the Freedom To Speak Up Guardian during annual or sick leave;
- a more formal approach to learning from Freedom To Speak Up cases;

- the perception amongst staff that they had, or might, suffer detriment from speaking up;
- the value to the Guardian of supervision from outside of the organisation; Ms Greenwood reported that this was now being arranged.

Mr Dillon noted that Freedom To Speak Up cases were disproportionately from administration and clerical areas. This had not changed from the last report and potentially needed more work to analyse the cases, and on culture and leadership style. There was further discussion on the data associated with Freedom To Speak Up cases, particularly the low level of cases raised by the nursing workforce. Ms Greenwood underlined that further work was needed to address barriers to speaking up and to support line managers. Mrs Parkes added that nurses had access to other routes for raising concerns and it would be useful to know if these were being used, rather than via the Guardian.

Mr Barkley advised that Mr Morritt had received a letter from the National Guardian's office following the publication of the staff survey results which showed that Trust staff had concerns about speaking up. Support was offered to the Board in addressing this issue. Mr Barkley had attempted to progress this but was still awaiting a response and, in the meantime, he would add it to the programme of Board seminars. It was important that the Board understood why staff were reluctant to raise concerns and to address those issues.

Mr Barkley encouraged Ms Greenwood to use the Reportable Issues log, which was presented at Private Board meetings, to raise issues from Freedom to Speak Up cases.

It was agreed that a discussion about cover for the Guardian would be progressed outside of the meeting.

Action: Mr Morritt

Ms Greenwood was thanked for her report, and she left the meeting.

13 Maternity and Neonatal Report (including CQC Section 31 Update)

Ms Wells-Munro presented the report. She highlighted the rise in cases in Post-Partum Haemorrhages over 1500mls in July and reported that there had been one neonatal death, which was being reported and reviewed under the agreed processes.

In terms of the Single Improvement Plan, Ms Wells-Munro reported that 23 actions were off-track at the time of the report. An assessment of the plan had been undertaken to identify those improvements which could be progressed within existing resources. The assessment had also included clinical prioritisation and the risk of not taking the actions in the plan.

Ms Wells-Munro reported that Maternity Services had implemented the RSV vaccination programme for pregnant women.

The Board congratulated Ms Wells-Munro on the clear evidence of improvement in Maternity and Neonatal Services.

Ms Wells-Munro provided a brief verbal report of the CQC visit to Maternity Services at York Hospital on 9 September. This had been very positive overall. Mrs Parkes advised that a similar visit to Maternity Services at Scarborough Hospital was being scheduled. She remarked that the Trust's relationship with the CQC was open and transparent, and the improvement work was being recognised.

The Board approved the CQC Section 31 Update.

Ms Wells-Munro was thanked for her report, and she left the meeting.

14 CQC Compliance Update Report

Mrs Parkes presented the report. She drew out the following points:

- the CQC visit to the ED at York Hospital on 29 July had been very positive;
- the Trust was working with CQC on transferring the remaining actions to business as usual, to be monitored under existing governance frameworks;
- actions continued to be closed via a rigorous process overseen in Journey to Excellence meetings;
- there were ongoing discussions with the CQC to remove the two Section 31 notices imposed on the Trust as there was now sufficient evidence that the conditions of registration were met.

15 Responsible Officer Annual Report

Dr Stone presented the report, noting that she continued to oversee over 700 doctors as the Responsible Officer for the Trust, St Leonard's and St Catherine's Hospices and Brainkind.

Dr Stone reported that a new Medical Appraisal Lead had been appointed and efforts continued to increase the number of medical appraisers. Regular meetings were held to monitor appraisal compliance, with a view to encouraging better engagement with the process. Compliance had improved and the deferral rate for revalidation had reduced to below the national average, as the process was now well-embedded.

Professor Morgan referred to the number of "not agreed exceptions" to the completion of appraisals and asked if there were any issues which should be raised with the Board. Dr Stone responded that the figure reflected the need for a change in culture and better engagement with the appraisal process.

16 Medical Education and Training Self- Assessment Report

Dr Stone presented the report which was the annual report encompassing all clinical training programmes, except medical undergraduates. The Board was required to approve the report before submission to NHS England. Dr Stone advised that it covered different aspects of education and training, and she outlined some of the challenges and achievements detailed in the report.

Professor Morgan raised queries about two of the standards which had been marked as exceptions, specifically in relation to the suitability of the Trust's educational facilities. Dr Stone agreed that whilst the training was always delivered, it could be more done more efficiently if the Trust was not limited by physical capacity. It was agreed that Dr Stone would discuss further with the team responsible for the report whether the statement should be marked as an exception.

In response to a question about supervision, Dr Stone confirmed that every trainee doctor must have a named supervisor. Consultants were encouraged to train as supervisors.

Subject to any amendments as discussed, the Board approved the Medical Education and Training Self-Assessment report for submission to NHS England.

17 Vascular Imaging Unit (VIU) Equipment Suites

Mr Bertram presented the Business Case.

The Board approved the procurement of two VIU equipment suites to be installed in the new VIU build.

18 Questions from the public received in advance of the meeting

There were no questions from the public.

19 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 23 October 2024 at 9am 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. Update 31.07.24: Dr Stone advised that this should be presented to the Board as part of the Research Strategy; the target date was therefore moved to November.	Jul 24 (from Feb 24) Nov 24 (from Jul 24)	Amber
BoD Pub 16	31-Jul-24	5.1	Children and Young People Community Waiting List	Present paper with a timescale for initiatives to reduce waiting lists, which would include details of numbers of first out-patient appointments each month compared to the number of referrals.	Chief Operating Officer		Oct-24	Green
BoD Pub 17	31-Jul-24	10	Trust Priorities Report	Add SPC charts for emergency care attendance and Type 1 attendances to the TPR.	Chief Digital and Information Officer		Oct 24 from Sep 24	Amber
BoD Pub 18	31-Jul-24	10	Trust Priorities Report	Statistical Process Control (SPC) chart to be added to the TPR for– non-elective admissions data.	Chief Digital and Information Officer		Oct 24 from Sep 24	Amber
BoD Pub 20	31-Jul-24	10	Trust Priorities Report	Present a paper to the Resources Committee which would provide further detail on follow-up partial bookings for outpatients.	Chief Operating Officer		Oct-24	Green
BoD Pub 22	31-Jul-24	10	Trust Priorities Report	Review use of the terms “baseline” and “target” in the TPR.	Deputy Chief Digital and Information Officer	Update 25.09.24: Mr Hawkins advised that the use of these terms had been reviewed. It was noted that some inconsistencies remained which would be raised under Item 11. The due date for the action was extended.	Oct 24 from Sep 24	Amber
BoD Pub 26	25-Sep-24	5	Matters arising/action log	Include in the TPR unvalidated data on operations cancelled on or after the day of admission.	Chief Digital and Information Officer		Oct-24	Green
BoD Pub 27	25-Sep-24	11	Trust Priorities Report	Ensure sub-divided data on attendances in ED is added to TPR.	Chief Operating Officer		Oct-24	Green
BoD Pub 28	25-Sep-24	11	Trust Priorities Report	Provide further information to the Board on the categorisation of patients arriving at ED by ambulance	Chief Operating Officer		Oct-24	Green
BoD Pub 29	25-Sep-24	11	Trust Priorities Report	Provide further information on the deadlines for work to improve collection of ethnicity data	Chief Operating Officer		Oct-24	Green
BoD Pub 30	25-Sep-24	11	Trust Priorities Report	Investigate anomaly in TPR re: target rate for Trust's Duty of Candour	Chief Nurse		Oct-24	Green
BoD Pub 31	25-Sep-24	11	Trust Priorities Report	Ensure that metric relating to Serious Incidents was removed from the TPR.	Chief Digital and Information Officer		Oct-24	Green
BoD Pub 32	25-Sep-24	11	Trust Priorities Report	Check figure for antepartum stillbirths in August.	Chief Nurse		Oct-24	Green
BoD Pub 33	25-Sep-24	11	Trust Priorities Report	Communicate the reduced IT Service Desk capacity flagged in the report to staff via the Staff Bulletin.	Chief Digital and Information Officer/Director of Communications		Oct-24	Green
BoD Pub 34	25-Sep-24	11	Trust Priorities Report	Discuss learning points from the junior doctor induction programme with Dr Stone.	Chief Digital and Information Officer/Medical Director		Oct-24	Green
BoD Pub 35	25-Sep-24	12	Freedom to Speak Up Annual Report	Progress discussions about cover for the FTSU Guardian	Chief Executive		Oct-24	Green

Report to:	Board of Directors
Date of Meeting:	23 October 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 Objectives

- ☒ Timely, responsive, accessible care
- ☒ Great place to work, learn and thrive
- ☒ Work together with partners
- ☒ Research, innovation and transformation
- ☒ Deliver healthcare today without compromising the health of future generations
- ☒ Effective governance and sound finance

Board Assurance Framework

- ☒ Quality Standards
- ☒ Workforce
- ☒ Safety Standards
- ☒ Financial
- ☒ Performance Targets
- ☒ DIS Service Standards
- ☒ Integrated Care System
- ☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

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	23 October 2024	

Chair's Report to the Board – October 2024

1. The day after our September Board meeting I spent most of the day visiting wards and teams based in the South Wing of Scarborough Hospital. These included the Emergency Dept, Ash Ward, Maternity Ward, Labour Suite, SCBU, Women's Unit, Eye Clinic and the Cancer Information Centre. There are several issues that I picked up from colleagues that I met which I will follow-up with relevant Directors, including the leaking roof above Maternity.

2. I Chaired a meeting of the Trust's Nomination & Remuneration Committee and a few days later the Council of Governors' Nomination and Remuneration Committee which approved the recruitment pack including advert for the NED position which will become vacant in January. The interviews are scheduled for late November.

3. I had a good introductory meeting with the Trust's Chief Dietitian. The couple of issues that help was sought was more space for dietitians based in the portacabin at York and funding for a Catering dietitian.

4. I attended the meeting of Chairs organised and Chaired by Dame Linda Pollard, Chair of Leeds Teaching Hospitals NHS Trust. There were a really good range of speakers, including the Deputy Chair of NHS England. A couple of days after the meeting I received an email from Dame Linda informing me that she would be stepping down as Chair of LTHT having served that Trust for more than decade. Her leadership alongside that of Sir Julian Hartley was absolutely transformational. She will leave an outstanding legacy with the Trust being so respected and influential both regionally and nationally. Whilst mentioning Sir Julian, I could not be more pleased that he will be taking up the role of Chief Executive of the Care Quality Commission. I am certain that he was the ideal candidate not only because of his huge knowledge and experience in the NHS but also his track record of leading the development of organisations.

5. I had the pleasure of welcoming new Governors who attended the new Governors induction programme. I will follow this up with introductory 121 meetings with each of the new Governor.

   Martin Barkley, Trust Chair.

Report to:	Board of Directors
Date of Meeting:	23 October 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 Objectives

- ☐ Timely, responsive, accessible care
- ☐ Great place to work, learn and thrive
- ☐ Work together with partners
- ☐ Research, innovation and transformation
- ☐ Deliver healthcare today without compromising the health of future generations
- ☐ Effective governance and sound finance

Board Assurance Framework

- ☐ Quality Standards
- ☐ Workforce
- ☐ Safety Standards
- ☐ Financial
- ☐ Performance Targets
- ☐ DIS Service Standards
- ☐ Integrated Care System
- ☐ Sustainability

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This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

For the Board of Directors to note the report.

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

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

Chief Executive's Report

1. We Need to Talk

From 14 October the local NHS across Humber and North Yorkshire is embarking on We Need to Talk, a four-week conversation with people through social media and in-person focus groups about the future of the NHS in our area.

It will bring to light some of the difficulties faced by the NHS, whilst giving people an opportunity to signal how they might want the NHS to change to meet the challenges of today and the demands of the future.

In a snap poll carried out by NHS Humber and North Yorkshire Integrated Care Board (ICB) ahead of the public engagement, almost 63 per cent of the 428 people who responded said the NHS needed to change.

Health leaders in Humber and North Yorkshire want to create better community services closer to people's homes, more specialist hospitals and centres for excellence to provide the best emergency, expert and high-quality care for those who need it, make better use of technology, and focus on prevention and early intervention to ensure people live more years in good health.

Reducing gaps in life expectancy between people in our richest and poorest communities remains a key priority, together with creating an NHS workforce that's "adaptable, effective and happier".

The launch of We Need to Talk follows the publication of a report by Lord Ara Darzi into the state of our national health service. Lord Darzi concluded the NHS "is in a critical condition" but "its vital signs are strong".

The Government says a 10-year plan for the NHS will be published in the New Year, but it has already said it wants to see more community care, better use of digital technology and more done to prevent ill health.

Further information about We Need to Talk and details of how people can get involved in the conversation can be found on the ICB's website, including a short survey.

As part of the Integrated Care System, we will be asking our staff to engage with the conversation, and we will be aligning our Trust's developing strategy to the outcomes of the engagement exercise.

2. Industrial action

SHYPS industrial action

A number of Scarborough, Hull and York Pathology Service (SHYPS) colleagues have been involved in industrial action resulting from a dispute with the Trust over staffing and workforce issues.

This has involved staff from the Microbiology services in York and Scarborough, and the Blood Sciences services at Scarborough Hospital.

To date there have been three episodes of industrial action, and we have been notified by Unite the Union of their intention to continue with further strike action planned for 30 and 31 October.

We are actively involved in discussions with this group of staff, their union representatives, and the SHYPS senior leadership team in a bid to bring this to a satisfactory conclusion and are engaging ACAS to support these conversations.

As with other periods of industrial action, we have plans in place to deal with disruption to services, and we are working closely with our staff and union representatives to ensure we continue to provide safe care for our patients during any period of industrial action.

Continuous action in Primary Care

Meanwhile, the BMA's GP contractor/partner members in England are continuing with their industrial action. The extent to which practices are taking action across our patch is varied, however we are starting to see some signs of potential impact on our services where there appears to have been an escalation in the scale of the action being taken.

As I have briefed previously, unlike the industrial action carried out by other staff groups, no defined timeframe has been announced, with the suggestion that it may continue in some form for an extended period.

We are carefully reviewing where we may need to mitigate against this impact, even if this is for a fixed period of time, to ensure we can continue to provide a safe service for those patients requiring secondary and acute care.

3. Scarborough UECC opening

In a short but incredibly important update, I can confirm that our contractor for Scarborough's new Urgent and Emergency Care Centre has agreed a handover date of week commencing 18 November 2024, now that the build is virtually complete.

This means that clinical moves can take place week commencing 25 November for all services moving into the UECC, with the aim of the centre being fully operational by the end of that week.

Thanks to everyone for the hard work, persistence and patience behind the scenes to get us to this point – we are finally there and ready for a new chapter in Scarborough Hospital's history to begin.

4. Hull York Medical School (HYMS) rankings

Positive news for Hull York Medical School (HYMS), which has been ranked fifth for Medicine as part of the 2025 Guardian University Guide Rankings. The league table ranks UK institutions by subject, and looks at student satisfaction, number of staff, expenditure per student, and career prospects. It considered eight different metrics in total, with HYMS scoring much higher than previously for National Student Survey (NSS) Teaching and NSS feedback, resulting in a rise in position from 15th in the 2024 rankings to 5th in 2025.

Congratulations to all colleagues involved with this achievement.

5. Chief AHP retires

This month we bid a fond farewell to Melanie Liley, Chief AHP and Director of Community Partnerships, who is retiring from the Trust following a long and varied career in the NHS. A physiotherapist by profession, Melanie has held a range of leadership positions, including a period as Interim Chief Operating Officer where she was a member of our Board. Melanie will be missed not only by us as a Board but also by the many colleagues she has provided leadership and support to over her career. She has also been instrumental in advocating for AHPs in the Trust, and her work to raise the profile of the importance of the role AHPs in the multi-disciplinary leadership and management of the Trust is a fantastic legacy of which she should be proud.

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. September and October's nominees are in **Appendices 1A and 1B**.

Date: 23 October 2024

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

September 2024

Elaine White, Urgent Care Practitioner, and Alix, Student Nurse | **Selby** | **Nominated by relative**

My daughter sustained an injury and having her assessed at another clinic, I felt something still was not quite right, so I took her to Selby UTC. From the moment I arrived, the team were kind and welcoming, making me feel that I was not just an over-cautious parent and I had done the right thing. After being triaged and waiting to be assessed, we were called in and greeted by the Elaine and Alix. Both Elaine and Alix were the kindest, most compassionate nurses I have ever encountered, and they are an absolute credit to the team. After chatting with them both, I realised there was only Elaine and one other member of staff managing the whole UTC that day, yet they never made us feel like a nuisance, or that we were troubling them. Instead, they made us feel like they had all the time in the world to talk and help with my daughter's injury.

Elaine was fantastic with my daughter, she listened to her and got to her level so she did not feel worried and eased her nerves where needed. They treated my daughter with the upmost care, and I will always be grateful for this and for making sure she was well, properly treated, and had a positive memory of coming to hospital. I want to thank both Elaine and Alix for their fantastic care. They are superstars and the Trust should be very proud of them.

Emma Ellis, Senior Occupational Therapist	**Community**	**Nominated by colleague**

Emma is our lone superstar OT providing community-based Occupational Therapy input to our vast South Hambleton & Ryedale Community. The demand she faces is unprecedented, and yet she works every day with a cheerful smile, providing superb holistic care to our frail and often very complex patient population.

Since 2022, she has been involved in the care of a patient with advanced Parkinson's disease through various referrals into our service, helping support them and their family through their disease progression. After the patient passed away, Emma received a beautiful message to say thank you for all her input over the years and was specifically thanked in their obituary. I am so completely moved and so thoroughly proud of Emma for always working to the highest of her professional standards. She is an absolutely shining example of our Trust values, and a testament to the amazing work AHPs achieve in Community. I am sure the family would be delighted to know she will be recognised by the Trust with this nomination in addition to their own very kind tribute.

Katherine Langthorne, Generic Therapy Assistant	**York**	**Nominated by colleague**

Kat is an absolute star through and through, consistently bringing joy into the team. Kat had been working alongside a patient who had been referred to social services to explore discharge from hospital to a care placement. The patient was extremely keen to return home and was able to give reasons as to why they wanted this. Kat was quick to speak with the social worker dealing with the patient's case and requested a review to see if they could in fact return home. Kat's intervention was successful and it was decided that they could achieve their goal and return home with some additional care support.

Her caring nature and desire to achieve person-centred care really shines through in everything that she does!

Isabel Coe, Outpatients Clinic Manager | **York** | **Nominated by colleague**

Izzy has been such a great support over the last few weeks. She has always been on hand when I have needed support, is conscientious with her decisions, and ensures that the patients come first. She is always happy to help and will take the time out to support you, no matter what.

Steven Hunt, Senior Sonographer | **York** | **Nominated by colleague**

Steve has provided over 20 years of dedicated service to our patients undergoing TRUS biopsy. He has performed thousands of TRUS biopsies in this time and helped countless anxious patients through what can often be one a very uncomfortable and embarrassing experience. Steve's incredibly high levels of skill, professionalism, and attention to detail have helped to get these men the results they need for diagnosis and treatment. As our department moves forward with changes in procedure, we thank Steve for being such a fantastic colleague and core member of the Urology clinical team.

Samantha Wells, Healthcare Assistant | **Scarborough** | **Nominated by colleague**

Samantha is an absolute credit to the hospital. She comes in every day bright and bubbly with a massive smile on her face. Her laugh is infectious and you know that if Sam is on the ward, then she is going to have every patient and staff member smiling. She works relentlessly and goes above and beyond to do the best for the patient. She is also incredibly kind and has so much patience and understanding.

Sam is a team player and she helps the domestics with mealtimes, always getting stuck in. I have seen her up and singing and dancing with patients; she treats every person with such compassion, love, and respect. Sam brings such a positive light to Cherry Ward. She is truly one in a million and a credit to Cherry Ward and to Scarborough Hospital!

Marie Hallam, Audiology Service Manager | **Bridlington** | **Nominated by colleague**

I have not had the easiest time throughout this past year, and Marie has shown nothing but support, compassion, and care towards me. Through manageable steps and small goals, Marie has supported my mental health and helped me back into the office. I cannot thank her enough for her help and encouragement to achieve this. She made me feel worthy and a valuable part of an amazing team.

Jonny Armstrong, Healthcare Support Worker **York** **Nominated by colleagues**

Jonny has worked on Ward 15 for over a year, and since his first day he has displayed the Trust values, day-in day-out, and has delivered outstanding patient care. Regardless of how busy the shift is, Jonny will be the first person to offer to help and is always grateful for any help he receives. He ensures that all team members are supported and is an excellent role model to our new healthcare support workers. Jonny delivers all his care to absolute best of his ability and always to an exceptional standard. He ensures patients get the best care, regardless of what time of day it is or how many staff are on shift, and always has a smile on his face.

Jonny will be the first person to offer to support any new members of staff and is always looking to further his knowledge not only for himself, but new members of staff as well. We are very grateful for the support that Jonny gives his team and new HCSWs and know they are in good hands when with him.

Hayley Robson-James, Midwife | **York** | **Nominated by patient**

I am writing to share my heartfelt appreciation for Hayley, a Midwife, for the exceptional care she provided during the birth of my baby at York Hospital.

I first met Hayley two years ago when I had my first child, and she was a true source of comfort during an extremely traumatic time. I was so relieved to see her again this time, knowing I would be in safe hands. Due to past experiences, I find it incredibly difficult to trust anyone. Returning to a place that had previously caused me trauma, I never thought it would be possible to feel safe and secure again, and, without Hayley, that simply would not have been possible.

Hayley is one of the most compassionate people I have ever met. She always ensured I had everything I needed, and she even checked in with my partner to make sure he was OK too. She listened to me, respected all my choices, and never made me feel like a burden. Her understanding of my mental health and how to best support me was incredibly reassuring, and she knew exactly how to care for me in a way that felt personal and thoughtful.

Hayley truly went above and beyond, and her care made a huge difference to my experience. I am extremely grateful for everything she did and want to ensure her hard work and kindness do not go unnoticed. She made a real difference to my experience and to my family. Hayley has helped restore some of my trust in hospitals, and I will be forever thankful to her. I will never forget what she did for us.

Joshua Thompson, Administration Assistant | **Scarborough** | **Nominated by colleague**

Josh has been nothing but so supportive while working on my own in such a busy office. I could not do my job without Josh and the team.

Hannah Giordano, Midwife **York** **Nominated by patient**

I would like to express my deepest gratitude and thanks to two members of staff who were phenomenal during my recent delivery of my second daughter. My first was born during the COVID pandemic, where I experienced a traumatic and painful experience during labour, delivery, and recovery. During my second pregnancy my anxiety and stress about the upcoming birth was debilitating. I felt trapped within this to make certain birth choices, not the ones I truly wanted.

On arriving in one of the delivery rooms my midwife, Hannah, simply asked me if I wanted to try my original birth plan from four years ago, explaining how this could be accommodated and made to happen. Not an inconvenience, a choice. And one I was incredibly excited to jump on. Hannah and her student Isobel made my dream delivery come true. They were incredible. They were kind, patient, supportive, caring, and compassionate and I felt like I was in the most competent and skilled hands. I feel so healed from this experience, like my faith has been restored in the system, and this is truly down to two members of staff. Thank you, so much, to Hannah and Isobel. You deserve every thanks you get, and best of luck to Isobel starting on her new career.

Rachel Johnson, Patient Services Assistant **York** **Nominated by colleague**

When I visit patients on the ward, I have observed Rachel's interactions with patients and colleagues on multiple occasions. She builds a great rapport with patients where others cannot, particularly one of our patients who was not eating, drinking, or speaking very much. She is also warm and friendly with colleagues. She demonstrates the Trust values and additionally warmth, humour, and compassion. Thank you for your warm presence and being you, Rachel.

Daniel Robinson, Administrative Assistant **York** **Nominated by colleague**

Dan has a very kind, calm manner and is very efficient. He has helped many members of staff who have had problems with the new car parking process. It can be so anxiety provoking to incorrectly receive a fine but he is always the other end of the phone to sort it out and reassure that it is nothing to worry about. He deserves recognition for doing a job which must be so tedious but still remaining understanding.

Jordan Davis, Security Officer **York** **Nominated by colleague**

Jordan has been nothing but supportive, helping me on the window to ensure that patients and staff have someone to talk to when I am busy. Jordan goes above and beyond to help me in the office and deserves a star and much more. He is a credit to the Security Team.

Jacob Elliott, Student Nurse **York** **Nominated by colleague**

Jacob displays the Trust values with all his work. During one shift, a patient was distressed after being moved in the night. Jacob sat and listened to all their concerns and offered reassurance. He also identified some issues of concern and took the steps to call in specialists to assist in resolving the issue. He went above and beyond and displayed maturity, compassion, and professionalism.

Helena Davis, Phlebotomist **York** **Nominated by patient**

Helena is a real star. I had been referred to the hospital because my GP surgery had struggled to find veins and get blood from me. Consequently, I was a bit anxious given my previous experience. The first phlebotomist I saw also struggled, she was eventually able to get a small amount of blood from me but, on checking with a colleague, was told this was not enough. She then asked Helena to help. Helena was confident and kind. She kept me distracted with conversation and good humour and was able to get sufficient blood. What a professional!

Francesca Nolan, Labour Ward Co-ordinator **York** **Nominated by patient**

Frankie was part of delivering our miracle baby. She was caring, compassionate, calm, informative, and professional throughout all the care she was part of. When active labour became difficult due to my baby getting tired and having to hold off pushing, the cord became wrapped round my baby's neck, she managed to help keep the situation calm and keep me focused so we could all work together to get them here safely.

I will be forever grateful for the outstanding care I received from her and will always remember her as she has had such a positive impact and special role in helping us have a happy ending to a very difficult fertility journey. Thank you so much!

Nicola Jones, Midwife | **York** | **Nominated by patient**

Nicola was our allocated midwife during our time on the Labour Ward. We discussed our difficult fertility journey with her and from the offset she was incredible. We received outstanding care from start to finish, she kept us informed at every stage, and she included my husband which was important to us both. Nicola provided all options and information where needed. She was supportive and caring when things progressed and physically became more difficult. She helped keep me calm when I was anxious after labour as well during a manual delivery of placenta.

I cannot express how grateful I am for such a positive experience and wanted Nicola to receive recognition and thanks for been part of our extremely difficult journey, she went above and beyond. Additionally, she had a student midwife with her and as a nurse myself, I wanted to comment what a great mentor and role model she was for the student midwife. I cannot fault any care we received at all. Triage, labour, and G2 were all amazing, but Nicola really did have a huge positive impact on my experience. Thank you!

Olivia Griffiths, Digital Communications Officer | **York** | **Nominated by colleague**

I would like to nominate Olivia Griffiths for a Star Award for her work with the maternity team over the last few months. Olivia agreed to support us in producing a maternity discharge from hospital video, a project that has been discussed for several years. Olivia has supported us throughout the process of writing the script, supporting us with edits to make it more conversational, filming, editing, and putting together the video, and embedding QR codes and links.

Olivia has working collaboratively and flexibly with the team; she has been so kind and supportive. The team are so grateful to Olivia for her skills, knowledge, and support during this project us to make this important improvement to our services.

Julie Walker, Occupational Health Service Lead | **York** | **Nominated by colleague**

Julie took the role of Service Lead to cover a secondment post. This role was beyond her previous role, but Julie took it on and has excelled in the work she has done. She has been a big part of the new occupational health Cority system, dedicating her time and effective decisiveness. Any problems have been raised and resolved to make it easier for managers and recruitment and Occupational Health staff to use the system efficiently. She is a consummate professional and goes above and beyond our expectations to support our team, our customers, and our mission. We would not be where we are today without Julie's dedication and enthusiasm to make Cority work for everybody.

Julie has taking on the new role like a duck to water and shows she has great leadership skills. She has a strong set of values, cares deeply about occupational health, and promotes the services to a high level. Julie is an active listener and always reachable, supporting her staff and creating a positive work environment. She will go out of her way to support you with her empathetic and caring demeanour. Nothing is too much for Julie and she will think outside of the box if she does not know the answers. Julie is continuously working hard to make a bigger and better Occupational Health. Julie has assigned staff to the hospitals for drop-in vaccine sessions so staff on shift can be immunised, and now she is preparing for the next chapter, such as the upcoming flu and COVID clinics.

Julie constantly praises her staff and gifts us with a homemade treat at Christmas to show her gratitude. She ensures we are hydrated on hot days with bottles of water and encourages us to take part in wellbeing days and team building activities. I am grateful to be part of such a great team and having Julie support me through my own personal struggles when she was only a phone call away. Julie is an asset to Occupational Health and has worked so hard over the past year, taking on an almost impossible task with new challenges.

Ward 31 **York** **Nominated by patient**

I was admitted to Ward 31 within an hour of being told I had leukaemia. It was a tough time for me and I was crying into my pillow on the first night as I felt so confused and alone. Nurses came to comfort me and explain to me how they would always be available if I needed anyone to talk to. The staff were incredible at keeping my spirits high, explaining anything I needed to know about medication or tests I needed to go for, allowing me to keep some independence taking my own medication most of the time, and, when I left, helping explain to me how to inject myself.

I was on the ward for a few weeks and then readmitted a few days later. Everyone was so kind and made me feel so welcome again. The return really made me feel low as I had not wanted to return so soon and Ian woke me with a bacon sandwich the next morning after finding out I could request one. In the time I was in there, some of the other patients were challenging, but the staff continued to treat everyone with the same patience and compassion. Although I hope to remain well enough to stay out of hospital, I know that Ward 31 staff would take good care of me.

North Community Team	**Community**	**Nominated by colleague**

The team is short staffed in general, but this day, we had less staff that usual. The team I worked with were excellent and supported me when I was worried about things. The team pulled together and completed all tasks due that day, they even attended my meetings so that there was no delay in patient care. Members of staff worked extra hours and covered areas unfamiliar to them.

The care and compassion they showed to me made a huge difference to how I was thinking and feeling. My team leader was fantastic, she listened and provided care and support when needed. Every single member of the team acted concerned over my wellbeing. My colleagues did not have to do this, yet they went above and beyond to support me whist pulling together to meet the patients' needs in a timely manner. It makes a huge difference in your career and day-to-day working life if you feel supported by your colleagues. My colleagues showed me how excellent they are that day and how well they can work together to put the needs of the patients first whist supporting each other.

Elinor Tomalin, Medical Student	**Scarborough**	**Nominated by colleague**

On a very busy recent shift, Elinor entered the ward and asked if she could help with any care tasks. While explaining the routine tasks, a patient became extremely unwell. Straight away Elinor asked how she could help. She quickly sought all equipment needed to help this patient and helped relay information to colleagues. While colleagues and I assisted the patient, Elinor helped the other patients in the bay with their needs, such as personal cares.

Elinor stayed on the ward and helped until the patient was stable; in this time, she liaised with the doctors and nurses to understand why the patient was so unwell, this helped her hugely in her training and she did extremely well. Elinor was extremely helpful in this situation and it was great to see her level of enthusiasm and dedication to the patients. I believe Elinor will make a fantastic doctor and I hope to work with her again. Thank you, Elinor, and keep up the good work!

Patita James, Catering Service Operative **York** **Nominated by colleague**

Patita is a valued member of our team and I want her to know we are very lucky to have her working with us. Thank you, Patita.

Ayse Kucukkoylu, Catering Service Operative **York** **Nominated by colleague**

Ayse has not been with the catering team long, but in the short time that she has, she has brought a smile, joy, and a happy working environment. Thank you, Ayse.

Emma Pavis, Sister **York** **Nominated by colleague**

I joined this team in September after feeling like I needed a new challenge. Emma, the manager, is super. She is extremely professional and has ensured a smooth transition from my old ward into a new team. She has constantly checked in to review my progress and taught me a lot while making sure I had the opportunity to practice what I have learnt. Emma has been extremely supportive and has a lovely attitude towards the job, she has pushed me to further my career, and I have now enrolled onto the band 4 programme, and I could never have done this without her.

I was bereaved earlier in the year and Emma was extremely caring and sensitive when it came to my return to work. In my entire work life, I have never been as happy as I am now, and I would like Emma to be recognised for this support she has given me. Emma is a big promoter of diversity, and she recognises talent from all over the world which is apparent in such a diverse and multicultural team. I want to say thank you for bringing the best out of people and keep doing your best work, you are a fantastic manager.

Fiona Hargreave, Palliative Care Registrar **York** **Nominated by colleagues**

Fiona joined our palliative care team this year and demonstrated a huge passion in providing a safe, effective, and caring approach to our patients. She truly goes above and beyond to ensure that palliative patients receive the best care. She has been a driving force in implementing the new ReSPECT forms in the Trust, supporting and educating staff and patients to make the transition safer and more effective.

Fiona has proven an incredible support to us. She listens and is responsive when we need advice and support, nothing is too much trouble, and she thrives on helping with the more complex patients. She also works the on-call rota for the hospice, so can be on call overnight and then come in for a busy shift the next day. Despite being so busy, she always prioritises her patients and team to make sure that we are all looked after.

Fiona is an incredible baker and brings in the most delicious cakes when she feels that we need a bit of a pick me up. Fiona has been a ray of light since she joined our team and her steadfast, reliable, and straight-talking approach is a breath of fresh air. She has so much energy, and her enthusiasm and passion for palliative care is infectious. This needs to be recognised and appreciated across the Trust.

Jemma Clancy, Specialist Palliative Care Nurse **York** **Nominated by colleague**

Jemma has been providing cross-site cover for the palliative care team in Scarborough, alongside balancing her clinical educator role and CNS role at York. She has worked additional shifts on her days off to provide support to the team in Scarborough when staffing numbers have been depleted. Jemma is committed to delivering gold standard care to the palliative patients she sees. She is one of the most caring and compassionate nurses that I have had the privilege to work with. Her communication skills are incredible, and she has endless amounts of patience with more complex patients and their families.

Patients and their relatives often feedback that her caring and compassionate nature has been an amazing support to them. Whenever staff are feeling overwhelmed or struggling emotionally, she is there to provide a listening ear. Jemma deserves recognition for always embodying the Trust values. Jemma provides everything that York Hospital strives to achieve in terms of Trust values.

Carol Burnett, Domestic Assistant **York** **Nominated by relative**

I would like to recommend Carol, the domestic assistant on Ward 14, for a Star Award. Not only is she thorough and conscientious with exceptionally high cleaning standards, but she is a pleasure to interact with. She is always good humoured and funny. My family and I have been visiting my mother on Ward 14 for six weeks, and Carol has always greeted us with warmth and compassion. We look forward to seeing her and enjoy our banter together!

We are extremely grateful for the superb care she has received from every single hospital employee. Of all my mother's carers, we shall miss Carol the most. Please accept our sincerest appreciation for this most wonderful member of your team at such a distressing time in our lives.

Denise Cope, Cleaning Operative	**York**	**Nominated by colleague**

Denise is the most helpful member of staff we have in our team. She works all over the Trust, including York Hospital, Nelsons Court, White Cross Court, St Monica's, and renal centres. We can call her on the day and she will be happy to go to any of these areas. I have never heard her say “No” when asked to go anywhere.

Suzi Ord, Staff Nurse, Niamh Drummond, Healthcare Assistant, and Holly Allinson, Student Nurse	**Scarborough**	**Nominated by patient**

I arrived at Scarborough Hospital by ambulance and was taken to resus with DKA. The team in there were like angels. I was conscious for most of the duration, and I could see the efficiency, responsiveness, and dedication the nursing team, led by Suzi, demonstrated. They worked under significant pressure, juggling resources and workload, to deliver a seamless service. All with a great bedside manner and being personable, they literally saved me. Thank you.

Kym Burkett, Staff Nurse	**Scarborough**	**Nominated by relative**

I want to nominate Kym for going above and beyond in her care and attention during my mother’s time on Oak Ward. Kym listened and understood my concerns and I did not feel dismissed. She was there for mum but also worked in partnership with me to support my mum. Kym has renewed my faith that there are effective and caring nurses in your Trust. I want her to be recognised for her integrity and professionalism. I cannot thank her enough.

Jenifer Simpson, Healthcare Assistant | **Scarborough** | **Nominated by relative**

Jenny was not just caring; she was interested in making and motivated to make a difference to me and my mum. She was diligent, tenacious, professional, and engendered trust. I want her to know her efforts are very much appreciated. She is the best healthcare assistant I have come across in the 35 years I have been caring for my mother.

Kayleigh Roberts, Service Manager | **Scarborough** | **Nominated by colleague**

Kayleigh has taken on a new role as Service Manager and has taken any obstacles in her stride. She has modernised the Cardiorespiratory Department's admin team with new practices and SOPs. She spends so much time and effort making sure everything runs as smoothly as possible for everyone in the team.

Desmond Spencer, Generic Therapy Assistant **York** **Nominated by patient**

I cannot thank Des enough for his patience, care, and careful handling following knee replacement surgery. In addition to getting the perfect balance between encouragement, firmness, and compassion during physiotherapy, he also managed an unpleasant pre-syncope episode during physiotherapy when my blood pressure dropped, causing me to feel very unwell and faint. I was very anxious and scared, but Des was able to expertly manage both the physical challenges of ensuring I was seated safely with no possibility of falling and reassuring me so I felt safe and calm.

Des had a gentle and kind but firm approach to the physiotherapy I needed to undertake and gave me honest feedback regarding when I would be ready to go home. I appreciated his honesty and positive encouragement. He was the person who made a huge and positive impact upon my recovery. I would like to nominate him for a Star Award because during that painful and stressful time he was a shining star.

TACC Ops Management Team **York** **Nominated by colleague**

I have had the pleasure of being part of the TACC (Theatres, Anaesthetics, and Critical Care) Ops Management Team for the past 12 months. I have seen how Maggie, Anthea, and Sarah work tirelessly across all three sites and countless departments/areas to deliver on both national and Trust targets. They are visible, supportive, involved, and caring managers for their directorate, and I have seen how the various teams they are responsible for appreciate their leadership - both clinical and non-clinical.

TACC is a challenging, complex environment but they successfully manage this whilst remaining positive, respectful, selfless, and professional. I am new to the Trust and management and I have learnt so much under their guidance, as well as seeing how their many teams value their consistent, supportive, and inclusive leadership. Day Unit, ICU, Theatres, Admission areas, Waiting List, Patient Flow teams, and PACU have all fed back how much they appreciate their management and, for this, I think the three of them should be recognised.

Selena Rea, Staff Nurse	**Nelsons Court**	**Nominated by colleague**

Selena goes above and beyond to look after her patients and provide safe care. She is always helping other members in her team and checking if anyone needs help. She is a real asset to the MES team!

Paediatric Emergency Department Team	**York**	**Nominated by relative**

First, I would like to give special thanks to the receptionist who checked my daughter in. She was lovely, so professional and kind and she had a calm and polite manner. She was like a little beam of sunshine. She is credit to the hospital for being so lovely in such in a busy Emergency Department. Lyndsey was also an absolute delight. She was so kind and compassionate and provided speedy and top rate care to my daughter.

After a quick triage, we were through to the lovely lady in X-ray (I did not catch her name). To her I would like to say, thank you ever so much for being so gentle and reassuring with my Eva. You explained what it was and why you were doing it, treating Eva as not just a child by talking her through it all. This is a perfect way to treat a young child who is a little anxious and sore. Thank you! Even on our way back to ED, we were helped by a passing nurse who saw I was a little confused about where to go. She could have just walked by but instead showed kindness by stopping to direct and assist. You have an amazing staff! We were seen again by Lyndsey, who treated my daughter's wound and provided me with the correct after care advice and leaflet. She reassured me when I was worried that I had wasted everyone's time. Lyndsay, thank you ever so much for being so kind and caring and for the fast pace at which we got through the department. I am super thankful for you and for your assistance.

The whole department were fantastic and provided care that was way above any previous experiences we have had within a hospital setting. Thank you so much. The hospital should be proud of the amazing staff that were on shift this evening as they were beyond fantastic. Not all superheroes wear capes, some wear NHS-issued uniform and name badges! Thank you again.

Jason Angus, Healthcare Assistant | **York** | **Nominated by relative (1), relative (2), relative (3), and relative (4)**

(1) Jason was an absolute magician at keeping everyone calm and laughing. He is a sweet, well-natured person and a credit to the department. He gave us all the necessary information we needed after my daughter was injured.

(2) When my daughter came into hospital with a high fever and was quite upset, Jason spoke to her gently, telling her everything is OK. We still have the glove in the car that he magically sent away and she loves telling that story.

(3) Jason is a wonderful human who cheered up my child and my sister. He did such a good job that they are hoping to be able to visit again soon to see some more magic tricks!

(4) My son cut his head significantly. He was covered in blood and Jason was so calm and kind and put me and my son at ease. He did some magic tricks with my son and his teddy which really impressed him. He cleaned him up, cleaned the wound, and explained what was happening. He could see I was struggling and trying to hold back the tears, and he was so kind to me and made a cup of tea and explained that everything was going to be OK. Jason was just wonderful.

Jason was also so lovely to my oldest child who had witnessed the accident and gave them both stickers. Jason also gave my little boy a gold star from his uniform as a special prize for being brave and he has not taken it off since. I cannot thank him enough. All the staff we met were wonderful, but Jason was the first person we met, and he just helped calm me down. Thank you.

Louisa Watkins, Midwife **York** **Nominated by colleague**

Louisa comes on shift and takes everything in her stride. No shift feels unsafe. During a challenging day yesterday, Louisa kept so calm and kept her head above the water so the women were safe and the staff really felt safe too. Louisa goes above and beyond and is always helpful to others, taking workloads spreading them out and offering a helping hand. We really are lucky to have a midwife like Louisa!

Belinda Smale, Nurse Practitioner **York** **Nominated by patient**

When I attended with a fractured ankle, I was seen by Belinda. She was fantastic and took an immense amount of time over my treatment. Nothing was too much trouble. I wish to express my sincere thanks for her manner, approach, and empathetic style when dealing with me.

Gareth Ducey, Chef **York** **Nominated by colleague**

During the last month we have struggled with chefs in the catering department due to unforeseen circumstances. During this period, Gareth has worked extremely hard and been heavily relied upon due to staffing shortfalls, offering his support within the team. Gareth has shown exemplary attitude in line with the Trust values by going the extra mile. He changed his days off to accommodate the business to ensure we are always able fulfil our requirements as a Trust. He has shown great team spirit and was always on hand to offer any additional support whenever required.

Gareth has done this with a smile on his face and never complaining. The catering production team all demonstrate a great teamwork, but Gareth has really stepped up, which is very much appreciated.

Sarah Bowman, Medical Engineering Administrative Officer	**Scarborough**	**Nominated by colleague**

Sarah exemplifies outstanding dedication and professionalism in her role as the face of the Medical Engineering department in Scarborough. Every day, she greets visitors with a genuine smile and a warm welcome, making a positive impression on everyone she encounters. Her consistency and reliability are unparalleled; she embraces every task with a commitment to excellence.

Recently, Sarah has faced significant pressures due to resource shortages beyond her control. Despite these challenges, she has not only maintained her high standards but has also innovated new working practices and developed more efficient methods to complete tasks. Her proactive approach in adapting to new practices has been instrumental in keeping the service running smoothly. While the team has rallied around her, Sarah's dependability, and initiative in stepping up to additional responsibilities are truly deserving of recognition. Her ability to sustain exceptional service under difficult circumstances highlights her indispensable role within the Trust and YTHFM.

Same Day Emergency Care	**York**	**Nominated by patient**

The entire SDEC unit of York Hospital deserve an award. They made it a pleasure to visit. They work phenomenally well as a team who obviously enjoy working with each other, whilst maintaining approachable and highly professional standards. Every member of the department that I met was a pleasure to meet. From the extremely friendly and efficient ladies who delivered food and hot drinks to all the nursing staff whose paths I crossed who were lovely. Their high levels of friendliness and professionalism made a scary time for me all the better. They thoroughly deserve an award and need to understand that they are so very much valued in their roles.

Endoscopy team	**York**	**Nominated by patient**

I attended for a colonoscopy and made it to the reception desk before I ended up in a heap on the floor, not feeling well with a high heart rate and dizziness. The staff quickly got me into a wheelchair and into one of their recovery bays. They looked after and monitored me, and a doctor checked me over. I did not end up having the colonoscopy done and was instead admitted to AMU for a few days.

I wanted to say thank you to the endoscopy team for looking after me. Their shift started with looking after me before any other patients had even gone in for their procedures. They were all so kind and reassuring and were happy to have me in one of their recovery beds until I could be admitted to AMU. They sorted my blood tests, ECG, and observations prior to getting taken to the ward. I had a gastroscopy a few weeks prior to this and again the whole team were so lovely and caring. The endoscopy team work well together to give patients the best experience when they may be worried or scared.

Lena Rafiq and Molly Dale, Staff Nurses	**York**	**Nominated by patient**

I was admitted on to AMU for a few days following an adverse reaction to colonoscopy bowel prep and issues with my heart rate. During my first two days on the ward, Lena and Molly were my nurses. They both have amazing bedside manners and were so kind and caring. Molly and Lena made sure that the doctors were aware of what was going on with my heart rate and that it was captured on ECGs. They also ensured I was not discharged while I was still feeling unwell and while my heart was still misbehaving.

I wanted them both to know they are amazing at their jobs and that the Trust is lucky to have them. I watched them interact with all the other patients in my bay and they treated each person as an individual and so kindly. AMU is a very busy and demanding ward, and still nothing was too much bother for them, and how busy they were did not affect the standard of care.

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

I attended ED after injuring my arm. The department was continually full and busy. Despite the pressure and workload, all members of staff, from checking in and triage to x-ray, and doctor on discharge, could not have been more patient, caring, and understanding. This helped those waiting to be equally patient, grateful, and caring. It helped restore my faith in human nature. Thank you, ED, you are all absolute stars.

Lena Rafiq, Staff Nurse	**York**	**Nominated by colleague**

We recently had a patient have a stroke while being cared for in the Acute Medical Unit. Lena was able to quickly identify the problem, carry out assessments, and escalate it for the doctor to review urgently. This resulted in the patient being referred to the stroke team who provided the investigations and care needed. This is not an isolated incident, as Lena has always been a proactive nurse who likes communicating with patients and their families, besides being thorough in every work she does. She is great nurse!

Rhys Standfield, Palliative Care Educational Lead	**Scarborough**	**Nominated by relative**

I work for the Trust in a clinical role, but I recently experienced being on the other side when my dad spent his final days of life in Scarborough Hospital. The care he received was excellent, and Rhys in particular supported not only Dad, but also us as a family through what was a very hard time.

Rhys provided support, kindness, and laughter to us over the course of the week that he was in hospital. He was informative, helpful, and caring and addressed the difficult conversations head on, which was exactly what we needed. Rhys is a credit to the Trust, and I felt it important to recognise how fantastic he is in his role.

Elaine McQuade and Alison Farnhill, Ward Clerks	**White Cross Court**	**Nominated by colleague**

Elaine and Alison took on supporting the lower limb specialist wound clinic as well as continuation of their other roles. There were the challenges of learning new skills and new procedures, but both embraced these challenges and supported our team with professionalism and empathy to our patients. They became an invaluable part of our service and I would like to share appreciation both from the team and the patients they supported.

Audiology team	**York**	**Nominated by relative**

Our daughter has had ongoing chronic problems with her ears. This team have given her regular appointments, plus arranged ear moulds and medication. They have transformed her health and wellbeing. Thank you all so much, it is really appreciated by the whole family.

Ashley Cowton, Anaesthetist	**Scarborough**	**Nominated by colleague**

A patient on Rainbow Ward required cannulation but they were difficult to cannulate due to their medical condition and having a lot of fear and anxiety. It was decided that they needed to be sedated to perform the cannulation.

Ashley was amazing with the child throughout the whole experience. He talked them through what he was doing and put their anxiety at ease. He chatted to about TV shows that they enjoy and explained everything that he was doing. He also rang their tertiary care centre to check that he was using a dressing that was appropriate for their complex medical condition.

Ashley made what could have been a traumatic experience as nice as possible for the child. Ashley then rang the ward to follow up on the patient a few days later to see how she was doing.

Amy Jacks, Midwife | **Scarborough** | **Nominated by colleague**

Part of Amy's job role is to be a practice assessor to student midwives, assessing their overall performance and confirming their achievement of practice learning objects. I have recently worked alongside Amy where she identified a student who was struggling to meet their objectives. Amy promptly flagged this and initiated additional support for this student. This support, however, went above and beyond her job role. Amy used her free time to arrange meetings, check on the student's progress, and seek out and arrange learning opportunities.

With Amy's dedicated support and investment, the student successfully passed the placement block. Amy is an exemplary practice assessor, and we are incredibly grateful for the support that she provides to the students.

Becca Hunter, Clerical Officer | **Community** | **Nominated by colleague**

I would like to nominate Becca because she has gone above and beyond since joining the children's therapy admin team. She is a valuable member of our team and is always ready to help when we have been under pressures due to staffing. She is a star!

Hannah Howe, Medical Secretary | **York** | **Nominated by patient**

When I arrived, Hannah showed me where to go and wait and was very supportive and friendly. After the procedure I had a fit and fainted and she came to check up on me and have a chat about it. She did not have to do this but it was comforting. It was nice that she came to check up on me and be compassionate and caring. I would like to thank everyone who helped me during this time, but Hannah went above and beyond, which I really appreciate. I understand the NHS is under pressure, but it is nice that a staff member put that aside and showed true concern and compassion and took a few minutes out to talk to me.

Oak Ward	**Scarborough**	**Nominated by relative**

My daughter was admitted to Oak Ward with metabolic acidosis and ketosis. She has high functioning ASD and anxiety making illness even more challenging for her. The staff on Oak Ward have been amazing, treating her with such care and compassion despite how incredibly busy the ward was. In particular, Senha, Charli, Victoria, Harry, Sophie, and Jessica.

Not only did they show incredible care towards Jess, but they looked after me too. I was able to stay with her which was so important to us because of the ASD. I have truly appreciated the time medical staff have taken to look after Jess and regularly update us, answering my many questions! Thank you again.

Single Point of Access team	**Community**	**Nominated by colleague**

The SPA team and two district nurses worked together on a pilot to reduce the number of tasks sent through to the District Nursing Hubs. This would enable staff to spend less time managing tasks, reduce duplicity, and ease the burden on the nurse in charge, freeing them up to support patients and new members of the team. The staff in SPA were so helpful and supportive of the pilot and went out of their way to make us feel welcome and help us in any way they could to ensure the pilot ran smoothly.

All the team, with no exceptions, worked in partnership with us, learning from each other and giving us a greater understanding of the calls coming through to them. It also helped them by having clinical advice available in a timely manner. This has resulted in myself and my colleague spending our shift when triaging over the weekend with the team and offer reciprocal support to help patients and staff requiring support from the district nursing teams. The Star Award nominations is a way of thanking them for everything they do for the district nursing teams.

Aoi Deguchi, Healthcare Assistant | **York** | **Nominated by colleague**

Aoi is passionate about her work and patient care is her top priority. She is dedicated and helpful, with no task being too much for her. She has a very kind and welcoming smile, can coordinate well, and is a good team player. She has stood out as a hardworking and dedicated individual in all she does.

Long COVID MDT **York** **Nominated by colleague**

The long COVID team have been working tirelessly over the last three years to improve the lives of patients referred with post-COVID syndrome. This is a relatively new clinical condition affecting many patients, some of whom experience complex combinations of persistent and very disabling symptoms. At present, there is little in the way of clinical evidence to support more rigid diagnostic criteria or targeted medical treatments. Management therefore mainly revolves around therapy support and self-management with lifestyle adjustments, etc. Since the long COVID MDT service was opened in 2021, referral rates have been high and waiting times for in person, individual therapy review have become very long. Combined with the fact that many of these patients have been symptomatic for many months (sometimes years) before referral, the team recognised that a change to the pathway was required to help embed self-management principles earlier and start patients on the pathway to recovery sooner.

The pathway has now been transformed, with newly referred patients receiving a triage telephone call within two to four weeks of referral. If needed, further investigations or specialist referrals can be made, and most patients are enrolled onto an online group education and self-management programme. These sessions give them opportunity to hear from our therapists and the group nature of the sessions provides peer support and the knowledge that they are not alone in their experiences. At the end of the programme, each patient is contacted by telephone to update on their progress and to establish if they need referral for further individual bespoke clinical sessions with a member of the team. In addition, patients are enrolled onto an app which provides tools for monitoring symptoms, further self-management resources, and the ability to directly message the team.

Feedback from the group sessions has been overwhelmingly positive. Furthermore, the waiting time for meaningful clinical intervention has been transformed; going from an up to six-month wait from referral to clinical review, to a few weeks. I am proud of the team for their ongoing work and innovative approach to supporting this group of patients, who otherwise can struggle for many months or years with significant impacts on their quality of life.

York, Scarborough, and Bridlington Endoscopy teams	**York, Scarborough, and Bridlington**	**Nominated by colleague**

The endoscopy teams at York, Scarborough, and Bridlington were assessed at the end of 2023 for JAG accreditation. This process is extremely lengthy, with all staff working together to provide evidence prior to the visit so they could prove they met the standards required to meet the accreditation level. This process took months of work in the lead up to the visit by the national assessment team. The assessment team undertook site visits to all three endoscopy units at York, Scarborough, and Bridlington. This is the first time the units have been assessed jointly. Following the rigorous assessment process and a 6-month action plan, the teams were awarded accreditation by the Royal College of Physician's Joint Advisory Group on GI Endoscopy.

More than 20,000 diagnostic and complex therapeutic procedures are undertaken each year at the Trust, and the JAG accreditation is awarded to endoscopy services which have demonstrated they meet best practice standards. In the accreditation report, the assessing team were extremely complimentary about the service, including the clinical teams, management team, and support services, describing evidence of "high quality clinical leadership and engagement between teams" and how the "harmonising of the excellent practices between sites will provide a high quality of care to all patients and training for all the workforce". The assessors noted that the service is well led and well governed. The services were also congratulated on supporting international recruitment of team members and the value they add to the diversity of the service and patient care.

The accreditation has been awarded for five years, subject to successful completion of an annual review which will be undertaken in November 2024. This team have been phenomenal in their drive to achieve this accreditation demonstrating the very best of teamwork, support, and hard work. I feel very proud to work with them all and supporting them to provide the best services they can for our patients.

Penny Furness, Healthcare Support Worker | **Scarborough** | **Nominated by colleague**

Penny works as a healthcare support worker (HCSW) in Scarborough Hospital's Emergency Department and is truly an asset to this area. She demonstrates our Trust values in an area where a patients' first impressions of the whole hospital are formed. She is friendly, professional, approachable, and an excellent ambassador for the hospital and the NHS. Penny has been trained through our 'Buddy System' and she is always willing to guide new HCSW's in the department, taking new to care band 2 HCSW's under her expert instruction. She has remarkable healthcare knowledge and escalates, in a timely manner, a patients care to a registered nurse.

Penny will go above and beyond for all patients and always acts as an advocate when needed, listening to the patients' views and concerns. She has a wealth of knowledge and is excellent at providing information for the patient to make their own informed decisions, signposting to relevant agencies, while remaining within her limitations. Penny looks forward to new challenges and embraces any new opportunities to learn new skills that could potentially bring improvements to the department and to patient care.

Justine Smalley, Relief Ward Clerk | **Scarborough** | **Nominated by colleague**

To support my job application to be a ward clerk, I was looking to shadow a ward clerk to gain NHS administration experience and exposure. Justine kindly agreed to let me shadow her. Justine was great person to shadow. She was open, kind, and patient. She made me feel at ease and explained the tasks.

Elaine Langan, Patient Experience Administrator | **York** | **Nominated by colleague**

Elaine has been helping my team in the Women's Unit at York and Scarborough hospitals to set out our annual patient satisfaction surveys. She has been so helpful and shown great patience with someone whose skill set is not IT. I have found her knowledge to be excellent and she has managed to solve issues around our surveys that have caused us many problems over the years. She made herself available at a moment's notice when I gave her little to no time to turn the surveys into a useable format. She is a credit to her team.

Anu George, Staff Nurse | **York** | **Nominated by colleague**

I would like to nominate Anu for a Star Award because she is a huge credit to our ward. Anu is kind and caring and always goes out of her way to support patients with anything they need. No job is too big or too small for Anu, she is an excellent team player. This is an award that Anu thoroughly deserves and that will give her the recognition for the amazing nurse she is.

Tallulah Allan, Healthcare Assistant | **York** | **Nominated by colleague**

I work on Ward 39 and have worked with Tallulah on many occasions. She goes above and beyond for patients. She never says no when asked for help and patients and staff all love her. This month, she has been Star of the Month on our ward to acknowledge her hard work and dedication. We are all proud to have Tallulah on our team.

Ryan Seed, F1 **York** **Nominated by colleague**

Dr Seed went out of his way to travel from Liverpool to York on his day off to complete a coroner's referral for a deceased due to no other doctor being able to complete it in a timely manner. His manner, politeness, friendliness, and professionalism in understanding the urgency of the task and taking the time to travel the distance to complete this for us was above and beyond and prevented further delay for the family. Ryan spent time reviewing the patient's medical notes and completed the document required with care and compassion.

Deborah Hawkshaw, Nursing Band 6, and Nicola Slade, Senior Occupational Therapist **York** **Nominated by colleague**

Nicola and Debbie were superstars in helping me to fulfil a palliative patient's wish to be at home when they pass. The family had let us know on Sunday they would want the patient to be at home and these two had ensured her discharge was fast tracked and got everything done to get her home. They helped me to arrange hospice at home care, organised carers for multiple times a day, and ensured the family did not have to stress regarding funding. They also helped me liaise with the district nurses to ensure the patient's care at home was compassionate and caring like it was at the hospital. Thank you, both, for all your help. I could not have done it without you.

Nichola Burdett, Specialist Nurse **York** **Nominated by colleague**

Nikki was amazing at ensuring my patient's palliative care was absolute. She ensured the patient had syringe drivers in place before going home and helped me to organise all the palliative care parts so that my patient was able to have her wish to be at home during this time fulfilled. We were able to fast track her discharge with all the support in place from various nursing teams.

Nikki went above and beyond communicating with the family and ensuring my patient's pain was kept in control. She liaised with doctors to ensure she was comfortable throughout her stay at the hospital and that she remained comfortable when she was discharged. Thank you for all your help!

Danielle Crampton, Healthcare Assistant **York** **Nominated by colleague**

Danielle went above and beyond for a patient who had no fixed abode. The patient mentioned the day before that they had no other clothes and felt bad as they thought their clothes were dirty and that they were smelly, which they felt upset the rest of the patients. The next night, Danielle brought them in some fresh clean clothes and the patient was very happy with this. They showered and changed straight into them, and he was so grateful for it. Thank you, Danielle, for always going above and beyond for our patients.

Hannah Miller, Community Nurse **Community** **Nominated by colleague**

Hannah is a hardworking, kind, professional nurse that cares for her patients in the community so well. She is such a joy to work with and is an asset to the team and the patients she cares for. Thank you, Hannah, for all your wonderful hard work supporting the team, it never goes unnoticed!

Carla Maginnis, Domestic Supervisor | **York** | **Nominated by colleague**

Carla has gone above and beyond during staff shortages during the last two months. She has covered the office, come to work on her days off, and worked late and weekends. She works to the best of her ability, ensuring offsite units are staffed. Management recognises the pressure this has put on her and want to say thank you!

Patricia Hunter, Domestic Training Manager | **York** | **Nominated by colleague**

Patricia has worked extremely hard to help the team during recent staff shortages in both the supervisor team and the HPV team. She has worked long hours to ensure that the shifts are covered, including on her days off, night shifts, and weekends. Management recognises that Trish always goes above and beyond to help us and want to say thank you!

Joanne Gill, Diabetes Specialist Nurse | **York** | **Nominated by patient**

I turned up at the diabetes department without an appointment with severe bruising on both arms from faulty blood glucose sensors in a state of anxiety over an array of diabetes-related problems and asked to speak to somebody who might be able to help. The receptionist was exceptionally helpful. She asked me to wait and after a very short time Joanne Gill, the Specialist Diabetes Nurse, came to fetch me into her office. I cannot speak too highly of her gentle concern and compassionate care. She applied a new sensor to my arm and showed me a better way of applying them; she told me she would arrange for me to be invited to an insulin management course in York. Above all she listened to me and encouraged me.

Orlagh Mulholland, Consultant Dermatologist **York** **Nominated by colleague**

Dr Mulholland is very passionate about all patients under her care and goes above and beyond to ensure these patients are managed in a timely manner, especially within the cancer pathway. She is a very caring, compassionate, and supportive to her patients and colleagues, making working alongside her a privilege and joyful experience.

The skin cancer team frequently hear positive feedback from patients, and we felt this should be recognised, as well as recognition for her dedication to the skin cancer service. Well done, Dr Mulholland, this is a much-deserved award nomination from the Skin Cancer CNS team.

Jacob Harlow, Clinical Learning Facilitator | **York** | **Nominated by colleague**

I am thrilled to nominate Jacob for his outstanding dedication and invaluable contributions as a Clinical Learning Facilitator during the four-week HCSW academy. Jacob's commitment to excellence and unwavering support have significantly impacted not only me but also countless healthcare support workers (HCSWs).

Throughout the academy, Jacob consistently demonstrated a remarkable level of professionalism and expertise. His deep understanding of clinical practices and teaching methodologies has empowered HCSWs to excel in their roles with confidence and proficiency. Jacob's ability to convey complex concepts in a clear and accessible manner has been instrumental in the professional development of all participants. Moreover, Jacob's compassion and empathy have shone through in his pastoral support of me and others. His genuine concern for the wellbeing of his students extends beyond the classroom, creating a nurturing environment where individuals feel valued and supported.

One of Jacob's most admirable qualities is his knowledge, which transcends his years of experience. His insights and guidance reflect a depth of understanding that is truly commendable and have undoubtedly enriched the learning experience for everyone involved. Jacob's dedication, expertise, and unwavering support make him a deserving candidate for recognition. He has positively impacted the lives and careers of many, me included, and I am honoured to nominate him for this well-deserved acknowledgment.

Colette Walkington, Biomedical Scientist **Hull** **Nominated by colleague**

Colette has been commended by the Infectious Diseases Consultant for diagnosing Malaria in a young boy who presented at ED with confusing symptoms that were posing a mystery. A full blood count was sent to the laboratory and Colette identified abnormal results and made a blood film to review down the microscope. She spotted malarial parasites in the blood film (not easy in a normal blood film stain), contacted ED, and did all the relevant tests and stains needed to identify the Malaria and provide the clinical team with an accurate parasitaemia level. She was also helpful to the ID Consultant, Haematology Registrar, and clinical team in ED. Well done Colette!

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

October 2024

Pinpoint Research Team **York** **Nominated by colleague**

I am nominating the Pinpoint Research Team for their exceptional teamwork and outstanding results. Their dedication has led to them recruiting the highest number of monthly participants so far for the Pinpoint Study, across both York and Scarborough hospitals.

Each member of the team plays a crucial part in identifying, approaching, and gaining consent from participants, and without all their hard work the study would not be able to run. They consistently go above and beyond in a busy clinical setting; ensuring all potential patients are approached and given the opportunity to take part in this important area of research. They are a pleasure to work with and their ability to support each other deserves to be recognised and celebrated.

Lena Rafiq, Staff Nurse **York** **Nominated by colleague**

I would like to nominate Lena for all her hard work since joining the AMU team. She has received lots of feedback from patients pointing out her kindness and compassion. She also steps up to take charge and coordinate the busy AMU team on days when there are no band 6 nurses. She has proven herself to be an asset to the team, and I believe her hard work should not go unrecognized.

Vicki Render, Clinical Lead – Stroke | **Bridlington** | **Nominated by colleagues**

For the past four months, Vicki has split herself between three sites; Bridlington and York hospitals and White Cross Court, dedicating her time to support staff and improve patient services. Vicki has demonstrated her vast experience and knowledge in stroke and has been approachable, supportive, kind, and open to all members of the team. She has strived to improve service flow and integrate the various teams to improve communication and general efficiency.

Vicki has additionally gone above and beyond to cover two highly demanding jobs across three sites over four working days. She has provided educational sessions on various related therapist techniques in line with updated RCP and NICE guidelines. She has also been a huge support to all patients with complex needs, directing members of the team to where they can get support and what we can offer as a service. Vicki has encouraged an open and honest work environment where all members of the team could discuss any non-clinical related concerns and she has actioned the right support for the team such as burnout workshops. She has been a great asset to all the teams and we would like her to be aware of our appreciation and support.

Casey Arnott, Sister	**Scarborough**	**Nominated by patient (1) and colleague (2)**

(1) Casey rocks. She has taken care of me twice now and nothing is too much trouble. She is an awesome person.

(2) I am nominating Casey for a Star Award in recognition of her outstanding contribution during a night shift in the ED. While covering the Minor Injuries Unit, she responded to a pre-alert call for a trauma patient and noticed her colleague in Resus was feeling overwhelmed with two other critically ill patients. Without hesitation, Casey stepped in to assist, making thorough preparations for the incoming trauma patient. Her delivery of care was exemplary, displaying compassion and empathy throughout the patient's treatment.

Casey's commitment to providing excellent nursing care continued until the patient was discharged, demonstrating her dedication and professionalism. Her willingness to go above and beyond, despite only offering assistance, is truly commendable and deserves recognition. Casey's exceptional care has made a significant impact on this patient's experience.

Willow Ward and Polly Dickerson, Consultant in Ophthalmology	**Scarborough**	**Nominated by patient**

The whole team on Willow Ward were responsible for making my experience incredibly positive. They were caring, welcoming, warm, and compassionate. I was very anxious the morning of my surgery, and they put me at ease and explained all the procedures to me as they went along. My aftercare was explained to me and my follow up appointment with Ms Dickerson was great. It was five-star treatment. What a brilliant, fantastic team! Thank you.

Sophie Ruszczynski, Cancer Pathway Coordinator | **York** | **Nominated by colleague**

Sophie is the multi-disciplinary team (MDT) coordinator for the head and neck and thyroid MDTs. She works tirelessly to ensure the MDTs run smoothly and that all patients are discussed appropriately. Sophie will receive hundreds of emails a week, juggles many patients, scans, and histology reports, and always does it perfectly. She is reliable and it is incredibly reassuring being able to pass her the details of a patient, knowing that she will track them and bring them to the MDT at the right time.

While I hope that Sophie knows that the rest of the head and neck team really appreciate all that she does, I suspect that none of the patients that she helps so much will ever realise how crucial her role is to their care. I hope the Trust recognises how good she is and the service that she allows us to provide on behalf of the people who will unfortunately never know how much she helps them.

Joanne Radley, Healthcare Assistant | **Scarborough** | **Nominated by colleague**

When I came to ED, Joanne was taking the blood pressure of everyone who came in. She had a smile and kind word for everyone. I was there for eight hours so had plenty of time to see everything. She was on her feet for the whole shift and, during my eight hours in ED, I never saw her sit down. Then, an hour before she was due to finish her shift, she came round to everyone with a smile to see if they would like a tea or coffee. I have never seen anyone work so hard and will never forget her!

Harriet Gibson, Associate Practitioner | **Scarborough** | **Nominated by colleague**

I would like to nominate Hattie for her excellent job in our ED. She has recently gone above and beyond for a patient and concerned relatives. The patient was in ED and was discharged home by the RATs just before our night shift started. Later in the night, the patient's family phoned us to ask if we knew where they were as they had not returned home to Manchester as not answering their phone. Hattie took over leading on this and we started by asking the patient transport team if they had received a referral for the patient, but they had not. Hattie had spoken to the patient during the previous night shift and had learned that they were a in holiday maker at the Scarborough Hotel. Hattie contacted the hotel, but they never arrived there either. Their family and we were worried about them. Hattie phoned the local taxi firm to ask if they had had any bookings under the patient's name but they had not.

Finally, Hattie phoned another Hotel and the staff there were able to locate them and passed on the message that they needed to contact their family to let them know they were OK. We were so glad to have located them and that they were safe. Throughout the rest of the shift, she continued to show kindness to patients, including escorting one to HRI for an urgent MRI. She is a team worker and there for the patients need. I highly recommend her for a Star Award.

Jessica Tong, Critical Care Nurse | **York** | **Nominated by colleague**

I worked with Jessica overnight, where she was co-ordinating a busy night shift on intensive care. She showed amazing leadership, organisation, and compassion for staff and her patients throughout the shift. We had an especially challenging patient who was unwell and requirement input from ED, security, and the police to keep them safe and the staff safe. She went above and beyond to achieve this with a good outcome for the patient in very challenging circumstances. She constantly ensured that the staff were supported, thanked everyone involved and made sure people had a break, me included. She is an asset to the ICU team.

Anna Simmons, Deputy Sister | **York** | **Nominated by colleague**

We are launching a new software to support the eRostering system, which will replace EOL. This app will allow staff to see their roster, view bank shifts, make requests for leave/shifts, etc. Since mid-September, the eRostering team have been offering drop-in sessions and visiting clinical areas to offer direct support to staff making the change to the new software.

We visited Ward 11 and found that Anna had been proactive in supporting her colleagues to make the change to the new app in advance of any support from eRostering. All the ward seemed happy with the new app and Anna was happy to continue to offer any assistance to her colleagues. We are looking for Super Users to fulfil this type of role and Anna forged ahead without being asked or receiving any direct training herself. She was confident and positive about the change and was glad to have helped others. Anna went above and beyond her normal role to help her team and deserves recognition and thanks.

Ella Banken, Medical Laboratory Assistant, and Emma Blundell, Associate Practitioner | **York** | **Nominated by colleagues**

Ella and Emma have been invaluable to the set up and delivery of a commercial research study delivered by the Surgery and Family Health Care Group of the Research and Delivery Department. Whilst being brand new to the department themselves, they have shown exemplary competence by assembling a meticulous schedule of delivery for a clinical research trial of high complexity. They have provided excellent laboratory training to the delivery team, contributing to the safety and wellbeing of our research patients. We are so grateful for all their support!

Rapid Assessment Team **York** **Nominated by colleague**

The Rapid Assessment Team in York consists of excellent physiotherapists, occupational therapists, and social workers who go above and beyond every day. Each member of team utilises their expert and advanced skills to promote excellent patient-centred care. The team are an incredibly asset to ED as they support significantly with patient flow and admission avoidance and contribute to MDT decision making. The team also work very hard around service improvement, and team members have developed a statistic gathering system that supports with quantitative data feedback around performance. This data also highlights the significance and impact of therapy in the ED.

