The Chair invites you to attend a meeting of the Public Trust Board

Thursday 08 September 2022
9.00am – 1.00pm
Seminar Rooms 6, 7 and 8 in Trust Headquarters, Pinderfields Hospital
(For Board members)

Due to COVID-19 the meeting will held in person for Board members only, however it will be streamed via Microsoft Teams Live for members of the public to join. The link will be available on the Trust website on the Monday prior to the meeting

AGENDA

09.00 – 09.20: Clinical Story: Paediatric Diabetes				
Section 1		**Administration**		
09.20 – 09.40	1.1	Chair's Opening Remarks and questions from the public		
	1.2	Apologies for Absence:		
	1.3	Quorum/Declarations of Interest		
	1.4	Attendance Matrix		Paper/Information
	1.5	Risk Appetite Matrix		Paper/Information
	1.6	Unconfirmed Minutes of the meeting held on 14 July 2022		Paper/Approval
	1.7	Matters Arising		Paper/Review
	1.8	Chair's Report	**Mr Ramsay**	Paper/Assurance
	1.9	Chief Executive's Report	**Mr Richards**	Paper/Assurance
Section 2		**Leadership and Governance**		
09.40 – 10.40	2.1	Report from the Chair of the Risk Committee meetings held on 21 July and 18 August 2022	**Mrs Davies**	Paper/Assurance
	2.2	Board Assurance Framework (Principal Risks 3 and 4) and Trust Level Risk Register	**Mrs Parkes/ Ms Beckett**	Paper/Assurance
	2.3	Fit and Proper Persons Annual Report	**Ms Beckett**	Paper/Assurance
	2.4	Risk Management Framework	**Mrs Parkes/ Ms Beckett**	Paper/Approval
	2.5	Tier 1 Committee Proposal	**Ms Beckett**	Paper/Approval
BREAK				

Section 3		**Effectiveness**		
10.55 – 11.35	3.1	Report from the Chair of the Resource and Performance Committee held on 27 July 2022	**Mr Stone**	Paper/Assurance
	3.2	Trust Board Performance Report	**Mrs Whitaker**	Paper/Assurance
	3.3	Green Plan Annual Report 2021/22	**Mr Braden**	Paper/Assurance
Section 4		**Quality and Safety**		
11.35 – 12.30	4.1	Report from the Chair of the Quality Committee for meeting held on 02 September 2022 *(report from the meeting on 05 August 2022 provided for information)*	**Dr Throssell**	Verbal/ Paper/Assurance
	4.2	Maternity Services *(including an update on the Maternity Incentive Scheme)*	**Mrs Parkes**	Paper/Assurance
	4.3	IPC Annual Report	**Mrs Parkes**	Paper/Assurance
	4.4	Learning From Deaths	**Dr Stone**	Paper/Assurance
Section 5		**Other Matters**		
12.30 – 13.00	5.1	Innovation Strategy	**Dr Stone/ Mr Bond**	Presentation /Decision
	5.2	Teaching Hospital Application	**Dr Stone**	Paper/Assurance
	5.3	Any other business (previously noted to the Chair)	**All**	Verbal
	5.4	The next meeting of the Public Trust Board is scheduled to take place on Thursday 10 November 2022 from 9.00am. Details on the venue are to be confirmed and will be dependent upon latest national guidance on COVID-19 and social distancing.		

FOR INFORMATION:

6.1	Equality Diversity and Inclusion Annual Report 2021-22

The Mid Yorkshire Hospitals NHS Trust

MY Paediatric Diabetes Service

Dr Victoria Hemming, Paediatric Consultant

Mrs Sally Jennians, Paediatric Diabetes Specialist Nurse

September 2022

Working together
making a difference

An Associated Teaching Trust

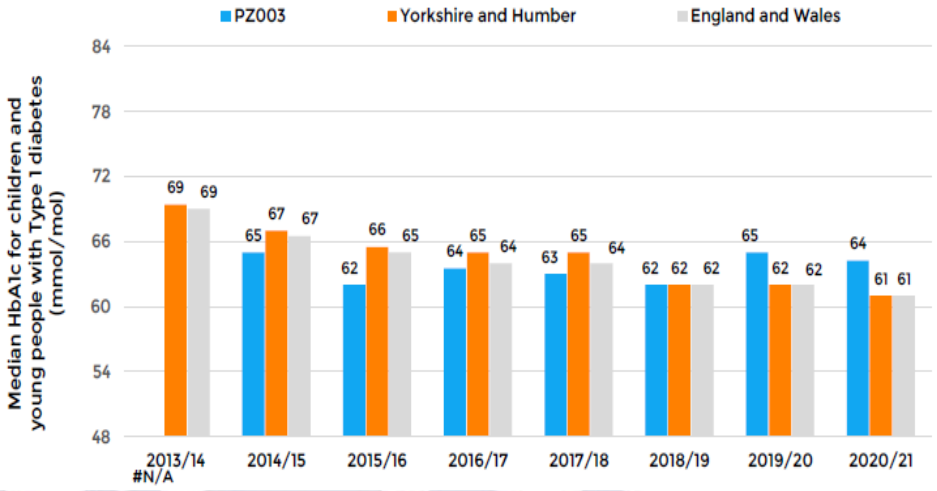
Paediatric Diabetes Team

Demographics

- 213 Wakefield & Pontefract
  - 95.6% White
  - 2.2% Asian
  - 37.4% Most deprived quintile
  - 8.8% Least deprived quintile
- 114 Dewsbury
  - 67.8% White
  - 27.8% Asian
  - 47.8% Most deprived quintile
  - <5% Least deprived quintile

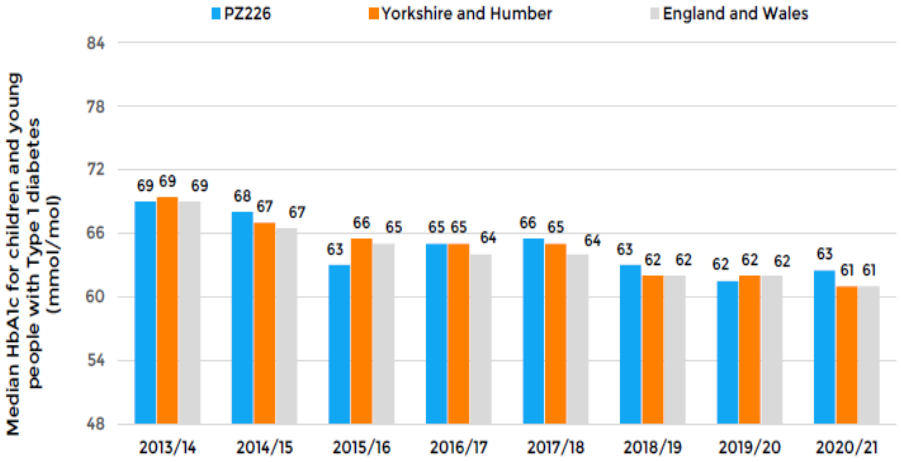
NPDA – HbA1c

Pinderfields & Pontefract



Dewsbury

Figure 16: Median HbA1c for children and young people with Type 1 diabetes



NPDA – Key care process

Pinderfields & Pontefract

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
HbA1c (all ages)	100.0%	100.0%	100.0%	100.0%	99.5%	97.1%
Thyroid (all ages)	86.1%	90.2%	83.2%	88.4%	96.2%	86.5%
BMI (all ages)	99.3%	99.3%	98.7%	100.0%	99.5%	86.0%
Blood Pressure (12+)	100.0%	100.0%	97.4%	98.9%	98.2%	85.7%
Urinary albumin (12+)	79.0%	80.8%	79.5%	75.0%	94.6%	76.2%
Foot exam (12+)	65.4%	78.2%	62.8%	68.2%	93.8%	46.7%

Dewsbury

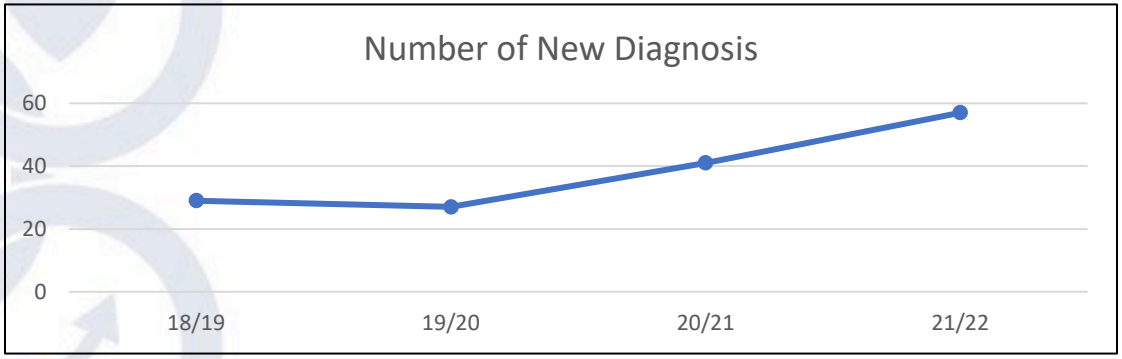
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
HbA1c (all ages)	100.0%	100.0%	100.0%	100.0%	100.0%	94.5%
Thyroid (all ages)	78.9%	81.9%	79.6%	88.3%	96.7%	84.6%
BMI (all ages)	100.0%	100.0%	99.0%	100.0%	98.9%	76.9%
Blood Pressure (12+)	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%
Urinary albumin (12+)	76.0%	75.5%	71.2%	81.6%	93.3%	83.3%
Foot exam (12+)	62.0%	94.3%	73.1%	83.7%	100.0%	52.1%

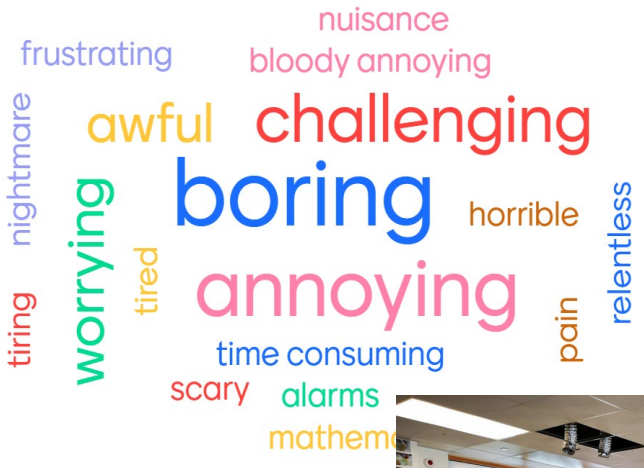
Covid 19 effect

- Virtual clinics
- HbA1c clinics
- Virtual Education
- Virtual MDT & QI meetings
- Virtual meetings across region
- School Education packages

Covid 19 effect

- Home visits stopped
- School visits stopped
- Peer support sessions stopped
- Residential weekend stopped
- Staff moved to support acute services
- Number of new diagnosis



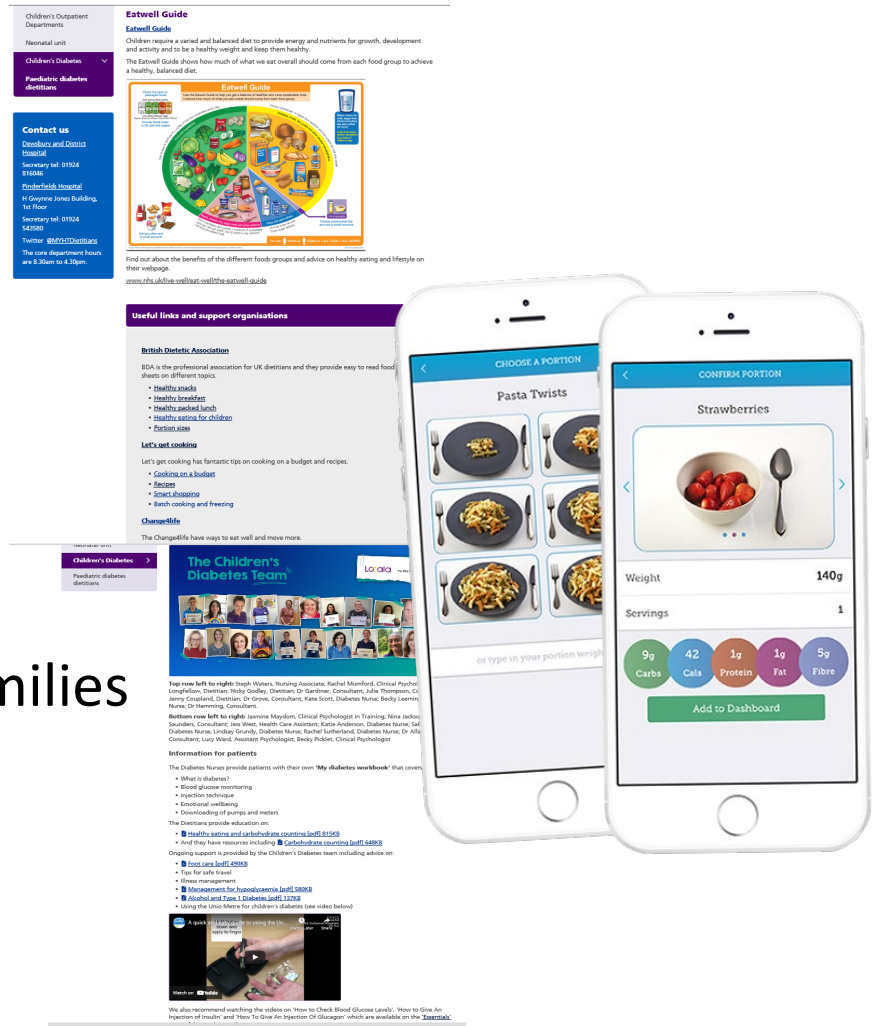


It's not just clinics

- Cook and eat sessions
- Healthy eating sessions
- Peer support groups
- South Asian carb counting groups
- Next steps days
- Moving up day
- Coffee mornings
- Christmas parties

Patient support

- New diagnosis
- 1st year of care
- High HbA1c pilot booklet
- Resources
  - Webpage
  - Information leaflets for families
  - Digibete app
- Carbs and Cals app pilot
- Additional contacts
- Diabetes advice line

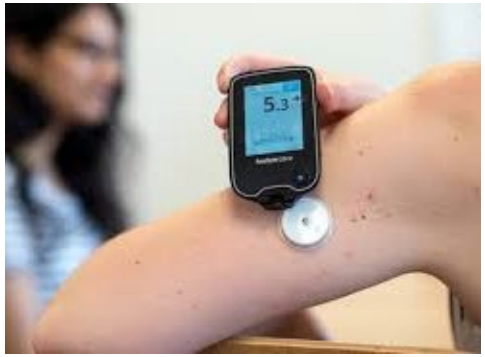


Psychology

- Finding support reassuring
- Having resources on emotional responses
- It's like a grief process, it takes time
- Space to talk about diabetes
- Knowing support is there
- Connecting with others

Staff training

- Ward nurse training
- Link nurses
- Induction for medical staff
- Department education programme



Technologies

- Inequality in access
- Digital poverty
- Language barriers

Challenges

- Increasing patient numbers and technology use
- Inequality of access in technology use
- Amount of psychology time
- Amount of dietician time
- Transition

Achievements

- Recovering from Covid 19 effect
- Education and peer support sessions
- Increasing use of technologies
- Working together with Locala

Children & young people with diabetes are superheroes without capes

We're just
their side kicks

REGISTER OF INTERESTS – BOARD OF DIRECTORS AND KEY DECISION MAKING STAFF – SEPTEMBER 2022

The Mid Yorkshire Hospitals NHS Trust (the Trust) and the people who work with and for the Trust, collaborate closely with other organisations, to deliver high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As a Trust and as individuals, there is a duty to ensure that all of the Trust's dealings are conducted to the highest standards of integrity and that NHS monies are used wisely to use the finite resources in the best interests of patients All existing Board members should declare relevant and material interests and if they have any doubt about whether to declare or not, they should discuss this with the Trust Chair. The purpose of this register is to disclose information relating to any monetary interest (or other personal or professional benefit) or conflict of interest to which a director is subject which may reasonably be thought – by any other person – to influence his or her actions in the performance of his or her duty as a director of, or key decision maker in, the Mid Yorkshire Hospitals NHS Trust.

Directors and key decision making staff are responsible for providing accurate and clear content describing the nature and scope of interests.

Name	**Position**	**Description of Interest**	**Gifts** Last 12 months	**Hospitality** Last 12 months
TRUST BOARD				
Keith Ramsay	Chair	Member of the West Yorkshire Association of Acute Trusts Committee in Common Member of the WYH Partnership Board Member of the West Yorkshire NHS Chairs' Group Patron, Thackray Museum Chair of Dewsbury Town Development Board Chair of the Remuneration Committee of Shadow West Yorkshire and Harrogate Integrated Care Board Chair of Board ABE UK	Nil	Nil
Simon Stone	Non-Executive Director (SID)	Nil	Nil	Nil
Julie Charge	Non-Executive Director	Employee Salford University Star Mat Academy Trustee	Nil	Nil

Gary Ellis	Non-Executive Director	Chief Executive The Coalfields Regeneration Trust (*The CRT is a subcontractor to the Five Towns PCN in Wakefield relating to a health and wellbeing programme)* Director of Wholly Owned Subsidiary companies of The Coalfields Regeneration Trust Non-Executive Director with Berneslai Homes Nominated Governor South West Yorkshire Partnership NHS Foundation Trust	Nil	Nil
David Throssell	Non-Executive Director	Emeritus Consultant, Sheffield Teaching Hospitals NHS FT Faculty member and facilitator, Royal College of Anaesthetists' Leadership and Management Programme	Nil	Nil
Mahmud Nawaz	Non-Executive Director	Employee Lloyds Banking Group Member of the Leeds Teaching Hospitals NHS Trust Organ Donation Committee NHS Blood and Transport Organ Donation Ambassador Chair Relate Bradford & Leeds British Transplant Games (Leeds 2022) Stakeholder Board Member School Governor – Stanley Grove Primary Academy Council Member – Outwood Grange / City Fields	Nil	Nil
Len Richards	Chief Executive	Member of the West Yorkshire Association of Acute Trusts Committee in Common Member of the Wakefield Integrated Partnership Board Member of the WYH Partnership Board Non-Executive Director Life Sciences Hub, Wales Chair at NHS Quest Strategic Advisor at Liaison Group Limited	Nil	Nil
Dawn Parkes	Deputy Director of Nursing and Quality	Nil	Nil	Nil
Karen Stone	Medical Director	Nil		Nil
Jason Matthews	Deputy Director of Finance	Son works at Trust as Dietetic Assistant on staff bank. He has involvement in processing of consumables ordering and invoice processing	Nil	Nil
Trudie Davies	Chief Operating Officer	Nil	Nil	Nil

Phillip Marshall	Director of Workforce and OD	Wife is employed by the Mid Yorkshire Hospitals NHS Trust	Nil	Nil
Paul Curley	Chief Clinical Information Officer	Founding Fellow Faculty of Clinical Informatics Clinical work at Leeds Teaching Hospitals NHS Trust	Nil	Nil
Joanne Webster	Director of Adult Community Services	Corporate Director Adults & Health Wakefield Council Chief Officer of NHS Wakefield Clinical Commissioning Group	Nil	Nil
Mark Braden	Director of Estates, Facilities and IM&T	Nil	Nil	Nil
Lindsay Barron	Insight Programme NED	Employed under contract as contingent resource via Public Sector Resourcing.	Nil	Nil
Name	**Position**	**Description of Interest**	**Gifts** Last 12 months	**Hospitality** Last 12 months
KEY DECISION MAKING INDIVIDUALS				
Matt England	Associate Director of Planning and Partnerships	Chair of Trustees Scholes Out Wife employed by Leeds Teaching Hospitals NHS Trust as a Paediatric OT	Nil	Nil
Alison Grundy	Interim Director of Operations – Division of Medicine	Nil	Nil	Nil
Kay Duxbury	Interim Director of Operations – Families and Clinical Support Services	Nil	Nil	Nil
Jo Halliwell	Director of Operations Division of Medicine	Son is employed in Theatres as an HCA	Nil	Nil
Keely Robson	Director of Operations – Division of Surgery	Relationship with Trust employee	Nil	Nil
Richard Robinson	Divisional Clinical Director Families and Clinical Support Services	Private practice – Spire Elland and Spire Methley Park Director and Shareholder RJR & Co Ltd Member Woodside Radiology LLP Wife is Senior Manager at NHS Digital	Nil	Nil

Jamie Yarwood	Divisional Clinical Director Surgery	RCOA (Royal College of Anaesthetist) GPAS (Guidelines for the Provision of Anaesthetic Services) Burns and Plastics Author Faculty of Intensive Care Medicine Quality and Standards Committee	Nil	Nil
Mark Freeman	Divisional Clinical Director Medicine	Nil	Nil	Attendance Sponsorship to European Association for the study of diabetes Speaker for Novonordisk
Sarah Robertshaw	Divisional Clinical Director – Acute services	Chief Medical Officer at Croft Circuit, team member of British Super Bikes and Silverstone circuit.	Nil	NIl
Ian Wilson	Deputy Medical Director	Deputy Chair BMA Ethics Committee Member BMA Consultants Committee Regular invited speaker Healthcare Events Conferences Regular invited speaker on job planning Council of Trustees The Kirkwood Hospice	Nil	Nil
Mahesh Nagar	Associate Medical Director	Trustee of the Yorkshire Indian Society Charitable Trust Tribunal Member – Medical Practitioners Tribunal Service at GMC Shares in CLYZ Laboratories	Nil	Nil
Ian Carr	Associate Director – Medical Directorate	Nil	Nil	Nil
Phil Deady	Director of Pharmacy	Director of a Property Management Company	Nil	Nil
Jennifer Beckett	Company Secretary	Nil	Nil	Nil
Roy Evans	Deputy Director of Estates, Delivery and Digital Services	Residential property letting	Nil	Nil
Chris Mannion	Deputy Director of Workforce	Nil	Nil	Nil

Karen Benstead	Interim Director of Operations Adult Community Services	Nil	Nil	Nil
Mike Lewis	Head of PMO	Deputy President for the West Yorkshire and York Society of the Institute of Chartered Accountants in England and Wales Yorkshire Regional Lead, NHS Projects Future programme	Nil	Nil

The Mid Yorkshire Hospitals NHS Trust 2022/2023
Trust Board Attendance Register
(Private meetings)

Key

	Present
	Apologies sent
D	Apologies sent and deputy attended where appropriate
	Did not attend or send deputy
	Not required/other absence

Quorum : No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and directors (including at least one of whom is also an Executive Director of the Trust and one who is a non-executive director) is present.

Position	Member	Deputy	14 Apr 2022	12 May 2022	09 Jun 2022	07 Jul 2022	Aug 2022	08 Sept 2022	13 Oct 2022	10 Nov 2022	09 Dec 2022	12 Jan 2023	09 Feb 2023	09 Mar 2023
Chair	Keith Ramsay	Not applicable					NO MEETING							
Chief Executive	Len Richards	Trudie Davies												
Non-Executive Director	Julie Charge	Not applicable												
Non-Executive Director	Gary Ellis	Not applicable												
Non-Executive Director	Mahmud Nawaz	Not applicable												
Non-Executive Director	Simon Stone	Not applicable												
Non-Executive Director	David Throssell	Not applicable												
Director of Finance	Jane Hazelgrave	Jason Matthews												
Interim Director of Finance	Jason Matthews	Donna Cassidy												
Medical Director	Karen Stone	Ian Wilson												
Director of Nursing and Quality	David Melia	Dawn Parkes												
Interim Director of Nursing and Quality	Dawn Parkes	Rachel Diamond												
Chief Operating Officer	Trudie Davies	Jo Halliwell	D											
IN ATTENDANCE														
Company Secretary	Jennifer Beckett	Not required												
Director of Estates, Facilities and IMT	Mark Braden	Not required												
Chief Clinical Information Officer	Paul Curley	Not required												
Director of Workforce and OD	Phillip Marshall	Chris Mannion			D									
Director, Community Services	Jo Webster	Not required												
Head of Communications	Charlotte Burton	Not required												
Insight Programme NED	Lindsay Barron	Not required												
Insight Programme NED	Asif Ameen	Not required												

MYHT : Risk Appetite Matrix

To support risk assessment of delivery of strategic objectives and decision making

STRATEGIC OBJECTIVE	PRINCIPAL RISK	Principal risk no	Averse	Minimal	Cautious	Open	Eager	Board set appetite
1. Keep our patients safe at all times	1. Failure to maintain the safety of patients	1	**Zero appetite** for any decisions which will impact upon patient care and outcomes and/or the Trust's clinical reputation.	Appetite for taking **very limited clinical risks** if essential to patient care and outcomes. Such risks are assessed and have robust mitigation and control measures in place	Appetite for taking **moderate clinical risks** if essential to patient care and outcomes. Such risks are assessed and have robust mitigation and control measures in place	Appetite for taking **significant clinical risks if essential** to patient care and outcomes. Mitigation controls are not fully implemented.	Appetite for taking **significant clinical risks** that may result in **serious events, never events or formal regulatory action.** Mitigating controls are not fully implemented.	Cautious
	2. Failure to maintain and develop Trust estate and equipment	2	**Zero appetite for decisions which threaten the delivery of safe and effective patient care and outcomes, and regulatory status.** Avoidance of any clinical, infrastructure, environmental, financial, people impacts or losses. Priority for close management controls, with governance & oversight.	Lifecycle equipment, infrastructure and technologies with sub-optimal risk management capability **largely avoided or prioritised as part of the Trust's change programme.** Decision making authority held by senior management and only prepared to accept very limited possibility of material financial impacts or loses if essential to safe and effective patient care.	Risk based assessments in place to **meet regulatory standards** to deliver safe and effective patient services, recognising the financial constraints mean that not all equipment, technology and infrastructure can modernised at the same rate. Limited financial impacts or losses are accepted if they yield benefits to patient care and outcomes and robust oversight processes in place.	Appetite to take investment decisions to invest and/or accept financial impacts or losses in areas which are likely to expose the Trust to **periodic operational service failures,** for the benefit of patient care and outcomes.	Appetite to take investment decisions to invest and/or accept financial impacts or losses in areas which are likely to expose the Trust to **regular operational service failures** to ensure patient care and outcomes improve.	Cautious
2. Provide excellent patient experience and deliver expected outcomes	3. Failure to provide excellent patient experience	3	Zero appetite for decisions which impact patient experience, and regulatory status. Therefore, a defensive approach to operational service delivery, protecting services. Priority for close management controls, with governance & oversight.	Appetite for taking very limited clinical and people risks if essential to delivering patient experience. All risks are assessed with mitigating controls in place and need to meet regulatory requirements.	Appetite for taking moderate clinical or people risks if essential to delivering patient experience. Such risks are assessed and have robust mitigation and control measures in place.	Appetite for taking significant clinical, people or financial risks if essential to patient experience or if mitigations would overcome or limit the likelihood of sub-optimal patient care or experience.	Appetite to take significant clinical, financial or people risks that may give rise to opportunities, but which are likely to expose the Trust to sub-optimal patient experience or regular service failures or serious events, never events or formal regulatory action.	Cautious
	4. Failure to provide expected outcomes	4	**Zero appetite** for any decisions which will impact upon patient care and outcomes and/or the Trust's clinical reputation.	Appetite for taking **very limited clinical risks** if essential to patient care and outcomes. Such risks are assessed and have robust mitigation and control measures in place	Appetite for taking **moderate clinical risks** if essential to patient care and outcomes. Such risks are assessed and have robust mitigation and control measures in place	Appetite for taking **significant clinical risks if essential** to patient care and outcomes. Mitigation controls are not fully implemented.	Appetite for taking **significant clinical risks** that may result in **serious events, never events or formal regulatory action.** Mitigating controls are not fully implemented.	Cautious
3. Be an excellent employer	5. Failure to recruit and develop an effective workforce	5	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	Eager

	6. Failure to engage and retain an effective workforce	**6**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	Eager
4. Be a well-led and governed Trust with sound finances	7. Failure to achieve financial sustainability and VFM	**7**	Avoidance of financial loss is a key objective. We are only willing to accept the low cost options as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest in the short-term for a long-term benefit/ return if the investment demonstrates alignment to the organisational strategy. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible long-term benefit/return, accepting the possibility of financial loss (with controls in place). Resources allocated without firm guarantee of return - "investment capital" type approach.	Open
	8. Failure to comply with targets, statutory and regulatory duties and functions	**8**	**Zero appetite** for any decisions that present risks to the Trust complying with the statutory and regulatory requirements.	Only prepared to accept the possibility of **minor regulatory observations**, if related actions are essential to the safe and effective patient care and outcomes.	**Prepared to accept the possibility of moderate regulatory observations/judgements** but which have clear timeframes for improvement and risk management processes in place.	**Significant regulatory and/or statutory observations /judgements** are reported, but any impacts to patient care and outcomes are likely to be limited.	**Significant regulatory and/or statutory observations/ judgements** are reported which are impacting on patient care and outcomes	Minimal
5. Have effective partnerships that support better patient care	9. Failure to have effective relationships with partnering organisations	**9**	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to the organisation. External interest in the organisation viewed with concern and managed formally by senior decision-makers with escalation and regular review in place when working with stakeholders.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention. External interests in the organisation viewed with caution and regular review and escalations in place when working with stakeholders.	Tolerance of risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest in the organisation with dynamic local risk assessment in place when working with external stakeholders.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisations reputation with key partnerships and local risk assessments.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potential enhancing reputation of organisation. Actively seek partnership working arrangements recognising that joint risk management will be required.	Open
6. Provide excellent Research, Development and Innovation Opportunities.	10. Failure to support research, development , transformation and innovation for the benefit of patients and the NHS	**10**	Defensive approach to objectives - aim to maintain or protect, rather than to create or innovate. General avoidance of systems/technology developments, given, if they fail, they will waste time, resource and may have a negative impact on reputation. Priority for tight management controls and oversight with limited devolved decisions taking authority.	Innovations always avoided unless essential or commonplace elsewhere. Only essential systems/technology developments to protect current operations, given, if they fail, they will waste time, resource and may have a negative impact on reputation. Decision making authority held by senior management	Tendency to stick to the status quo; innovations in practice avoided unless really necessary. Systems/technology developments limited to improvements to protection of current operations., given, if they fail, they will waste time, resource and may have a negative impact on reputation. Decision making authority generally held by senior management.	Innovation supported with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operational delivery, accepting there is a possibility of wasting time, resource and negative impact on reputation. Responsibility for non-critical decisions may be devolved.	Innovation pursued - desire to "break the mould" and challenge current working practices. New technologies viewed as a key enabler of operational delivery, accepting there is a possibility of wasting time, resource and negative impact on reputation. High levels of devolved authority - management by Trust rather than tight control.	Eager
Striving for Excellence	11. The Covid-19 Pandemic represents a significant risk to the operations of the Trust and wider system and NHS	**11**	**Defensive approach to operational service delivery** - aim to invest in current risk management capabilities to protect service delivery. Priority for close management controls, with governance & oversight.	Risk management capabilities in place to **meet regulatory standards** to deliver safe and effective patient services. Robust oversight processes in place.	Appetite to move away from some aspects of national guidance if there is robust oversight and controls in place and limited investment required.	Appetite to take decisions (including the investment in time and resources) in areas which are likely to assist operational recovery long-term but may result in some elective service interruptions short-term.	Appetite to take decisions (including the investment in time and resources) in areas which are likely assist operational recovery long-term but **will** result service interruptions short-term (elective and/ or non-elective).	Open

MINUTES FROM THE PUBLIC TRUST BOARD

Minutes of a meeting of the Public Trust Board held virtually via Microsoft Teams Live on Thursday 14 July 2022 from 9.00am

PRESENT

Mr Keith Ramsay	Chairman
Mr Len Richards	Chief Executive
Mrs Trudie Davies	Deputy Chief Executive / Chief Operating Officer
Mrs Dawn Parkes	Acting Director of Nursing and Quality
Mr Mahmud Nawaz	Non-Executive Director
Mrs Julie Charge	Non-Executive Director (joined the meeting at 10am)
Mr Simon Stone	Non-Executive Director
Dr David Throssell	Non-Executive Director
Mr Jason Matthews	Acting Director of Finance
Dr Karen Stone	Medical Director
Mr Gary Ellis	Non-Executive Director

IN ATTENDANCE

Mr Mark Braden	Director of Estates, Facilities and IM&T
Mr Phillip Marshall	Director of Workforce and Organisational Development
Mrs Jo Webster	Chief Officer, Wakefield Place
Mr Asif Aseem	Insight Non-Executive Director
Mrs Charlotte Burton	Head of Communications
Ms Jen Beckett	Interim Company Secretary
Mrs Lisa Robson	Corporate Governance Officer (minutes)
Miss Sophie Johnson	Executive Assistant (shadowing Mrs Robson)
Dr Ann-Marie Henshaw	Director of Maternity and Women's Services (agenda item 4.2 only)
Mrs Heidi King	Assistant Director of Workforce and OD (agenda item3.3 only)
Ms Tilly Poole	Programme Lead for Community Transformation (agenda item 5.1 only)
Mrs Lucy Beeley	Programme Manager – Urgent and Emergency care (agenda item 5.2 only)
Dr Dorothy Frizelle	Clinical Psychology (clinical story presentation only)
Dr David Aaron	Clinical Psychology (clinical story presentation only)
Dr Nigel Wainwright	Clinical Psychology (clinical story presentation only)
Dr Rachel Mumford	Clinical Psychology (clinical story presentation only)
Mrs Kate Woodrow	Chief Pharmacist, Harrogate and District Foundation Trust (shadowing Len Richards)

MEMBERS OF THE PUBLIC IN ATTENDANCE AS OBSERVERS

AGENDA

ACTION

CLINICAL STORY: CLINICAL PSYCHOLOGY

Mr Ramsay welcomed colleagues from the Clinical Psychology Team who gave a presentation detailing an outline of the service and impacts from the pandemic on both patient and staff wellbeing. The following was highlighted:

- Work had taken place to build on the existing staff wellbeing provision, minimizing barriers to accessing care and forming MY Wellbeing Matters with easy to access referral routes for staff whilst ensuring they were still able to provide services to patients
- New ways of working had to be developed for supporting patients also including reprioritisation of the workforce, how to deal with Covid-19 as well as the effects of long-Covid and mobilise funding accordingly
- Covid had also had an indirect impact on treatment and the growing need for mental health services across the country which would require further work both in the team and with commissioners
- The pandemic had a significant impact on children and young people. The Team were only commissioned into paediatric burns and diabetes departments but significant increases had been seen in these areas. There was a significant unmet need for children with different conditions and a gap analysis was taking place with regard to this
- Health inequalities had been significantly impacted by the pandemic and audits were taking place to ensure services were accessible and referral figures were representative of the local population. The team had also undergone anti-racism practice training which had been really valuable
- With regard to staff wellbeing, work was taking place to learn from the Covid-19 Clinical Cohort (CoCCo) Study: Empirically Grounded Recommendations for Forward-Facing Psychological Care of Frontline Doctors. This was a grounded model for staff wellbeing based on the experience of frontline doctors with a series of interventions including:
  - Basic needs – culture of care and compassion
  - Information and communication – how mental health conditions were talked about and how people could be encouraged to discuss them
  - Embedded support – a system of peer support
  - Psychological Interventions – there was an array of options available to staff at the Trust which the team were proud of.

Mr Ramsay thanked the team for their attendance at Trust Board commenting that the service and team were valued by the Trust.

Mr Stone asked what the Trust could do differently with regard to protected characteristics. The team noted they were undertaking audits to review who

they were providing services to so they could understand if there were areas of the population which were being missed. Work could then take place with regard to how referrals were discussed, understanding what this might mean to specific people as well as understanding stigma and misunderstandings. The team had taken part in some impactful training which included how culture could be addressed, aspects of inclusivity and not creating minority and marginalized groups in every day clinical practice. It was felt that the system had a part to play with regard to referrals.

Mr Stone suggested an ICS approach would be beneficial to connect with partners and ensure conversations were taking place to enable patients to access services.

Mr Richards added that work was taking place with regard to the culture of the organisation and there had been a focus on compassionate leadership and psychological safety at the Leadership Community Forum. He commented that there was an opportunity to explore what this meant to people and what was required to create a safe environment.

Further to a question from Mr Nawaz, it was noted that the team were working with the voluntary sector to use their expertise to break down barriers and the integrated care pathways were a strategic priority. With regards to young people, there was a particular focus on wellbeing in schools but there was a gap in the provision of paediatric psychology.

Further to a question from Mr Ramsay, it was confirmed that the shortage pf Paediatric psychology was on the Clinical Psychology risk register.

Mrs Webster asked how the work undertaken by the team was connected to the People Plan for Wakefield. Dr Wainwright explained that he worked part-time at the Trust and was also the Clinical Lead in the ICS wellbeing hub so he was involved in this work. He advised that they were on a similar journey to the Trust with regard to understanding commissioning partnerships with the voluntary sector to enable collaboration work in communities and assess need and interventions required.

Mrs Parkes thanked the team for the presentation noting that she was glad that Paediatrics had been included in this and asked if the team also dealt with the psychological care of the family. It was confirmed that care would often be a combination of the young person and their parents.

Mr Ramsay thanked the team for attending the meeting noting that work was needed both at hospital and system level and he would be happy to welcome the team back to a future meeting for an update.

ADMINISTRATION

T025/22 CHAIRMAN'S OPENING REMARKS

Mr Ramsay welcomed everyone to the meeting noting that Mrs Parkes was attending in her official capacity as the Interim Director of Nursing. He

advised that this was the first public meeting since the appointment of the new Chief Finance Officer and Chief of Planning and Partnerships and he looked forward to welcoming Amy Whittaker and Emma Hall at their first meeting in September.

Mr Ramsay also noted that the new Health and Social Care Bill had been enacted which formalised West Yorkshire ICB and he looked forward to continued collaboration with partners.

Mr Ramsay also noted that the hospital remained very busy with both acute and unplanned activity as well as an increase in Covid positive patients which was in line with the national picture. He commented that it would be a challenging winter and preparation was key with focus on patient and staff resilience and wellbeing.

There were no questions received from the public prior to the meeting and therefore the agenda was commenced.

T026/22 APOLOGIES FOR ABSENCE

Apologies were recorded for Mr Curley and Lyndsay Barron.

T027/22 QUORUM/DECLARATIONS OF INTEREST

The meeting was quorate in line with the Trust's Standing Orders. The Declarations of Interest register was recorded for information.

T028/22 ATTENDANCE MATRIX

The attendance matrix was noted.

T029/22 UNCONFIRMED MINUTES OF THE MEETING HELD ON 13 MAY 2022

The minutes of the previous meeting held on 13 May 2022 were recorded as a true and accurate record of the meeting.

T030/22 MATTERS ARISING

The following matters arising were reviewed:

T007/22 Chair's Report – activity undertaken in month had been included in the Chair's Report. **COMPLETE**.

T008/22 Chief Executive Report – An update on the Unplanned Care Transformation Programme was included in the agenda. **COMPLETE**.

T013/22 Annual Operating Plan and Budget – the 2021/2022 Annual Operating Plan was included on the agenda. **COMPLETE**.

T013/22 Annual Operating Plan and Budget – Mr Marshall confirmed he had circulated an email to board members explaining why there seemed to be an improved vacancy position against a deteriorating position in a different category. **COMPLETE**.

T031/22 CHAIR'S REPORT

Mr Ramsay noted the detail captured within his report, there were no questions from members.

T032/22 CHIEF EXECUTIVE REPORT

Mr Richards shared the report and specifically brought to the attention of the Board the MEET UP Conference held at the Trust which had brought together representatives from across the Integrated Care System (ICS) and University of Leeds to discuss advances made in teaching. He raised this in the light of the Trusts aspiration to reach Teaching Status and noted that comments received at the end of the conference had been exceptional with regard to the Trust leading the field in delivering teaching, particularly for Foundation Year One and Two Doctors.

Mr Richards also drew the Boards attention to the latest meeting of the West Yorkshire and Harrogate System Leadership Executive Group where the Chief Executive, Rob Webster had mentioned the Trust in his opening comments. He had commented on how the Trust was driving innovation across the ICS and specifically highlighted the six week surgical pathway for children with learning disabilities and encouraged other organisations to review their practice with regard to this.

Mr Ramsay thanked Mr Richards for the report noting that the Trust had achieved JAG accreditation on all three sites and appointment of Zuzanna Sawicka to an Associate Medical Director which was an innovative role working across acute and community services. Mr Ramsay also recognised the review of the leadership structure in the Division of Families and Clinical Support Services which would hopefully lead to achievements in the Division.

With regard to the operational pressures section of the report, Mrs Davies confirmed that there were significant demand pressures in the organisation noting that this would be apparent in the performance update to be discussed later in the meeting.

With regard to ambulance handovers, Mr Ramsay noted that the Chair of Yorkshire Ambulance Service had referenced the Trust nationally on the work which had taken place to improve performance and congratulated the teams involved in this.

Dr Throssell noted that an update with regard to work with NHS Quest would be helpful at some point in the future. **ACTION**. **TD**

Leadership and Governance

T033/22 REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE HELD ON 5 JULY 2022

The report was given verbally. Mr Ellis said :-

- Assurance had been received with regard to the Draft Accounts and Trustee Report from the Annual Trustee Meeting which was held prior

to the Charitable Funds Committee and a copy of the Fundraising Report was included at the back of the papers for information

- Gifted Philanthropy had been appointed from 1 July 2022 to progress the next phase of the MRI appeal and authorisation was agreed for the development of a dedicated bespoke website to feature the MRI appeal branding
- Initial work had begun to secure a £30k development fund from NHS Charities Together
- The Committee had asked for opportunities to be explored on how the Charity could be more visible at place level taking into account other significant organisations such as the local hospice
- Further plans were to be developed with fund holders to consider how they could utilise fund balances over £20k
- A particular area to escalate to Board was the importance of quickly establishing a physical presence in a prominent location in Pinderfields Hospital. This was required to improve the Charity's profile and support the fundraising work for the MRI appeal.