Despite not having a team lead embedded in the team currently, members of this team demonstrate leadership skills daily. This team has been hit with hard times, low staffing, and challenges much like other teams, but they continue promote and accept change in the hopes of providing an even better service. I expect that this team will continue to grow and rise to challenges no matter how difficult and to do their best for the patients that need them.

Patrick Collins, Healthcare Assistant **Scarborough** **Nominated by relative**

Special thanks to Patrick for being so kind to my dad when he came into ED. Throughout the night, Patrick went the extra mile and spent time while doing observations, chatting to Dad about his cars, working life, and friends. Dad so happy and energised in his lovely chats with Patrick. This made a huge difference to his last few days before he passed away. Thank you, Patrick, your kindness will stay with me forever.

Endoscopy team	**Scarborough**	**Nominated by patient**

I came in for an endoscopy and colonoscopy, and from the moment I walked into the department, I was treated with the utmost kindness and respect. What could have been very undignified procedures were carried out in a way that meant my dignity was completely respected. From the receptionist to the consultant, and everyone else I came into contact with, were faultless. The department itself was spotless. The whole department deserve a big well done. They certainly provided a five-star service.

Mandy Boyd, Deputy Facilities Manager	**York**	**Nominated by colleagues**

Mandy has played a pivotal role in setting up over 450 user access accounts and email addresses across multiple sites. By utilizing email searches to identify staff without email access or with unused accounts, she proactively ensures that they receive the necessary access. Her efforts have been instrumental in helping the soft services transition to digital pay statements.

Mandy has also stepped in to assist other sites struggling to complete this significant task, all without expecting anything in return. She never complains, always prioritises teamwork, and consistently seeks opportunities to improve systems for the benefit of others. Mandy is a team player and a valuable asset to our teams. The small things always have the biggest impact on moral.

Angela Keenan, Medical Artist | **York** | **Nominated by colleagues**

Angela, at very short notice, was able to translate our pathway redesign ideas for Selby Urgent Treatment centre into something much more presentable. She created an impressive piece of work in a tight timescale. making the drawings we sent her look amateurish. It was a piece of work that would have taken us a long time to put together and delayed our project plan.

Despite the original plans being difficult decipher in some points, through her great communication skills and understanding, she was able to pull this together without any complication. She followed all the Trust's values of excellence and kindness. She went the extra mile for the benefit of patients who will be on cared for on this pathway and for us and our lack of digital skills. It is much appreciated. Thank you, Angela.

Caitlynn Eckhardt, Specialist Nurse | **Bridlington** | **Nominated by colleague**

Caitlynn has been especially helpful with the fast-track discharge of a palliative care patient under my care. She ensured they had oxygen installed in their home and kept me updated throughout this process so the patient could have their wish of being discharged home fulfilled. Caitlynn kept coming on the ward to support and check on the patient and her family. She went above and beyond with the other teams involved to ensure the patient was discharged safely and compassionately. Thank you for all your help.

Nicoleta Clarke, Healthcare Assistant | **York** | **Nominated by patient**

I met Nicoleta when I was admitted to hospital with a fractured hip when I was on holiday. I was so frightened because I did not know anyone. Nicoleta was a beautiful shining face full of support and optimism. Every day she was my cheerleader and gave me the hope and strength to go on. She goes above and beyond what her duties require. Nicoleta is truly one of a kind.

Louise Moran, Administrative Assistant	**Selby**	**Nominated by colleague**

During the launch of the new roster software, Loop, we visited different sites and areas. Louise put herself forward as a point of contact, got the software downloaded herself, and asked for some time with me so she could assist any staff not able to visit during the drop-in. It was quite a busy day with lots of enquiries and I was grateful for Louise's assistance in addressing some of the staff members' queries about the new app and ensuring everyone was seen too.

The rostering team are asking for Super Users going forward to act as support resources for the departments, but Louise did all of this without being asked to help. She was also friendly and made me feel welcome in a new site environment. She deserves a formal thank you, via this nomination, for her role in supporting the launch for Selby-based staff.

Jo Collier, Senior Audiology Practitioner	**York**	**Nominated by colleague**

Jo is an outstanding colleague who demonstrates the Trust values every day. You frequently see her go above and beyond for patients. I have patients sing her praises and get disappointed that they are not seeing her. The patients are often still chatting with her as she walks them to the waiting room. There have been days when she has offered to see patients during her lunch breaks or admin time as she has so much care for her work and her patients.

Jo recently had a patient who had significant ear wax build-up, and she managed to make an appointment with ENT for wax removal as patients struggled to use their hearing aids with the wax. She used her lunch break to book an appointment for that patient to ensure she could check their hearing aids were functioning better. I later saw that patient during a different appointment, and they spoke about how much it meant to them that Jo to do all of that for them and that they were able to hear their family better.

Dan Hartlett, Imaging Support Worker	**York**	**Nominated by colleague**

I want to nominate Daniel for a star award after he was using the lift with a patient unknown to him. The lift malfunctioned and the patient told him they were claustrophobic and proceeded to have a panic attack inside the lift. Daniel spent 20 minutes calming and reassuring the patient as they were struggling to breath due to hyperventilating. His compassion and ability to stay calm and reassure the patient means Daniel deserves a Star Award.

Sophie Bilbrough, Community Staff Nurse	**Community**	**Nominated by colleague**

I want to nominate Sophie for a Star Award as she stayed after work hours and revamped the staff notice board in the staff room. She also rearranged the staff room to make it more user friendly and cleaned and hoovered. She created a fun “staff pets board” with everyone’s pets on and this put a smile on everyone’s face and increased moral. Sophie is an asset to the team and goes the extra mile.

Ward 39 **York** **Nominated by relative**

Our dad was a long stay patient on Ward 39. The whole ward showed nothing but patience, kindness, and care, often over and above. Nothing was ever too much trouble and the patient-centred care on Ward 39 is like nothing we as a family have ever seen. It is a blueprint for how all hospital wards could and should be; whatever Andrew is doing as a leader needs bottling and sharing with others.

Ward 39 are a strong team and a team that oozes care and compassion, really taking the time to get to know their patients and their families, and doing all they can to get them through what can be a rollercoaster, not just ticking the boxes. We had some very tough times, and through it all (in no particular order) Jan, Lisa, Marie, Will, Tallulah, Nicoleta, Jerril, Elisha, Tia, Alfons (agency), Nicole, Justine, Theo, Claire, Steph, Josebel, Fernando, and all the team were amazing and truly are superstars. We will forever be grateful.

We lost count of their acts of kindness; they were so numerous. The standouts were:

- Jan who never gave up and went the extra mile to build a strong, caring, and respectful connection with dad. This was crucial with dad due to his complex health and reluctance to engage. Without Jan's determination we feel there is a strong chance Dad would not have made it. She is an excellent role model and we saw her behaviours mirrored by others.

- Lisa for being super supportive when things got tough and frustrating and really listening and acting on what she heard.

- Will, Tallulah, and Nicoletta who got us all through some dark days, not just making sure dad was OK, but that we were too. They put the care in healthcare assistant.

- Marie for being the sunshine of the ward. Nothing was ever too much trouble and she noticed the little things like how dad likes his porridge (and then left that information for colleagues when she was off) and made the most of a therapy dog opportunity for him. We believe that the mental health of our dad, and other patients we got to know,

improved when Marie was on shift. She is excellent at her job and a true inspiration.

- All who helped make dad's wish to attend my sister's wedding and give her away a reality. From Claire arranging permission, to Jan and Tallulah getting him ready and Jan, Will, and Marie giving him the confidence to go - they were all amazing.

All these things matter, and there were many more from those mentioned, so many we could probably write a book. Ward 39 is a fantastic ward providing holistic care. Thank you all for everything, we will miss our times on Ward 39 and the amazing team. I doubt we will ever think or say that about any other hospital ward in the future - they truly are unique and should all be proud every day of the work they do. They are a credit to the Trust. Thank you.

Regan Heyworth, PACS Support Officer | **York** | **Nominated by colleague**

Regan is a member of the PACS team, which is the team that helps keep the radiology system running. Regan is often the person who responds to my emails asking for help to get imaging across to other local trusts so we can progress care. He always actions the tasks quickly and updates me when it is done. I am nominating him because it never seems too much trouble for him. He always personalises the emails with things such as “have a nice day” and “hope this helps” which makes it feel more like a conversation than a transaction.

I could not do my job without Regan and the team as we rely on them to get images to where we need them to go. I get a lot of emails and the personal touch Regan adds means I do noy mind reading and responding to his. He is an unsung hero, along with the rest of the PACS team.

Gemma Bird, Special School Nurse | **Community** | **Nominated by colleague**

Gemma was on shift as the only registered nurse at Hob Moor Oaks special school and was alerted to an issue with one of the children by their classroom staff. She immediately attended and having assessed the needs of the child, coordinated with YAS to have the child transferred to hospital for treatment urgently. She remained calm and diligent throughout and was commended by school staff for her compassion and caring nature.

The schoolteacher said, “I would like to share with you how amazing Gemma was when a child was taken poorly last week. Gemma was so calm and so supportive to the child and staff. She was calm and very organised with everything. At the end of the day, she came to the Hub to give us an update which was very much appreciated.”

I think Gemma demonstrated professionalism and compassionate care in a difficult situation, and was able to support the child, school staff, and the child’s family.

Haldane Ward	**Scarborough**	**Nominated by patient**

The Haldane Ward team are a friendly, happy, and polite team, from the cleaners to the nurses to the surgical team. They made to feel comfortable from start to finish. They are a caring team. Well done Haldane Ward, you are a great team doing a great job.

Gemma Kane, Orthoptist	**York**	**Nominated by relative**

We have met a lot of professionals since having our daughter. Gemma always goes above and beyond for our disabled daughter. She is so thoughtful and attentive and it is such a pleasure to visit her. She is caring and compassionate and it never feels like a chore to visit her.

Rashid Abbasi, Consultant | **Scarborough** | **Nominated by colleague**

Dr Abbasi joined the team as a Locum Consultant in May 2024. A week later, we unexpectedly found ourselves a consultant down. It left a gap in ward cover, multiple clinics, and most notably all the lung cancer work. Most locum doctors would have shrugged their shoulders or run a mile from the ensuing disruption. Instead, he took on the role of cancer lead; chairing MDT meetings, triaging referrals and scans, carrying out the weekly bronchoscopy list, and undertaking fast track clinics. Doing so meant giving up the working from home day which was part of his original agreement. At the time, Dr Abbasi was commuting approximately 70 miles to Scarborough every day. The only way to ensure adequate ward cover and set up clinics meant going to Bridlington Hospital due to room availability, adding almost 20 miles more to his journey. Despite travelling nearly 200 miles every day, you could rely on Dr Abbasi to remain cheerful, kind, approachable, and willing to help. Thankfully, he now spends a few nights locally so we do not have to worry about him as much.

Dr Abbasi has a wonderful manner with patients. Everyone comments on how happy patients are after meeting him – even if he has delivered bad news! Everyone gets his full attention for however long they need. His ability to bond with patients quickly allows him to advocate on their behalf, irrespective of age or background. He is universally loved by the respiratory team and was truly God sent in our hour of need. There is no doubt our service on the east coast would have collapsed without him. Dr Abbasi is an inspiration to those around him and credit to the profession. He deserves a lot more than a Star Award, but it will have to do!

Marta Cieslak, Staff Nurse **York** **Nominated by relative**

My mum was in the Vascular Imaging Unit to have a procedure. Everyone was caring and welcoming to her. I saw Marta look after my mum after the procedure. She was kind and understanding.

When Marta returned my mum to her ward, she stayed to help her use the bathroom as the ward was busy, even though she had already handed mum over to the Ward. She then helped change my mum's bedding and clothes. Marta showed the Trust values and nothing was too much trouble for her, even though I knew it was getting close to her shift ending. I am very grateful for Marta's care and compassion during a stressful time.

Peter Coleman, Waiting List Co-ordinator **York** **Nominated by colleague**

Peter has gone above and beyond to help sort out my surgery. He is kind, considerate, and extremely knowledgeable and I think he deserves to be recognised for his professionalism. He is an amazing gentleman.

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

I was a day case for a hip operation on Kent Ward. The care I received from all the staff associated with Kent Ward was first class. I was apprehensive about the operation, but from the moment I arrived on the ward until I left, I felt supported and cared for. Nothing was too much trouble for the staff. I also felt involved in the whole process every step of the way, everything was explained to me and I was encouraged to ask questions and voice any concerns I had.

I have heard that the NHS is broken, but what I experienced on Kent Ward that day was far from broken. I could not have had better care anywhere in the world or if I had paid thousands of pounds for it. I would like to take this opportunity to say a huge personal thank you to the whole team. Well done all.

Michelle Croft, Housekeeper	**Scarborough**	**Nominated by colleague**

Michelle is an extremely valuable member of our team. We had a patient who was stressed about being in hospital. They had developed headaches and could not sleep well. The patient said that all they needed was some fresh air. Michelle, despite being busy as the ward housekeeper, took the patient outside two to three times a day. The patient felt much better and their headaches improved.

Jules Rennison, Maintenance Worker	**Malton**	**Nominated by colleague**

Jules is always helpful and friendly. He goes above and beyond to provide an efficient maintenance service for Malton Hospital. He acts quickly when issues are identified. For example, I found a leak coming through the ceiling on the main corridor which could have been a slip hazard to patients and staff members. As soon as he was informed, he acted quickly identify the leak and ensure that patients and staff members were safe.

Dhillon Young, Healthcare Assistant	**York**	**Nominated by patient**

Dhillon is focused on paying attention to individual needs amidst his busy role. He has consistently, during the two weeks I have been on the ward, been accurate in where his energy and attention goes for every patient on the ward, and this has been carried out with good humour and diligence. No task was left undone. He even came to say goodbye to me at the end of his shift, as he knew I was being discharged before his next shift.

Diabetes Service	**York**	**Nominated by patient**

I was referred to the diabetes team when blood tests showed I might have type 1 diabetes. The team were friendly, put me at ease, and explained everything at the right level. They really took the time to allay some of my fears. Also, I am transgender and I especially appreciated that they did not misgender me. I am feeling so much healthier now I am on the right medicine.

Jan Simpson, IT Trainer	**York**	**Nominated by colleague**

I am nominating Jan for a Star Award because, from the moment I met her, she has been nothing but helpful. She is a fantastic trainer and she goes above and beyond when we have S1 and IT issues in the South and North Community. Thank you, Jan.

Luke Addison, Clerical Officer	**York**	**Nominated by colleague**

I am nominating Luke for a Star award as he is always helpful and efficient at getting our uniforms over to us, which has previously been a challenge as we are not based on site. I would like to thank Luke as he saves us lots of time. Thank you from the South and North community teams.

Andrew Smith, Discharge Liaison Officer	**York**	**Nominated by colleague**

Andy went above and beyond to source bed rails so an end-of-life patient could go home. There was an issue with the patient's bed at home and we were advised that this bed would need to be uplifted and a new bed delivered as the required bed rails could not be sourced. This could mean a wait of up to five days for the old bed to be collected and then a further delay before a new bed is delivered. The nature of this patient's condition meant they were unlikely to live long enough for this process to happen. Andy went above and beyond by not only sourcing these bed rails, but also by liaising with Medequip to deliver and fit these within four hours. Thank you, Andy, you really are a star!

Outpatient Department	**Malton**	**Nominated by colleague**

Over the last six months, all the Malton OPD staff have actively supported eye clinic during a shortage of staff. This meant we were able to avoid cancelling clinics. I want to say thank you. I only joined a month ago but I can still see their teamwork and commitment.

Ward 28	**York**	**Nominated by colleague**

I came up to Ward 28 to take a patient down to the Discharge Lounge. The patient was asleep so a Healthcare Assistant tried to wake them up. The patient did not want to leave the ward so argued with the Healthcare Assistant. The Discharge Liaison Officer then came over to explain why they needed to go to the Discharge Lounge. Along with their physio, they were able to persuade them to go to the Discharge Lounge. During all of this, the Ward 28 team were outstanding. Well done Ward 28.

Wendy Oliver, Deputy Sister **York** **Nominated by colleague**

I have had the pleasure of working alongside Wendy for many years. Wendy is a much loved and respected member of the team. She not only gives unconditional support and knowledge to the staff on SAU and Ward 14, but she is often sought after by other wards for her help and experience. She does this without hesitation and makes sure it is not only her team that is supported on a night shift, but all wards that need it. If staff need her help, she gives advice with understanding and compassion, and always offers to go out of her way to help. She is very hard working and makes sure the whole team work together to provide the best care we can give. Her attention to detail and experience makes her, without a doubt, one of the best nurses within this Trust.

In emergency situations Wendy is often a port of call for many staff due to her experience and calm nature. In stressful moments, or moments of conflict, she remains professional and calm, while also making herself very approachable to anyone who needs her. With more complex patients who require more intervention or support, she is very thorough in making sure all documentation and appropriate referrals are done so the best care is provided. Wendy is well respected and admired by all the staff, not only on Ward 14, but also from medical staff and surrounding wards. She upholds the Trust values and values of the NMC, and always goes above and beyond for patients and staff. This is just a snapshot of how exemplary Wendy is as a nurse, and how we should all strive to be like her. The Trust is very lucky to have her.

Philippa Middleton, Sonographer **Scarborough** **Nominated by patient**

Phillipa conducted my ultrasound scan. During the scan, Phillipa took the time to listen to my journey of being diagnosed with endometriosis with compassion and empathy. She made me feel listened to, which is not always the case with my condition. I was very touched with how Phillipa went the extra mile to make me feel heard.

Claire Tuson, Specialist Nurse | **York** | **Nominated by patient**

My referral to the team was quick, an appointment was made within two weeks via a telephone conversation and I received a letter confirming that appointment. The nurse specialist was caring and compassionate and explained the process in detail.

On the day of the appointment, the nurse let me to be seen before my appointment time and introduced herself. Throughout the appointment, she was caring and ensured everything was explained to me in a very clear and methodical manner. Details were explained thoroughly and the next steps involved in my care. Approximate time scales for test results were also discussed. An explanatory leaflet was given with a contact telephone number if I had any further questions. She made me felt at ease throughout and accompanied me to my blood tests. She stayed with me and them accompanied from the department. An NHS employee to be proud of and not to be taken for granted.

Jasmine Kent, Physiotherapist | **Scarborough** | **Nominated by colleague**

Jasmine has been a band 5 physiotherapist in the elderly team over the past six months. It has been a difficult time to be a part of the team, but Jas rose to the challenges and took everything in her stride, frequently stretching up to band 6 responsibilities. She went to an extremely difficult best interest meeting earlier this week, where she was surrounded by staff more senior than herself. She did lots of investigation work in preparation and advocated for the patient excellently. Nothing seems to phase Jas. Her get up and go attitude and heart for the patients is why I am nominating her for a Star Award.

Paige Taylor, Staff Nurse	**Scarborough**	**Nominated by relative**

My mum was recently admitted to Juniper Ward on end-of-life care and Paige was one of the nurses looking after her. My mum instantly took a liking to Paige and was very fond of her. Unfortunately, my mum's condition worsened and she was taken to a hospice. We were very surprised to see Paige there on secondment. She continued to care for my mum while she was there and was there when she peacefully passed away. Having Paige be a constant in her care made a huge difference to us as a family and I cannot thank her enough for her care and compassion. She is an asset to the Trust and exemplifies the Trust values.

Abigail Mayes, Staff Nurse	**Scarborough**	**Nominated by colleague**

Abi is an amazing colleague and the support that you get from her is unbelievable. I went through a very hard time in my life and she helped me all the way through. She has checked up on me on shift, was a shoulder to cry on, and gave me the strength I needed to carry on whilst on shift. She supported me through the entire process from start to finish. Even now she will still check up on me.

When working with Abi, she always listens to your concerns and will do everything in her power to help. Even after a rough shift Abi takes the time to talk and offer support. She had a patient with dementia and we gave them a teddy bear to help them remain calm and not feel alone. This showed me the compassion Abi has for others. She puts her patients and colleagues before herself. She is a fantastic nurse and a credit to the ED at Scarborough. I want to thank Abi for all her support. What an amazing colleague and an amazing person she is.

Juniper Ward **Scarborough** **Nominated by relative**

My mum was admitted to Juniper towards the end of her life. The team on Juniper were amazing with the time they took with her and the care they provided. From Alan who made her multiple cups of tea and was never offended when she did not drink them, to Yvonne and Richard who kept me up to date with what was happening, and everyone in between. Thank you all so much.

Nikolaos Pantzaris, Specialty Reg General Surgery **Scarborough** **Nominated by patient**

Dr Nick Pantzaris did my colonoscopy and he is a true professional. He put me at ease from start to finish and described what was happening during my procedure. He also told me about any discomfort that was about to happen so I was well prepared for it. He took great care of me and was very thorough. He is a fantastic endoscopist and I cannot thank him enough.

Ana Gabay, Staff Nurse **Scarborough** **Nominated by patient**

I recently had a colonoscopy at Scarborough Hospital and Ana Gabay looked after me when my procedure was done. She was kind and caring and is a fantastic member of the team. Thank you so much.

Bev Taylor, Sister **Scarborough** **Nominated by patient**

I recently had a colonoscopy at Scarborough Hospital and Bev Taylor looked after me from start to finish. She immediately put me at ease and was kind and caring. She is a fantastic nurse and a true professional. She is a brilliant asset to the team and I cannot thank her enough. Thank you, Bev, you are amazing.

Janine Dawson, Associate Practitioner | **Scarborough** | **Nominated by patient**

I recently had a colonoscopy at Scarborough Hospital and Janine Dawson was a true professional and fantastic at her job. She put me at ease and is a fantastic asset to the team. Thank you so much.

Glenna Panis, Staff Nurse | **Scarborough** | **Nominated by patient**

I recently had a colonoscopy at Scarborough Hospital and Glenna Panis was with me through my procedure and put me at ease the whole way through. She is a true professional and a fantastic asset to the team. Thank you very much.

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

I recently had a colonoscopy at Scarborough Hospital and Limy Mathew was a true professional and looked after me during my procedure. She is a fantastic asset to the team and I would like to say thank you very much.

Emergency Department | **Scarborough** | **Nominated by patient**

I recently went to Scarborough ED to have an ECG and the staff were fantastic, Heidi on reception, Richard, a nurse, who did my ECG, and Dr Adam who looked after me. These people are truly amazing and I cannot thank them enough for looking after me and taking their time to find out the problem. Thank you all so much.

Amy Johnson, Nursing Band 7 | **York** | **Nominated by patient**

I would like to commend the care and treatment that Amy Johnson provided me at the Urgent Care Centre. Upon arrival at the UCC I was slightly lost and wandered into the nurses and treatment area. I was warmly greeted by Amy who was sympathetic and compassionate to my injury and promptly offered pain relief before directing me to the seated waiting area. We waited patiently and was finally assessed and treated. Amy was apologetic for the prolonged wait owing to be understaffed and complex caseloads. Despite the hectic workload and long duty hours, Amy was warm, personable, and thoroughly explained the process and treatment plan I would receive that day and beyond.

What resonated with me, and in part, prompted me to commend Amy, and her UCC team, was the upmost dedication to her profession under what must be the most challenging of workplace environments. Amy told me she loves her job. She is probably one of many unsung heroes within the Trust, and the wider NHS, that perhaps get little recognition. Amy is undoubtedly an asset to the Trust.

I left feeling truly valued as a patient and reassured that I had received high quality care and treatment. Amy went over and above what you would reasonably expect as a patient. Often, we are quick to criticise and slow to recognise exceptional service in whatever setting. I sincerely hope Amy is recognised and appreciated by your organisation.

Jessica Wade, Consultant | **Scarborough** | **Nominated by colleague**

Recently, one of Dr Jess's junior medical colleagues sustained a needlestick injury whilst treating a patient who appeared to be high risk for serious blood-borne viral infections. This was, understandably, an extremely anxious time for the resident doctor involved in the incident and, because of the hour of the day, help from the usual sources was not easily obtained. Dr Jess was incredibly supportive of her colleague and went over and above to ensure that they were provided with the appropriate treatment and response that they needed.

The resident doctor was grateful for the support and practical help provided to them and, as a result, felt much better about the events that had taken place and felt looked after as a team member. On that day, Jess embodied the Trust values of excellence, openness, and kindness. She made the difference between a horrendous experience for her colleague and a tolerable one, for which her resident colleague is extremely grateful.

Williams Acholonu, Healthcare Support Worker | **York** | **Nominated by colleague**

From day one, Williams has been such a happy, smiley, and friendly person. Although he has only worked in the department for a couple of months since finishing the HCSW Academy, he demonstrates the Trust values and behaviours in everything he does. He is kind and caring towards patients and nothing is ever too much.

Since starting, I have heard so many positive comments about Williams and his approach to the caring profession. So, Williams, on behalf of all of us that admire your happy outlook on life and your passion for the job, well done. You are an asset to our team and our patients.

Megan Kane, Ophthalmic Imaging Technician	**York**	**Nominated by colleague**

Megan has had the idea of making a booklet to help children before they have medical photography as this can be scary for them. I think that this is a commendable effort off her own bat.

Jean Cooper, Healthcare Assistant, and Kirsten Power, Healthcare Assistant	**York**	**Nominated by colleague**

In recent weeks, the department have been very short staffed. Jean and Kirsten have given 110% helping everyone in the department. They always put the patient first and they never hesitate in helping our specialist nurses, consultants, admin staff, reception team, and physiotherapy department. They are positive and helpful and nothing is ever too much for them. They are an absolute credit to the neurology and outpatient departments. We would be lost without you both. Thank you for everything you do.

Sue Dawson, Clinical Skills Facilitator	**Scarborough**	**Nominated by colleague**

I recently attended my yearly ILS recertification. It was not until the course started that I realised that I might find the course challenging on a personal level. Sue created a supportive environment where I felt able to speak up and share my story and worries. During the course Sue was extremely mindful of this and adapted the course for me whilst still ensuring that I and the other candidates met our learning objectives. I am extremely grateful for Sue's kindness and for creating a supportive environment in which to learn and develop. Working alongside colleagues like Sue is truly what make our organisation a wonderful place to work.

Heidi Buckle, Generic Therapy Assistant	**Scarborough**	**Nominated by colleague**

Heidi works hard in her role within the therapy team. The role has been especially challenging over the last six weeks where she has done the work of three people. Yet she has continued to do her job with her usual enthusiasm and, despite everything she has faced, has continued to do her absolute best for all her patients. She is a great team player and communicates well with her peers. The patients love her and she always has a smile on her face.

Tom Douthwaite, Security Officer	**Scarborough**	**Nominated by colleague**

While on patrol, Tom noticed an elderly patient in distress at the main entrance. Tom approached the patient and asked if they were okay. After a brief conversation, Tom learned that they were waiting for their transport home, were thirsty and alone, and had no money. Tom offered to bring them something to drink. Tom used his own money to purchase the patient a bottle of water and reassured them. Through this small act, Tom demonstrated the Trust value of kindness.

Jemini Mistry, Audiologist | **York** | **Nominated by colleague**

Jem has recently become a band 6 specialist paediatric audiologist, and now leads her own two tester paediatric clinic. While working in our paediatric two tester clinic, Jem has shown great compassion and understanding to our patient's parents.

On one occasion, we saw a child with a parent who was particularly worried about the child's hearing and speech. The child passed the hearing test with flying colours, however, as Jem knew how concerned the parent was, she performed extra tests to reassure the parent, even though this was a test Jem was yet to do without supervision of a senior audiologist. Jem remained calm in the situation, reassured mum, and encouraged the child as we carried out the test and gave a thorough and reassuring summary of the results. Jem made sure to spend the time talking to the parent about their concerns, encouraging them to seek further advice and referrals where appropriate. It is lovely to see Jem flourish in this new role!

Hawthorn Ward | **Scarborough** | **Nominated by colleague**

We recently had a patient on our ward who had autism and had a hospital passport for their stay. The team on Hawthorn that cared for her and her new baby all took the time to read her passport and really get to know her, not just as a patient but as a person, which she said really helped her to feel safe and cared for on our ward. There were some complications with the patient, but the midwives caring for her took so much time and care explaining and reassuring her.

We had a new maternity support worker, Jess, who was only on her second day, when the patient's blood pressure became quite high due to her white coat syndrome and the pressure she felt for it to be normal to be able to be discharged. Jess spent lots of time using different approaches to relax her, including playing some music that was meaningful to the patient. Jess managed to get the all-important readings she needed and the patient discharged home with her newborn. A real team effort!

Rebecca Lawty, Maternity Support Worker	**Scarborough**	**Nominated by patient**

I would just like to thank Becky for the care and empathy she gave when I was at my most vulnerable. She went above and beyond to help me and nothing was too much trouble. I was staying on Hawthorn Ward after having my first baby. I had not had a good night previously due to how I was feeling. She went above and beyond for me and nothing was too much for her. Every first-time mum, in fact, all mums, need someone like her looking after them. Thank you so much.

Monica Reeve-Smith, Administrator	**York**	**Nominated by colleague**

Over the past few weeks, I have noticed how caring, compassionate, and empowering Monica is to patients, as well as how helpful and pleasant she is. I am nominating Monica for a Star Award as her drive, enthusiasm, and kindness is noticed and because she stands out for the patient-centred care she offers over the phone.

Gabriella Valks, Ward Sister	**York**	**Nominated by colleague**

Gabriella is my ward manager. I am an internationally educated nurse (IEN) and Gabby has been nothing but supportive since I began working at the Trust. She has helped me and other IENs on the ward blend in smoothly. She acknowledges our efforts but will also point out our flaws and provide us with range of options on how we can do better. I am very lucky to be working with such a compassionate person as Gabby.

Andrew Holmes, Security Supervisor	**York**	**Nominated by colleague**

Overnight there was a burst water main on Wigginton Road, which had then flowed onto the hospital grounds, almost completely covering the main road into the hospital. Andy went above and beyond to make sure it did not get worse for the safety of staff, patients, and visitors and went out to clear the drains in dropping temperatures to clear the flood water. The water was cleared within about 10 minutes thanks to Andy's quick thinking. This meant cars were able to navigate the main road more effectively, making it safer for all road users and pedestrians. Andy is a highly dedicated member of the security team at York Hospital.

Emily Potter, Staff Nurse	**York**	**Nominated by patient**

Emily is fantastic at looking after people in recovery. She is friendly and upbeat, with a very caring nature. She put me at ease from the moment I came back onto the ward and nothing was too much trouble. I want to thank her for being so attentive and proactive when she noticed something was not right in my case and took action when it was needed.

Emily ran her room in a welcoming manner and everyone felt so much at ease. She brought a lovely glow to the room. She brings a personal touch, building relationships with her patients by talking about interests and anything that builds a connection. Emily oozes positivity that makes you instantly feel better. What a star member of staff, she is made for her job!

Brian De-Alker, Assistant Facilities Manager	**Scarborough**	**Nominated by colleague**

I am nominating Brian for being an excellent manager. It does not matter how busy or stressful things are, he will always take the time to talk to you. He will do his best for you and often works crazy hours to cover for sickness. He goes above and beyond for this hospital and we really are lucky to have him. He works incredibly hard and is a credit to the hospital.

HPV Team, Elaine Dixon, Service Manager, and Jo Dea, Head of Facilities	**York**	**Nominated by colleague**

Over the last few weeks, several ward moves have been scheduled and, as part of these, the requirement for HPV spaces between them becoming vacated and then reoccupied has been a key element to ensure we do everything to minimise future risks of infection. At the last moment we had to rearrange a few of the ward moves and condense them into a shorter period, as well as adding additional moves.

The team who manages, coordinates, and undertakes the HPVing have been flexible, accommodating, and considerate and have done everything to ensure all the work could be done on time. This resulted in the moves happening on time and not having to cancel patients. They have done this alongside the normal requirement for cleaning wards and areas. E laine and Jo have been nothing but professional, kind, and considerate of all that was asked of them and the team. They and the whole team demonstrated the Trust values, they put the patients first, and it has been a pleasure working with them as part of this series of moves.

Labour Ward and Maternity Theatre Team | **York** | **Nominated by relative**

My wife and I recently had our first child delivered through York Hospital Maternity Services. From the first appointment through to triage, delivery, and our latest midwifery led postpartum check-up, we could not have asked for more. Every member of staff we came across was friendly and knowledgeable and could not do enough for us. Whilst this nomination is for the team that specifically supported us through the weekend of delivery, our heartfelt thanks extends to everybody involved in our wider journey, throughout which we felt fully supported and exceptionally well cared for. If ever we had a query or concern, it was addressed immediately. The ward was always immaculately clean, so credit to the team responsible for maintaining such high standards.

This award nomination is, however, dedicated to the most wonderful set of midwives and the surgical team whose service and care towards to us that weekend was, quite simply, as good as it gets. Thank you to all involved and a special note for Karen and midwives who supported us so professionally through labour and to the midwife El, who later looked after our new arrival throughout the first night in the absence of Dad and reassured Mum throughout, allowing her to get some rest. El's support and calm, caring manner really did epitomise the incredibly high standard of care we received throughout this process.

Thanks also to the surgical team led by Consultant Charlotte, we are eternally grateful. You brought our child into the world in the calmest, reassuring, and fantastically efficient manner. As a dad to be you had my heart and soul on the operating table that evening, I knew at the time and I know now they could not have been in better hands. Keep up the fantastic work.

Heather Stuart, Deputy Associate Chief Nurse, and Lorraine Noble, Operational Practitioner	**Scarborough**	**Nominated by colleague**

At 3am, I received a telephone call from Heather as I was second on-call. She calmly recounted that she had been called in to respond to a fire incident on Mulberry Ward at Scarborough. It appeared that the fuse box had caught alight and burnt out as it had been in contact with water from a suspected leak. The Facilities on-call had been contacted and was on site to review the issue. At this point, the second fuse box started 'sizzling' so it was clear that this was going to be affected too.

As there was no power to support IV pumps, call bells, lighting etc., Heather worked with Lorraine to make a swift decision to evacuate the ward. They both came up with a speedy plan to move the 16 patients to EAU and Haldane, which we had already opened to six patients due to capacity issues on site. They kept all the patients and staff calm and enacted the move within 40 minutes, enabling the Facilities team to secure the ward safely until the contractor electricians could attend on site the following morning.

I was struck by their level of calm, their professionalism, their practical 'can-do' attitude, and their commitment to acting quickly to maintain safety. This was towards the end of what had been an exceptionally busy shift, with significant pressure on ED and the wards and high activity from YAS ambulances. I know they will both just feel this is part of their job, but I would like to recognise their exceptional efforts during that night shift and to say thank you.

Laura Johnson, NMTR and NICOR Coordinator | **Scarborough** | **Nominated by colleague**

Laura's role is quite often forgotten about or not even known by a lot of colleagues within the Trust. Laura strives to give 100% to her role and always achieves this, even when faced with system changes, IT issues, and a lack of the accurately recorded data that she requires to do her job effectively. Laura is always proactive, self-sufficient, and dedicated to achieving her deadlines, which she always manages to do. Jonathan Dunn, Roo Byrom, and I wanted to nominate her for a Star Award to acknowledge and thank her for her dedication to the role, the patients, and the Trust.

Jonathan said, "Laura has been extremely helpful when I have come into a new role. She has helped me understand the processes regarding patient identification and the data needed for NMTR. She has helped gather data on rehab prescriptions at short notice. We will be aiming to mimic the patient identification process Laura has developed in York."

Roo said, "She is absolutely fantastic. She has made such a difference to my service. She is super dedicated and so thorough and detailed orientated. She has worked so hard to become familiar with heart failure and its terminology. I would be lost without her. She is such an asset."

Oliver Lashkar, Catering Operative **York** **Nominated by relative**

I would like to nominate Oliver from Ellerby's for a Star Award for the care, compassion, and overall kindness he displayed to me. I am a member of staff at York Hospital, but at this time, I was staying in the hospital with my young child who was very poorly on Ward 17. I was running on very little sleep and was extremely worried. I had to stay in with my son for five days and when I had a small window of time to leave the ward and get some food, Oliver was always there with a smile and asked how me and my son were doing. He showed empathy and compassion and his acts of kindness which were very much appreciated.

Oliver's personality, mannerisms, and caring nature gave me a few moments of light relief during a worrying time, which truly made a difference to me. I am very grateful to Oliver for his kindness. For him to display such care and compassion towards people at such a young age is remarkable. I am sure I am not the only one who Oliver has made a difference too and he should be really proud of himself. Keep being you.

Henrietta Tully, Generic Therapy Assistant

Community

Nominated by colleague (1) and colleagues (2)

(1) I want to pass on my huge thanks and praise to Henri from the children's therapy team. She went above and beyond after a busy day at Scarborough Engineering Week, giving up an extra hour of her own time to assist us with a SEND child in meltdown. Henri stayed calm and professional in an extremely challenging situation, coordinating the effort from multiple people, providing comfort to a distressed parent, as well as keeping an extremely dysregulated child safe from harm. Without her professionalism and insight, the already challenging situation would have proven much worse. Thank you, Henri.

(2) I want to express my heartfelt gratitude for Henrietta's incredible support and dedication in assisting with the SEND child during Scarborough Science and Engineering Week. Herr kindness, patience, and genuine care made a world of difference, not only ensuring the child felt heard and supported, but also fostering an environment where they could feel safe. Her calm and compassionate approach when the child started to meltdown was invaluable, she handled the situation with such grace, helping to soothe and redirect them, whilst simultaneously supporting the mum, both emotionally and physically.

On top of that, staying an extra hour without being asked was an extraordinary gesture, showing just how committed and selfless she is. Her efforts truly embody the spirit of inclusion, and we deeply appreciate the time, energy, and compassion she gave. Thank you for making such a lasting impact, your help will not be forgotten!

Committee Report

Report from:	Quality Committee
Date of meeting:	15th October 2024
Chair:	Steve Holmberg

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

ALERT
ED Coding – Concern, previously identified, continues and solutions are in train but the issue is complex and will take more time to resolve
ASSURE
Quality – Committee continues to hear evidence of the strengthening of governance processes within Care Groups and clinical areas supported by corporate teams e.g. IPC meetings, Journey to Excellence with elements such as ward accreditation. Sustained improvements in outcomes are anticipated to take time to show but the direction of travel is grounds for encouragement **Nephrectomy –** Committee had previously heard of instances of patient harm associated with long waits and disease progression prior to surgery. Current waiting times are reassuringly extremely short **Never Events –** Committee assured that Trust follows NHSE pathways for investigation and learning. Committee also assured about improvements to processes to support Trust as a 'learning organisation' **Audit Reports –** Committee received assurance regarding actions from Audit Reports. Further assurance that Corporate teams and Audit are working collaboratively to ensure that maximum value is derived from audits. Committee heard of specific examples where audit had supported and helped drive quality improvements. Committee will receive completed audit reports moving forward

ADVISE
Maternity – In-month data continues to show stable situation. Rise in PPH not currently a particular concern **IPC –** In-month data show key HAIs continue to run ahead of trajectory **Mortality –** Q1 Report did not raise specific concerns on overall or individual cause mortality data

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
Family Health CG – Community: Committee received report evidencing a service under strain with rising individual case loads and high sickness and stress levels. Committee offered its help for cross-agency working to reconfigure and support service Gynaecology: Waiting times for benign and cancer services remain among the most difficult in the Trust. Gynaecology is identified as a challenged service across the ICB. Committee heard about 2 incidents of harm related to delayed hysteroscopy. Mitigations and improvements were now in place including – early clinical triage of all hysteroscopy referrals, new consultant appointments and colposcopy specialist nurse Paediatrics: Committee remains concerned about some delays in emergency pathways. Situation is complex due to different ages at which paediatrics 'cuts-off' in different services. Committee received assurance that there is coordinated work underway to ensure that care pathways will be best aligned to service provision **Gastroenterology –** Committee discussed the staffing challenges to the service at Scarborough. Assurance given that monitoring processes are in place to identify any concerns regarding emergency provision

Committee Report

Report from:	Resources Committee
Date of meeting:	15 October 2024
Chair:	Lynne Mellor

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

ALERT

- **Operations:** The Committee discussed and raised concerns about the Urgent and Emergency care position which despite intervention does not appear to be improving overall - ECS trajectory of 68.6% not met with a performance of 64.4%. After an improvement last month, ambulance handover over time has deteriorated. The acuity of ambulance arrivals has increased also with a daily average of 120 in September i.e. the most acute category patients (1&2) has seen a 12% increase from September last year. Some assurance given with the following plans in place:
  - The Ambulance handover teams are being encouraged to handover patients that are fit to sit so that Ambulance handover could happen more quickly.
  - At the start of November, the ICC system control centre will launch with YAS and Nimbus, working together on calls and diverting calls to different services to reduce Cat 3&4 arrivals to ED.
  - 2.2 WTE funded additional nursing staff, will provide support at peak ambulance times for York and Scarborough from 21 October.
  - Continuous flow SOP - to move patients proactively, to be introduced mid-October, to address ED 'exit block.'
- **Workforce**: The Committee again discussed the impact, and the risks associated with the industrial action in Microbiology services, York hospital and Blood Sciences, Scarborough hospital. The Committee noted the plans in place to mitigate the risk to patients and services. It noted the key date of 22 October for conciliation talks in a meeting with ACAS.

ASSURE

- **Operations:** The Committee discussed the Cancer position and again saw an improvement in the 28-day Faster Diagnosis standard for August - an improvement to 71.9% (above trajectory). However, several specialities still failing to hit the 75% FDS trajectory e.g. Urology, gynaecology, with some assurance given that improvement plans are in place.
- The Committee welcomed the news that the RTT65 position for the Trust is improving with 18 patients waiting over 65 weeks at the end of September and the Committee noted the Trust is aiming to deliver its target of zero patients as soon as possible.
- The Committee discussed the issues in Outpatients such as the Trust waiting time for Rapid Access Chest pain clinic and was assured plans are in place and to be presented in January 2025 as part of the Clinical strategy for Cardiology.
- Diagnostics - the Committee welcomed the continued improvements being seen in several specialities.
- **Workforce:** The Committee applauded the efforts for the Trust to achieve a full year with no off-framework agency supply in October. The Committee also was assured that the Trust ended four medical agency bookings in September and converted a further three agency workers to Trust positions via substantive contract, fixed term contract and bank contract.
- **Finance**: The Committee was assured that the cash position for the Trust has improved as NHSE have provided the ICB with £50M in funding, of which £16.6M deficit support funding has been awarded to the Trust – thus a balanced plan for month 6.
- **Nursing and Midwifery:** The Committee noted once again the positive improvements to the nursing workforce e.g. the registered nurse vacancy forecasted position of 3% for later in Q3. The Committee noted the nursing trajectory update which shows a risk of rising to 9% for registered nurse vacancies – the Committee were assured plans are in place to address gaps through for example increasing potentially the number of Nursing Associates and nursing

apprentices. The Committee applauded the work on e-rostering improvements and noted the savings of £146k.

- **Medicine:** the Committee welcomed the new report for medical and dental workforce for Q2 and it gave assurance that there is an increasing 'grip and control' over standards e.g. appraisal completions, revalidation completion rates. The Committee discussed the medical vacancies including the highest areas of impact e.g. 40% Acute, some assurance has been evidenced with a steady improvement against these vacancies and the improvement in the recruitment process. The Committee agreed a spotlight for the next quarter report would be on locum spend including a profile of spend YTD and any forecasts.

ADVISE

- **Operations:** The Committee noted the Trust is ahead of its elective recovery plan 24/25. It also discussed in detail the paper on the Elective Recovery plan and noted the work needed on the cleansing of data particularly for patients who appear to be waiting for their first appointment and follow up partial booking. The Committee agreed urgent action is needed on the data cleanse to produce a more detailed accurate report to make sure any potential patient issues are addressed and risks mitigated. A report on the approach and timescales for this work will come back to the November committee..
- The Committee discussed the Emergency Planning Resilience and Response Report and noted that a plan is in place with actions to address the gaps.
- **Workforce**: The Committee noted the flu campaign is marginally ahead for the first 2 weeks of vaccinations compared to last year, however it was recognised the Trust needs to improve its vaccination rates, as just over a third of the workforce were vaccinated last year.
- The Committee noted the launch of the annual national Staff survey which runs until 29 November. The Committee discussed response rates need to improve (last year only a 39% response rate). In the first week we have had an 8% response rate compared to 14% peer average. The Committee noted a few supporting activities to encourage completion of the survey including promoting you said we did as well as change makers involvement and line manager briefings to support completion of the survey in work time.
- **Nursing and Midwifery:** The Committee noted and discussed the paper to support funding gaps in maternity services. The committee discussed three key areas for potential release of efficiency savings 1. Scrub nursing for maternity theatres, 2. Clinical education and training resource, 3. Statutory and mandatory training provision. The Committee discussed how the run rate is being looked at in conjunction to this, where vacancies in the Trust establishment plans which are not essential may help to support this case further. The Committee noted an updated report will be submitted to the Board in November.
- **Finance:** The Committee noted an adjusted deficit position of £2.6M, against a planned deficit of £1.3M. The Committee noted the planned £26M CIP benefit towards the target of £33M, £12M of which has been delivered in month 6. The Committee discussed the ICB summit which was a review of getting to the best possible financial position for the end of the fiscal. It was noted actions would follow to aim to close gaps across the system – e.g. the Committee wondered if any action can be taken as a result of the Summit for the Trust to close its CIP gap and for example help address the high-risk plans of £9.7M.
- **YTHFM:** The Committee welcomed YTHFM Energy Procurement Update and Future options report and noted the forecast savings potential.
- **Digital:** The Committee noted and welcomed the news that the EPR contract has been signed.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Risk discussed with each report, no additions to current registers.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 10

TRUST PRIORITIES REPORT

Table of Contents

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Summary

Priority Metrics

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
ED - Proportion of all attendances having an initial assessment within 15 mins	2024-09			66%	Target	67.8%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024-09			7.5%	Target	19.5%
ED - Emergency Care Standard (Trust level)	2024-09			68.6%	Target	64.4%
ED - Median Time to Initial Assessment (Minutes)	2024-09			18	Target	4
ED - Proportion of Ambulance handovers waiting > 60 mins	2024-09			10%	Target	27.4%
Cancer - Faster Diagnosis Standard	2024-08			70%	Target	71.9%
Cancer - 62 Day First Definitive Treatment Standard	2024-08			62.1%	Target	76%
RTT - Total Waiting List	2024-09			45532	Target	45020
RTT - Waits over 78 weeks for incomplete pathways	2024-09			0	Target	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024-09			0	Target	18

Executive Summary:

The September 2024 Emergency Care Standard (ECS) position was 64.4%, against the trajectory of 68.6%. Median wait time to initial assessment in ED has remained unchanged at 4 minutes in September 2024.

Please note; in line with national reporting deadlines cancer reporting runs one month behind. The Cancer performance figures for August 2024 saw an improvement in the 28-day Faster Diagnosis standard (FDS) to 71.9% (compared to 71.3% in July 2024). This was above the trajectory submitted to NHSE for the end of August 2024 (70%). 62 Day waits for first treatment August 2024 performance was 76%, a 4% improvement on the July 2024 position (72%). 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 September 2024. Please note that the methodology supplied by NHSE that is used within the TPR will show this metric as a 'Fail' as the assurance icon looks across the entire SPC (25 data points). As the Trust had RTT 78-week waits within that 25 month timeframe the methodology displays it in this way.

At the end of September 2024, the Trust had eighteen RTT patients waiting over sixty-five weeks. The Trust is working to achieve the national ambition to have zero RTT65 week waits as soon as possible. The final unvalidated end of September 2024 position for RTT 65-week waits was circa 1,650 for the North East and Yorkshire region. The nationally estimated position was circa 21,000.

OPERATIONAL ACTIVITY AND PERFORMANCE

October 2024

Operational Activity and Performance

Acute Narrative

Headlines:

The September 2024 Emergency Care Standard (ECS) position was 64.4%, against the trajectory of 68.6%. Median wait time to initial assessment in ED remained unchanged at 4 minutes in September 2024.

The Trust did not achieve the September 2024 average ambulance handover time target of 39 minutes and 29 seconds with performance of 51 minutes and 18 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 Emergency Departments.

Factors impacting performance:

- Ambulances arrivals at our Emergency Departments continue to rise (September 2024 average of 149 per day against the September 2023 average of 129, a rise of 16%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) once again saw a rise from a daily average of 107 in September 2023 to a daily average of 120 in September 2024 putting significant pressure on our EDs (12% increase).
- Demand increasing for beds, the daily average admissions via ED in September 2024 was 154 patients compared to 143 in September 2023, a rise of 8%.
- Number of patients who have Length of Stay of 21+ days reduced compared to the end of August 2024.
- 1,172 lost bed days in September 2024 due to patients with No Criteria To Reside (NCTR). This level equates to a 39 bedded ward being occupied for every day of September.
- Demand and acuity.
- Timing of Ward Rounds and Senior Review.
- Community capacity in particular social provision.
- Infection Prevention Control (IPC) outbreaks.

Actions:

Please see following pages for details.

Summary MATRIX 1

Acute Flow

MATRIX KEY

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

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT	* % of SDEC admissions transferred to downstream acute wards	* ED - Emergency Care Attendances * ED - Median Time to Initial Assessment (Minutes) * Number of SDEC attendances * Number of RAFA attendances (York Only)	* ED - Proportion of all attendances having an initial assessment within 15 mins * ED – A&E Attendances – Types 2 & 3
COMMON CAUSE / NATURAL VARIATION		* ED - Total waiting 12+ hours - Actual number of all Type 1 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 Ambulance handovers waiting > 60 mins * ED - Ambulance average handover time (number of seconds)	* 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 - Emergency Care Standard (Type 1 level)
SPECIAL CAUSE CONCERN		* 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 * ED - Proportion of Ambulance handovers waiting > 30 mins

Acute Flow (1)

Scorecard

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 09			66%	Target	67.8%
ED - Proportion of all attendances seen by a Doctor within 60 mins	2024 09			55%	Target	24.6%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024 09			7.5%	Target	19.5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2024 09			2005.2	Baseline	1998
ED - 12 hour trolley waits	2024 09			0	Target	645
ED - Emergency Care Attendances	2024 09			19574.1	Baseline	17183
ED - Emergency Care Standard (Trust level)	2024 09			68.6%	Target	64.4%
ED - A&E attendances – Type 1	2024 09			10089	Target	10220
ED - Emergency Care Standard (Type 1 level)	2024 09			49.9%	Target	42.5%
ED – A&E Attendances – Types 2 & 3	2024 09			7144	Target	6963
ED - Median Time to Initial Assessment (Minutes)	2024 09			18	Target	4

KPIs – Operational Activity and Performance

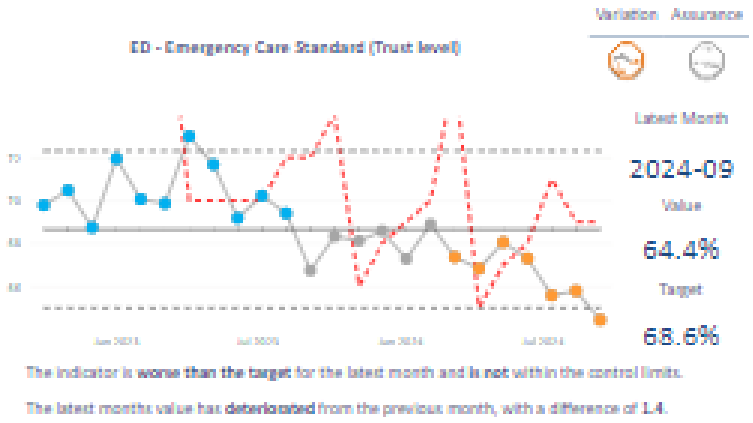
Acute Flow (1)

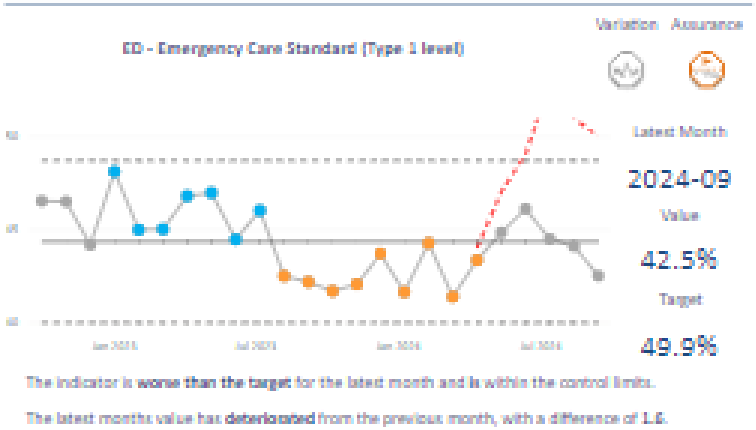
Executive Owner: Claire Hansen

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.





Actions:

- The Optimal Care Service (OCS) is undergoing a 'reset' at Scarborough Hospital. The main challenges include finance and workforce. The team is looking into innovative workforce models such as utilisation of Advanced Care Practitioners (ACPs).
- At Scarborough, the QI team is involved in reviewing the pathway with the clinical team to determine the scope for development and training, particularly the streaming elements.
- At York, a table-top exercise has been undertaken to work through the streaming and senior clinical input. The themes are being explored in conjunction with the Trust Quality Improvement (QI) Team to improve the pathway.
- The focus continues at York to be on ensuring the pre-existing Minor Illness service (provided by a GP) is used to full capacity and that more non-Majors patients are sent to the ringfenced additional non-Majors capacity when safe to do so.

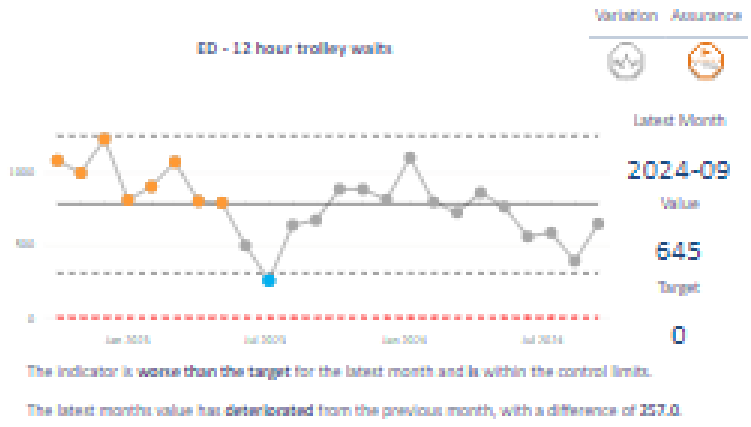
KPIs – Operational Activity and Performance

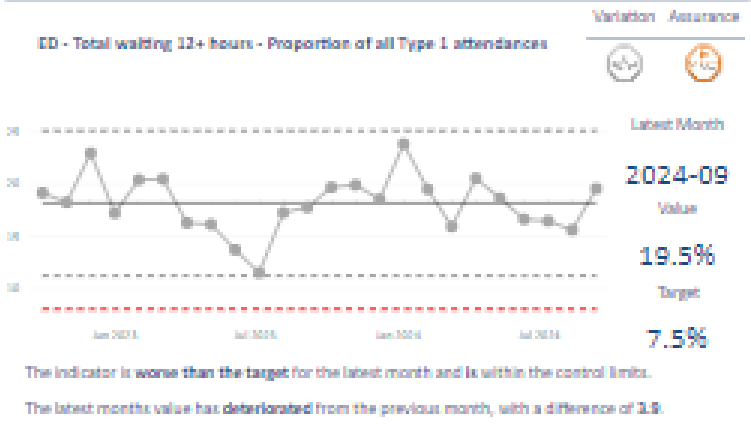
Acute Flow (2)

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.





Actions:

- The DCOO UEC has established daily (weekdays) breach validation meetings with both EDs going through all non-admitted breaches to understand themes and put in mitigations as appropriate.
- As of early October, both ED teams have a renewed focus on analysing the top ten waiters per week to the root causes to improve.
- The Integrated Assessment Units (IAU) continues. The IAU will improve the pathway and patient journey increasing the ratio of same day and short stay emergency care through an established task and finish group. The group reports into the Unscheduled Care Improvement Programmes (UCIP) Board.
- The implementation of Flow Coordinators in our Emergency Departments has been identified as a priority immediate action. The medicine care group Operations Managers are fulfilling the duties of this role on a rota basis, with a workforce/finance review underway to identify any available opportunities to recruit substantively.
- The Trust is working to implement a Continuous Flow SOP across both acute sites. In essence this process will allow patients to flow across UEC under set timelines to address the ‘exit block’ in both EDs. This is currently going through engagement with lead clinicians with launch in early to mid-October.

Acute Flow (2)

Scorecard

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

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
ED – A&E Attendances – Types 2 & 3	2024 09			7144	Target	6963
Number of SDEC attendances	2024 09			2379	Baseline	2369
Percentage of SDEC attendances transferred from ED	2024 09			65%	Baseline	59.9%
Percentage of SDEC attendances transferred from GP	2024 09			23.4%	Baseline	24.3%
% ED attendances streamed to SDEC Within 60 mins	2024 09			43.6%	Baseline	51.3%
% of SDEC admissions transferred to downstream acute wards	2024 09			20%	Target	14.1%
Number of RAFA attendances (York Only)	2024 09			133.3	Baseline	117
Number of attendances at SAU (York & Scarborough)	2024 09			839	Baseline	909
ED - Proportion of Ambulance handovers within 15 mins	2024 09			65%	Target	20.8%
ED - Proportion of Ambulance handovers waiting > 30 mins	2024 09			5%	Target	52.6%
ED - Proportion of Ambulance handovers waiting > 60 mins	2024 09			10%	Target	27.4%
ED - Number of ambulance arrivals	2024 09			4302.3	Baseline	4416
ED - Ambulance average handover time (number of seconds)	2024 09			2369	Target	3070

KPIs – Operational Activity and Performance

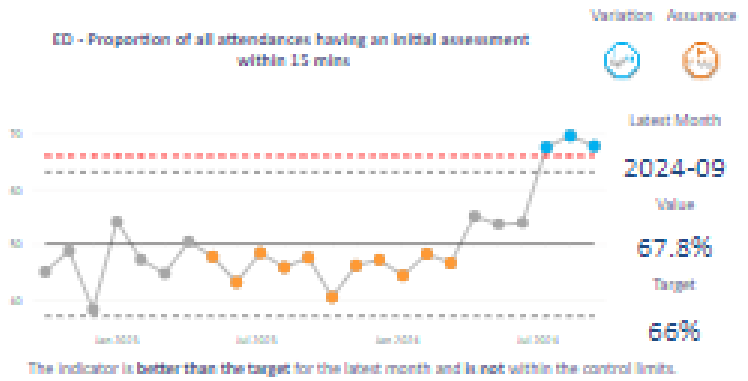
Acute Flow (3)

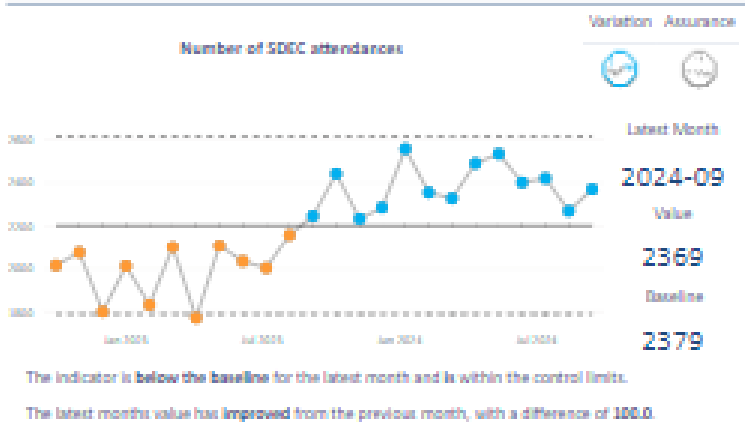
Executive Owner: Claire Hansen

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.





Actions:

- The teams are analysing the average attendances by hour of the day heat map to understand how their workforce models can be adjusted to reflect periods of increased pressure considering recent demand patterns.
- Supported by ECIST and regional NHSE colleagues the Trust will be receiving clinical input into leadership of EDs to ensure the pathway criteria, including initial time to assessment and time to see a doctor is improved.
- The IAU will facilitate movement of patients across UEC to Same Day Emergency Care (SDEC) as appropriate.

KPIs – Operational Activity and Performance

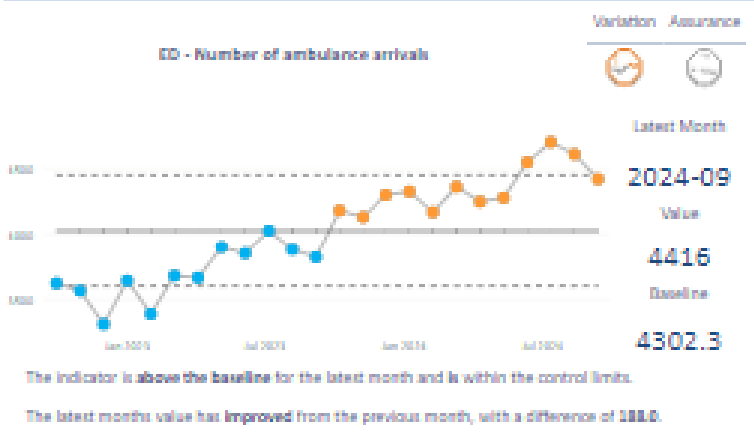
Acute Flow (4)

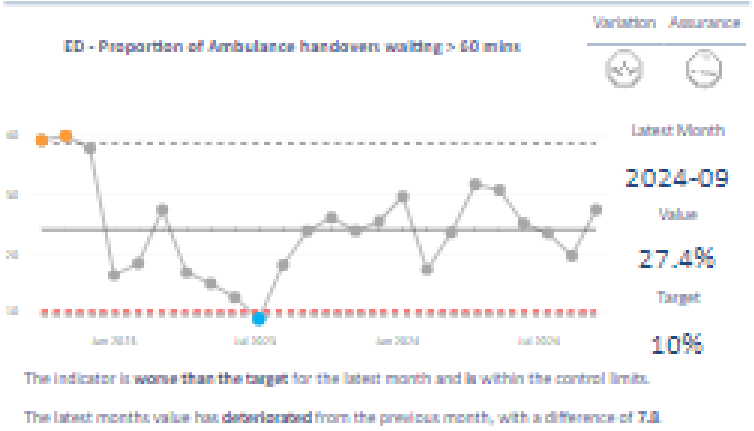
Executive Owner: Claire Hansen

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.





Actions:

- The entire immediate recovery actions as well as systematic improvements will consequently impact ambulance performance.
- The Continuous Flow SOP will also ensure proactive movement of patients out of our EDs resulting in decompression of the departments.
- A handover nurse and flow co-ordinator role in the department will also focus efforts to handover and manage flow through the ED. Emergency Medicine has been supported by 15 nurses from elsewhere across the Trust to support with ambulance handovers.
- The Community Improvement Group (CIG), chaired by Deputy Chief Operating Officer, brings together system partners to develop and review ED avoidance pathways and alternatives to ED including:
  - 2hr Urgent Community Response
  - Frailty Crisis Hub
  - Virtual Wards
  - CAT 3 and CAT 5 clinical triage
  - Single Hub model
  - Urgent Treatment Centres

Summary MATRIX 2

Acute Flow

MATRIX KEY

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

ASSURANCE

VARIATION

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

Acute Flow (3)

Scorecard

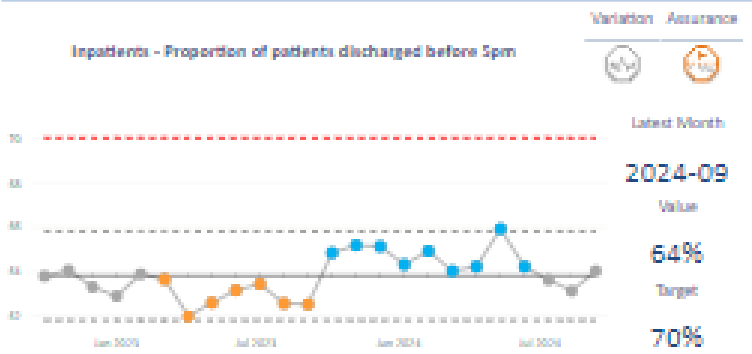
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

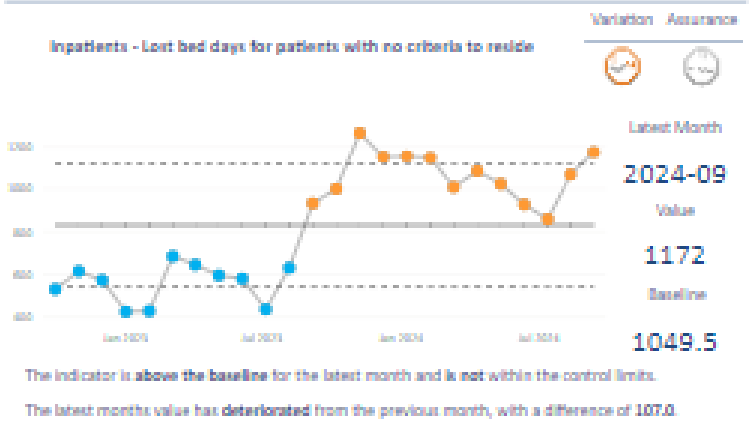
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Patients receiving clinical Post Take within 14 hours of admission	2024 09			90%	Target	76.7%
Patients with Senior Review completed at 23:59	2024 09			47.6%	Baseline	47.3%
Inpatients - Proportion of patients discharged before 5pm	2024 09			70%	Target	64%
Inpatients - Lost bed days for patients with no criteria to reside	2024 09			1049.5	Baseline	1172
Inpatients - Percentage of adult G&A beds occupied by patients not meeting the criteria to reside	2024 09			14.6%	Target	18.3%
Number of non-elective admissions	2024 09			6776	Target	5947
Number of zero day length of stay non-elective admitted patients	2024 09			2010	Target	2244
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2024 09			115	Target	139
Overnight general and acute beds open	2024 09			838	Target	861
Of those overnight general and acute beds open, percentage occupied	2024 09			92%	Target	93.7%
Community bed occupancy/availability	2024 09			100%	Target	85%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

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





Actions:

- 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 by December 2024. Operational implementation group now established and technical work progressing well.
- Work continues, led by an elderly care consultant and senior allied health professional, to improve the timeliness and effectiveness of board rounds on some key wards (AMU York and Beech, Scarborough).
- Following a Discharge to Assess (D2A) workshop on the 25th of September, all partners have agreed to move towards a notification process rather than the Trusted Assessor Form (TAF). Considering a notification system, discharge command centres (integrated discharge hubs) need to be designed to ensure safe and effective movement of patients to home or to more appropriate settings. The first draft design is planned to be presented to the next DIG forum in mid- October 2024.
- A daily 2nd line escalation with the systems partners' senior teams has been established to ensure we have solutions for patients waiting more than 14 days following TAF. This will be step by step reduced to more than 7 days and then more than 3 days.
- City of York Council is looking into commissioning 10 D2A beds in time for winter. The challenges to delivery are therapy input and social service in-reach.

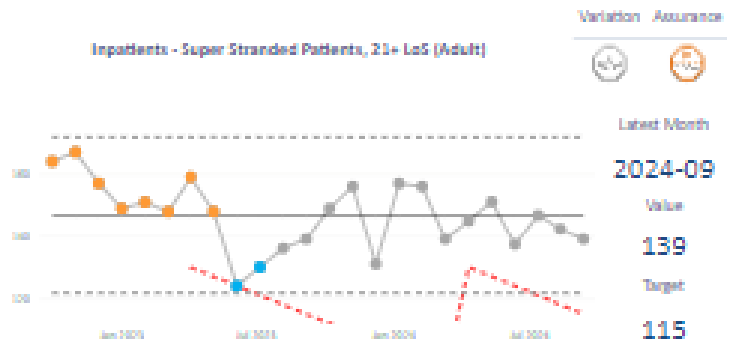
KPIs – Operational Activity and Performance

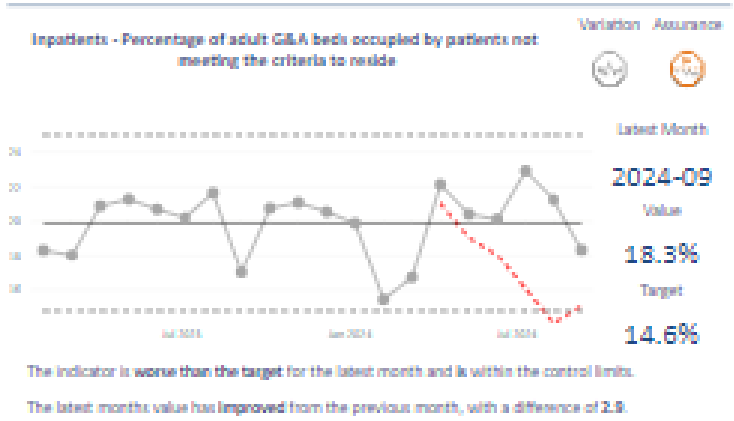
Acute Flow (6)

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).





Actions:

- The discharge improvement project (part of UCIP) is underway and will support improvements to NCTR occupancy rates.
- A joint piece of work is currently underway with Place partners to calculate the impact of some of the improvements that are planned, so that we can better understand how the gap between current performance and trajectory will be closed.
- It is planned that a review of super stranded patients who are not medically optimised will be undertaken. The challenge is medical input into this exercise.

Operational Activity and Performance

Cancer Narrative

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

The Cancer performance figures for August 2024 saw an improvement in the 28-day Faster Diagnosis standard (FDS) to 71.9% (compared to 71.3% in July 2024). This was above the trajectory submitted to NHSE for the end of August 2024 (70%).

62 Day waits for first treatment August 2024 performance was 76%, a 4% improvement on the July 2024 position (72%).

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.

Factors impacting performance:

- August 2024 saw 2,652 total referrals across all cancer sites in the trust at an average of 85 per calendar day, this was below the April to July 2024 daily average of 92 referrals per day.
- The following cancer sites exceeded 75% FDS in August 2024: Breast, Haematology, Head and Neck, NSS and Upper GI. Colorectal, Skin and Lung achieved the internal trajectory but did not achieve FDS. Urology 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 August: Breast, Haematology, Head and Neck, Lung, Skin and Upper GI. All other sites except for Gynaecology surpassed internal trajectories but did not achieve the national 62-day target.
- 31-day treatment standard was aside from Head and Neck (92.6%) at 98% across all sites.
- 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:

Please see following pages for details.