Mr Ramsay commented on the support of the Charity for staff wellbeing during the hot weather by offering ice-creams on all three sites. He also noted that he encouraged people to put forward bids with regard to staff wellbeing noting that the charity was there to serve a purpose and they wanted to help improve patient experience.

The meeting of the Public Trust Board **NOTED** the verbal Chair's Report from the Charitable Funds Committee held on 5 July 2022.

T034/22 REPORT FROM THE CHAIR OF THE RISK COMMITTEE MEETING HELD ON 16 JUNE 2022

The report was presented by Mrs Davies including:-

- The Committee had reviewed the methodology for assessing risk following discussion at the last Board meeting regarding the rating of the risk of Black, Asian, Minority and Ethnic (BAME) representation at band 7 and above. The Committee agreed that the correct process had been followed and on review the score had been lowered due to the likelihood score reducing, this being the case due to detailed action plans now being in place to resolve.

Mr Stone noted the emerging risk of RMO resilience at DDH and queried the option of removal of RMO cover at peripheral sites. Mrs Davies agreed with this, she confirmed that this was the reason for reviewing options which might also include different models or different on-call models.

Mr Ramsay queried the reduced score of the risk in relation to the Trusts energy supply from Gazprom. Mr Braden confirmed that the Trust had served notice as part of the normal renewal process and had committed to a different provider.

The meeting of the Public Trust Board **NOTED** the Chair's Report from the

Risk Committee held on 16 June 2022.

T035/22 BOARD ASSURANCE FRAMEWORK AND TRUST LEVEL RISK REGISTER

Ms Beckett presented the paper and thanked those involved in supporting the Corporate Governance Team in developing the new format and Risk Appetite matrix, it was hoped this would inform strategy development and support management in decision making going forward. Ms Beckett went on to advise that, of the 11 Principal Risks, 5 had significant assurance ratings, 4 had partial assurance ratings and the Board were asked to agree on the assurance level for the two Principal Risks for which they held responsibility.

The following Principal Risks were discussed:

- **9, Failure to have effective relationships with partnering organisations** – The Board were happy that the assurance rating could remain at significant for this principal risk
- **11, The Covid-19 pandemic continues to represent a significant risk to the operations of the Trust and wider system and NHS** – whilst it was felt that good controls were in place, there was a lot of uncertainty with regard to Covid and it was noted that the number of Covid positive inpatients were increasing and causing challenges in the organisation. It was therefore agreed that the assurance rating would remain at partial for this principal risk.

Mr Stone confirmed that he liked the updated format of the BAF including separation of the actions to the bottom of the principal risk but noted that some of these were incomplete and asked that this be updated for the next report to Board. **ACTION**. **JB**

Dr Throssell suggested some updates which could be included in the BAF such as achievement of JAG accreditation, WHO Surgical Checklist compliance with four months of consistent performance. It was agreed that these would be included in the BAF. **ACTION**. **JB**

Mr Ellis reflected on the emerging risks with regard to the organisations long term financial sustainability and asked if there was a view on this in relation to the BAF. Mr Matthews confirmed that direction from the regulators was awaiting with regard to introduction of an oversight framework and the possibility of the agency cap being reintroduced.

Mr Braden asked if the Board would be willing to consider sustainability being added to the BAF as a Principal Risk. He explained that it had been noted in the ICS that this was a key strategic risk for organisations and Boards were being asked that this forms part of the BAF. The Board were happy with this approach and Ms Beckett confirmed that this would be discussed and brought back to Board in September.

The meeting of the Public Trust Board **RECEIVED** the full Board Assurance Framework and Trust Level Risk Register, **AGREED** on the assurance

rating for Principal Risks 9 and 11 and **APPROVED** the Risk Appetite Matrix.

T036/22 KIRKLEES PLACE PARTNERSHIP ARRANGEMENTS

Mr Richards confirmed that the Kirklees Place Partnership Arrangements were built on the same principles as the Wakefield position, it was important to note that this would be reviewed in 12 months' time and any member of the Board could call for a review. This included the new structure with regard to meeting arrangements and he suspected that there might be a limiting factor in this as all organisations had to attend these meetings but he would update the Board if this became an issue.

Mr Stone noted that section 7.14 referred to the Trust working with 9 communities in Kirklees, Mr Richards confirmed that this was generic and the Trust would increasingly work with Calderdale and Huddersfield Foundation Trust and this was a nuance of the arrangements.

The meeting of the Public Trust Board **APPROVED** the Kirklees Place Partnership Arrangements

T037/22 ANNUAL OPERATING PLAN 2021/22

Mr Matthews presented the 2021/22 Annual Operating Plan which showed progress on service developments and plans throughout the year which the Board were asked to note.

Mr Ramsay noted that collaborative work had taken place with Leeds Teaching Hospitals NHS Trust (LTHT) in vascular surgery and asked if the service had since stabilised. Dr Stone explained that this work had taken place some time ago further to changes in the shared model, due to retirements and changes in the consultant body there had been a revamp of the plan for the future which was sustainable.

Dr Throssell noted the section with regard to health inequalities and waiting list stratification, a subsequent page noted building on work from CHFT and there had been national discussion regarding a tool for this. He asked if the Trusts intention was to change its approach with regard to this. Mrs Davies confirmed that this was not the case, a model was being tested in some trusts but she had not seen any real evidence with regard to the long term impact of this. She added that this piece of work had moved on from the narrative in the report as the Trust were not using the CHFT model.

Mr Stone noted reference to a business case for a Staff App however this did not appear in the 2022/23 plan. Mr Marshall confirmed that this was still on the list of requirements and discussions were ongoing.

Mr Ramsay stated that there had been some great work at Place and the Trust had active involvement in developing these arrangements.

The meeting of the Public Trust Board **RECEIVED** the Annual Operating Plan 2021/22

T038/22 ANNUAL OPERATING PLAN 2022/23

Mr Matthews presented the 2022/23 Annual Operating Plan advising this was an updated version to the one presented in May, the main changes included performance ambitions, development of virtual wards and submission of a breakeven plan. This was presented as the final version.

Mr Ramsay felt there was more work required regarding research targets and Mr Richards advised that he had asked Dr Stone to lead on this to produce more aspirational and ambitious targets for research as the Trust moved towards Teaching status.

The meeting of the Public Trust Board **RECEIVED** and **APPROVED** the Annual Operating Plan 2022/23.

T039/22 FREEDOM TO SPEAK UP REPORT

Mrs Parkes highlighted that there had been a significant increase in the number of concerns raised compared to previous quarters. It was also noted that there had been a substantial rise in management concerns raised in Q4.

With regard to the table referring to professional groups, Dr Throssell asked that the actual number of staff in each group be included so the Board could see if there were any staff groups who were speaking up more, noting that it was hard to understand this from percentages as the denominators were different.

Dr Throssell commented that there were national concerns regarding staff reporting suffering detriment as a consequence of speaking up and asked if the Trust were proactive in seeking out this information. Mrs Parkes felt this was a good point, she confirmed it had not been flagged as an issue at the Trust but they could be more proactive in seeking this information.

Mr Stone queried the Freedom to Speak Up training, Ms Beckett confirmed that Mr Townend was working with Organisational Development regarding implementation. It had been recommended that the training be implemented in stages and frequency had to be considered against all the other Mandatory and Statutory Training (MAST) modules.

Dr Throssell noted the leadership principle from the National Guardians Office (NGO) 10 principles which underpinned the role of the Guardian in the Freedom to Speak Up Strategy which suggested that the Freedom to Speak Up Guardian met with the Non-Executive Directors regularly. He stated that there was a lead Non-Executive Director for speaking up so he did not think it necessary for all Non-Executive Directors to regularly meet with the Guardian and felt this needed rewording to reflect this.

The meeting of the Public Trust Board **RECEIVED** and **ACCEPTED** the Report to Board on Freedom to Speak Up.

Effectiveness

T040/22 REPORT FROM THE CHAIR OF THE RESOURCE AND PERFORMANCE COMMITTEE HELD ON 29 JUNE 2022

Mr Stone presented the Chairs report form the last meeting of the Resource and Performance Committee noting that this included an operational update to the performance data which had been shared at the meeting to ensure up to date information was being discussed. He highlighted the following:

- Supply chain issues were becoming more significant
- With regard to Model Hospital, the Trust were the best performing Trust in WYAAT across a range of measures and the only Trust in the system performing better than national average. Mr Ramsay commended this achievement and congratulated all involved.

Mr Matthews confirmed that the Procurement Team were aware of shortfalls in supply chain and were managing this on a priority basis with any issues being escalated. With regard to the capital programme, Mr Braden advised that some lead times had been extended by suppliers, some of this risk had been mitigated as the programme had commenced early in the year and these issues were being managed through the programme sub-groups.

It was noted that conversations were taking place regarding timely data for both Trust Board and Tier One Committees.

The meeting of the Public Trust Board **NOTED** the Chair's Report from the meeting of the Resource and Performance Committee held on 29 June 2022.

T041/22 TRUST BOARD SCORECARD

Mr Matthews presented the Trust Board Scorecard and asked members to comment on specific areas:

Caring:
Mrs Parkes highlighted that despite pressures in the team, the Emergency Department had maintained 70% positive experience results in the Friends and Family Test.

Safe:
Mrs Parkes confirmed that an enhanced action plan was in place for C.diff which was making an impact and there had been no cases in June.

Mr Ramsay noted that reported patient safety incidents that are harmful: acute services was reported at 36.9% against a target of 27%. Mrs Parkes stated that this related to falls and pressure ulcers and was reflective of the acuity of patients as well as those with no Reason to Reside.

Mr Ramsay also queried the Medication error causing severe harm or death, Mrs Parkes did not know the details of this and would review.

Effective:
There were no queries with regard to the Effective domain.

Responsive:
Mrs Davies noted that there was a lot of information included in the report and welcomed questions from the Board.

Mr Stone noted that the Trust were above the national average for cancer targets and congratulated the team with regard to this. Mrs Davies advised that actions had been taken following the Dermatology review which enabled two week wait to return to 14 days, however there had been a further surge of activity and a planned locum had withdrawnmeaning that the position had since deteriorated. She confirmed that a summit was planned with system partners and more work was needed to sustainably recruit into Dermatology.

Mr Ramsay noted a significant increase in ambulance handovers in May and asked if this related to diversions from other Trusts. Mrs Davies confirmed that this was mostly from growth in attendances, however the Trust did take diverts on an official basis through escalation. There were also soft diverts when YAS diverted ambulances to a Trust they were aware did not have long waits. Permission was not requested for soft diverts and due to the risk assessment work which the Trust had undertaken the Trust would always be a recipient of a soft divert as there were no ambulances waiting. Mrs Davies felt it was important to note that attendance levels were significantly higher than expected which was a reflection of pressures both regionally and nationally.

Mr Ramsay commented that he had recently visited the Emergency Department with Dr Throssell and they had both been very impressed by the resilience of the team.

Mrs Webster advised that she had raised concerns regarding the ambulance soft divert. She also commented that an increase in attendances was being seen in all sectors noting there had been a 25% increase in urgent care requests for GP practices. There was also the added complication of the need of individuals presenting as a complex package and workforce challenges outside of the hospital. Staff wellbeing was also a concern.

Planned care:
Mrs Davies advised that activity levels were still high but recovery plans were in place along with actions to address, however, planned care demand was higher than predicted. In Q1 there had been 3k more referrals than expected, this was outside of that planned for in the transformation agenda which meant that more work was needed to manage the capacity and demand imbalance. Planned activity would not meet the level of demand which meant that waiting lists would continue to grow and radical changes or capacity increase needed to be considered.

Mr Richards felt this showed the unsophisticated way the Trust modelled data with regard to demand. Capacity needed to be built to respond to the challenges over the next two years and a longer term forward look was required to make judgements with regard to activity modelling.

Well-Led
Mr Marshall advised the Board that it was expected that the Trust would receive an agency cap target with new controls, this was likely to conflict with other data on the dashboard such as surge bed staffing etc. Actions continued across all Divisions with regard to temporary staffing spend.

With regard to sickness, national guidance had been received which ended the Covid-19 sick pay provisions and normal rules would apply. This had been communicated to staff.

Dr Throssell queried the sickness and vacancy targets which had changed since the last report. Mr Marshall confirmed that national benchmarking data had been taken into consideration and these had been updated to more realistic targets.

Income and Expenditure:
Mr Matthews advised that the month two position showed a deficit plan, however at month three they would be reporting against a breakeven plan. It was expected that the Trust would receive £15.9m from the Elective Recover Fund, however there was a risk to achieving this as it was dependent on the end of year achievements.

The cash balance was still strong and payments were being made in line with creditor agreements.

Mr Ellis asked what a comfortable cash balance was from a liquidity position. It was confirmed that expected reasonable cash position would be included in the next Board paper to aid monitoring.

Mr Matthews confirmed there were no concerns to report with regard to capital. Mr Braden added that there had been a lot of activity to develop the capital plan. With regard to the Better Payment Practice Code, 95% of creditors were being paid within 30 days, this exceeded the target and meant that the Trust were able to support the local economy. Mr Richards commented that this was an important point in the current economic climate and it was important that these levels were maintained.

The meeting of the Public Trust Board **NOTED** the Trust Board Scorecard.

T042/22 STAFF SURVEY REPORT
Mrs King attended the meeting to present the Staff Survey Report and highlighted the following:

- The structure of the survey had been aligned with the themes of the

People Promise

- Of the 9 elements, the Trust was above average for two, the same as the average for two and slightly below average for the remaining five
- Work was taking place to support improvement in different areas including supporting managers with leadership style etc.
- The respondent profile was noted with more staff declaring long term conditions and those who had caring responsibilities. This linked with the themes of the people promise
- There was a decline in staff recommending the Trust as a place to work and receive treatment however this was the same nationally
- Culture work was taking place including the establishment of a People and Culture Committee.

Mr Ramsay recognised the improvements which were more in line with the national average, however he stated that this did not stop the Trust from having an upward trajectory. He asked if the respondent profile was comparable with other trusts both regional and national. Mrs King confirmed that she would look into this. Dr Throssell also requested that respondent profile include professional groups.

Mr Ramsay asked where Kirklees were in their work with regard to the people plan, Mrs Webster confirmed that Kirklees were at the beginning of their journey with regard to this and were learning from Wakefield best practice.

Mr Stone queried wording of the question 'In last 3 months, have not come to work when not feeling well enough to perform duties'. Mrs King confirmed this was an error and should refer to staff who had attended work when they did not feel well enough to perform their duties.

Mr Ramsay said that an area of concern was staff recommending the Trust as a place to receive care for friends and family and he felt that more work was needed in this area. Mr Marshall agreed that more work was needed and stated that this was a question which could be misinterpreted as some may not view the Trust as their local hospital which they would attend for treatment.

Mrs Parkes noted that 70% of staff did not find appraisals valuable, this was a concern as an appraisal should be an opportunity to celebrate achievements. Mr Marshall advised that he had asked Internal Audit to look at this point.

Further to a question from Mr Nawaz, Mrs King confirmed that 50% of respondents had reported being subjected to abusive behaviours, however a high percentage was seen as a positive for this as people felt able to report these. Mr Nawaz advised that this concerned him from a culture perspective, Mr Richards agreed with this concern and that more work was needed but confirmed that this was better than the previous year. Mr Nawaz also noted an increase in black, Asian, minority and ethnic (BAME) staff experiencing

discrimination at work which was also a concern. Mr Stone agreed that this was a concern but they needed to understand if this increase was due to more staff experiencing discrimination or because more staff felt able to report incidents.

Mr Ramsay queried what the next steps would be, Mrs King confirmed that work would continue on the action plan as well as development of the People and Culture Committee. Areas of concern would be addressed and preparation would take place for the next survey. Mr Marshall added that there had been full review of the BAF Principle Risks which detailed actions which fed into these indicators. It was also discussed at the Resource and Performance Committee and Finance and Performance Groups with the Divisions.

Mrs Davies also advised that culture work was taking place within the Trust, the Senior Leadership Team met fortnightly and had deeper conversations with regard to change with planned seminars, the team took every opportunity to discuss leadership and influence. She felt that deep listening and intense leadership, changing behaviours and a whole organisational approach was needed to make a difference.

The meeting of the Public Trust Board **NOTED** the Staff Survey Report.

Quality and Safety

T043/22 REPORT FROM THE CHAIR OF THE QUALITY COMMITTEE FOR MEETING HELD ON 1 JULY 2022

Dr Throssell provided a verbal update from the recent meeting, noting the following points:

Annual Organ Donation Report

- From 13 consented donors, MY facilitated 10 actual solid organ donors, with 21 patients receiving a transplant, during 2021/22
- The Trust referred 96 patients to NHSBT's organ donation team. No referrals were missed, and 47 patients met the criteria for inclusion in the Potential Donor Audit
- A specialist nurse was present at all organ donation discussions, in line with best practice
- Education in end-of-life care and donor optimisation for Critical Care medical and nursing staff was ongoing
- Preparations towards MY being designated as a Tissue Alliance hospital were a key focus for the next year.

Medicines Optimisation Group

- Improved levels of compliance with oxygen prescribing was being maintained and the Trust continued to be better than national average in this area.

Division of Medicine Governance review

- An update was given about progress against the 14-day cancer

waiting time standard in dermatology. Despite the challenges faced in meeting this standard, the backlog of patients fell from 200 to 0 during the course of June, though ongoing pressures meant that this position is unlikely to be sustained
- It was explained that the Division continues to operate beyond its funded bed base, and measures being taken to address this, including work to reduce the number of patients MoFD, was described
- A lead SACT nurse and Clinical Lead for Oncology had been appointed.

Division of Acute Care Governance review
- A further update was provided on development work on Gate 12, when it was explained that a map of form, function and future of the ward was being drawn up
- The Division reported that for a period of 28 days during May, there were no breaches of the 60-minute ambulance standard
- The impact on staff of patients' and carers' comments on social media about their care was discussed, and it was agreed that more consideration of this issue was needed at Trust level.

Division of families and clinical support services Governance Review
- Medical and midwifery staffing gaps were affecting timely delivery of a range of maternity governance functions. Similar challenges were affecting the delivery of governance activity in Children's services
- Radiology, Therapies & Maternity Services have concerns about delays in the recruitment and on-boarding process following submission of the preferred candidate notification. The Division was working with HR colleagues to address this issue
- Due to sickness and vacancies within the Community Team for Learning Disabilities (CTLD), the capacity/demand situation across the service had deteriorated, and a backlog of patients had developed. A recovery plan was in place, and patients with safeguarding concerns, and those needing medication reviews were being prioritised. Specialist nurse recruitment was also under way
- Concerns were increasing about the availability and pricing of a range of standard stock consumables used across the Division. Particular concerns relate to radiological contrast media, urodynamics consumables in gynaecology and Home Enteral Feeding products
- 95% of women were triaged using BSOTS within 15 minutes, and PPH rates remain low at 3.5%.

Health and Safety Committee report to QC
- Generally good and consistent compliance with core and role-specific training was reported, however, fire safety training was an outlier with 86% compliance.

Patient Experience sub-committee

- The draft Patients, Families and Carers' engagement and experience dashboard was presented and discussed by the Committee.

Patient safety and clinical effectiveness sub-committee

- The report of the investigation into the incomplete mailing of letters to highly clinically-vulnerable patients in December 2021 had been presented to the committee. The investigation had identified no evidence of patient harm as a result of this episode.

Board Assurance Framework Review

- The committee discussed Principal Risk 1, and whilst it was acknowledged that improvements had been seen in some issues feeding into this risk, it was agreed that these had not yet reached the threshold to move from partial to significant assurance.

Attendance

- It was felt that there was an underrepresentation of Allied Health Professionals at the Committee and it had therefore been agreed that Andrew Hodge, newly appointed Director of Allied Health Professionals would become a member of the Committee, Dr Throssell asked for agreement from the Board that this could be included in the Committee Terms of Reference. The Board confirmed they agreed with this.

Further to the last report to the Committee, Mr Braden confirmed that he was still awaiting information from Consort and Equans with regard to window restrictors and the Trust were continuing to press for this through contractual measures.

With regard to the issue with recruitment in the Division of Families and Clinical Support Services, Mr Marshall confirmed he had looked into this and found no specific examples of material delays. He also commented that he would welcome being involved in the work regarding the impact of social media comments on staff.

The meeting of the Public Trust Board **NOTED** the updates from the Chair of the Quality Committee and **AGREED** that the Director of Allied Health Professionals become a member of the Committee.