Summary MATRIX
CANCER

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 * % of patients waiting 63 or more days after referral from cancer PTL * Total Cancer PTL size	
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait from diagnosis to first treatment	* Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result
SPECIAL CAUSE CONCERN			

CANCER
Scorecard

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

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Cancer - Faster Diagnosis Standard	2024 08			70%	Target	71.5%
Cancer - 62 Day First Definitive Treatment Standard	2024 08			62.1%	Target	76%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2024 09			143	Target	189
% of patients waiting 63 or more days after referral from cancer PTL	2024 09			12%	Target	8.7%
Cancer 31 day wait from diagnosis to first treatment	2024 08			96%	Target	99%
Total Cancer PTL size	2024 09			2497.1	Baseline	2103
Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result	2024 09			80%	Target	70.5%

KPIs – Operational Activity and Performance

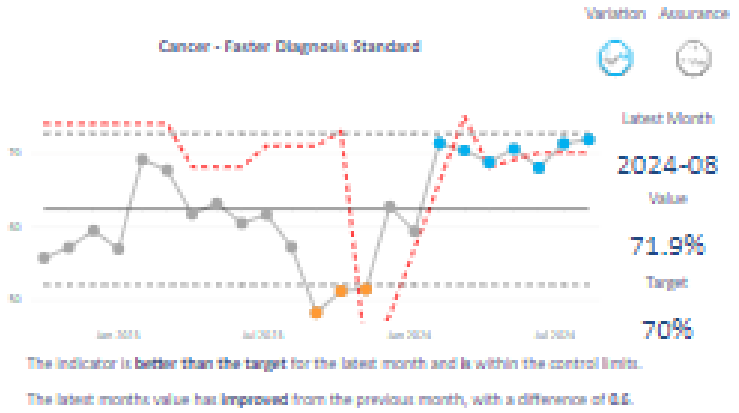
Cancer (1)

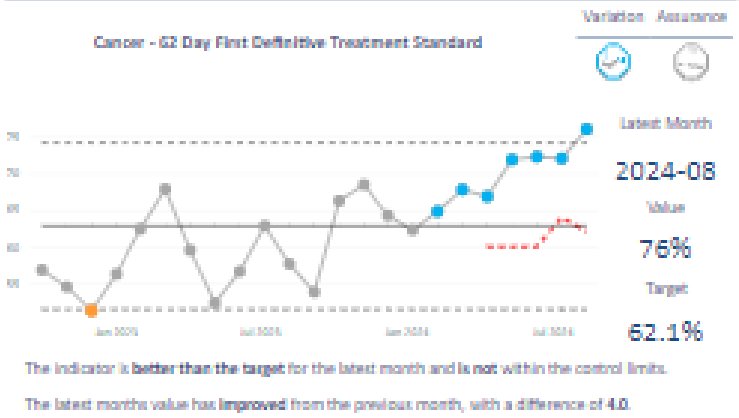
Executive Owner: Claire Hansen

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.





Actions:

- Working with Cancer Alliance and Primary Care Place lead to support ambition of 80% Lower GI referrals accompanied by FIT result. Data allows specific practices to be targeted, with system colleagues leading conversations.
- Cancer site operational teams are reviewing winter plans to maintain capacity.
- Recruitment continues in specialities with consultant vacancies.
- Anticipating opportunity to bid for further NHSE cancer performance recovery funding, and work being undertaken with the most challenged sites to understand support required and deliverable within this financial year. Majority of existing Cancer Alliance SDF schemes and existing NHSE performance recovery schemes commenced.
- Urology improvement workshop scheduled for October 2024 with further plans to expand to other cancer sites.
- 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 has been received by the Trust.

Operational Activity and Performance

Referral to Treatment (RTT) Narrative

Headlines:

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

At the end of September 2024, the Trust had 18 RTT patients waiting over sixty-five weeks. The Trust is working to deliver zero patients waiting over 65 weeks as soon as possible.

Factors impacting performance:

- The Trust's RTT Waiting list position is ahead of the trajectory submitted to NHSE as part of the 2024/25 planning submission, 45,020 against the trajectory of 45,532.
- 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** is in line with last month with 55.4% at the end of September 2024 compared to 55.9% at the end of August 2024. The target for this metric is 92% which was last achieved nationally in February 2016.
- The Trust delivered the trajectory for RTT52 weeks; 1,159 against the trajectory of 1,446. RTT52 week waits reduced by 160 compared to the end of August 2024 (1,319).
- Delivery of the 2024/25 elective recovery plan. Initial analysis shows that at the end of September 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 111% against the submitted plan, this is linked to the monetary value of the case mix that has been seen year to date.

Actions:

Please see following pages for details.

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

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

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
RTT - Total Waiting List	2024 09			45532	Target	45020
RTT - Waits over 78 weeks for incomplete pathways	2024 09			0	Target	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024 09			0	Target	18
RTT - Waits over 52 weeks for Incomplete Pathways	2024 09			1466	Target	1159
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024 09			92%	Target	56.4%
RTT - Mean Week Waiting Time - Incomplete Pathways	2024 09			9	Target	18.5
Proportion of BAME pathways on RTT PTL (S056a)	2024 09			1.7%	Baseline	1.8%
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2024 09			12.1%	Baseline	12.4%
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2024 09			66.8%	Baseline	66.1%

KPIs – Operational Activity and Performance

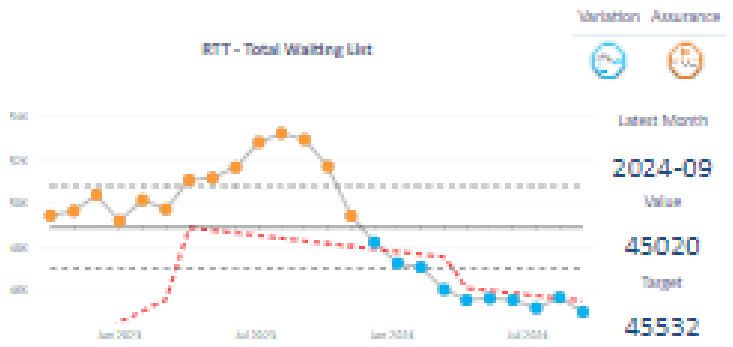
Referral to Treatment RTT (1)

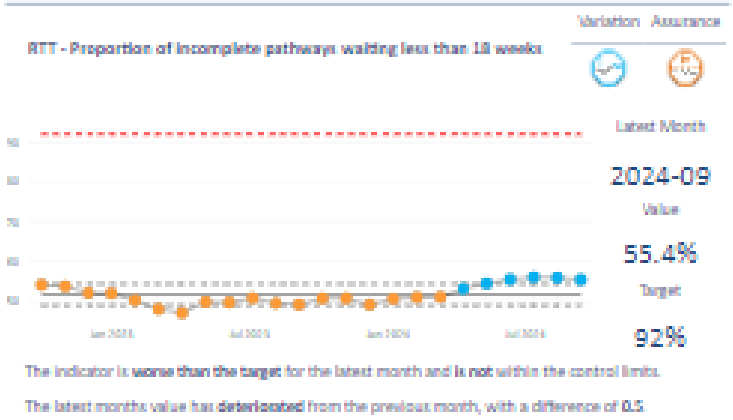
Executive Owner: Claire Hansen

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.





Actions:

- Our new Power business intelligence (BI) RTT patient tracklog list (PTL) tool for Operational Managers went live at the start of October 2024.
- The Trust's RTT Waiting List continues to have a high 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 which 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. The project 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.
- 2024/25 Elective Recovery plan continues with the following workstreams:
  - Outpatient improvement.
  - Theatre improvement.
  - Diagnostic improvement.
  - Cancer.
  - Children and Young People.
  - Productivity and Efficiency.
  - Health inequalities.

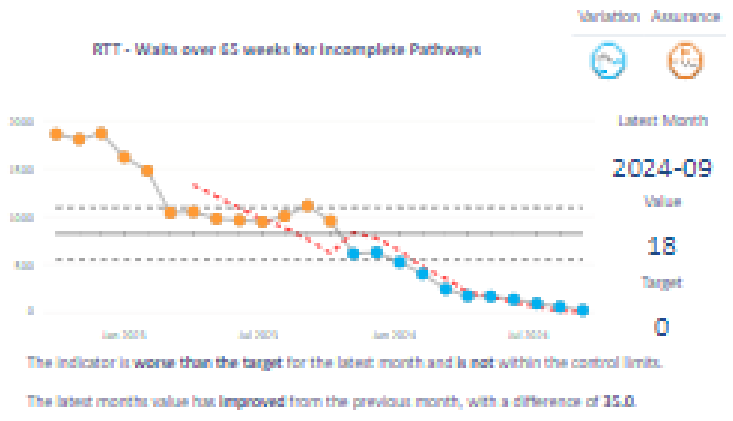
KPIs – Operational Activity and Performance

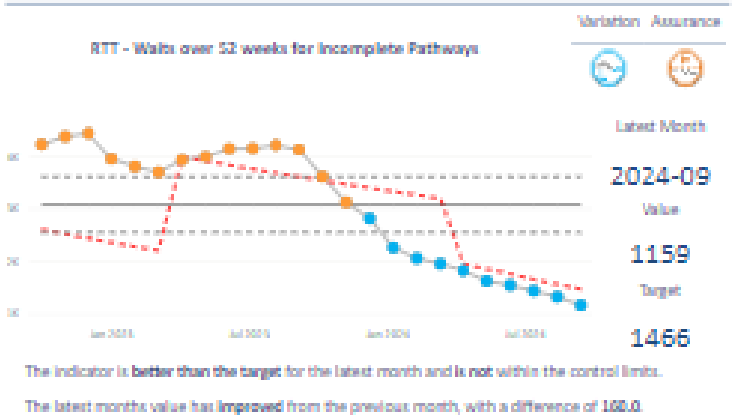
Referral to Treatment RTT (2)

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.





Actions:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 and RTT65 weeks.
- Chief Operating Officer led review meetings were in place for specialties with RTT65 'risks' throughout September 2024.
- The Trust's activity plan is aligned to our improvement trajectory to deliver an improvement to have no more than 923 RTT52 week waits by the end of March 2025, that was submitted to the national team on the 2nd of May 2024. To achieve this trajectory our Care Groups must make a collective net monthly reduction of between 80 to 110 patients throughout 2024-25. This was achieved in September 2024 with a net 160 patients removed from this cohort.
- Exploring mutual aid and independent sector capacity for Neurology. An offer has been received from an independent supplier that is being worked through by Medicine Care Group and Finance colleagues.

Health Inequalities

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

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile

At end of: **September 2024**

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	19	5434	12.39%	8.88%
2	18	6134	13.98%	13.59%
3	19	9230	21.04%	20.94%
4	18	9709	22.13%	20.68%
5	18	13361	30.46%	35.90%
Unknown	19	1042		
Total	**19**	**44910**		

RTT PTL by Ethnic Group

At end of: **September 2024**

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	18	29333	98.23%	94.34%
Black, Black British, Caribbean or African	16	65	0.22%	0.94%
Mixed or multiple ethnic groups	17	121	0.41%	1.26%
Asian or Asian British	17	233	0.78%	2.97%
Other ethnic group	18	111	0.37%	0.49%
Unknown	18	12054		
Not Stated	19	2993		
Total	**18**	**44910**		

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.

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 - DNA rates * Electives (based on Activity v Plan)	* 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	* Outpatients: Follow Up Attendances (Activity vs Plan) * 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*	* Outpatients - Proportion of appointments delivered virtually (SO17a)
SPECIAL CAUSE CONCERN	* Percentage of elective admissions which are day case	* Day Cases (based on Activity v 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

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 09			25%	Target	20.8%
Outpatients - DNA rates	2024 09			5%	Target	4.6%
Outpatients: 1st Attendances (Activity vs Plan)	2024 09			18923	Target	17288
Outpatients: Follow Up Attendances (Activity vs Plan)	2024 09			45879	Target	43385
Outpatient procedures	2024 09			7910	Target	12773
Outpatients: Follow up Partial Booking (FUPB) Overdue (over 6 weeks)	2024 09			0	Target	28424
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2024 09			4.5%	Target	3.6%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2024 09			99%	Target	10.1%
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 06			0	Target	14
Day Cases (based on Activity v Plan)	2024 09			6602	Target	7066
Electives (based on Activity v Plan)	2024 09			588	Target	672
Percentage of elective admissions which are day case	2024 09			85%	Target	91.3%

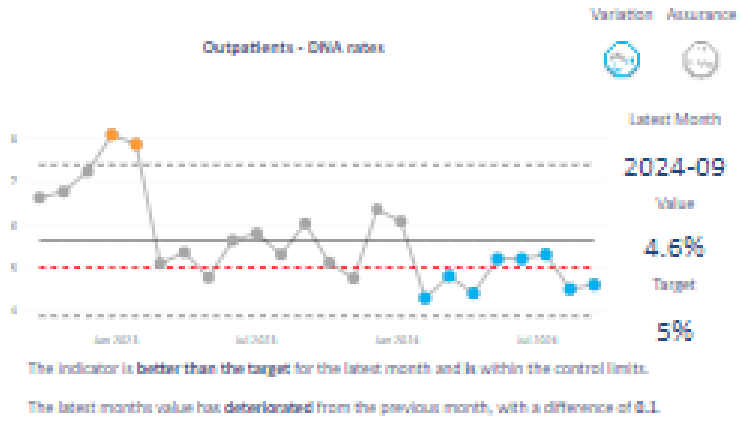
KPIs – Operational Activity and Performance

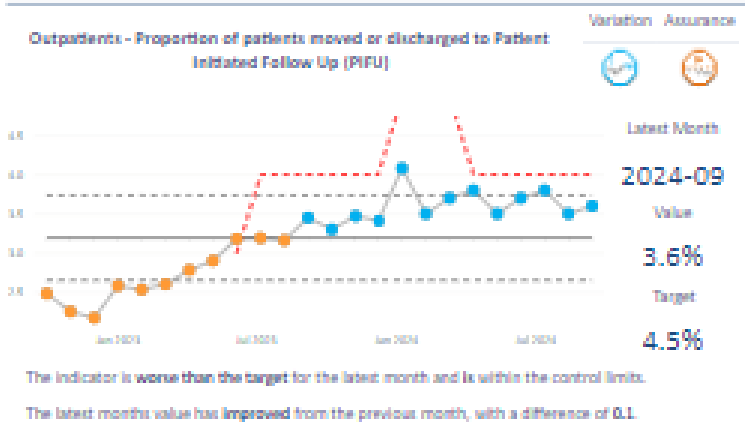
Outpatients (1)

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 continues to positively impact DNA rates.

Actions:

- The addition of patients to a PIFU list has been automated, and the Outpatient Delivery Group (ODG) is creating a mechanism to allow Care Groups to roll out across their specialties. The Trust is working through the Information Governance implications to allow patients to request PIFU appointments digitally.
- Outpatient Procedure Code (OPCS) project is ongoing to improve outpatient procedure coding with Acre Groups using reports to target specific areas where correct recording has not occurred. The Trust delivered the NHSE planning priority of 46% of first and outpatient procedures as a proportion of outpatient in September 2024 with performance of 48.2%.
- The ODG is creating the roll out plan for Referral for Expert Input (REI) to coincide with the introduction of the new interface with the E-Referral Service (eRS) to facilitate automatic upload of referrals which is tentatively planned to go live in late November 2024.

Headlines:
The September 2024 Diagnostic target position for patients waiting less than six weeks at month end was 72.9% (up from 68.5% at the end of August 2024), against the trajectory of 74.2%. The Trust saw month on month improvement from the end of August 2024 in the following:

- MRI.
- CT.
- Non-obstetric Ultrasound.
- Barium Enema.
- Audiology.
- Echocardiography.
- Urodynamics.
- Colonoscopy.
- Cystoscopy.

Factors impacting performance:
- Complexity of CDC programme delivery and delay to activity go live for a range of tests.
- Acute and cancer demand for diagnostic tests remains a challenge.
- 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.
- Biggest risk remains in CT and NOUS. NOUS is improving except for the specialist USS backlog (MSK). A time out day is planned for October 2024 to agree further actions.
- Capital programme in place for replacement of aging equipment over the next 2/3 years, including MRI and CT. CT3 at York is now planned for replacement in May 2025.
- Complex booking and administrative processes which adds to delays. Recruitment to administrative roles is planned.
- Workforce challenges across most imaging modalities and consequence of higher banding for CDC mobile so seeing increased attrition of staff.
- Age-extension of bowel cancer screening programme has led to increased demand.
- Increase in outsourced work leading to longer reporting times due to lack of in-house reporting capacity.

Actions:
Please see page below.

Summary MATRIX
Diagnostics

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

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT		* Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI * Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography * 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 * Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy
COMMON CAUSE / NATURAL VARIATION		* 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 * Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology
SPECIAL CAUSE CONCERN		* Diagnostics - Proportion of patients waiting <6 weeks from referral - CT * Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema * 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

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 09			74.2%	Target	72.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2024 09			71.3%	Target	84.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2024 09			75.2%	Target	62.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non obs Ultrasound	2024 09			86.7%	Target	77.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2024 09			83.3%	Target	84.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2024 09			74%	Target	61.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2024 09			88.3%	Target	57.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2024 09			42.9%	Target	86.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2024 09			95.5%	Target	79.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2024 09			95%	Target	66.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2024 09			44%	Target	35.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2024 09			58.3%	Target	74.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2024 09			44.5%	Target	65.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2024 09			82.8%	Target	83%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2024 09			77%	Target	68%

KPIs – Operational Activity and Performance

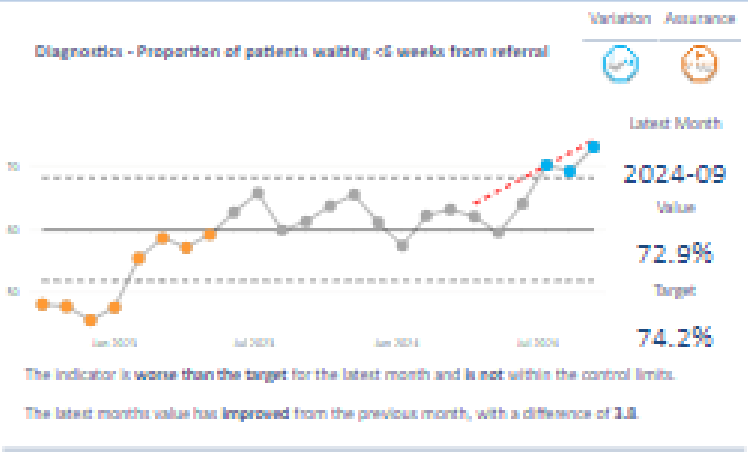
Diagnostics (1)

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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Actions:

- Selby CDC rooms went live w/c 9 Sept with booked sessions.
- Endoscopy:
  - JAG accreditation achieved for all three units in September 2024.
  - Capacity and demand analysis undertaken. Shows significant gap. Review of points per lists to understand impact of surgical consult and scope model is underway.
  - Workforce plan in progress for the next 3 years.
  - New dashboard live for TAT (Turnaround times). The data clearly shows an improving position with average turnaround in September 2024 at 23 days, compared to a high of 83 days back in November 2023.
- Imaging:
  - CT recovery plan in progress including insourcing of Cardiac CT with CT Task and finish group planned to reduce unnecessary requests.
  - CT3 YH replacement; new MRI scanner in May 2025 from NHSE funding.
  - Increase in DEXA activity planned from November 2024.
  - CDC acceleration activity agreed for Bridlington.
  - HNY productive partners work to identify good practices and productivity and efficiency improvements in imaging. Also support visibility of each Trusts information to inform mutual aid discussions.

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

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	2024-09			0	Target	4
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2024-09			95%	Target	81%
Children & Young Persons: RTT - Total Waiting List	2024-09			3870.3	Baseline	3827
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024-09			92%	Target	63.4%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2024-09			0	Target	19

KPIs – Operational Activity and Performance

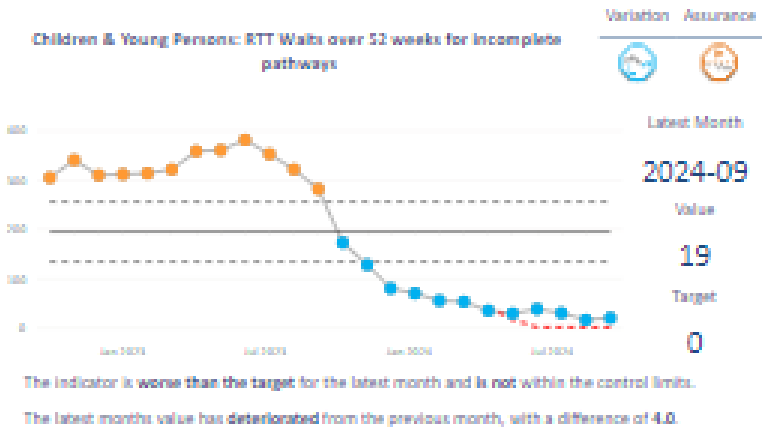
Children & Young Persons

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 19 against a revised internal trajectory of zero. The Trust is seeking to deliver zero CYP patients waiting over 52 weeks as soon as possible.

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.
- Undertook super Saturday operating lists in August 2024 to reduce waits for children,.
- 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. This is in phase 2 of the plan which will be 2025.
  - Strategy for day case surgery for children – trial day case list at Scarborough was undertaken in September 2024.
  - Going further for children waiting times for surgery
  - Stabilise community waiting lists. – Business case for additional workforce being taken through executive committee for approval.

Summary MATRIX
Community

MATRIX KEY

HIGH IMPROVEMENT
IMPROVEMENT
NEUTRAL
CONCERN
HIGH CONCERN

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

COMMUNITY
Scorecard

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 09			33	Target	33
Percentage of Virtual Ward beds occupied	2024 09			80%	Target	60.6%
Community Response Team (CRT) Referrals	2024 09			470.2	Baseline	474
Total Urgent Community Response (UCR) referrals	2024 09			331.4	Baseline	458
2 hour Urgent Community Response (UCR) care Referrals	2024 09			100.9	Baseline	137
2 hour Urgent Community Response (UCR) Compliancy %	2024 09			70%	Target	87.6%
Number of Adults (18+ years) on community waiting lists per system	2024 09			804.3	Baseline	872
Number of CYP (0 17 years) on community waiting lists per system	2024 09			726	Baseline	1873
Number of District Nursing Contacts	2024 09			21063.3	Baseline	19704
Number of Selby CRT Contacts	2024 09			2808.2	Baseline	2066
Number of York CRT Contacts	2024 09			4645.4	Baseline	3748
Referrals to District Nursing Team	2024 09			2262.1	Baseline	2106
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2024 09			1056	Target	790

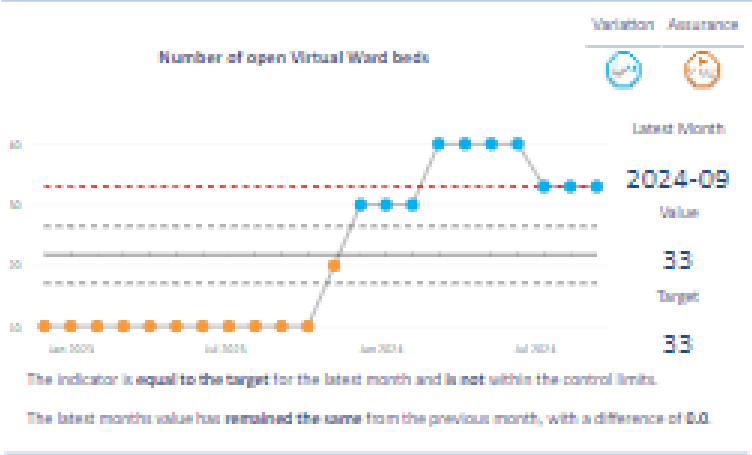
KPIs – Operational Activity and Performance

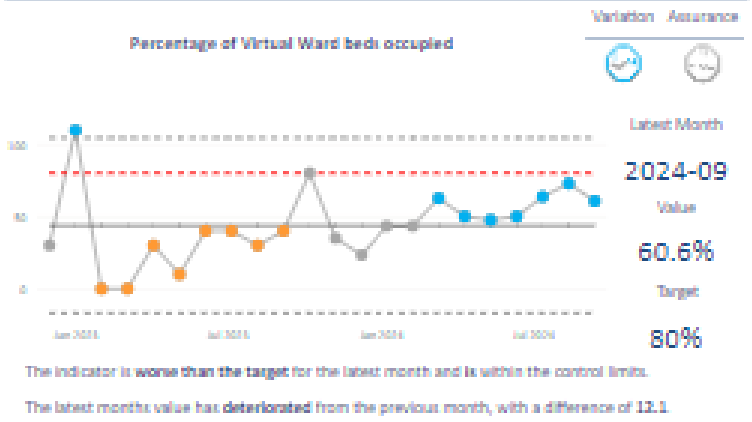
Community (1)

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 ambition for virtual ward utilisation rate is 80%; at the last report to the ICB our utilisation rate was 61% however utilisation on 8th October 2024 is 75%. Conversations are ongoing with the ICB about more sophisticated measures of success.
- Work is ongoing with RAFA, SDEC and ED to increase referrals from these areas to the Frailty and Heart Failure virtual wards.
- The York Frailty virtual ward is now technology-enabled through the system Inhealthcare which was procured with externally awarded funds at the end of last financial year. Our Heart Failure virtual ward team is in the final stages of building a technology-enabled pathway. The quality of care remains high on both VWs with both meeting their access standards and consistently high patient feedback with no complaints. GIRFT are being invited to review the wards later this year.
- The team is continuing to remodel the workforce for Frailty and Heart Failure virtual wards, to make the best use of available funding.
- The Heart Failure team remain keen to expand its remit and support an in-reach service into Emergency Departments, however this would require additional investment.
- The Community UEC Improvement project, part of UCIP, oversees virtual ward usage and improvement. It recently requested that a respiratory virtual ward is reconsidered. Previous scoping work resulted in a request for additional funding (shared with the resource committee); that was not possible and therefore the ask now is to identify what is achievable on a smaller scale with no additional funding.
- Another aim is to develop an IV antibiotic pathway to start at home and prevent an admission. Microbiology are concerned about the risks so more work and careful consideration is required. CHCP have a pathway in place that we are learning from.

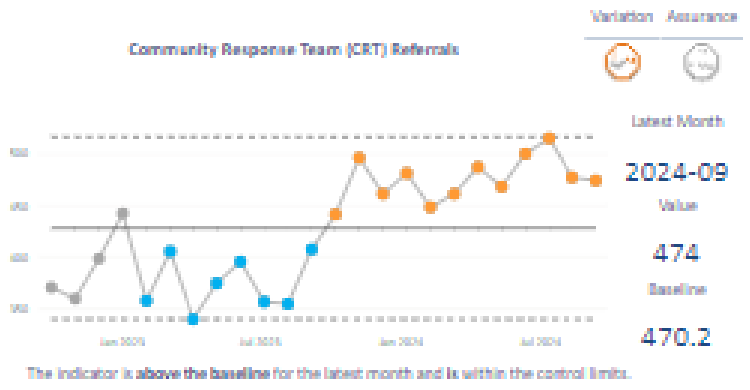
KPIs – Operational Activity and Performance

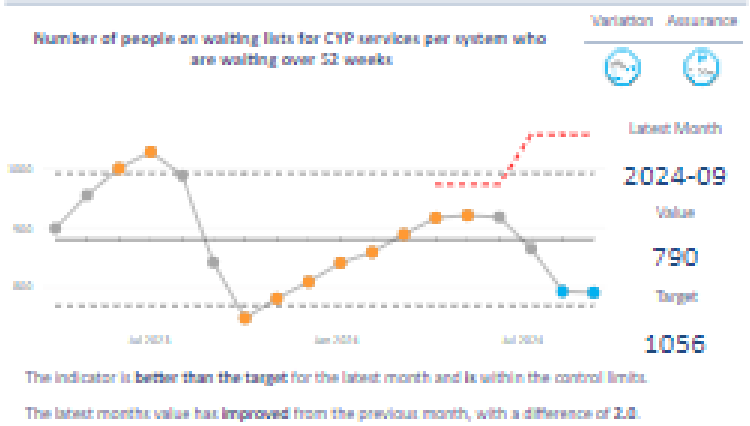
Community (2)

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 Community Response Teams remain above the average control. The continued development of the Frailty Crisis Hub will likely have further impact on referrals with the YAS pathway developments.
- **SPC2:** The number of Children and Young People waiting over 52 weeks or more fell for the third consecutive month, down from 792 at the end of August 2024 to 790 at the end of September 2024.

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.
- **SPC1:** Additional therapy resource has been funded by NYCC place to support step down beds and IPU flow in the Selby area only.
- **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. A business case for additional capacity is being presented to executive committee for approval.
- **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

October 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 * Patient Falls per thousand Bed Days * Patient Safety Incidents per thousand Bed Days * Harmful Incidents per thousand bed days * Trust Duty of Candour (Stage 3) * In Hospital Deaths	
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 * Medication Incidents per thousand bed days * Total Number of Never Events Reported * Monthly SHMI * Monthly HSMR	
SPECIAL CAUSE CONCERN		* Percentage of Patient Safety Incidents with Moderate or Above Harm * Trust Duty of Candour (Stage 1) * Trust Duty of Candour (Stage 2)	

Quality & Safety
Scorecard (1)

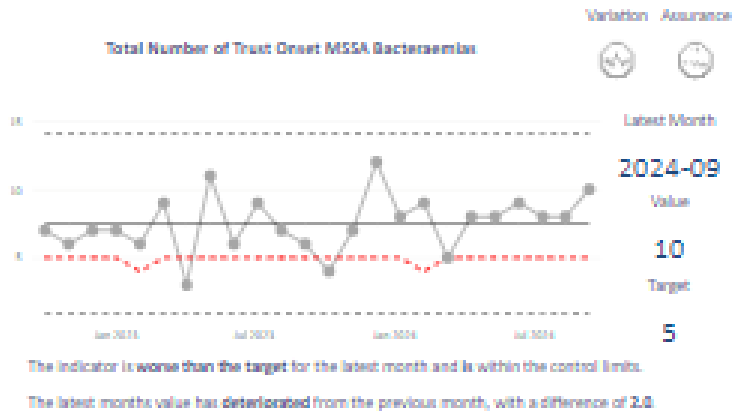
Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

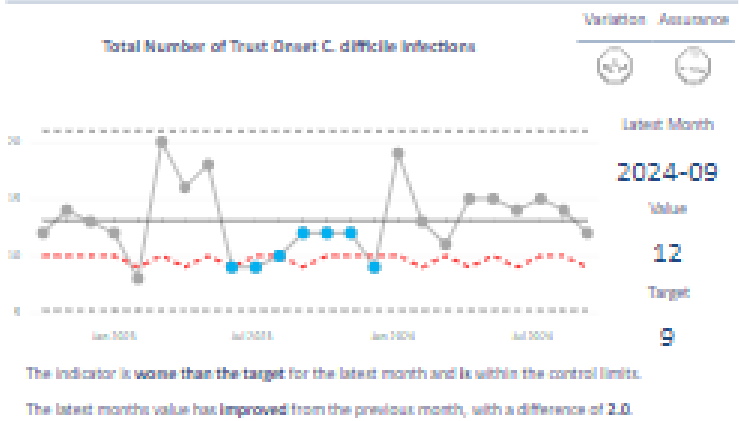
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Total Number of Trust Onset MSSA Bacteraemias	2024 09			5	Target	10
Total Number of Trust Onset MRSA Bacteraemias	2024 09			0	Target	0
Total Number of Trust Onset C. difficile Infections	2024 09			9	Target	12
Total Number of Trust Onset E. coli Bacteraemias	2024 09			12	Target	13
Total Number of Trust Onset Klebsiella Bacteraemias	2024 09			4	Target	3
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2024 09			2	Target	1
Inpatient Acquired Pressure Ulcers	2024 09			139	Baseline	133
Pressure Ulcers per thousand Bed Days	2024 09			4	Baseline	4.5
All Patient Falls	2024 09			250	Baseline	232
Patient Falls per thousand Bed Days	2024 09			9	Target	7.8
Medication incidents per thousand bed days	2024 09			5	Baseline	4.2

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 thresholds for 2024/25 have now been received, they are a 5% reduction on the 2023/24 year end position.





Factors impacting performance:

- MSSA bacteraemia breached the internally set target of 5 cases with 8 cases recorded in August, 1case attributed to Medicine Care Group, 5 attributed to Surgery Care Group, 2 cases attributed to the Cancer and Specialised Services Care Group. 87.5% of the cases are attributed to York Hospital and 12.5% of the cases are attributed to Scarborough Hospital. The Trust is 17 cases over the year- to date target.
- The Trust has recorded 3 MRSA Bacteraemia cases for 2024/25 against a zero target, all of the cases were recorded in the first quarter of the year.
- 14 Trust attributed Clostridioides difficile cases against a trajectory of 12. Of the 14 cases 72% were attributed to York Hospital, 14% attributed to Scarborough Hospital, 14% attributed to community hospital sites. The Trust is 13 cases over the year to date target.
- Ward 29 was closed for 5 days in September due to an outbreak of Norovirus
- We are seeing an increase in the number of Covid-19 cases which is impacting on operational flow

Actions:

- The care group IPC/AMS meetings have all now commenced and are reviewing and actioning improvement requirements.
- All MSSA bacteraemia undergo a review using a PSIRF approach, learning identified improvement needed with hand hygiene compliance, IV cannula documentation, ANTT compliance. The move towards care groups leading in these reviews has commenced with the CSCS care group who have had the highest cumulative number of cases with 5 cases attributed to them.
- The MSSA /MRSA suppression treatments are being updated in line with changing guidelines
- Internal audit of Cannula Management Action plan one action remaining to close and evidence to support this is being finalised.
- Clostridioides difficile cases are reviewed using PSIRF approach, learning identified is being addressed via the Care Group IPC/AMS meetings.
- IPC has been the topic for September and October in the Chief Nurse Year of Quality.

Quality & Safety
Scorecard (2)

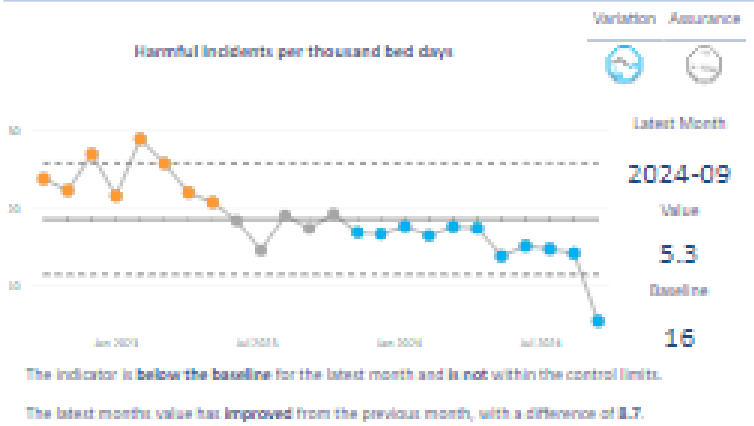
Executive Owner: Adele Coulthard **Operational Lead:** Dan Palmer

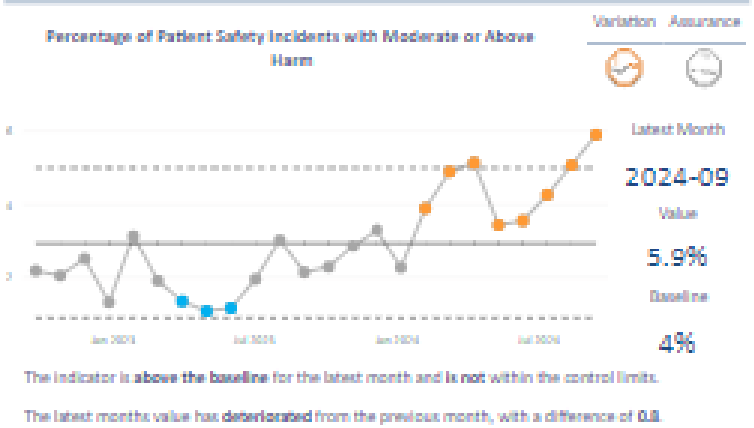
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Patient Safety Incidents per thousand Bed Days	2024 09			48	Baseline	13.8
Harmful Incidents per thousand bed days	2024 09			16	Baseline	5.3
Percentage of Patient Safety Incidents with Moderate or Above Harm	2024 09			4%	Baseline	5.9%
Trust Duty of Candour (Stage 1)	2024 09			92%	Baseline	84.8%
Trust Duty of Candour (Stage 2)	2024 09			90%	Baseline	72%
Trust Duty of Candour (Stage 3)	2024 09			91%	Baseline	93%
Total Number of Never Events Reported	2024 09			0	Target	0
In Hospital Deaths	2024 09			201	Baseline	200
Quarterly SHMI	2024 03			100	Target	98.3
Monthly SHMI	2024 05			100	Target	92.9
Quarterly HSMR	2024 06			100	Target	111.8
Monthly HSMR	2024 06			100	Target	121.8

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:

Duty Of Candor:

Duty of Candor is monitored via datix dashboards. However, the process is overseen by each individual care group. It is the care groups responsibility to report on this information via other reporting avenues.
The patient safety team are unable to influence if the care groups send letters when reasonably practical.

It should be noted that this data only shows two stages of duty of Candor. Which reflects the new policy however we still have the old stages of duty of Candor running concurrently.

Moderate Harm:

The Bench marking target is based on last years out turn. The harms should be benched marked against providers of a similar size and service.

Having a base line target for the level of harm the organisation we tolerate can be detrimental. The level of harm is subjective decided by clinical staff. This decision making can differ between members of staff and is not an exact science.

The number of moderate harm incident can also be affected by the number of incidents that are yet to be investigated. Until the investigation is complete the level of harm may not be determined. The trust current has over 2000 incidents where the investigation has either not commenced or has not been finalised.

This means that there could be incidents with an incorrect level of harm assigned to them.

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 Inpatient Recommend % * Friends and Family Test - Trust Maternity Recommend %	* 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 * Obstetrics and Gynaecology: Serious Incidents * Obstetrics and Gynaecology: Moderate Incidents	* Friends and Family Test - Trust ED Recommend %
SPECIAL CAUSE CONCERN		* Trust Complaints	

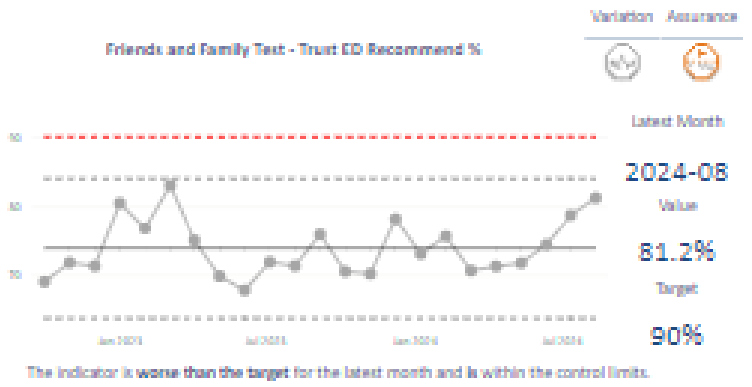
Quality & Safety
Scorecard (3)

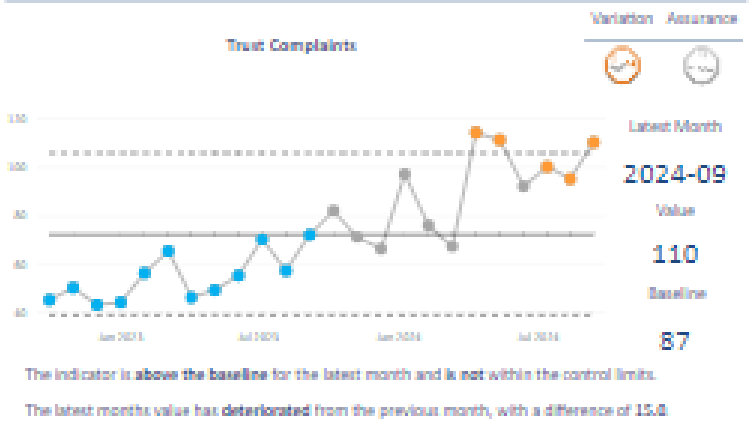
Executive Owner: Dawn Parkes **Operational Lead:** Tara Filby/ Sacha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Friends and Family Test - Trust ED Recommend %	2024 08			90%	Target	81.2%
Friends and Family Test - Trust Inpatient Recommend %	2024 08			90%	Target	97.4%
Friends and Family Test - Trust Maternity Recommend %	2024 08			90%	Target	100%
Trust Complaints	2024 09			87	Baseline	110
Needlestick Injury or Sharps Incident	2024 09			17	Baseline	21
Staff Slips, Trips and Falls	2024 09			4	Baseline	2
RIDDOR	2024 09			2	Baseline	0
Antepartum Stillbirths	2024 08			0.7	Baseline	0
Intrapartum Stillbirths	2024 08			0	Baseline	0
Early neonatal deaths (0 7 days)	2024 08			1	Baseline	2
PPH > 1.5L as % of all women - York	2024 08			4.6%	Baseline	5.3%
PPH > 1.5L as % of all women - Scarborough	2024 08			2.6%	Baseline	1%
Obstetrics and Gynaecology: Serious Incidents	2024 09			0.1	Baseline	0
Obstetrics and Gynaecology: Moderate Incidents	2024 09			13.2	Baseline	11

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

October 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		* Community midwife called in to unit - Scarborough * L/W Co-ordinator supernumerary % - Scarborough	
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough	* Bookings <10 weeks - Scarborough * Bookings ≥13 weeks (exc transfers etc.) - Scarborough * Births - Scarborough * No. of women delivered - Scarborough * Women affected by suspension - 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	* Planned homebirths - Scarborough * Homebirth service suspended - Scarborough * Anaesthetic cover on L/W - Scarborough
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (1)

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

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Bookings - Scarborough	2024 08			169	Target	109
Bookings <10 weeks - Scarborough	2024 08			90%	Target	57.8%
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2024 08			10%	Target	2.8%
Births - Scarborough	2024 08			113	Target	99
No. of women delivered - Scarborough	2024 08			112	Target	99
Planned homebirths - Scarborough	2024 08			2.1%	Target	0%
Homebirth service suspended - Scarborough	2024 08			3	Target	31
Women affected by suspension - Scarborough	2024 08			0	Target	2
Community midwife called in to unit - Scarborough	2024 08			3	Target	0
Maternity Unit Closure - Scarborough	2024 08			0	Target	0
SCBU at capacity - Scarborough	2024 08			1.3	Baseline	0
SCBU at capacity of intensive care cots - Scarborough	2024 08			4.3	Baseline	7
SCBU no of babies affected - Scarborough	2024 08			0	Target	0
1 to 1 care in Labour - Scarborough	2024 08			100%	Target	100%
L/W Co ordinator supernumerary % - Scarborough	2024 08			100%	Target	96.3%
Anaesthetic cover on L/W - Scarborough	2024 08			10	Target	5

Summary MATRIX 2 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION

	ASSURANCE		
	PASS	HIT or MISS	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)

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

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Normal Births - Scarborough	2024 08			57%	Target	49.5%
Assisted Vaginal Births - Scarborough	2024 08			12.4%	Target	7.1%
C/S Births - Scarborough	2024 08			40.3%	Baseline	43.4%
Elective caesarean - Scarborough	2024 08			19.3%	Baseline	18.2%
Emergency caesarean - Scarborough	2024 08			21%	Baseline	25.3%
Induction of labour - Scarborough	2024 08			43.2%	Baseline	47.5%
HDU on L/W - Scarborough	2024 08			5	Target	5
BBA - Scarborough	2024 08			2	Target	0
HSIB cases - Scarborough	2024 08			0	Target	0
Neonatal Death - Scarborough	2024 08			0	Target	1
Antepartum Stillbirth - Scarborough	2024 08			0	Target	0
Intrapartum Stillbirths - Scarborough	2024 08			0	Target	0
Cold babies - Scarborough	2024 08			1	Target	0
Preterm birth rate <37 weeks - Scarborough	2024 08			6%	Target	1%
Preterm birth rate <34 weeks - Scarborough	2024 08			1%	Target	3%
Preterm birth rate <28 weeks - Scarborough	2024 08			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	* 3rd/4th Degree Tear - assisted birth - Scarborough	* Breastfeeding Initiation rate - Scarborough	* Carbon monoxide monitoring at 36 weeks - 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 * 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)

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 08			0%	Target	0%
Breastfeeding initiation rate - Scarborough	2024 08			75%	Target	84.8%
Breastfeeding rate at discharge - Scarborough	2024 08			65%	Target	63%
Smoking at booking - Scarborough	2024 08			6%	Target	11%
Smoking at 36 weeks - Scarborough	2024 08			6%	Target	5.4%
Smoking at time of delivery - Scarborough	2024 08			6%	Target	13.9%
Carbon monoxide monitoring at booking - Scarborough	2024 08			95%	Target	75.2%
Carbon monoxide monitoring at 36 weeks - Scarborough	2024 08			95%	Target	64.5%
SI's - Scarborough	2023 10			0	Target	1
PPH > 1.5L as % of all women - Scarborough	2024 08			2.6%	Baseline	1%
Shoulder Dystocia - Scarborough	2024 08			2	Target	1
3rd/4th Degree Tear - normal births - Scarborough	2024 08			2.8%	Target	1%
3rd/4th Degree Tear - assisted birth - Scarborough	2024 08			6.1%	Target	0%
Informal Complaints - Scarborough	2024 08			0	Target	1
Formal Complaints - Scarborough	2024 08			0	Target	1

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	
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 * L/W Co-ordinator supernumerary % - York	* Planned homebirths - York * Homebirth service suspended - York
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (1)

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

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Bookings - York	2024 08			295	Target	265
Bookings <10 weeks - York	2024 08			90%	Target	71.7%
Bookings ≥13 weeks (exc transfers etc.) - York	2024 08			10%	Target	4.5%
Births - York	2024 08			245	Target	209
No. of women delivered - York	2024 08			242	Target	206
Planned homebirths - York	2024 08			2.1%	Target	0%
Homebirth service suspended - York	2024 08			3	Target	26
Women affected by suspension - York	2024 08			0	Target	3
Community midwife called in to unit - York	2024 08			3	Target	0
Maternity Unit Closure - York	2024 08			0	Target	1
SCBU at capacity - York	2024 08			0.4	Baseline	0
SCBU at capacity of intensive care cots - York	2024 08			20.9	Baseline	31
SCBU no of babies affected - York	2024 08			0	Target	0
1 to 1 care in Labour - York	2024 08			100%	Target	99%
L/W Co ordinator supernumerary % - York	2024 08			100%	Target	100%
Anaesthetic cover on L/W - York	2024 08			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	
COMMON CAUSE / NATURAL VARIATION		* Normal Births - York * Assisted Vaginal Births - York * C/S Births - York * Elective caesarean - York * Emergency caesarean - York * Induction of labour - York * BBA - York * Neonatal Death - York * Antepartum Stillbirth - York * Cold babies - York * Preterm birth rate <37 weeks - York * Preterm birth rate <34 weeks - York * Preterm birth rate <28 weeks - York	
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (2)

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

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Normal Births - York	2024 08			57%	Target	50.2%
Assisted Vaginal Births - York	2024 08			12.4%	Target	14.1%
C/S Births - York	2024 08			35.9%	Baseline	35%
Elective caesarean - York	2024 08			14.3%	Baseline	18%
Emergency caesarean - York	2024 08			21.7%	Baseline	17%
Induction of labour - York	2024 08			46.2%	Baseline	42.6%
HDU on L/W - York	2023 10			5	Target	8
BBA - York	2024 08			2	Target	0
HSIB cases - York	2024 08			0	Target	0
Neonatal Death - York	2024 08			0	Target	1
Antepartum Stillbirth - York	2024 08			0	Target	0
Intrapartum Stillbirths - York	2024 08			0	Target	0
Cold babies - York	2024 08			1	Target	0
Preterm birth rate <37 weeks - York	2024 08			6%	Target	8.1%
Preterm birth rate <34 weeks - York	2024 08			2%	Target	1.4%
Preterm birth rate <28 weeks - York	2024 08			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 * Smoking at time of delivery - 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 * 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)

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 08			0%	Target	0.5%
Breastfeeding initiation rate - York	2024 08			75%	Target	87.1%
Breastfeeding rate at discharge - York	2024 08			65%	Target	70%
Smoking at booking - York	2024 08			6%	Target	5.7%
Smoking at 36 weeks - York	2024 08			6%	Target	2.4%
Smoking at time of delivery - York	2024 08			6%	Target	6.2%
Carbon monoxide monitoring at booking - York	2024 08			95%	Target	89.4%
Carbon monoxide monitoring at 36 weeks - York	2024 08			95%	Target	69.6%
SI's - York	2023 10			0	Target	2
PPH > 1.5L as % of all women - York	2024 08			4.6%	Baseline	5.3%
Shoulder Dystocia - York	2024 08			2	Target	1
3rd/4th Degree Tear - normal births - York	2024 08			2.8%	Target	1.9%
3rd/4th Degree Tear - assisted birth - York	2024 08			6.1%	Target	0.5%
Informal Complaints - York	2024 08			0	Target	1
Formal Complaints - York	2024 08			0	Target	4

WORKFORCE

October 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) * Medical and dental vacancy rate * Total Agency Whole Time Equivalent Filled * 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 corporate induction compliance
COMMON CAUSE / NATURAL VARIATION		* Monthly sickness absence * Overall vacancy rate * Midwifery vacancy rate * Registered Nursing vacancy rate * AHP vacancy rate * Total Bank Whole Time Equivalent Filled * Appraisal Activity	* Medical & dental staff stat/mand training compliance
SPECIAL CAUSE CONCERN			

Workforce
Scorecard (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

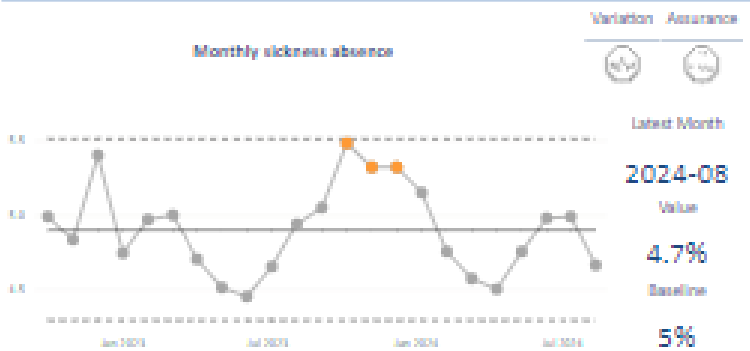
Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

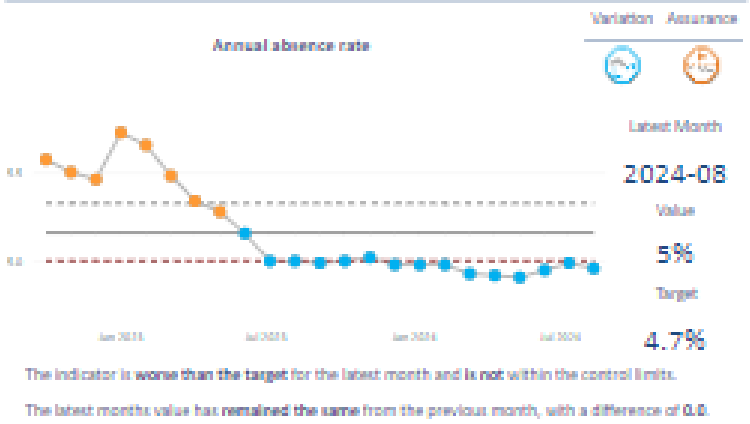
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Monthly sickness absence	2024 08			5%	Baseline	4.7%
Annual absence rate	2024 08			4.7%	Target	5%
12 month rolling turnover rate Trust (FTE)	2024 09			10%	Target	8.3%
Overall vacancy rate	2024 09			6%	Target	7.7%
HCSW vacancy rate	2024 09			5%	Target	5.2%
Midwifery vacancy rate	2024 09			0%	Target	1.4%
Medical and dental vacancy rate	2024 09			6%	Target	1.1%
Registered Nursing vacancy rate	2024 09			5%	Target	6.8%
AHP vacancy rate	2024 09			8.5%	Target	8%
Total Agency Whole Time Equivalent Filled	2024 08			151	Target	156.5
Total Bank Whole Time Equivalent Filled	2024 08			557	Target	709
OVERALL: Percentage of rosters approved six weeks before start date	2024 08			100%	Target	17.7%
NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent	2024 08			29299.3	Target	696.8
NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)	2024 08			22%	Target	30%

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

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





Factors impacting performance and actions:
In August we saw 422.05 WTE lost to sickness which is a decrease of 27.23 WTE from July. Over a ¼ of our sickness episodes in August were lost to stress/ anxiety (109.17 WTE) whilst musculoskeletal problems saw 49.16 WTE lost in the period.

The Influenza vaccination campaign began on 30th September. In the first week, 622 staff have been vaccinated by Occupational Health, and 594 by peer vaccinators (as of COP 7th October).

The Wellbeing Team and the Freedom to Speak Up Guardian will be visiting various wards and departments from October 2024, ongoing into 2025. The purpose is to raise awareness of what support there is available for staff in relation to health and wellbeing and the various speak up channels, ensuring staff know where to look for support and feel supported to do so.

The Wellbeing Team will also be holding a weeklong Menopause event. They will visit various Trust sites to share menopause information and resources and engage with staff about menopause.

The Design Phase of Our Voice Our Future will commence on 22nd October bringing back together Change Makers and the Transformation Team to design the actions needed to address the areas for improvement identified by the Change Makers. A Trust retention group has been established as part of the People Promise Exemplar programme, looking at how good practice can ben shared across the Trust. The recent focus has been on career development for colleagues.

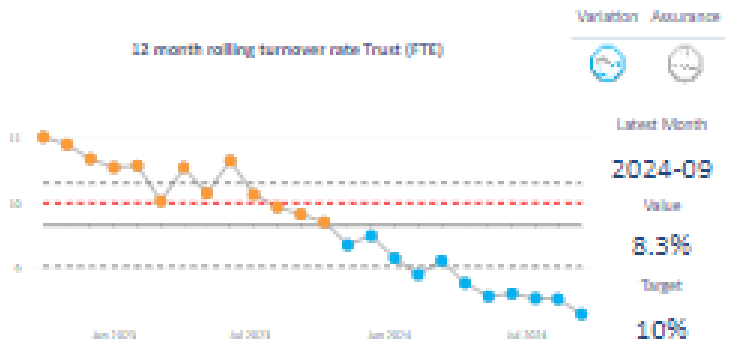
The annual national Staff Survey runs from 7th October to 29th November. The Trust response rate in 2023 was 39%. Targets have been set for each care group, corporate directorate and YTHFM to increase the response rate this year. Response rates will be reported weekly and at Executive Committee. The care groups and YTHFM will be required to report on actions being taken to improve response rates at their regular Performance Review Meetings. The 2023 results were poor (as previously reported in detail to Board). The corporate staff survey improvement plan was approved by Board and encompasses a wide-ranging programme of work to improve staff experience and includes stretch targets for the Trust to match the best scores in our peer group by 2025 for the themes of 'Engagement' and 'We are compassionate and inclusive'.

Industrial action took place in Microbiology at York and Blood Sciences at Scarborough on 30th September and 7th and 11th October. The Trust has approached ACAS to support conciliation discussions with Unite to seek a resolution to the dispute.

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:

During October and November, the Trust will be participating in a regional review of NHS providers' governance and systems for workforce planning and controls. At the beginning of the year, the Trust submitted an operational plan for 2024-25 which forecasted that its total workforce size (including substantive, bank and agency staff) would not increase during the financial year. This required that increased staffing to support new developments such as the Urgent Emergency Care Centre in Scarborough and the Community Diagnostic Centres in York, Selby and Scarborough, was offset by staffing reductions in other services. At the end of August, however, the variance between the Trust's staffing position and its plan was 210 WTE (growth).

This was accounted for through above-plan growth in substantive (150 WTE) and bank (83 WTE) staffing, with a small amount being offset by a higher-than-anticipated reduction (23 WTE) in agency staffing. A breakdown by staff group indicates most of the substantive workforce growth has been concentrated in the three largest clinical workforce groups: Additional Clinical Services (predominantly Health Care Support Workers – 100 WTE), Medical and Dental (41 WTE) and Registered Nursing and Midwifery (25 WTE).

The Trust is working in combination with the Humber and North Yorkshire Integrated Care System on the design of interventions to bring the position back to plan. To date, we have run the Mutually Agreed Resignation Scheme (MARS) and implemented an Enhanced Vacancy Control Process to support management of workforce size. At the same time, the Trust must ensure services are safely staffed with more than 6% of positions in the Trust and YTHFM (637 WTE) being vacant, and sickness absence running at 5% (422 WTE unavailable in August).

There are currently 10.68 WTE registered nurses undertaking pre-employment checks with the Trust, and a further 10.82 WTE nurses ready to commence with start dates booked in.

The Trust has allocated 98 pre-registered nurses (95.24 WTE) and has start dates booked in for 91 of those applicants, ready to commence in the coming weeks.

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:

The Trust welcomed 19 newly-recruited medical staff into posts during September, including 12 permanent Consultant appointments across all care groups.

In addition, 9 offers were made for medical posts across the Trust, including 2 consultants, 3 consultant locums and 4 speciality doctor posts within Surgery, Histopathology and Paediatrics.

The M&D vacancy rate presents an inaccurate picture to what we would expect to see for September's vacancy position. Due to system timings surrounding changeover, some staff have been counted twice and therefore a more accurate representation of our M&D vacancy rate might not be seen until next month's TPR.

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:

With an improved HCSW vacancy position, the Trust stopped generic recruitment for HCSW posts which has been reflected in a reduction in the numbers coming through the recruitment pipeline. There are currently 9.79 WTE HCSWs undertaking pre-employment checks with the Trust, with an additional 3 HCSWs booked onto upcoming HCSW Academy dates. Moving forward the Trust will use bespoke adverts to recruit HCSWs to specific vacancies. The impact of this decision on the Trust's HCSW vacancy position will be monitored closely.

Work continues to review HCSW positions in the Trust to ensure appropriate alignment with national agenda for change job profiles at Bands 2 and 3. The profiles were previously reiterated to make explicit that HCSWs undertaking clinical tasks align to Band 3. NHS providers across England have subsequently found that many HCSWs require a re-grade from Band 2 to Band 3 to reflect the work they are undertaking in practice.

At the start of October, the Trust commenced a review of tasks being undertaken by HCSWs working in outpatient and clinic settings. Meanwhile the latest six-monthly establishment review of staffing requirements for adult inpatient units will be used to confirm the necessary future HCSW skill-mix unit-by-unit. The Trust is also in correspondence with Humber and North Yorkshire Integrated Care Board about arrangements for back-payment where it is found that HCSWs have been required to work above their grade over several years.

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. Following the completion of the apprenticeship programme with the University of York there has been a further increase of Nursing Associates from August to September, going from 61 to 66 headcount and 56.81 WTE to 61.16 WTE.

The Trust is getting ready to welcome 7 pre-registered midwives who are due to start with the organisation in early November and will all be working on the Scarborough site.

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								
Jun-24	2523.56	129.80	111.75	284.75	43.20	146.52	82.37	-12.66
Jul-24	2550.07	144.91	116.36	294.81	33.54	160.51	74.78	-25.98
Aug-24	2556.91	150.80	108.40	314.50	55.30	170.10	83.40	-5.70
HCA								
Jun-24	1261.78	95.90	57.42	270.94	117.62	224.72	0.00	71.40
Jul-24	1255.81	73.33	59.39	263.31	130.59	220.96	0.00	88.24
Aug-24	1254.05	44.77	56.35	279.70	178.58	237.20	0.00	136.08
M&D								
Jun-24	1027.69	78.09	45.20	188.94	65.65	98.76	60.05	35.52
Jul-24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aug-24	1051.72	79.19	44.62	177.37	53.56	107.90	39.82	23.91

Factors impacting performance and actions:

The Nursing eRostering Assurance 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 shifts 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 times. The groups is working to identify ward areas with reduced vacancy and sickness rates etc, where routine agency use can be 'switched off'.

The Trust has negotiated with its remaining nursing agency suppliers, to bring the rates for all ad hoc nursing agency shifts within the NHSE agency price cap from 1st October. This leaves only a limited number of agency block bookings within Maternity and Theatres outside the agency price caps.

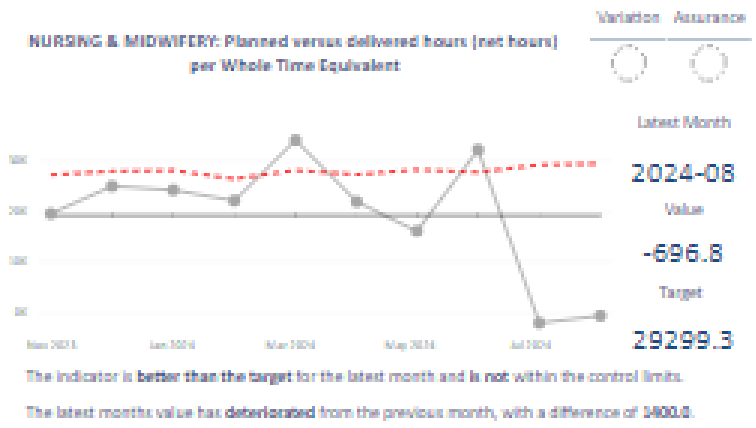
In October, the Trust will achieve a full year with no off-framework agency supply.

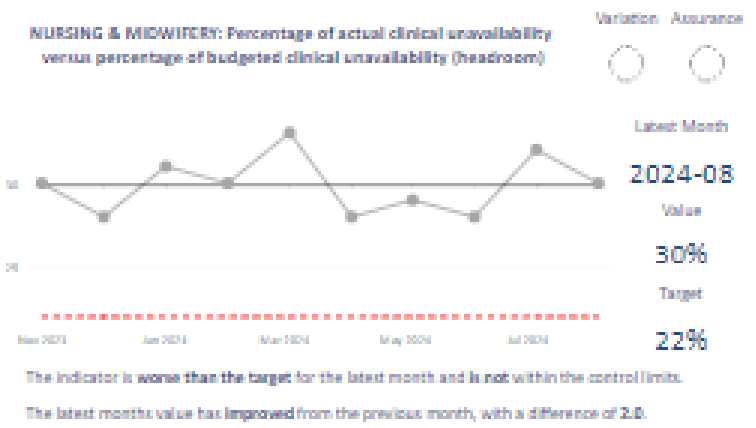
The Trust ended 4 medical agency bookings in September and converted 3 agency workers to Trust positions via a substantive contract, fixed term contract and bank contract.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Ensure maximum availability of workforce through effective rostering, supporting reduction in temporary staffing reliance.
Target: Net hours fewer than 12.5 hours per person. Clinical Unavailability within budgeted headroom.





Factors impacting performance and actions:

The initial scope of the eRostering Improvement Project is nursing in-patient ward areas, whereas the metrics reported include all nursing and midwifery rosters and may present a more variable position until the improvement work expands.

Within nursing in-patient ward areas, the latest data shows 89% of rosters were published on time (up from 86% for the previous roster period). Only 6 wards were not approved on time, 4 within Surgery and 2 within Medicine. The aim is to publish 100% of rosters with at least 6 weeks notice.

The Trust's aim is to achieve Level 4 of the Level of Attainment Standards within nursing in-patient ward areas by the end of December 2024. The Trust has recently achieved Level 1 and has just one action left to meet Level 2, with clear plans in place to keep the organisation on track to meet its target of Level 4 by the end of the year.

To maintain the Level of Attainment standards, the Trust is required to share specific rostering KPIs within this report. This includes the number of wards utilising self-rostering or the auto-roster function within the rostering software, and the percentage of staff on eRostering by staffing group.

For the latest roster period, the Trust has 3 areas (5% of ward-based nursing and midwifery rosters) trialling self-rostering; wards 31 and 26, along with EAU Scarborough. 12 wards (21% of rosters in scope) made use of the auto-roster function, with an average of 20% of those rosters being auto-generated. Increasing the number of areas utilising self-rostering or the auto-roster function should release efficiencies for teams and support a better work life balance for staff.

Staffing Group	% on Healthroster	Staffing Group	% on Healthroster
Nursing and Midwifery	93	AHP	60
Additional Clinical Services	76	Healthcare Scientists	13
Sci and Technical	29	Medical and Dental	29
Admin and Clerical	31	Estates and Ancillary	3

100% of the nursing workforce are on eRostering within nursing rosters, the outstanding 7% above, relates to nursing staff engaged on non-nursing rosters. The Trust is aiming to have 90% of the clinical workforce on eRostering by Summer 2025, with plans to complete the full implementation of eRostering by Spring 2026.

Workforce
Scorecard (2)

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

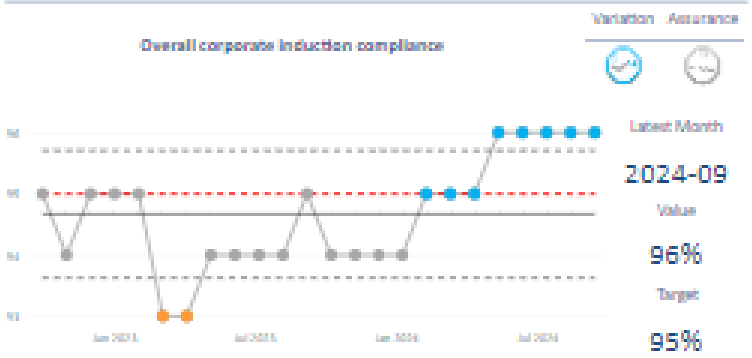
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Overall stat/mand training compliance	2024 09			87%	Target	86%
Overall corporate induction compliance	2024 09			95%	Target	96%
A4C staff stat/mand training compliance	2024 09			87%	Target	88%
A4C staff corporate induction compliance	2024 09			95%	Target	96%
Medical & dental staff stat/mand training compliance	2024 09			87%	Target	70%
Medical & dental staff corporate induction compliance	2024 09			95%	Target	94%
Appraisal Activity	2024 09			49.6%	Target	38.4%
Percentage recommending the Trust as a place to work (quarterly - data source is PULSE, Staff Survey data omitted for Q3)	2024 07			33.7%	Baseline	37.8%
Percentage recommending the Trust as a place to receive treatment (quarterly - data taken from PULSE, Staff Survey data omitted for Q3)	2024 07			35.2%	Baseline	39.9%

KPIs – Workforce

Workforce (7)

Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton & Gail Dunning

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



Factors impacting performance and actions:

Compliance with corporate induction has maintained at 96%, while mandatory training compliance has reduced to 86% in September. This has resulted from the arrival of 98 newly qualified nurses in the organisation, along with the September changeover of junior doctors; however, the Trust is confident of recovering the position in line with its compliance target once the 12-week grace period for training completion expires in December.

DIGITAL AND INFORMATION SERVICES

October 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 FOIs and EIRs responded to within 20 working days (monthly)	
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents* * Total number of calls abandoned * Number of information security incidents reported and investigated * Number of Patient Subject Access Requests (SARs) * Number of FOIs and EIRs received (monthly) * Number of FOIs and EIRs completed (monthly)	
SPECIAL CAUSE CONCERN		* Total number of calls to Service Desk * Percentage of Patient Subject Access Requests (SARs) processed within one calendar month	

Digital & Information Services (DIS)
Scorecard

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 09			0	Target	3
Total number of calls to Service Desk	2024 08			3500	Target	7761
Total number of calls abandoned	2024 08			500	Target	1826
Number of information security incidents reported and investigated	2024 09			38	Baseline	28
Number of Patient Subject Access Requests (SARs)	2024 09			419	Baseline	541
Percentage of Patient Subject Access Requests (SARs) processed within one calendar month	2024 09			100%	Target	99%
Number of FOIs and EIRs received (monthly)	2024 09			75.4	Baseline	62
Number of FOIs and EIRs completed (monthly)	2024 09			72.7	Baseline	63
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2024 09			80%	Target	98%

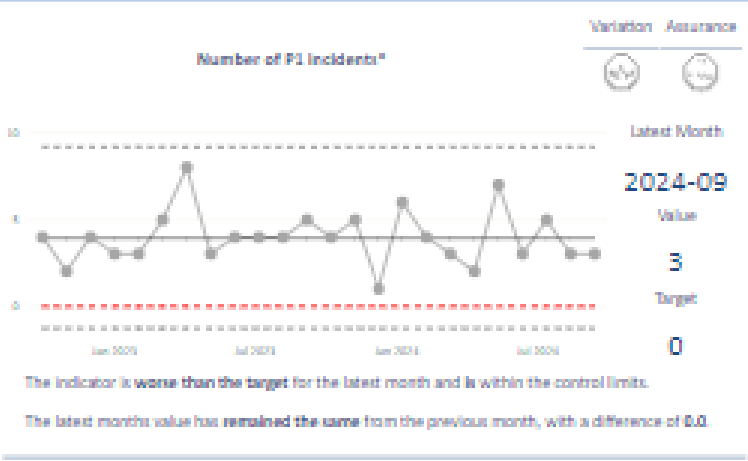
Digital & Information Services (DIS)

DIS (1)

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.

1. 5/9 - CPD authentication issues relating to planned work which had unexpected live impact:

    - Ongoing investigation with Oracle support.
    - Impact duration approx. 30 mins.
    - Limited impact on users (depending on which domain controller they were authenticated with) and if they were not already logged into CPD.

2. 15/9 (Sunday) White Cross Court network outage due to supplier's hardware fault:

    - Services restored 11:45 Monday 16th.

3. 15/9 National DNS issue affecting connections to some systems, including Summary Care Records, NHSmail and Smartcards.

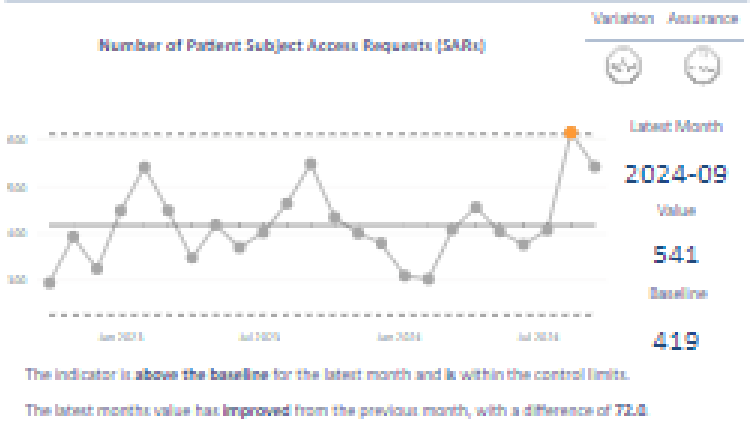
Digital & Information Services (DIS)

DIS (2)

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:

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. There has been a significant decrease in reported incidents – this was discussed with the datix team and there has been an overall drop in reporting.