T044/22 **MATERNITY SERVICES** *(update including an update on the Maternity Incentive Scheme)*

Dr Henshaw attended the meeting to present the paper noting the pertinent issues, these being:

- The Ockenden Insight visit had taken place on 13 June 2022, positive feedback was received including:
  - The evidence submitted prior to the visit was exemplary
  - Clear reporting structure
  - Good governance processes were in place with good examples of

testing learning.
This had been a robust visit and the final written report was awaited

- Progress was being made where possible with regard to the second Ockenden report, however Trusts had been guided by NHSI/E to await recommendations. There were 5 areas for the Trust to consider with regard to strengthening partnerships in maternity service development

- There were continued pressures in maternity services with regard to staffing gaps which were impacting both patient and staff experience

- There had been three full service suspensions in May 2022 as well as the temporary suspension of the Bronte Birth Centre. All impacting patient experience

- The shortfalls in staffing was also impacting governance functions, this was being actively managed. The Continuity of Carer Teams had also been impacted with just one team remaining however they were functioning well.

Mr Ramsay said that the Board were aware of gaps in midwifery but the report also referenced Consultant gaps in obstetrics and gynaecology and asked how imminently these would be filled. Dr Henshaw confirmed that this was a concern but recruitment was taking place and there had been an indication of some high calibre applications. There would be a period of risk but they were actively managing this.

Mr Stone queried the area covered by the Continuity of Carer Team, Dr Henshaw confirmed that the team looked after approximately 240 women in the Dewsbury area.

Mr Richards asked how Dr Henshaw envisaged the service at the Bronte Birth Centre working. Dr Henshaw felt that the preferred option was a good offer which would be open 24/7 with staff working between the centre and the patients home, she noted that this was a real opportunity for improvement with long term health benefits.

Dr Throssell noted that from the 14 moderate harm incidents, 3 related to service suspensions and queried what this meant. Dr Henshaw explained that when there was a closure a panel would review every patient affected and would either grade this up or down accordingly. She confirmed that no specific harm had been identified and the decision to suspend the service in these instances had been made to avoid harm.

Dr Throssell noted a statement at the beginning of the report with regard to continued improvement in quality and safety of services followed by a statement that the service was safe but fragile and queried how these two statements aligned. Dr Henshaw felt that this related to the complexity of

having many different sources of information, she felt that there was an improving position but this was on the backdrop of the challenges within the service. She confirmed she would reflect on this for future reports but confirmed that she would describe it as a fragile service due to the staffing gaps however this did not stop them from continually improving which was described within the report.

Mr Nawaz noted that the amount of women receiving Continuity of Carer was 6%, and due to the importance of this on health inequalities he asked what the ambition of the service was. Dr Henshaw noted that their first ambition was to become a fully established service and then maintain this. They continued to review actions to ensure they were doing the right thing for the people in the service and how patients were kept safe due to the change in the national picture.

The meeting of the Public Trust Board were **ASSURED** by the detail shared and discussed from maternity services.

T045/22 FORMAL AND INFORMAL COMPLAINTS SIX MONTH REVIEW

Mrs Parkes presented the report and highlighted the following:

- There had been a significant increase in complaints over the last year, this was a trend seen in most organisations following a dip during the pandemic
- There had been some ombudsman requests received from the beginning of the pandemic, the Trust would not normally deal with these types of requests if the complaint was over two years old however it was felt that it would be kind to consider them. It was noted that this may impact on the numbers
- The usual themes continued to be seen and there had been a significant rise in complaints regarding staff attitude, which was noted an issue of concern for the Trust as it was a measure of success with regard to patient experience.

With regard to the significant increase in complaints between October 2021 and March 2022, Mr Ramsay asked if these were all Covid related. Mrs Parkes confirmed that some elements were Covid specific such as communication from clinical areas but not with regard to care. She felt that the public were moving past Covid and reflecting back on their experiences during the pandemic. Mr Ramsay asked if capacity in the Patient Liaison Service had been considered with regard to the increase in complaints, Mrs Parkes confirmed that it had and three WTE members of staff had been added to the team to bring them back to pre-Covid numbers.

Mr Stone referred to feedback received and number or respondents who were not confident that the Trust would learn from their complaint noting that this could suggest that the Trust were being too defensive in their responses. Mrs Parkes confirmed that some detailed work had taken place with regard to this and organisational actions were ongoing however what

the Trust did not do well was evidence that action had been taken as there were immediate actions which could be reported back to complainants which would give confidence.

Dr Throssell provided an observation that the notion of complaints not being upheld or partially upheld could imply that a persons experience was not valued. Mrs Parkes thanked Dr Throssell for the feedback and agreed that this could be phrased better, she confirmed she would discuss this with the team.

Mr Ramsay commented that robust systems were in place which provided an appropriate level of assurance.

The meeting of the Public Trust Board were **ASSURED** by the Formal and Informal Complaints Six Month Review.

T046/22 RESPONSIBLE OFFICER MEDICAL REVALIDATION AND APPRAISAL ANNUAL REPORT

Dr Stone presented the report advising it was a requirement under the Responsible Officer Regulation to bring an annual report to Trust Board to demonstrate that the role of the Responsible Officer was being fulfilled as well as provide a report on performance and identify areas for action to mitigate potential risk.

Dr Throssell commended maintenance of really good appraisal rates for staff throughout the pandemic which was a real achievement.

Dr Throssell asked if there had been any recommendations from the GMC with regard to deferrals and non-engagement. Dr Stone confirmed that there were very few of these, as her team actively managed this they did not get to the point of a deferral. She confirmed that there had been no non-engagement instances as she has been able to manage these within the just and learning culture. Dr Throssell commented that this was really good performance.

Mr Richards reflected on earlier discussions regarding staff not feeling the value of their appraisal and asked if this information was specifically requested from doctors. Dr Stone confirmed that feedback was requested and the appraisal would not be closed until this was received. She confirmed she would ask her team to look at this and pull a report together, Mr Stone suggested that this would be a useful report for the People and Culture Committee.

The meeting of the Public Trust Board **RECEIVED** the Designated Officer Annual Report and **APPROVED** signing of the Statement of Compliance by the Chief Executive.

Other Matters

T047/22 AGEING WELL PROGRAMME

Mrs Webster introduced Ms Tilly Poole, Programme Lead for Community Transformation to give a presentation on the Ageing Well Programme. She advised in the context of discussions at Board with regard to high attendances, changes in demographics and health inequalities, something different was needed to care for patients outside of the hospital and the Virtual Ward was part of this work.

Ms Poole shard a presentation entitled Ageing Well and Virtual Ward Programme Update and highlighted the following:

Urgent Community Response Service

- There was emerging data that Emergency Department attendances had grown at a slower rate which would suggest that it was having an impact on demand in emergency care
- Next steps included increasing resilience and capacity of the service, support skill and competency development
- Work was taking place to increase the capacity of the team and provide equity across the district.

Virtual wards

- This was seen as an exciting and real opportunity for community to lead significant change in delivering services by providing acute care to people in their own homes
- Supported by national and regional programme infrastructure
- There was financial support but this was not on an ongoing basis so virtual wards needed to be built into the Trusts strategies and future plans
- Challenges included demand growth, workforce and winter
- Opportunities included the vision for the workforce with new career opportunities as well as enthusiasm for the work.

Mr Stone questioned the future financing of the programme, Mr Richards noted that the drive was to reduce demand on hospital and care for people in their homes where they wanted to be, finance in the longer term had yet to be decided. It was a fantastic programme and it was expected that there would be a combination of factors to finance in the future.

Mr Stone asked how risk was managed as a system, if demand was reduced and beds were filled with further unmet need there would be an issue. Mr Richards felt that the bigger risk was to do nothing as the hospital could not continue to run as it was. Mr Stone confirmed his support for this.

Mrs Webster commented that this programme should not be seen in isolation from the planned and unplanned care programmes, noting that the strapline was Start Well, Live Well, Age Well. If work took place to prevent people getting ill later on in life it would impact less on resources.

Dr Throssell was supportive of the model but queried how staff would deal with the extra capacity of virtual wards. Ms Poole confirmed the phasing of

the model had been done with clinical colleagues and teams had not been committed to anything they were not comfortable with. There were challenges with regard to recruitment and they were visiting other virtual wards across the country to understand what needed to be delivered and determine skills needs to recruit.

Mr Ellis asked where the Trust were in the process compared to others who were on the same journey. Ms Poole confirmed that both Leeds and Bradford had a frailty virtual ward for a number of years which meant there was learning for the Trust to use. Mrs Webster noted that the Trust did not have a virtual ward but they did have a significant infrastructure regarding the connecting care hubs which hosted primary care, community, social care, therapies, voluntary sector with a range of professions working together to manage care. There was also the willingness of the partnership in creating these roles and working together and use courage over comfort to work in a different way.

Mr Nawaz asked what help was needed from the Trust. Ms Poole confirmed that the development of cross system relationships had been helpful including the role of Mrs Webster and Dr Sawicka. Mrs Webster added that there was a challenge regarding clinical workforce.

The meeting of the Public Trust Board were **ASSURED** by the Aging Well Programme presentation.

T048/22 UNPLANNED CARE SYSTEM DELIVERY

Mrs Davies introduced Mrs Lucy Beeley Programme Manager – Urgent and Emergency care to give a presentation on Unplanned Care System Delivery. Mrs Beeley highlighted the following:

- Pre-hospital work included reduction in conveyances by ambulance
- In hospital work included primary care advice lines
- A draft dashboard was included in the presentation which reflected system rather than organisational performance.

Mr Ramsay noted some challenging targets stated in the report, such as a 40% reduction in ED attendances following consultation with GP and 20% reduction in the total number of patients with no reason to reside. He asked if these were realistic targets to reach by April 2023. Mrs Beeley stated that the aim was to ensure patients were receiving appropriate advice from GPs instead of using the ED. There might still be a need for patients to access same day emergency care services but at the moment this was all taking place through the ED. Mrs Davies added that, as Senior Responsible Officer for the programme, her challenge was the methodology to deliver at pace and scale noting that incremental change took a long time. If the methodology was followed it may take longer as they gained work from unmet need, the challenge was the risk threshold to move into true transformational change.

Mr Nawaz noted the high number of ambulance conveyances where the patient did not receive treatment, he felt that further understanding was needed with regard to these so there could be focus to reduce. Mrs Beeley said there were system challenges with regard to this however there was data to show where people had been on their journey and if there had been advice or clinical intervention when they arrived at the Trust. They had started work to look at patients who were discharged with advice only as this could link to a reduction in conveyance, they also needed to understand what paramedics needed to feel safe to make a decision and change this behaviour.

Mrs Webster gave assurance regarding the shared referral pathway scheme noting there had been reductions in cardiology referrals, patients were having better outcomes and experience as they were not sat on a waiting list. She felt there was an appetite among the clinical workforce to do things differently as ongoing practices could not be sustained and were not providing job satisfaction.

Mr Richards commented that he suspected that things would need adding into these programmes due to the scale of the challenge to move the emphasis of care from the hospital to the right place. Monitoring of opportunities from a world-wide point of view would be vital to see what was being successful as well as possible investment opportunities which the Trust could draw from for this work.

The meeting of the Public Trust Board were **ASSURED** by the Unplanned Care Programme presentation.

T049/22 ANY OTHER BUSINESS

Mr Ramsay confirmed he had not been made aware of any matters of other business.

T050/22 DATE AND TIME OF THE NEXT MEETING

The next meeting of the Public Trust Board is scheduled to take place on Thursday 8 September 2022 from 9.00am. Details on the venue were to be confirmed and would dependent upon latest national guidance on COVID-19 and social distancing but it was recognised that the Microsoft Teams live link may make the meeting more accessible to members of the public.

It was also noted the planning for the Annual General Meeting was underway for September 2022.

T051/22 CLOSE

There being no further business, the Chairman declared the meeting closed at 11.45am.

Chairman

Date: ……

……

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PUBLIC TRUST BOARD
MATTERS ARISING

DATE OF MEETING	AGENDA ITEM	ACTION	DEADLINE DATE	LEAD	PROGRESS
12 MAY 2022	**T007/22: Chair's Report**	To include range of activity undertaken in month in report.	July 2022	KR	**COMPLETE**
	T008/22: Chief Executive Report	To complete a report on the expected impacts of the system transformation programmes on MYHT unplanned care activity.	July 2022	JW/TD	**COMPLETE**
	T013/22: Annual Operating Plan and Budget	Financial plan to be shared with Board	July 2022	JM	**COMPLETE**
	T013/22: Trust Board Scorecard And True North	Review the staff vacancy data in the scorecard in relation to the accumulation of division performance equating to Trust performance	July 2022	PM	**COMPLETE**
	T021/22: Green Plan	Green plan baseline report to be received by Board in September	Sept 2022	MB	
14 JULY 2022	**T032/22: Chief Executive Report**	An update on NHS Quest to be arranged.	TBA	TD	
	T035/22: Board Assurance Framework and Trust Level Risk Register	Lead and completion dates to be added to the BAF PR actions	Oct 2022	JB	
	T035/22: Board Assurance Framework and Trust Level Risk Register	Noted updates to be included in the BAF including achievement of JAG accreditation, WHO Surgical Checklist compliance with four months of consistent performance	Oct 2022	JB	

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW			
Agenda item	1.8		
Paper title	Chairs Report		
Responsible Director	Chairman		
Author	Executive Assistant		
Previously considered by	Not Applicable – This report is only presented to Trust Board		
The Board/Committee is asked to:			
Approve	**Receive**	**For Information**	**Take assurance**
Executive summary			
The paper records the meetings attended by the Chairman since the last meeting of the Public Trust Board in July 2022. The paper also captures other elements of engagement, and the Chairman will expand upon these as necessary in the meeting.			

Link to strategic objective(s)	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	Nil

1. INTRODUCTION AND PURPOSE

This paper records the activity of the Chairman between 8 July 2022 and 31 August 2022.

2. DETAIL

The activities recorded within this report have taken place in accordance with the latest government advice and guidance related to the ongoing pandemic. Where visits have taken place in person these have been undertaken in line with the necessary requirements, including the use of PPE.

Internal meetings re strategy, assurance, etc:

- CQC Update – meeting held monthly between Chairman, Director of Nursing and Quality, Regulation and Compliance Lead and Non-Executive Director
- Chief Nurse Officer Interviews
- Public Trust Board
- Private Trust Board
- Met with Director of Adult Community Services
- Met regularly with the Chief Executive
- Strategy and Transformation Committee – in role as Chair
- Met with Freedom to Speak Up Guardian x2
- Introductory meeting with the new Fundraising Manager
- Met regularly with the Interim Company Secretary
- Resource and Performance Committee – in role as Attendee
- Board Seminar x2
- Met with Head of Organisational Development
- Organ Donation Committee – in role as Chair
- Introductory meeting with the new Director of Finance
- Tier 1 Committee Assurance Meeting – meeting held bi-annually with all Committee Chairs to review the Committee functions
- Non-Executive Director (NED) Briefing – meeting held monthly between the Chairman and Non-Executive Directors x2
- Introductory meeting with new Chief of Planning, Partnerships and Strategy
- Met with Director of Pharmacy
- Met with Director of Workforce and Organisational Development
- Consultant Interviews for Respiratory Medicine
- Met with Medical Director
- Introductory meeting with Head of Voluntary Services
- Met with Chief Clinical Information Officer (CCIO)
- Met with Insight Programme Non-Executive Director
- Met with Head of Clinical Services (Head & Neck)

Visits and presentations:

- Ossett Health Village to present MY Star award

- Visit to the Integrated Care Team at The Bungalow in Castleford
- Visit to Wakefield Intermediate Care Unit with Interim Director of Finance and Clinical Site Manager
- Junior Doctor Induction
- Level D, Gynaecology at Pontefract Hospital to present MY star award
- Visit from Jane MacDonald to Trust Headquarters and Education Centre – to support the MRI Appeal Fundraising campaign
- Scan Bureau at Pontefract Hospital to present a 50 Years NHS Service award
- Eye Centre at Pinderfields Hospital to present a MY Star award
- Visit from NHS West Yorkshire Integrated Care Board (ICB)

External meetings:

- Attended the NHS System Leads/MP Meeting – in role as Chair
- Introductory meeting with the Wellcome Trust
- Attended the West Yorkshire Integrated Care Board (ICB) Remuneration and Nomination Committee – in role as co-opted Member
- Met the Chief Executive from SPINE with the Associate Director of Planning and Partnerships
- Attended West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common – in role as Member.
- Attended the NHS Confederation Chairs Group – in role as Member.

3. RECOMMENDATION

The Trust Board are asked to note the content of this report.

Sophie Johnson
Executive Assistant
(Prepared on behalf of the Chairman)

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW				
Agenda item	1.9			
Paper title	Chief Executive Report			
Responsible Director	Chief Executive and Deputy Chief Executive			
Author	Personal Assistant			
Previously considered by	Not Applicable			
The Board/Committee is asked to:				
Approve	**Receive**	**For Information**	**Take assurance**	
Executive summary				
Full detail within the main paper.				

Link to strategic objective(s)	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	None

1. Awards

1.1. MY Star

- **Surprise presentation – MY Star Award – March 22**
  Elizabeth Kilburn – MY Star Elizabeth (known as Libby) is a Community Staff Nurse, part of Network 6 in Ossett and was nominated by Marie Quinsee, Clinical Team Leader.

  Libby cared for a young adult patient within the community who required a great deal of guidance through is treatment. She built trust and a rapport with the patient and his family and with her fast action, knowledge and input from other services, avoided the patient receiving an amputation to his foot.

  Since that time, the patient has grown in confidence and is now able to be independent using his wheelchair. Libby improved the patient's health journey by staying late on numerous occasions to enable other services to join up at the patient's home. She worked above and beyond to ensure he was listened to and valued, and the patient and his family cannot thank her enough.

  Chairman Keith Ramsay presented Libby with her award in a surprise presentation.

- **MY Star Award – May**
  Dr Vittaldas Pai, Associate Specialist in Ophthalmology, Eye Centre, Pinderfields Hospital

  Mr Pai was nominated by Beverley Cooper, Medical Secretary, for being the 'go to' clinician for all investigations/queries for paediatric ophthalmology for a solid three-month period.

  He has consistently gone over and above his regular duties to support the team in recent months, maintaining the screening of newborn premature babies as well as continuing to fulfil his other clinical duties in the department in adult clinics. He has always carried out his role in a pleasant and helpful manner, whilst sometimes being under tremendous pressure and is truly an asset to their department.

- **MY Star Award – June**
  Sarah Stevens, Clinical Nurse Specialist, Gynaecology, Pontefract Hospital
  Sarah was nominated by David Batterley, Digital Change Manager who was impressed with Sarah's attitude, determination and thoroughness when working with her on a recent Coloscopy project.

She worked with multiple teams, both internal and external to deliver the project - involving herself in technical and IT driven discussions, listening carefully and contributing a clinical perspective. Sarah proved herself to be flexible and responsive to the needs of the project, doing the majority of the user acceptance testing herself which took time and effort, often at short notice. This project could not have delivered without her support and the Colposcopy service will be benefiting from her efforts in helping to deliver this project for many years to come.

1.1 Teams of the Week

- 11 July 2022: Haematology: For ongoing hard work and dedication despite extreme pressures in the service
- 18 July 2022: Orthopaedics: For their commitment to resolving trauma issues occurring Sunday 17th July 2022.
- 25 July 2022: Estates and Facilities: For their outstanding work and commitment last week
- 01 August 2022: Colposcopy MDT
- 01 August 2022: TIF 2 Team
- 08 August 2022: Post Graduate Education Team: For running regional surgical training event which was great success
- 08 August 2022: ICU: For completing vents work recognising complex work around estates moves required

2. Update from the Chief Executive

2.1 Community employment partnerships, employability schemes and reducing health inequalities

The Trust is running a number of programmes to increase access to employment for members of our local community, in particular the more vulnerable members of our community. The aim is that by enabling improvements in socio- economic status for members of our community through employment this will lead to an improvement in health.

2.2 Kickstart

The Kickstart programme has offered young adults, aged 16-25, from the Kirklees community, who had been in receipt of Universal Credit for more than 6 months the opportunity for a 6- month training placement in the Trust. During their placements, the trainees have gained various work experience, skills and undertaken relevant “on the job” training. They have also undertaken an employability programme run by Kirklees Council and been supported with job application and interview preparation by our Kickstart Co-Ordinator. The trainees commenced their placements between November 2021 and March 2022 and we successfully appointed 12 trainees.

A number of our trainees have already completed their placement and several have secured employment in the Trust. One individual has secured a post with the local authority as a result of their placement. The remainder are due to complete their placement at the end of September 2022 and are currently applying for roles.

2.3 Sector Skills employability programme

In June 2022, we relaunched our Sector Skills Academies in partnership with the Wakefield Job Centre Plus team and Wakefield College. This programme enables clients from the Job Centre, who are long-term unemployed, to undergo assessments for a job without the need for a traditional job application. Clients are screened and proposed for the assessment centre by the job coaches in the Job Centre Plus team. Individuals participate in an information session run by the Trust to prepare them for assessment and then undertake a values-based assessment centre. If they are successful, they are offered a permanent role, subject to completing a two-week educational programme at Wakefield College, during which they complete modules and qualifications required for the role, such as Food Hygiene Certificate, and a full job application, supported by the college tutors and job coaches. This is followed by a four-week job placement in the Trust, during which they undergo relevant job training and undertake the role they have been offered. This affords individuals the opportunity to apply for roles in a supported manner, gain relevant and transferrable qualifications free of charge, and a realistic job preview during their placement, to help them determine if the role is right for them. This has enabled us to fill 10 ancillary roles so far and we are planning to run further programmes for the Wakefield Community and to launch in Dewsbury within the next month.

2.4 Partnership employability programme

In July, we ran an employability event to recruit trainee and apprentice Healthcare Assistants in partnership with the Wakefield Job Centre Plus team and the employability team in Wakefield Local Authority (the Step Up team). The target audience was people aged 16 and over, who are long term unemployed or in the 'less frequently heard from' groups within our local community. Individuals participated in an information session, similar to the Sector Skills Academy, and underwent a values- based assessment.10 individuals were offered apprenticeships at the event and a subsequent event has now been arranged for 9th September, where we hope to assess 40 individuals. The events have also been promoted by the Princes Trust to young people aged 16-30, who are young carers or classed as vulnerable. We are also planning to replicate this offer to the Dewsbury Community in the coming months.

2.5 Schools and colleges outreach

We undertake a variety of activities with local schools and colleges to engage young people in our community and encourage them into roles in healthcare. We guarantee interviews for Apprentice and Trainee Healthcare Assistants for students studying at any college within our immediate geographic footprint, who meet the essential educational threshold.

2.6 Partnership Board MYHT and CHFT

MYHT has a strong relationship with the Calderdale and Huddersfield Foundation Trust (CHFT), due to proximity and sharing provision of hospital services for the population of Kirklees. With continuing national and local challenges around workforce, operational pressures and finance, the two Trusts have worked more closely together on colloboartive areas of work. This has worked well in ensuring better access to services for all our patients than if e worked independently or in competition with each other.

To strengthen the partnership working further more regular, monthly, meetings between executives from each Trust have been taking place and to enhance this further and to support the process of joint working a draft Terms of Reference has been developed and a Partnership Agreement descirbing the principles of how the joint working arrangements will be enacted is being considered.

Currently, there are three areas of joint working with increased focussed support, these being Non-surgical Oncology, Maternity and Clinical Diagnostic Centres. The Partnership Board will focus on the startegic delivery, including:-

- Identifying actions that benefit our patients and their families,
- Understanding the needs of partners at place and sector and how jointly we can work with them and
- Creating a culture where partnership working is supported and made easier in both organisations.

2.7 TIF 1 progress and TIF 2 Approval

The Trust was awarded Target Investment Funds (TIF) under two schemes, TIF1 and TIF2. TIF1 enabled Surgical services to utilise capital funds to purchase equipment and modify the estates to improve productivity and increase capacity to treat our patients. Schemes included:

The formation of 3 clinic rooms for Oral and Maxillo-Facial Surgery to treble their capacity in Pinderfields for day case and one stop shop procedures.

The conversion of office space into a new local anaesthetic eye surgery theatre in the Eye Centre.

The conversion of theatres in Pontefract to make them 'clean-air', allowing Orthopaedics to double their elective surgery capacity on this site from next year and create an Orthopaedic Centre of Excellence.

TIF2 provided further capital investment that will build a brand new surgical building that will enable Surgeons to see and treat an additional 65,000 patients per year in Dewsbury, supporting innovative and ambitious treatment pathways that will deliver high-volume, low complexity surgery in a purpose-built theatre and clinic environment.

2.8 LGA feedback on ITOC

In July 2022 the system team who are looking to improve our discharge pathways (made up of Mid Yorkshire team colleagues, local authority team members and providers of care across the system), engaged a peer group to look at our system discharge programme and provide us with some feedback regarding the content, quality and assurance of our current programme. The 9 person peer group was made up of representatives from the Local Government Association (LGA), NHSE/I and Executive Director colleagues from Councils across the country.

They provided valuable insight and feedback to the team which included a positive reflection of the level of system working already evidenced including a good grasp of the operational challenges, an outward facing attitude to improvement and the seeking and acceptance of new ideas and ways of working. They did identify 12 recommendations themed around governance and leadership, information sharing and new models of care delivery which are now being more explicitly build into the system discharge programme.

2.9 Citizens Advice Bureau

The Trust is entering into a partnership arrangement with the Citizens Advice service to offer free, confidential, and impartial advice to staff and visitors. The confidential service will include help and advice on a wide range of subjects including for example support and advice related to financial difficulties/cost of living . The Citizens Advice service will be based on the Pinderfields site but there will be a variety of ways to access the support from a face-to-face appointment, specialist appointments via telephone/MS Teams and an advice line, to ensure that it is accessible for everyone.

By working in partnership with the Citizens Advice service we hope that this will make accessing such a service easier for our staff (adding to our existing staff support offers) and also for our patients, particularly at what is a very challenging time for individuals and families. We are expecting the service to be available from October this year.

2.10 Innovation

Len Richards, Chief Executive, Phillip Marshall, Director of Workforce and Organisational Development, and Stuart Bond, Director of Innovation, met with Professor Susan Cooke, CEO of the University of Huddersfield's 3M Buckley Innovation Centre to discuss potential innovation opportunities relating to workforce development. The other topic we discussed was how we can work together better on innovation as it relates to the NHS – medicines, medical devices, digital, diagnostics and ways of working. We had second meeting with Professor Cooke and Liz Towns-Andrews, Professor of Innovation to talk about the new Health Innovation Campus at the University.

There are some excellent opportunities to build joint appointments with the University, focusing on allied health, nursing, pharmacy and other non-medical roles. We will also work with the University to build leadership training and development opportunities. We will contribute to the development of the innovation campus, which will provide a significant boost to health care innovation in the region. This will mean better health and wellbeing for our communities through improvements to the way we do things in the NHS, alongside opportunities for businesses, and the chance to share our work to a wider audience through journal publications.

The health care inequalities in asthma project that is being led by Dr Llinos Jones has received a boost, through the provision of 10 extra half days of time to help the project to become more sustainable. Dr Jones and the team have begun evaluating the project in collaboration with the University of Huddersfield. Additional support from the project is being provided by the Yorkshire and Humber Academic Health Sciences Network and the Programme Management Office.

3. WYAAT Programme Executive Meeting

The last meeting of the WYAAT Programme Executive took place on Tuesday 02 August 2022. The main focus of discussion was an update on Head and Neck Surgery, ICB Risk Management, Elective Recovery, Clinical Leadership Proposal and the WYAAT Strategy Development and Plan for the Executive Teams Time out.

4. Kirklees Health and Care Executive Group

The last meeting of the Kirklees Health and Care Executive Group took place on Friday 02 September. The main focus of discussion was an ICS update including footprint conversions, current system pressures and winter planning considering the recent National letter.

5. **West Yorkshire and Harrogate Diagnostic Board**
It was agreed in the last meeting of the WY Diagnostic Board in July that the meeting would be cancelled in August. The next meeting is scheduled for 23 September.

6. **Wakefield District Health and Care Partnership Board**
The next meeting of the Wakefield District and Care Partnership Board is not until Thursday 22 September.

7. **West Yorkshire and Harrogate System Leadership Executive Group**
The last meeting of the WY&H System Leadership Executive Group took place on Tuesday 02 August. The main focus of the discussion was the current position of COVID-19, the system pressures and next steps in the recovery of elective services, pressures at Yorkshire Ambulance Services NHS Trust and implications of the NHS pay award for 2022/2023.

8. **Operational Pressures - Deputy CEO/Chief Operating Officer Update – 31 August 2022**
Please note – this is an evolving situation and therefore, accurate numbers are not provided as they will change.

- **Covid** –The number of Covid in-patients and staff absence due to Covid has slowly improved during July and August. As a result, the Strategy group has reduced the frequency of meetings to once per week and IPC measures have been reduced, such as mask wearing in non-clinical areas and visiting access has been increased.
- **Vaccination** – The vaccination hub will resume in THQ at the end of September for a two-week period with the aim of co-administering the Covid and Flu vaccination to staff.
- **Demand –** demand levels across planned and unplanned care remain high. In response to activity levels, detailed forecasting work has been undertaken with divisional teams to inform longer term capacity planning and mitigation.

- **Cancer 2WW** – Pressures faced during the early part of the year in Dermatology services were mitigated in May, however, further demand increases and unexpected unavailability of locum Consultants has caused further concern during June and through the summer. This will continue to compromise overall performance. Innovative solutions such as alternative workforce from the head and neck team are starting to show some improvement.

Key Updates:

- A Winter Board has been established at System/Place level. The Place lead is Michala James, Trudie Davies is system SRO and Jo Halliwell is the MYHT Winter lead. The board will report to the provider collaborative and through MYHT governance processes. Key activities have been agreed and a clear plan with measurable outcomes articulated.

- Capacity monies have been made available following a national application process to support the substantiation of Wards A1 and Ward 4 as well as the development of 25 community beds. This work will be overseen by the winter board.

- A number of key products have been in short supply over the summer. This included products such as Bowel Prep and Iodine scrub for theatres. A number of other products have required short notice substitution. This risk has been noted in risk committee and a task and finish group has been established to ensure cross organisational understanding and assessment of these risks as they arise.

- The TIF bid processes continue across all three sites. MYEYE centre work is complete, Pontefract Orthopaedic centre is progressing and due to conclude in early 2023, plan for a modular build at DDH to increase surgical activity have been approved.

- MYHT have been asked to do a 15 minute presentation on some of the recent MYQIS work at the Yorkshire and Humber AHSN QI network event on September 22. The focus will be on the Ambulance handover work and 5S process in DDH ED.

Rebecca Ward
Personal Assistant
(Prepared on behalf of the Chief Executive and Deputy Chief Executive)

COMMITTEE REPORT TO TRUST BOARD – AGENDA ITEM 2.1a

Meeting	**Risk Committee**
Date of meeting	**21 July 2022**
Completed by	**Trudie Davies**
Risk registers reviewed	**Division of Medicine** **Division of Acute Care** **FCSS** **Workforce and Organisational Development** **BAF 11**
COMMITTEE AGENDA ITEMS	
Are there matters of concern or importance to escalate to Trust Board or another Committee?	Key escalations made by the committee are:- • Risk 6016 added to TLRR - Risk of available workforce for surge capacity on A1 and Ward 4 due bed available and No R2R, impacting on patient care & experience – although mitigations were in place for these had been challenged due to Covid absence within the workforce and surge capacity remained open in a number of areas due to demand. • Risk 5219 on the TLRR has been reworded from "Risk of overcrowding in ED causing extended stays due to insufficient outflow e.g. bed availability resulting in potential harm" to "Risk of patient harm due to extended stays within the ED." • Risk 6023, "Risk that children with complex CAMHS care needs are not receiving care within a dedicated CAMHS inpatient facility" was added to the TLRR. The Chair asked the service to liaise with DOM given the presentation was often into those services.
Where has the Committee received assurance?	There was discussion about the subjectivity of scoring risks by individuals across services and the impacts of individuals own risk tolerance on scoring. Noting there are a number of risks still greater than 15 on datix, Mrs Davies asked that the ongoing review with divisions bringing all risks over 15 continue, noting that risk committee were well placed to review the impact of risks on the whole organisation and to offer support with consistency. **Division of Medicine** - Recall of Philips CPAP and ventilators had been undertaken a process was in place but some patients are still waiting an equipment delivery - The sustainability of the spinal injuries rehabilitation services was noted given the on-call frequency. A shared care model was being considered. - The impact on vacancies within haematology was discussed **Division of Acute Care**

	- The impact on ED of women attending in labour due to the Bronte Birth centre temporarily closing was discussed. - There was discussion about the impact and delays of mental health patients in ED due a lack of timely access to psychiatric assessment. - It was highlighted that space to offload ambulance handovers would be compromised and allocated to Covid positive patients when demand was high and space in the department compromised. Mrs Davies asked this to be reviewed with IPC due to the impact on the wider system of delaying ambulance handovers. **Division FCSS** - The Director of Midwifery informed the Committee of a potential Never Event that was currently under investigation. - The high number of risk scoring over 15 in the division was noted and it was asked by the committee that these be reviewed within the division and brought back to the next committee meeting. **Division FCSS** - It was noted that there are many risks in the division. The division have been asked to check their risk profile. - The division highlighted a Staffing shortfall impacting on the frequency of rehabilitation for ESD stroke patients. - A risk relating to routine respiratory patient's condition deteriorating due to pulmonary rehab waiting time was noted as having good mitigations in place. - A risk relating to the suspension of wound management training was highlighted and the division were asked to review the scoring of this. **Workforce** - It was noted the violence and aggression risk wording was important and the committee were asked for their views on wording and scoring before this was finalised on datix. BAF principal risk 11 was shared and it was agreed this would be reviewed and shared with Covid 19 strategic group.
Has the Committee asked for any further action to be taken, if so, what action, by whom and within what timescale?	
ANY OTHER MATTERS TO BE REPORTED TO TRUST BOARD	
None	
COMMITTEE ADMINISTRATION	
Committee Self-Assessment for 2021/22 complete?	**Yes**

Terms of Reference up to date?	**Yes reviewed in March 2022**
Workplan up to date?	**Yes (reviewed to accommodate new division)**
Committee Annual Report due?	**Completed March 2022**

COMMITTEE REPORT TO TRUST BOARD – AGENDA ITEM 2.1b

Meeting	**Risk Committee**
Date of meeting	**18 August 2022**
Completed by	**Trudie Davies**
Risk registers reviewed	**Division of Surgery** **Medical Directorate (including Medicines Optimisation and Pharmacy)** **Nursing Directorate** **FCSS (15+ risks only)** **BAF 11**
COMMITTEE AGENDA ITEMS	
Are there matters of concern or importance to escalate to Trust Board or another Committee?	Key escalations made by the committee are:- - Supply issues were noted which were separated into two elements. The first being medicine supplies which was business as usual for Pharmacy with processes to manage on a day to day basis and monitor through the Medicines Optimisation Group. - The other issue related to supply of goods which was outside the control of the Trust and was causing risk which the Trust had not seen before including cancellation of lists – action agreed with DOF to establish a new process of escalation via the divisional and procurement routes to identify concerns early and take mitigating action. Emerging risks identified by FCSS: • Potential reduction in neonatal cots in region which will have an impact on local pathways • Increased financial pressures (£150-£200K) relating to the cost of contrast media for radiology • CT/MR Courtyard scheme – cost and time of delivery risk
Where has the Committee received assurance?	There was a discussion regarding the scoring of some risks, it was noted that there was a useful tool in the Risk Management Framework to aid risk scoring this and Divisions/Directorates were asked to review their risks against this. **Division of Surgery** - Ventilation works were complete and the associated risk had therefore been closed. - The ABC consultation had been competed with plans for the team to move to DDH on 12 September 2022. There is an ongoing risk of recruitment to the team however they were looking at new opportunities within the local DDH population - The availability of supplies was impacting on confidence in managing theatre sessions and there had also been issues with the quality of some goods. These had been escalated through internal governance and to NHSE/I.

	Medical Directorate - Risk 3067, identification and management of patients with sepsis – risk score reduced to 10 from 12 due to approved CCOT service business case. Following discussion the Committee recommended that this risk be removed from the TLRR noting that continued monitoring would take place and be reported to Board through performance reports. **Medicines Optimisation** - Assurance was provided with regard to medicines supply risk, this was an ongoing risk within Pharmacy but was dealt with on a day to day basis and managed through the Medicines Optimisation Group **Pharmacy** - There was a risk of the availability of ward pharmacy staff due to vacancies, the team had been managing a vacancy rate of 50%. Robust mitigations were in place with positive recruitment and improvements were expected by the end of September. **Nursing** - Risk 6043 relating to poor compliance with pressure ulcer prevention and management strategies had been fully reviewed with a fresh approach however increasing numbers in the Emergency Department and LoS had meant that the risk score of 16 had been maintained pending assessment of actions. The new Patient Safety Incident Response Framework had been launched which would also impact this risk - Risk 5973, Risk to patient safety if the actions implemented in response to National Patient Alerts are not embedded – assurance was received that a lot of work had taken place and escalation to PSCE and QC was evident. The risk score remained 12 pending audit feedback on actions - There was work to do with regard to the risk to patient safety due to non-compliance with Enhanced Care Policy. This was further affected by HCA vacancies and a security workforce review as needed as a different skillset was required to enact the policy. **Families and Clinical Support Services** - The Division had reviewed the 15+ scored risks further to a conversation at the last meeting, it was recognised that there was an inconsistency in scoring methodology and the Division were asked to adopt the method outlined in the Risk Management Framework which would help to recraft the risks and provide a better baseline which reflected the true 15+ Risks.

	BAF principal risk 11 was shared following review with the Head of Infection Prevention and Control, this had also been shared with the Covid-19 Strategic Group.
Has the Committee asked for any further action to be taken, if so, what action, by whom and within what timescale?	

ANY OTHER MATTERS TO BE REPORTED TO TRUST BOARD	
None	
COMMITTEE ADMINISTRATION	
Committee Self-Assessment for 2021/22 complete?	**Yes**
Terms of Reference up to date?	**Yes reviewed in March 2022**
Workplan up to date?	**Yes (reviewed to accommodate new division)**
Committee Annual Report due?	**Completed March 2022**

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW			
Agenda item	2.2		
Paper title	Trust Level Risk Register and Board Assurance Framework (Review of Principal Risks 3 & 4)		
Responsible Director	Dawn Parkes, Director of Nursing		
Author	Jen Beckett – Company Secretary		
Previously considered by	The Trust Level Risk Register is considered monthly at Risk committee. Principal Risk 3 and 4 are considered at Quality Committee on a quarterly basis.		
The Board/Committee is asked to:			
Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

The summary of Trust Level Risk Register (TLRR) is also presented to give Board members the latest position and to help inform discussions and decisions made at the Board meeting.

As part of the continual review process of the Trust's Board Assurance Framework Principal Risks 3 and 4 are presented for review. Principal Risk 3 is " Failure to provide excellent patient experience" and Principal Risk 4 is " Failure to provide expected outcomes." These both relate to delivery of strategic priority 2, "to Provide excellent patient experience and deliver expected outcome."

The Board are asked to:
- Note the changes to the TLRR
- Review principal risks 3 and 4

Link to strategic objective(s)	*Highlight relevant box from the below:*
	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	*Highlight one box from the below:*
	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	None known at this time.

1. Information and Purpose

The Trust Board considers that it is good governance practice to consider one or two of the eleven principal risks, derived from the Board Assurance Framework (BAF), at each meeting where the full BAF is not on the agenda. The Board will continue to receive quarterly updates on the overall Board Assurance Framework.

The purpose of this paper is to review principal risks 3 and 4. Principal Risk 3 is " Failure to provide excellent patient experience" and Principal Risk 4 is " Failure to provide expected outcomes."

2. Background

The Board carries out an annual review of the BAF at a Board Development Seminar and all principal risks are allocated to lead Executive Directors and Tier 1 Committees or Trust Board. Tier 1 Committees consider their relevant sections on a quarterly basis and provide a level of assurance to the Trust Board.

The HFMA's NHS Audit Committee Handbook describes the Board Assurance Framework as '*the key source of evidence that links the organisation's mission critical strategic objectives to risks, controls and assurances and is the main tool which the Trust Board uses in discharging its overall responsibility in respect of internal control*'.

A principal risk is a risk which may threaten the achievement of the Trust strategic objectives and should be considered by the Board as the most significant risks. These risks are only reported and discussed at Trust Board level, however, related operational and corporate risks recorded in Datix are identified. In contrast, operational risks relate to the Trust's day to day functioning are reported in Trust, Directorate, Divisional, Project and Specialty Risk Registers. Those scoring over 12 are consider at Risk Committee and where they are deemed to be of significant importance to delivery of the Trust's strategic or yearly operational plans these are included in the TLRR.