Actions: Continue targeted communication to continue this trend.

Number of information security incidents reported and investigated

Factors impacting performance:

There has been a significant increase in SARs, we believe this is due to a request for maternity records because a Tiktok video which has been widely shared showed and encouraged people to access their records. We have seen a decrease in these requests this month.

Actions:

The teams processes are being reviewed by the IG manager, this may impact on timeliness of responses later in the calendar year.

Digital & Information Services (DIS)

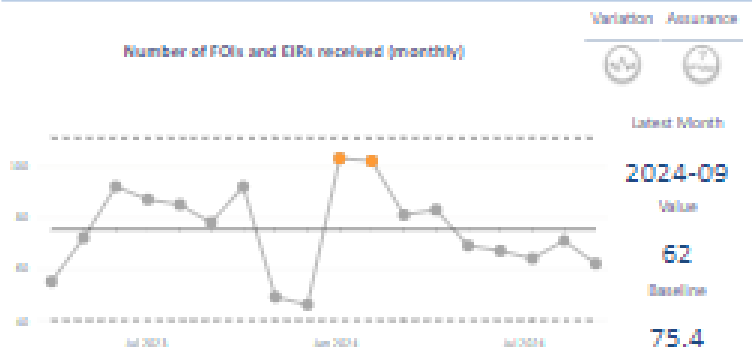
DIS (3)

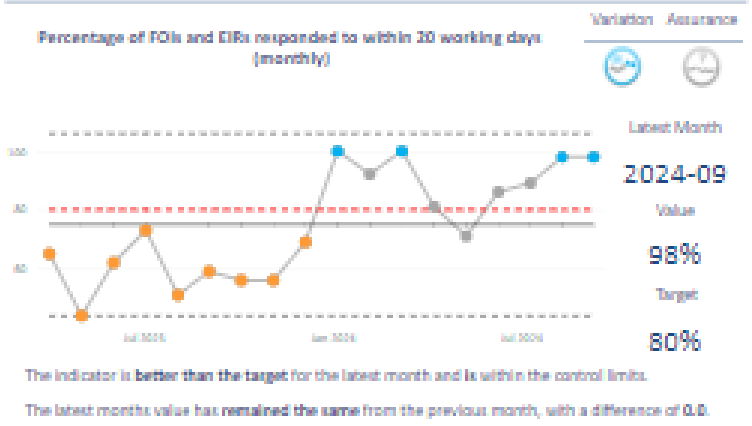
Executive Owner: James Hawkins

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 reasons for the decline of requests is not yet fully understood.

Actions: N/A

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

October 2024

- The Trust resubmitted its Operational Financial Plan to NHSE on 12 June 2024, which presented an adjusted I&E deficit of £16.6m. In September the Trust was advised that deficit funding support, to the value of our £16.6m deficit, will be released in October. This brings the financial plan to balance as per the table opposite.

- The Trust's plan forms part of a wider HNY ICB I&E balanced plan following receipt of £50.0m across the system.

- The Trust's actual operational I&E deficit is now £17.2m, 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 FINANCIAL PLAN 2024/25
SUMMARY INCOME & EXPENDITURE POSITION

	£000
INCOME	
Operating Income from Patient Care Activities	
NHS England	79,591
Integrated Care Boards	605,594
Other including Local Authorities, PPI etc.	7,142
	692,327
Other Operating Income	
R&D, Education & Training SHYPS etc..	76,547
Total Income	**768,874**
EXPENDITURE	
Gross Operating Expenditure	-827,157
Less: CIP	53,266
Total Expenditure	**-773,891**
OPERATING SURPLUS/ (DEFICIT)	**-5,017**
Finance Costs (Interest Receivable/Payable, PDC Dividend)	-12,152
SURPLUS/ (DEFICIT) FOR THE YEAR	**-17,169**
ADJUSTED FINANCIAL PERFORMANCE	
Net Surplus/ (Defciit)	-17,169
Add Back	
I&E Impairments	16,734
Remove capital donations/grants I&E impact	435
ADJUSTED FINANCIAL SURPLUS/(DEFICIT)	**0**

Summary Dashboard and Income & Expenditure

Finance (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£0.7m	-£1.3m	↓	Deteriorating
Forecast Outturn I&E Variance to Plan	£0.0m	£0.0m	-	Static
Core CIP Delivery Variance to Plan (£20.0m Target)	£0.7m	£2.1m	↑	Improving
Corporate CIP Delivery Variance to Plan (£33.3m Target)	-£2.5m	-£3.2m	↓	Deteriorating
Variance to Agency Cap	£0.6m Above	£0.5m Above	↑	Improving
Month End Cash Position	£1,0m behind plan	£3.6m ahead of plan	↑	Improving
Capital Programme Variance to Plan	£1.9m ahead of plan	£2.5m ahead of plan	↑	Improving

	Plan	Plan YTD	Actual YTD	Variance	Forecast
	£000	£000	£000	£000	£000
Clinical Income	724,711	367,888	377,900	10,012	744,836
Other Income	70,577	35,386	37,026	1,640	78,115
Total Income	795,288	403,274	414,926	11,652	822,951
Pay Expenditure	-513,913	-264,515	-265,245	-730	-521,641
Drugs	-68,162	-34,341	-38,522	-4,181	-75,209
Supplies & Services	-85,666	-42,793	-46,083	-3,290	-91,076
Other Expenditure	-162,567	-58,132	-63,426	-5,293	-143,183
Outstanding CIP	30,075	1,125	0	-1,125	0
Total Expenditure	-800,233	-398,656	-413,277	-14,621	-831,109
Operating Surplus/(Deficit)	-4,945	4,618	1,649	-2,969	-8,158
Other Finance Costs	-12,225	-6,136	-4,590	1,546	-9,011
Surplus/(Deficit)	-17,169	-1,518	-2,941	-1,423	-17,169
NHSE Normalisation Adj	17169	218	297	79	17169
Adjusted Surplus/(Deficit)	0	-1,300	-2,644	-1,344	0

The I&E table takes into account the £16.6m deficit support funding and presents a balanced plan. From a YTD perspective, the table confirms an actual adjusted deficit of £2.6m against a planned deficit of £1.3m for September (Month 6). The pressure to balance remains for month 6 for the whole ICB. This is linked with the Financial Tier Rating (Current rating for the ICB is 3+), which means potential intervention and special measures for the system.

As a Trust we have not hit balance in M6, we are £1.3m adverse to plan, support has been received for industrial action, but there continues to be risk in the position linked to additional ERF income and stocking up evidence (smoothed spend).

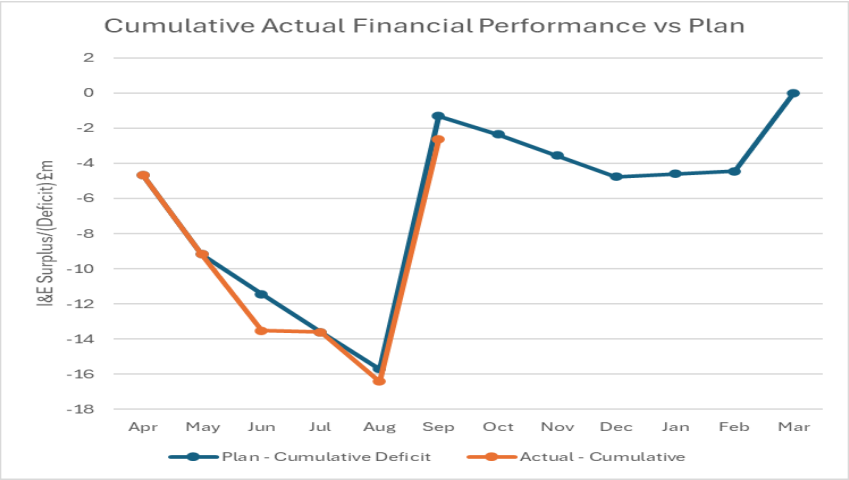
Key Subjective Variances: Trust
Finance (3)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	(826)	ERF Performance currently behind plan for specialist related activity. Reimbursement of Cancer Drug Fund currently behind plan	No mitigation or action required.
ICB Income	10,806	ERF overperformance	No mitigation or action required.
Employee Expenses	-730	Agency, bank and WLI spending is ahead of plan to cover medical vacancies and deliver 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	(4,181)	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	(3,290)	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	(1,125)	The Core Programme is £2.1m ahead of plan and the Corporate Programme £3.2m behind plan at M6	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.
Other Costs	(5,293)	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 is expected to compensate. Some other smaller adverse variances to be investigated. Plan updated to incorporate increased expenditure in relation to ERF overtrade. Plan in other offset against drugs / CSS and employee expenses.	Investigation of other variances not linked to increased elective activity.

Cumulative Actual Financial Performance vs Plan

Finance (4)



On the 12th June the Trust resubmitted it's plans which aligned M1 & M2 to actual expenditure and assumed, in M12, 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.

In September the Trust received £16.6m deficit support funding to improve our plan to a balanced position.

The YTD plan is an adjusted deficit of £1.3m at M6 with an actual deficit of £2.6m.

Forecast			
	Adjusted Surplus/(deficit)		
Scenario	Plan £'000	Forecast £'000	Variance £'000
Likely Case	0	-8,471	-8,471
Best Case	0	0	0
Worst Case	0	-20,392	-20,392

Likely Case
The likely case forecast is a deficit of £8.5m against a balanced plan. This forecast assumes the issue around High Cost Drugs (HCD) and Direct Access Pathology (DA Pathology) are partly resolved (50%). It assumes the current £5.2m planning gap in the CIP programme is not resolved, and that a proportion of high risk schemes are not going to deliver the reduction in run rate required to meet the plan.

Best Case
The best case forecast assumes we will hit our balanced plan, this is not without risk and includes high level assumptions around the flow of the £4.2m required as our share for the whole system to meet a balanced plan, plus assumptions around working closely with the ICB to address the overspends on HCD and DA Pathology. This also assumes full delivery of our CIP programme.

Worst Case
The worst case forecast is a deficit of £20.3m against the balanced plan. This forecast assumes no resolution with the ICB in respect of HCD & DA Pathology and assumes further slippage in efficiency delivery.

Cumulative Actual Financial Performance vs Plan

Finance (5)

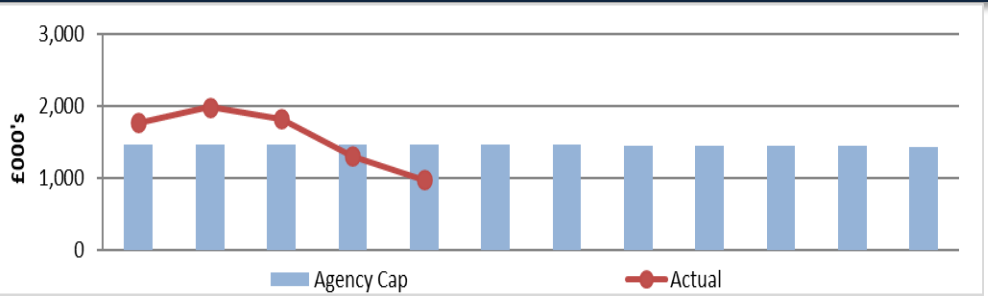
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Year to Date 2024/25 Care Group Financial Position							
Care Group	Annual Adjusted Budget	YTD Budget	YTD Actual	YTD Variance	YTD Adjusted Budget	YTD Adjusted Variance	Key Drivers of YTD Adjusted Variance
	£000	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	204,366	101,236	103,675	-2,440	102,951	-725	Overspend driven by Outsourcing of Cell Path and Radiology Reporting and within Tariff Drug Spend, offset by Vacancies and CIP Delivery.
Family Health Care Group	79,509	39,764	41,107	-1,344	40,256	-852	£0.9m relates to the premium cost of covering medical vacancies, £0.5m Midwifery overspend, £0.4m Community Nursing overspend, £0.4m non-pay underspend, £0.3m overachieved CIP.
Medicine	180,469	91,242	96,750	-5,507	91,821	-4,929	£4.5m relates to the premium cost of covering medical vacancies, £1.8m drug overspend.
Surgery	150,529	71,682	78,246	-6,564	76,277	-1,969	Overspend mainly relates to Junior Doctor's pay costs over budget - £2m (driven by premium cost to cover vacancies as well as having rotas over substantive budgets). Other cost pressure relates to the theatre capacity gap reduced by non-recurrent vacancy savings.
TOTAL	614,873	303,923	319,778	-15,855	311,305	-8,473	

Full Year 2024/25 Care Group Forecast Financial Position						
Care Group	Annual Adjusted Budget	Forecast Prior to Mitigating Actions	Mitigating Actions	Forecast Post Mitigating Actions	Forecast Variance	Key Drivers of Forecast Variance
	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	204,366	207,152	-1,175	205,978	-1,612	Overspend expected to remain on Outsourcing of Histology, however slight reduction expected in within tariff drugs and Radiology Reporting costs.
Family Health Care Group	79,509	82,377	-385	81,993	-2,483	£1.8m relates to the premium cost of covering medical vacancies, £1.1m Midwifery overspend, £1.1m Community Nursing overspend, £0.6m non-pay underspend, £0.2m overachieved CIP.
Medicine	180,469	192,719	-191	192,528	-12,059	£8.8m relates to the premium cost of covering medical vacancies, £3.7m drug overspend and £2.2m CIP planning gap.
Surgery	150,529	157,228	-719	156,509	-5,980	£3.5m over-spend on Junior Doctors mainly related to premium cost of covering medical vacancies (£0.9m Agency; £0.5m WLIs, £2.1m Med Bank Pay); £2m Theatre capacity gap; £0.2m unachieved CIP & £0.3m CSS over-spend due to non-elective activity over plan (3%)
TOTAL	614,873	639,476	-2,469	637,007	-22,134	

Agency, Workforce, Elective Recovery Fund

Finance (6)



	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,555.22	2,410.82	144.40	67,533	70,539	-3,006
Scientific, Therapeutic and Technical	1,268.54	1,195.79	72.75	33,261	32,674	587
Support To Clinical Staff	1,912.96	1,725.33	187.63	30,936	31,219	-283
Medical and Dental	1,053.52	1041.93	11.59	67,111	76,408	-9,297
Non-Medical - Non-Clinical	3,179.72	2,837.09	342.63	55,370	53,332	2,038
Reserves				9,306	0	9,306
Other				997	1,073	-75
TOTAL	9,969.96	9,210.96	759.00	264,515	265,245	-730

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 6 Phase (Av %)	Activity to Month 6 Actual	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	104.00%	£128,452,102	£63,732,684	£75,177,354	£11,444,669	122.7%
West Yorkshire	103.00%	£1,347,881	£668,763	£613,195	-£55,568	94.4%
Cumbria and North East	115.00%	£170,165	£84,429	£114,822	£30,393	156.4%
South Yorkshire	121.00%	£150,189	£74,517	£73,537	-£980	119.4%
Other ICBs - LVA / NCA	-				*£0*	-
All ICBs	***104.02%***	***£130,120,337***	***£64,560,394***	***£75,978,908***	***£11,418,514***	***122.4%***
NHSE Specialist Commissioning	113.38%	£4,514,034	£2,239,679	£2,057,785	-£181,894	104.2%
Other NHSE	104.13%	£287,288	£142,541	£130,357	-£12,183	95.2%
All Commissioners Total	**104.31%**	**£134,921,659**	**£66,942,614**	**£78,167,050**	**£11,224,436**	**121.8%**

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 September expenditure on agency staffing was £0.5m ahead of plan (M5 £0.6m 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.

The table illustrates that a key driver for the pay position (other than reserves) is spend against Medical and Dental staff. 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 £11.2m surplus for the period.

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

Cost Improvement Programme
Finance (7)

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 - September Position

	Full Year CIP Target	September 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	8,520	5,336	3,184	10,357	22,969	25,595	7,730	12,207	4,171	9,217
	33,326	**8,520**	**5,336**	**3,184**	**10,357**	**22,969**	**25,595**	**7,730**	**12,207**	**4,171**	**9,217**
Core Programme											
Medicine	4,152	1,028	1,062	-34	1,903	2,248	2,551	1,600	2,501	0	50
Surgery	4,120	1,019	1,433	-413	2,519	1,602	3,929	192	3,312	617	0
CSCS	6,290	1,555	2,590	-1,035	5,017	1,273	6,024	266	5,722	215	87
Family Health	1,797	445	959	-515	1,464	333	2,170	-373	2,027	143	0
CEO	104	26	20	5	41	63	41	63	41	0	0
Chief Nurses Team	207	51	14	37	28	179	126	81	126	0	0
Finance	382	95	201	-106	231	151	231	151	231	0	0
Medical Governance	23	6	6	-1	13	10	58	-36	58	0	0
Ops Management	233	58	139	-82	227	6	232	1	232	0	0
DIS	427	106	207	-101	413	13	490	-64	490	0	0
Workforce & OD	361	89	46	43	92	270	334	27	141	194	0
YTHFM LLP	1,840	455	313	143	886	955	1,468	372	962	82	424
Central	0	0	0	0	0	0	4,817	-4,817	4,800	18	0
	19,936	**4,932**	**6,990**	**-2,059**	**12,834**	**7,102**	**22,473**	**-2,536**	**20,643**	**1,268**	**561**
Total Programme	**53,262**	**13,452**	**12,327**	**1,125**	**23,191**	**30,071**	**48,068**	**5,194**	**32,850**	**5,439**	**9,778**

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 22 schemes which, following an initial risk assessment, give planned savings of £25.6m towards the £33.3m target.

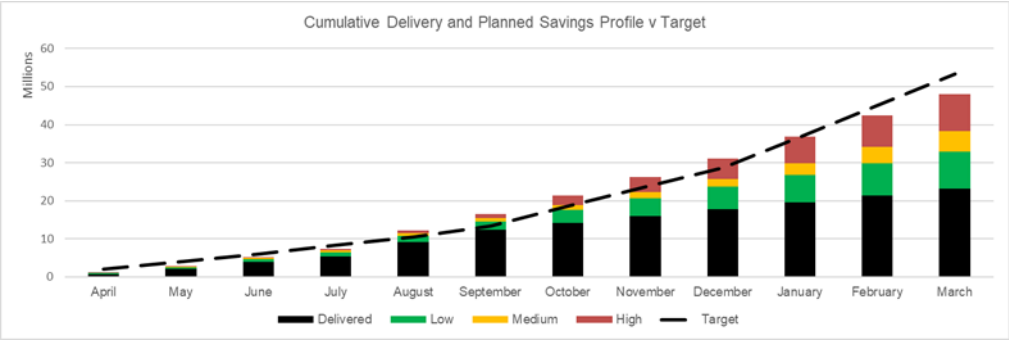
In September £10.4m of the target was delivered in full year terms, £7.4m of which are recurrent savings. The YTD position shows delivery of £5.3m against target of £8.5m, £3.2m behind plan.

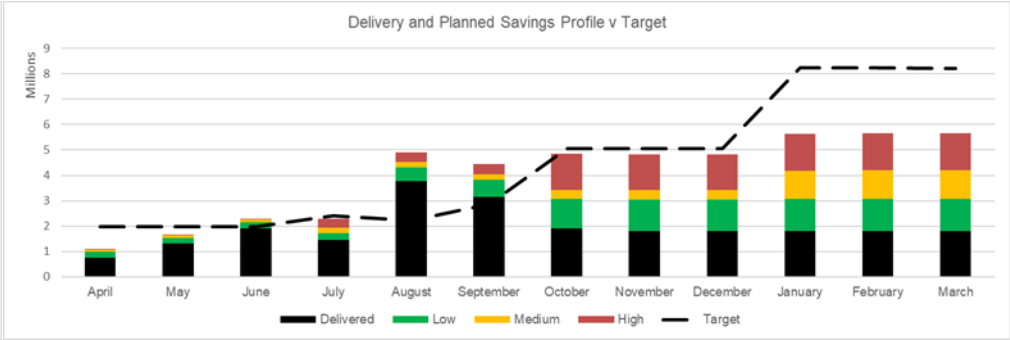
Core Efficiency Programme

The core efficiency programme currently has plans totalling £22.5m towards the required £20m target.

In September £12.8m of the target was delivered in full year terms £6.6m of which was recurrent. The YTD position shows delivery of £7m against target of £4.9m, £2.1m ahead plan.

Cost Improvement Programme (2)
Finance (8)





Efficiency Programme - High Risk Plans Summary

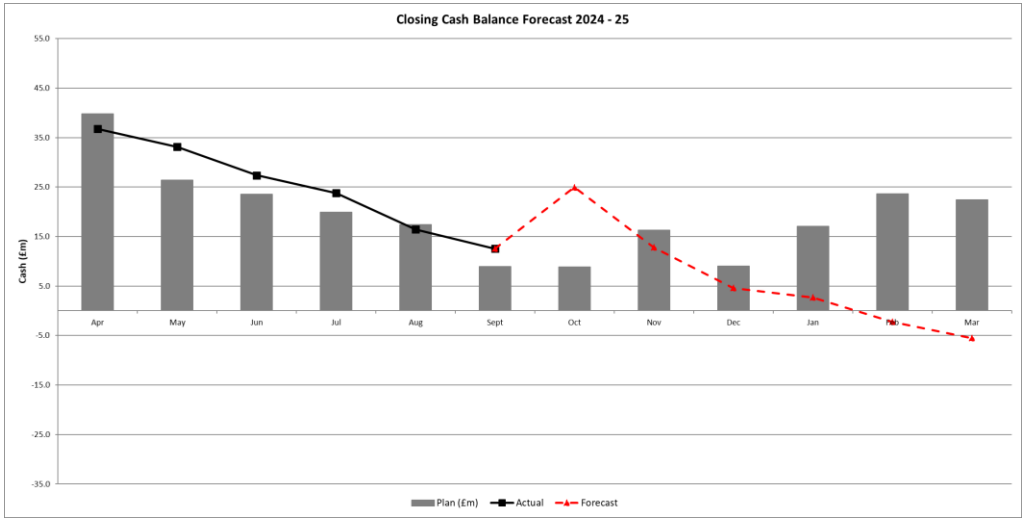
CG/Directorate	CIP Scheme	Planned Saving	Comments (Reason for High Risk, who looking at and efforts to de-risk)
		£000	
Corporate	Review of Community Bed Model of Care	2,625	Family Health CG working on PID, scheme yet to be worked up hence High risk to delivery.
Corporate	Further NCTR Bed Reduction	2,250	High risk as dependant on closing wards. COO completed QIA. System discussion is on-going.
Corporate	Confirm York ED and Community Unit Establishments	1,856	Medicine CG working on PID, scheme yet to be worked up hence High risk to delivery.
Corporate	Full Corporate Review of all Agency Medical	1,125	Work currently under way within Workforce team, oversight by MD. High risk due to possible duplication with other schemes and potential time needed to take action.
Corporate	Review remaining covid funded posts where funding has been removed	1,125	QIA completed by COO Team and currently under review by Exec Team.
Corporate	Car Parking Income	236	High risk pending discussion with Legal team by Finance Team.
YTHFM	Various YTHFM Schemes including Upgrade to Vee belt drives £148k, Bed linen change frequency £139k.	424	YTHFM management team to review risk status.
CSCS	Various SHYPS Schemes	87	CSCS Management team to review risk status.
Medicine	Single Improvement Programme	50	Historic scheme being assessed by Medicine CG to see if still a valid scheme.
		9,778	

Current Cash Position
Finance (9)

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 September was £3.6m 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	23,821	16,460	12,559						



The cash forecast graph illustrates the cash position based on the actual cash balance at the end of September, at £12.6m against a plan balance of £9m.

The red dotted line on the graph opposite illustrates the Trusts current forecast cash trajectory based on current cash run rates. The peak in October is the £16.5m deficit funding agreed by the ICB in September.

Based on the forecast cashflow the Trust will be applying in Q4 for cash support to start in February.

Please note the current cashflow forecast does not include the recently announced pay awards. The cash required to fund these is expected to flow from the ICS.

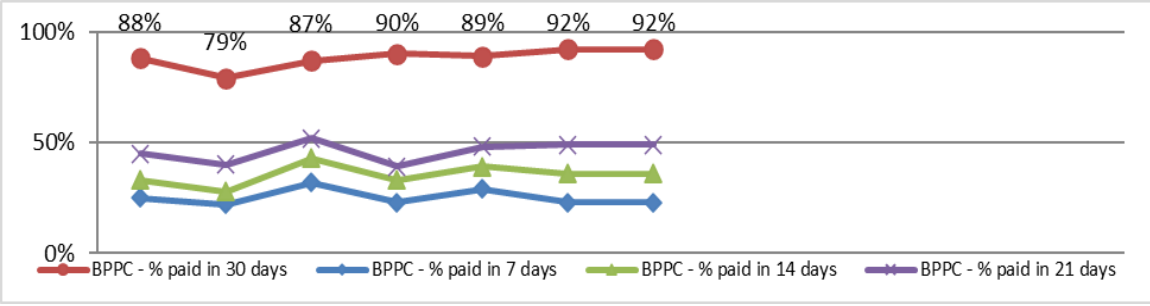
Current Capital Position and Better Payment Practice Code (BPPC)

Finance (10)

Capital Plan 2024-25 £000s	Capital FOT 2024-25 £000s	M6 Planned Spend £000s	M6 Actual Spend £000s	Variance to Plan £000s	Variance to FOT £000s
51,870	54,520	9,780	12,333	2,553	0

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

The capital programme at month 6 is £2.5m ahead plan. £2.9m of this variance is due to several schemes running ahead of the plan phasing including backlog maintenance, York Spec CT and DIS including EPR. These are offset by the IFRS 16 leasing programme running behind plan by £0.4m.



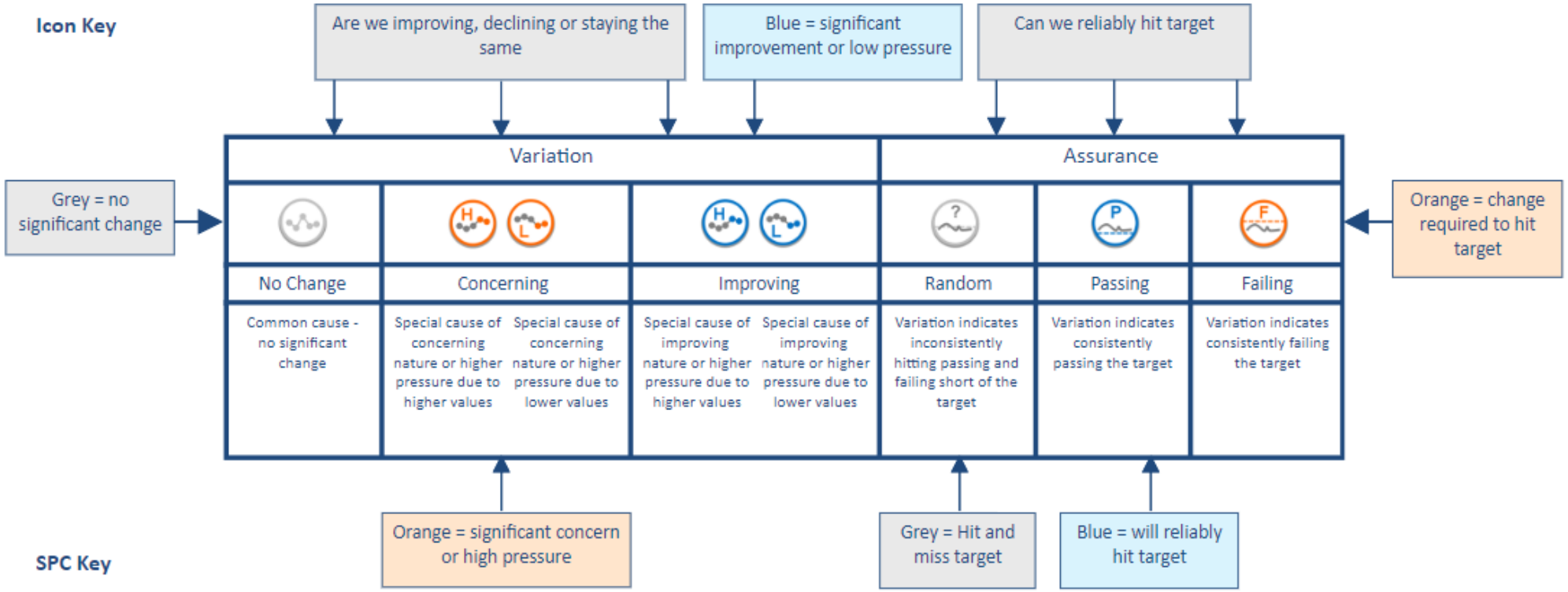
Better Payment Practice Code

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.

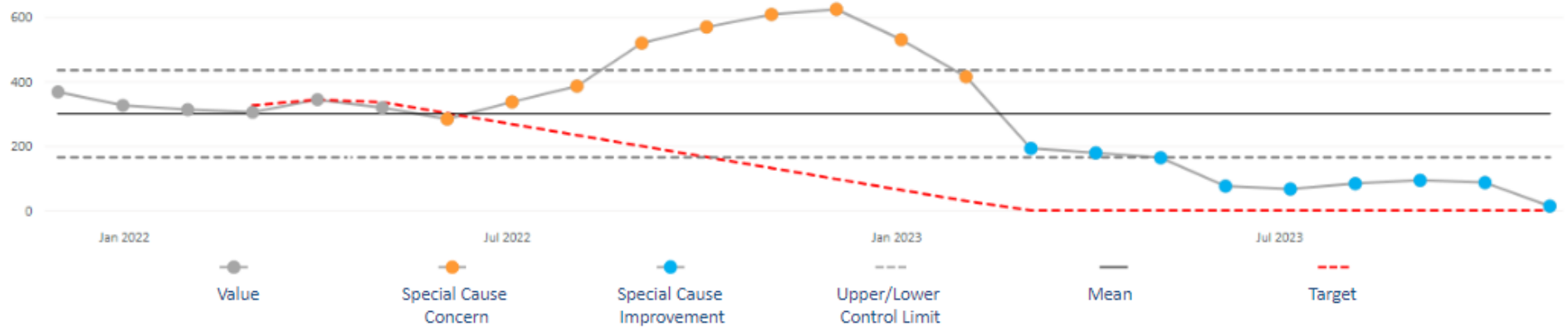
The table illustrates that in September the Trust managed to pay 92% of its suppliers within 30 days.

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 are near the upper or lower control limit. The target can be either static or moving.

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.

Report to:	Trust Board
Date of Meeting:	23rd October 2024
Subject:	Maternity Neonatal Safety Report
Director Sponsor:	Dawn Parkes, Chief Nurse (Maternity Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

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

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

Summary of Report and Key Points to highlight:
This report provides an update on the progress of improvements in the maternity and neonatal service as well as provide monthly key quality and safety metrics for the services for the month of August 2024.

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

Report History
Quality Committee

Meeting	Date	Outcome/Recommendation
Quality Committee	15/10/24	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 August 2024 there was sadly two neonatal deaths, these deaths meet the criteria for reporting to MBRRACE-UK and will be reviewed using the National Perinatal Mortality Review tool.

One of these cases and a further case that required transfer to the tertiary unit have met the criteria for reporting to Maternity and Neonatal Safety Investigation (MNSI) team and also to NHS Resolution (NHSR) under the early notification scheme. Confirmation for acceptance of the cases by NHSR is yet to be received.

There has been an increase in the % of postpartum haemorrhage over 1500mls to 3.9 % (12 cases) from the previous month of 3.5 % (12 cases). This remains above the national target of 2.9% per 1000 births. All cases of PPH over 1500mls are reported via Datix and graded as moderate harm to ensure all are reviewed either as a single case or as a cluster review. Any new themes are actioned accordingly. This has now been added to the Maternity Annual Forward Audit Plan with monthly retrospective audits being undertaken from the end of October to ensure clinical care is in line with previous identified actions and clinical guidance. Quarterly reporting of the results and improvements through the Maternity Directorate Meeting and Maternity Assurance Group.

Annex 2 provides the August 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 Trust Board are asked to approve this submission to CQC.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

Progress to deliver against the plan as required continues. To date 58 out of the 214 milestone actions have been completed.

14 milestone actions are at risk of becoming off track with the end date prior to 31/10/24.
59 milestone actions are off track as the delivery date has passed and action has not been fully completed. The reason for this is the challenge to deliver sustainable change against the capacity of the teams related to the resource and staffing gap across the services.

Maternity and Neonatal services have now received the results of the perinatal culture score survey that was conducted in March and April of this year across all professional groups and clinical settings. The response rate was 37% (266 respondents). Culture conversations will happen across both sites over the coming weeks with the Culture Coach provided by Korn Ferry (the supporting organisation) where staff will be encouraged to articulate the changes they need to see to improve their working lives and the culture within the services. There are many areas for improvement, but the key focus will be into the following four areas:

- **Improvement readiness**
- **Burnout and workload strain**
- **Safety Climate**
- **Estate**

The culture conversations will gather all the actions and develop an overarching action plan which will be incorporated into the Maternity and Neonatal Single Improvement Plan (MNSIP), with progress of delivery monitored through the Maternity directorate meeting and the Maternity Assurance Group.

The trajectory for the delivery of Saving Babies Lives Care Bundle V3 has been submitted and accepted by the LMNS/ICB that show best endeavours to meet full compliance by March 2026.

This is monitored the through the MNSIP and quarterly meetings with the LMNS/ICB. This links through to the compliance of the 10 safety actions of the Maternity Incentive Scheme (MIS). A full review of the MIS standards delivery progress has been undertaken and key evidence supporting compliance will be presented to the November 20204 and January 2025 Quality committee as well as Trust board for approval and sign off, ready for submission in March 2025.

The service has responded to the thematic review undertaken by NHS Resolution into early notification cases. A full response has been provided to the clinical fellows and read only access to the MNSIP has been shared. Further correspondence is waited for acceptance of the actions taken by the service in response to the themes, actions and recommendations made.

A reset and review of the progress against the exit criteria for the Maternity Safety Support Programme (MSSP) was undertaken on the 14th October. The meeting was attended by LMNS/ICB and regional maternity leads along with the Maternity Improvement Advisor (MIA) and the Lead MIA for the MSSP, along with the Chief Nurse, Medical Director, Director of Midwifery, Clinical Director and the Maternity services leadership team. Following a full review and presentation by the leadership team it was agreed that the service would remain on the programme but with a reduced support from the MIA. The service sought dedicated support from NHS England to undertake a capacity and demand exercise to ensure the medical cover for Obstetrician and Gynaecology meets the requirements of the service in line with national standards. Another review meeting will occur in 6 months' time. Positive feedback was received for the leadership commitment and motivation, changes presented and seen on the unit visit at the end of the meeting. A written review will be received which will be shared with the Trust Board in November.

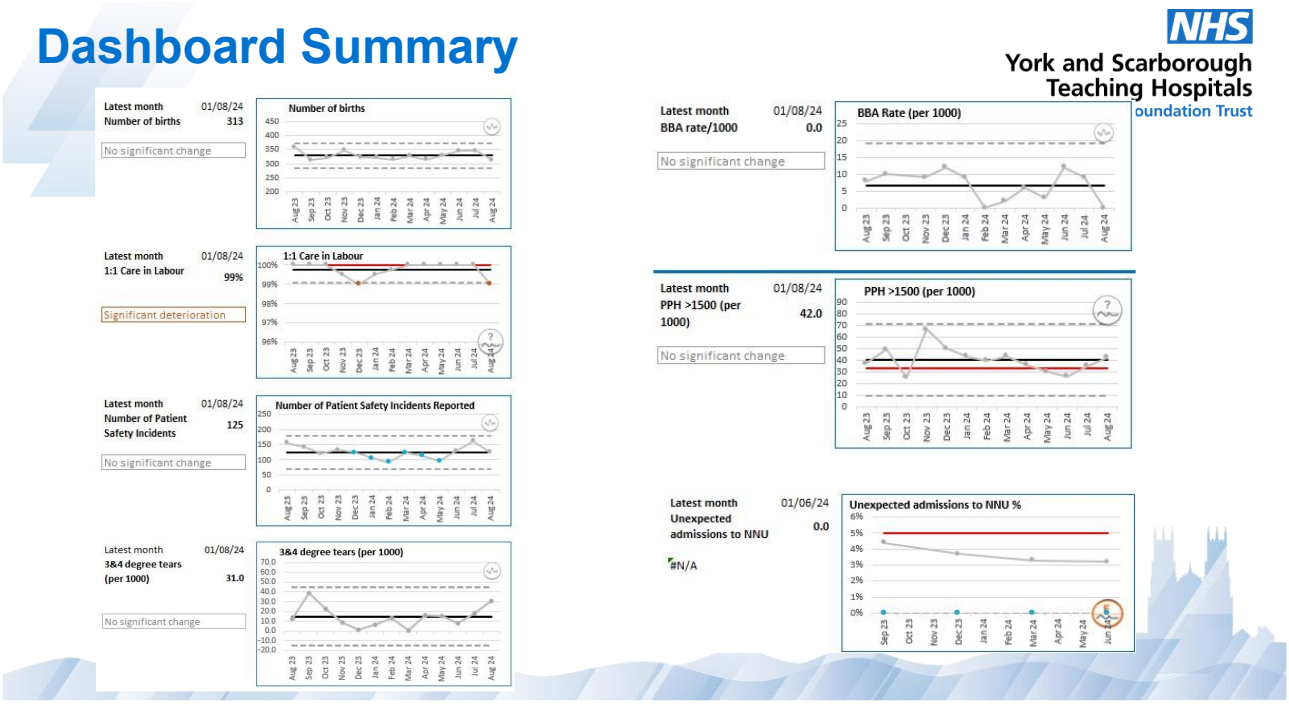
Key Achievements in September

- Implementation of the Respiratory Syncytial Virus (RSV) Programme cross-site
- Health Inequalities bid submitted to support Personalised Care Plans and additional transformation resource.
- CQC invited to visit and improvement progress to date shared.
- Stakeholder engagement lead by Director of Midwifery at the Council of Governors meetings
- Director of Midwifery and Chief Nurse presented paper at North Yorkshire and Humber Scrutiny Committee
- Completed the Aqua Collaborative Programme - LMNS developing the Induction of Labour guideline.
- Inaugural Complaints, Concerns and PSIRF Panel commenced.
- Maternity Feedback Survey YSTHFT drafted with the MNVP

Recommendations to Trust Board

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

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



Report to:	Quality Committee
Date of Meeting:	15 October 2024
Subject:	Maternity 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 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:

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 October 2024 monthly submission to the CQC which provides assurance on progress and impact on outcomes in August 2024.

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Maternity Assurance Group	08.10.2024	Minor amendments required

Annex 2

CQC Section 31 Progress Update

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

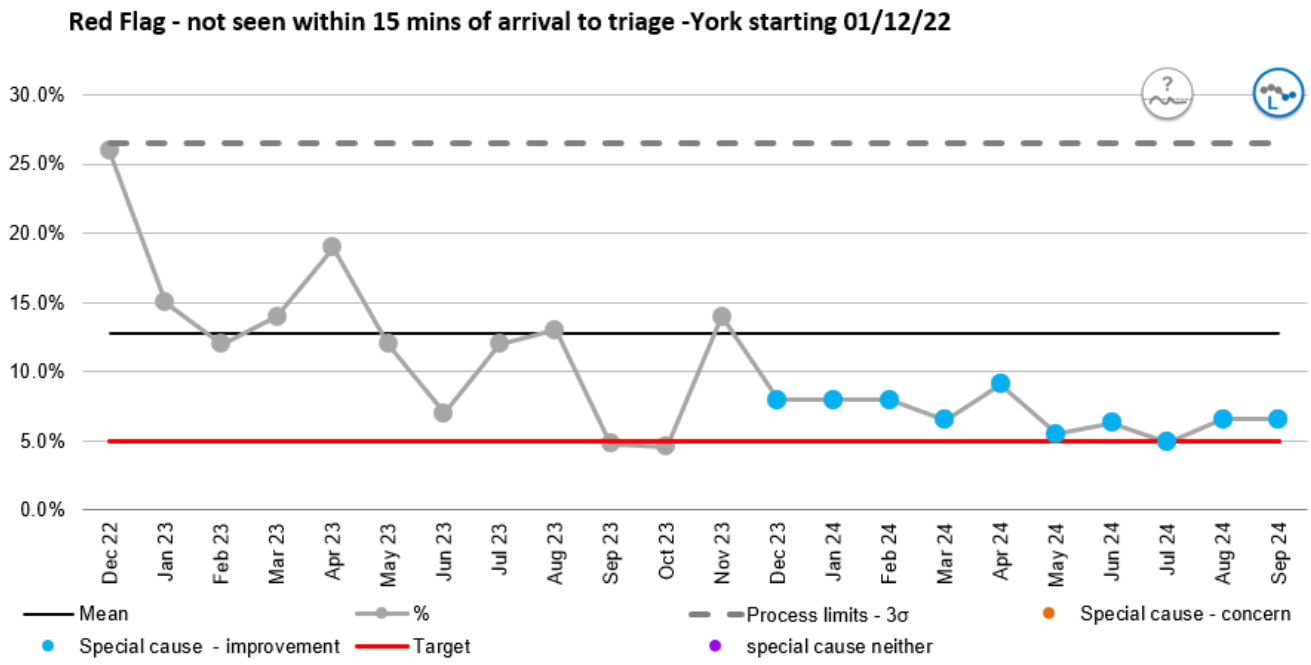
Current Fetal Monitoring compliance figures, by site, set against the target of 85% at the end of August 2024 are outlined below.

Staff Group	York	Scarborough
Midwives	92% (170/184)	93% (65/70)
Consultants	93% (14/15)	86% (6/7)
Obstetric medical staff	88% (14/16)	89% (8/9)

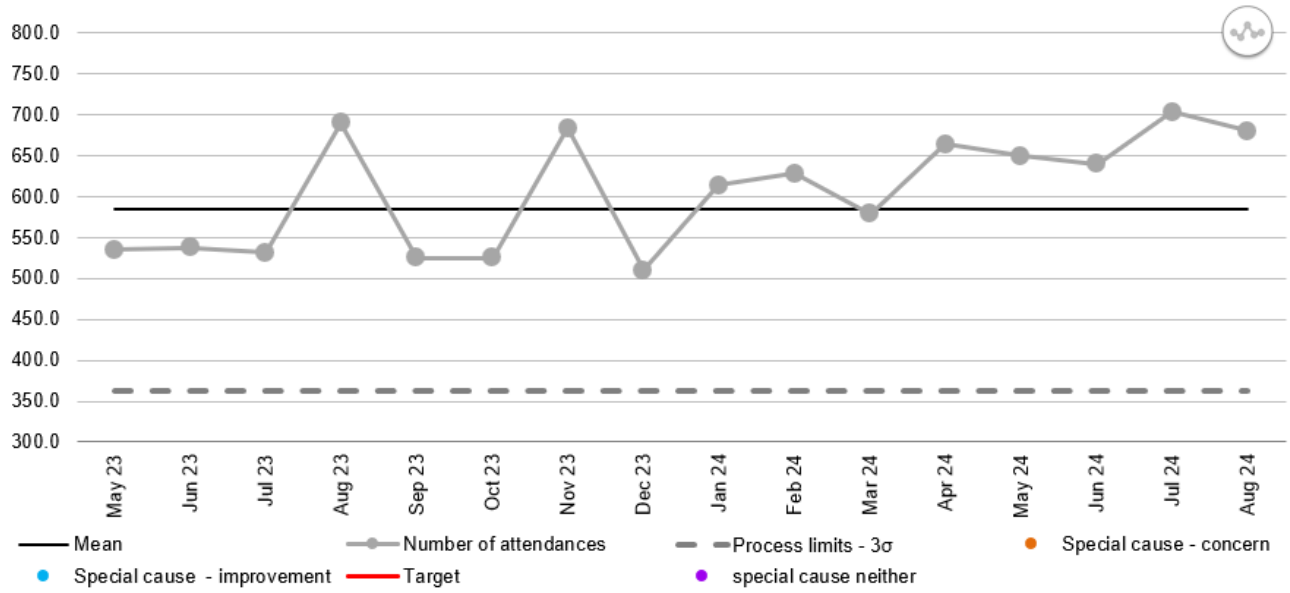
Of the consultants that are not complaint at York half a day was completed, and the second half rebooked for October. The Scarborough consultant is not currently undertaking acute work and therefore not required to undertake CTG review or interpretation at this time.

Training projections continue to show that compliance will remain above 85% for all staff groups into Q3 2024/25.

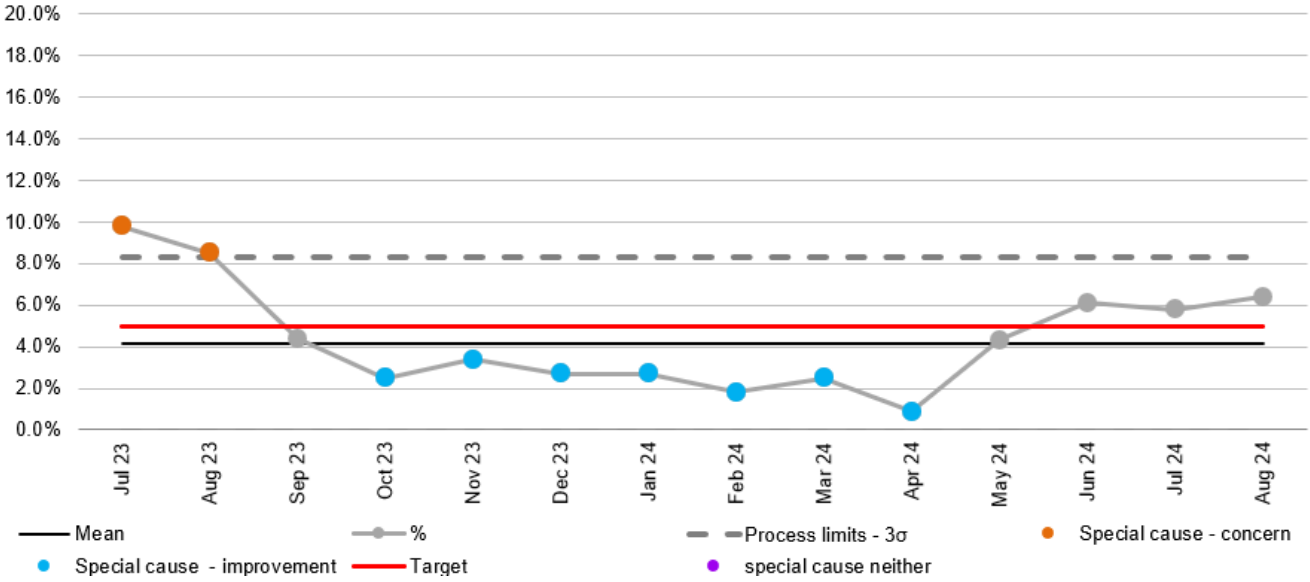
A.4 Assessment and Triage

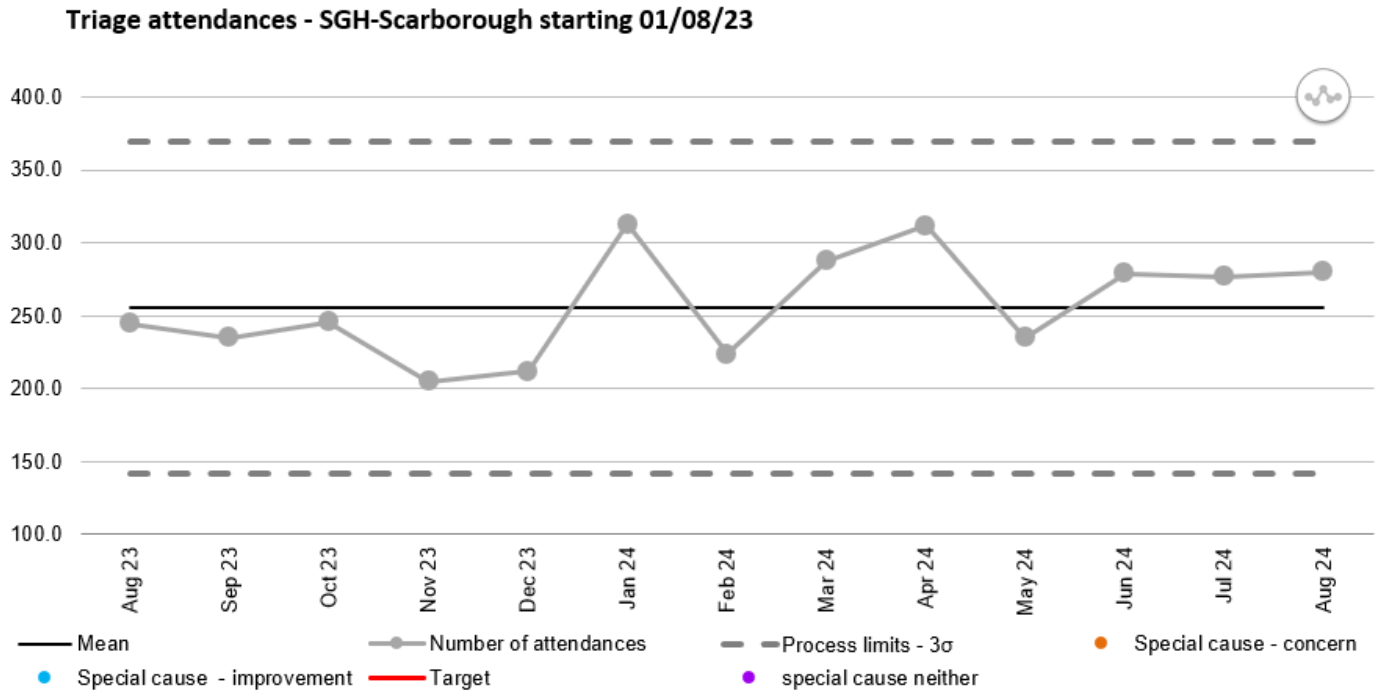


Triage attendances - York -York starting 01/05/23



Red Flag - not seen within 15 minutes of arrival to Triage-Scarborough starting 01/07/23





Staffing and skill mix remain a challenge across the Scarborough site which has resulted in Triage continuing to be provided on Labour Ward in times of high acuity and escalation. In the month of September this was further impacted on due to ongoing water ingress through the maternity unit roof and closure of beds to maintain the safety of service users.

B. Governance and Oversight of Maternity Services

B.1 Post-Partum Haemorrhage (PPH)

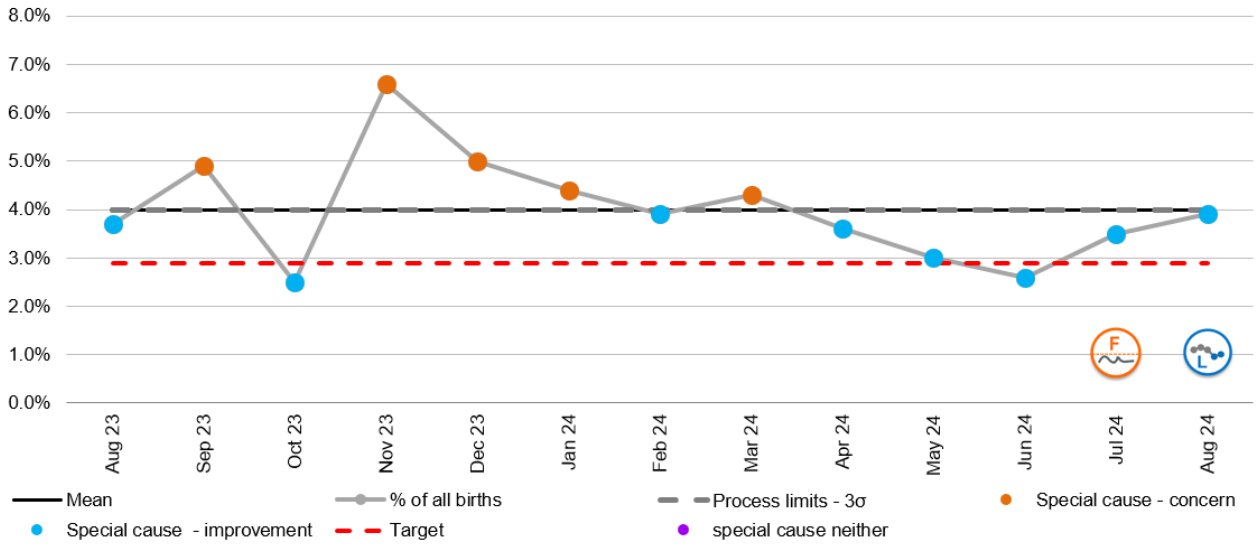
PPH over 1.5 litres

The reduction in the rate of post-partum haemorrhage (PPH) over 1500ml is a key priority for the maternity service. The PPH rate for August 2024 was 3.9% of all deliveries across both sites.

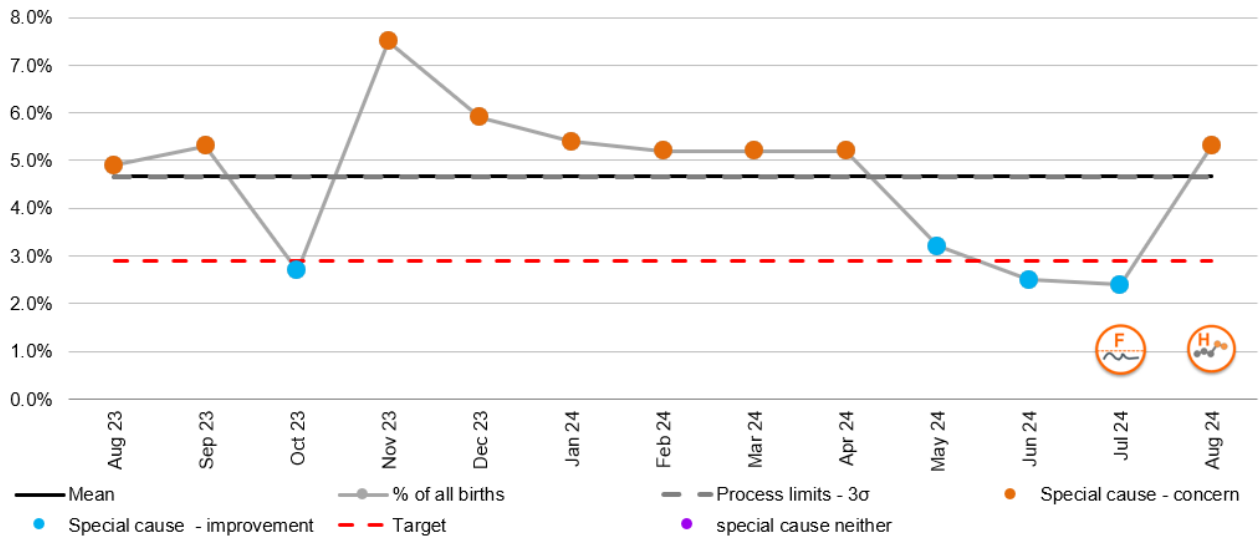
All PPHs are reviewed at the Maternity Case Review meeting, there have been no new themes identified in the reviews and the themes identified link to the ongoing improvement workstreams identified in the cluster review.

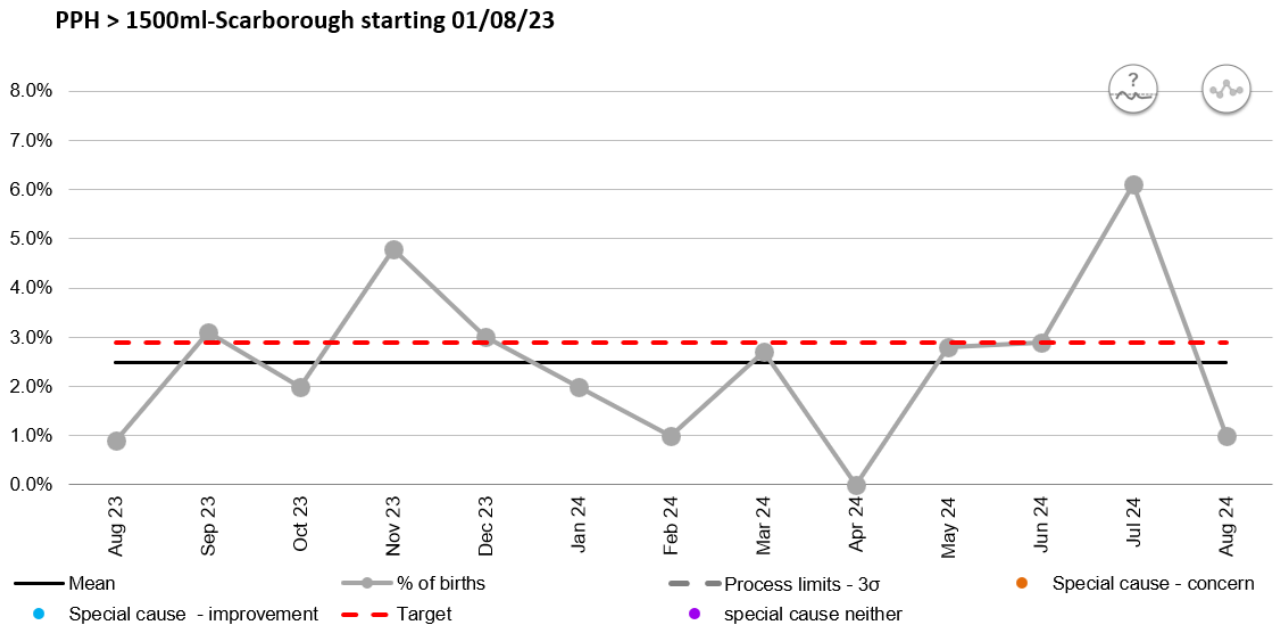
Blood Loss	Number in August 2024
1.5l – 1.9l	9 (range 1.5l – 1.7l)
2l – 2.4l	2 (range 2l - 2.2l)
> 2.5l	1 (2.5l)

PPH > 1500ml-Trustwide Maternity starting 01/08/23



PPH > 1500ml-York Maternity starting 01/08/23





Update on PPH Improvement Project

- Findings from reviews shared with wider MDT, including anaesthetic and obstetric colleagues regarding delayed administration of uterotonic in theatre. Updated education programme in relation to measuring of blood loss led by the Practice Development Midwives and Labour Ward Coordinator team with posters in place to support this.
- The Oxytocin guideline is being updated and combined into Care of Women in Labour Guidance, with aim of reducing hyperstimulation.
- Findings presented and discussed over three weeks at the Hot Topics Forum. Individuals have been identified to lead improvements in:
    1. clinical lead in emergencies.
    2. handover process including SBAR-D.
    3. administration of uterotonics.
    4. activation of Massive Obstetric Haemorrhage and emergency bleep cascade, including scrub nurses and twice daily huddle.
- Promotion of best practice with PPH risk assessment and proforma shared with all teams.
- iPads now in place at both sites. Compliance has increased to 70% for both risk assessment and proforma (increased from 42%).
- Suturing training continues with Practice Development Midwives team, plus external training identified subject to funding.
- PPH dashboard built by BI team utilising measures gleaned from reviews which is accessible to all staff.

B.2 Incident Reporting

There were 20 moderate harm incidents reported in August 2024.

Datix ID	Incident Category	Outcome/Learning/Actions	Outcome
22652 22581 22464 22422 22327	PPH >1500ml	Cluster review completed, action and learning are being embedded	Key findings and recommendations of the review now embedded with the PPH QI (Quality

22111 22109 21828 21463 21462 21282 21281			Improvement) project and part of the MNSIP (Maternity and Neonatal Single Improvement Plan)
22701	Postnatal Readmission	AAR review undertaken	Learning identified and shared
22227 21811 21783 21464 21421	3rd degree tear	To be included in the quarterly perineal tear audit	Learning from the audit shared with teams
22166	Transfer for cooling	Referred to MNSI	Local review undertaken for immediate learning
21620	Neonatal Death at 38 weeks (cardiac abnormality)	Notification to MBRRACE-UK	Learning identified and shared

B.4 Management of Risks

B.4.1.1 Project Updates York

The refurbishment work on the maternity theatres the the York site has been delayed due to further testing required on the air quality systems. It is estimated that this will be completed by early October 2024 when both theatres will have been refurbished and can be used.

B.4.1.2 Project Updates Scarborough

A review of the use of HUGS tags at Scarborough has been undertaken and the timeframes implementation of the new X-TAG system has been escalated to the Executive Committee. As mitigation in the interim, the service is ensuring the safety of babies and families by employing 24/7 security until a permanent solution can be reached.

B.4.2 Scrub and Recovery Roles

Recruitment is ongoing with interviews being conducted throughout the month of September 2024.

Current vacancy figures are:
York: 1.76 WTE
Scarborough: 0.98 WTE

There is collaboration across maternity and surgery to review the national requirements of having two scrub nurses for each list, the potential benefits and risks in not meeting this standard that may release some staff funding back into maternity services to support recruitment of midwives as an alternative.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	23 October 2024
Subject:	CQC Update Report
Director Sponsor:	Dawn Parkes, Chief Nurse 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 Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☒ Quality Standards
☐ Great place to work, learn and thrive	☐ Workforce
☒ Work together with partners	☒ Safety Standards
☐ Research, innovation and transformation	☐ Financial
☐ Deliver healthcare today without compromising the health of future generations	☐ Performance Targets
☒ Effective governance and sound finance	☐ DIS Service Standards
	☐ Integrated Care System
	☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendations:

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

Report History *(updated to include Appendices A, B and D)*

Meeting	**Date**	**Outcome/Recommendation**
Patient Safety and Clinical Effectiveness Sub-Committee	9 October 2024	*Presented and accepted*
Quality Committee	15 October 2024	*Presented and accepted*

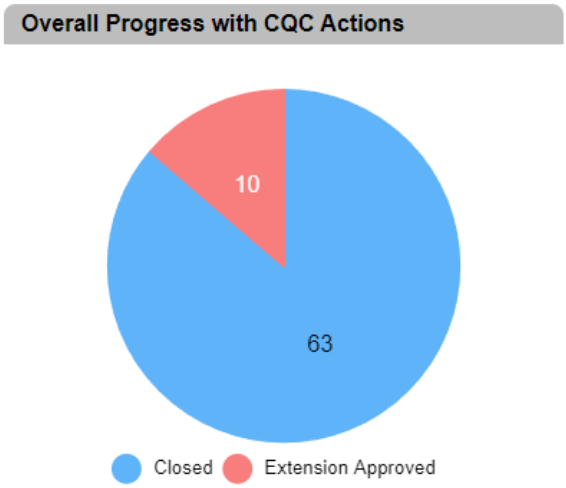
1. Progress Update

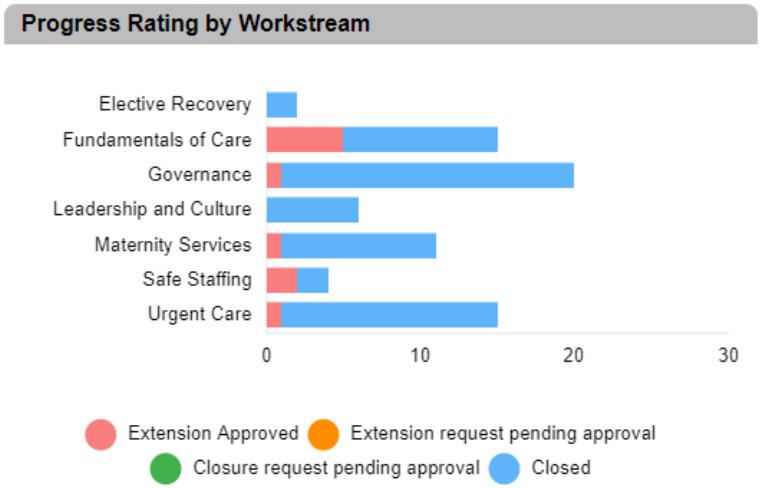
The CQC visited Maternity Services at York Hospital on 9 September 2024. This was not an inspection, the CQC have been invited onsite by the Chief Nurse.

The visit consisted of a presentation focusing on the improvements made since the last inspection, and a walkaround the department. The CQC praised the apparent transparency and openness in the reporting, but also that the staff came across as empowered and motivated in delivering improvements for the service users.

The CQC will be visiting Maternity Services and the Urgent and Emergency Care Centre on 4 February 2025.

Nine actions have been closed at the Journey to Excellence meetings held in September 2024. Progress with the CQC Improvement Plan, as of 30 September 2024, can be seen in the charts below.





2. Journey to Excellence Meetings

The agenda for the Journey to Excellence meeting has been updated to move the Trust beyond responding to the CQC Improvement Plan. A schedule of updates on themes from ongoing CQC actions has been agreed. These will commence in October 2024, starting with Mental Capacity Act on 14 October 2024.

Work to procure an external Well-Led Assessment for Q4 is in progress.

Following positive feedback on the Trust process for managing CQC actions, the CQC acknowledged the need to move on from reporting on the must and should do actions. A process was suggested to manage the ongoing work associated with the delivery of actions into business as usual monitored through the existing Trust governance mechanisms.

Individual reports for the Trust Directors were presented through Journey to Excellence and the 'Data Source for Implementation / Sustainability' and Governance Mechanism for Implementation / Sustainability' aspects reviewed. The outcome of this review, in the form of tabled actions, can been seen in **Appendix A** and **Appendix B**.

3. 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 September 2024.

The documentation to support the removal of the section conditions has been received meetings are planned during October 2024 to complete this.

4. 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 when monthly audit results are available to support progress.

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.

5. 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 patient safety incidents (PSI'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 three CQC cases received since the last report, written (30 September 2024), two were complaints about patient care and one complaint regarding phones not being answered.

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

6. CQC Updates

On the 15 October 2024, two reviews were published which will inform the future direction of the CQC: the final report of Dr Penny Dash's review and the first report of the independent review by Professor Sir Mike Richards.