3. Assessment

a. Trust Level Risk Register

There are currently 22 risks on the TLRR. Since the last report to Trust Board in July the following changes have occurred:

- **Risk 5173**, risk to patient safety due to the significant numbers of staff absent due to Covid, score has increased to 9 (previously 6)
- **Risk 3067**, identification and management of patients with sepsis – risk score reduced to 10 from 12 due to approved CCOT service business case and risk removed from TLRR.
- **Risk 3220**, Harm to patients caused by poor compliance against pressure ulcer prevention and management strategies (Trust Risk), has been rephrased and replaced with **risk 6043**, Risk of harm to patients caused by poor compliance with pressure ulcer prevention and management strategies
- **Risk 5219** description has been updated to Risk of patient harm due to extended stays within the ED

Five new risks have been added to the TLRR:-

- **Risk 5218**, Risk of crowding due to high volume of attendances resulting in potential harm to patients has been escalated on to the TLRR.
- **Risk 6002**, Review of IR(ME)R regulation compliance
- **Risk 6016**, risk of available workforce for surge capacity on A1 & Ward 4 due bed availability and number of R2R, impacting on patient care & experience
- **Risk 6022**, Risk that children with complex CAMHS care needs are not receiving care within a dedicated CAMHS inpatient facility.
- **Risk 6068**, Cultural factors influencing the reporting of incidences of violence and aggression against staff has been added to datix and the TLRR.

b. Principle Risks

The Board should consider the following:

1. The risk
2. The controls in place
3. Gaps in controls
4. The assurances
5. Gaps in assurances
6. Assurance Level
7. Actions
8. Lead executive and committee
9. Current risk rating
10. Other questions/comments/challenges:
    a. What risks are included on DATIX and other risk registers which link to this overall principal risk
    b. If there are no TLRR risks relating to this principal risk – does that feel right?

4. Conclusion and Recommendation

The Board are asked :-

- To review the TLRR.
- To review the Principal Risks 3 and 4.

Jen Beckett
31 August 2022

Appendix 1 – TLRR

TLRR Summary as at End August 2022								
Reference	Date Risk Recorded on Datix	Divisional Ownership	Risk	Inherent rating	Current rating	Target rating	Previous month rating	Mar v April
2170	13/10/2014	Workforce & OD	Ability to maintain funded establishment in difficult to recruit to roles (including RN, HCA and medical roles)	16	12	6	12	↔
2186	01/10/2014	Nursing & Quality	The impact of Registered Nurse and midwifery vacancies potentially poses a risk to patient safety and experience.	20	12	12	12	↔
3325	05/05/2017	Medical Directorate	Failure to comply with NEWS Policy	15	10	8	10	↔
4461	30/09/2019	Workforce & OD	Selection challenges, lack of career progression, employment experience prevent proportionate BAME representation above Band 7	16	12	6	12	↔
4627	28/01/2020	FCSS	Risk of failing to provide a consistently high quality Maternity service	25	20	5	20	↔
4800	17/06/2020	DoAC	Risk of patients experiencing harm due to excessive time to transfer to PGH from peripheral sites	16	9	8	9	↔
5173	19/11/2020	COO	Risk to patient safety due to the significant numbers of staff absent due to Covid related reasons	25	12	9	6	↑
5218 (NEW to TLRR)	20/12/2020	DoAC	Risk of crowding due to high volume of attendances resulting in potential harm to patients.	20	20	8	20	↔
5219	21/12/2020	DoAC	(NEW WORDING) Risk of patient harm due to extended stays within the ED ~~Risk of overcrowding in ED causing extended stays due to insufficient outflow e.g. bed availability resulting in potential harm~~	20	20	12	20	↔
5482	11/07/2021	DOM	Risk to inpatient bed availability due to inability to timely discharge MOFD & Super-stranded patients resulting in operational pressures and use of full capacity beds	20	20	9	20	↔
5484	12/07/2021	DOM	Risk to the sustainability of the Oncology Service due vacancies impacting on service delivery & patient care	25	16	8	16	↔
5571 (previously 972)	07/09/2021	Nursing & Quality	Failure to comply with Infection Prevention and Control Policies, Procedures and Guidelines	16	16	12	16	↔

5701	24/11/2021	COO	There is a risk that issues and events within partner organisations will impact on the delivery of efficient services at MYHT	20	12	9	12	↔
5816	01/03/2022	Finance	Risk of achievement of 2022/23 I&E Control Total	16	16	6	16	↔
5828	07/03/2022	EFIT	Risk of ransomware attack on the Trust IT systems	15	15	10	15	↔
5955	18/05/2022	COO	Risk of not achieving constitutional targets	20	16	9	16	↔
5903 (linked to 2414)	03/05/2022	DOS	Due to vacancies and skill mix in theatres there is a risk to the Divisional Elective Recovery Plan	16	12	8	12	↔
6002 (NEW)	29/06/2022	EFIT	Review of IRMER regulation compliance	20	16	4		
6016 (NEW)	04/07/2022	DOM	Risk of available workforce for surge capacity on A1 & Ward 4 due bed availability & numbers of R2R, impacting on patient care & experience	12	9	6	9	↔
6022 (NEW)	17/07/2022	FCSS	Risk that children with complex CAMHS care needs are not receiving care within a dedicated CAMHS inpatient facility	20	20	12	16	↑
6043 (replacing 3220)	03/08/2022	Nursing & Quality	Risk of harm to patients caused by poor compliance with pressure ulcer prevention and management strategies	16	16	9		
6068 (NEW)	26/08/2022	Workforce & OD	Cultural factors influencing the reporting of incidences of violence and aggression against staff	15	15	12		

Strategic Priority	Provide Excellent Patient Experience and deliver expected outcomes	Associated Trust level risks	Assurance Rating				Year	2022/2023	Risk Appetite
Principal Risk	3. Failure to provide excellent patient experience	4627, 5701, 5484, 2186, 2170, 3067, 3325, 4461, 5219 (other linked risks 2805, 4296)	Q2	Q3	Q4	Q1	Quarter	2	**CAUTIOUS** Appetite for taking moderate clinical or people risks if essential to delivering patient experience. Such risks are assessed and have robust mitigation and control measures in place.
Executive Lead	Director of Nursing and Quality		21/22	21/22	21/22	22/23	Inherent Risk Score	16	
Committee	Quality Committee						Current Risk Score	16	

Key Controls	Assurance	Gaps in Controls	Gaps in Assurance
PALS and Complaints and Bereavement service	Patients Friends and Family Test (FFT). National Patient Surveys. Reduction in number of formal complaints. Quarterly staff pulse survey recommends Trust as a place to receive care. Parliamentary and Health Service Ombudsman feedback reports. Patient Experience Sub Committee Report to Quality Committee. Six monthly Complaints report received by Trust Board. Reduction in number of formal complaints - KPI's are monitored at the Patient Experience Sub-committee. Increase in the number of PALS enquiries received with an increase in the number of concerns being resolved informally. Complaints Dashboard shared at the Patient Experience Subcommittee. Complaints Satisfaction Questionnaire being monitored. Bereavement Survey – quarterly analysis of feedback to Patient Experience Subcommittee. Monthly Integrated Performance Report received at Quality Committee. MY Quality Strategy 2018 - 2022 Scorecard. Quality Committee Scorecard. End of life dashboard to the Patient Experience Sub-Committee. Quarterly complaints data submitted to NHS Digital.		Numerous improvement action plans which don't speak to each other and there is therefore a risk of inconsistency.
Patient Experience and Engagement Framework 2022	Framework developed in conjunction with external stakeholders and Trust staff. Development of agreed actions has been made with oversight of Trust priorities. Development of an improved patient experience scorecard.	Poor numbers of returned Patient FFT reviews since the reintroduction of the process. Lack of Divisional capacity, due to COVID-19 pandemic and reset agenda, leading to a reduction in ability to focus on patient experience. Improvement priorities and reports to Patient Experience Sub Committee.	Patient engagement processes are in a very early stage and have yet to develop maturity to make an impact. Poor results (in comparison to other Trusts) in national inpatient survey.
NHS Constitution Standards	The Equality Delivery System 2 (EDS2) annual report 2019-2020. National Annual Staff Survey and Quarterly Pulse Staff Survey results. Freedom to Speak Up arrangements and feedback. Equality, Diversity and Inclusion Annual report for 20/21 to Resources and Performance Committee.		
DATIX risk register individual TLRR risks and actions			
Clear statement of Trust values and behaviours			

ACTIONS

Action	Lead	Update	Completion Deadline
Implement CQC action plan	TY/DP		
Review the process for Datix action plan. (PR1)	RD		
Implementation sharing of Patient Experience and Engagement Framework across organisation and system partners	DP		

Plan to have greater oversight of all improvement plans in accordance with the patient experience and engagement framework 2022 to ensure consistency and appropriate trustwide actions.	CB		
Safe Staffing Review to be delivered to Exec Team & R&P in December 2021		**COMPLETE**	
Development of a Patient experiences and Engagement Framework	DP/CB	**COMPLETE**	

Strategic Priority	Provide Excellent Patient Experience and deliver expected outcomes	**Associated Trust level risks**	**Assurance Rating**				**Year**	2022/2023	**Risk Appetite**
Principal Risk	4. Failure to provide expected outcomes	4627, 5701, 5484, 2186, 2170, 3067, 3325, 4461, 5219 (other linked risks 3292, 4296)	**Q2**	**Q3**	**Q4**	**Q1**	**Quarter**	2	**CAUTIOUS** Appetite for taking moderate clinical risks if essential to patient care and outcomes. Such risks are assessed and have robust mitigation and control measures in place
Executive Lead	Director of Nursing and Quality		21/22	21/22	21/22	22/23	**Inherent Risk Score**	16	
Committee	Quality Committee						**Current Risk Score**	16	

Key Controls	Assurance	Gaps in Controls	Gaps in Assurance
Escalation policies	Process in place for managing review and update of policies in a timely way.	Compliance by authors to meet the review timescales due to other work pressures	An increasing extension to policies due to lack of timely revision.
Service accreditations	Stroke Board and SSNAP rating JAG accreditaiton		
NHS Constitution standards	Care delivered within national access standards. The Equality Delivery System 2 (EDS2) annual report 2019-2020. National Annual Staff Survey and Quarterly Pulse Staff Survey results. Freedom to Speak Up arrangements and feedback. Equality, Diversity and Inclusion Annual report for 20/21 to Resources and Performance Committee.		
Staff training	Monthly FPG meetings and the Resource and Performance Committee.	Compliance with MAST and role specific training	
Working to NICE guidelines	Reports to PSCE sub-committee		
DATIX risk register individual TLRR risks and actions			
Learning from Deaths Policy and reports	Learning from Deaths reports to the Quality Committee. Medical examiner system.		
Clinical Governance arrangements including PSCE sub-cttee and Patient Experience sub-committee	GIRFT Visits		

ACTIONS

Action	Lead	Update	Completion Deadline
Monitoring via the IPR report and performance management including FPG and RAP	PM		
Implement CQC action plan	DP/KS/TY		
Review the process for Datix action plan. (PR1)	RD		
Review effectiveness of the Patient Experience sub-committee for appropriateness and effectiveness in light of new framework.	DP		6/9 months or time to implement framework.

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW			
Agenda item	2.3		
Paper title	Fit and Proper Persons Annual Report		
Responsible Director	Chief Executive		
Author	Company Secretary		
Previously considered by	This has not been considered previously elsewhere		
The Board/Committee is asked to:			
Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

Fit and Proper Person Tests are carried out annually by the Trust on all those within the scope of the Trust Fit and Proper Person Policy which is based on the requirements of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC guidance for providers and CQC Inspectors (January 2018), describes the application of the regulations as follows: '…*apply to all CQC registered providers (other than individuals or partnerships). Within the organisation, they apply to all Board directors, Board members and equivalent, who are responsible and accountable for delivery care, including associate directors and any other individuals who are members of the Board irrespective of their voting rights*…'

The Trust has extended this definition to include deputy directors who may deputise for executive directors at board and committee meetings, and other senior decision making individuals at Band 8d and above.

In April 2022 annual round all of the testing was complete, all are satisfactory and there are no concerns to report.

Link to strategic objective(s)	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	There is no financial impact

1. Introduction and Purpose

This paper sets out the Trust's approach to assessing whether individuals, within scope, meet the requirements of the Fit and Proper Person Regulations and remain so for the duration of their employment or engagement. This is the third annual report to the Trust Board at a meeting in public.

2. Background

Regulation 5 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014, refers to the Fit and Proper Person Regulations. The details of Regulation 5 may be accessed on the CQC web page here.

The CQC guidance for providers and CQC Inspectors (January 2018), describes the application of the regulations as follows: '…*apply to all CQC registered providers (other than individuals or partnerships). Within the organisation, they apply to all Board directors, Board members and equivalent, who are responsible and accountable for delivery care, including associate directors and any other individuals who are members of the Board irrespective of their voting rights*…'

The CQC has guidance on the Fit and Proper Person regulation which can be found on their website here.

The Trust has extended this definition to include deputy directors who may deputise for executive directors at board and committee meetings, and other senior decision making individuals at Band 8d and above.

The regulations will be breached if:

- A director is unfit on a mandatory ground such as a relevant undischarged conviction or bankruptcy
- A provider does not have a proper process in place to make the robust assessments required by the regulations
- On receipt of information about a director's fitness, a decision is reached on the director that is not in the range of decisions a reasonable person would make
- A director has been responsible for, or privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying on a regulated activity.

During 2021/22, (most recent) Internal Audit carried out a review of the system for Fit and Proper Person tests in the Trust and their overall opinion is shown below:

High	The review has concluded with a High Assurance. This review found that the Trust has appropriate systems and processes to comply with the Fit and Proper Persons regulation.

	Record keeping in relation to the FPP checks for staff that fall within the scope of the FPP was found to be sound. Audit testing found that the records being retained would allow the Trust to demonstrate compliance with Regulation 5 should it be requested. Internal Audit testing showed that the Trust is complying with the regulations. There were some instances where documentation was not available. The individuals these instances occurred were long term employees and checks were carried out upon their initial recruitment within the Trust. In all of these cases a supporting signed file note by a member of the senior leadership team was in place to confirm the checks in question had been performed.

3. 2022 Assessment of the Fit and Proper Person Test at Mid Yorkshire Hospitals NHS Trust

The Trust's Fit and Proper Person's procedure is described in a Trust Policy and is available on the Trust intranet policy library for all staff and Board members to access. The Policy sets out the process for carrying out the checks for new starters and ongoing tests, and actions in the event of a matter of concern being raised. An explicit comment has been included in relation to the approach to DBS checks which is in line with the latest guidance on the CQC website here.

The Trust undertakes an enhanced DBS check, where the eligibility criteria are met, for executive directors, non-executive directors and associate non-executive directors, and the remaining senior staff who meet the eligibility criteria and are within scope, to check that they are not on the children's and / or safeguarding barred list which would prohibit them from holding office. CQC has provides a Frequently Asked Questions publication on DBS checks which can be found here.

The Trust has liaised with the NHSI public appointments team and requested and received information to ensure the Trust Fit and Proper Person records are complete and accurate. All non-executive directors gave their permission for the information to be shared.

Following a previous recommendation from Internal Audit and as good practice, the completed testing is shared with the Director of Workforce and Organisational Development for a review and understanding of the process and sample testing of three Fit and Proper Person test folders.

This paper sets out at Appendix 1, the Trust Fit and Proper Person Register.

4. Proposed Policy updates

The policy has been reviewed, there are only two changes proposed these are:-

a. Clarity on the senior management roles which will be subject to Fit and Proper Person testing

The policy currently states "This Policy applies to all new and existing permanent and interim appointments to senior decision making individual roles, Directors and Non-Executive Director positions within the Trust."

It is proposed this be amended to:-

"This Policy applies to all new and existing permanent and interim appointments to senior decision making individual roles, these being:-

- Executive and Corporate Directors
- The Chair and Non-Executive Directors (including associate Non-Executive Directors)
- Roles regularly attending and contributing to the Board (namely the Company Secretary and Associate Director of Communications)
- Those deputing for directors (including the Associate Director for the Medical Directorate)
- Divisional Operational and Clinical Directors
- The Directors of Pharmacy and Midwifery
- Other senior decision makers as agreed necessary by consensus of the Chair and Chief Executive."

b. Inclusion of the NED recruitment propose which outlines NHSE and MYHT roles in Fit and Proper Person testing when newly recruited, appendix 2.
It is proposed this is add as an appendix in the policy.

5. Conclusion and Recommendation

The conclusion of the Fit and Proper Person testing for April 2022 is that all of the tests have been carried out to a satisfactory conclusion. It is therefore recommended that the Trust Board :-

- Notes the information included in this report and take assurance.
- Agreed the proposed additions to the Fit and Proper Person policy.

Appendix 1 – FPP compliance for staff in post subject to FPP testing as of April 2022

Name/role	Start date in current post	Recruitment checks completed	DBS check where eligible	Professional registration	Annual self-declaration signed 2022	Annual appraisal	Google, social media	Disqualification as Director/ Companies House or Trustee /Charities Commission	Insolvency register
NON EXECUTIVE BOARD MEMBERS									
Keith Ramsay Chair	01.06.19	Processed by NHSI and Trust May/June 2019	Enhanced DBS – clear	n/a	Yes	Satisfactory	Clear	Clear	Clear
Simon Stone NED	01.06.15	Processed by NHSI May 2015	Enhanced DBS – clear	n/a	Yes	Satisfactory	Clear	Clear	Clear
Julie Charge NED	08.12.15	Processed by NHSI December 2015	Enhanced DBS – clear	Yes – CIMA qualification certificate	Yes	Satisfactory	Clear	Clear	Clear
Gary Ellis NED	1.10.19	Processed by NHSI and Trust Sep/Oct 2019	Enhanced DBS – clear	n/a	Yes	Satisfactory	Clear	Clear	Clear
David Throssell NED	1.04.20	Processed by NHSI and Trust Mar/Apr 2020	Enhanced DBS – clear	n/a	Yes	Satisfactory	Clear	Clear	Clear
Mahmud Nawaz NED	23.11.20	Processed by NHSI and Trust Oct/Nov 2020	Enhanced DBS – clear	n/a	Yes	Satisfactory	Clear	Clear	Clear

Name/role	Start date in current post	Recruitment checks completed	DBS check where eligible	Professional registration	Annual self-declaration signed 2022	Annual appraisal	Google, social media	Disqualification as Director/ Companies House or Trustee /Charities Commission	Insolvency register
EXECUTIVE BOARD MEMBERS									
Len Richards CEO	01.10.2021	Processed by Trust as part of recruitment	Enhanced DBS – clear	n/a	Yes	Yes	Clear	Clear	Clear
Karen Stone Medical Director	01.01.2015	Processed by Trust as part of recruitment	Enhanced DBS - clear	GMC registration and revalidation in date	Yes	Yes	Clear	Clear	Clear
David Melia Director of Nursing and Quality	01.09.2015	Processed by Trust as part of recruitment	Enhanced DBS - clear	NMC registration and revalidation in date	Yes	Yes	Clear	Clear	Clear
Jane Hazelgrave Director of Finance	01.01.2016	Processed by Trust as part of recruitment	Enhanced DBS - clear	Professional registration CIMA in date	Yes	Yes	Clear	Clear	Clear
Trudie Davies Chief Operating Officer	01.09.2017	Processed by Trust as part of recruitment	Enhanced DBS - clear	n/a	Yes	Yes	Clear	Clear	Clear
Mark Braden Director of Estates,	01.11.2018	Processed by Trust as part of recruitment	Enhanced DBS - clear	n/a	Yes	Yes	Clear	Clear	Clear

Facilities and IM&T									
Paul Curley Director, Community Services	01.04.2022	Processed by Trust as part of recruitment	Enhanced DBS - clear	GMC registration and revalidation in date	Yes	Not yet due	Clear	Clear	Clear
Phillip Marshall, Director of Workforce and OD	01.08.2018	Processed by Trust as part of recruitment	Enhanced DBS - clear	CIPD registration valid and in date	Yes	Yes	Clear	Clear	Clear
Jo Webster, Director of ACS	01.04.2022	Processed by the CCG and confirmed to the Trust	Enhanced DBS - clear	n/a	Yes	Not yet due	Clear	Clear	Clear

Name/role	Start date	Recruitment checks completed	DBS check where eligible	Professional registration	Annual self-declaration signed 2022?	Annual appraisal	Google, social media	Disqualification as Director/ Companies House or Trustee /Charities Commission	Insolvency register
SENIOR MANAGERS									
Jen Beckett Company Secretary	11.10.2021	Processed by Trust as part of recruitment	Enhanced DBS - clear	n/a	Yes	Yes	Clear	Clear	Clear
Karen Benstead, Director of Operations, ACS	01.04.2022	Processed by Trust as part of recruitment	Enhanced DBS - clear	NMC registration valid and in date	Yes	Yes	Clear	Clear	Clear
Chris Mannion Deputy Director of Workforce	11.02.2019	Processed by Trust as part of recruitment	Enhanced DBS - clear	CIPD registration valid and in date	Yes	Yes	Clear	Clear	Clear
Ian Wilson Deputy Medical Director	01.07.2013	Processed by Trust as part of recruitment	Enhanced DBS - clear	GMC registration valid and in date	Yes	Yes	Clear	Clear	Clear
Ian Carr Associate Director, MD's office	01.04.2015	Processed by Trust as part of recruitment	Enhanced DBS - clear	n/a	Yes	Yes	Clear	Clear	Clear
Roy Evans Deputy Director of EFIT	21.02.2022	Processed by Trust as part of recruitment	Enhanced DBS - clear	n/a	Yes	Yes	Clear	Clear	Clear