The full reports can be viewed here:

- Review into the operational effectiveness of the Care Quality Commission: full report: Dr Penny Dash

- Review of CQC's single assessment framework and its implementation: Professor Sir Mike Richards

A summary of each report is also included in **Appendix D** and **Appendix E.**

7. Recommendations

The Board of Directors is asked to:

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

Appendix A: CQC actions which need continued oversight for full implementation
(the ten actions included in the pie chart in Section 1)

Ref	Action	Data Source for Implementation	Governance Mechanism for Implementation
12	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.	- Trust Priorities Report (TPR) - Signal reporting - Nucleus data - Tendable results - Datix Incident and Complaints Data	- Infection Prevention Assurance Group, Patient Safety and Clinical Effectiveness, Quality Committee. - Excellence Meetings - PRIM - Executive Committee oversight - Falls, Pressure Ulcers and Nutrition and Hydration Governance under review and plans to link into the Core Quality Standards Group - Care Group Infection Prevention and Control Group
14	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.	- TPR - Signal reporting - Nucleus data - Tendable results - Datix Incident and Complaints Data	- Excellence Meetings - PRIM - Executive Committee oversight - Nutrition and Hydration Governance under review and plans to link into the Core Quality Standards Group
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.	- Pharmacy Audit Programme - Tendable - Datix incidents - Internal Audit programme	- Medicines Optimisation Group - COSHH with the Health and Safety Assurance Group - Excellence Meetings - Patient Safety and Clinical Effectiveness - Weekly Quality and Safety
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)	- Learning Hub for training compliance - TPR	- Resources Committee - Board of Directors - PRIM

Ref	Action	Data Source for Implementation	Governance Mechanism for Implementation
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.	- ESR - Staffing rosters - Safecare data - TPR	- Resources Committee - Board of Directors
30	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.	- MCA Audit results including to the quarterly report. - TPR & Learning Hub for training data	- Integrated Complex Needs Group - Patient Safety and Clinical Effectiveness Sub Committee, Quality Committee, Board of Directors
33	The trust should ensure that resuscitation trollies in Maternity and Urgent and Emergency Care are checked in line with trust policy and records are available to evidence completion.	- Tendable	- Excellence meetings - Maternity Assurance Group (for Maternity as no Excellence Meetings)
35	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).	- Sepsis audit data - Learning hub training data - TPR	- Patient Safety and Clinical Effectiveness - Deteriorating Patient Group - PRIM
55	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.	- Signal dashboards	- VTE Group, reporting through Patient Safety and Clinical Effectiveness
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.	- Tendable - Reporting from X Tag	- Family Health Care Group Governance - Excellence Meetings

(click to return to the main document)

Appendix B: CQC actions which have been implemented and monitoring for sustainability is required

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
1	The trust must seek and act on feedback from relevant persons on the services provided, for the purposes of continually evaluating and improving such services	- Staff Survey - Pulse Survey - Our Voice, Our Future Feedback - Board Visibility Programme Feedback - Friends and Family Feedback - Patient & Carer experience forums - Healthwatch feedback	- Resources Committee - Patient Experience Sub-Committee, Quality Committee, Board - Board Development Sessions
2	The trust must ensure the organisation supports all staff, including those with particular equality characteristics, to feel respected and valued and supports an environment where staff are encouraged to speak up and raise concerns without fear of blame or reprisal.	- Freedom to Speak Up Guardian Reporting - Staff Networks Reporting - Staff Survey - Pulse Survey - Our Voice, Our Future Feedback - Board Visibility Programme Feedback	- Resources Committee - EDI Workstream - Patient Experience Sub-Committee, Quality Committee, Board - Board Development Sessions
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	- Q-Pulse Data on Overdue documents	- Executive Committee for Policy Approval - PRIM Quality Reporting - COEG standing agenda item 'overdue documents' - Quarterly Quality Committee Report on Clinical Policies - Audit and Documentation Group in Maternity, Maternity Directorate meeting
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.	- Staff Survey - Pulse Survey - WRES / WDES data - Feedback from the Race and Equality Network. - Freedom to Speak Up paper presented at LNC, JNCC & Board of Directors. - Progress with the Behavioural Framework - Frequent reporting on the progress and impact of the Our Voice, Our Future Programme and the Change Maker role.	- EDI Workstream - Resources Committee - Board of Directors
5	The trust must ensure it takes account of the Workforce Race Equality Standard, Workforce Disability Equality	- WRES / WDES data	- Resources Committee - Board of Directors

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
	Standard and NHS staff survey data to ensure both staff from ethnic minority groups and disabled staff are not disproportionately disadvantaged by working in the organisation.		
6	The trust must ensure that structured case reviews are focused on the implementation of recommended actions and the actions are monitored, completed, and recorded.	- Datix Mortality Review Data	- Learning From Deaths Group reporting to Patient Safety and Clinical Effectiveness
7	The trust must fully investigate and seek to learn from the death of a person with a learning disability or autistic people including seeking LeDeR reviews.	- Datix Mortality Review Data	- Learning From Deaths Group reporting to Patient Safety and Clinical Effectiveness
8	The trust must ensure that risks recorded at corporate level and in the board assurance framework are current, not duplicated and have clear actions for mitigation which can be monitored and measured.	- BAF - Risk Registers	- Risk Committee - Board of Directors
9	The trust must ensure there is an accountability framework for care groups to monitor performance on action plans or mitigating risk.	- PRIM slides	- Executive Committee for approval - Patient Safety Clinical Effectiveness for Post Implementation Review
10	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.	- Staff survey - Pulse data - Board Visibility feedback - Back to the Floor Feedback	- PRIM - Care Group Board meetings (now include operational performance and assurance information) - Operational Directorate Meetings attended by Care Group SLT. - Executive Committee (membership now includes Clinical Directors and Associate Chief Operating Officers) - Bi-monthly Senior Medics meeting hosted by the Medical Director.
11	The trust must ensure that there is adequate oversight of the harms caused by delays to assessment and treatment.	- Datix Incidents - Datix Complaints	- Waiting List Harms Group chaired by DCOO. - PRIM
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.	- Datix Complaints Data	- Weekly Quality and Safety - Patient Experience Sub-Committee, Quality Committee, Board of Directors - PRIM - Excellence Meetings

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
15	The trust must gain assurance that learning from incidents and risks are shared within the organisation to prevent the risk of reoccurrence.	- Datix incidents and reporting	- PSIRF Working Group, Operational Group and Strategic Group - Weekly Quality and Safety - Patient Safety and Clinical Effectiveness - Board of Directors Reportable Issues
16	The trust should ensure that it follows the recommended period for repeating and recording Disclosure and Barring Service checks for directors.	- Outcome of the fit and proper person test	- Board of Directors
17	The trust should consider ensuring all recording and timelines for grievances and disciplinary processes are a complete and contemporaneous record.	- Disciplinary and Grievance Data from HR Records	- Resources Committee
19	The trust should consider increasing the frequency of safeguarding reporting to board to improve oversight.	- Board of Director agenda	- Board of Directors
20	The trust should consider recruiting looked after children specialist nurses to support capacity for initial health reviews.	- *ICB funding not approved*.	Resources Committee
21	The trust should ensure it meets the criteria for accessible information standard (AIS).	- Friends and Family Feedback - Patient & Carer experience forums - Compliments, Concerns and Complaints data	- AIS Task and Finish Group reporting through the Patient Experience Sub Committee
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.	- Feedback from the staff networks reported through the EDI workstream. - WDES data - Staff survey data	- EDI workstream - Resources Committee - Board of Directors
24	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.	- TPR - Datix for Incident and Complaints Data - Friends and Family data - LMNS data	- UEC Programme Board - Maternity Assurance Group

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
26	The trust must ensure that where necessary patients have risk assessments completed and reviewed as per guidance employed.	- Signal reporting - Nucleus data - Tendable results - Datix Incident and Complaints Data	- Excellence Meetings - PRIM
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.	- Signal reporting - Nucleus data - Tendable results - Datix Incident and Complaints Data	- Excellence Meetings - PRIM - Executive Committee oversight - Nutrition and Hydration Governance under review and plans to link into the Core Quality Standards Group
28	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.	- Documentation audit outcomes - ED coding data	- Patient Safety and Clinical Effectiveness Sub-Committee oversight of rectification of coding issues in ED - Information Governance Group
31	The trust should ensure that monitoring and action plans are in place should water checks and legionella checks fail.	- Water checks	- Trust Strategic Water Safety Group, Health and Safety Assurance and Non-Clinical Risk Group
32	The trust should consider introducing patient record, consent and pain management audits.	- Local audit plans	- Corporate oversight at Clinical Outcome and Effectiveness Group, Patient Safety and Clinical Effectiveness and Quality Committee.
34	The trust must ensure that the new ED environments do not compromise the fundamental standards of care staff can provide to patients, protects their privacy and dignity, and ensures staff can offer them emotional support. There should be sufficient side rooms for medical staff to see and treat patients, barriered isolation rooms for infectious patients, handwash basins and storage areas for equipment	*Significant updates to ED environments post inspection*	n/a
36	The trust must ensure ED staff review national patient safety alerts for relevant learning and ensure measures taken around historic alerts are maintained.	- Datix Alert data	- Weekly Quality and Safety meeting. - Reported as part of the Patient Safety Report to Patient Safety and Clinical Effectiveness Sub-Committee

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
37	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.	- Smartsheet data on Quality Account Programme Progress	- Clinical Outcomes and Effectiveness Group - PRIM
39	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.	- Datix Incidents and Complaints	- Care Group Governance Meetings
40	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	- Nucleus Data - Mental Health audit tool (to be reviewed)	- Mental Health Steering Group reporting through Patient Safety and Clinical Effectiveness Committee
41	The trust must ensure all patients in ED at York are wearing wristbands at all times for improved safeguarding, security and easier identification when prescribing and administering medications.	- Tendable	- Excellence Meetings
42	The trust must ensure that in Urgent and Emergency services at York, staff do not place patients at higher risk such as those with IV access or allergies in inappropriate environments for their needs and observe them accordingly.	*This was linked to the previous ED environment at York.*	n/a
43	The service should ensure the IPC team and sepsis leads are better embedded and visible in the department to support staff with potentially infectious patients, assessments, or audits.	*Action implemented*	- Support at Care Group Governance Meetings - Care Group Infection Prevention and Control Meetings - Infection Prevention and Control Corporate Governance
44	The service should review pharmacy CD inspection policy to ensure it is clear how often inspection should take place.	- Q-Pulse document data	- COEG - Medicines Optimisation Group - PRIM
45	The trust should review the process in Urgent and Emergency Care at York for recording of controlled drugs to ensure all documents are completed in line with NICE guidance.	- Monthly Medicine Optimisation Reports - Pharmacy Audit Programme - Tendable ward review	- Medicine Optimisation Group

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
46	The trust must ensure that that care meets the needs of service users by improving referral to treatment times.	- TPR	- Ongoing monitoring happens through the elective programme governance structure up to Elective programme board which provide updates to Executive committee. There is a weekly elective recovery meeting (WERM) - PRIM
47	The trust must ensure that all bank and agency staff had a full induction and competencies assessed prior to them working in the medical service.	- Once live, compliance with local induction for bank staff will be monitored through the Learning Hub.	- Resources Committee - Care Group Governance Meetings
48	The trust must ensure that there is sufficient space around patient beds, with oxygen and suction placed by every bed.	- Medical Engineering 2x yearly audit	- Medical Devices Management Group - Non-clinical Health and Safety Group
49	The trust must ensure the Care Group 2 risk register identifies all the current risks including none compliance to referral to treatment targets, consultant, and nursing staffing shortfalls.	- Care Group Risk Registers	- Care Group Quality Governance meeting. - Corporate Risk Committee
50	The trust should ensure that safety huddle documentation is formalised across the Medical Care service at Scarborough.	*Documentation in use*	- Care Group Quality Governance meeting
51	The trust must ensure that in Medical Care at York, mixed sex breaches where men and women share the same area do not occur.	- Monthly validation of mixed sex unjustified breaches reported on DATIX	- Quarterly reporting to the Patient Experience Subcommittee
52	The trust must ensure that in Medical Care at York, patient's own medicines books are completed on admission, when the medicines are returned to them on discharge and that time critical medicines are given when prescribed.	- Pharmacy Quarterly report on controlled drugs - Monthly medicine optimisation reports - Medicines management audit schedule - Tendable	- Controlled drug management group - Patient Safety and Clinical Effectiveness
53	The trust should ensure that cleaning records are completed for all clinical areas in Medical Care at York.	- Synbiotix audits	- EPAM - Cleaning Standards Group - Infection Prevention and Control Corporate Governance
54	The trust should ensure that equipment such as drip stands, and ceiling hoists were available on ward 23 at York.	*Action completed*	n/a
56	The trust should ensure that patients on the acute stroke ward 23 received their daily 45 minutes of rehabilitation.	- Review of data to capture therapeutic interventions led by the SSNAP co-	- Care Group Governance Meetings - SSNAP oversight

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
		ordinator. Ongoing liaison with Hull and Leeds.	
57	The trust should ensure that psychology services are made available for patients.	- CPD activity and waiting list data	- Cancer, Specialist and Clinical Support Services Operational meetings
58	The trust should ensure they achieve joint advisory group (JAG) on gastrointestinal endoscopy accreditation.	- JAG visits / reports	- Cancer, Specialist and Clinical Support Services Operational meetings and presented at the Executive led PRIM - Regulations and Accreditations Group reporting through Patient Safety and Clinical Effectiveness
59	The trust should ensure that consultants lead daily ward rounds on the emergency assessment unit at York to ensure patients are discharged and improve patient flow.	- Signal data	- Urgent and Emergency Care Improvement Programme - Same Day Emergency Care Workstream
60	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.	- TPR	- Discharge Improvement Group leading on the workstream as part of the Urgent Care Improvement Programme.
61	The trust should consider identifying dedicated rehabilitation and kitchen areas for use when undertaking patient assessments on the acute stroke ward.	*ward refurb underway*	*ward refurb underway*
62	The trust should ensure that patient information on white boards remains confidential throughout the medical care service at York is not located in areas where the general public can see it.	- Information Governance Walk arounds	- Information Governance Executive Group
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.	- H&S Reports	- Outcomes reported through Health and Safety Assurance Group.

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
64	The service must implement a robust governance process and risk management strategy. For example, they must ensure they instigate a process to effectively triage women in a safe environment. They must ensure they have effective risk management processes in place to manage and mitigate all risks.	- Maternity Quality and Safety Framework - BSOTS Implementation Reporting Internal Audit Action delivery	- Maternity Assurance Group Maternity Assurance Group Maternity Q&S
65	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.	- Delivery of Audit Plan	- Audit and Guidelines Group in Maternity - COEG - PRIM
66	Maternity Services must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff.	- Datix Incident Data	- Daily incident review process - Datix escalations at weekly Quality and Safety meeting - Monthly monitoring at the Women's Health Clinical Governance meeting and oversight from Maternity Assurance Group
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	- Maternity training data - Retention data	- Reporting on the preceptorship completion though Family Health Governance
68	The trust should ensure that Maternity can evidence the decision making and governance processes surrounding the use of balloon catheters at both sites.	- Induction of Labour review process as part of the LMNS. Included in the Maternity Single Improvement Plan	- Audit and Guideline Group in Maternity.
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.	- Learning hub for training and appraisal data. - Training records in Maternity - Staff survey	- Family Health Care Group Governance - PRIM - People and Resources Committee - Board of Directors oversight of training and development
70	The trust must ensure that in Maternity, there are sufficient quantities of cardiotocography (CTGs), central monitoring and telemetry equipment. This was to ensure women and babies are continually assessed and monitored.	n/a	n/a

Ref	Action	Data Source for Sustainability	Governance Mechanism for Sustainability
72	The trust must ensure that in Maternity, the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance	- Tendable ward review - IPC data	- Maternity Assurance Group and Family Health CG Board review of mandatory training - IPC Group within the Family Health Care Group. Corporate IPC Group reporting through Patient Safety and Clinical Effectiveness
73	The trust must ensure both Maternity theatres are serviced, maintained, and fit for purpose in line with best practice guidance.	- Delivery of the maternity theatre refurbishment	-Surgery and Family Health Care Group Governance Meetings

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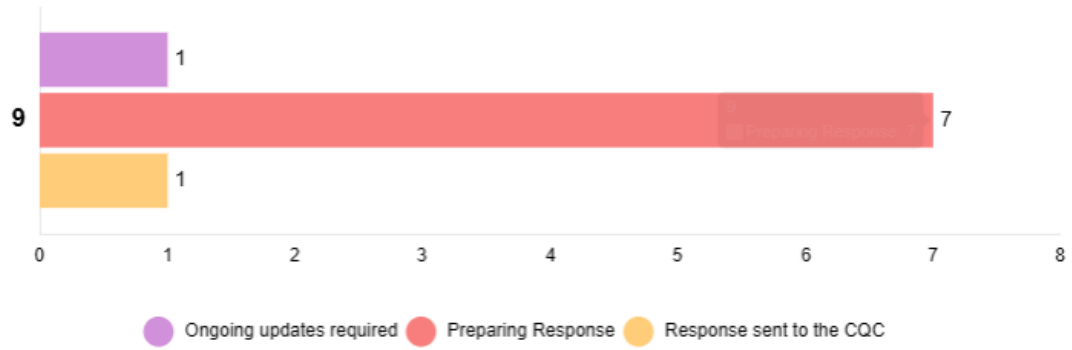
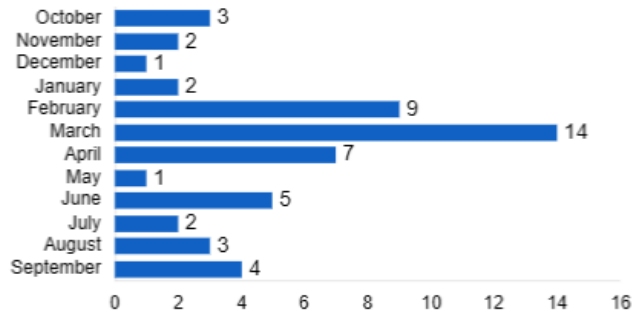
Appendix C
CQC Cases / Enquiries (1 October 2023 to 30 September 2024)

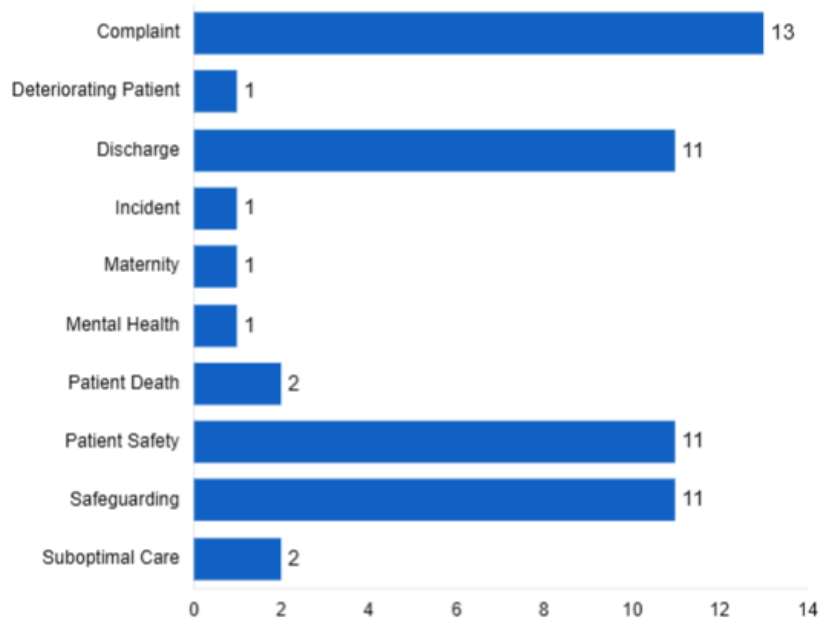
Number of Open CQC Enquiries / Cases



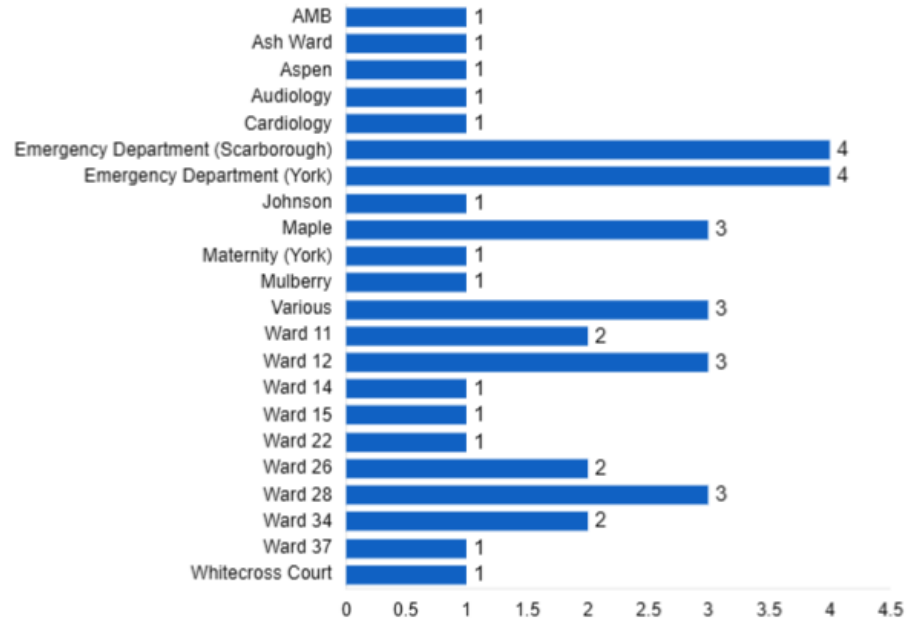
Number of Enquiries Received



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Appendix D

Review into the operational effectiveness of the Care Quality Commission: full report: Dr Penny Dash

Published 15 October 2024

On the 15 October 2024 the Department of Health published the full report of the review into the operational effectiveness of the Care Quality Commission, led by Dr Penny Dash, Chair of the North-West London Integrated Care Board.

The review has found significant failings in the internal workings of CQC, which have led to a substantial loss of credibility within the health and social care sectors, deterioration in the ability of CQC to identify poor performance and support a drive to improved quality, and a direct impact on the capacity and capability of both the social care and healthcare sectors to deliver much-needed improvements in care.

The conclusions are summarised around 10 topics:

Conclusion 1: poor operational performance

There has been a stark reduction in activity with just 6,700 inspections and assessments carried out in 2023, compared with almost 15,800 in 2019. This has resulted in:

- a backlog in new registrations of health and care providers
- delays in re-inspecting after a ‘requires improvement’ or ‘inadequate’ rating
- increasing age of ratings

The reduction in activity has resulted in considerable delays in re-inspecting providers after a ‘requires improvement’ or ‘inadequate’ rating. The time to carry out a re-inspection following a ‘requires improvement rating’ has risen from 142 days to 360 days in the same time frame.

As well as carrying out fewer inspections overall, CQC has moved away from ‘comprehensive’ inspections to more ‘focused’ inspections examining a few service areas or key questions (quality domains). Of inspections carried out between 1 January 2024 and 30 July 2024, 43% were assessments under the new SAF, a fifth were ‘comprehensive’ and 36% were ‘focused’. In 2023, of 6,734 inspections, 3,107 were ‘comprehensive’ and 3,598 were ‘focused’. This compares with years 2015 to 2019 where around 90% of all inspections were ‘comprehensive’

CQC’s unpublished business plan for 2024 to 2027 includes a target for 16,000 assessments to be carried out in 2024 to 2025

Conclusion 2: significant challenges with the provider portal and regulatory platform

New IT systems were introduced at CQC from 2021 onwards. However, the deployment of new systems resulted in significant problems for users and staff.
The review has concluded that poorly performing IT systems are hampering CQC’s ability to roll out the SAF, and cause considerable frustration and time loss for providers and CQC staff.

Conclusion 3: delays in producing reports and poor-quality reports

All sectors told the review that they can wait for several months to receive reports and ratings following assessments. The review has heard multiple comments about poor-quality reports - these have come from providers and from members of the public.

Poor-quality and delayed reports hamper users' ability to access information and limit the credibility and impact of assessments for providers. There should be greater consistency in the quality of reports and learning from examples of better-quality outputs that have been published.

Conclusion 4: loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring, resulting in lost opportunities for improvement

CQC underwent an internal restructuring in 2023, alongside the introduction of the SAF and new IT systems. The restructuring moved operational staff from three directorates with a focus on specific sectors into integrated teams operating at a local level, resulting in a loss of expertise.

The review has found that the current model of generalist inspectors and a lack of expertise at senior levels of CQC, combined with a loss of relationships across CQC and providers, is impacting the credibility of CQC, resulting in a lost opportunity to improve health and social care services.

Conclusion 5: concerns around the single assessment framework (SAF) and its application

The SAF has set out 34 areas of care quality (called 'quality statements') that could be applied to any provider of health or social care with a subset applied to assessments of integrated care systems (ICSs) and local authorities. These align to the five domains of quality used for many years and referred to as 'key questions' within the SAF. For each of the 34 quality statements, there are six 'evidence categories'. These are: people experience, staff experience, partner experience, observations, processes and outcomes.

The review has identified seven concerns with the SAF as follows:

- the way in which the SAF is described is poorly laid out on the CQC website, not well communicated internally or externally, and uses vague language
- there is limited information available for providers and users or patients as to what care looks like under each of the ratings categories, resulting in a lack of consistency in how care is assessed and a lost opportunity for improvement
- there are questions about how data on user and patient experience is collected and used
- more could be done to support and encourage innovation in care delivery
- there is insufficient attention paid to the effectiveness of care and a lack of focus on outcomes (including inequalities in outcomes). Of the assessments carried out under the SAF up to 30 July 2024 across six different sectors, 75% of assessments looked at the 'safe' key question, whereas only 38% looked at the 'effective' key question.
- there is no reference to use of resources or the efficient and economic delivery of care, which is a significant gap. Within the SAF, there is no quality statement that considers use of resources or efficient delivery of care. The review understands that 'use of resources' assessments used to be conducted by NHS England, but were paused during the pandemic and are no longer done.

- there is little reference to, or acknowledgement of, the challenges in balancing risk and ensuring high-quality care across an organisation or wider health and care system.

Conclusion 6: lack of clarity regarding how ratings are calculated and concerning use of the outcome of previous inspections (that often took place several years ago) to calculate a current rating

The review has learnt that overall ratings for a provider may be calculated by aggregating the outcomes from inspections over several years. This cannot be credible or right. Furthermore, providers do not understand how ratings are calculated and, as a result, believe it is a complicated algorithm, or a “magic box”.

Ratings matter - they are used by users and their friends and family, they are used by commissioning bodies (the NHS, private health insurers and local authorities), and they drive effective use of capacity in the sector. They are a significant factor in staff recruitment and retention.

Conclusion 7: there are opportunities to improve CQC’s assessment of local authority Care Act duties

The Health and Care Act 2022 gave powers to CQC to assess local authorities’ delivery of their adult social care duties after several reports and publications identified a gap in accountability and oversight of adult social care. The review found broad support for the overall assessment framework but also heard feedback that the assessment process and reporting could be improved.

Conclusion 8: ICS assessments are in early stages of development with a number of concerns shared

The Health and Care Act 2022 introduced a new duty for CQC to review and assess ICSs. Statute sets out three priority areas for CQC to look at: leadership, integration and quality of care; and the Secretary of State can set priorities on other themes. CQC developed a methodology for these assessments, which was tested in pilots in Dorset and Birmingham and Solihull, but wider rollout has been paused as a result of a number of concerns shared with the review.

Conclusion 9: CQC could do more to support improvements in quality across the health and care sector

The review heard a consistent comment that CQC should not be an improvement body per se, but, at the same time, could do more to support the health and care sectors to improve. It could do this, for example, through the description of best practice and greater sharing of new models of care delivery, leading international examples of high-quality care and more innovative approaches - particularly the use of technology.

Governance structures within organisations are crucial to improvement. A greater focus on how organisations are approaching and delivering improvement, rather than looking at input metrics, could enable more significant improvements in quality of care.

Conclusion 10: there are opportunities to improve the sponsorship relationship between CQC and the Department of Health and Social Care (DHSC)

DHSC's sponsorship of CQC should promote and maintain an effective working relationship between the department and CQC, which should, in turn, facilitate high-quality, accountable, efficient and effective services to the public.
The review has found that DHSC could do more to ensure that CQC is sponsored effectively, in line with the government's Arm's length body sponsorship code of good practice.

Other areas for further consideration

Several areas have been raised with the review team but not yet considered in detail. These are:

1. One-word ratings. The government recently announced that Ofsted would end the use of one-word ratings and so it would be reasonable to similarly consider their use in health and social care. Changes to one-word ratings could be beneficial in allowing greater clarity to be brought to the different key questions of quality, allowing a 'balanced scorecard' approach across 'safe', 'effective', 'responsive'/'caring' and 'well led'.
2. Finances within CQC - both how CQC is funded, and the costs of running the organisation efficiently and effectively.
3. The need to ensure the NHS Federated Data Platform results in a single 'data lake' across the health and social care sectors.
4. The wider regulatory landscape and the burden of regulation, including the relationship between CQC and the NHS England Oversight Framework. mapping of the regulatory landscape of healthcare identified over 100 organisations which exert some regulatory influence on NHS provider organisations and recommended a review to ensure more effective and responsive regulation

Recommendations

1. Rapidly improve operational performance, fix the provider portal and regulatory platform, improve use of performance data within CQC, and improve the quality and timeliness of reports. Progress has been made with staffing, and particularly attracting thoe with prior experience working in the CQC. The quality of reports needs to be improved.
2. Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility. Consideration should be given to a programme whereby the top-performing managers, carers and clinicians from across health and social care are appointed or apply to become assessors for 1 to 2 weeks a year with a high accolade being given to those accepted on the programme.
3. Review the SAF and how it is implemented to ensure it is fit for purpose, with clear descriptors, and a far greater focus on effectiveness, outcomes, innovative models of care delivery and use of resources.
4. Clarify how ratings are calculated and make the results more transparent.
5. Continue to evolve and improve local authority assessments.
6. Formally pause ICS assessments.
7. Strengthen sponsorship arrangements to facilitate CQC's provision of accountable, efficient and effective services to the public.

Next steps

Over the next four months, a second review will report on proposed improvements to the wider landscape for quality of care, with a focus on patient safety.

Over the next six months, there needs to be:

- rapid improvements to operational performance within CQC
- significant steps taken towards rebuilding expertise within CQC
- significant steps taken towards fostering stronger relationships with providers and the wider sectors to resurrect credibility

Over the next 12 months, the SAF needs to be fundamentally enhanced and improved with:

- a review of quality statements
- far greater emphasis on effectiveness, outcomes, innovation and use of resources
- clear descriptors for each quality statement

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Appendix E

Review of CQC's single assessment framework and its implementation Professor Sir Mike Richards Former Chief inspector of Hospitals at CQC (2013 to 2017)

Published 15 October 2024

This review was initially proposed by the leadership of CQC before the publication of the interim report by Dr Penny Dash. Coincident with that publication in late July 2024, the Secretary of State for Health and Social Care announced that I would be conducting a rapid review of CQC and, in particular, to consider whether the single assessment framework introduced in late 2023 is fit for purpose.

The transformation programme that followed the 2021 CQC strategy had three key elements:

- A major organisational restructure.
- The introduction of a single assessment framework across all the sectors that CQC regulates (hospitals, mental health services, ambulances, primary and community care services and adult social care).
- The development of a new IT system, named the regulatory platform.

These three initiatives are clearly interlinked, but this review has shown that all three have failed to deliver the benefits that were intended, despite being initially welcomed by providers. This has had the following major adverse consequences:

- CQC has been unable to fulfil its primary purpose "to ensure health and care services provide people with safe, effective, compassionate high-quality care and to encourage these services to improve". Far fewer inspections have been carried out than in previous years; publication of inspection reports have been seriously delayed, and providers have expressed serious concerns about both the inspection process and the quality of the reports.

- Staff involved in inspections have become demoralised and angry that their concerns about the changes have not been listened to by senior leadership. This has led to considerable numbers of staff leaving the organisation, further compounding the problems relating to assessments, inspections and enforcement. However, I found that many of the remaining staff remain committed to the purpose of CQC and are desperate to see things improve.

- The structural re-organisation has resulted in separation of those responsible for developing policy and strategy related to regulation from those responsible for operational delivery. Operational reality has therefore not been reflected in policy and strategy.

- Clinical leadership and oversight of the inspection programmes has been lost as Chief Inspectors are no longer directly responsible for the inspections in their own sector and are less available and visible to support those at the front line. For the past 2 years, CQC has only had 2 Chief Inspectors (both of whom are currently interim), rather than the 3 as set out in legislation.

- The single assessment framework, while having some positive elements derived from the previous assessment approach, is far too complex and, as currently constituted, does not allow for the huge differences in the size, complexity and range of functions of the services that CQC regulates. One size does not fit all. Some elements of the quality statements are causing confusion both to CQC inspectors and to providers. In addition, the evidence categories and scores are causing major delays to report writing.

- The regulatory platform has had a serious adverse impact on the working lives both of CQC staff and of those working in provider organisations who are expected to upload information onto a 'provider portal'. People who use the platform say that there are, as yet, no signs that these problems are being resolved.

- Staff morale is low, especially among inspection staff, as seen in the results of the most recent staff survey. Sickness levels have risen over recent years, especially among inspection staff.

- Staffing levels in the inspection teams are currently insufficient to undertake the duties of the regulator within reasonable timescales. Staff remain concerned that they are unable to respond to emerging risks in a timely way. Insufficient induction and training has been given to new staff.

- While recognising the independence of the regulator, providers across health and social care report that the previous sense of partnership with CQC to develop effective approaches to assessment of quality has been lost.

- Progress on the use of data to inform assessments of hospital services has been at best very modest over the past several years. In some respects, the intelligence available to inspection teams is less useful than it was pre-pandemic. This has a particularly negative impact on assessments of outcomes for people using services.

- Processes to ensure consistency of judgements and the adequacy of relevant evidence – which is vital to good regulation – have been adversely affected by the downgrading and dilution of quality assurance processes.

- Over the past 2 to 3 months, CQC has started to take steps to mitigate some of the problems identified in this report. However, the organisation needs to go much further.

General views on the transformation programme from NHS trusts

The views of NHS chief executives on the new approach can be summarised as follows:

- Inspection teams sometimes lack credibility, without adequate knowledge of the sector, and lack seniority especially for assessment of the well-led key question at trust level.

- The culture among inspection teams has changed for the worse. There is now no sense of partnership. Inspectors are only looking for what is wrong – not for evidence of what is good or innovative. Inspection teams can instil fear, warning that if findings are challenged, the outcome will be worse.
- CQC is on a downward spiral and should revert to what was working previously.

- Judgements are inconsistent.

- Some senior staff in trusts are no longer willing to take part in inspections due to a feeling that objectivity had been lost and that outcomes appeared pre-determined.

- Some trust CEOs noted the difficulty in approaching CQC's senior team and felt that it had become detached from the sector.

Recommendations

Structure

1. The organisational re-structure has had a serious negative impact. **CQC should revert to the previous structure**. Separate sector-based inspection directorates led by **Chief Inspectors** should be re-established and the Regulatory Leadership directorate should be re-integrated with the inspection directorates.

2. **Cross-directorate working** can still be achieved either for thematic or strategic work by giving relevant people responsibility for this as part of their job plans. Similarly, integration between sector inspection teams can be maintained by giving dual responsibilities for integration at a local (perhaps ICS level) and specialism/sector responsibility for a wider geography (perhaps 2 or 3 ICSs depending on population size) to staff at Deputy Director or 'head of' level.

3. **Simplify the single assessment framework** and ensure it is fit for purpose in each sector, rather than slavishly expecting a single approach to work well across all sectors and for systems assessments. As a start, remove the evidence categories and scoring at evidence category level.

4. **Model the resource needed** to undertake inspections at reasonable intervals, both with comprehensive inspections and with a more limited approach (see below).

5. Re-establish **relationship owner** roles for all sectors.

6. Remove the separation between the roles of **assessors and inspectors**.

Assessment framework

1. Abandon the concept of a **'single assessment framework'**. The services that CQC regulates are diverse and it has not proved helpful in practice.

2. Retain the **5 key questions** across all sectors. They have stood the test of time, though some simplification might be desirable.

3. Retain the **I statements** as these are liked by many people I have spoken with. They can act as useful prompts when asking about people's experience of care.

4. Retain the **quality statements** but modify where necessary to avoid overlap and to make inspection simpler. Agree which quality statements are most needed for inspections in different sectors/services and then use consistently.

5. Routine use of all **evidence categories** for all quality statements should be abandoned. This is complicating the single assessment framework without benefit. The evidence categories should only be used as an aide memoire to ensure evidence is corroborated

6. **Scoring** at evidence category level should be abandoned.

7. **Key lines of enquiry (KLOEs)** relevant to the quality statements selected for inspection in a sector or service should be developed. For hospitals, these can largely be taken from the previous methodology.

8. **Standards** relating to the quality statements/KLOEs should be developed in conjunction with the National Quality Board, NHS England, Royal Colleges and representative bodies in adult social care. CQC's National Professional Advisers should take a leading role in this for individual services.

9. The **evidence** that should be sought for each quality statement should be defined and a handbook of rating characteristics should be developed.

10. **Peer review** should be encouraged at least for hospital inspections. This should build on the current role of the executive reviewer. All trusts should be expected to contribute to a pool of reviewers.

11. **Immediate feedback** should be given at the end of inspections, though with caveats that this may change on review of further evidence. At the very least, serious adverse findings should be brought to the attention of the relevant person in the provider and confirmed in writing.

12. **'Quick fixes'.** If minor negative findings are noted on an inspection, these should be included in a report. However, if these can be rectified swiftly (say within 2 weeks) and adequate assurance can be given that this has occurred, they should not affect ratings.

13. **Quality assurance** processes for reports and ratings should be reviewed by CQC. This is vital to help ensure consistency and should be undertaken by staff with expertise in the relevant sector.

14. **Reports** must provide a narrative that can be understood both by the provider and by the public. Suggested word lengths for different sections may be helpful, but a degree of flexibility should be allowed.

15. **Training** in the use of the simplified assessment framework recommended above should be given very high priority.

Data and insight

1. **Available data should be used more effectively**. High priority should be given to working with NHS England, Healthcare Quality Improvement Partnership (national clinical audits) and the Get It Right First Time (GIRFT) programme and others to develop a shared view of data required for assessments and ratings

2. Measures of **patient experience** collected by hospitals and GP practices should be standardised, so that evidence on this is comparable between providers and is available on much larger numbers of service users. This could potentially also be applied to the adult social care sector.

3. Retain the **'clinical searches'** approach that has been developed for primary care. However, this should be able to be done centrally, reducing the time taken by SPAs on individual practice data. This would help to identify high or low risk practices before an inspection. It would also release SPAs to participate in inspections, adding to credibility.

4. The **NHS staff survey** has been demonstrated to be an effective measure of the culture of NHS trusts. Results from the survey should be incorporated into inspections of the well-led key question.

Staffing

1. An **urgent review of staffing** within the current operations and regulatory leadership directorates should be undertaken. This should assess the numbers of staff at different grades with expertise in the different sectors that CQC regulates.

2. The role of **Deputy Chief Inspector** should be reinstated, with additional posts being re-created. The current network director role is unsustainable.

3. An increase in the number of **inspection team staff** will almost certainly be needed at other levels, if CQC is to undertake appropriate numbers of inspections within reasonable timescales

4. **Pay bands** should also be compared with comparable roles in the NHS and adult social care.

5. Recruitment will almost certainly be needed in some areas.

Prioritisation of future inspections

It will take time to restructure and get CQC back to full activity, but experience from 2013/14 shows that, if there is sufficient will, this can be done reasonably quickly. More staff in specialist areas will be needed to replace those lost in recent years. It will take time to train them fully.

It will therefore be important to determine priority for inspections in different sectors. It is unlikely to be possible to undertake comprehensive inspections covering all five key questions for all of the previously determined 'core services' within a reasonable timescale.

In all sectors: The use of evidence categories and scoring should be suspended, and narrative reports should be re-commenced to avoid further delays.

In hospitals: National Professional Advisers have stressed **the importance of assessing the 'safe' and 'well-led' key questions in NHS trusts** in the first instance. They have also recommended **starting with services that are most likely to carry high risk. These are A&E/emergency departments, medical inpatients and maternity services**. Abbreviated methodologies that were developed during the pandemic might also be valuable. For maternity services, the approach recently used to inspect and rate 131 services can act as a model.

In all sectors: Close working with partner bodies (e.g. local authorities, ICBs and NHS England) may be valuable in identifying organisations with highest risk that need the most urgent inspections.

(click to return to the main document)

Item 13

Report to:	Public Trust Board
Date of Meeting:	23 October 2024
Subject:	Safeguarding Annual Report 2023 - 2024
Director Sponsor:	Dawn Parkes – Chief Nurse
Author:	Nicola Cowley – Head of Safeguarding & Complex Needs

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

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

Trust Objectives

☐ Timely, responsive, accessible care

☐ Great place to work, learn and thrive.

☒ Work together with partners

☐ Research, innovation, and transformation

☒ Deliver healthcare today without compromising the health of future generations

☒ Effective governance and sound finance

Board Assurance Framework

☒ Quality Standards

☒ Workforce

☒ Safety Standards

☐ Financial

☐ Performance Targets

☐ DIS Service Standards

☐ Integrated Care System

☐ Sustainability

Equality, Diversity, and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion, and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental, and social.

Recommendation:

The Board are asked to note the work of the Safeguarding Team and the impact on the wider Trust.

Where terminology marked with * please see Appendix 1 for descriptor.

Report History

Meeting	Date	Outcome/Recommendation
Integrate Safeguarding Group	26/04/2024	Approved by members
Patient Safety & Clinical Effectiveness	08/05/2024	Acknowledged but requested for shorter condensed report for future submissions
Quality Committee	21/05/2024	Acknowledged but requested for shorter condensed report for future submissions

Safeguarding Annual Report

1. Introduction and Background

This annual report to Trust Board reflects the arrangements to safeguard and promote the welfare of children, young people, and adults at risk within York and Scarborough Teaching Hospitals NHS Trust for the period of April 2023 to March 2024. The report concentrates on the key safeguarding activity and risks within the organisation. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of section 11 Children Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act (MCA) 2005, the Care Act 2014 and the Prevention of Terrorism Act (2005).

The report is structured and presented with the key elements of the Safeguarding Accountability & Assurance Framework (SAAF)* and Schedule 32 of the NHS Standard contract* as set out below:

- Leadership
- Workforce
- Training
- Systems
- Partnership collaboration
- Service Development

Additionally, the report will consider, Schedule 32 of the NHS Standard Contract requires that specific systems to be in place to enhance safeguarding in the following areas:

- Child Protection-Information Sharing*.
- NHS contribution to local safeguarding partnerships
- Prevent*
- Domestic abuse*
- Female Genital Mutilation*

Local Safeguarding Context

York and Scarborough Teaching Hospitals NHS Foundation Trust is a key partner agency for safeguarding within the integrated Care System. This is achieved by:

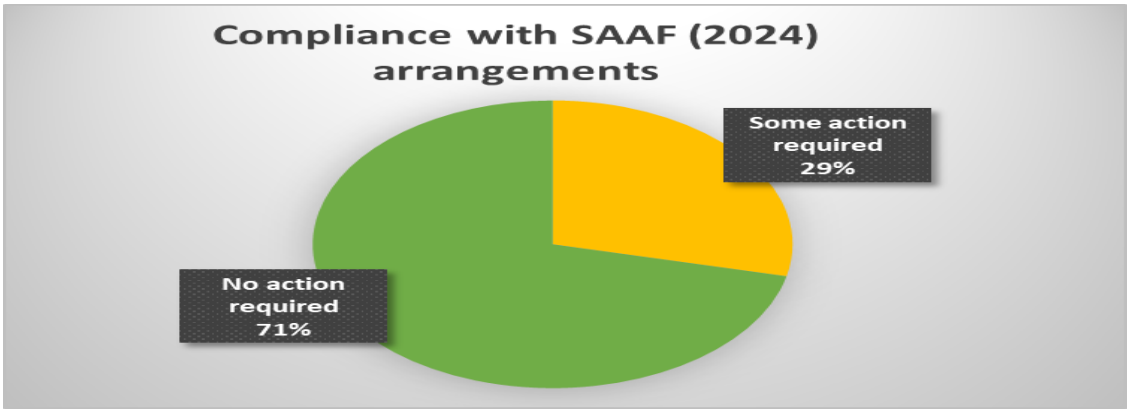
- A strong robust safeguarding team across the whole organisation including maternity, paediatrics, and adults. This is further complimented by the Mental Capacity Lead Practitioner, the Dementia Admiral Nurses, the Named Nurse for Complex Needs (Autism), the Learning Disability Liaison team and the Lead Professional for Complex Needs as part of the wider team covering key vulnerable groups.
- Membership of City of York, North Yorkshire, and East Riding Safeguarding Adults Board (SAB), the sub-groups of both the SAB and the Safeguarding Children's Partnership (SCP).

- Participation of the multi-agency audits from both the SAB and SCP and ensuring that internal audits are in place to respond to national and local trends
- Active contribution to both Safeguarding Adult Reviews (SARs) and statutory reviews instructed by the Safeguarding Children Partnership Boards.
- Active contribution to Domestic Homicide Reviews (DHRs) with the associated Community Safety Partnership
- Active participation at complex safeguarding meetings and arranging discharge planning meetings with multi-agency participation
- Attendance and dissemination of information at the Multi-Agency Risk Assessment Conference (MARAC) when appropriate
- Dissemination of domestic abuse notifications from the police regarding pregnant women
- Attendance to support the Prevent agenda
- Close liaison and dissemination of information with and from the children's Multi Agency Safeguarding Hub (MASH)
- Emergency department Safeguarding and Paediatric Liaison Nurses (EDSLN & SLN) in post who scrutinise the Emergency Department (ED) lists and in-patient admissions on a daily basis to share information between hospitals and community services, which enables children and their families to receive appropriate care and support post discharge
- Robust safeguarding administration from two specific members of the team who support the safeguarding team.

The Trust Integrated Safeguarding Group (ISG) monitors the Trust's progression against the SAAF.

2. Considerations:

The Trust compliance status against the SAAF at 31/3/2024 is as follows (See appendix 2 for breakdown):



This is expanded upon in the next section.

3. Current Position/Issues (structured around the key elements of the Safeguarding Accountability & Assurance Framework (SAAF) and Schedule 32 of the NHS Standard contract.)

3.1 Leadership and Governance

Safeguarding Governance

York and Scarborough Teaching Hospitals NHS Foundation Trust is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Children's Act 2004, the Care Act 2014 and other statutory and national guidance. The safeguarding roles, duties, and responsibilities of all organisations in the National Health Service (NHS) including the Trust, are laid out in the NHS England 'Accountability and Assurance Framework' (2022).

The Trust is highly committed to safeguarding with a strong culture of safeguarding vulnerable individuals of any age that have contact with services – either as patients, visitors, or staff. Therefore, robust governance processes are in place to ensure that services delivered are responsive to and are enacting Safeguarding multi-agency policies and procedures for all patients in our care who are at risk of, or are experiencing, abuse.

The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding. These have been fulfilled and enhanced throughout 2023/2024.

Leadership is defined at executive level with the Trust Chief Nurse holding executive ownership of Safeguarding. The executive lead also acts as Named Senior Officer for allegations made against staff. There is a requirement for a Non-Executive Director to also hold the Safeguarding portfolio. The Board have been approached and there will be a Non-executive Director nominated by April 2025.

The Head of Safeguarding and Complex Needs provides strategic direction for adult, children's and maternity safeguarding and supports the Chief Nurse in the executive role. The role of Named Senior Manager for allegations against staff is fulfilled by the Head of Safeguarding and Complex Needs, who also attends the Safeguarding Adult and Safeguarding Children Partnership Board.

The Named Professionals provide the organisation with operational advice, support, and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes. They are supported by safeguarding practitioners/advisors.

The SAAF leadership element states that it is a requirement the NHS provider Boards of Directors receive a Safeguarding Annual Report, and this report is evidence of compliance in this requirement.

3.2 Workforce

The Trust Safeguarding structure workforce establishment includes substantive roles for Named Nurse, Named Midwife and Named Doctor for Safeguarding Children. However, we do not have a Named Nurse for Children in Care nor the Named Nurse for Safeguarding Adults. This was included in our annual investment request as it is part of required workforce under the SAAF but for 2023/2024 funding was unavailable. We will continue to submit an investment request in 2024/25. Additionally, if there is movement within the teams, we will review the structure and where possible re-direct current budget to address the gaps.

For assurance, any Looked after Children business is absorbed by the Named Nurses, Named Midwife, and the rest of the team. Initial Health Assessments* (IHA) performed by the Trust have also been reduced significantly since the contract for IHAs went to another provider - however, we still carry out IHAs for newborns and children with complex needs.

The Safeguarding Adult Team are also absorbing the roles and responsibilities of the Name Nurse for Safeguarding Adults. The Head of Safeguarding & Complex Needs (HOSCN) formerly held this role. The increasing strategic demands and expanding portfolio of the HOSCN however, will impact their ability to take on further duties falling to the specialist nurses to manage.

During 2023/2024 The Named Professional Team comprises of:

- 1.8 whole time equivalent Named Nurse (Children)
- 0.8 Whole time equivalent Named Midwife (Children and Vulnerable Women)
- 2.0 sessions a week Named Doctor (Children)

3.3 Training

The SAAF requires safeguarding arrangements to be in place for the training of all staff in accordance with the intercollegiate safeguarding competencies, included in induction programmes for all staff and volunteers and safeguarding supervision arrangements for relevant staff.

From the 01/04/2023 the Trust moved to a blended training delivery approach to support easier staff access to training; this includes online content, face to face and self-mandated study depending on the level of training assigned. This aligns the Trust to the recommendations of intercollegiate document ‘Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff’ (2019). This was a priority set out within the 2022/2023 Annual Report.

The team supplement statutory training with contributions to the Staff Induction Programme and in 2023/2024 embedded Safeguarding within the Midwifery New Starter Preceptorship Programme – within this 2 hour session we cover policies, Badgernet, contacts referrals, supervision, Female Genital Mutilation,

intercollegiate, and training requirements and in addition we present a case study which includes a Domestic Abuse element. There were 8 2 hour induction sessions presented in 2023/2024.

The table below sets out the training levels achieved for the period of April 2023 – March 2024. For all the levels of required training for our staff, the required target is 90% compliance. We have seen all training compliance levels achieved across the areas except Level 3 Safeguarding Children & Level 3 Specialist. (Staff requiring Level 3 are paediatric case holders and Level 3 specialists training is for all doctors/health professionals working exclusively or predominantly with children and young people.)

Training	Target	2022/23	2023/24
Safeguarding Children Level 1	90%	88	⇧ 91.5
Safeguarding Children Level 2	90%	85	⇧ 90
Safeguarding Children Level 3	90%	73	⇩ 71
Safeguarding Level 3 Specialist	90%	74	⇧ 76
Safeguarding Adults Level 1	90%	90	⇔ 90
Safeguarding Adults Level 2	90%	92	⇩ 91
PREVENT Basic Awareness	90%	90	⇔ 90
PREVENT Level 3	90%	92	⇩ 90

Actions to address compliance below 90%

We continue to explore ways of supporting training compliance (whilst remaining compliant with the Intercollegiate document - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff and the NHSE SAAF) by working with Clinical Directors and Heads of Nursing to address and target non-compliance.

In addition, the Named Midwife has secured an agreement with Family Health Care Group to provide midwifery staff 6 hours of paid time to meet their e-learning requirements. The Named Midwife will continue to report monthly compliance to the Maternity Senior Leadership Team.

Supervision

The SAAF outlines the required safeguarding supervision arrangements for staff managing a paediatric case load – 4 sessions per year.

For 2023 2024 supervision compliance stood at 83% (84% 22/23) across the trust.

Due to the Corporate Learning & Development (CLAD) self-certification system, which involves a 12-week rolling programme of compliance, there will be some practitioners who will show as 3 sessions one year and five the next but remain compliant. This may, in some instances, result in a reduced CLAD recorded supervision compliance figure.

The team have continued to support compliance with supervision by implementing a programme of “sunrise” and “twilight” supervision sessions and in addition increase training sessions to train more staff to become supervisors.

3.4 Systems (Including NHS Standard Contract requirements)

Child Protection Information Systems (CP-IS):

CP-IS has been in operation within both Trust Emergency Departments (ED) throughout 2023 - it was launched in 2018. Use of the system continued to strengthen since then but through audit in 2023 we found there was a reduction in the uploading of this information on our East Coast site and was not always consistently accessed when a child attends. This reduction was understood to be due to the introduction of the new booking and triage systems at Scarborough. The Team worked with Medicine Care Group to address this risk and improve compliance. At time of writing (October 2024) 100% compliance was achieved in the most recent audit.

The Safeguarding Children Team reviewed phase one of the CP-IS rollout and have identified a small cohort of children attending Child Assessment Unit (CAU) or the ward directly whom the existing CP-IS processes would not capture. This is a priority action for the team to address with Family Health directorate.

The team ambition for 2024/2025 is to meet the National standard that CP-IS is be embedded within maternity from April 2024. A Standard Operating Procedure has been developed in readiness and CP-IS launched in Maternity across site April 8th. Our Named Midwife is to audit compliance from July following a 3-month introductory period.

Female Genital Mutilation (FGM) Reporting:

Since April 2023, the team has been responsible for FGM Trust quarterly reporting to NHS ENGLAND – as per the FGM Act duty of Health providers. In 2023/2024 we reported 26 FGM cases. We are developing a mandated field in maternity initial assessment to ensure we are asking the question. This will be in place by quarter 1 2024/2025.

Prevent

Whilst there were no referrals made to Prevent in 2023/2024, the trust provided research to contribute to Channel Panels in our region (19).

Domestic Abuse

The Teams contribute weekly to MARAC* (Multi-agency Risk Assessment Committees) for two localities across the region. By providing research and comment on risk, the team contribute to a multi-agency risk management plan.

In reviewing attendances to ED, they also make relevant referrals to IDAS* (Independent Domestic Abuse Services) and MARAC. Cases of suspected domestic abuse were identified via the ED coding system resulting in 136 referrals to MARAC.

The 2024/2025 service development plan for expansion of the teams' domestic abuse support will mean we can extend our MARAC representation to the remaining MARAC meetings in our region, the aim being that by April 2025 we will contribute to all 5 MARACs in our region.

Arrangements for dealing with allegations against staff.

Where the Trust becomes aware of an allegation against a staff member of abuse, a referral to the Local Authority Designated Officer/Person in a position of Trust (LADO/PIPOT*) is required. The Trust must then examine transferrable risk to our patients and assure ourselves and the LADO/PIPOT of both support to that staff member and any patients in their care.

2023 2024 saw a formalised process adopted to support the process and offer further assurance to the partner agencies. Additionally, a quarterly Reflection and Update meeting has been established allowing relevant national guidance/legislation to be presented to ensure knowledge in this arena remains current.

There were 17 contacts made regarding staff who were alleged to have caused harm under the LADO/PIPOT process.

The policy relating to the management of allegations of abuse against our staff will be reviewed in July 2024.

Safeguarding policies and procedures

All Safeguarding related policies are in date at 31/3/2024. The policy tracker is reviewed as part of the Safeguarding work plan and presented as assurance at the Integrated Safeguarding Group.

3.5 Partnership collaboration

The Trust is represented at Safeguarding Adult Boards/Children Partnerships* where invited by the Head of Safeguarding & Complex Needs (HOSCN), who also contributes to subgroups from the board/partnerships. The table evidences collaboration.

Local Authority	Safeguarding Adult Board	Safeguarding Children Partnership (SCP)	Subgroups	Safeguarding reviews*
East Riding	Minutes only, attendance by exception	Minutes only, attendance by exception	Minutes only, attendance by exception	0 (SCP reviews) 1(safeguarding adult review)
North Yorkshire	Minutes only, attendance by exception	Minutes only, attendance by exception	2 groups (Adult Board)	Thematic review (3 cases) 7 Rapid reviews – children 6(safeguarding adult review)
City of York	Attendance by Head of Safeguarding & Complex Needs	Attendance by Named Nurse for Safeguarding Children	3 groups (adult Board)	3 Rapid reviews (children) 11 (safeguarding adult reviews)

This participation provides opportunities to inform training, themes, and service development planning.

Themes that have emerged from these reviews are as follows:

- Documentation
- Information sharing
- Engagement with fathers/hidden males
- Professional curiosity
- Prevention of harm messages
- Professional escalation of safeguarding concerns and agency challenge
- Capturing the voice of the child.

Thematic learning (described above) is incorporated with safeguarding mandatory training presentation.

On conclusion of each review process, the outcomes are shared at governance level to ensure learning is shared and subsequently monitored. This allows us to feedback assurance to the Integrated Care Board designated Nurse team.

3.6 Service development – Care of 16-17 year old in acute settings

The Safeguarding Liaison Nurse has been in post since April 2023 and their role was to support staff on adult wards to care for our young people on the adult ward. As this was a new role, the aim was to increase awareness and use systems to flag where our young people are admitted to adult wards.

Over the year 2023-2024, the '16–17-year-old placed on adult wards' process has been embedded and reviewed by the team. This process involves a daily review of children, highlighted from data, placed away from paediatric areas for inpatient care. The records are reviewed to establish the reason for admission and if required the ward is contacted; the team contacts partner agencies or Trust staff, with an offer of support or for information sharing purposes.

In 2023-2024, 581 16–17-year-old children were placed on adult wards. Reason for admission is reviewed by the Safeguarding Liaison Nurse (SLN). 117 (20%) required SLN contact to the wards, follow up or action. This process assures the Trust that these children placed away from paediatric areas have safeguarding children oversight.

As it has been noted that many of the children have been discharged before review, the Team is working with Digital and Information Services to see if data can be provided in real time – a system is to be in place by quarter 3 of 2024/2025.

Maternity IT Systems (MITS):

The new maternity IT system has been operational since March 2023. This came without a clear Safeguarding pathway and for a brief time initially there was a separate paper process, meaning there was a risk safeguarding information would not be accessible/visible. To address this the Named Midwife worked with the maternity digital team to develop Safeguarding Pathways and operating procedures. The team also underwent training to navigate the new system.

From April 2024 we can now access and populate safeguarding information. Next steps are to gain read only access for SCBU and ED to improve information sharing. This will remain on the Risk Register until assurance can be given that Maternity has fully embedded safeguarding within the BadgerNet system. Audits take place quarterly to mitigate risk and identify areas for escalation.

Non accidental injuries to non-mobile babies

Following learning from a national serious case review (trust unconnected) the team in collaboration with the Named Doctor for Safeguarding Children will review their processes in relation to the presentation of injuries to non-independently mobile babies, incorporating the learning from this review. The completed guidance will be complete by quarter 2 2024/2025

Domestic Abuse Service development

The team attended a number of Domestic Abuse/Non-Fatal Strangulation conferences which have led to the proposed expansion of the Domestic abuse support provision within the team. Plans include increasing the workforce using Continual Professional Development (CPD) funding, development and review of policies, a training needs analysis and governance via the NHS England Domestic Abuse mapping tool. Progress will be reported throughout 2024/2025.

4. Summary

The annual report for 2023-24 provides an overview of the safeguarding work at the Trust. It provides assurance that our practices meet the national statutory and mandatory requirements. There are areas to improve in all areas of SAAF requirements, they are described below.

5. Next Steps

In summary, priorities for the Safeguarding team are as follows:

- Leadership
  - Appoint Non Executive Director for safeguarding by January 2025
- Workforce
  - Continue to submit investment requests annually to bridge the gaps in workforce.
  - Review movement/relocation of staff within the team to consider re-direction of funds to address the functions of the roles.
- Training
  - Improve, with the support of Care Groups, training & supervision compliance to 90%
- Systems
  - CPIS in Urgent treatment Centres – processes will be embedded so that 100% CP-IS compliance is achieved by April 2025.
  - 16-17 year old – we have a system where admission of a young person to our adult wards is “in the moment” to enable swift patient and staff support. This is dependent on Digital teamwork plan but is aimed to be in place by April 2025.
- Develop services/resources in the following areas:
  - Domestic abuse service development – Job Description and recruitment process in place by end of quarter 1 and for quarter 3 start. Quarter 4 plans include Training Need Analysis and resource review. Progress reports will be made routinely to the Integrated Safeguarding Group.
- Partnership
  - Contribute wider regionally to MARAC (currently restricted to City of York and North Yorkshire due to capacity) - The 2024/2025 service development plan for expansion of the teams’ domestic abuse support will mean we can extend our MARAC representation to the remaining MARAC meetings in our region, the aim being that by April 2025 we will contribute to all 5 MARACs in our region.

Date: October 2024

Appendix 1 – Report aide memoir – terminology
Appendix 2 – At a glance SAAF compliance (2023 2024)

Appendix 1 – Report aide memoir – terminology

Term	Descriptor
Safeguarding Accountability & Assurance Framework (SAAF)	NHS England has in place the Safeguarding children, young people, and adults at risk in the NHS: safeguarding accountability and assurance framework, which sets out clearly the safeguarding roles and responsibilities of all individuals and organisations related to their statutory requirements and appropriate accountabilities for the safeguarding of children, young people, and adults at risk of harm or abuse.
Schedule 32 of the NHS Standard contract	Safeguarding forms part of the NHS standard contract (Service Condition 32) and commissioners will need to agree with their providers, through local negotiation, what contract monitoring processes are used to demonstrate compliance with safeguarding duties.
CP-IS	The Child Protection - Information Sharing (CP-IS) service helps health and social care workers share information securely to better protect children and young people who are known to social care because they are looked after or have a child protection plan. CP-IS links IT systems across health and social care in England to help organisations share information securely
Prevent	The Prevent duty requires specified authorities such as education, health, local authorities, police, and criminal justice agencies (prisons and probation) to help prevent the risk of people becoming terrorists or supporting terrorism
Domestic Abuse	Under the Domestic Abuse Act statutory agencies must have systems in place to support victims of domestic abuse
Female Genital Mutilation(FGM)	The FGM Act 2003 (amended 2015) statutory agencies have a duty to notify where a patient has been subject to FGM.
Initial Health Assessments	This is a statutory health assessment that is required to be completed within 28 days of coming into care. It is completed by a doctor known as a Paediatrician.

Term	Descriptor
Local Authority Designated Officer/Person in a position of Trust (LADO/PIPOT*)	The acronym LADO and PIPOT refer to the specific role of the designated officer employed by the local authority to manage and have oversight of allegations of individuals working with adults and children.
Safeguarding Adult Boards(SAB)/Children Partnerships*	The overarching purpose of an SAB is to help and safeguard adults with care and support needs. It does this by assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance. assuring itself that safeguarding practice is person-centred and outcome focused. Local Safeguarding Children Partnerships are the key statutory mechanism for agreeing how the relevant organisations in each local area cooperate to safeguard and promote the welfare of children, with the purpose of holding each other to account and ensuring that safeguarding children remains high on the agenda across the partner agencies.

Appendix 2 – At a glance SAAF compliance (2023 2024)

SAAF Arrangement	Compliance status
Workforce -named nurse, named doctor, and named midwife for safeguarding children	Arrangements in place
Workforce - a named nurse and named doctor for children in care	No named nurse for children in care
Workforce- a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead	No named lead for adult safeguarding
Systems - arrangements for dealing with allegations against staff	Policy in place
Leadership - executive lead for safeguarding children, adults at risk and prevent	Leadership defined at executive level
Leadership - an annual report to be submitted to the trust board	Safeguarding Annual reports included in Board reporting system
Systems - safeguarding policies and procedures	All policies are in date
Training - training of all staff in accordance with the intercollegiate safeguarding competencies	Training in place based on safeguarding competences
Training -included in induction programmes for all staff and volunteers	Training in place for induction
Training - safeguarding supervision arrangements for staff	Supervision arrangements in place for case holders
Partnership- staff are aware of their personal responsibilities for safeguarding and information sharing	Included in Safeguarding Multi-agency policies and procedures

SAAF Arrangement	Compliance status
Service development - developing and promoting a learning culture to ensure continuous improvement	Reporting processes in place to escalate learning. Policies based on Voice of child/making safeguarding personal as per Multi-agency/Partnership working. Local learning built into Trust Level 3 safeguarding children training package and cascaded through supervision and newsletters
Schedule 32 of the NHS Standard Contract	**Compliance status**
CP-IS use	**Gaps identified and escalated. In work plan for 2024.**
NHS contribution to local safeguarding partnerships	**Full board and partnership commitment**
Prevent	**Systems in place (Policies, training, leadership, and reporting mechanism)**
Domestic Abuse	**Systems in place (Policies, training, leadership, and reporting mechanism) – Further development in 2024**
FGM	**Systems in place (Policies, training, leadership, and reporting mechanism)**

Report to:	Board of Directors
Date of Meeting:	23 October 2024
Subject:	Pay Gaps Report
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Diversity and Inclusion

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 Pay Gaps paper is the result of data analysis for York and Scarborough Teaching Hospitals including York and Scarborough Facilities Management staff and is for the Trust's Board of Directors assurance. The Gender Pay Gap (GPG) is reported to the Resources Committee and Trust Board in advance of the March 2025 deadline. The data snapshot date for both pay gaps was 31 March 2024.

Gender Pay Gap

- The mean and median GPG data has reduced for the entire workforce.

Ethnicity Pay Gap

The requirement to report on a pay gap for ethnicity is new to the NHS. When averaging across the entire workforce, the Trust does not have an ethnicity pay gap which is extremely positive. However, breaking the data down has identified an EPG for medical and dental staff.

Appendix 1 – visual representation of the data.

Recommendations:

- The Women's network, Organisational Development, Workforce Planning and Development, Medical Workforce and Human Resources teams should continue to implement actions.
- The Medical Workforce Team should continue to address the Mend the Gap.
- Further analysis of the EPG for the Trust's Medical and Dental workforce by the Medical Workforce team.

Summary:

The NHS EDI Improvement Plan's success metric for this High Impact Action is to see a year-on-year improvement in pay gap reporting. An improvement is evident with the GPG, data analysis for 2025. Data analysis of the EPG in 2025 will be able to provide a year-on year comparison.

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

Meeting	Date	Outcome/Recommendation
Resources Committee	20 August 2024	Report on action plan from Medical Workforce Team in 6 months time

1. Introduction and Background

Ensuring our staff work in an environment where they feel they belong, can safely raise concerns, ask questions and admit mistakes is essential for staff morale – which, in turn, leads to improved patient care and outcomes.

This can only be done by treating people equitably and without discrimination.
An inclusive culture improves retention, supporting us to grow our workforce, deliver the improvements to services set out in our Long-Term Plan, and reduce the costs of filling staffing gaps.

2. Considerations

Mend the Gap

Mend the Gap describes the actions the NHS should take to address the Gender Pay Gap in medicine, such as promoting flexible working for all. The recommendations in this document tend to be addressed implicitly through the work implemented in improving the overall Gender Pay Gap. Therefore, there has not been a dedicated Mend the Gap Action Plan.

Two local Trusts, i.e., Harrogate and District NHS FT and Humber Teaching NHS FT have also decided not to implement any different actions as they have a year-on-year reduction in their Gender Pay Gap. Our Trust has updated the Flexible Working Policy, which was ratified on 4 July 2024, this will now be communicated within the Trust.

Gender Pay Gap

The Trust's 2024 Gender Pay Gap data was analysed ahead of the March 2024 deadline and was approved by the Trust's Board of Directors in 2023. There remained a year-on-year improvement from 2021 and several teams within the Trust are taking the lead with implementing actions to continuously improve the disparities.

Ethnicity Pay Gap

2024 is the first year the Trust will be reporting on its Ethnicity Pay Gap as it is now incorporated into the NHS EDI Improvement Plan.

3. Current Position/Issues

Appendix 1 provides a visual representation of the data.

Gender Pay Gap

Entire Workforce

The data for the entire workforce identifies that the mean and median GPG has reduced since 2024, mean from, 26.96% to 21.91% and median from, 7.40% to 7.28%.

Clinical Excellence Awards

The legislation requires Trusts to report on 'bonus' payments. Clinical Excellence Awards for medical staff technically fall into the definition of a bonus payment for the purpose of this report. The bonus mean GPG has reduced since 2024 from 32.5% to 24.9% in 2025, the bonus median is 50%. Bonus pay percentage split between men and women for Consultants is 69.57% and 30.43% respectively.

Ethnicity Pay Gap

Entire Workforce

There is no EPG for the entire workforce, for AfC both ethnic groups are paid equally. For medical and dental, white staff earn more.

Information to note: there is a pay gap for white colleagues for the entire workforce but there is no requirement to report on this as it is not considered to be an EPG. (Mean pay gap -16.90%, median pay gap -13.38% in 2024.)

Consultant Bonuses

There is an EPG for Consultant bonuses (Clinical Excellence Awards). The mean EPG in 2024 is 5.59%. The median EPG in 2024 is 41.96%.

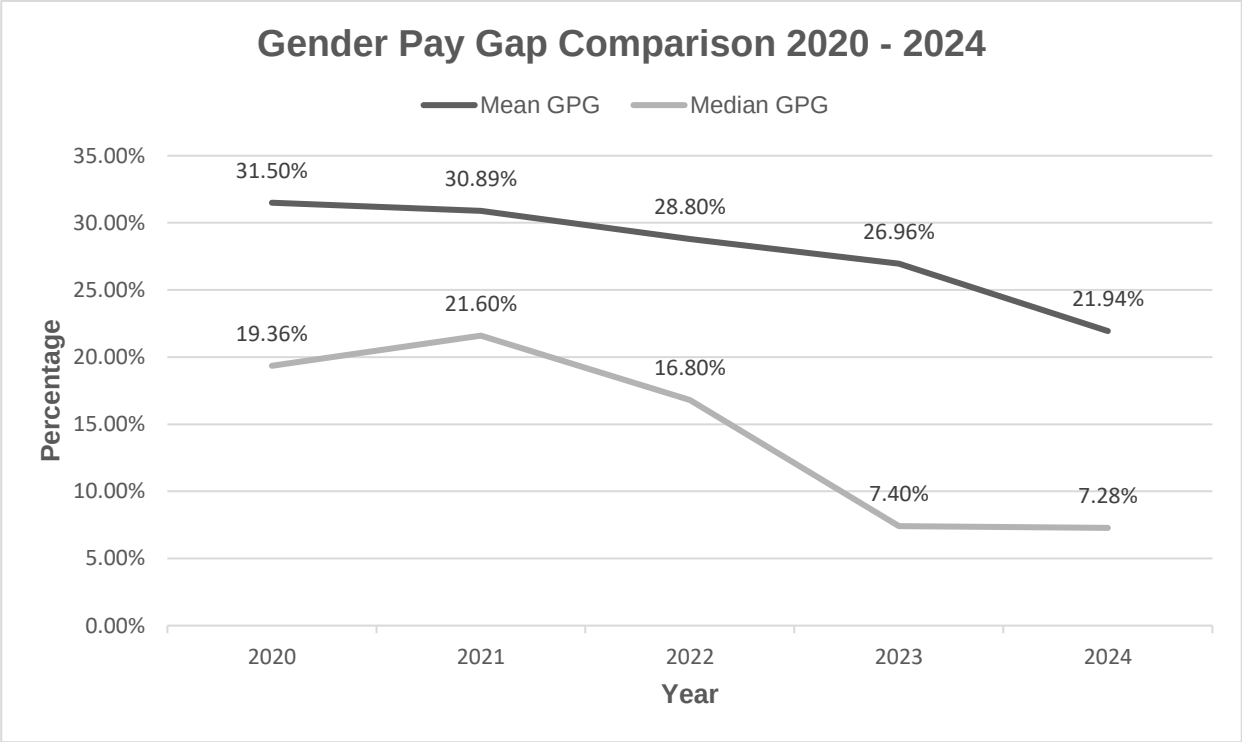
Medical & Dental

There is an EPG for medical and dental colleagues (mean pay gap 6.15% and median 15.03% in 2024).

Considerations:

- There are more white consultants than BME consultants
- White consultant's average length of service is 8.6 years and Black and Minority Ethnic staff's is 6.53 years. This will impact on earning potential.
- BME medical and dental staff might lack the confidence, encouragement and support to apply for a Clinical Excellence Award

4. Summary



Recommendations:

We seek to see a year-on-year reduction in pay gaps. We are seeing some improvements but will continue with the following to drive further understanding and reductions.

- The Women's network, Organisational Development, Workforce Planning and Development, Medical Workforce and Human Resources teams should continue to implement actions to improve the GPG. (For example, GPG Women's staff network lead and publicise the up dated Flexible Working policy.)
- The Medical Workforce Team should continue to address the Mend the Gap review. (For example , they advertise all jobs as Less Than Full Time, publicise the Flexible Working policy for men and women, review pay setting arrangements and greater attention to the distribution of additional work and extra payments.)
- As there is an EPG for the Trust's Medical and Dental workforce, it is recommended that the Medical Workforce team, analyse the data to identify the specific details of the disparities.

5. Next Steps

The results of this GPG and EPG analysis will be discussed with the relevant teams to encourage continuous work to address the disparities.

2024 is the first year the Trust is analysing its EPG, therefore 2025 will be the first year that a year-on-year comparison can be made.

The Resources Committee has requested a report on the action plan in February 2025.

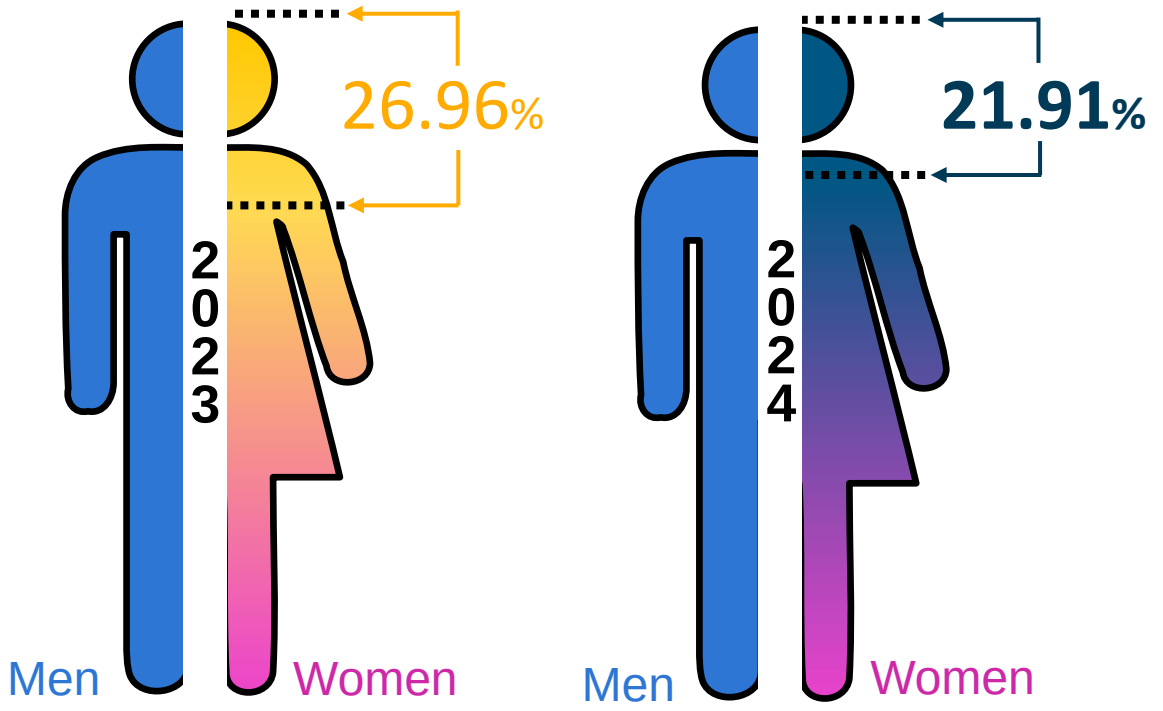
Date: 5 August 2024

Gender Pay Gap 2025

The gender pay gap describes the difference between the average earnings of all the women in an organisation compared to the average earnings of all the men in that organisation. This is not the same as equal pay, which is about ensuring men and women doing the same or comparable jobs are paid the same.

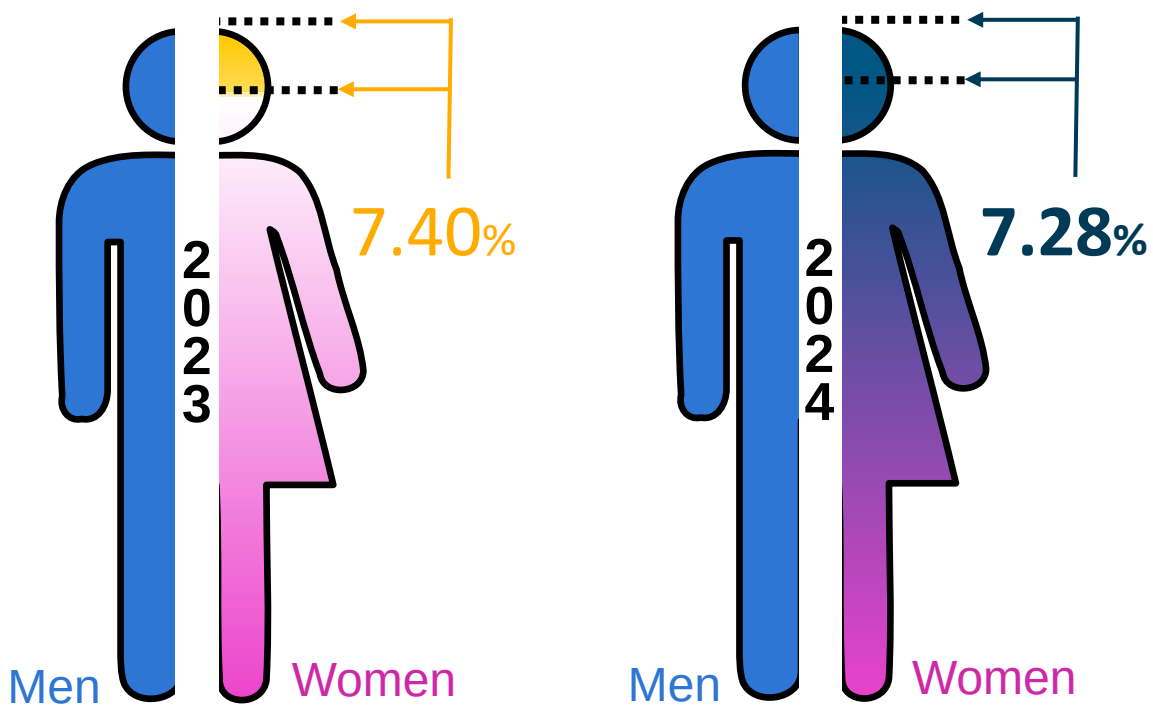
York and Scarborough Teaching Hospitals NHS Foundation Trust

Mean gender pay gap



Mean is the average of all of the numbers

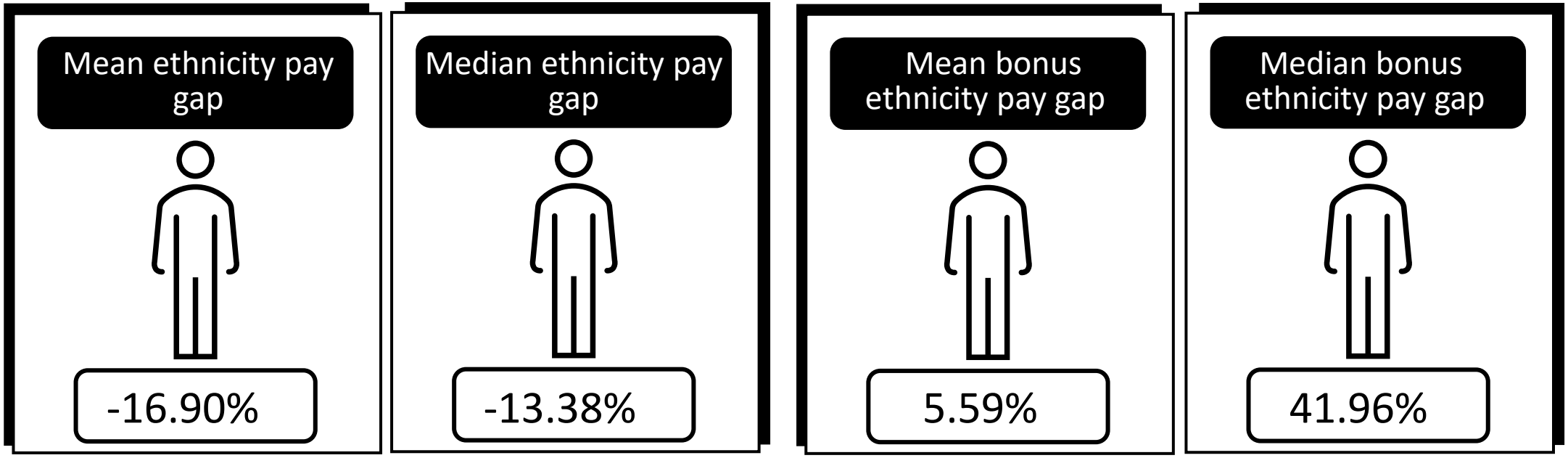
Median gender pay gap



Median is the middle value (or midpoint) when the data is ordered from least to greatest

Ethnicity Pay Gap 2024

York and Scarborough Teaching Hospitals NHS Foundation Trust



Report to:	Board of Directors
Date of Meeting:	23 October 2024
Subject:	Quarter 1 (24/25) Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Ed Smith – Deputy Medical Director Tim Lord – Patient Safety Lead

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

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

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

Summary of Report and Key Points to highlight:

This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
  - HSMR (Hospital Summary Mortality Indicator)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:
  - Nationally mandated data
  - Locally mandated data
  - Quality account data
- Learning from deaths – themes and actions
  - Themes from SJCRs considered by the LfD Group in Q1
  - Trend of sepsis not being identified/acted upon escalated to current sepsis work within the organisation
  - Example of positive communication
- Service developments
  - Revision of LFD escalations and theming now part of the monthly Patient Safety report – prompts quicker escalation pathway from LFD

Metric	Result
Crude mortality	Crude mortality is **2.94%** (HSMR) and **3.39%** (SHMI) for this current fiscal year
SHMI – HES HED[1] (Data to Nov 2023)	SHMI year to February 2024 is **96.69**
SHMI - NHS England[2] (Data to Dec 2023)	SHMI for year to February 2024 is **98.79**
HSMR[3]	HSMR for year to May 2024 is **111.98**

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

Recommendation

Trust Board to note the report and receive the escalations.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

Report History

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

Meeting	Date	Outcome/Recommendation
LfD Group	19/09/2024	
Patient Safety and Clinical Effectiveness Committee	09/10/2024	
Resources Committee	15/10/2024	

1. Y&SH NHS FT mortality rates

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

1.1 Crude Mortality - unadjusted

Crude Mortality rate is the percentage of patients that have died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.

The crude mortality stands at 3.39% of all non-elective admissions.

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

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

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

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

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

Two risk-adjusted mortality rates are presented:

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

The latest **NHS-England Summary Hospital Mortality Index (SHMI)** to February 2024 shows the SHMI was **98.79** The SHMI in comparison to other Trusts is displayed below (Figure 2).

The **SHMI HES data** reports the SHMI at **96.69**;
Expected deaths 3227, observed deaths 3121
In-hospital deaths 2131
Out of hospital deaths 990

This is categorised 'as expected'.

Figure 1 SHMI benchmarked against other Trusts (Y&ST highlighted)

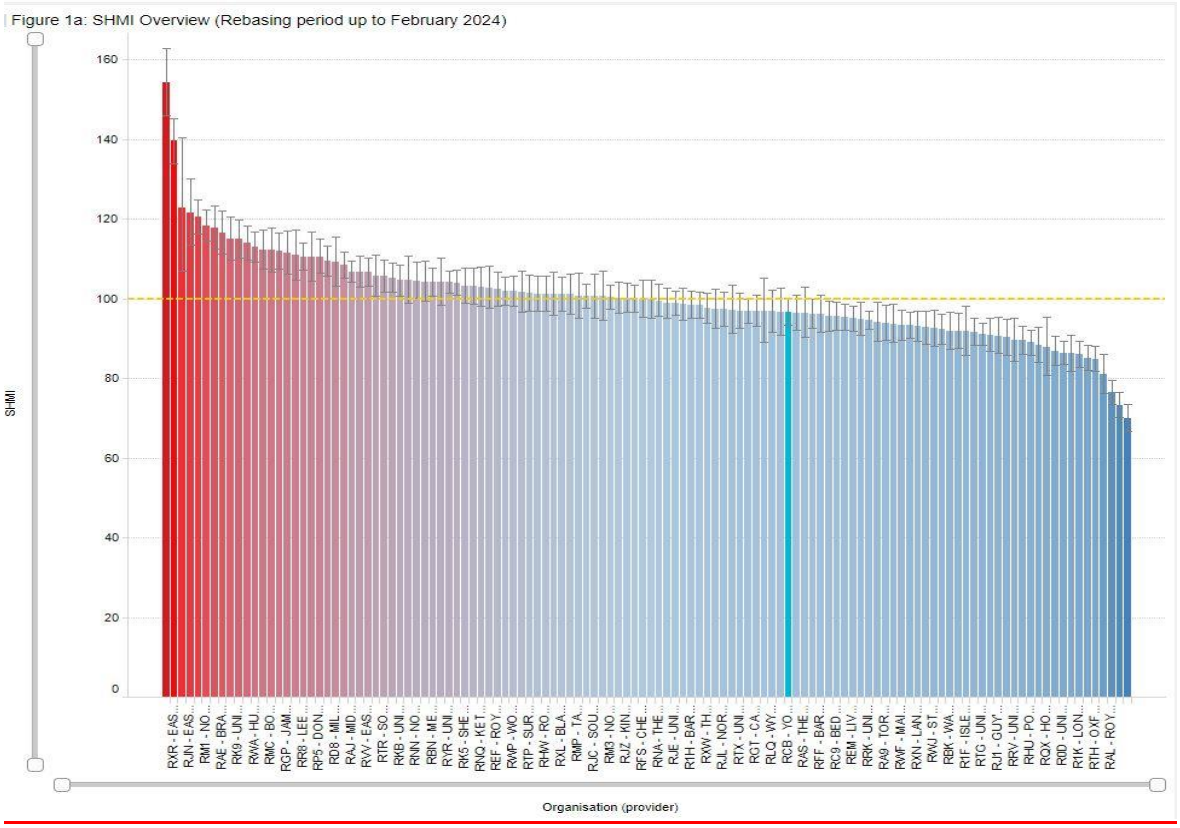


Figure 2 SHMI Funnel plots (in comparison with other Trusts)

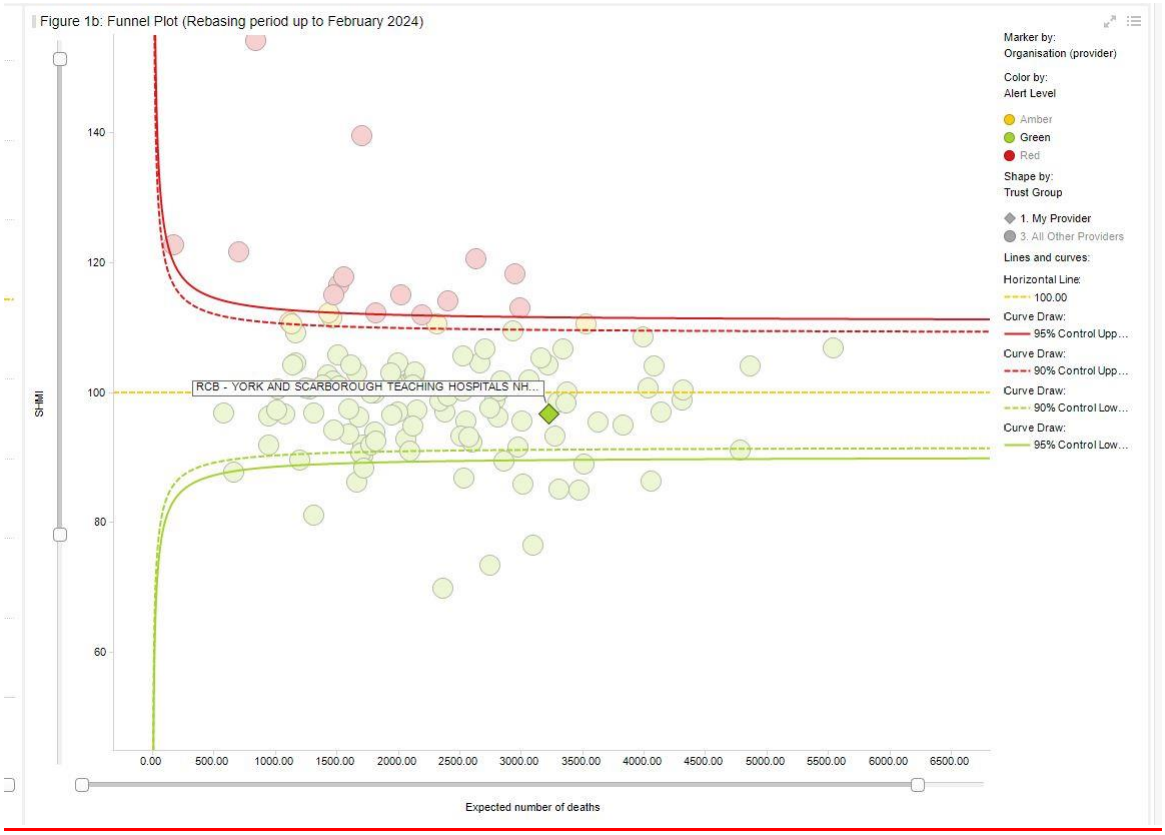
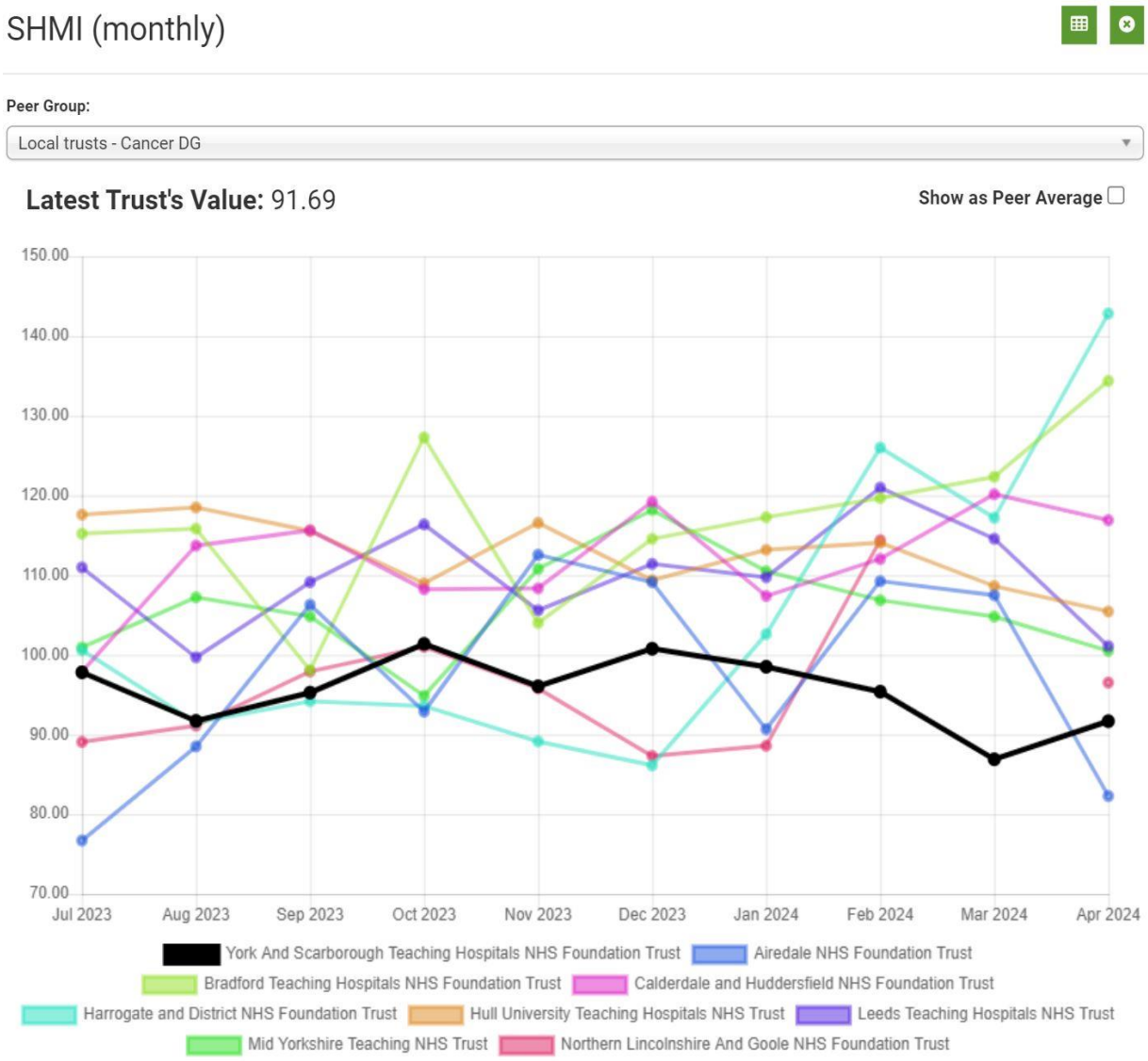


Figure 3: Time series data for SHMI showing comparison with local Trusts (ours = black line)



1.3 Hospital Standardised Mortality Ratio (HSMR)

The HSMR measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics e.g., demographics. It does not include as many diagnostic groups as the SHMI (only about 85% of total patient numbers) and this may affect applicability of the measure.

The most recent HSMR covers the period to May 2024 and is reported as follows:

Crude mortality rate 2.94%

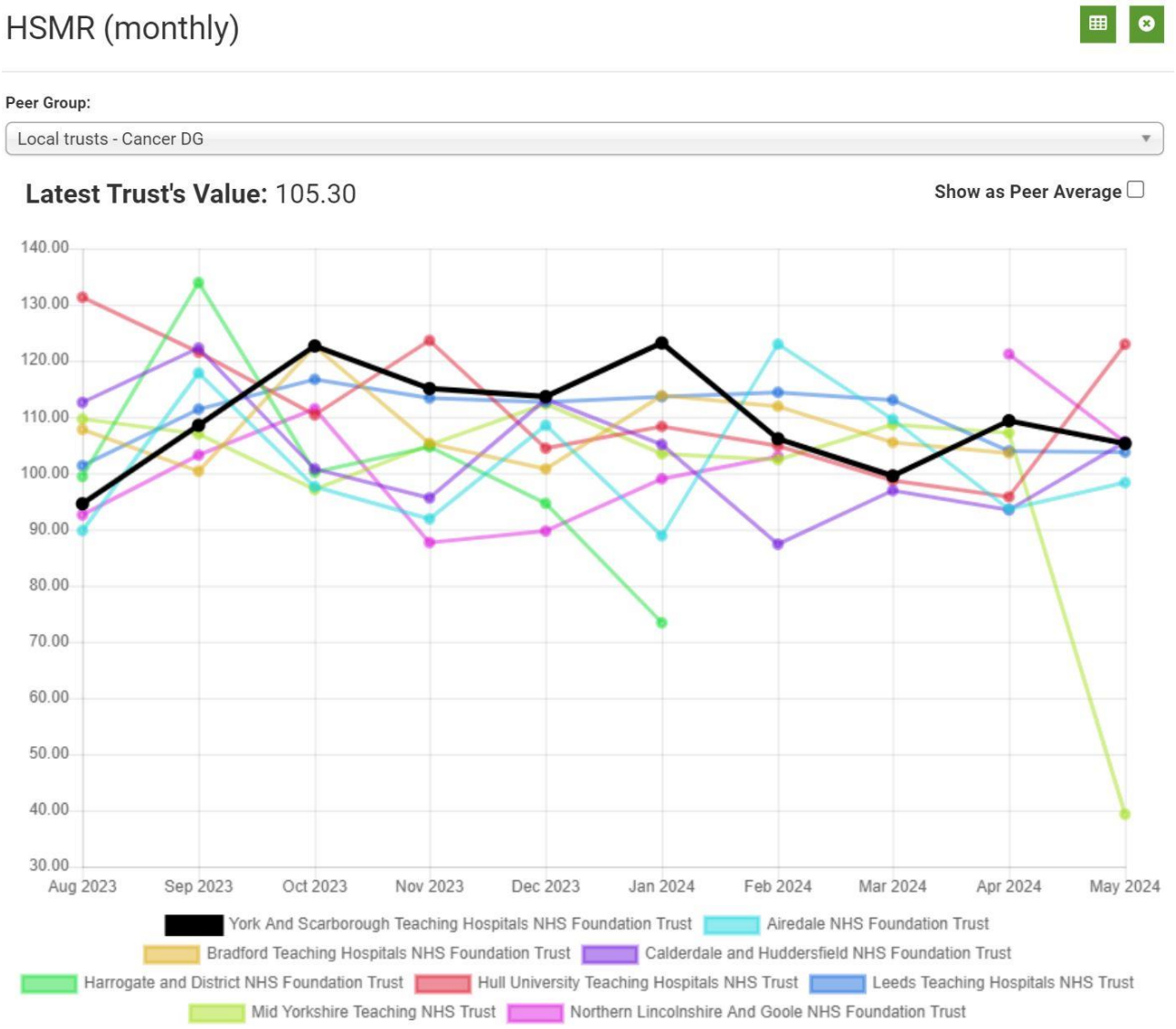
Expected deaths 1847 Observed deaths 1649

HSMR: 111.98

The HSMR remains higher than would be expected and it is unclear at present as to what might be contributing to this. We are currently looking at the hospital mortality coding to understand potential influences on this rate, and to understand the variability of the reported rate over time.

It is possible that the influence of palliative care coding is responsible for the relatively high HSMR but this requires further work to establish (lower levels of palliative care input AND/OR palliative care coding appears to be associated with a higher HSMR as a result of the methodology used.

Figure 4: HSMR monthly data compared with other local Trusts (Y&STHFT= black line)



2. Diagnostic groups most contributing to our mortality rates

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

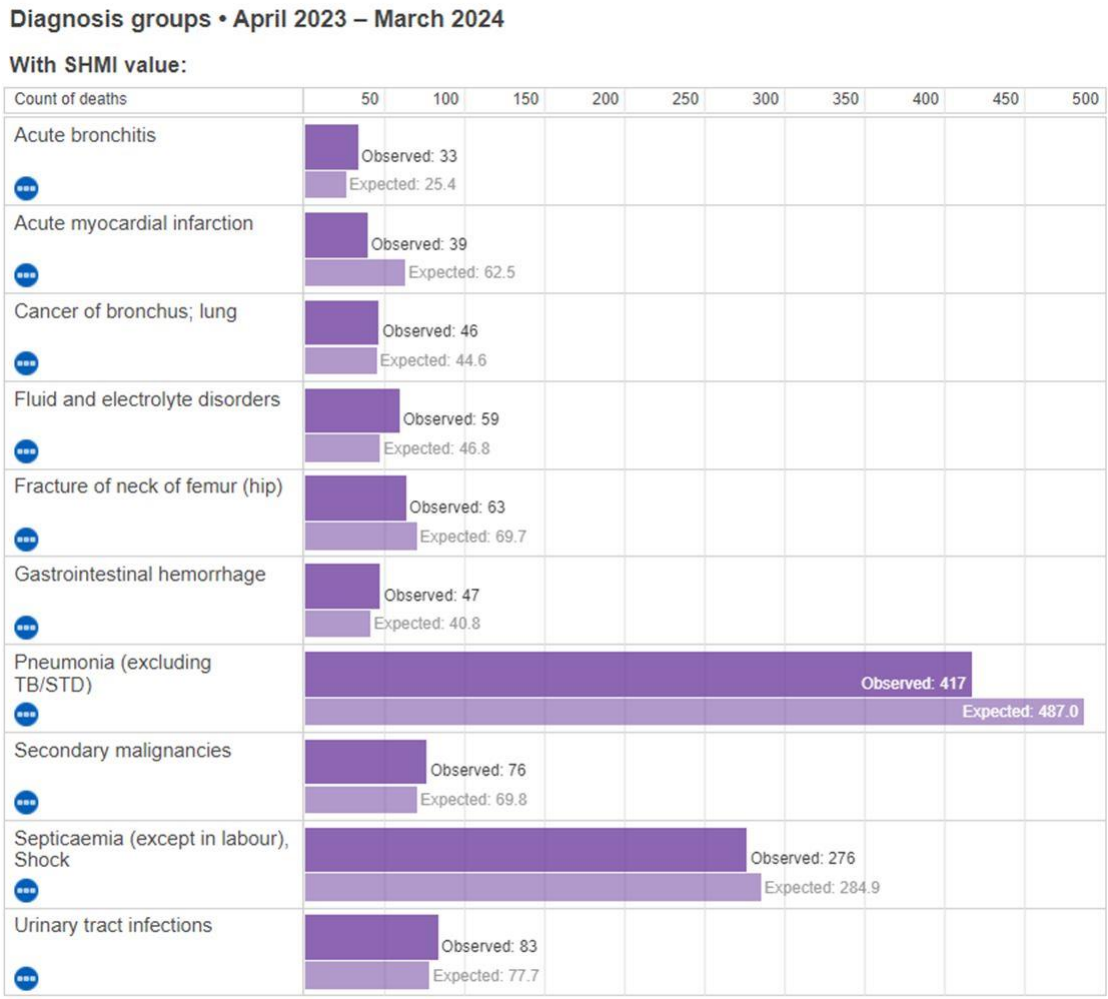
The way in which coding is applied to patients that die in the Trust can significantly affect mortality statistics. The “depth of coding” (coding of co-morbidities as well as primary diagnosis) is important as it allows for more accurate calculation of the expected number of deaths that should be seen during a specific time period. Coding of the primary diagnosis will also affect mortality statistics in particular diagnostic groups.

The depth of coding produced by the Trust’s coding team compares very well with other organisations. For instance, with respect to the current HES SHMI calculation our Trust’s average

comorbidities number 6.24 (with a national average of 4.8). In terms of comorbidity coding York and Scarborough Trust ranks as the 6th best of all Trusts nationally.

The most recent breakdown of differential SHMI for common diagnostic groups is displayed in figure 5 below. At present there are no particular diagnostic groups causing concern, however this data does triangulate with other patient safety work that we are undertaking. For instance, there is a potential for a mortality association of gastrointestinal bleed patients transferred as emergencies for endoscopies from Scarborough to York, and we have recently introduced a transfer protocol to support the rapid transfer of acutely ill patients needing emergency treatment of patients with bleeds between the acute hospital sites. It is also important to understand the detail behind the headline coding group. For example, mortality for a group of codes for "acute bronchitis" is higher than expected. However, when the underlying codes are examined, the high mortality is reflective of the sub-group: lower respiratory tract infections only. This code may be more reflective of a final diagnosis of pneumonia, but the cases haven't been coded as such.

Figure 5: SHMI associated with various diagnostic groups (from HES data)



3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and

reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

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

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

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

3.1 Nationally mandated data and information

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

When reading the table, SJCRs are Structured Judgement Case-note Reviews; SIs are Serious Incidents and PSII are Patient Safety Incident Investigation. It should be noted that that PSIIs replaced SIs when the new PSIRF was introduced.

Table 1 – National data summary

	Jan	Feb	Mar	April	May	June
	Quarter 4 (23/24)			Quarter 1 (24/25)		
Total in-patient deaths (inc ED, exc community)	258	202	202	196	199	183
No. SJCRs commissioned for case record review[1]	5	6	9	7	4	8
No. SIs/PSII commissioned of deceased patients	0	0	0	0	0	1
No. deaths likely due to problems in care	See tables below					

1 The SJCRs are those requested in month

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

Figure 6 shows the outcomes of the SJCRs **completed and reviewed** during Q4 23/24 and Q1 24/25:

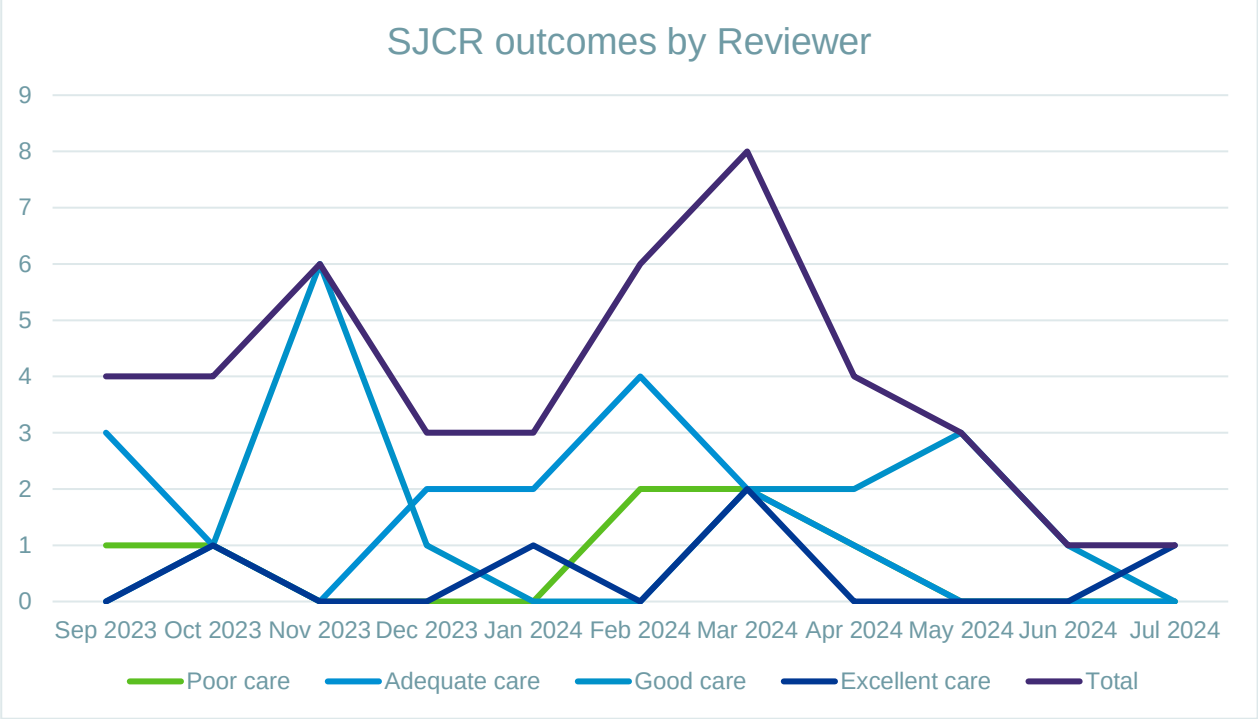
- Figure 6 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission.
- Table 3 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q1 8 SJCRs were reviewed (12 in Q4):

- The overall care score was given in 8/8 of cases.
  - The Reviewer found care **good** in 6/8 of cases.
  - The Reviewer found care to be **adequate** in 1 case and **poor** care in 1 case.

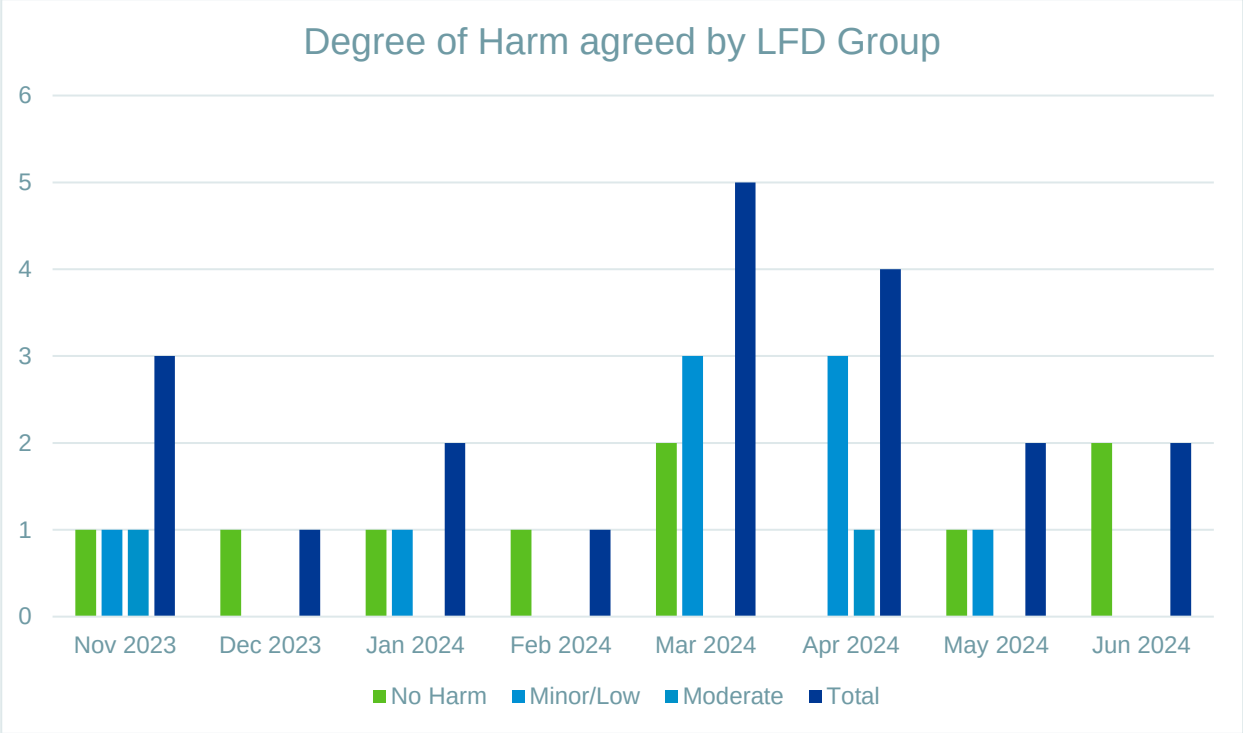
- The Learning from Death Group agreed harm leading to death in 0 cases, moderate harm in 1 case, minor in 4 of cases and no harm in 3 cases.

Figure 6 – SJCR outcomes assigned by the Reviewer (overall score)



The LfD group will decide on level of harm for the SJCRs presented. The degree of harm levels are No harm, Minor, Moderate, Severe and Death.

Figure 7 – SJCR outcomes following review by LfD Group (degree of harm)



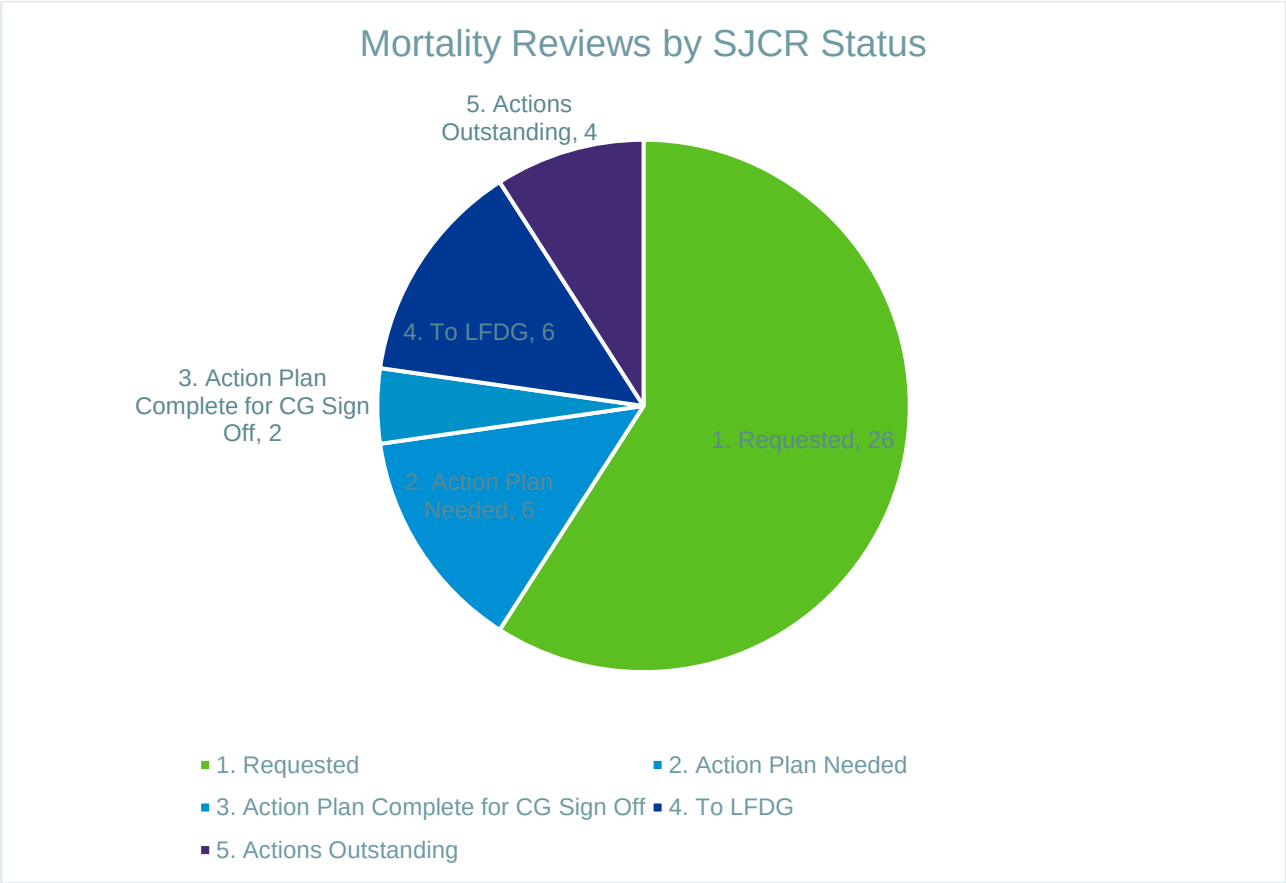
3.2 Locally mandated data

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

Data on progress of investigations at point of reporting (11/07/2024)

Overall no. of SJCRs open 44 (previously 43 as of 11/04/2024)

Figure 8 – Status of open SJCRs (date collected 11/07/24)



	Q4 (23/24)	Q1 (24/25)
Number under review	21	26
Awaiting action planning	3	2
Actions outstanding	4	4
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	10	15

3.3 Quality account data

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

Table 2 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2023/24. (please note that the numbering of these relate to the numbering dictated by the Quality Account Report which is why they differ from the rest of the report.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2023/24 but were investigated during 2024/25 and hence not reported in the 2023/24 Quality Account.

Item	Requirement	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25
27.1	Total number of in-hospital deaths	505	666	669	578
27.2	No. of deaths resulting in a case record review or SI/PSII	ME: 440 SJCRs:6 SI:10	ME: 556 SJCRS: 15 SI:11	ME:588 SJCRS:20 PSII: 0	ME:536 SJCRS:21 PSII: 1

	investigation (requested reviews of patients who died in 22/23 and 23/24)				
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 23/24)	1	2	0	0
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 4 SI: 1	SJCR: 6 SI: 0	SJCR: 6 SI:4	SJCR: 1 PSII:0
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0	0	2	0
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	1	2	2	0

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

[2] Reviews completed in 2024/25 after the 2023/24 Quality Account was published

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

4. Learning from Deaths - themes and actions

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

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

Local SI/PSII investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs. A specific report is escalated to Patient Safety and Clinical Effectiveness with summarised learning.

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

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

Table 3 below shows the source of SJCR requests for Q3 & Q4, it should be noted that there can be more than one source however to avoid duplication only the original inputted source is considered in this table.

Table 3 – Source of request for SJCR

SJCR Request Source	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06
1. Initial Mortality Review	1	0	0	0	0	0
2. Medical Examiner Review	1	1	0	0	1	0
3. Learning Disabilities	1	3	3	3	1	4
4. NoK Concern/Complaint	0	0	0	0	0	0
5. Care Group	2	2	6	4	2	4

4.1 Themes from SJCRs considered by the LfD Group in Q4:

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

The introduction of DCIQ and the mortality module has meant that themes and trends identification has had to be updated. During the creation of the mortality module it was decided that themes would be based on the same ones as the other modules in DCIQ to allow cross comparison and triangulation of data when required.

The themes are identified within the Learning from Deaths meeting. These themes identified are shown in Table 4.

Table 4 – Themes identified

	01--2024	02-2024	03-2024	04-2024	05-2024	06-2024
Acting on Results	0	0	0	1	0	0
Clinical Assessment	0	0	0	0	0	0
Communication/Documentation	0	0	1	2	0	0
Delayed Diagnosis/Treatment	0	0	1	1	1	0
Learning Disabilities	0	0	1	0	0	0
Nutrition and Hydration	0	0	0	1	0	0
Pathways/Process	0	0	0	1	0	0

5.0 Escalations & Learning

The 2024/25 year the methods of reporting from LFD has evolved. As part of the monthly Patient Safety Report, any escalations or potential themes are discussed and reported back the following month. Therefore this part of the report will add in each months content with any further narrative when required. This report is presented at the Patient Safety and Clinical Effectiveness Subcommittee reviewing the previous months meetings escalations and learning.

May 2024

There were no escalations from Learning from Death (LFD) meeting in April. The PST from the March meeting were tasked with reviewing SJCRs which identified delays in identifying and treating sepsis, particularly initial antibiotics.

A search of Mortality module in DCIQ and Datix covering April 23-April 24 was conducted. 14 results produced, these SJCRs were then reviewed.
Reference was made in 9 of a delay in either identifying possible sepsis or antibiotics being administered. In no cases the delay in antibiotics was identified as the reason for the patient death.

This snapshot audit gave further evidence that another form of investigations in the form of SJCR has produced similar findings and reaffirms the need for improvement work around sepsis. This information was therefore fed into the ongoing work being carried out within the organisation in response to our management of sepsis.

June 2024

There were no escalations from Learning from Death (LFD) meeting in May. Likewise, there were no significant trends or themes identified from the discussions. Two referrals to improvement groups were made; one to the end of life group and one to the VTE committee.

On a positive note, there was an example where the care received leading up to death should be commended. An SJCR was prompted due to the patient being LEDER however the SJCR clearly showed proportionate and appropriate management of the patient whilst in our care. The communication particularly was highlighted as being excellent. The use of kind, clear language when discussing with the family and carers, such as,

"This patient is critically unwell, and sick enough to die…"

"We are going to help ensure that he stays as comfortable as possible in approaching the end of this life."

These are particularly important as we have seen themes over the last 2 years of poor communication with families through the SJCRs and other forms of feedback such as datix and complaints. This highlights that the teams do get it right and able to balance and explain the decisions made around the end of life pathway.

July 2024

Learning from Death (LFD) meeting in June identified no trends from the 6 SJCRs discussed within the meeting.

Concerns were raised during the meeting of the conclusions of the levels of care within the SJCR reviews. This was because as part of the SJCR process the investigator will score different parts of the patient journey; admission, ongoing care and end of life care, along with an overall score. The SJCR ID728 prompted a discussion as to why a score of 'adequate care' was given when clear evidence of poor practice was highlighted, particularly as the patient expressed a desire to not be resuscitated, a TEP (treatment escalation plan) was not discussed however due to the documentation being illegible this was not followed and so CPR was attempted. This has prompted firstly the importance of early consideration of TEPs, particularly for cardiology patients.

This discussion also highlighted the need to review the conclusions drawn within SJCRs and for improved clinician attendances to the LFD group for discussions to prompt further scrutiny over SJCRs and their assessment of care and the conclusions drawn.

5. Service developments

5.1 Learning From Deaths Report

This report has continued to evolve, and this latest version has further demonstrated the ability for the Patient Safety Team to pull off all the data from the mortality module. This report has shown that the data from the mortality module can be used to create ongoing run charts of numbers which allows for easier interpretation of data and understanding of the report content.

6. References

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

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

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

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

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

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

1. SHMI (NHSE) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to

national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.

3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

Report to:	Board of Directors
Date of Meeting:	23 October 2024
Subject:	Medical Eduction Annual Report 2023-2024
Director Sponsor:	Dr Karen Stone
Author:	Rachael Snelgrove, Head of Medical Education

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

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

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

Summary of Report and Key Points to highlight:

This report provides an overview and update on the activities, performance and quality from the training year August 2023 – August 2024.

York and Scarborough Teaching Hospitals NHS Trust support the education and professional development of 520 Undergraduate Medical Students and 420 Postgraduate Doctors in Training, alongside Locally Employed Doctors (LEDs), Speciality & Associate Specialist (SAS), Consultants and Physician Associates across all Specialities.

Undergraduate education is completed in partnership with the Hull York Medical School (HYMS), in partnership with NHSE Workforce, Training & Education (WT&E), formally known as Health Education England (HEE).

Postgraduate Medical Education within the Trust is commissioned by NHSEWT&E and the Trust acts as a Local Education Provider (LEP). NHSEWT&E is responsible for the management and coordination of Specialised and Foundation programmes in conjunction with the Speciality Schools, led by the Regional Postgraduate Dean.

Responsibility of their education and training within the Trust is led by the HYMS Clinical Dean, Prof. Vijay Jayagopal and Director of Postgraduate Medical Education, Dr Lucy

Glanfield, alongside the Head of Medical Education, Senior Educators and administrative teams on each site.

The GMC sets standards for all education and training which are benchmarked by their Quality Monitoring framework outlining the assurance process which includes the annual GMC survey for trainees and trainers, GMC and NHSEWT&E engagement and quality visits and more local school interventions when required.

The Trust has a well-developed Senior Medical Education Faculty, with Phase Leads in Undergrad and College Tutors and programme tutors in Postgrad, alongside a faculty of named supervisors across Medical Education. Training for GMC accredited Supervisors is provided in-house, alongside managing the revalidation of the GMC trainer status every 5-years. A series of Masterclasses have been developed to support educators and supervisors navigate through some of the complexities within Medical Education.

There are many areas of good quality medical education and training across the Trust. However, the GMC National Training Survey (NTS) results for Postgraduate training in 2024 revealed a number of areas of concern, in particular; local teaching, feedback and induction.

Undergraduate Medical feedback is collected through the National Student Survey (NSS) annually. Throughout the report, key themes are identified for improvement, including the desire for more structured teaching in certain specialties, challenges related to clinical exposure and hands-on experience.

Recommendation:
Trust Board is asked to note the contents of this report.

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

No ☒ Yes ☐

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

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

Meeting	Date	Outcome/Recommendation

Annual Update of Undergraduate and Postgraduate Medical Education 2023-2024

1. Purpose

This report provides an annual update on Medical Education at York and Scarborough Teaching Hospitals NHS Foundation Trust. This includes Undergraduate Medical, Postgraduate Medical and Dental, Undergraduate (student) placements and postgraduate substantive Physician Associates.

2. Medical Educational Administration and Governance

Medical Education sit within the Medical Directorate and is led by Prof. Vijay Jayagopal, Undergraduate Clinical Dean and Dr Lucy Glanfield, Postgraduate Director of Medical Education (DME). Each site then has named deputies and Educational Leads, as shown in Appendix one. The management of the service is led by the Head of Medical Education.

There are four Education Centres across York and Scarborough for UG and PG Education, managed by the UG and PG Medical Education Managers.

The Clinical Dean and Postgraduate DME, supported by the Head of Medical Education and the Medical Education Managers, manage and monitor issues arising from local processes and intelligence as well as the national surveys. They work together with Trust Teams, Deanery Heads of School, Training Programme Directors, Medical School Dean and faculty to manage challenges as they arise.

HYMS local governance is managed through the quarterly Clinical Learning and Teaching Board (CLTB) meetings, chaired by the Clinical Dean/Head of Medical Education.

Postgraduate Medical and Dental local governance is managed by the monthly Senior Education meeting, chaired by the DME.

Both meetings' assurances, quality and escalations are fed through the Head of Medical Education to the Learning, Education and Development (LEaD) committee and up to Resource Committee as required. The NHSEWT&E UG and PG Annual Self-Assessment report is reviewed at Resource Committee and approved at Board of Directors. This annual self-assessment is multiprofessional, capturing all training and education within York and Scarborough Hospital.

A risk register of educational challenges is held by Medical Education Teams. National survey results are monitored and action plans drawn-up with Specialty Leads

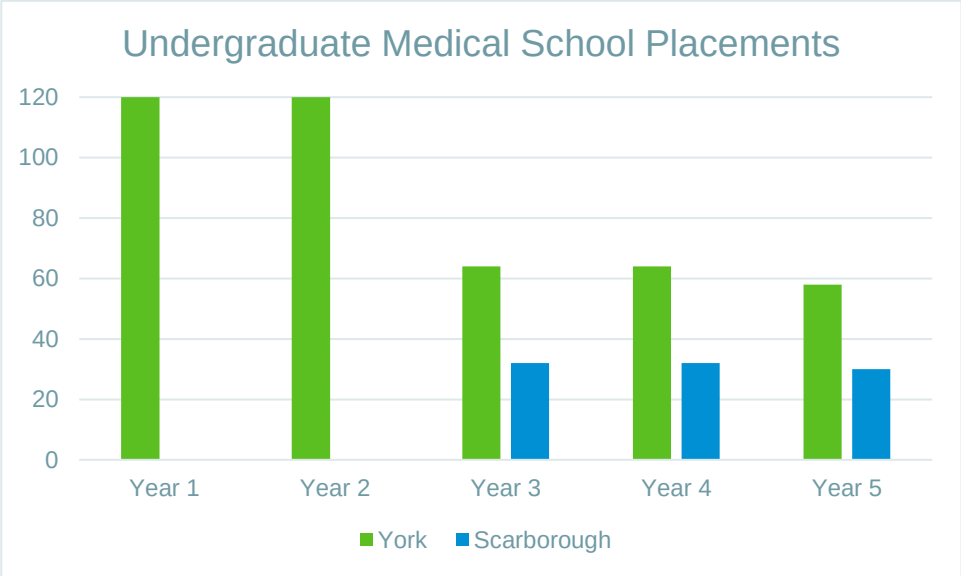
Direct interactions with medical workforce with the introduction of a bi-monthly Junior Education Forum meeting have not had the intended engagement. These meetings were designed to discuss Postgrad educational issues, concerns, or successes. A different format will be adopted for the 2024-25 academic year.

Exception Reporting by resident doctors continues against work schedules and education opportunities. Guardian of Safe Working Hours have reported 243 exception reports submitted, 6 of these were missed educational opportunities, during 2023-2024.

3. Undergraduate Medical Education

3.1. Overview

York and Scarborough hospital sites host undergraduate medical students on placement throughout the academic year. The Trust is currently hosting 520 students on placement, as shown below:



Following a 5-year National Undergraduate Medical School Expansion, the Trust has expanded its provision of clinical placements by 60%.

3.2. Areas of Note – 2023/24

The following are areas of note for 2023/24. A full list of achievements, challenges and objectives are provided in Appendix Two.

- **Administration**

During the past year the undergraduate administrative teams between York and Scarborough have been combined under central management. This has supported expansion of student numbers and has led to more effective cross-site collaboration resulting in an increase in quality and provision of training for students. By sharing best practices and utilising resources across both sites, teams have ensured all students within the Trust receive equitable and high-quality educational experiences.

Additionally, the team have successfully trialled and implemented the upcoming Medical Licensing Assessment in partnership with the Hull York Medical School Assessment team into final year clinical exams. This is a significant change and puts the team in a positive position ahead of the nationwide mandatory implementation in the next academic year.

- **Undergraduate Simulation**

As a medical school the team work collaboratively with the University of York undergraduate nursing programme to include interprofessional education into simulation sessions, constantly increasing the bank of scenarios based on real clinical events and incorporating student feedback.

Along with the expansion of student placements, the size of clinical teaching groups continues to be a challenge to accommodate for teaching and physical space. Innovative ways to teach have been established such as developing Escape Room sessions to

enhance student learning experience and utilising peer feedback to ensure standards remain high with larger teaching groups.

Following recent visits to Bridlington hospital and liaising with clinical teams, students will now have opportunity to attend Bridlington hospital to enhance their learning and achieve some of their required clinical skills. Bridlington staff are excited and looking forwards to welcoming the HYMS students learning with them.

Basic and Paediatric Basic Life Support (PBLS) was historically taught by the Trust Resuscitation team. Due to increasing workloads this was no longer a feasible option which resulted in the team upskilling our clinical teaching fellows to facilitate these sessions for both Year 3 and 4 students. The results have been positive and will be fully imbedded in the curriculum this academic year. Unfortunately, Immediate Life Support (ILS) continues to be delivered by a third party at a considerable expense, which will require ongoing review due to the financial impact incurred.

- **Research**

The Trust has two Clinical Academics in partnership with HYMS, Professor Richard Gale (Consultant Ophthalmologist) and Dr Simon Davies (Consultant Anaesthesiologist).

Through collaboration with HYMS the Trust has provided research activity time to four consultant colleagues. This investment in their time has been given on the basis of their potential to develop independent research in line with Trust and HYMS objectives.

The Clinical Skills Team are research active through the leadership of Dr William Lea. Their research includes a study funded by the MPS Foundation entitled; “Pressure Points: Identifying Patterns of Stress in Medical Students' Responses to Clinical Situations through Simulation”.

3.3. Student Feedback

The annual National Student Survey (NSS) provides Trusts with key indicators of areas for improvement and best practice. The results are given at Appendix Four.

The feedback is given across the Medical School, so it is not site specific. Consequently, some areas of feedback such as ‘organisation and management’ are challenging to interpret since feedback can relate to the University, the Trust or partner Trusts. To improve locally available data the undergraduate management team have developed a local feedback and response process. This has supported continuous improvement and has enabled the team to work collaboratively with students, the Trust, and the University, to ensure a holistic and responsive approach to meeting educational needs, addressing concerns, and continuously enhancing the learning environment.

The 2023-2024 student feedback, in conjunction with local feedback, provides valuable insights into several key themes for areas of improvement. These areas include:

- preference for more structured teaching in certain specialties,
- students getting sufficient clinical exposure and hands-on experience
- concerns regarding the balance between taught sessions and self-directed learning.

Ongoing monitoring, evaluation, and collaboration with students and faculty will remain integral to efforts to further improve the delivery of the undergraduate programme and the experience of students placed with the Trust.

In additional to the NSS, The Guardian publishes UK National Medical School rankings annually. HYMS has reached No.5 in the country out of a total of 34 Medical Schools, moving HYMS up 10 places from the 2023 results. The results are shown below:

2025	Institution	Guardian score/100	Satisfied with teaching	Satisfied with feedback	Student to staff ratio	Spend per student/10	Average entry tariff	Value added score/10	Career after 15 months	Contin-uation
5	Hull York Medical School	85.8	88.8	78.9	6.1	9	167	n/a	100	98.5

3.4. 2024/25 Priorities

Undergraduate Medical Education is ambitious for 2024/25 and focused on maintaining and enhancing the quality of clinical placements amidst a likely expansion in student numbers. The primary goal is to ensure that all students placed within the Trust have opportunity to meet their learning outcomes and gain the highest standard of experiential experiences. To achieve this, we are committed to recruiting and retaining highly qualified and enthusiastic tutors, as well as securing stable placements for students within various hospital departments as detailed in Appendix Two.

However, these goals are not without their challenges. The ongoing pressures within the NHS make it increasingly difficult to maintain continuity of experience for student clinical placements. This strain is most apparent in the recruitment of tutors, particularly for consultant-led teaching, and in providing students with the necessary clinical skills acquisition. Furthermore, these pressures may impede new curriculum developments, especially given the anticipated increase in student numbers.

In line with the recommendations in the Long-Term Workforce Plan, scoping is underway with Undergraduate & Postgraduate stakeholders to identify ways to expand the Medical & Dental workforce in 2025 and beyond.

4. Postgraduate Medical and Dental training

4.1. Overview

During the training year 2023-2024 the Trust had the below Doctors and Dentists in post:

Host site	Staff
York – Medical	273
York - Dental	6
Scarborough	136
Trustwide Resident Doctors	415

Number of doctors	Training/Grade
153	Foundation
101	Lower Tier Training
41	GP Training
5	Academic Training
115	Higher Tier Training
130	Locally Employed Doctors
130	Specialty and Specialists

In 2021 the Foundation School announced expansion for F1 & F2 posts. Over the last three years, the Trust has expanded Foundation placements taking the organisation to a total of 153 Foundation placements across sites.

All posts are located within Secondary Care services within the Trust and Foundation placements in Primary Care and Mental Health services, facilitated in partnership with Tees, Esk and Wear Valleys NHS Foundation Trust.

Over the last few years there has been an increase in the number of Postgraduate Doctors in Training opting to train part-time (Less Than Full Time LTFT). This is supported by training programmes and the Trust. Accommodating LTFT training posts brings added complexity to organise, with a financial, rota and supervision impact on the Trust. At present there are 81 Doctors in training who work LTFT.

Most Doctors in training spend 12 months in a training post. Foundation and Core Medicine programmes compromise of 4-month rotations across Specialities, whereas GP, Core Surgical and run-through programmes are 6-12 month rotations.

The 2023-2024 academic year saw 367 doctors in Postgraduate training receive successful Annual Review of Competency Progression (ARCP) outcomes which enabled them to progress to the next stage of their training. Adverse outcomes may be due to a requirement for additional training needs or completion of clinical hours. Medical Education teams work closely alongside College Tutors and Educational Supervisors to support doctors through ARCP, particularly those who need additional support or time to progress to the next stage of their training.

Each Doctor in training is assigned a GMC accredited named Educational Supervisor (ES). This is a pivotal role in medical education as the named supervisor is responsible for the overall supervision and management of a trainee's educational progress during their placement(s). The allocation of education supervision has been challenging across the year for multiples reasons:

- Capacity within medical job plans – demands on clinical time mean there are challenges to dedicate time in job plans for supervision.
- Expansion in medical workforce in terms on both trainee and non-training grades means that there are more medics requiring planned supervision.
- Specialities with long term vacancies in the senior medical workforce, for example Acute Medicine in York and Gastroenterology in Scarborough.
- Educational Supervision for 31 Foundation posts outside the trust for GP and Psychiatry.

4.2. International Medical Graduates (IMG)

In 2023-2024 Medical Education put increased focus on International Medical Graduates, who often need additional professional and pastoral support but tend to have poorer experiences and differential attainment compared to UK graduates. Through collaborative working with the International Nursing Team, Medical Education has developed a multi-professional induction for all international staff joining the organisation, which will be implemented early 2025.

These induction sessions will focus on welcoming staff to the UK and the Trust and cover some of the challenges international staff face such as communication skills, roles and responsibilities in the NHS and clinical skills.

Early 2024 also saw the establishment of the first cohort of IMG mentors, undergoing their training through the Organisational Development team, ready to be assigned to their first mentees in 2024-2025 academic year. This is a much-required resource to enable IMGs to be welcomed and supported upon joining the Trust.

4.3. Locally Employed Doctors and Speciality And Specialist (SAS) Doctors and Dentists

In addition to the Postgraduate Doctors in Training, there are 130 Locally Employed Doctors (LED) and 130 Speciality And Specialist (SAS) Doctors at the Trust. These doctors are not in formal training posts, either taking time out of training or progressing their careers through the SAS grades. These posts do not receive tariff or salary support funding from NHSE but still have development and supervision requirements. The DME and Medical Education team, along with the LED and SAS Tutors support this group of doctors.

Surgery Care group have recently established an in-house 2-year rotational programme for LEDs to achieve Core Training competencies enabling them to progress to Speciality training. This programme mirrors the formal surgical training programme and enables the LEDs to take part is structured training and educational opportunities and have the equivalent to an ARCP at the end of the programme to formally sign them off. This programme has been designed in conjunction with the Royal College of Surgeons, with the hope to use this as a template for other specialities to design similar in-house programmes.

Moving into this next academic year, work has started to develop an in-house Portfolio Pathway (formally known as CESR) programme to support LED and SAS doctors who wish to obtain Specialist registration. As a Trust there is a need to ensure there are opportunities for LED and SAS doctors to develop and progress whilst in Trust employment, and provide opportunities for progression. This is alongside workforce planning, recruitment and retention of this staff group given there are growing numbers of people choosing to progress their medical careers through SAS routes.

4.4. Postgraduate Simulation

In-situ simulation has successfully been embedded in Scarborough Maternity and Emergency Medicine. Sessions occur monthly with multi-professional teams, alongside the Simulation Lead and Clinical Educators. Scenarios involve simulated actors and moulage (special effects make-up) to bring scenarios to life. Work is already underway to implement In-Situ simulation in Acute Medicine on both sites along with widening to include other specialities.

Through the Trusts Abdominal Wall Reconstruction (AWR) unit led by Mr Chintapatla, the Simulation team worked alongside the University of York to develop research and produce a synthetic abdominal wall skin block. Using this technology and expertise within the Trust, a series of workshops have been hosted, which include opportunity for candidates to watch Surgical Teams operating in real time from the Education Centre. This is the only educational offering of this work in the UK and has proved very popular with Surgical Teams visiting York from all over the UK.

Together with Hull and NLAG the simulation team have developed a simulation network. In 2024 the Trust held its first regional Simulation conference in Scarborough and the 2025 regional conference will take place in York.

4.5. Physician Associates

This last year was a challenging year for Physician Associates (PA) colleagues nationally and locally with a significant amount of scrutiny about the scope of their roles and uncertainty about the expansion of this workforce. The regulation of PAs under the General Medical Council is expected to be in place by January 2025.

There are currently 9 PAs substantively employed at the Trust. All work at York Hospital and are based in Haematology, Orthopaedics, Oncology, Dermatology, ENT and Respiratory specialties.

The Trust has a professional lead for the PA workforce who has responsibility for support and governance of PAs alongside Medical Education and the Medical Director. A PA governance document has been produced to ensure accountability and standardisation across the PA workforce. Generic PA Job Descriptions have recently been approved and to be rolled out shortly, enabling standardisation across the Trust for the PA role, with Speciality specific addendums attached. PAs now have a distinct mandated smart scrub uniform to help provide an identify for them with staff and patients.

During 2023/24 York Hospital also hosted its first Postgraduate PA students from HYMS on clinical placement. These placements were undertaken in General Surgery and Urology, providing students with hospital experience. Feedback received from these students was outstanding and has resulted in further students requesting York as their placement.

During 2024/25 the Trust will continue to explore in partnership with HYMS the future direction of the PA education programme, including potential to expand PA placements and substantive roles within the Trust.

Faculty and Supervision

All named educational and clinical supervisors are required to fulfil the GMC accredited training requirements, of which training is provided in-house. Alongside this training each named supervisor has a requirement to undertake Equality, Diversity and Inclusion eLearning and have an annual appraisal.

A deep dive was started last academic year, and continues into this academic year, to identify & train all ESs to meet GMC Trainer accreditation requirements. This has ascertained that there is a proportion which do not have all elements of the requirement fully completed. Work has begun to improve this position with regular training session on each site. To date there are 315 Consultants and SAS GMC accredited supervisors, of these 65% are currently active supervisors. The remaining 35% may not be currently active due to capacity within job plans, part time working or are supervising trainees at other sites.

Each Speciality has a named College Tutor who is the interface between the Specialty School and the Trust. Medical Education host quarterly off-site College Tutors updates enabling the Tutors to network, share best practice and receive educational updates. Each College Tutor receives an annual appraisal by Medical Education which informs their Trust appraisal. 100% of College Tutors completed appraisal in 2023-2024.

A series of Educational Supervisor Masterclass workshops have been established, proving a refresher in good practice, finance and hot topics such as LTFT, importance of induction, neurodiversity, International Medical Graduate support and Returning to Training.

5. Medical Education Finance

Medical Education is funded through the National NHSE Educational Contract, which covers all clinical placement activity in England.

Annually, the Trust receives £6m for Undergraduate Medical Education and £11m for Postgraduate Medical and Dental Education.

Two thirds of the Postgraduate funding is allocated for trainee salary support, funded at 50% base salary. The remainder compromises of a placement fee per trainee for delivery and provision of training and education without out Trust.

The placement tariff covers funding for all direct costs involved with the delivery of Education, as detailed in appendix three.

6. Medical and Dental Study leave

Medical and Dental study leave for Consultants, SAS and LEDs is facilitated by the Medical Education Team. Consultant and SAS Doctors and Dentists have a 30-day and £3000 study leave allowance over a three yearly cycle. LED study leave is calculated upon start date and individuals are entitled up to 15 days and £500 per 12month cycle, plus funding to support Advanced Life Support training if required.

During the last study leave cycle (April 2021 – March 2024) Medical Education received 3,156 applications and claims to the value of £670,200, highlighted in the table below;

April 2021 - 2024	
Consultant	
Study leave applications	2311
NHS leave applications	267
Estimated costs	£690,425.59
Claimed costs	£531,127.37
SAS	
Applications	578.00
Estimated costs	£157,227.00
Claimed costs	£139,073.00

A new Study leave system for Consultants, SAS and LEDs is currently being established, for implementation in April 2025. This will change from the current paper-based system to an electronic system. As part of this project there will be a refreshed Study Leave Policy and a system for expenses to be claimed in-advance of attending study.

7. Education Quality and monitoring; National Student Survey (NSS) and the GMC National Training Survey (NTS).

Each Spring the GMC run a National Training Survey (NTS) to gather information to understand the experiences of doctors in training posts and their trainers from across the UK. It is the largest annual survey of doctors in the UK. Doctors in formal training posts, along with their Educational and Clinical Supervisors are invited to take part in the survey. The survey is used by the GMC to monitor and report the quality of Postgraduate Medical Education and Training.

Where education and training is considered as below national standard the GMC may work with local NHSE Workforce, Training and Education departments and Trusts to open conditions to monitor quality and provide support to ensure high quality training and education is achieved. At present, and for a number of years, York and Scarborough Trust have had no open conditions.

This year there were 255 doctors in training posts and 95 trainers (named educational or clinical supervisors) from the Trust who completed the survey. This is just over half the doctors in training but 95 trainers out of 225 active trainers across the Trust.

There are several specialities for which there is no data supplied as the survey participants were below 3. Work will be undertaken to engage these specialities, many being within General Medicine, to ensure feedback is received next year to inform the future of Medical Education at the Trust.

As highlighted in Appendix Five, the Trust's overall NTS results against all domains are, all but one, within the National Interquartile Range (IQR). The outlier, which has shown a decline three years in a row sits under Adequate experience. Local teaching has been highlighted in previous years as below IQR whereas this year it has slightly improved to be within National IQR.

Site and specialty specific observations are summarised as follows:

- Radiology – results have consistently excelled over the last 4 years, having consistent above average IQR ratings. In particular to note in this year's results, an increase to 100% satisfaction with clinical supervision out of hours. Apart from one domain all areas for Radiology have scored above 71%.
- General Surgery – this specialty has had challenges in recent years. Significant work has been undertaken in the last 12-months on rota design, access to training opportunities and workload. Improvement is demonstrated in this year's NTS with an above IQR score for General Surgery Scarborough workload at 57%.
- Local teaching – across most specialities there is poor feedback for this domain. Many Higher Speciality trainees in the Trust have weekly regional teaching rather than local departmental teaching, but there is improvement to make within the Trust. Work is underway with specialities to review teaching opportunities and increase engagement and advertise opportunities in teaching for new and existing senior medical staff.
- Acute Medicine (York) - is a known ongoing challenge with high clinical workloads and consultant vacancies resulting in a lack of access to teaching and supervision. Plans are in place to mitigate these challenges over the next 12months including continuation of consultant recruitment.
- Intensive Care Medicine – this is a new area of concern in the 20224 NTS. There are several below IQR domains, with significant decline in some areas, for example teamwork scoring 75% in 2023 and 58% in 2024. Work is underway with the department and College Tutor to establish opportunities for improvement and understand more about resident doctors' experiences.
- Obstetrics and Gynaecology - Scarborough O&G has declined in some areas, going from above IQR to within, but in York 7 domains have declined to below IQR, with a significant drop in overall satisfaction, rota design and local teaching.
- Vascular (York) – this specialty has scored a triple red in rota design. This metric has shown a steady decline over the last three years. Results show there has been

an increase from 2023 at 15% to 2024 at 28% but this is still below national IQR. Engagement is underway with the department to understand more about the reasons for this decline.

8. Forward look to 2024-2025

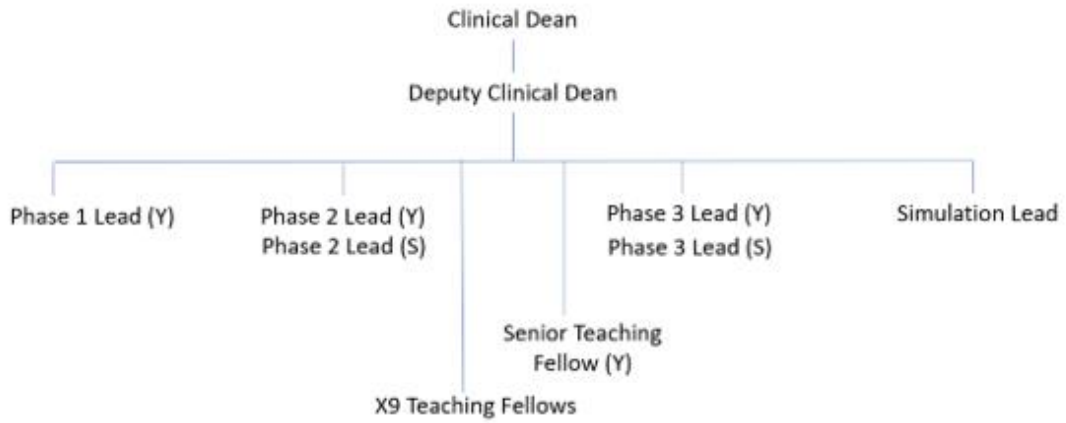
The 2024-2025 academic year includes the second round of Medical School and Postgraduate expansion in line with the recommendations in the Long-Term Workforce plan. Work is actively underway with Care Groups and Senior Medical Leaders to ensure robust plans are in place to be in a position to expand whilst retaining high quality placements, supervision and training opportunities.