Dawn Parkes Deputy Director of Nursing	16.09.2013	Processed by Trust as part of recruitment	Enhanced DBS - clear	NMC Registration valid and in date	Yes	Yes	Clear	Clear	Clear
Jason Matthews Deputy Director of Finance	10.07.2016	Processed by Trust as part of recruitment	Enhanced DBS - clear	CIPFA registration valid and in date	Yes	Yes	Clear	Clear	Clear
Phil Deady Director of Pharmacy	22.09.2014	Processed by Trust as part of recruitment	Enhanced DBS - clear	GPHC registration valid and in date	Yes	Yes	Clear	Clear	Clear
Alison Grundy Director of Operations - FCSS	01.08.2015	Processed by Trust as part of recruitment	Enhanced DBS - clear	n/a	Yes	Yes	Clear	Clear	Clear
Jo Halliwell Deputy COO and Director of Operations - DOM	29.06.2020	Processed by Trust as part of recruitment	Enhanced DBS - clear	NMC Registration valid and in date	Yes	Yes	Clear	Clear	Clear
Keely Robson Director of Operations - Surgery	29.06.2020	Processed by Trust as part of recruitment	Enhanced DBS - clear	N/A	Yes	Yes	clear	clear	clear
Mahesh Nagar – Associate Medical Director	01.10.2019	Processed by Trust as part of recruitment	To be confirmed	GMC registration valid and in date	Yes	Yes	clear	clear	Clear

Appendix 2 – NED recruitment process

Recruitment Roadmap

Non-Executive Director (NED) recruitment

NHS
The Mid Yorkshire Hospitals
NHS Trust

1 Pre-interview

Approval, Advertising & Shortlisting

- 1A Vacancy confirmed between Mid Yorkshire Hospitals and NHSE in accordance with Standing Orders.
- * ***Associate NEDs:*** *Where additional expertise is identified as needed within the Board, an Associate NED may be headhunted by the Chair. In these instances, the process to be followed commences at 2A*
- 1B NHSE advertise the vacancy on the Trust's behalf. Relevant Trust information to be included in the advert (Trust structure, skills requirements, need to fulfill FPP standards)
- 1C NHSE send applications to MYHT (or if a consultancy is used the firm will longlist)
- 1D Selection panel review applications and confirm shortlist for interview (Panel includes NHSE representative for appointments to Chair)

2 interview

Interviewing Process

- 2A Interviews and assessments conducted by:
  - Chair of Mid Yorkshire Hospitals NHST
  - An external representative (for both NED and Associate NED appointments)
  - NHSE representative for appointments to Trust Chair

  If stakeholder panel agreed members to include minimum of CEO, DoWF + 1 other, (if Chair recruitment wider stakeholder panel required)
- 2B ID , right to work and qualifications checks undertaken when attend for interview
- 2C Panel confirm agree on proposed preferred candidate

3 approval

NHE/I Approval Process

- 3A NHSE complete checks on proposed preferred candidate including checks on:
  - Qualifications
  - ID / Right to Work
  - References
  - Directors disqualification
  - Insolvency
- 3B Proposed candidate is proposed to NHSE committee for ratification
- 3C NHSE confirm appointment to the successful candidate and Mid Yorkshire Hospitals. NHSE inform MYHT Chair and agree who will contact candidate
- 3D NHSE issue standard terms and conditions of office to successful candidate

4 engage

FPP Tests and Onboarding

- 4A NHSE – will provide the background checks and references with MYHT (with candidate's permission)
- 4B MYHT undertake the following checks:
  - Health clearance
  - Criminal records check
  - Checks against the insolvency register, disqualified directors register, and charitable Trustees register (if not shared by NHSE/I)
  - Social media check
  - Board Level Declaration
- 4C **Other onboarding processes**
  - ID Badge submission
  - Access card submission
  - 'Hire' process on ESR
  - Trust NED induction policy reviewed with candidate and meetings set up

Time to celebrate!

Our Values: CARING, IMPROVING, RESPECT, HIGH STANDARDS

Action required by NHSE

Action required by the Trust

V1 last updated: 7th June 2019

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW			
Agenda item	2.4		
Paper title	The Risk Management Framework		
Responsible Director	Director of Nursing and Quality		
Author	Company Secretary Head of Risk and Safety		
Previously considered by	Risk Committee		
The Board/Committee is asked to:			
Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

The Risk Management Framework is a document which is reserved for Board approval.

This version (3.1) has been updated by the Company Secretary and the Head of Risk and Safety and shared with Risk committee, who have recommended approval by Trust Board.

This version includes:-
- Detail on risk appetite following development of the risk appetite matrix
- Clarity on definition on what should be included on the TLRR
- A change from "initial" risk score to "inherent" risk score
- Updates to job titles, formatting and ordering

The Trust Board are asked to:-
- Approve v3.1 of the Risk Management Framework
- Agree the frequency for review/ review date by Trust Board.

(n.b the paper is presented with track changes to highlight were updates have been made, which will be removed on publication).

Link to strategic objective(s)	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	£nil

The Mid Yorkshire Hospitals NHS Trust

Risk Management Framework

Document Reference No.	Corp064
Version No.	3.0
Issue Date	~~9 July 2021~~TBC
Review Date	~~Review date is 2 years 9 months after issue date~~TBA
Document Author	Company Secretary, Assistant Director of Nursing – Patient Safety and Risk
Document Owner	Assistant Director of Nursing – Patient Safety and Risk
Accountable Executive	Chief Executive and ~~Director~~ Chief ~~of~~ Nursing Officer ~~and Quality~~
Approved by	Trust Board
Approval Date	~~8 July 2021~~
Document Type	Policy/Framework
Scope	Board members (executive and non-executive), Employees, Third parties acting on behalf of the Trust under contract; Students and trainees; Agency staff engaged by the Trust; Secondees.
Restrictions	None

VERSION CONTROL/REVIEW AND AMENDMENT LOG

Version No	Date	Description of change
0.1	May 2017	Initial Issue. This initial issue brings together the Corp06 Risk Management Strategy and the Corp076 Risk Management Policy into a single document. The review and amendment logs for those documents are included can be found in the archived documents.
0.2	June 2017	Amendments and comments included from the nursing risk management team
0.3 – 0.5	July 2017	Comments included from members of GRIP and ED
1.0	July 2017	Intranet version
2.1	July 2021	Minor formatting changes and updates to reflect current arrangements for Risk Management
3.0	July 2022	Changes made:- - Inclusion of more detail on risk appetite - Clarity on definition on what is included on the TLRR - Change from initial risk to state inherent risk - Updates to job titles, formatting and ordering

ENGAGEMENT AND CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role/Description
Company Secretary ~~(V2.1)~~
Assistant Director of Nursing – Patient Safety and Risk ~~(V2.1)~~
~~Patient Safety System Development Manager~~Head of Risk and Safety

Circulated to the following for consultation

Date and version	Role/Designation
July 2020 V 1.1	Risk committee ~~Members of GRIP~~
	Executive Directors
	~~Deputy~~ Director of Nursing

Evidence Base
List any national guidelines, legislation or standards relating to this subject area Health and Safety at Work Act 1974 Management of Health and Safety at Work Regulations 1999 NHS Resolution CQC NHS Constitution

EQUALITY IMPACT ASSESSMENT SUMMARY

Directorate: Corporate	**Area:** Company Secretary
Policy/Project Summary: .	
What are you seeking to achieve with this work? *What has prompted this change? What are the intended outcomes of this work?*	To update the Risk Management Framework ~~which is due July 2020~~inline with changes to terminology and use of risk appetite (July 2022)
Who will be affected by it and why? *(e.g. Public, patients, service users, staff, etc.)*	Board members (executive and non-executive), Employees, Third parties acting on behalf of the Trust under contract; Students and trainees; Agency staff engaged by the Trust; Secondees.~~Staff, contractors, Board members~~
Information	
What information is available about the current situation to assist decision making? *(e.g. data, intelligence, research or national guidelines; staff and patient experience)* No significant change to the processes	

Impact Analysis

Based on the information available, an assessment of the current situation and the changes being proposed is there the possibility of a differential impact (positive or negative) on the groups listed below?
(Enter Y/N against each characteristic and a rationale with evidence)

	Y/N		Y/N
Disability	N*	**Gender Reassignment & Transgender**	N
Gender/Sex	N	**Religion or Belief**	N
Race	N	**Pregnancy and Maternity**	N
Age	N	**Marriage & Civil Partnerships:**	N
Sexual Orientation	N	**Carers**	N

Rationale for Answers Above:
(Explain for each characteristic, why it is considered that there may or may not be an impact)

Disability – if a member of staff who was required to manage risk as part of their role had a disability that meant that access to DATIX was affected, eg sight, arrangements would be put in place

Summary of Actions Planned as a Result of the Assessment
(Indicate timescales and lead officers for each action)

This would be picked up in the training for DATIX and appropriate adjustments . No member of staff is allowed to DATIX without having received the training.

Assessed By

~~Celia Weldon~~Jennifer Beckett, Company Secretary
Rachel Diamond, Assistant Director of Nursing – Patient Safety and Quality

1. POLICY STATEMENT

The Trust is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Trust's governance framework and system of internal control. Risk management involves much more than noting risks in a register – it is about identifying and managing risks, particularly those that present the biggest challenge to the Trust in meeting its objectives.

The Risk Management Framework (the Policy) sets out guidelines and will assist staff in identifying and analysing risks in their respective areas. The Policy outlines the purpose of the risk assessment process, the risk grading tool/matrix and the risk register. The Policy also refers to the Trust Board Assurance Framework and the Trust Level Risk Register.

The Policy is regularly reviewed and updated to ensure it continues to be consistent with the Trust Strategy and reflects national guidance and legislation.

The aim of the Policy is to provide assurance that the Trust is:

- Providing high quality care in a safe environment
- Complying with legal and regulatory requirements
- Meeting key strategic objectives and values.

The benefits of an effective approach to risk management are as follows:

- Reduction in risk exposure through more effective targeting of resources to address key risk areas
- Improvements in economy, efficiency and effectiveness resulting in a reduction in the frequency, and/or severity of incidents, complaints, claims, staff absences and other losses
- Demonstrating compliance with applicable laws and regulations
- Enhancing the reputation of the Trust and increased public confidence in the quality of the services
- Continued development of a 'lessons learned' culture and improvements in systems and controls.

2. OBJECTIVES

The key objectives of this Policy are to:

- Support the achievement of the Trust's objectives, including divisional objectives, by continually developing a dynamic approach to strategic risk management and the effective use of the Board Assurance Framework (BAF)
- Continue to embed risk management systems and processes within the organisation and promote the culture that risk management is everybody's business
- Clearly define roles and responsibilities for risk management
- Create an environment that is as safe as is reasonably practicable by ensuring that risks are continuously identified, assessed and managed and, where possible, eliminate, transfer or reduce risks to an acceptable level

- Share lessons learned and embed best practice
- Ensure a culture of transparency and willingness to report risks, incidents and near misses
- Establish clear and effective communication that enables a comprehensive understanding of risks at all levels of the organisation by developing the use of Divisional and Specialty Risk Registers and the Trust Level Risk Register (TLRR)
- Provide appropriate training to staff to ensure effective implementation of this Policy
- Maintain continued compliance with national standards and legislation.

The Policy also ensures that the structures and responsibilities for managing risks and for escalating to a higher level where necessary, are set out. Risk Registers are available at Trust Level, Directorate, Divisional, Specialty and Programme with a 'bottom up' element for identifying and recording risk and a 'top down' element for stratifying risks, to facilitate escalation and delegation.

3. DEFINITIONS

Risk is the threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. It is measured in terms of likelihood and consequence.

Risk Management is the identification, assessment, and prioritisation of risks followed by coordinated and economical application of resources to minimise, monitor, and control the probability and/or impact of unfortunate events or to maximise the realisation of opportunities.

The **Risk Management process** covers all processes involved in identifying, analysing, assigning ownership, taking action to reduce/mitigate the risks, and monitoring and reviewing progress.

Risk Assessment is a systematic process of assessing the likelihood of something happening and the consequence of the risk actually happening.

Board Assurance Framework (BAF) is a structured document which enables the Board to gain assurance that risks to achievement of the Trust's strategic objectives are being appropriately managed. The BAF is cross referenced to the TLRR and is a mechanism for identifying and understanding the following:

- The high level strategic (Principal) risks to achieving the Trust's objectives
- The key controls that are in place to manage those risks as far as reasonably practicable
- The assurances that the controls are working effectively
- ~~The ongoing management of the risks identified~~
- Whether there are any gaps in control or assurances in relation to those risks and the actions to address these.
- The risk appetite as the level of risk the Board have agreed they are willing to take in pursuit of the objective~~.~~

Strategic/Principal risks are those risks which represent a threat to the achievement of the Trust's strategic objectives, or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Trust Board and incorporated in the BAF, and should be managed at executive level.

Trust Level Risk Register (TLRR) contains those risks that are the most important for the Trust Board and senior leadership to be aware of and monitor progress closely. These are not always the highest rated risks as described on page 9 of this Policy

Operational Risks are by-products of the day to day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks, regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks can be managed by the department which is responsible for delivering services.

Risk Registers are live documents comprising of a list of risks, to include a description summary, in order of priority. The risk register is generated electronically from the Trust's electronic risk management system (DATIX) and reflect risks that have been placed on the system and approved by Clinical Divisions and Corporate Departments.

Governance is the systems and processes by which the Trust leads and controls functions in order to achieve its organisational objectives, safety, and quality of services, and in which it relates to the wider community and partner organisations.

Annual Governance Statement is an annual statement bringing together a position statement and evidence on governance, risk management and internal controls within the Trust.

Assurance is the confidence the Trust has, based on sufficient evidence, that controls are in place, operating effectively and its objectives are being achieved.

Risk Appetite is the level of risk the organization is willing to take in order to achieve it's objectives.

Risk Tolerance is the acceptable level of variation that is tolerable around a particular set of risk-based objectives or metrics.

The BAF and Risk Registers ~~and the BAF~~

	BAF	TLRR	Divisional and Directorate
Risk Type	Risks to the Trust's strategic objectives	High level risks in the context of operational and corporate objectives	Broad range of operational and corporate risks
Risk Owner	Key focus for the Trust Board and risks managed by Executive Directors	Key focus for the Board and Executive Directors. Risks managed by senior managers	Key focus for Divisional management teams and Risk Committee. Risks managed by divisional teams
How risks are identified	Risks identified by the Trust Board as having the potential to impact on delivery of the strategic objectives ~~and Executive Directors or escalated from the TLRR~~	Risks identified through escalation from Divisional and Directorate risk registers via the Risk Committee	Risks identified through risk assessment and may be linked to incidents, audits, external assessments or qualitative information
Coverage	Includes assurance levels assessed by Tier 1 Committee or Board, related TLRR risks, objectives, risk appetite, risk score, controls, assurances, gaps in controls and assurances and action plan	Includes details of the risk, ~~initial~~inherent, current and target score, controls and mitigating action plans. Risks deemed to impact on the achievement of strategic objectives need to be escalated to the BAF	Includes details of the risk, ~~initial~~inherent, current and target score, controls and mitigating action plans. Risks should be escalated to the TLRR following the guidelines in the table below

TRUST LEVEL RISK REGISTER	DIRECTORATE AND DIVISIONAL RISK REGISTER
Typically comprises of between 15 –to 20 risks, some of which may be confidential	Typically a much higher number of risks
~~All r~~Risks rated 15+ which could impact on the delivery of the operational plan and longer-term on the Trust achieving it's strategic objectives~~,~~ ~~**except for those which are specifically division based and not relevant on a Trust wide basis**~~	For reporting to Risk Committee, this equates to all divisional/directorate risks rated 12+, for the following: • Families and Clinical Support Services • Division of Medicine • Division of Acute Care • Division of Surgery • Adult Community Services • Estates, Facilities and IMT • Finance • Medical Directorate • Nursing Directorate • Workforce and OD
Some risks rated 12 – 15 which are either: • To be aware of as the risk may increase/develop • Of ~~signific~~significance~~ant~~ **Trust wide** and appropriate for Board level awareness	

4. SCOPE

The Policy applies to:

- Trust Board members
- Employees
- Third parties acting on behalf of the Trust
- Students and trainees
- Agency Staff engaged by the Trust
- Secondees.

Systems and processes for the management of risk

~~The~~ This framework sets out the Trust's ~~has two~~ main system~~s~~ to facilitate the management of risk. ~~,~~ ~~i~~In addition to the processes described in this Policy, staff should refer to the Incident reporting Policy and Procedure for systems relating to the management of incidents.

What the Trust must achieve

The Department of Health requires the Chief Executive to sign an Annual Governance Statement which draws together a position statement and evidence on governance arrangements in the organisation, including, how risk management and internal controls support the provision of a coherent and consistent reporting mechanism. The Annual Governance Statement requirements are published annually by NHSE and the document is subject to external audit review and sign off.

The Annual Governance Statement covers the following areas:

- Scope of responsibility of the Accountable Officer (Chief Executive)
- The purpose of the system of internal control
- Capacity to handle risk and the risk and control framework
- Major risks
- Internal Audit
- Well Led Assessments
- Quality Governance arrangements
- Clinical Audit
- Data Quality
- Workforce and Pension
- Care Quality Commission
- Register of Interests
- Trust Board
- Sustainable Development
- Review of economy, efficiency and effectiveness of the use of resources
- Information governance
- Annual Quality Account
- Compliance with the NHS Provider Licence
- Business Continuity Planning
- Review of effectiveness
- Significant Control Issues.

5. ROLES AND REPONSIBILITIES

The Board of Directors is responsible for approving the Risk Management Framework and for ensuring effective systems for managing risk.

Chief Executive is responsible for maintaining an overall system of control including risk management.

~~**Director of Nursing and Quality**~~ **Chief Nursing Officer** is the Executive Director with responsibility for the process of risk management.

Assistant Director of Nursing – Patient Safety and Risk has responsibility for ensuring, on behalf of the Director of Nursing and Quality that there are effective systems in place for the management of clinical and non-clinical risk and for the implementation and maintenance of the electronic risk management system

Company Secretary is responsible for ensuring that the mechanisms are in place to make the Trust Board aware of the most significant operational risks via the TLRR, and the Strategic/ Principal ~~-~~Risks via the BAF.

Senior Information Risk Owner (SIRO) The ~~Director of Finance is the~~ SIRO and is the nominated lead to ensure that the Trust's information risk is properly identified and managed and that appropriate assurance mechanisms exist.

Executive and ~~Directors~~Corporate Directors have delegated responsibility for managing risks in accordance with their portfolios and as reflected in their job description. For example, the ~~Director of~~Chief Finance Officer has executive responsibility for financial governance and other linked financial risks. Directors will take a lead on Principal Risks aligned to their portfolios. ~~Executive~~ Directors are responsible for ensuring that:

- Suitably competent staff are identified to lead on risk management in the directorate and that their role and responsibilities are clearly understood
- Staff are familiar with the Policy and aware of their responsibilities for risk
- Staff attend appropriate training for risk
- Risks (strategic and operational) are effectively managed i.e. identified, assessed and that action plans to reduce risks are developed, documented on the electronic risk management system (Datix), and regularly reviewed
- Service developments, business cases and capital plans are formally risk assessed
- That the processes for approval and validation of risk are adhered to and can be demonstrated.

Divisional Clinical Directors, Directors of Operations and ~~Heads~~ Associate Directors of Nursing or equivalent are responsible for ensuring effective risk systems for risk management, compatible with this Policy, are in place within their divisions/directorate, and ensuring their staff are aware of the Risk Management Framework.

~~**Patient Service Managers**~~ **Deputy Directors of Operation/ Heads of Clinical**

Service / Matrons / Department Managers are responsible for ensuring effective risk systems for risk management, compatible with this policy, are in place within their specialty areas, to ensure that:

- Suitably competent staff are identified to lead on risk management in the ward/ department and that their role and responsibilities are clearly understood
- Staff are familiar with the Policy and aware of their responsibilities for risk Staff attend appropriate training for risk
- Risks (strategic and operational) are effectively managed i.e. identified, assessed and that action plans to reduce risks are developed, documented on Datix, and regularly reviewed
- Service developments, business cases and capital plans are formally risk assessed.

Ward Sisters/Charge Nurses, Departmental Managers are responsible for ensuring effective systems for managing risk are in place at ward/department level.

Divisional Heads of Governance and Divisional Governance Managers are responsible for ~~co-ordinating~~coordinating risk management processes in their divisions and maintaining the Divisional Risk Registers.

All Managers within the Trust are accountable for the day to day management of risks of all types within their area of responsibility. They are charged with ensuring that risk assessments are undertaken throughout their area of responsibility on a pro-active basis, that preventative action is carried out where necessary and relevant risk registers are up to date. They are also responsible for seeking seeking appropriate expertise from corporate and specialist teams about the implementation of risk reduction plans. ~~advice about implementation of risk reduction plans from the Risk Manager as appropriate~~

Staff (including contractors/agency staff) must ensure they are familiar and comply with the Policy and relevant professional guidelines and standards.