Collaborative working has started to review the recommended actions in the 'Improving the working lives of doctors in training'. Some actions have already been met but a collaborative approached across Education, Medical Employment and Workforce planning will be required to achieve and sustain change to improve conditions and experiences for doctors.

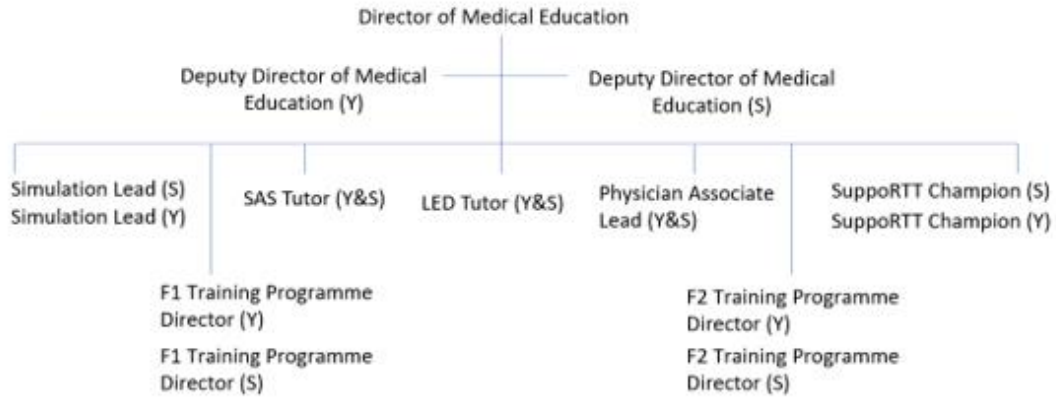
Amongst the challenges it is important best practice and excellence is celebrated and shared with colleagues across the Trust. Medical Education are looking to host the first multi-professional celebration of education in the Spring of 2025, showcasing all areas of excellence in education and learning.

Appendix One

Undergraduate Senior Team



Postgraduate Senior Team



Appendix Two – Undergraduate Achievements, Challenges and Objectives

Undergraduate Achievements:

- Running a successful undergraduate programme that consistently receives some of the best student feedback for any of the HYMS sites.
- Improving quality and consistency of training year on year.
- Engaging clinicians and the wider healthcare team in medical education despite the increasing challenges outlined in the section below. We continue to retain and recruit new consultant tutors throughout all phases. With several consultants having regular HYMS teaching in their formal job plans this has allowed for consistency of teaching but also for attractive job plans, helping recruitment.
- Organising and running on site clinical exams for phase II and phase III students.
- Running a successful group of 9 full time teaching fellows, offering a robust appraisal, feedback and observation process in addition to excellent pastoral support. With our support most of our teaching fellows are able to complete a PGCert in Medical Education and are successful in their Specialist Training applications.
- Successfully introducing several new Simulation and Virtual Reality teaching session across year 3, 4 and 5.
- Running a pioneering Simulated Hospital course, SHaRP, that enables year 5 students to be better prepared for their first Foundation placement.
- Setting up and maintaining a formal pastoral care system to take students from year 1 to their first medical job with the necessary formal and informal support if and when required.
- Introducing formal resilience sessions for Phase II students led by a Trust psychologist.
- Expanding and formalising the Assistantship period to ease the ‘cliff-edge’ transition to first medical job.

Undergrad Challenges:

- To continue to be able to provide outstanding undergraduate education to all our students given increased student numbers in recent years. Across a whole academic year we now accommodate up to 120 different year 1 students, 120 year 2 students, 128 year 3 students, 128 year 4 students and 174 year 5 students. Ward learning and teaching opportunities are therefore at a premium and are only going to get more in demand.
- Space – the current space in LaRC is not sufficient. There is no more space than when HYMS started, and now there are significantly more students, support staff and teaching fellows. We need lecture theatre capacity for whole year groups, sufficient number of rooms to facilitate multiple small group teaching at one time, dedicated space for teaching fellows and dedicated space for management and clinical skills staff.
- To maintain teaching by senior clinicians and other healthcare professionals as they become increasing busy with clinical work.
- To continue to be able to have formal HYMS sessions in Consultant/SAS job plans to enable ring fenced teaching time.
- To continue to attract good teaching fellows to the teaching programme

- To be able to give students the continued academic and pastoral support they need in ever challenging times.
- To maintain a reliable supply of patient volunteers to enable clinical examinations to continue to be representative and differentiating

Future objectives:

- To widen student participation in the SHaRP course
- To widen tutor participation in all activities outside of direct teaching e.g. OSLER assessments, educational supervision, OSLER and OSCE examinations and in tutor training events
- To replace several experienced outgoing senior clinical tutors with experienced clinicians
- To be able to peer review as many existing tutors as possible.
- To maintain current faculty, SLO staff, management and clinical skills staff to ensure continuity going forwards.
- Strengthening simulation and virtual teaching to complement face-to-face teaching in the context of increasing demand and numbers.

Appendix three

The Placement tariff for 2023- 2024 as per the Department of Health and Social Care:

Type of Placement	Original tariff for placement activity in 2023 to 2024	Additional uplift following pay deals	Revised tariff for placement activity in 2023 to 2024 tariff
Medical undergraduate (all placements)	£31,937 plus MFF	2.0%	£32,552 plus MFF
Medical postgraduate	£12,398 plus MFF Plus a contribution to basic salary costs. See Annex A. See paragraph 7.9 for further information on separate funding arrangements for study leave.	2.0%	£12,637 plus MFF Plus a contribution to basic salary costs. See Annex A. See paragraph 7.9 for further information on separate funding arrangements for study leave.

Medical Education Tariff funding:

- Direct staff teaching time within a clinical placement
- Teaching & student facilities, including access to library services
- Administration costs
- Infrastructure costs
- Educational supervision
- Pastoral and supervisory support
- Trainee study leave and time for clinical exams
- Health and well-being (excluding any occupational health assessments that are carried out by the university and funded separately)
- Course fees and expenses (as required to achieve professional registration)
- Student or trainee accommodation costs (medical undergraduate tariff only)
- In-course feedback and assessment
- Formal examining

Appendix Four - National Student Survey results 2023 and 2024

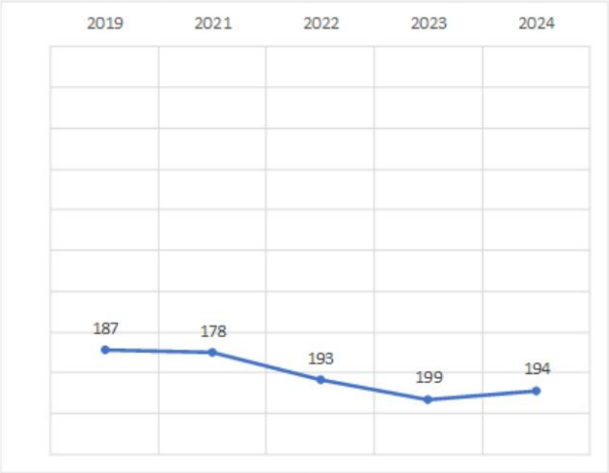
NSS Questions (% Agree)	2023	OfS Medicine sector bench mark 2023	2024	OfS Medicine sector bench mark 2024	2023 question ranking among UK medical schools	2024 question ranking among UK medical schools
Teaching on my course	84.73	85.60	91.83	85.45	26 out of 37	10 out of 37
Learning opportunities	82.30	80.90	85.73	82.42	18	9
Assessment and feedback	76.11	67.60	81.07	78.30	8	5
Academic support	73.45	80.00	85.00	85.57	31	16
Organisation and management	39.82	54.30	43.00	75.30	30	30
Learning resources	84.23	83.80	83.33	87.00	22	16
Student Voice	65.48	65.00	71.11	74.01	24	11
Student Union	56.70	68.40	72.13	72.91	NA	16
Mental wellbeing services	81.08	78.80	93.88	78.58	NA	2
Freedom of expression	72.73	77.20	74.31	86.44	NA	NA
Response rate (%)	73%	72%	68%			

Appendix five

GMC NTS 2024 Trust overview (trainees)

UK-Wide Rankings by 2024 Trusts are ranked 1-230	194	**Eng Rankings by 2024** Trusts are ranked 1-199	179	**Local Rankings by 2024** Trusts are ranked 1-21	17

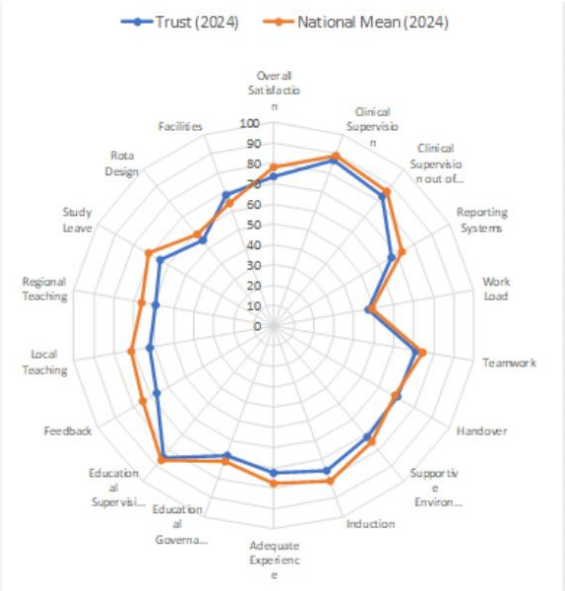
Long-term UK-Wide Overall Ranking



UK-Wide Ranking by Indicator (2024)

Indicator	Rank	Out of
Overall Satisfaction	190	230
Clinical Supervision	181	229
Clinical Supervision out of ho	175	223
Reporting systems	203	228
Work Load	141	230
Teamwork	181	226
Handover	81	222
Supportive environment	169	230
Induction	207	230
Adequate Experience	205	230
Educational Governance	188	230
Educational Supervision	160	230
Feedback	207	228
Local Teaching	211	229
Regional Teaching	204	229
Study Leave	195	230
Rota Design	171	223
Facilities	56	227

Trust score compared to national mean (trainees)

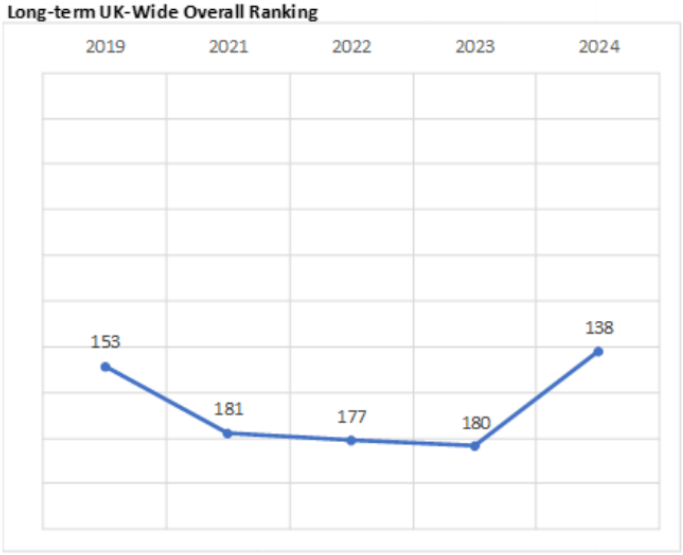


Indicator	Trust	National Mean
Overall Satisfaction	73.39	77.71
Clinical Supervision	86.71	89.13
Clinical Supervision out of ho	83.36	86.55
Reporting systems	67.02	72.68
Work Load	47.08	48.82
Teamwork	71.17	74.62
Handover	70.18	68.92
Supportive environment	71.59	74.69
Induction	75.78	81.02
Adequate Experience	72.46	77.75
Educational Governance	67.75	71.22
Educational Supervision	84.54	86.3
Feedback	66.75	74.31
Local Teaching	61.8	71.27
Regional Teaching	59.4	65.92
Study Leave	64.42	71.34
Rota Design	54.7	58.65
Facilities	68.63	63.9

GMC 24 NTS Trainers survey overview

UK-Wide Rankings by 2024 Trusts are ranked 1-226	138	**Eng Rankings by 2024** Trusts are ranked 1-196	122	**Local Rankings by 2024** Trusts are ranked 1-20	13

Long-term UK-Wide Overall Ranking



UK-Wide Ranking by Indicator (2024)

Indicator	Rank	Out of
Supportive Environment	156	226
Educational Governance	129	225
Professional Development	104	226
Appraisal	148	226
Support for Training	95	226
Time to Train	63	226
Rota Issues	168	224
Handover	71	220
Resources to Train	192	226

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	23rd Oct 2024
Subject:	Research & Innovation New Strategy 2025-2028
Director Sponsor:	Dr Karen Stone, Medical Director
Author:	Lydia Harris, Head of Research and Innovation

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:

We have had another great few years in R&D and we have a lot to be proud of. Now its time for our next strategy that will now incorporate Innovation and run from 2025-2028 and has been created alongside the Trust new strategy so they are complementary.

Recommendation:

The Board of Directors considers the new Research and Innovation strategy and approve its content.

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

No ☒ Yes ☐

Report History

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

Meeting	Date	Outcome/Recommendation
N/A	N/A	N/A

New Research & Innovation Strategy 2025-2028

1. Introduction and Background

The R&I Department is a department that facilitates and delivers research and innovation across all our Care Groups, on most of our sites, with research teams based in York, Scarborough, Laboratories and Pharmacy. We have had some great achievements over the past three years from our previous strategy that have been relayed to the Board of Directors annually.

This report now presents our next strategy that will now incorporate Innovation and run from 2025-2028 and has been created alongside the Trust new strategy so they are complementary. In addition, many internal and external stakeholders were encouraged to review the draft R&I strategy over the past three months, during its creation and all comments have been incorporated, where possible.

2. Current Position/Issues

2.1. Trust Overview

The R&D department, has now become the R&I Department (Innovation), this is because our Trust are being noticed regionally for our innovative activities (such a workforce initiatives, James Turvills ColoCap study and Daisy, the A&E robot). As such the ICS requested that we showcase our innovation more, in this new Research and Innovation strategy.

As part of our new R&I strategy we have a new mission and vision that are as follows

Mission
To create a healthier future for our community and beyond through research, collaboration, and innovation, leading to a healthier future for our patients.

Vision
To bring research opportunities to all our patients and staff.

This strategy will be implemented and delivered by working closely with our care groups, Lead nurse for research in Nursing & Midwifery, Head of AHP research, lead collaborators and stakeholders (internal and external), and a core group will meet quarterly to drive the work packages forward.

2.2. Our Objectives

We have designed our new R&I strategy around five key objectives, as follows.

- **Workforce** We will develop our workforce ensuring it is central to everything we wish to achieve over the next few years.
- **Infrastructure** We will work with our Care Group Leads and Executive Team to develop our research infrastructure and capacity.
- **Collaboration** We will foster new relationships and build on pre-existing collaborative partnerships to strengthen our research and innovation portfolio.
- **Excellence** We will deliver research excellence and innovation both commercially and non-commercially.

- **Finance** We will secure sustainable funding for future research activities.

  These objectives will form the framework of our strategy action plan and work packages, through which progress will be monitored and reported.

3. Next Steps

Once this R&I strategy is approved by yourselves, an action plan will be created to deliver work packages to assist with our five key objectives.

Annual updates will be provided to the Board of Directors against each of these objectives.

Date: 14th October 2024

Kindness Openness Excellence

York and Scarborough Teaching Hospitals
NHS Foundation Trust

2025–2028

Research & Innovation Strategy

Table of Contents

Foreword

We are proud to share our next Research Strategy for 2025-2028.

Research and Innovation is an integral part of our plans at York and Scarborough Teaching Hospitals NHS Foundation Trust. Being research active brings lots of positives to our organisation; we know that research-active hospitals provide higher quality care, can attract commercial and non-commercial income, and support recruitment and retention across professions. As Trust leadership we are committed to the wider benefits which being engaged in research can bring to the health of the nation and the effective working of the NHS.

Our vision for Research and Innovation at the Trust is simple: to bring research opportunities to all our patients and staff.

This strategy builds on the notable achievements across our Trust over the past ten years. We have areas of significant strength; 4,000 patients a year recruited into trials, a growing commercial research arm, major NIHR studies hosted, and growing investment in research infrastructure. For a Trust of our size, these and other strengths mean we are high achievers for research and innovation.

Delivering top quality care for our patients is our business, and being an organisation that supports research and innovation, alongside our excellent patient care makes us an excellent organisation to work in and be cared in.

York and Scarborough is a great place for growth in research and innovation over the next 4 years. We have an innovative and active Research and Innovation department which is well connected to academic partners. There are research-active staff across professional groups and specialties. We have clinical leaders who are at the cutting edge of innovation and research in specialties such as gastroenterology and ophthalmology. Our geography covers coastal, rural, and urban areas with a range of socio-economic and demographic attributes.

We are excited to work with our patients, carers, staff, and partners in implementing this strategy.

Simon Morritt
Chief Executive

Dr Karen Stone
Medical Director

1.0 Introduction

This document sets out the strategic direction for Research and Innovation for York & Scarborough Teaching Hospitals NHS Foundation Trust for 2025–2028 all focussed on our mission and vision.

Mission

To create a healthier future for our community and beyond through research, collaboration, and innovation, leading to a healthier future for our patients.

Vision

To bring research opportunities to all our patients and staff.

We are a Research and Innovation active acute and community care 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 - an area covering 3,400 square miles.

We manage eight hospital sites and have a workforce of around 10,000 staff working across our hospitals and within the community. Our population faces particular health challenges that have historically been under-represented in terms of research activity.

The size and structure of our Trust and our catchment population bring opportunities for us to deliver meaningful clinical research and innovation to this population. We have patient cohorts in coastal, rural, and urban areas with a mixture of backgrounds including, differing health accessibility, health engagement, as well as varied socio-economic and demographic characteristics. Our existing close collaborations with our stakeholders and academic partners means that we are an excellent Trust and community in which to conduct research and innovation. This is demonstrated through our Trust having recruited over 50,000 patients to clinical trials in the past 12 years.

2.0 Review of activities from the last strategy

In the last three years the Trust has achieved some excellent research and innovation outputs that we feel really demonstrate our Research and Innovation department's capabilities, alongside the enthusiasm and commitment of our workforce for developing and delivering research and innovation. This has included ideas from our home grown locally developed research.

Our key highlights as a centre of excellence in research development, delivery and innovation are as follows:

2.1 Research Activities

01

Clinical Academics

In acknowledgement of their continued participation in the academic activities of Hull York Medical School (HYMS), Professor Richard Gale (Consultant Ophthalmologist) and Dr Simon Davies (Consultant Anaesthesiologist) have both been awarded clinical academic status.

02

Clinical Directorship

In acknowledgement of his continued participation in the academic activities of HYMS and impressive gastroenterology research portfolio, Professor James Turvill has been appointed to a personal chair at HYMS, the Trust Clinical Director of Research and Innovation, and the regional Clinical Research Network for SPED Lead (Screening, Prevention, and Early Diagnosis).

03

Research and Innovation in Scarborough

We have created the new Scarborough Coastal Health and Care Research Collaborative (SHARC) based in Scarborough Hospital to work alongside the community with multiple health and care needs. The research hub was established to champion research on the Yorkshire Coast and to increase our capability and capacity to conduct research and innovation in Scarborough.

04

Continued Collaboration

We continue to grow strong collaborations with the Institute for Health and Care Improvement at York St John University, and SeeChange (Voluntary, Community, and Social Enterprise in Scarborough). This has funded joint research posts and PhD studentships to strengthen these research relationships.

05

Dedication to Innovation

We continue to work innovatively to provide research development opportunities and mentoring for all our staff and have offered PhDs, Masters qualifications, research nurse bank and secondment opportunities throughout the years.

06

Increased Research Activity Time

Through our collaboration with HYMS we have provided research activity time to several consultant colleagues who are looking to develop Trust research for the future.

07

Critical Friend Review

We undertook a critical friend review of our Trust's research activity with another Trust in the region of similar size and learned from their feedback.

08

Continued to Communicate Metrics

We have ensured that our research metrics are reported at Trust Board level and Care Group level regularly, to evidence research activity and value for money.

10

Continued to Grow Sponsorship

We have grown our sponsorship activities even further to support our home-grown researchers, to harness and support the expertise of researchers.

11

Substantially Increased Grant Applications

We routinely submit five times more research grant submissions than in previous years, with many applications being successful and funded.

2.2 Delivery Activities

01

Recruited 12,000 Patients into Trials

Over the past three years we have recruited approximately 12,000 patients into clinical trials, these include several COVID-19 trials and a COVID-19 vaccine trial.

02

Secured a Dedicated Research Space

We have secured dedicated research space to see research participants in, at both our Scarborough and York sites.

03

Helped to Shape National Policy

We recruited 60 children to the Harmonie vaccine study under Dr Dominic Smith. The study investigated Respiratory Syncytial virus (RSV), one of the leading causes of hospitalisation in all infants worldwide and affects 90% of children before the age of two. The study found that 80% of hospitalisations can be prevented with this vaccine. In 2023, the Joint Committee on Vaccination and Immunisation (JCVI) advised that an RSV immunisation programme should be developed in the UK, thanks to this trial.

04

Continued Public Involvement

We have strengthened our research lay panels and ensured they are well trained and supported to assist with our research endeavours at both York and Scarborough.

05

Top 10 Nationally for Recruitment

Over the last three years we have consistently ranked within the top 10 highest nationally recruiting Trusts for Gastroenterology and Ophthalmology.

2.3 Innovation Activities

01

The ColoCap Study

We have won our biggest research grant to date via Professor James Turvill's NIHR bid, receiving just over £3.0m to evaluate colon capsule endoscopy across England, Scotland, and Wales — the ColoCap study. This study started set up in April 2024 and runs for three-and-a-half years. This will see our Trust lead a study of national importance across 30 sites.

02

Strategic Recruitment

We have recruited a Commercial Research Manager and a Grant Writer, two strategic posts that have seen our research activities grow.

03

First Global Recruitment

Our commercial research portfolio continues to grow and in 2023/2024 we gained a 1st Global recruit, a 1st European, and a 1st UK recruit to commercial studies.

04

1,000 BaBi York and Scarborough Participants

We have opened the long-term BaBi (Born and Bred in) York & Scarborough study; all mothers and babies born in York and Scarborough are eligible to participate. This study captures routine data from all babies born in our Trust, which will later be joined up with wider linked data sources throughout the child's development. We have already started collaborative work with researchers and other health and care partners to prioritise the use of the BaBi data set to inform future research and commissioned services.

05

The DAISY Robot

We have supported homegrown innovation, including the DAISY project. This is a Diagnostic AI system for a Robot-Assisted A&E Triage robot that will be trialled to collect its first real-world data in Autumn 2024.

Our Research and Innovation Strategy 2025-2028

Workforce Development

Provide training opportunities to all staff, ensuring career development in research roles.
Increase the number of staff participating in research career pathways (e.g., PhDs, MScs, internships).
Develop and fund hybrid research/clinical roles to integrate research into daily practice.
Create research champion roles across departments to foster engagement.
Promote research opportunities at recruitment and staff on-boarding stages.

Research Infrastructure

Expand digital health capabilities to support clinical trials and data collection.
Establish SHARC, a dedicated research centre at Scarborough Hospital, to address health inequalities on the Yorkshire Coast.
Build a commercial research team to improve study setup times and increase participation in global studies.
Develop a Safe Data Environment for research applications and data sharing within the Integrated Care Board (ICB).

Financial Sustainability

Pursue external grants and commercial research opportunities to fund innovation.
Increase commercial research income through expansion of our commercial portfolio.
Improve EDGE system usage for invoicing and financial tracking to ensure timely and accurate distribution of funds.
Apply for innovation grants (e.g., Innovate UK) to support cutting-edge research and technology development.

Collaborative Partnerships

Deepen partnerships with our academic collaborators to drive our research and innovation projects.
Collaborate with Contract Research Organisations (CROs) to attract more commercial research opportunities.
Strengthen ties with local universities and fund PhD studentships to boost innovation.
Develop partnerships with the Voluntary Community and Social Enterprise (VCSE) sector to engage hard-to-reach communities.

Research Excellence

Deliver high-quality research recognised through peer-reviewed publications.
Grow sponsorship activities to support internal researchers and ensure regulatory readiness.
Continue to recruit patients for clinical trials and ensure their involvement in setting research priorities.
Strengthen the communications strategy for disseminating research outcomes across various platforms.
Promote innovation in healthcare by supporting new ideas and research-led solutions.

3.0 Our Objectives for 2025–2028

These achievements have occurred in the face of our Trust facing significant operational challenges in terms of workforce recruitment and retention, quality and safety in the care we deliver, acute and emergency care provision and the recovery of elective services. This research strategy recognises these difficulties and outlines our objectives which will contribute to the path the Trust is taking to address these challenges.

The Research and Innovation Department is in a unique position to support the Trust in the delivery of its strategy, building on the opportunities, investment and track record of recent years.

The overarching objectives for this strategy are to commit to 1) the development of the workforce, 2) research infrastructure, 3) building collaborative partnerships, 4) research excellence, and 5) increased research finance. The measures for these deliverables will be excellence and financial accountability. These will form an action plan that will be a working document to run alongside this strategy.

These objectives align with our local Universities' and Institutes' research objectives and the Integrated Care System's refresh policy of 2024, that states they wish to drive delivery improvement through research and innovation.

Workforce

We will develop our workforce ensuring it is central to everything we wish to achieve over the next few years.

Infrastructure

We will work with our Care Group Leads and Executive Team to develop our research infrastructure and capacity.

Collaboration

We will foster new relationships and build on pre-existing collaborative partnerships to strengthen our research and innovation portfolio.

Excellence

We will deliver research excellence and innovation both commercially and non-commercially.

Finance

We will secure sustainable funding for future research activities.

3.1 Workforce

Development of our workforce is central to everything we want to achieve over the next few years. We see it as the fundamental shift that is required within our Trust to take the research delivery within our hospitals and community to the next level.

We wish to work with senior colleagues within our Care Groups and Executive Team to create a research skilled workforce across all our professional groups (nurses, midwives, AHPs, and consultants for example), rather than just in the medical workforce.

To do this we need to think innovatively to offer creative and attractive job opportunities with research time allocated, which will bring a research active work force into our hospitals. We need to retain and attract talented clinical staff to support our research and innovation agenda at our Trust.

We will work with our Care Groups and Executive Team colleagues, to develop research career pathways that offer and support career development opportunities to our staff, and to support them to understand how they can embed research and innovation in their everyday roles.

This will include opportunities such as:

- Associate Principal Investigator schemes
- AHP and Nurses and Midwives (Inc. Student Nurses) research development opportunities
- Academic Clinical Fellow schemes
- NIHR career development schemes
- MSc and PhD opportunities
- Strategic Consultant appointments
- Research champion roles
- Developing our research bank to be multi professional and disciplinary
- Internships and Apprenticeships
- Further develop the Clinical Research Practitioner role

We will provide and support training and professional development opportunities in research for our staff by utilising national and regional training courses (and funding schemes). We will also create online resources such as training modules, that can be accessed freely by all our staff.

We will ensure opportunities for research career development are advertised widely and are easily accessible to all staff, and will work with our Care Group operational teams to ensure they know of the different roles and opportunities available to their staff.

We will embed research and innovation opportunities into every stage of workforce career development in the Trust. We will focus on a joined-up approach that takes us from trainee support to growing our own researchers through to attracting and nurturing potential researchers for the Trust.

This will affect the way we advertise for substantive posts in all areas, subsequently interview and induct appointees, and support their onward career development through job planning and appraisal.

Innovation is also important to embed into our research, so staff feel empowered to innovate in their place of work, and work with the Research and Innovation Team to deliver innovative projects to our patients. This will include such opportunities as:

NHS CLINICAL ENTREPRENEUR PROGRAMME

Access to NHS Clinical Entrepreneur Programme

Innovation Champion Network

Medipex Innovation Champion Network

Humber and North Yorkshire Health and Care Partnership

Participation in Humber & North Yorkshire ICB IRIS Innovation Community of Practice

Health Innovation Yorkshire & Humber

Access to Medipex and Health Innovation Yorkshire & Humber Introduction to Innovation Workshop

3.2 Infrastructure

We will work with senior colleagues within our Care Groups and Executive Team to further develop the research infrastructure we already have in place within our Trust, across all our hospital sites. This is key to building capacity and capability to develop and deliver research and innovation across our Trust. This will include an operational framework to support our research active workforce.

Our priority within this objective is to grow our research and innovation on the Yorkshire Coast to address the health inequalities seen there. We will secure a physical site for a dedicated Research and Innovation Centre within Scarborough (preferably at the Scarborough Hospital site), that will house our research team, and offer dedicated research facilities for our researchers and the community. Integral to this development is to further develop the research infrastructure within the Voluntary Community and Social Enterprise (VCSE) sector of Scarborough, and to widen our community research champions effectively. This will allow us to build on our strengths, develop research themes and support research opportunities including collaborations with partners and commercially funded research.

Commercial Research

We will create a bespoke commercial research team, that will be housed alongside our Care Group research nurses, but they will solely work on commercial research. This will speed up our commercial study set up time (crucial to commercial companies) even further to increase our credibility with commercial partners as well as offering local patients access to novel treatments. We will aim to gain more 1st Global and 1st European recruitment opportunities and increase overall commercial activities which will also generate more financial income streams into the Trust.

Digital Health Technologies

We will learn to embrace digital health technologies further and promote research, innovation, and transformation in healthcare.

Born and Bred In: York and Scarborough

We will develop further and capitalise on the data collected from the Born and Bred in (BaBi) study being run at both York and Scarborough sites babi-study (yorkhospitals.nhs.uk). This will see us working regionally and nationally to support the development of a Safe Data Environment (SDE) across our Integrated Care Board and to develop collaborations and grant applications to utilise the data we collect in research applications. The BaBi dataset is an innovative project as it will generate new insights, which in turn fuel new research questions, motivations for funding, research studies, and subsequent outputs to better deliver our services. This in turn generates more data and interest in BaBi, fuelling a virtuous cycle of research and innovation projects to better our care.

BORN & BRED IN
York and Scarborough

3.3 Partnerships

We will continue to develop strategic collaborations and partnerships, to purposefully strengthen our research portfolio, and to remain a trusted partner for our collaborators to work with. These will be based on the opportunities brought by our workforce and infrastructure, and our commitment, to bringing research to our community.

We have already built up a large network of partners we work with, and we will continue to strengthen these relationships by creating and writing new grant opportunities: York and Scarborough Teaching Hospitals NHS Foundation Trust Research & Innovation Department - Our Partners (yorkhospitals.nhs.uk). We will also go wider and include any new research entities that may come into the research field (such as Health Determinants Research Collaborations (HDRCs), and the Yorkshire and Humber Research Delivery Network (RDNs). We will also reach out to new partners to support BaBi initiatives and ideas.

Strategic Alliances

Strategic alliances will be built with Contract Research Organisations (CROs) and Pharmaceutical companies, to ensure we capitalise on all the commercial opportunities we can, and to retain our excellent track record of commercial research delivery. We will strive to make the Commercial Research Team within our hospital regionally and nationally recognised as the place to go for commercial research.

SHARC

The Scarborough Coastal Health and Care Research Collaborative (SHARC) is critical to our research development on the Yorkshire Coast. As such we need to continue to grow our strategic partners with Scarborough and its rural surroundings. We need to continue to develop our relationships with York St John University and VCSE contacts. We will support, develop, and fund PhDs with our local universities and Research Fellows under SHARC. We also need to strengthen our links in primary care so we can offer innovative research delivery options to the community and support vaccine trials within our region.

Patients are always included in our research development and ideas and as such we have already developed two research lay panels, one for York and one for Scarborough. Their involvement will continue, and we will strengthen their involvement, especially on the Yorkshire Coast as SHARC develops over the coming years.

SHARC
Scarborough Coastal Health and Care Research Collaborative

Our Partners

We also have many partners supporting us in our innovation work, including many collaborations with the University of York and York St John University (supporting multiple innovation projects), Medipex, Health Innovation Yorkshire and Humber and our strategic partnerships with Innovation, Research & Improvement System (IRIS) at Hull and North Yorkshire Integrated Care Board. We will continue to develop and strengthen our innovation opportunities with these partners throughout the coming years.

3.4 Excellence

We will continue to develop and deliver excellent research and innovation, and to be a centre of excellence for our research delivery, both commercial and non-commercial. We will continue to support clinical trials and evidence-based practice by facilitating participation in clinical trials across the Trust. We will also continue to grow our sponsorship activities and ensure we are an effective and thorough sponsor organisation which supports our home-grown researchers. We will continue to provide assurance to our Executive team around Care Quality Commission (CQC) research standards and Medicine and Healthcare Regulatory Agency (MHRA) regulatory requirements and GCP inspection readiness.

Community

We will work with our community to develop research ideas that meet the community healthcare needs of our population. We will do this through a series of research prioritisation exercises that will involve a wide range of stakeholders, and our patients and our community. Once research priorities are identified these will be worked on with our partners to develop grant submissions.

We will develop and promote mechanisms to support home-grown innovation; supporting research initiatives, and promoting innovative solutions to healthcare challenges. We will provide resources and support for staff to explore new ideas.

External Research

We will continue to develop a clear external research profile, through a wide range of communication and dissemination activities and we will support dedicated posts within Research and Innovation to act as our communications officer and develop them to ensure they can utilise all formats in our communication endeavours.

ColoCap

Finally, we aim to strengthen our Innovation portfolio by creating, developing and adopting evidence-based innovations to deliver our care and we will create and disseminate the evidence to demonstrate the benefits of colon capsule endoscopy (ColoCap Study).

3.5 Finance

Securing sustainable funding for future research activities is critical to our future success. Our strategy both recognises the financial difficulties facing our Trust and the opportunities that it can bring.

Through our excellent clinical trial delivery, we will continue to receive our Research Delivery Network funding to support our research delivery activities.

Commercial Research Portfolio

In addition to this, we will strengthen our commercial research portfolio to ensure an increase in commercial funding, that will be distributed following our commercial research funding model, which ensures that the income follows activity, wherever that is within the Trust.

Research Capability Funding

Through increased National Institute for Health and Care Research (NIHR) grant applications we will see an increase in our Research Capability Funding (RCF), that will be distributed amongst partners, to further develop NIHR grant submissions.

We will also continue the work innovatively on the in-house data management system, EDGE, to develop our invoicing capabilities, ensuring all research income that can be invoiced for is received, and distributed internally to the areas of the Trust where the trial activity has taken place.

Innovation

In addition, we will increase our applications and success to innovation-related funding e.g. InnovateUK. We will use our strategic partnership with Health Innovation Yorkshire & Humber, to broker connections with innovators in relation to joint grant applications, giving the Trust access to national funding pots requiring innovator-led applications, e.g. UK Research and Innovation, InnovateUK and Small Business Research Initiative (SBRI). We will also improve awareness and utilisation of local innovation funding.

4.0 Conclusion

I am so proud of what we have achieved over the past few years and for all the work we aspire to do within this new strategy. We are driven to achieve our Mission (To create a healthier future for our community and beyond through research, collaboration and innovation, leading to a healthier future for our community) and our Vision (To bring research opportunities to all our patients and staff). We will ensure that the research and innovation activities for York & Scarborough Teaching Hospitals NHS Foundation Trust will continue to develop, so expanding our Research and Innovation portfolio.

We will continue to offer greater opportunities to get involved with research for our patients and staff and to ensure, through our growing partnerships and collaborations, we continue to achieve our aspirations.

Thank you to all the team, staff, and our patients who support the research and innovation endeavours of our Trust, I look forward to seeing what we can achieve in the coming few years.

Lydia Harris
Head of Research and Innovation

OUR RESEARCH AND INNOVATION STRATEGY

2025–2028

RESEARCH INFRASTRUCTURE

Expand digital health capabilities

Establish SHARC to address health inequalities on the coast

Build a commercial research team

Develop a Safe Data Environment for research applications and data sharing within the Integrated Care Board (ICB)

WORKFORCE DEVELOPMENT

Provide training opportunities to all staff

Increase staff in research career pathways

Develop and fund hybrid research/clinical roles

Create research champion roles

Promote research opportunities at recruitment stages and at staff-onboarding

COLLABORATIVE PARTNERSHIPS

Deepen partnerships with HYMS and SHARC

Collaborate with Contract Research Organisations

Strengthen ties with local universities and fund PhDs

Develop partnerships with the Voluntary Community and Social Enterprise (VCSE) sector to engage hard-to-reach communities

FINANCIAL SUSTAINABILITY

Pursue external grants and commercial research opportunities

Increase commercial research income through expansion of our commercial portfolio

Improve EDGE system usage for invoicing and financial tracking

Apply for innovation grants to support cutting-edge research and technology development

RESEARCH EXCELLENCE

Deliver high-quality research recognised through peer-reviewed publications

Grow sponsorship activities

Continue to recruit patients for clinical trials and ensure PPI

Strengthen the communications strategy for dissemination

Promote innovation in healthcare by supporting new ideas and research-led solutions

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust
Research and Innovation Department

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Report to:	Board of Directors
Date of Meeting:	23 October 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 Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☐ Quality Standards
☒ Great place to work, learn and thrive	☒ Workforce
☒ Work together with partners	☒ Safety Standards
☒ Research, innovation and transformation	☐ Financial
☒ Deliver healthcare today without compromising the health of future generations	☒ Performance Targets
☒ Effective governance and sound finance	☒ DIS Service Standards
	☒ Integrated Care System
	☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The Board of Directors is requested to:

- note the progress of the EPRR Core Standards Action Plan for this quarter.

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

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

Meeting	Date	Outcome/Recommendation
Resources Committee	15.10.2024	

Overview of Progress Since Last Paper

- The Emergency Planning and Business Continuity Awareness Course developed by the EPRR team has now been published onto the Learning Hub
- 5 actions from the action plan have turned from red to amber, and 5 actions have turned from red/amber to green
- The EPRR training needs analysis has been published and staff are progressing with their health commander portfolios.

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
Governance	(G)		6	7	8
	(A)		1		
	(R)	10	3	3	2
Risk Assessment	(G)		1	2	2
	(A)				2
	(R)	3 (4)	2	2	
Duty to Maintain Plans	(G)		4	6	6
	(A)		3	2	3
	(R)	14	7	6	5
Command & Control	(G)		3	**Completed**	
	(A)		0		
	(R)	3	0		
Training & Exercising	(G)		2	2	4
	(A)		2	2	
	(R)	4			
Response	(G)		2	2	3
	(A)		2	2	1
	(R)	5	1	1	1
Warning & Informing	(G)			1	1
	(A)				
	(R)	2	2	1	1
Cooperation	(G)		2	2	3
	(A)			1	1
	(R)	4	2	1	
Business Continuity	(G)		3	4	4
	(A)		3	4	4
	(R)	11	5	3	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	3			
	(A)			3	3			
	(R)	6	4					

4. Points to Note from the Last 3 Months

Since the last report the committee should note:

- **Risk Register.** 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, approved by the EPSG and has been circulated. The EPRR Team have now published an EPRR and business continuity awareness course on the Learning Hub.
- **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 finalised and signed off for implementation with the ICB and other Healthcare partners in the event of a critical or major incident declaration.
- **Business Continuity.** The Emergency Planning Manager (EPM) has completed a Business Continuity Course at the National Emergency Planning College and is working with the care groups with the progression of their business impact analyses and business continuity plans. Once these are complete, a Trust business impact analysis will be conducted.
- **Core Standards.** A draft core standards audit has been submitted to the ICB will be completed by the end of the year. From that, a new action plan will be developed and report to the resources committee against that action plan.

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 submitted identifying a Band 7 EPRR Training Manager being established to deliver the training articulated in the Training Needs Analysis and for a Band 4/5 Emergency Planning Officer to assist with CBRN and departmental training on the York site. The specific resources are not available and to minimise the identified shortfalls other training resources are currently being identified to support the EPRR team and this should be in place by Dec 24.
- **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: 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 incided in future Board reports. A good practice example is to set out your Board report along the lines of each of the 10 domains of the core standards.**	3 - The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation. (R)	RC	Q2 - 24	3 - (03/04/2024) This will not change until Board report is submitted in Dec 24 therefore likely to be RED for CS submission.
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. 7 - (02/10/2024) - QIA conducted and submitted to Chief Nurse and Chief Operating Officer. Result - no further direct resource however worj to be conducted in 2025 to gain support from Clinical Educators.
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.

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

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 Group. Emily Clark to be contact for progression of work.
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. (A)	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	RC	Q4 - 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
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	
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. (G)	RC / CR	Q2 - 24	30 - (19/12/2023) TNA to include analysis of indvidual training requiements in detail, an overview of collective training both voluntary and mandatory and to capture routine testing requirements. Minimum requirement for Q2-24 is collective training overview and routine testing. The individual training analysis may still be partial for next year's assessment. 30 - (07/02/2024) Incuded in EPM work schedule 30 - (03/04/2024) Date set for TNA develoment
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	A				31 - Capture all training into central log / register. (G)	AB	Q3 - 23	
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	R				32 - Develop Trust MS Teams Channel to manage responder training for On Call Staff. (G)	RC / CR	Q4 - 24	32 - (19/12/2023) Barrier to completion exists as ICB and NHS E need to provide the centralised training programme to allow the Trust to plan to fill the gaps. 32 - (03/04/2024) Due for publication next week.
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	A	National requirements that mechanisms are in place to **ensure that ALL staff are aware of their role in an incident and where to find plans relevant to their areas of work**. The expectation is that this is part of mandatory training. We cannot see evidence provided which outlines general awareness of where plans are available outside of to on call staff, or the number of staff that have been trained as part of mandatory/general awareness training - for example % of staff trained against total number within the organisation, and associated reports of Trustwide compliance to Board	Evidence to be provided of mandatory training or general staff awareness training Trustwide in order to meet the element about "role awareness"		33 - Develop EPRR Awarenes statutory and mandatory training for all staff and hosted on Learning Hub. (G)	RC / CR	Q4 - 24	33 - (04/04/2024) EPRR Team to develop TNA and then CR understands the requirement for platform access. Form going to Learning Hub Committee on 5th Aug. 33 - (080824) Learning Hub site endorsed. CR to finalise presentation and upload then consider dissemination and recording of completion.

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 t**his model was acceptable in order to meet compliance as long as they were able to demonstrate the availability of Loggists sufficient to their needs in both in and out of hours communications tests**	37 - Amend the Trust Call In Policy to include, in addition to the 6 monthly CONFIRMER Test, a bespoke loggist campaign test and a manual ring round test by the loggist manager. Record of test to be a Lessons Identified Template submission. (G)	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.

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							
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. (A)	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. (G)	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.

Ref	Domain	Standard name	Standard Detail	NHS E Final Grading	NHS E Concerns Raised	NHS E Recommended Action	NHS E General Observation or Secondary Challenge	Trust Action	Actionee	Target Date	Remarks / Update
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G			Recommendation - as an NHS organisation under standard contract and in line with the minimum set of standard outlined within the NHS EPRR core standards we would advise the organisation to review their current BCM arrangements in line with the requirements as set out in domain 8 for Business Continuity and the NHS England Business Continuity Toolkit 2023	45 - Review of BC Framework and EPRR Policy to confirm compliance. (G)	CR	Q2 - 24	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	G			**Recommendation - whilst the core headings of a BCMS are contained within the BCMS section of the Trust BCP Annexe, these elements are very light touch in comparision with the level of detail we would anticipate a Trust of this size having in summarising its BC activities and associated governance. We feel this is likely due to the BCMS (planning) sitting in an annexe to the Trust Major Incident Plan (response) and we would advise that these elements are included in either a standalone BC Policy or BCMS framework which goes into the level of detail outlined in the NHS England Business Continuity Toolkit 2023.**				Note: Recommendation incorporated into Action 45.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	National requirement for the organisation to annually assess and document the impact of disruption to its services through Business Impact Analyses (BIAs). Whilst evidence of single impact assessment templates have been provided there is no evidence included in the folder which outlines the following - **he organisation has identified prioritised activities by undertaking a strategic Business Impact** Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it.	Evidence to be provided as set out in the standard detail, supporting information and evidence examples	Recommendation - as an NHS organisation under standard contract and in line with the minimum set of standard outlined within the NHS EPRR core standards **we would advise the organisation to review their current BCM arrangements in line with the requirements as set out in domain 8 for Business Continuity and the NHS England Business Continuity Toolkit 2023**	46 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (A) 46A - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 47 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (R)	CR CR CR	Q2 - 24 Q2 - 24 Q2 - 25	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.
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. T**his should include a risk assessment to consider areas where patients may self present - not just ED and UTC staff, and should be evidenced by Trust training slides and evidence of training records**. No evidence provided which outlines training to wider staffing groups which covers "staff that may make contact with a potentially contaminated patient, whether in person or over the phone" and which should include IOR principles. **No evidence of IOR training or trailining 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 Teaching Hospital
Facilities Management

Item 19

Report to:	Board of Directors
Date of Meeting:	23rd October 2024
Subject:	Management Group Terms of Reference
Director Sponsor:	Chair, YTHFM Management Group Director of Resources
Author:	Governance Manager

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

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

Trust Priorities	YTHFM Board Assurance Framework
☐ Our People	☒ People
☒ Quality and Safety	☒ Quality & Safety
☐ Elective Recovery	☐ Financial
☐ Acute Flow	☐ Growth
	☐ Sustainability
	☐ Partnerships

Summary of Report and Key Points to highlight:

Enclosed are the Terms of Reference for Management Group. The Terms of Reference have been updated in line with governance arrangements and moved onto the new Trust template.

YTHFM now has a permanently appointed chair (appointed June 2024 and member representative of Y&STHFT) which has allowed for the updating of the Terms of Reference. Previously, due to a number of very senior management changes and the absence of a Managing Director, previous versions (5 and 6) were not approved by the Trust due to discussions taking place in the organisation about whether to have an independent chair or not and also a request to rename the Management Group to Management Board which were not in line with its Members Agreement.

Updates are shown in red.

Management Group approved the revised Terms of Reference in September 2024 and they are presented to Board of Directors for final sign off.

Recommendation:
Board of Directors is asked to approve the updated ToRs.

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Management Group	24th September 2024	Approved

NHS
York Teaching Hospital
Facilities Management

Terms of Reference

Terms of Reference for: Management Group	NHS York Teaching Hospital Facilities Management
Authors Name: **Director of Resources**	
Contact Name: **Governance Manager**	
Scope: **Management Group**	**Alignment of YTHFM strategy to the Building Better Care Priorities:** **People** **Quality & Safety** Elective Recovery Acute Flow *Identify which is relevant*
Keywords: business management and contractual performance	**Replaces:** **v4**
To be read in conjunction with the following documents: MSA and Members Agreement	

Unique Identifier: **MG**	**Review Date:** **August 2024**	
Issue Status: **Final**	**Issue No:** **v5**	**Issue Date:** **September 2024**
To be Authorised by: Management Group Board of Directors	**Authorisation Date:** **24th September 2024** **23rd October 2024**	
Document for Public Display: **No**		
After this document is withdrawn from use it must be kept in an archive for 6 years.		
Archive: **YTHFM X Drive > Managing Director > Meetings > Management Group**	**Date added to Archive:** **23rd October 2024**	
Officer responsible for archive: **YTHFM LLP Governance Manager**		

Management Group
Terms of Reference

1. Status	
1.1	The Management Group is a formal meeting of Representatives of the Members of York Teaching Hospital Facilities Management Limited Liability Partnership (YTHFM) as set out in clause 5 of the Members Agreement.
2. Purpose of the Group	
2.1	The Management Group will deal with all things necessary to carry out the purpose and business of YTHFM. This will include but not limited to development and implementation of business plans, policies and procedures and budget. It will monitor the operating and financial performance of YTHFM, prioritise and allocate resources, manage and develop talent and manage the risk profile of YTHFM LLP. It will promptly give or make available to the Board of YSTHFT and/or NHFML such information, reports and other documents as requested.
3. Authority	
3.1	The Management Group authorised to act in the best interests of YTHFM and in accordance with YTHFM's Reservation of Powers and Scheme of Delegation.
3.2	The Members and YTHFM agree that YTHFM shall not undertake a Reserved Matter without having passed a Members Resolution. Reserved Matters are set out in Schedule 4 of the Members Agreement *(copy attached).*
4. Legal requirements of the Group	
4.1	GOV.UK, "Set up and run a limited liability partnership (LLP)", Set up and run a limited liability partnership (LLP) - GOV.UK (www.gov.uk)
5. Role and duties	
5.1	Reserved Matters (schedule 4 of the Members Agreement) including:
-	Amendments to the Agreement.
-	A change of name for YTHFM.
-	The allocation of any further profit share in YTHFM other than in accordance with the Business Plan.
-	Approval of the Annual Business Plan.
-	Approval of the Annual Accounts.
5.2	Responsibility for the achievement of budgets and operational plans.
5.3	Management and regular review of business and financial performance of YTHFM.
5.4	Responsibility for compliance with relevant regulations. Receive and manage regulatory requirements where appropriate, ie. from CQC (independent regulator for health and social care).
5.5	Ownership for the identification and management of risk across YTHFM's business.

5.6	Responsibility for maintaining a sound system of internal control and to manage the internal controls and governance environment and prepare regular reports for presentation to Members as required by Section 13.4 of the Members Agreement: • Quarterly report on the Business Plan • Information required by Regulatory bodies • Information relating to Tax returns
5.7	Responsibility for the integrity of management information including ERIC and PAM reporting, and PLACE where appropriate.
5.8	Ensuring the development of YTHFM policies and procedures as and when required. Management Group can approve YTHFM policies and procedures within the remit of the Group.
5.9	Optimisation and allocation of YTHFM's resources subject to and in accordance with YTHFM Reservation of Powers and Scheme of Delegation including business continuity.
5.10	Ensuring succession planning is in place.
5.11	Responsibility for YTHFM's legal structure and compliance.
5.12	To escalate by exception, any areas of concern that Management Group cannot address to EPAM.
5.13	Management Group standing Agenda items currently agreed as: <u>Business</u>: • Register of Directors Interests • Action Log • Managing Director update • Governance matters • Annual / national submissions <u>Assurance</u>: • Health & Safety (including HSE regulator information) • Operational Risk Register • Compliance • Finance • Internal Audit including limited assurance reports • Workforce • Sustainability <u>Information</u>: • Operational Management Group minutes • To be in receipt of relevant national publications and alerts • Any Other Business and managed in line with its annual Work Programme. The following items will come to the meeting periodically or as required: • Capital Planning report which may include asset performance and performance of NHS Property Services

	• Business Plan Review
6. Membership	
6.1	The membership of the Management Group will be as set out in section 5.3 of the Members Agreement and will comprise of three YSTHFT Representatives and one NHFML representative. • YSTHFT Member Representative (Non-Executive Director and Chair) • YSTHFT Member Representative • YSTHFT Member Representative • NHFML Member Representative (Director) In the event that the Chair is unable to attend, a Chair will be agreed by the Members prior to the meeting or at the meeting by the Representatives attending the meeting. The following Directors and Managers will be in attendance: • Managing Director • Director of Resources / Company Secretary • Director of Facilities Management • Head of Finance • HR Business Partner • Governance Manager (Secretariat) Other officers will be invited to attend the meeting as necessary.
7. Quoracy	
7.1	The Management Group will be quorate with 3 Member Representatives providing there is at least one YSTHFT representative in addition to the Chair and at least one NHFML representative present.
8. Frequency of meetings	
8.1	Meeting arrangements will be as set out in Section 5.3 of the Members Agreement which is summarised below: The Management Group will meet monthly. All supporting papers will be circulated seven days in advance of the meeting. Copies of all agendas and supplementary papers will be retained by the Governance team, Resources Division, YTHFM LLP in accordance with good practice and the organisation's requirements for the retention of documents. Any Representative may call a Management Group meeting at any time by not less than five business days notice in writing to all Member Representatives, specifying the place, day and time of the Management Group meeting and a statement of the matters to be discussed at the meeting.
8.2	Where Representatives/attendees of the Management Group are unable to attend a scheduled meeting, they should provide their apologies in a timely manner, to the Chair and Secretariat of the Management Group.

8.3	Minutes will be drafted within five business days after the meeting and checked by each Member Representative.

9. Administrative support

9.1	The Management Group will be supported administratively by the Resources Division, YTHFM, who will ensure: • Agreement of the agenda with the Committee Chair. • Collation and distribution of papers at least five days before each meeting. • Minutes are taken, actions followed up prior to the next meeting and records. are maintained of matters arising and issues to be carried forward. • Support the Chair and attendees as required. • Very Senior Managers are supported in carrying out their duties in delivery of committee roles and duties.
9.2	The Management Group will maintain a register of attendance at the meeting. Attendance of less than 75% will be brought to the attention of the Chair of the Management Group to consider the appropriate action to be taken. The attendance record will be reported as part of the Management Group Annual Report. The Annual Report will be presented to the Management Group for approval and then forwarded to the Members.

10. Monitoring Effectiveness and Compliance with Terms of Reference

10.1	The Management Group will carry out an annual review of its effectiveness and provide an annual report to Management Group on its work in discharging its responsibilities, delivering its objectives and complying with its Terms of Reference.
10.2	The Terms of Reference once agreed will be ratified by the Board of Directors.

11. Review of Terms of Reference

11.1	The Management Group Terms of Reference will be reviewed bi-annually.

Author	**Governance Manager**
Owner	**Director of Resources**
Date of Issue	**September 2024**
Version #	**V5**
Approved by	**Board of Directors – 23rd October 2024**
Review date	**September 2026**

Appendices:

Appendix 1 - Reserved Matters schedule

ToR attachment.pdf

Appendix 2 - Management Group Structure

Management Group Governance Structure

Report to:	Board of Directors
Date of Meeting:	23 October 2024
Subject:	Update and Restatement of Approval for the VIU and TIF2 Business Cases
Director Sponsor:	Andrew Bertram, Finance Director
Author:	Andrew Bertram, Finance Director Jamie Baxter, Project Manager Andrew Bennett, Capital project Manager Liz HIll, ACOO Karen Priestman, ACOO

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

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

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☒ Quality Standards
☒ Great place to work, learn and thrive	☒ Workforce
☐ Work together with partners	☒ Safety Standards
☒ Research, innovation and transformation	☐ Financial
☐ Deliver healthcare today without compromising the health of future generations	☒ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System
☐ Effective governance and sound finance	☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken

place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:
The Board of Directors is asked to note that both Business Cases already have approval but, in recognition of the time lapsed, restate approval to proceed and to confirm the continued use the funding as per the original terms and conditions of the approved memoranda of understanding with the Department of Health and Social Care.

Not to approve would require the return of the external Department of Health and Social Care funding.

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

No ☒ Yes ☐

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

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

Meeting	**Date**	**Outcome/ Recommendation**
n/a		

Update and Restatement of Approval for the VIU and TIF2 Business Cases

1. Introduction and Background

The Board of Directors approved a business case for the development of an expanded Vascular Imaging Unit (VIU) on 29 June 2016. This case included two additional catheter laboratories, a hybrid theatre and an expanded Post Anaesthetic Recovery Unit (PACU) on the York Hospital site. The capital was funded through a Foundation Trust Financing Facility approved loan.

To date it has not been possible to deliver this scheme. Firstly, the original design and construction was paused due to the presence of extensive public utilities under the proposed construction site which were not identified until very late in the preparation phase of construction. A significant period of negotiation attempting to re-route the utilities further delayed the project, but this was ultimately unsuccessful, and the project design was aborted.

The project then also suffered significant delays linked to the covid pandemic.

During this time, we have been able to manage the capital funding across financial years through a combination of deferral of loan drawdown and brokerage. The funding is still available, but we are now at the limit of any deferral ability.

A second attempt at design was undertaken but this proved prohibitively costly when taken to the market for the construction costing phase. This design was aborted.

In the post-pandemic period, the Trust was successful in a TIF2 capital bid for funds to develop our capacity for elective recovery. Whilst the original vascular development is a separate case to the TIF2 bid, there were obvious synergies to consider in the constructions phase of the schemes. This paper concerns both schemes.

A third attempt at delivering this project has commenced using new architects and specialist project management support. This has resulted in an affordable project delivering the original VIU expansion proposals alongside the additional TIF2 elective treatment and procedure rooms capacity.

Given the time that has passed it is relevant and appropriate to re-confirm the position to progress both schemes.

2. Summary of the Programme

The complete scheme seeks to move the Trust from the current VIU with two catheter laboratories, to a new VIU facility with a suite of 4 laboratories, to extend the PACU and to deliver a new Vascular Hybrid Theatre and Procedure Rooms at both York and Bridlington.

VIU

Clinical reviews have ascertained that the current environment is not fit for purpose and is non-complaint against a number of regulatory requirements. Further, it also will not facilitate the cross-site five-year strategic plans to increase workload, repatriate activity and introduce new procedures and technologies. Capacity is constrained by the lack of pre-assessment and recovery space, the inability to provide Ultrasound examinations and the deficiency of appropriate imaging laboratory facilities and equipment. It is not possible to physically expand any of these areas and facilities within the existing footprint of the unit. The benefits in the original scheme were designed to address the following specific documented issues:

- Current capacity is insufficient to meet current activity demands, far less any future activity increases forecast in the report.
- Image review facilities cannot accommodate the appropriate clinical team members, compromising effective communication and case review.
- No reception and waiting area for patients or relatives/carers – not conducive to ensuring patient confidentiality or dignity.
- Pre-assessment and recovery facilities are not compliant with Department of Health standards for single sex accommodation.
- The unit has no isolation facilities for patients with infection.
- Staff facilities are not appropriately sized and cannot accommodate the current number of personnel working in the unit.
- Inadequate storage facilities which are non-compliant with CQC.
- Inadequate facilities to comply with food hygiene regulations.

This development has been at the proposal stage for 6 years. During that time the team has been waiting, in anticipation, for service development and improved facilities for themselves and the service users. The delay to this project has had an effect on staff morale with increased difficulty in recruiting and retaining staff due to a working environment that is not fit for purpose. The current situation has a negative effect on the health and wellbeing of staff.

PACU

A key issue to be addressed by this project is the capability and capacity deficits in the current PACU in Main Theatre. The current PACU facilities are not compliant with Department of Health Standards for Health Building Note (HBN) 26; Association of Anaesthetists of Great Britain and Ireland (AAGBI), Immediate Post Anaesthesia Recovery standards, British Anaesthetic and Recovery nurses (BARNA), Standards of Practice which all support facilities for the surgical patient.

The new facility will provide:

- Seven additional recovery spaces (increase from 11 spaces to 18 spaces)
- More space between recovery spaces to improve patient experience and make it easier for staff to care for patients within the environment

- Improved IPC compliance through the provision of an isolation area and adequate hand hygiene facilities.
- Paediatric isolation through the provision of a separate area that will also allow parental privacy.
- Extended programmed level of HDU care for those identified as high risk prior to discharge to NEU i.e. vascular patients
- A more suitable environment for critical care escalation capacity if required
- Improved visibility of patients in PACU through redesign of the nurse's station
- Significant improvement in storage facilities which will address health and safety concerns and enhance the working environment for staff
- Reduced manual handling due to an improved working environment

The newly designed PACU does not fully deliver on the specification set out in the relevant HBN but will deliver a significantly improved environment, mitigating many of the current IPC and H&S concerns. The additional recovery spaces are crucial to support initiatives to improve theatre utilisation and reduce wait times for both acute and elective surgery.

Hybrid Theatre

This scheme allows for the development of an additional theatre at the York site. This theatre will be equipped as a vascular hybrid theatre which allows for complex endovascular operations to be performed utilising state-of-the-art interventional radiology alongside vascular surgery. Access to a hybrid theatre is a requirement for arterial centres and forms a key part of the vascular surgery strategy. Due to their age and size, none of the existing theatres at York Hospital are able to be converted to a hybrid theatre (as has happened in most other hospitals).

An additional 730 elective procedures can be undertaken each year through the development of the vascular hybrid theatre which will support continued reduction of waiting times for elective surgery. The theatre also delivers a key recommendation of the Trust's Vascular GIRFT action plan and would be the first hybrid theatre within the Humber and North Yorkshire ICB.

Procedure Rooms

GIRFT's 'Right Procedure Right Place' project requires Trusts to relocate procedures which are appropriate from day surgery settings to outpatient procedure rooms. There is a shortage of outpatient procedure rooms at the Trust and very few which have the required levels of ventilation, hence the reliance on day surgery theatres to undertake these procedures currently. It is also very important to ensure that there is an adequate recovery area for patients to sit in following their procedure; nearly all our current outpatient procedure rooms do not have such an area adjoining the procedure rooms.

The scheme provides space and facilities for the development of two outpatient procedure rooms at York Hospital and two outpatient procedure rooms at Bridlington

Hospital. These rooms will be installed with the adequate number of air changes to allow for the following procedures to be relocated from day surgery units:

- Skin lesion excisions
- Local anaesthetic pain injections
- Prostate biopsies
- Flexible cystoscopies
- Local anaesthetic varicose vein procedures
- Local anaesthetic dental procedures
- Carpal tunnel and local anaesthetic hand surgery procedures

Development of dedicated outpatient procedure suites on the York and Bridlington sites will enable around 2,280 additional day case procedures at York and 416 day case procedures at Bridlington.

3. Current Position/Issues

The Chief Executive and Finance Director have recently approved the letting of a £0.3m contract to strip out the area planned for construction of the catheter laboratories. This is well within their delegated authority. This is in readiness for the construction scheme to commence. Irrespective of whether the scheme goes ahead or not the space requires strip out.

The anticipated costs of the combined schemes and the available funding are described below.

Funding remaining and available from FTFF loan and TIF2 capital funding is £24.4m (with a planned and facilitated spend profile of £16.4m in 24/25 and £8.0m in 25/26). This is our target spend profile across the financial years.

Blue Light (our specialist project managers) have advised of costs of £22.1m with an additional provision for equipment of £2.2m. This is within the available envelope.

Following a market procurement exercise we have costs for the hybrid theatre element of the scheme at £5.6m. This is within the Blue Light cost estimate of £8m specifically for the Hybrid Theatre. Chair's action was taken on Wednesday 9 October to approve the letting of a contract for the construction of the hybrid theatre at £5.6m. This was necessary to guarantee the production slot immediately and to help ensure the Trust can deliver the project in the necessary timescale, recognising the restrictions associated with the funding.

4. Summary

The Trust has previously been successful in securing funding for significant capacity expansion, and facility improvements, associated with vascular and cardiac procedures as well as delivery of the elective recovery programme. If this funding is not used for its original intended purpose, then it must be returned.

Due to significant project delays these schemes have not been delivered but we do now have a way forward. Due to the time lapsed from original Business Case approval, the Board of Directors is asked to refresh its understanding of the proposed work and to reaffirm its approval to proceed.

5. Timeline for Project Delivery

The Trust is managing this project through a formal project structure. The estimated stretch target timeline for the project is outlined below. The programme may be subject to change depending on the materialisation of project risks.

VIU	
Strip Out Works	mid-October 2024 to late December 2024
PCSA to Main Contract Award	mid-September 2024 to late November 2024
Construction	mid-November 2024 to late March 2025

Modular Build (Hybrid Theatre, offices, stores)	
Contract award	early October 2024
Detailed design & fabrication	October 2024 – February 2025
Groundworks design	July 2024 to mid-September 2024
Groundworks tendering	mid-September 2024 to late October 2024
Groundworks on site	November 2024 – December 2024
Modular delivery and on-site build	February 2025 – March 2025

PACU Expansion	
PCSA to Formal contract award	mid-September 2024 to late November 2024
Construction	late November 2024 to January 2025

Treatment Rooms at Bridlington	
Designing	August 2024 – October 2024
PCSA to Main Contract Award	November 2024 to December 2024
Construction	January 2025 to March 2025

Outpatient Procedure Rooms at York
These works depend on completion of the new VIU (vacating the old VIU) and therefore the programme can be developed at a later stage.

6. Recommendation

The Board of Directors is asked to note that both Business Cases already have approval but, in recognition of the time lapsed, restate approval to proceed and to confirm the continued use the funding as per the original terms and conditions of the approved memoranda of understanding with the Department of Health and Social Care.

Not to approve would require the return of the external Department of Health and Social Care funding.

Date: 23 October 2024

Report to:	Board of Directors or Committee
Date of Meeting:	23rd October 2024
Subject:	Targeted Lung Health Check Business Case
Director Sponsor:	Claire Hansen, Chief Operating Officer
Author:	Beth Eastwood, Head of Cancer

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

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

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☐ Quality Standards
☐ Great place to work, learn and thrive	☐ Workforce
☐ Work together with partners	☐ Safety Standards
☐ Research, innovation and transformation	☐ Financial
☐ Deliver healthcare today without compromising the health of future generations	☒ Performance Targets
☐ Effective governance and sound finance	☐ DIS Service Standards
	☐ Integrated Care System
	☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The Board approves this business case and endorses work to continue at pace as a priority to commence delivery of the programme in 2025.

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

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

Meeting	Date	Outcome/Recommendation
TLHC Project Board	25th July 2024	Approved
Cancer Delivery Group	25th July 2024	Approved
CSCS Board	5th August 2024	Approved
Elective Recovery Programme Board	13th August 2024	Approved
Trust Executive Committee	21st August 2024	Approved
Respiratory Business Meeting	4th September	Approved
Trust Executive Committee	16th October 2024	Approved

Targeted Lung Health Check Programme Business Case

1. Introduction and Background

Targeted Lung Health Check (TLHC) is a precursor to a national lung screening programme and are included as a key deliverable in the 24/25 national NHS Operational Planning Guidance, Humber North Yorkshire (HNY) Cancer Alliance Delivery Plan and Trust Cancer Transformational Programmes. It is referenced in Lord Darzi's September 2024 report on the NHS as a programme which has contributed 'notable improvements in early detection of cancer'.

The TLHC programme involves inviting eligible populations to a telephone assessment, and those who meet the criteria in the national protocol, to a low dose CT scan. The ambition is that these scans are delivered as close to the local population as possible in mobile CT vans, in locations such as supermarket carpark, to encourage uptake.

This programme has the capacity to detect and diagnose lung cancer sooner, which would in turn reduce mortality. Lung cancer is the most common cause of cancer death in the UK, with Cancer Research UK estimating that it accounts for 21% of all cancer deaths.

Using trust staging data over the past 12 months, 30.2% lung cancers were diagnosed at 'an early stage' (stage 1 & 2). 19% Lung cancers were at stage 3 when patients were diagnosed, and 41% lung cancers were diagnosed at stage 4 (note: 12% of lung cancers had staging data 'unknown').

Cancer Alliance modelling (included in the business case- Appendix 1) suggest 94, 299 patients are eligible across the Trust footprint, with 45, 298 (48%) anticipated to take up an initial telephone assessment and 21, 936 to go onto to have a baseline mobile CT scan. 38,106 follow up scans will take place over the programme period.

Cancer Alliance modelling suggests 307 lung cancers will be diagnosed over the course of the programme from the initial scans (April 2024- November 2028). Across the trust, 446 lung cancers were diagnosed over the past 12 months. The TLHC programme, if treated as new patients rather than replacing patients who would come forward at a later stage, would represent roughly a 20% increase in diagnosed lung cancer annually. Further lung and other cancers are modelled to be found through follow up scans.

Executive Committee in April 2025 approved the progression of the development of the business case. An internal project board was set up to discuss and agree a delivery model, which informed the costings of the business case, and included representation from care groups, place, cancer alliance, public health colleagues and primary care. Trust Executive Committee in August and October 2024 approved and endorsed this business case to go to Trust Board for approval, have received assurance around the ability of the respiratory service to accommodate the additional demand.

2. Considerations

The Trust is one of the few in the country without a TLHC programme. The establishment of this is vital to diagnose lung cancers earlier and is outlined as a requirement of the 24/25 NHSE Operational Planning guidance, in addition to the National Lung Cancer Audit recommendation. By diagnosing lung cancers earlier, curative treatment can increase life expectancy. Cancer research UK data suggests that patients diagnosed with lung cancer at stage 4 have less than a 20% chance of one year survival and less than 5% chance of 5-year survival, and lung cancer remains a national outlier at the volume of patients diagnosed at a late stage.

The preferred option would be to deliver the programme more cost effectively by utilising system mobile CT capacity, where available. This could provide savings approximately £3 million, when compared to the cost of insourcing /outsourcing mobile CT. However, there are barriers within the system to utilising current TLHC CT capacity and Community Diagnostic Community (CDC). The Trust workforce is also currently not in place to support the expansion in internal scanning and reporting. Therefore, the business case outlines the cost of providing the TLHC programme utilising outsourced CT mobile capacity, workforce and reporting.

The business case includes the costs to deliver the TLHC programme and an increase in the lung cancer pathway. The case costs the delivery of the programme until 2028, at which point the national direction of travel is to implement a national screening programme. The THLC pilot is due to take place from 1st April 2025 to 31st March 2029, once all costs and income are taken into account, the project will make a contribution to the Trust of £897,000 in total over these 4 financial years. The costs over the 4 years include £24,000 of Capital purchases and £11.6m of revenue expenditure, this expenditure will be offset by £12.5m of income from lung health check assessments and CT scans associated with this. The project will incur a cost pressure in the first year of operating (2025/26) but this will be recovered in the further 3 years of the project.

3. Current Position/Issues

The entirety of the business case is based upon a level of patient engagement, modelled by the Cancer Alliance, at a rate of 48% uptake from the eligible population.

Modelling & Activity Rates

- The business case has been based on Cancer Alliance Modelling and assumptions on patient uptake and activity run rates from NHSE pilot sites. The 307 lung cancer diagnosis expected to be found by the programme from April 2025- December 2028 for the purposes of the business case has been treated as new patients and additional activity. This is because the intention is to find the lung cancer earlier, and therefore be able to offer interventions which would not be the case if diagnosed at stage 3 and 4. The other secondary care lung cancer activity in terms of referral numbers (c. 300 over 3 ½ years) and subsequent cancers found from follow up scans are assumed to be replacement for existing referrals (GP/A&E/Consultant Upgrades).

- There is risk that the modelling and assumptions do not match the reality of the programme uptake and findings. However, given the Trust is the last in the region to

roll out, there can be a level of confidence in the findings from the pilot sites which have been established since 2019 and have informed the models.

- Robust data has not been made available for the impact on secondary care on other incidental findings. There is a risk that there is unknown impact on services such as cardiovascular, which have not been costed in the business case. A level of assurance was provided to Executive Committee on 16th October 2024, based on the incidental finding volume from the North Lincolnshire and Goole (NLAG) programme.

- Learning from other pilot sites suggests there can be a proportion of the incidental findings which need to be managed in primary care. A phased roll out plan will be developed to manage the patient flow with involvement of primary care and place leads. However, the current position with GP collective action may make engagement with primary care and support for this programme more challenging.

Finance & Patient Engagement

- The business case projects an income of £897,000 over the period of the business case. There is an initial loss in the first year, however contained within this are one off set up costs which we have formally applied to NHSE national programme for support with. It is unclear at this stage how much funding will be provided for pump priming the programme in 24/25.

- The business case income is dependent upon patient engagement with the programme to achieve the required run rate, and correct assumptions from NHSE modelling. There is a risk that patient engagement is too low, which would cause a financial pressure for the trust as the income would not match the expenditure required to deliver the programme.

- Engagement over the assumptions in the model would create additional activity and income, however there would need to be an increase in staffing to accommodate the TLHC programme and a risk that the incidental findings to secondary care could create an operational pressure.

Staffing

- There are current vacancies within the specialities required to deliver this programme: respiratory and radiology. The trust currently only has 1 substantive lung cancer consultant, with the remainder of the service being delivered by locums. There is an acknowledgement that even with the revenue from the business case (subject to approval), recruitment to the vacancies may not be successful. The roll out of this programme without substantive consultant, administrative and nursing staffing would create additional pressures on existing services. A supplementary respiratory paper was presented to Executive Committee on 16th October 2024 to give a level of assurance.

- Both radiology and respiratory have requested the ability to appoint to TLHC positions, during current recruitment rounds, should they have appointable candidates and subject to Executive Committee approval of the business case.

- Due to the roll out of the programme across the trust footprint but noting that the lung cancer pathways are separated in York and Scarborough, the business case represents cumulative WTE's and PA's required. There will need to be an element of flexibility cross site to deliver this programme, dependent on where the mobile CT

and therefore referral pathways into the trust, is physically located at any given time.

- Feedback from other TLHC pilot sites have suggested that the nursing retention can be challenging. This will be mitigated through flexible job plans and the offering of training opportunities, such as Spirometry (which is not currently included in the current roll out plan).

- NHSE national programme will be approached, subject to Executive Committee approval, for pump prime funding to support the establishment of the programme and allow for staff training and shadowing from existing TLHC sites across the system.

CT Capacity

- Access to CT capacity represents the largest cost in this business case. This cost could be reduced by utilising system CT capacity: existing TLHC mobile CT and CDC sites and vans. This would require system support and direction.

- Rental costs for mobile CT spaces have been estimated based on previous contracts for the purposes of the business case. There is a risk that this is higher and therefore creates a cost pressure for the trust. Onsite trust CT scanning options must be considered, however recognising that the ethos of the TLHC screening in the community, a hybrid solution may need to be developed for roll out. This needs to balance patient engagement against best use of scanning infrastructure.

Public Health Initiatives

- This programme is a golden opportunity for public health initiatives to be delivered in the community alongside the mobile CT scan. This could include smoking cessation and cardio-vascular disease prevention programmes. This is being explored with Trust Tobacco teams, public health place colleagues and with the intention of being co-designed following patient feedback.

Transition to National Screening Programme

- It is expected that clarity will be provided in the coming year around the establishment of a national lung screening programme in 2028/29. The TLHC programme is essential to create the infrastructure to support this but there is not clarity yet post 2028 around the structure of the funding of the programme.

- The current direction of travel is a system hub and spoke model. This would require consultation with any staff employed by the trust to deliver a TLHC programme. Physical space will also be required for staff to work from the trust for the duration of the TLHC programme.

4. Summary

- The establishment of a TLHC programme is a national and local priority and will diagnose cancer earlier, offering curative treatment to patients.
- The business case suggests this programme would generate £897,000 income over 3 ½ years (April 2025- December 2028), noting initial cost pressures, prior to the implementation of a national screening programme. This includes the costs of an increase in the lung cancer pathway infrastructure.

- Further cost savings could be identified if mobile system CT capacity could be utilised.
- There are risks associated with the business case, primarily around recruitment of staff, income generation against trajectories and current GP engagement with collective action context.
- Beyond 2028/29 there is an assumption that a national screening service will be implemented which could change the model of delivery.

5. Next Steps

This has been supported by the regional Cancer Board. With Trust Board's approval, work will need to continue at pace to meet the ambitious deadline of patient invitations out and scanning commencing by 1st April 2025. This programme mobilisation will be led and supported by corporate operations, with the intention that there will be a handover to Specialist and Clinical Support Services where this screening service will sit.

With a Trust Executive Committee recommendation, Cancer Alliance is leading on behalf of the system a review of current TLHC mobile and available diagnostic CT capacity which could be utilised to deliver this programme.

NHSE have been approached via the Cancer Alliance TLHC programme for pump prime costs to support establishing the programme, similarly to other pilot sites. Funding resources are being explored.

With Executive approval, recruitment to current trust vacancies (such as radiology and respiratory) can identify and appoint suitable candidates for TLHC positions.

Date: 16 October 2024

APPENDIX Ai

Business Case Approvals

- Potential cases should be outlined at Annual Planning
- Business Case Completed (Revenue and/or Capital)
- Care Group Board - Revenue Approval <£50k
- CPMG - Capital Approval <£50k
- Chief Executive, usually through the Executive Committee (Revenue) / CPEG (Capital) - Approval £50k - £500k
- Executive Committee - Revenue & Capital Approval £500k - £1m
- Board of Directors - Revenue & Capital Approval >£1m
- CAP Board / ICB Review of all cases that impact / benefit the wider ICS
- Post Project Evaluation - 12 months after implementation

in

Stakeholder Considerations

YTHFM LLP	•Is accommodation required? •Is cleaning / maintenance of accomodation required? •Are porters / catering / laundry & linen required? •Is maintenance of medical equipment required?
Digital Information Services (DIS)	•Does the change require a system change? •Does the change require new digital functionality? •Does the change require a new digital solution? •Has the DIS Change Request Process been followed?
Care Groups	•Consider the impact of your business case on other Care Groups - have they been engaged where required? •Mandatory consultation for stakeholder groups is included in section 8 of the business case summary
Sustainability	•Does the business case impact on the Trust's sustainability programme?
Commissioners	•Where additional funding is required this should be discussed with commissioners (i.e the ICB)
Other Providers within the ICS	•Does the business case have an impact or provide a benefit to other provider organisations within the ICS?

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2024/05-14

2. Business Case Title

Targeted Lung Health Check Programme

3. Sponsorship, Management Responsibilities & Key Contact Point

The Business Case 'Owner' should be the appropriate Care Group or Corporate Director, or where appropriate an alternative lead Clinician nominated by the respective Care Group Director. The 'Author' will be the named manager supporting the owner of the Business Case, who will have responsibility for the development and writing of the Business Case, and will be the key contact point for enquiries.

3.1 Sponsorship Confirmation (where neither are the Owner or Author of the Business Case)

Care Group/ Corporate Director	**Name**	**Date of Agreement**
	Claire Hansen	

Care Group Manager	**Name**	**Date of Agreement**
	Kim Hinton	

3.2 Management Responsibilities & Key Contact Point

Business Case Owner:	**Kim Hinton, Deputy Chief Operating Officer**

Business Case Author:	**Beth Eastwood, Head of Cancer**
Contact Number:	**07929 095972**

STRATEGIC CASE

The purpose of the strategic section of the business case is to make the case for change and to demonstrate how it provides strategic fit.

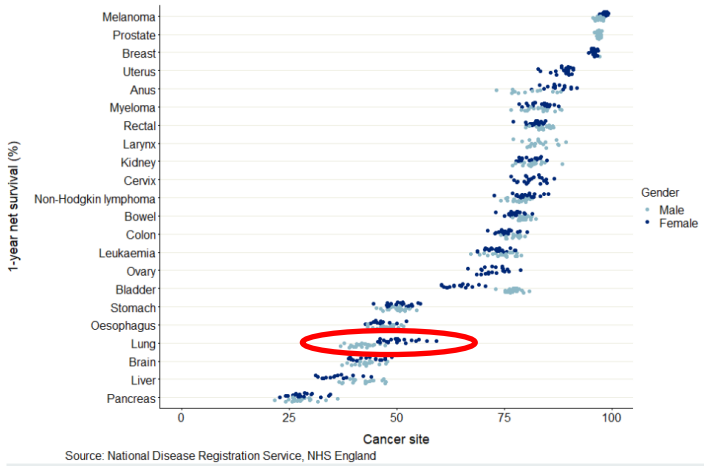
4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change.

Targeted Lung Health Checks (TLHC) form part of the NHS Long-Term Plan and 24/25 Operational Planning Guidance, aimed at targeting adult populations between 55-74 who have previously or currently smoke, to detect lung cancer at an earlier stage and improving outcomes for patients. It involves inviting a target population to a telephone assessment, and those who meet the criteria are then invited for a low dose CT scan of their chest.

The NHS Long Term Plan emphasises the national ambition to detect and diagnose cancer earlier, with a target of 75% cancers diagnosed at stage 1 or 2 by 2028. The primary aim of TLHC is to reduce mortality from lung cancer by detecting it earlier in at-risk populations. Lung cancer is the most common cause of cancer death in the UK, with Cancer Research UK estimating that it accounts for 21% of all cancer deaths. NHS England data suggests a less than 50% patients diagnosed with lung cancer survive for more than 1 year. This is in part due to the proportion of lung cancers diagnosed at stage 3 and 4, and the rapid progression of the disease.

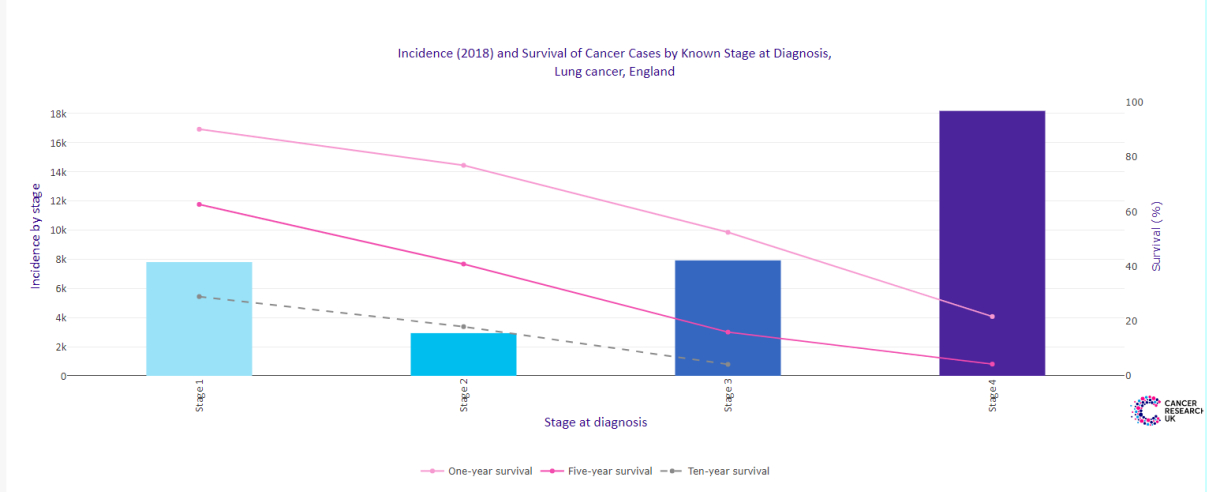
Figure 7: Age-standardised 1-year net survival (%) for adults diagnosed in the period 2016 to 2020 and followed up to 2021: 22 common cancers, by gender for CAs



Source: National Disease Registration Service, NHS England

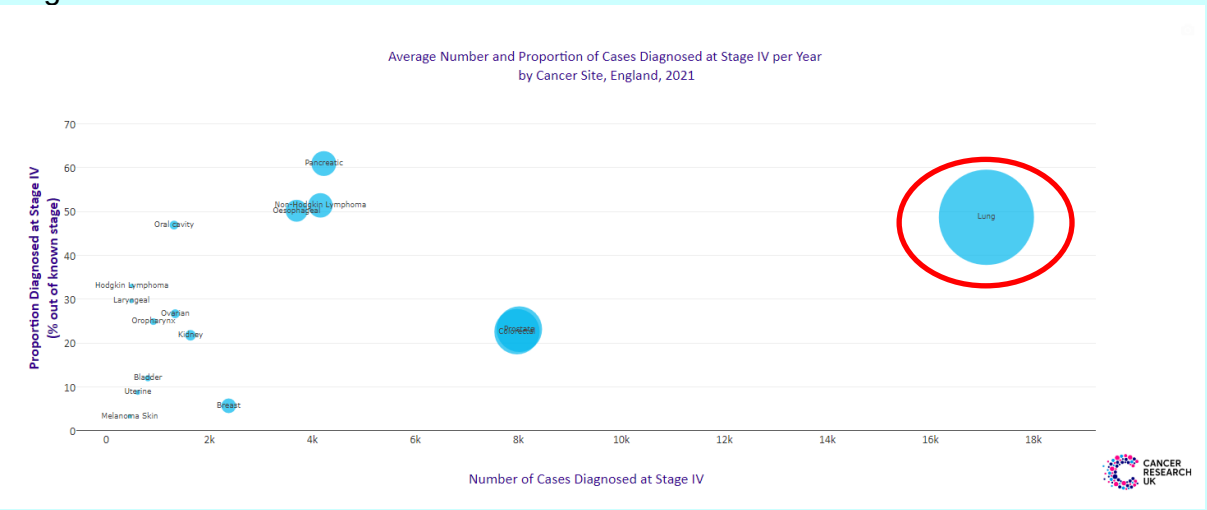
Geographic patterns of cancer survival - NHS England Digital

Cancer research UK data suggests that those patients diagnosed with lung cancer at stage 4 have less than a 20% chance of one year survival and less than 5% chance of 5 year survival.



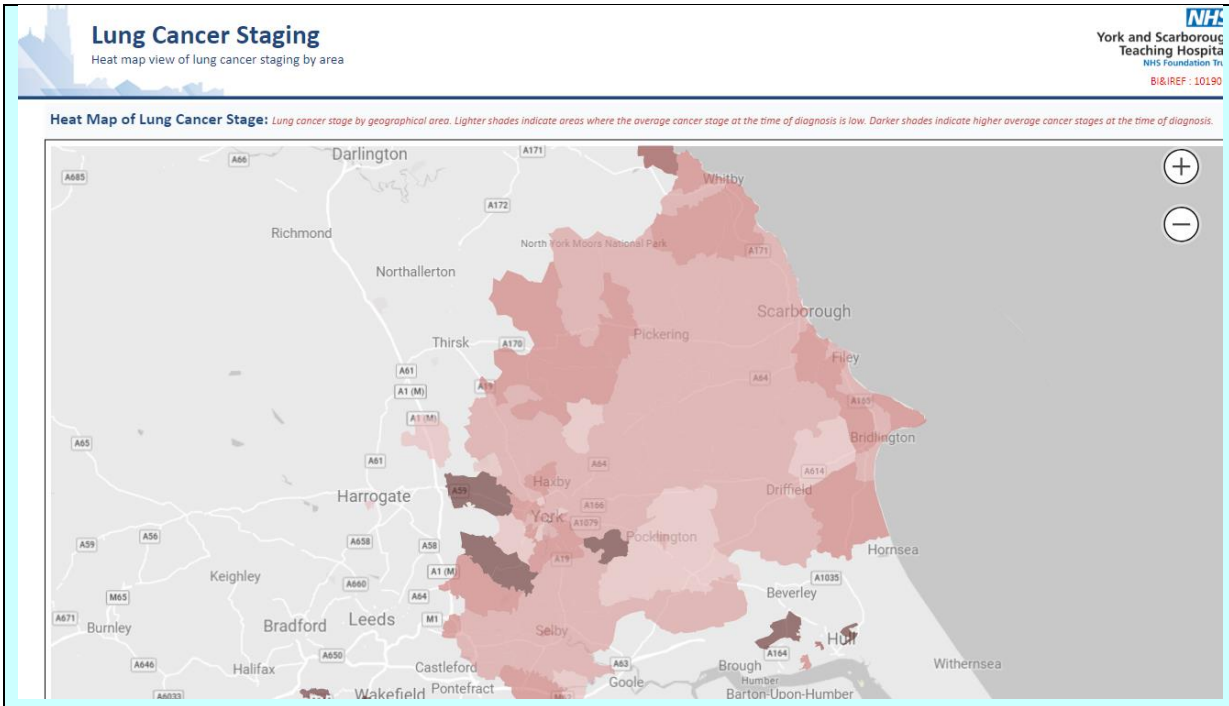
https://crukcancerintelligence.shinyapps.io/EarlyDiagnosis/

Lung cancer remains a national outlier at the volume of patients diagnosed at a late stage.



https://crukcancerintelligence.shinyapps.io/EarlyDiagnosis/

Using trust staging data over the past 12 months, 30.2% lung cancers were diagnosed at 'an early stage' (stage 1 & 2). 19% Lung cancers were at stage 3 when patients were diagnosed, and 41% lung cancers were diagnosed at stage 4 (note: 12% of lung cancers had staging data 'unknown'). This is displayed on the Trust footprint below.



To support the earlier diagnosis of lung cancer, Targeted Lung Health Checks were commissioned as national pilots and commenced development and implementation from 2019. National protocol and quality assurance standards outline the programme.

This is a precursor to a national lung screening service, which is aimed to be established from the TLHC infrastructure in 2028-29. The CT scans are expected to be delivered within local communities, and pilot sites have used supermarket carparks and leisure centres. There is a golden opportunity for the Trust, using a health inequalities approach and in partnership with local patient community groups, public health colleagues and primary care to offer other targeted health interventions alongside the CT scans. This is being designed as part of the roll out plan but could include smoking cession, blood pressure and cholesterol checks and dentistry. Spirometry will not be offered initially at the TLHC CT scan, however this will be included in the wider roll out model.

Services have been established for the populations covered by NLAG and HUFT trusts, as a national decision was taken to commence the programme by targeting areas of highest deprivation and smoking prevalence. York & Scarborough have been given a suggested mobilisation date of 1st April 2025 for the first scans to take place. This requires work at rapid pace in this financial year to develop and agree a model of delivery, work with system partners to secure scanning capacity, recruit several roles in nursing and administration, and ensure current patient administration, IT and reporting systems are set up to support efficient delivery.

This programme has the opportunity to extend the life span of the patients, by detecting and treating lung cancer earlier, who would otherwise be provided with best supported care due to the late diagnosis.

This business case outlines the TLHC programme until November 2028, as a national lung screening programme is expected to commence in 2029.

5. Capacity & Demand Analysis

Where a key issue raised concerns of the availability of sufficient capacity to meet anticipated demand on the service, it must be supported by a Capacity and Demand analysis to clearly demonstrate the gap in capacity, with the results presented below. Please refer to the Business Case guidance document for the guidance and access to the preferred capacity and demand model. If required, support in completing the model is available through the Corporate Operations team (contact Andrew Hurren on extension 5639).

The NHSE/ Cancer Alliance model suggests the below population inclusion over the next three ½ years. This has been split into two models due to the difference in smoking prevalence in Bridlington compared to the rest of the Trust geography, and therefore conversion rate to telephone assessment between the areas.

Trajectory modelling - Vale of York Place plus Scarborough Practices and North Yorkshire			
Use yellow cells to input your eligible population and ever smoking rates, or enter your eligible ever smoker population. The orange cells are also pulled through into other spreadsheet tabs, altering them here will change data in other tabs.			
Stage	**No.**	**%**	**Comment**
Total 55-74 population	211,731	100.0%	Aged 55-74 & 364 days
Eligible ever-smoker population	86,810	41.0%	Of Total eligible population
Appointments booked	41,669	48.0%	Of Ever Smoked (uptake reduced from 50%)
Non attendees	3,333	8.0%	Of Appointments Booked
LHC's performed	38,335	92.0%	Of Appointments Booked
Positive LHC's	20,816	54.3%	Of LHC's analysed-local conv applied
Excluded from CT scan	624	3.0%	Of Positive LHC's
Non attendees (initial CT scans)	0	0.0%	Of Positive LHC's
Initial CT scans performed	20,192	97.0%	Of Positive LHC's
Indeterminate - require second scan	2,665	13.2%	Of Initial CT Scans performed
Negative CT Scan - 24 months follow-up	17,304	85.7%	Of Initial CT Scans performed
Negative CT Scan - 48 months follow-up	15,107	87.3%	Of 24 month scans
Findings	**No.**	**%**	**Comment**
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	557	2.76%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Lung Cancers found	283	50.8%	Of Needing clinic investigation
24 months follow-up	17,304	85.7%	Of Initial CT Scans performed
Patient needing clinical investigation following 24 month scan	415	2.4%	Of 24 month scans
Lung Cancers found at 24 months follow-	272	65.5%	Of Needing clinic investigation
Total cancers found	555	N/A	Including those found at initial, 3, 12 and 24 months scans
Treatments	**No.**	**%**	**Comment**
Surgery	283	51.0%	Of Cancers found
Stereotactic Body Radiation Therapy (SA	68	12.2%	Of Cancers found
Chemo-Radiation	51	9.1%	Of Cancers found
Radiation treatment (XRT)	51	9.1%	Of Cancers found
Surgery and Adj Chemo	43	7.7%	Of Cancers found
No Treatment	26	4.6%	Of Cancers found
Chemo	26	4.6%	Of Cancers found
Best Standard Care	8	1.5%	Of Cancers found

Trajectory modelling - Bridlington - Drs Reddy and Nunn, Humber Primary Care			
Use yellow cells to input your eligible population and ever smoking rates, or enter your eligible ever smoker population. The orange cells are also pulled through into other spreadsheet tabs, altering them here will change data in other tabs.			
Stage	**No.**	**%**	**Comment**
Total 55-74 population	12,928	100.0%	Aged 55-74 & 364 days
Eligible ever-smoker population	7,498	58.0%	Of Total eligible population
Appointments booked	3,599	48.0%	Of Ever Smoked (uptake reduced from 50%)
Non attendees	288	8.0%	Of Appointments Booked
LHC's performed	3,311	92.0%	Of Appointments Booked
Positive LHC's	1,798	54.3%	Of LHC's analysed-local conv applied
Excluded from CT scan	54	3.0%	Of Positive LHC's
Non attendees (initial CT scans)	0	0.0%	Of Positive LHC's
Initial CT scans performed	1,744	97.0%	Of Positive LHC's
Indeterminate - require second scan	230	13.2%	Of Initial CT Scans performed
Negative CT Scan - 24 months follow-up	1,495	85.7%	Of Initial CT Scans performed
Negative CT Scan - 48 months follow-up	1,305	87.3%	Of 24 month scans
Findings	**No.**	**%**	**Comment**
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	48	2.76%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Lung Cancers found	24	50.8%	Of Needing clinic investigation
24 months follow-up	1,495	85.7%	Of Initial CT Scans performed
Patient needing clinical investigation following 24 month scan	36	2.4%	Of 24 month scans
Lung Cancers found at 24 months follow-	23	65.5%	Of Needing clinic investigation
Total cancers found	48	N/A	Including those found at initial, 3, 12 and 24 months scans
Treatments	**No.**	**%**	**Comment**
Surgery	24	51.0%	Of Cancers found
Stereotactic Body Radiation Therapy (SA	6	12.2%	Of Cancers found
Chemo-Radiation	4	9.1%	Of Cancers found
Radiation treatment (XRT)	4	9.1%	Of Cancers found
Surgery and Adj Chemo	4	7.7%	Of Cancers found
No Treatment	2	4.6%	Of Cancers found
Chemo	2	4.6%	Of Cancers found
Best Standard Care	1	1.5%	Of Cancers found

Trajectory and activity modelling has been produced by the cancer alliance to demonstrate the required telephone assessment and CT run rates to achieve total population coverage by December 2028. This model gives an indication of the incidental findings which require secondary care clinical investigation (2.76% of initial CT scans). This model excludes activity around other incidental findings, including Coronary Artery Calcification, which requires primary and/or secondary care input to manage.

Using Trust SIGNAL data, total Lung Cancer diagnosis from 1st September 2022 – 24th June 2024 is at 825 patients. Whilst there is variation between the months, an average would suggest that around 40 lung cancers per month are diagnosed, from an average of 128 referrals per month. Using the Cancer Alliance Model, TLHC would therefore add an additional 307 lung cancers found at the first scan over 3 ½ years to this activity, on average around 7 diagnosis of lung cancer a month. There is not yet enough evidence from TLHC sites which were established earlier to build in an assumption around how many patients diagnosed through TLHC would have presented elsewhere for referral prior to the establishment of the service. These 307 patients therefore will be treated as additional demand. This is particularly since the assumption is that there will be an ability to offer curative treatment as opposed to best supportive care, which requires additional interventions. The other 7 referrals for non- lung cancer diagnosis per month from TLHC are assumed to be subsumed into current referral activity (e.g. otherwise presented through consultant upgrades/ A&E presentations).

The 24-month lung check internal scans, which find further lung cancers, have been included in activity modelling and run rates for 2027/28/2028-29. A proportion of these 24-month interval scans will take place prior to the national lung screening roll out, estimating up to 159 lung cancers found at the 24 month scan. For the purposes of the business case, this has assumed to be replacement for current lung cancer referrals and diagnosis, due to heightened awareness of signs and symptoms of lung cancer from engaging in the initial screening process. Further activity will need to be included in the subsequent business case once clarity confirmed by NHSE as to the national lung cancer screening model, from 2028.

The additional demand from the lung cancer pathway has been worked through for this business case. Modelling has not been made available from other pilot sites to confirm whether this programme is expected to produce additional activity in other modalities, such as cardiovascular.

This business case includes the cost for mobile CT as this is required to deliver the programme and at the moment would require outsourcing due to the nature of the mobile scanning being done within local communities. There could be opportunities to offset or reduce this cost if CT capacity was utilised at a system level, such as the use of existing TLHC mobile CT vans or Community Diagnostic Centres.

6. Alignment with the Trust's Strategic priorities

The Trust has identified four strategic priorities that ensure there is a focus for its emerging priorities and objectives, and assists in the communication to staff, patients and other stakeholders.

Indicate using the table below, to what extent the preferred option is aligned with these strategic priorities. It is expected that the preferred option will align with at least one of the strategic priorities.

Strategic Priority	Describe how the case is aligned to the Strategic Theme
Priority 1 – Our People	Deliver new cross-site service and improve the capability to retain nursing staff in facilitating rotational posts across a range of areas (triage/ CT scanning/ MDT discussions). Potential opportunities to expand roles to respond to the new clinical pathways being developed in partnership with primary care, particularly in CVD findings.
Priority 2 – Quality & Safety	Increase life expectancy and quality by reducing clinical risk as a result of finding and diagnosing lung cancer, and other serious disease, earlier. Providing a service for our patients which is currently delivered elsewhere, of which they are not able to access.
Priority 3 – Elective Recovery	Increased capacity for targeted diagnostics and meeting national cancer waiting time targets to diagnose and treat cancer at an earlier stage.
Priority 4 – Acute Flow	To reduce the emergency presentation and late stage diagnosis of lung cancer, and other complications as a result of the progression of disease, through A&E and requiring admission.

7. Business Case Objectives

Setting robust spending or investment objectives is essential in making a coherent case for change; the case should identify SMART (Specific, Measurable, Achievable, Relevant, Time bound) to address one or more of the following generic drivers, see page 23 of the guidance for full description of drivers. List the business case objectives and the metrics and measures below:

Description of objective	Metric	Quantity Before	Quantity After
Increase in lung cancer diagnosed at early stage (1&2) in comparison to diagnosis at stage 3&4	Cancer Staging Data (national COSD submission)	Stage 1&2 : 30.2% Stage 3: 19% Stage 4: 41%	See below for 3/6/12 month – this is national NHSE pilot and final stage shift in lung cancer has not yet been finalised.
Ability to offer curative treatment for lung cancer patients	Treatments Offered – increase in 1st definitive treatments	Note: curative surgery & radiotherapy performed at Tertiary Centre- IPT for treatment in SCR would provide baseline with BI&I support around triangulation of staging data	To be developed – expected 15-20% increase in offered 1st definitive treatment
Increase in 1 and 5 year survival rates from lung cancer	Lung Cancer Survival Rates	National Lung Cancer Audit (NLCA) data triangulated with Trust CPD/ Cancer Spell Data -benchmark of patients diagnosed with lung cancer at stage 4 have less than a 20% chance if one year survival and less than 5% chance of 5 year survival.	Increase in Lung Cancer survival rates – to be developed

Patient Engagement with programme	Number of Telephone Assessments Completed/ Initial baseline scans performed	0	45, 298 - initial telephone assessment 21, 936 - baseline mobile CT scan
Increased targeted diagnostic capacity	Number of TLHC baseline CT scans	0	40,000
Offer other services to local communities at point of offering CT Scans e.g. smoking cessation/ spirometry	Additional services/ interventions offered at CT scans	0	2 per scan
Improved patient experience	National Cancer Patient Experience Survey & Local Lung Cancer surveys	TBC- awaiting latest CPES data (available 1st August 24)	To quantify after latest CPES data received
How will information be collected to demonstrate that the benefit has been achieved? Information is collected through various national mandatory data submissions (CWT/COSD), alongside mandatory TLHC programme specific uploads to NHSE (see Appendix A) It is important to note there is a time lag in the staging data and survival rates, which means that the impact may not be seen immediately, or indeed even by the end of the programme.			

8. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the Business Case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above.

Where external stakeholder support is vital to the success of the Business Case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment. If the Business Case spans more than one Care Group or Directorate the expected/required close collaboration in such circumstances must be evidenced.

Examples of stakeholders include lead clinicians, support services (e.g. Digital Information Services (DIS), Capital Planning re: accommodation, YTHFM LLP re Estates & Facilities support services), Commissioners (e.g. HCV ICB, NHSE, etc.), patients & public, etc.

See page 24 of the guidance for a checklist of potential questions that should be considered when assessing stakeholder involvement.

A 'Not-Applicable' (N/A) response is not acceptable in this section of the case unless accompanied by the name of the relevant stakeholder that has confirmed there is no applicable involvement in the case.

Stakeholder	Confirmation of Stakeholder Support
Mandatory Consultation	
Respiratory Medicine & Lung Cancer Specialists	Involved in development of BC
Radiology	Involved in development of BC
Laboratory Medicine (SHYPS)	Involved in development of BC
Patient Administration	Involved in development of BC
Digital Information Systems (DIS)	Involved in development of BC
Other Consultation	
North Yorkshire, Vale of York and East Riding Council	Involved in development of BC
Cancer Alliance	Involved in development of BC
Place Directors	Involved in development of BC

ECONOMIC CASE

The purpose of the economic case is to identify the proposal that delivers the best value for money.

The economic case should identify the preferred option when measured against the issues identified in section 4 of the strategic case, how it closes the capacity gaps identified, how it meets the business case objectives outlined in section 7 and how it meets the Trust's strategic priorities.

9. Options Considered

List, and describe briefly below the alternative options considered to resolve the issue(s) presented in Section 4 above. This should just be a factual description of the option, without at this stage, any comments on the pros and cons of the option. The inclusion of alternative workforce and clinical models should be considered when generating the list of options. Option 1 should always be Business as Usual (BAU) as a comparison to the options considered

Description of Options Considered
1. Do Nothing
2. Deliver TLHC Service using insourced / outsourced CT capacity
3. Deliver TLHC service using system CT capacity

10. Benefit and Cost Analysis

All identified options must be subject to a Benefit and Cost analysis, using the 'Investment Appraisal Scoring Sheet' (Appendix Aiii) and summarised below:

Summary Benefit Cost Analysis			
	Option 1	Option 2	Option 3
Objectives Score	15	75	60
	£000	£000	£000
Net Income & Expenditure	0	611	611
Net Present Value	0	1,208	1,644
Net Present Value Per Objective Point Scored (£000)	0.00	0.06	0.04
Overall Ranking (manually enter)	3	1	2

11. The Preferred Option

Detail the preferred option together with the reasons for its selection over the other options. This must be supported with appropriate description and data in demonstrating how it will address the issue(s) described in Section 4 above.

The case for the preferred option should include how the option closes any capacity gaps identified in section 5, with the results of the closed gap after using the preferred capacity and demand model. This section should also confirm that the preferred option meets the business case objectives identified in section 7.

The preferred option should be cross referenced to key attributes identified in the Benefit and Cost Analysis in section 10.

Confirm the preferred option
The preferred option would be Option 3, however there is a lack of clarity from national NHSE programmes around what can and cannot be utilised from existing CT infrastructure, including the TLHC CT scanners from other Trusts and Community Diagnostic Centres. Given the pace required for roll out prior to a national screening programme, Option 2 has been put forward below whilst conversations progress around Option 3. Should Option 2 be successful and CT scanning capacity is found within the system, CT outsourcing costs would be reduced and therefore a larger revenue stream for the trust created.
Describe how the preferred option addresses any capacity gaps identified in section 5

There is currently no provision for this service and the Trust is one of the few areas in England without a TLHC programme. This business case for TLHC includes an increase in lung cancer pathway, to accommodate the expected increase in capacity. This should also strengthen the Trust lung cancer service, by providing additional clinical, nursing and administrative resource.
Describe how the preferred option meets the Trust's strategic priorities in section 6
The preferred option meets the Trust strategic priorities in all 4 areas, as described above.
Describe how the preferred option meets the Business Case Objectives identified in section 7
The preferred option meets all objectives identified in section 7.
Describe how the outcome of the IASS in section 10 supports the preferred option?
The preferred option is the only top scoring option in the IASS, this is mainly due Option 3 relying on recruitment of in-house Radiographers and the delays this could cause on the pilot.

12. Consultant, and other Non-Training Grade Doctor Impact

*(Only to be completed where the preferred option **increases** the level of Consultant / non-Training Grade input)*

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the Business Case.

	Before	After
Average number of Pas	0	16.5
On-call frequency (1 in 14)	0	TBC

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**

Respiratory Consultant			**0**	**10**
Radiology Consultant			**0**	**4.5**
Cell Path Consultant			**0**	**2**

12.2 Job Plan Approval:

The Medical Director or Deputy, along with the Medical Workforce Manager must review all proposed Job Plans for new Consultant posts, as well as any Job Plans of existing Consultants where the proposed new post would have an impact on current working practices. The date that the Job Plans were approved must be provided below.

Date of Approval	
Comments by either the Medical Director or Deputy, or the Medical Workforce Manager	**Awaiting sign off**

13. Accommodation

If the delivery of this Business Case is reliant on the Care Group or Directorate submitting the case being allocated additional space (e.g. to accommodate new staff or to expand its services) the availability of this additional space should be established prior to the submission of the Business Case for approval.

If assistance is required in assessing the space requirements / availability of space to support this Business Case then help is available from Tony Burns (01904) 721856 or tony.burns@york.nhs.uk).

Does the implementation of the Business Case require additional space to be found and allocated?	**Yes**	**No**
	In part- the ethos behind the national TLHC programme is that mobile CT should be used in the community (e.g. supermarket carparks). The trust delivery model is anticipated to be a hybrid between community spaces and Trust sites. Some office space may be required for nursing and administrative staff, however the cancer alliance is working towards a hub & spoke screening model which may host staff.	
Has the space identified been confirmed available?	**Yes**	**No**
	Spaces have been identified but roll out plan will be developed as confirmed with ICB/ national team around the use of existing community spaces/ Trust sites and cancer alliance around a screening hub.	

	Yes	No
Have the costs associated with maintaining the space been included in the financial analysis?	Costs around the movement of the CT has been included in financial analysis and nominal estates maintenance costs for office space.	

Please tick

14. Benefits of the Preferred Option

The identification of the benefit(s) that are expected to arise from the Business Case is crucial to ensuring that a robust evaluation of the progress and delivery of the Business Case objectives is possible during any post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will arise from implementing the preferred option below. The benefits identified must be aligned to the business case objectives in section 7 and be tangible and capable of being evidenced through some form of measurement. The timings of when the benefits will materialise should be realistic.*

It is acknowledged that some benefits may not materialise until at least 6m, dependent on the purpose of the Business Case and, as the Guidance Manual indicates, in a small number of instances there may be a need to consider adjusting the timings of the reviews, dependent on the forecast timeframe for benefit delivery.

				(* from Estimated Implementation date)		
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m***	**At 6m***	**At 12m***
Earlier Diagnosis of Lung Cancer, to give curative treatment options to patients	Cancer Staging Data (national COSD submission)	Stage 1&2 : 30.2% Stage 3: 19% Stage 4: 41% (note % 'unknown')	This is national NHSE pilot and final stage shift in lung cancer has not yet been finalised.	Earlier stage diagnosis runs years behind so expected benefit realised in 2-3 years	Earlier stage diagnosis runs years behind so expected benefit realised in 2-3 years	Stage 1&2 : 30.2% Stage 3: 19% Stage 4: 41% (note % 'unknown')
Ability to offer curative treatment for lung cancer patients	Treatments Offered – increase in 1st definitive treatments (SCR)/ NHSE national TLHC programme upload	Curative surgery & radiotherapy performed at Tertiary Centre- IPT for treatment in SCR would provide baseline with BI&I support around triangulati	To be developed – estimated 10% increase in offered 1st definitive treatment across totality of programme	To be developed	To be developed	To be developed

		on of staging data				
Improved access to CT capacity	Additional CT Activity	0	Trajectory of 23,00 baseline scans by December 2028 Total CT scans (inc follow ups) 48,867 by December 2028	456 scans (cumulative, baseline and follow up)	2,392 scans (cumulative, baseline and follow up, including 3 month total)	6,279 scans (cumulative, baseline and follow up, including 3 month total)
Opportunity to provide other health interventions alongside CT Scans (Make Every Contact Count)	To be designed as part of health inequalities phased roll out plan, in conjunction with patient/ community groups & primary care	None	Local health interventions offered targeted to communities accessing CT scans	1 health intervention offered with CT scan (e.g, smoking cessation/ blood pressure check)	1 health intervention offered with CT scan (e.g, smoking cessation/ blood pressure check)	2 health interventions offered with CT Scan
Increase in 1 and 5 year survival rates from lung cancer	Lung Cancer Survival Rates	Cancer Audit (NLCA) data triangulated with Trust CPD/ Cancer Spell Data - benchmark of patients diagnosed with lung cancer at stage 4 have less than a 20% chance if one year survival and less than 5% chance of 5 year survival.	To be developed - This is national NHSE pilot and final stage shift in lung cancer has not yet been finalised.	To be developed but unable to quantify in first year programme	To be developed but unable to quantify in first year programme	To be developed but unable to quantify in first year programme

Improved patient experience	National Cancer Patient Experience Survey & Local Lung Cancer surveys	To be developed- CPES data released 1st August 2024/ local CNS Lung surveys	To be developed	To be developed	To be developed	To be developed

How will information be collected to demonstrate that the benefits have been achieved?

Information is collected various national mandatory data submissions (CWT/COSD), alongside mandatory TLHC programme specific uploads to NHSE. It is important to note there is a time lag in the staging data and survival rates, which means that the impact may not be seen immediately, or indeed even by the end of the programme.

The national roll out is still informing the development of the methodology of benefits realisation and metrics.

This programme requires a new dataset and nationally mandated data items. We anticipate this will be built into existing CPD and Soliton infrastructure, with minimum development work required.

15. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

In light of the difficulties being experienced both locally and nationally in successfully recruiting across a broad range of staff groups, the author should pay particular attention to the risks associated with fully recruiting to any new posts identified in the business case, supported by current market intelligence. Such risks need to be considered in the context of the likelihood (and timeframe) of the need to use agency or locum staff incurring premium costs for the Trust.

*The likelihood of any additional costs of risk **after** mitigation should be acknowledged in this section, and its impact recognised in the financial assessment of the case.*

Identified Risk	Proposed Mitigation	Value of Risk £'000
Recruitment difficulties and staff shortages to deliver expected activity levels against cancer alliance trajectories	Current vacancies out for interview in radiology and respiratory- opportunity to recruit & appoint for TLHC during these recruitment rounds if appointable candidates.	Impact on run rate – unable to quantify on hypothetical vacancies however could be cost neutral, if no staff recruited to deliver programme there is no programme to deliver income against trajectories. Risk is more likely to be in delay of pathways due to vacancies
Business case modelling has under/overestimated the expected demand within the lung cancer pathway	Model allows for increase in lung cancer pathway, however PA's and WTE are flexible cross site to be	There is a financial risk if staff are employed and TLHC activity is not there to support, however staff could

	deployed where need is required Main cost of business case is CT mobile & staffing- this will be on framework contract and could be reduced /increased if demand required Additional lung cancer activity would attract ERF income based on current models	be re-deployed to cover gaps in other services. See financial supporting commentary and run rate for value of risk year on year.
Patients do not engage with programme	CA modelling at 48% patient engagement with telephone assessment and 8% DNA rate for scan. Phased start- re-assess model and all staff not recruited at start of the programme CT mobile costs could be increased/ reduced dependent on patient engagement with programme Engagement activities will take place at trust, place and cancer alliance level.	Impact on income associated with run rate
Lack of clarity around impact on other modalities and performance	Assess the programme progresses and care groups to pick up through annual planning cycle ERF funding for additional activity Performance monitored via PRIM and WERM	Operational pressures could be caused by increase in unexpected demand, offset by assumption of future ERF funding for additional activity. If ERF is not available, additional business cases to use income surplus to support additional activity.
Overburdening of primary care with incidental findings	Primary care engagement & phased approached	No financial risk to trust but could impact relationships
Lack of clarity around transition to national screening programme	Assumptions applied to activity and costing model to take account up until December 2028 / March 2029 Review on national direction of travel and new business case would be required	Business case is costed to deliver national programme under current protocol. Business case ends at March 2029.

A hybrid approach to CT scanning (combination of hospital sites, CDC sites and mobile CT within communities) may cause fall off of patients who would have otherwise engaged	Monitoring of patient engagement rates and DNA rates against cancer alliance modelling, with additional mobile CT sessions put on if there is lower than expected run rates in certain areas.	Impact on income associated with run rate

COMMERCIAL CASE

The commercial case should demonstrate that the preferred option has considered additional approval routes required for the purchase of equipment or that a viable procurement route has been identified where required.

16. Is there a requirement to apply for funding via the Medical Equipment Resources Group (MERG), linked to this Business Case?

If 'yes', the completed and approved MERG form must feature as an attachment to the Business Case document.

Yes	
No	X

Please tick

If 'Yes' please state below what proportion of the overall Capital costs associated with the Business Case (see the Financial Pro-forma), relate specifically to equipment

Overall Capital Costs for the Business Case	
State the value of the Equipment within the above	

17. Is there a requirement to involve or liaise with the Procurement Department with regard to any aspects associated with this Business Case?

Yes	X
No	

Please tick

If 'Yes' please provide a brief summary to evidence the involvement and the outcome.

Contract for CT is on framework

FINANCE CASE

The finance case should demonstrate that the business case is affordable and the relevant source of funding is identified.

18. Financial Summary

18.1 Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the Care Group or Directorate as a result of this Business Case. The figures should summarise the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure		-24	-24
Income		4183	4183
Direct Operational Expenditure		-3569	-3569
EBITDA		614	614
Other Expenditure		-3	-3
I&E Surplus/ (Deficit)		611	611
Existing Provisions			
Net I&E Surplus/ (Deficit)		611	611
Contribution (%)			
Non-recurring Expenditure		-113	-113

Supporting Financial Commentary:

Non Recurring Costs - These costs relate to the need for additional PACS image Storage (£100k) and the Soliton and PACS integration work to ensure the TLHC images can be stored and accessed as required, there is pump prime income to offset this expenditure.

Income - The Activity related income relates to the LHC Assessments and to the CT Scans associated with these. The Non-Activity Related income in 24/25 is the pump priming required to set up the service.

Pay Costs - The Pay costs within this business case are related to the setting up of a TLHC team to assess the patients and the required Radiography and Cellular Pathology staff to carry out the diagnostic element of the TLHC pilot.
The team would include clinical leads in radiology, respiratory and a lead nurse assessor, in line with the national protocol.

Costs	WTE
Reporting Costs:-	
MDT (Consultant)	0.20
Booking - Band 3	0.20
PACS - Band 3	0.10
Medical Secretary - B4	0.20
Additional Cancer Findings	
Staffed CT Mobile -21 Hours	
MRI B6 Radiographer	0.09
MRI B3 Support Worker	0.09
Consultant Reporting Time	0.25
Nursing B5 Time	0.04
Admin B3 Time	0.02
CellPath Costs	
Admin - B3	1.00
Technical Support - B4	1.00
Consultant	0.20
Molecular Testing (£1240/Confirmed Case)	
Confirmed Cancer Numbers (based on CT Numbers)	
Reporting	
Lung Department Costs	
Consultant - 10PA's	1.00
Medical Secretary	0.5
B6 Nursing (Average WTE per year)	Average- from 2 WTE to 8 WTE
B7 - Lead	1.00
Admin Team	
Band 3 Admin	6.60
Band 4 Team Leader	1.00
Band 5 Admin Manager	1.00
Operational Manager - Band 7	1.00
Cancer Info Team - B5	0.27

Capital Costs and Capital Charges - The capital costs within this case are purely the costs of purchasing IT equipment and the capital charges related to this

Estate Costs - The business case assumes staff will be working in areas already maintained by the LLP so no further in house estate costs, the costs related to siting the mobiles in external premises is built into the Site Expenses line above.

18.2 Estimated Impact on Run Rate

Summarise the impact on current monthly income and expenditure run rate as a result of this Business Case. The current run rate should reference the average monthly income and expenditure over the last six months. Demonstrate how the run rate will change as a result of this business case in full, and at 6 months and 12 months following approval of the case. Show income as positive figures and expenditure as negative.

	Current Run rate	Revised Run Rate	Change	Change at 6 months	Change at 12 months
	£000	£000	£000	£000	£000
Income (+ve)					
Clinical Income		349	349	0	167
Non Clinical Income			0		
Expenditure (-ve)					
Pay		-98	-98	-13	-84
Non Pay		-199	-199	-1	-91
Non Operational expenditure		0	0		
Total	0	52	52	-14	-8

Run Rate Supporting Commentary:

This would result in a £879,000 contribution over the course of the programme. The long term impact of this BC is that the Trust run rate will improve by £52k per annum, whilst the pilot is being set up and patients working their way through the pathway in the early months there will be an increase of between £8 and £14k per month on the trust run rate. This can be mitigated by recruitment delays if patient take up is less than anticipated. Also Mobile days can be reduced if patient demand is reduced but income will also be affected in direct corelation.

Run Rate

2025/26	2026/27	2027/28	2028/29
-			
211,429	**239,818**	**611,304**	**258,161**

Central funding being sought for 2025/26 costs, in relation to one off set up costs and initial recruitment of staff to support onboarding and training whilst no income is being generated.

Any CT capacity that can be used at a system level will offset the CT mobile costs.

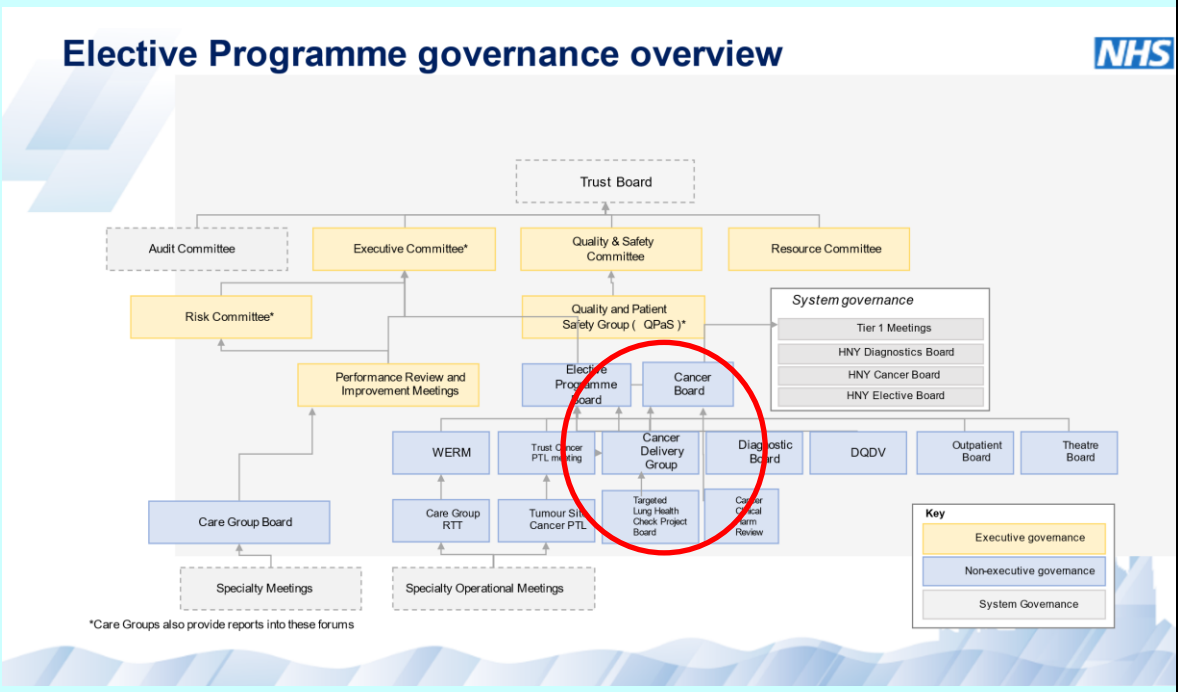
MANAGEMENT CASE

The management case should demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the preferred option.

19. Delivery

Describe the process put in place for successful delivery of the preferred solution, this should include the management of any potential risks, delivery of benefits, recruitment timescales and budgetary changes.

The York and Scarborough Cancer programme has a programme governance structure to oversee the delivery and risks of the programme, with agreed terms of reference for the project board and delivery groups:



The business case includes a programme manager to work across care groups to support recruitment, roll out, clinical pathways and risks.

The SRO for the project is the Deputy Chief Operating Officer, however the project is also supported by the Chief Operating Officer and Associate COO's from the Medicine and Cancer Services Care Group.

Once the programme is established and operational, a decision will be taken as to where it best sits for business as usual in terms of the trust care group structure.

20. Post Implementation Review (PIR)

Provide a self-assessment of the risk score and summarise below to determine whether a PIR is required, this will be validated at the time of approval of the business case, by the approving authority, see section 20 of the business case guidance:

Self-assessment score	Level of Risk	Outcome
8-9	Medium	PIR at the discretion of the approving individual or body

21. Estimated Implementation Date

State the estimated implementation date. This will be used as the start point of the review period where the Business Case is selected for Post Implementation Review (PIR).

Estimated Implementation Date	**April 2025** **Note: if pump prime funding is successful, then implementation to commence Q4 2024-2025**

22. Date of Completion:

Note: This date should be kept current on each occasion that the documentation is refreshed/ updated.

The use of version control is recommended to aid the auditing and tracking of current documentation, particularly if the Case spans more than one Care Group or Directorate with multiple contributors. The 'Final' version must be clearly indicated as such.

Date	July 2023
Version No.	V1

Appendix A

- National Standard Protocol https://www.england.nhs.uk/wp-content/uploads/2019/02/B1646-standard-protocol-targeted-lung-health-checks-programme-v2.pdf

- National Quality Assurance Standards https://www.england.nhs.uk/wp-content/uploads/2019/02/B1647-quality-assurance-standards-targeted-lung-health-checks-programme-v2.pdf

- National Data Collection Template

Copy of 240513 TLHC CA Data Collection Te

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2024/05-14
TITLE:	Targeted Lung Health Check Programme
OWNER:	Kim Hinton
AUTHOR:	Beth Eastwood

Capital

		Total £'000	Planned Profile of Change 2024/25 £'000	2025/26 £'000	2026/27 £'000	Later Years £'000
Capital Investment	(-ve)	0				
Equipment	(-ve)	-24	-24			
Property Transactions (Leases)	(-ve)	0				

Capital Notes *(including reference to the funding source)* :

All relates to IT equipment, including Laptops Radiologist Workstation and admin PC, will need purchasing prior to go live so spend will be incurred in 24/25.

Revenue

		Total Change Current £'000	Revised £'000	Change £'000	WTE	Planned Profile of Change 2024/25 £'000	2025/26 £'000	2026/27 £'000	Later Years £'000
(a) Non-recurring set up costs	(-ve)					-113			
(b) Recurring									
Income									
Income from Patient Care Activities:	(+ve)	0	4,183	4,183		0	2,006	2,968	4,183
Other Operating Income	(+ve)	0	0	0		284	0	0	0
Total Income		**0**	**4,183**	**4,183**		**284**	**2,006**	**2,968**	**4,183**
Operating Costs:									
Pay									
Medical	(-ve)	0	-223	-223	1.65	-37	-223	-223	-223
Nursing	(-ve)	0	-500	-500	10.50	-57	-340	-455	-500
Other (please list):									
Radiographers	(-ve)		-4	-4	0.09	0	-4	-4	-4
Cell Path	(-ve)		-64	-64	2.00	0	-64	-64	-64
Admin/Other Staff	(-ve)		-371	-371	10.98	-62	-371	-371	-371
DIS Staff			-9	-9	0.20	0	-9	-9	-9
Total Pay Costs		**0**	**-1,171**	**-1,171**	**25.42**	**-156**	**-1,011**	**-1,126**	**-1,171**
Non-Pay									
CT Mobile	(-ve)		-1,205	-1,205		0	-515	-784	-1,205
Radiology Outsourced Reporting	(-ve)		-749	-749		0	-334	-490	-749
Cellular Pathology	(-ve)		-257	-257		0	-109	-166	-257
General Supplies & Services	(-ve)			0					
Site Expenses	(-ve)		-175	-175		0	-125	-150	-175
Establishment	(-ve)		-12	-12		0	-12	-12	-12
NECS	(-ve)		0	0		-15	0	0	0
Transport	(-ve)			0					
LLP Costs (Facilities Mgmt & Estates)	(-ve)			0					
Other (please list):									
	(-ve)			0					
	(-ve)			0					
Total Non Pay Costs		**0**	**-2,398**	**-2,398**		**-15**	**-1,095**	**-1,602**	**-2,398**
Total Operational Expenditure		**0**	**-3,569**	**-3,569**		**-284**	**-2,106**	**-2,728**	**-3,569**
Impact on EBITDA		**0**	**614**	**614**	**25.42**	**0**	**-100**	**240**	**614**
Depreciation	(-ve)		-2	-2			-2	-2	-2
Rate of Return	(-ve)		-1	-1			-1	-1	-1
Lease Ammortisation	(-ve)			0					
Overall impact on I&E		**0**	**611**	**611**	**25.42**	**0**	**-103**	**237**	**611**
									+ favourable (-) adverse
Less: Existing Provisions	(+ve)	**n/a**		**0**					
Net impact on I&E		**0**	**611**	**611**		**0**	**-103**	**237**	**611**
									+ favourable (-) adverse

Revenue Notes *(including reference to the funding source)* :

Non Recurring Costs - These costs relate to the need for additional PACS image Storage (£100k) and the Soliton and PACS integration work to ensure the TLHC images can be stored and accessed as required, there is pump primin income to offset this expenditure.

Income - The Activity related income relates to the LHC Assessments and to the CT Scans associated with these. The Non-Activity Related income in 24/25 is the pump priming required to set up the service.

Pay Costs - The Pay costs within this business case are related to the setting up of a TLHC team to assess the patients and the required Radiography and Cellular Pathology staff to carry out the diagnostic element of the TLHC pilot.

Capital Costs and Capital Charges - The capital costs within this case are purely the costs of purchasing IT equipment and the capital charges related to this

Estate Costs - The business case assumes staff will be working in areas already maintained by the LLP so no further in house estate costs, the costs related to siting the mobiles in external premises is built into the Site Expenses line above.

			Board of Directors Only
	Owner	**Finance Manager**	**Director of Finance**
Signed	**Kim Hinton**	**Neil Barrett**	
Dated	23.7.24	23.7.24	

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2024/25	2025/26	2026/27	Later Years
Fixed Contract Element							
Non-elective admissions			0				
Outpatient Follow Ups			0				
A&E			0				
High Cost Drugs			0				
Other (please list):							
TLHC CT Scans		13,554	13,554	0	5,742	8,790	13,554
TLHC Assessments		13,215	13,215	0	9,859	13,215	13,215
Variable Contract Element							
Elective Inpatients			0				
Elective Day Cases			0				
Outpatient First Attendances			0				
Outpatient Procedures			0				
High Cost Drugs			0				

Income (*+ve*)

		Total Change			Planned Profile of Change			
		Current £'000	Revised £'000	Change £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	Later Years £'000
Fixed Contract Element								
Non-elective admissions	(+ve)			0				
Outpatient Follow Ups	(+ve)			0				
A&E	(+ve)			0				
High Cost Drugs	(+ve)			0				
Community Services	(+ve)			0				
Other (please list):								
TLHC CT Scans			3,456	3,456	0	1,464	2,241	3,456
TLHC Assessments			727	727	0	542	727	727
Variable								
Elective Inpatients	(+ve)			0				
Elective Day Cases	(+ve)			0				
Outpatient First Attendances	(+ve)			0				
Outpatient Procedures	(+ve)			0				
High Cost Drugs	(+ve)							
Other NHS Clinical Income								
	(+ve)			0				
	(+ve)			0				
Non NHS Clinical Income								
Private patient income	(+ve)			0				
Other non-protected clinical income	(+ve)			0				
Total Income from patient care activities		**0**	**4,183**	**4,183**	**0**	**2,006**	**2,968**	**4,183**
Other income								
Research and Development	(+ve)			0				
Education and Training	(+ve)			0				
Other (please list):								
	(+ve)							
	(+ve)			0				
Total other income		**0**	**0**	**0**	**0**	**0**	**0**	**0**

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE RUN RATE SUMMARY

		Total Change				Planned Profile of Change		
		Current £'000	Revised £'000	Change £'000		6 months £'000	12 months £'000	Later Years £'000
Income								
Income from Patient Care Activities:	(+ve)		349	349		0	167	349
Other Operating Income	(+ve)			0				
Total Income		**0**	**349**	**349**		**0**	**167**	**349**
Operating Costs:								
Pay								
Medical	(-ve)		-19	-19		-3	-19	-19
Nursing	(-ve)		-42	-42		-5	-28	-42
Other (please list):								
Radiographers	(-ve)							
Cell Path	(-ve)		-5	-5		0	-5	-5
Admin/Other Staff	(-ve)		-31	-31		-5	-31	-31
DIS Staff	(-ve)		-1	-1		0	-1	-1
Total Pay Costs		**0**	**-98**	**-98**	**0.00**	**-13**	**-84**	**-98**
Non-Pay								
Purchase of Healthcare from NHS Bodies	(-ve)		-100	-100		0	-43	-100
Purchase of Healthcare from non NHS Bodies	(-ve)		-62	-62		0	-28	-62
Clinical Supplies & Services	(-ve)		-21	-21		0	-9	-21
General Supplies & Services	(-ve)		0	0		0	0	0
Drugs	(-ve)		-15	-15		0	-10	-15
Establishment	(-ve)		-1	-1		0	-1	-1
Premises - (incl Business rates)	(-ve)		0	0		-1	0	0
Transport	(-ve)		0	0		0	0	0
LLP Costs (Facilities Mgmt & Estates)	(-ve)			0				
Other (please list):								
	(-ve)			0				
	(-ve)			0				
Total Non Pay Costs		**0**	**-199**	**-199**		**-1**	**-91**	**-199**
Total Operational Expenditure		**0**	**-297**	**-297**		**-14**	**-175**	**-297**
Impact on EBITDA		**0**	**52**	**52**	**0.00**	**-14**	**-8**	**52**
Depreciation	(-ve)			0				
Rate of Return	(-ve)			0				
Lease Ammortisation	(-ve)			0				
Overall impact on I&E		**0**	**52**	**52**	**0.00**	**-14**	**-8**	**52**
Less: Existing Provisions	(+ve)	**n/a**		**0**				
Net impact on I&E		**0**	**52**	**52**		**-14**	**-8**	**52**

Run rate notes:

The long term impact of this BC is that the Trust run rate will improve by £52k per annum, whilst the pilot is being set up and patients working their way through the pathway in the early months there will be an increase of between £8 and £14k per month on the trust run rate. This can be mitigated by recruitment delays if patient take up is less than anticipated. Also Mobile days can be reduced if patient demand is reduced but income will also be affected in direct corelation.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	23 October 2024
Subject:	Board Assurance Framework Q2 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 Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☒ Quality Standards
☒ Great place to work, learn and thrive	☒ Workforce
☒ Work together with partners	☒ Safety Standards
☒ Research, innovation and transformation	☒ Financial
☒ Deliver healthcare today without compromising the health of future generations	☒ Performance Targets
☒ Effective governance and sound finance	☒ DIS Service Standards
	☒ Integrated Care System
	☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The Board of Directors is asked to approve the Q2 2024/25 Board Assurance Framework.

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

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
Risk Committee	2 October 2024	Noted for update

Board Assurance Framework Q2 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 Q2 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 January Board of Directors meeting.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board Assurance Framework (BAF)

October 2024

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 ⇧	PR5 – Financial risk associated with delivery of Trust and System strategies	C → T	25	0 0 1	Director of Finance	Resources Committee
2 ⇨	PR2 – Inability to provide safe and effective care	I → C → T	20	0 0 5	Medical Director	Quality Committee
3= ⇨	PR3 - Failure to deliver constitutional/regulatory performance and waiting time targets	I → C → T	16	0 0 1	Chief Operating Officer	Resources Committee
3= ⇨	PR1 – Unable to deliver treatment and are to the required standard	I → C → T	16	0 0 3	Chief Nurse	Quality Committee
4 ⇨	PR4 – Inability to manage vacancy rates and develop existing staff predominately due to insufficient domestic workforce supply to meet demand	I → C → T	12	0 0 3	Director of Workforce & OD	Resources Committee
4 ⇨	PR6 – Failure to deliver safe, secure and reliable digital services required to meet staff and patients needs	I → C → T	12	0 0 1	Chief Digital & Information Officer	Digital Sub-Committee
5 ⇩	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	I → C → T	9	0 0 3	Director of Finance	Resources Committee
6 ⇨	PR7 – Trust unable to meet ICS expectations as an acute collaborative partner	I → C/T	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	⇔
PR2	Inability to provide safe and effective care	Medical Director	Quality Committee	5	5	25	5	4	20	6 LOW	OUT	4	3	12	⇔
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	⇔

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	⇔

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	⟷

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	4	4	16	3	3	9	12 OPEN	IN	2	3	6	↓

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	5	5	25	10 CAUTIOUS	OUT	3	2	6	↑

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 ICB expectations as an acute collaborative partner	Chief Executive	Executive Committee	3	3	9	2	3	6	12 OPEN	IN	2	3	6	⟷

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	16	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	Capital planning process (Trust and Estates Strategy)	Q1 - Capital Programme Executive Group(CPEG) monitoring minutes Q1 Business Planning Schedules
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)	- Q1-2 TPR Board and Committee reporting - Q1-2 Monthly Agency Usage reporting to Executive Committee	Annual Capital Programme Approval	April 2024 Board approved plan
Implementation of Clinical Standards	Q1 24/25 Board and Quality Committee reporting; Maternity, Nurse Staffing, IPC	Implementation of Workforce Strategy	Q1 TPR Nurse Staffing Reporting *Gap – poor diversity in leadership positions*	Monitoring and reporting against the capital programme	- Q1 CPEG, Resources Committee reporting and minutes - Q1 TPR Board and Committee reporting
Professional Standards Doctors Revalidation	Annual Board Revalidation Report Sept 2023 *Gap – Revalidation links to appraisal*	Operational Plan Implementation	Q1 Care Group weekly operational and monthly PRIM meetings	Monitor Bank Training Compliance Nursing and Midwifery Quality Assurance Framework	Q1 Bank Training Compliance Care group Reports: Non-medical and Medical
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		

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

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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	20	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 - Q1-2 Patient Safety and Clinical Effectiveness Sub-Committee reporting - Q1-2 PRIM meetings - Q1-2 Learning From Deaths Board and Quality Committee reporting - Q1-2 Patient Safety and Clinical Effectiveness escalation reporting to Quality Committee - Q1-2 Patient Experience Sub-Committee escalation reporting to Quality Committee - Elective and Cancer Care Tier review May reporting to Quality Committee and Board - Q1-2 Reportable Issues Log Board reporting	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-Q2 Patient Safety and Clinical Effectiveness Sub-Committee reporting and Quality Committee escalation - Q1-Q2 Patient Experience Sub-Committee reporting and Quality Committee escalation
Patient Safety Incident Response Framework (PSIRF) Implementation	Training of staff and reports concluded				
Gaps – overarching analysis and triangulation of all information. Clinical pressures divert clinical staff from Audit Assurance work. Ward to Board quality data.					

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?
Care Group Oversight	Redesign of Care Group governance and structure for Ward to Board reporting	Adele Coulthard	November 2024
Implementation of PRIM	Embedded PRIM monthly	Claire Hansen	March 2025 (review)
Evolving the content of MAG	MAG in place monthly	Sascha Wells-Munro	March 2025 (review)
UEC Assurance Group	Agenda developing to support improvement	Claire Hansen	March 2025 (review)
Embed Clinical Oversight and Effectiveness Group	Systematic trawl of all local/national audits and document control. Progress reviewed by Patient Safety and Clinical Effectiveness Sub-Committee monthly.	Richard Khafagy	March 2025 (review)

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	3	12

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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	16	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-Q2 Board and Resources Committee TPR reporting - Q1-Q2 PRIMs with all Care Groups reporting - Q1-Q2 Integrated Quality Improvement Group reporting *Gap – Specialty level dashboards not fully established with all metrics available*	Monitoring the effectiveness of waiting list management	- Q1-Q2 Board and Resources Committee reporting on performance - Q1-Q2 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-Q2 TPR Board and Committee reporting - Q1-Q2 PRIMs for each Care Group	Implementation of operational, winter, resilience and surge planning	- Q1-Q2 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

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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	12	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

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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: 25

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	5	5	25	CAUTIOUS (8-9)	OUT OF APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	16	25	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	- TPR Board and Committee reporting - PFR monthly to NHSE - Care Group PRIM meetings and Financial Review Meetings	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 and Vacancy Control *Gaps – payroll untimely informed of leavers*	- Salary overpayment recovery policy - Staff Reports, Finance to budget holders - Enhanced Vacancy Control Panel
Cash flow monitoring through debtors and creditors	- Monthly debtor and creditor dashboard - Trend data and Better Payment Practice reported to Resources, Executive Committees and Board				
Routine monitoring against cash flow	- 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 focus on delivery now and system wide medium-term financial planning to be developed later in the year.	Deficit funding released to ICB and distributed to Trusts. ICB lead grip and control plan delivery work underway (summit meeting happened). System focus on delivering the best possible system position.	Andrew Bertram	October 2024 though to March 2025.

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6

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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	12	12	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* Suite of policies and protocols in the process of being updated	- 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. Phishing campaigns conducted throughout 2024 (additional similar exercises planned). To further support these efforts, an article is planned for "Staff Matters" newsletter on October 24, aligning with Cyber Awareness Month	- 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* Board training on offer (noted at Digital Committee), and can be delivered when appropriate dates have been identified	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.* Access control policy being reviewed for publication	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. Working with other departments, e.g., Pathology, to formally gain insight to cyber processes of third-party vendors/suppliers (ongoing)		

Target Risk (After Actions Implemented)

I	L	Rating I x L
3	3	9

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)

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Ref PR7 Board Assurance Framework (BAF)

Ref: PR7	Strategic Objective: Our Partnerships	**PRINCIPAL RISK 7:** Trust enable to meet ICB 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	6	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 ICB 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 and Diagnostics	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 (CIC) to manage CAP business and CIC minutes - June 2023 Board agreed terms of reference and joint working agreement - Q1 and Q2 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	Collaborative Board established with HDFT	Terms of reference and meeting notes drafted		

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	December 2024 (review)

Target Risk (After Actions Implemented)		
I	L	Rating I x L
2	3	6

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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: 9

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 legal NHS England action against the Trust

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		
4	4	16	3	3	9	OPEN (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)
Current Risk Rating	16	9	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. Trust Green Plan and its governance through the Sustainable Development Group and the workstreams that report into it.	- Modern Energy Partners (MEP) concept design report on the Trust	PSDS Phase 3 grant applications approved for £4.7m for Bridlington Hospital for Net Zero and £4.3m for York Hospital decarbonisation process. PSDS4 application now being readied for submission to de-steam Scarborough Hospital with additional supporting items around PV, gladding and insulation.	- PSDS Grant work delivered in 2022/23 - Works undertaken at York and Bridlington 2023/24 - LED lighting project almost complete across most buildings in the Trust
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 and Trust's Green Plan)	Energy works and Staff Travel Plan are led by 2 senior officers in the Trust. Each have their own board who provides oversight to this work.	Officer and subject matter board oversight that reports into the Green Plan governance structure through the Sustainable Development Group.

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	November 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.	John Dickenson (York) & James Hayward (East Coast)	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
Q3 - Dec 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

Report to:	Board of Directors
Date of Meeting:	23 October 2024
Subject:	Schedule of Board Meetings 2025/26
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 Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care ☒ Great place to work, learn and thrive ☒ Work together with partners ☒ Research, innovation and transformation ☒ Deliver healthcare today without compromising the health of future generations ☒ Effective governance and sound finance	☒ Quality Standards ☒ Workforce ☒ Safety Standards ☒ Financial ☒ Performance Targets ☒ DIS Service Standards ☒ Integrated Care System ☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The Board of Directors is asked to note the meeting dates for 2025/26.

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

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

Schedule of Board Meetings 2025/26

1. Introduction and Background

York and Scarborough Teaching Hospitals NHS Foundation Trust's Board of Directors meet in public 10 times a year on monthly basis, excluding the months of August and December.

These meetings are followed by private meetings due to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

2. 2025/26 Board Meetings

The dates for the 2025/26 Board Meetings are scheduled as follows:

30 April 2025
21 May 2025
25 June 2025
30 July 2025
24 September 2025
22 October 2025
26 November 2025
28 January 2026
25 February 2026
25 March 2026

3. Board Visits

The Board of Directors will continue to visit Wards and Departments across the Trust following each meeting.