6. POLICY DETAIL

The organisational management of risk forms part of the Trust's overall approach to governance. The key forums for the management of risk in the Trust are set out below:

Trust Board of Directors – the Trust Board of Directors is responsible and accountable for ensuring the Trust has effective systems and processes for managing risk. It approves the Risk Management Framework and the Annual Governance Statement as part of the Annual report. The Trust Board is responsible for setting ~~the~~and ~~-~~agreeing the Principal Risks in the BAF and the risk appetite they are prepared to accept. The Trust Board will gain assurance from the Tier 1 Committees that the controls and assurances described ~~on the controls~~ are meeting the requirements set by the Board.

Audit and Governance Committee – a non-executive committee established by and accountable to the Trust Board of Directors, the Committee has delegated

authority from the Board to ensure that the overall system of risk management within the Trust is fit for purpose. It receives and reviews external and internal audit reports and the Annual Governance Statement. The Committee receives an annual report on the system of Risk Management within the Trust

Quality Committee – a Committee established by and accountable to the Trust Board of Directors. It is responsible for healthcare related governance and receives reports from the Trust's Divisional Governance Groups according to an annual work plan. The Committee also provides the Trust Board with an assurance assessment against each of the principal risks allocated to the Committee.

Resource and Performance Committee - a Committee established by and accountable to the Trust Board of Directors, to give detailed consideration to the Trust's financial, performance and workforce issues in order to provide the Board with assurance and information on key issues and clear decision points. The Committee also provides the Trust Board with an assurance assessment against each of the relevant principal risks allocated to the Committee.

Risk Management Committee – an executive Committee responsible for the scrutiny on a Division by Division and Directorate by Directorate basis of risks and management of those risks by:

- Providing a focus on the action plans and progress in implementing the actions to mitigate the risks
- Leading ~~to better~~continuous improvement of risk management processes and procedures across the Trust
- Agreeing which risks should to be escalated to the TLRR in line with this framework.

Divisional Clinical Governance Groups – Divisions have their own clinical governance groups which are accountable to Divisional Management teams. The Groups are responsible for ensuring that effective risk management systems and processes (including the maintenance of a divisional Risk Register) are in place and for reviewing risks within the division.

In addition to the above, other groups across the Trust (eg Patient Safety and Clinical Effectiveness sub-committee and the Infection Prevention and Control Group etc) have the responsibility to ensure that risks are identified and escalated as appropriate.

The Trust's process for risk management is detailed in:

Appendix 1: Guidelines to Identify, Assess, Action and Monitor Risks

Appendix 2 Guidelines for the Use of the Risk Register

Appendix 3: Guidelines for completing an electronic Risk Assessment Form on the Datix Risk Management System.

Appendix 4: Glossary of terms.

7. TRAINING

Risk Management Training is ~~mandatory~~ available for all members of staff who will be involved in the identification, recording and management if risk and the use of the electronic risk management system. Training is provided by the Risk Team and overseen by the Assistant Director of Nursing, Patient Safety and Risk

8. IMPLEMENTATION AND DISSEMINATION

Following approval by the Trust Board, the Policy will be disseminated to staff via the Trust intranet. This will be communicated to all staff via the Weekly Bulletin.

Risk training must raise and ensure sustained awareness throughout the Trust of the importance of identifying and managing risk, and that staff have the knowledge, skills, support and access to expert advice where necessary to implement the Policy.

Divisional ~~Governance Managers~~Senior Management Team will be responsible for ensuring that the Policy is disseminated and implemented in the Divisions via Divisional Governance Meetings.

9. MONITORING, COMPLIANCE, AUDIT AND REVIEW

Compliance with the Policy will be assessed in the following ways:

- For Specialties, sub-Specialties and Departments, risks will be reviewed at governance meetings and escalated as appropriate to the Divisional Governance meeting
- For Divisions, Divisional Risk Registers will be generated monthly for discussion at Divisional Governance meeting with escalation to DMT and Quality Committee
- The Risk Committee is responsible for reviewing all divisional and directorate risk registers of risks greater than 12 on a cyclical basis and in line with the workplan
- The Trust Board receives and discusses the full BAF and TLRR on a quarterly basis, and a summary of the TLRR on all months it meets.
- The Trust Board considers one or two principal risks in detail ~~at each meeting and receives and discusses the full BAF and TLRR on a quarterly basis~~between the quarterly reviews on a cyclical basis
- Annual review of training records to ensure appropriate staff at Divisional and Corporate level have undertaken risk training is undertaken by the Risk management team
- Risk is included in the Internal Audit Plan
- The Audit and Governance Committee consider the overall arrangements for Risk Management in the Trust on an annual basis.

10. ASSOCIATED DOCUMENTATION

Health and Safety Policy
Incident Management Policy
Claims ~~Management~~ Handling Policy and Process

Complaints Policy
~~Procedure for Whistleblowing~~Freedom to Speak Up Raising Concerns Policy
Disciplinary Policy and Procedure
Duty of Candour and Being Open Policy
~~RIDDOR Policy~~
Mid Yorkshire Hospitals Striving for Excellence Strategy

APPENDIX 1 : GUIDELINES TO IDENTIFY, ASSESS, ACTION/MITIGATION PLAN AND MONITOR RISKS

Risk Management covers all the processes involved in identifying, assessing risks, assigning responsibility, taking actions to reduce the risks, monitoring and reviewing the progress.

In order for the Trust to manage and control its risks, it needs to identify and assess them. This guide is a step by step approach to help staff undertake risk management through a systems process and ensure standardised consistency of approach across the organisation.

1. RISK IDENTIFICATION AND DOCUMENTING ON DATIX

Step 1 - Identify the risk
All potential risks must be identified in accordance with this Policy and the Datix training and process. This will ensure a consistent and methodical approach enabling the nature and the extent of the risk to be established and understood.

Risks can be identified in many ways and from many situations that may arise, for example:

- Incidents
- complaints
- Pro-active Risk Assessments
- Annual planning cycle
- Performance Management
- Audits – these could include internal and external audit, regulatory audits or internal management audits
- Staff/patient surveys
- Information from partner organisations
- National Recommendations/confidential enquiries
- Health and safety inspections
- CQC inspections.

The list is not exhaustive. In general, the more methods that are used the more likely that all relevant risks will be identified. There are two distinct phases to risk identification:

Initial risk identification – relevant to new services, new techniques, new projects etc.
Continuing Risk Identification – an assessment is required to address the risks of existing services and any changes made to these services.

Step 2 - Describe the Risk
It can prove difficult to properly describe a risk e.g. describing the impact and not the risk itself. See below a simple example guide to help define the risk accurately:

Objective: To travel from Dewsbury Hospital to Pinderfields (PGI) for a meeting at a certain time		
Risk Description		**Comment**
Failure to get from DDH to PGH for a meeting at a certain time	**X**	This is simply the converse of the objective
Being late and missing the meeting	**X**	This is a statement of the IMPACT of the risk and not the risk itself
Eating on the shuttle bus is not allowed therefore I was hungry	**X**	This does not impact on the achievement of the objective
Missing the shuttle bus causes me to be late and miss the meeting	√	This is a risk that can be controlled by ensuring I allow enough time to get to the shuttle bus stop
Severe weather prevents the shuttle bus from running and me getting to the meeting	√	This is a risk that I cannot control but against which I can make a contingency plan for.

To write a good risk statement consider:-

- What the risk is
- What the impact will be and
- What will cause it

Writing the risk Statement in the following format can assist with this

"There is a risk that <*consequence*> which will <*impact on*> due to < *cause*>
Or
Due to < *cause*> *there is a risk that* <*consequence*> which will <*impact on*>

Step 3 - Assess the risk

Having identified and described the risk, the next step is to assess the risk. This allows for the risk to be assigned a standard rating which determines what actions (if any) need to be taken. It also allows risks to be ranked in terms of their importance.

Ideally, risk assessment should be an objective process and wherever possible should draw on independent evidence and valid quantitative data. However, such evidence and data may not be available and assessor(s) will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

The risk assessment should be undertaken by someone competent in the risk assessment process and should involve staff who are familiar with the risk that is being assessed.

Risks are assigned a score based on a combination of the **likelihood** and the **consequences** of a risk occurring

The Trust uses three risk scores:

~~**Initial** **Inherent** **rating –** this is the score when the risk would receive if no mitigations or controls were in place is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and . The score may change over time if the underlying issue raised in the risk description worsens. It is used as a benchmark against which the effect of risk management actions will be measured.~~

Current rating – this is the score at the time the risk was last reviewed in line with review dates and is the rating based on the controls being in place. It is expected that the current risk score will reduce and move toward the target risk score as action plans to mitigate the risks are developed and implemented.

Target risk rating – this is the target score when the action plan has been fully implemented.

Step 3a - Consider the likelihood

The likelihood of the risk occurring should be assessed using:

1= Rare
2 = Unlikely
3 = Possible
4 = Likely
5 = Certain

Likelihood can be scored by considering frequency ie how many times the consequence(s) being assessed will actually be realized or probability ie what is the change the consequence(s) being assessed will occur in a given period,

Likelihood table:

Descriptor	Score	Frequency	Probability
Rare	1	This will probably never happen/recur	>1 in 100,000
Unlikely	2	Do not expect it to happen/recur but it is possible	>1 in 10,000
Possible	3	Might happen/recur occasionally	>1 in 1,000
Likely	4	Will probably happen/recur but it is not a persistent issue	>1 in 100
Certain	5	Will undoubtedly happen/recur, possibly frequently	>1 in 10

Step 3b - Score the consequences

Use the table on pages 19 - 20 – *Measure the Consequence,* to score the consequence, with existing controls in place:

Choose the most appropriate domain(s) from the left hand column (see table below) of the table, then work along the columns in the same row using the descriptors as a guide asses the severity of the consequence on the scale:

1 = Insignificant

2 = Minor

3 = Moderate

4 = Major

5 = Catastrophic.

What would you expect the consequences of the risk to be in most circumstances (not necessarily the worst-case scenario, but what is reasonably foreseeable).

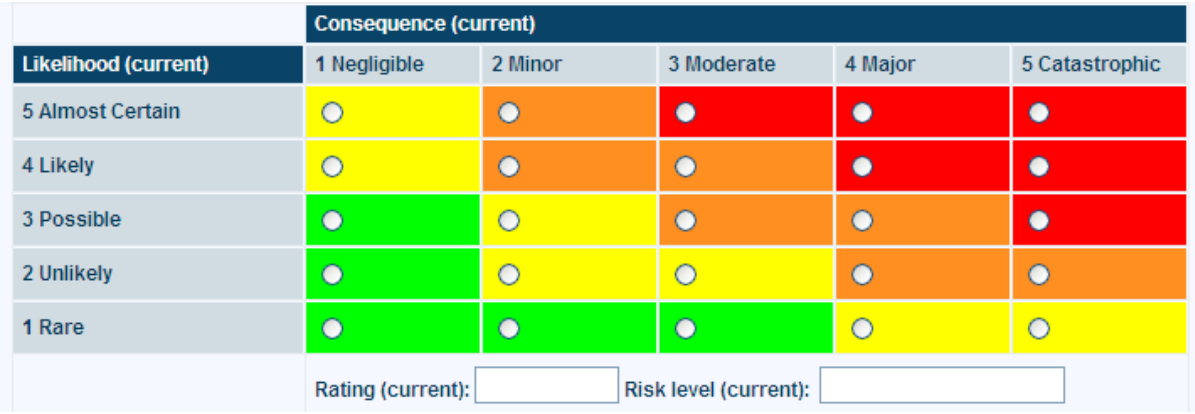
Some risks/incidents could have consequences in more than one column. Use the score of the ***highest*** column.

Take into account controls in place to reduce the consequences of the risk it if does occur e.g. contingency plans.

Domains	Insignificant	Minor	Moderate	Major	Catastrophic
Injury or harm **Physical or psychological** **Health and Safety**	Injury or illness not requiring intervention No time off work required	Minor injury or ill health – first aid or self-treatment–no incapacity Requiring time off work for <4 days Increase in LOS by 1-3 days	Moderate/significant injury or ill health Medical intervention necessary Requiring time off work 4 – 14 days Increase in LOS by 4 – 14 days RIDDOR/agency reportable	Major injuries or long term incapacity or disability Requiring time off work >14 days Increase in LOS by >14 days Prohibition notice issues	Death or major and permanent incapacity or disability Fatality and/or permanent incapacity/ disability or prosecution
Quality of the Patient experience/ outcome	Single resolvable problem in patient experience.	Patient experience directly related to clinical care, temporarily unsatisfactory–rapidly resolved.	Patient outcome or experience below reasonable expectation in one or more areas. Short term effects <7 days	Patient outcome or experience significantly below expectation across the board Long term effects >7 days	Totally unsatisfactory patient outcome or experience
Statutory	Coroners verdict of natural causes, accidental death, open	Coroners verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50,000 Issue of a statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in fine >£500,000	Coroners verdict of unlawful killing Criminal prosecution (incl corporate manslaughter) > imprisonment of Director/Executive
Environment	No or minimal impact breach of guidance /procedures	Breach of legal requirement.	Single breach of legal requirement. Improvement notice issued.	Multiple breach of legal requirement. Prohibition notice issued.	Multiple breach of legal requirement. Prosecution
Business/ Finance and service continuity	Minor loss of non-critical service Financial loss <£10,000	Service loss in a number of non-critical areas <2 hours or 1 area <6 hours Financial loss £10 – 50k	Loss of services in any critical area Financial loss £50 – 500k	Extended loss of essential service in more than 1 critical area Financial loss £500k - £1m	Loss of multiple essential services in critical areas Financial loss >£1m

Potential for complaint or litigation/claims	Unlikely cause of complaint. Litigation remote. Minimal reputation loss/limited awareness within organisation	Possible complaint. Litigation unlikely. Loss of reputation (widespread internal awareness) Claims < £10k	Possible complaint. Possible litigation. Loss of reputation. National paper reporting. Loss of services in a critical area Claims £10 – 100k	Litigation expected. Loss of reputation. National reporting Claims £100k - £1m	Litigation certain. National adverse publicity. Multiple claims or high value single claim >£1m
Information Governance	Damage to an individuals reputation. Possible media interest e.g. celebrity involved. Potentially serious breach. Less than 5 people affected ~~or risk~~	Damage to a team's reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high	Damage to a Service reputation/ low key local media coverage. Serious breach of confidentiality	Damage to the organisation's reputation/local media coverage. Serious breach with either particular sensitivity or risk to public confidence in the organisation	Damage to NHS reputation/national media coverage. Serious breach with potential for ID theft or over 100 people affected. Total loss of public confidence.
Reputation or adverse publicity	Within the Trust Local media 1 day, eg inside pages, limited report	Local media <7 days coverage, eg front page headline Regulator concern	National media <3 days coverage Regulator action	National media >3 day coverage Local MP concern Questions in the Houses of Parliament	Full public Inquiry Public investigation by regulator
Compliance inspection/audit	Non significant/ temporary lapses in compliance	Minor non-compliance with standards and targets Minor recommendations in report	Significant non-compliance with standards and targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation/ registration Prosecution Severely critical report

Risk Score



	Consequence (current)				
Likelihood (current)	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain					
4 Likely					
3 Possible					
2 Unlikely					
1 Rare					

Rating (current): Risk level (current):

Step 3c – Rating the risk (from combining the likelihood and consequence scores)
The risk score makes it easier to understand the Divisional, Directorate and/or Trust-level risk profile. It provides a systematic framework to:

- identify the level at which risks will be managed and overseen in the organisation
- prioritise remedial action and availability of resources to address risks
- direct which risks should be included on the TLRR (in part).

Scores	Risk grade	Responsibilities and accountability
1-3	**Low**	Risk assessment form completed and registered on Datix at discretion of divisions/directorates Divisional Governance Groups (or equivalent) to monitor action plan and review
4-6	**Moderate**	Risk assessment form completed and risk registered on DATIX Divisional Governance Groups (or equivalent) to monitor action plan and review
8-12	**High**	Risk assessment form completed and risk registered on DATIX New 'High' risks reported to the Risk Committee Divisional Governance Groups (or equivalent) to monitor action plan and review
15-25	**Extreme**	Risk assessment form completed and risk registered on DATIX New extreme risks to be reported to the Risk Committee and consideration given whether the risk should be escalated to the TLRR Divisional Governance Groups (or equivalent) to monitor action plan and review

Step 4 Documenting the risk
It is important that identified risks are appropriately completed in a standard format using the Risk Assessment Form on the Datix Risk Management System.

2. ADDRESSING AND MANAGING RISK

Addressing risks
Having identified, assessed, scored and rated the risk, the next stage is to decide and document an appropriate response to the risk. The response should describe how the Target Risk Score will be achieved.

In general there are four potential responses to address a risk once it has been identified and assessed:

Tolerate - the risk may be considered tolerable without the need for further mitigating action. For example if the risk is LOW or if the Trust's ability to mitigate the risk further is constrained, or if taking action is significantly costly. If the decision is to tolerate the risk, consideration should be given to developing and agreeing contingency arrangements to manage the consequences if the risk is realised.

Treat - managing the risk allows the organisation to continue with the activity giving rise to the risk, whilst taking mitigating action to reduce the risk to an acceptable level, i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but may not eliminate it. Action plans must be documented on the Datix risk assessment form, have a nominated person responsible for owning the risk, and progress monitored by the appropriate forum
.
Transfer - risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk. This is particularly suited to mitigating financial risks or risks to assets. It is important to note that reputational risk cannot be fully transferred.

Terminate – the only response to some risks is to terminate the activity giving rise to the risk or by doing things differently. However, this option is limited in the NHS (compared with the private sector) where many activities with significant associated risks are deemed necessary for public benefit.

3. APPROVAL AND VALIDATION

Once documented, all risks should be approved. Specialty and Divisional Teams have processes in place for the approval of new risks in their area. Further guidance and support is available from divisional governance leads.

4. REVIEWING A RISK REGISTER ON DATIX

Risks recorded on Datix must specify when the risk score, action plan and mitigated risk score will be reviewed. It is expected that as action plans are progressed the current risk score will move towards the mitigated risk score and may be closed (if the risk has been eliminated) or tolerated (if the risk remains but all planned mitigating action has been taken). This may be done in one review period but it may take longer, in which case a new review date must be set.

Excessive review dates will not be set beyond a 6 month period.

5. TLRR

When a risk is being developed on DATIX, there is an option to indicate which of the BAF principal risks it is aligned with (if applicable).

Risks scoring greater than 12 on divisional risk registers will be shared at risk committee. Risk committee will agree which risks are then included in the TLRR in line with this framework.

~~The Trust Board reviews the TLRR on a quarterly basis, alongside the BAF. The Audit and Governance Committee are responsible for ensuring that the Trust has an appropriate system of risk management in place. The Risk Committee reviews Divisional Risk Registers and the TLRR monthly. The content of the TLRR and the Divisional Risk Register is shown below:~~

~~**TRUST LEVEL RISK REGISTER**~~	~~**DIRECTORATE AND DIVISIONAL RISK REGISTERS**~~
~~Typically 15 – 20 risks, some of which may be confidential~~	~~Typically a much higher number of risks~~
~~All risks rated 15+, **except for** those which are specifically division based and not relevant on a Trust wide basis~~	~~All divisional risks rated 12+, for the following directorates/divisions:~~ • ~~Families and Clinical Support Services~~ • ~~Medicine~~ • ~~Surgery~~ • ~~Community~~ • ~~EFIT~~ • ~~Finance~~ • ~~Workforce and OD~~ • ~~Medical Directorate~~ • ~~Nursing Directorate~~
~~Some risks rated 12 – 15 which are either:~~ • ~~To be aware of as the risk may increase/develop~~ • ~~Of significant **Trust wide** and appropriate for Board level awareness~~	

Appendix 2 GUIDELINES FOR THE USE OF THE RISK REGISTER

Introduction

A Risk Register is a management tool that provides a comprehensive and dynamic understanding of an organisation's risk profile. If used effectively a Risk Register will not only drive risk management but should be used to inform decision making processes.

Overview

Using the Datix Risk Management system, the Trust uses tiered risk rating within the risk system to ensure risks are managed, escalated and reported at the appropriate organisational level.

Only risks that have been approved at the appropriate level are moved into stages 3 and 4 and will be included in the Risk register. Stage 5 is the resolved stage (not included in risk reports)

Datix Risk Registers include:

- A description of the risk and existing controls
- The source of the risk
- Risk ownership
- Current and target risk score
- Action plan
- Review date (up to a maximum of 6 months).

Appendix 3 GUIDELINES FOR COMPLETING AN ELECTRONIC RISK ASSESSMENT FORM ON THE DATIX RISK MANAGEMENT SYSTEM

Access a Risk Assessment form on Datix
All staff can access Datix on the front page of the intranet - **MY essentials – Reporting an Incident (using Datix),** or using the following link:

http://intranet.midyorks.nhs.uk/departments/corporate/nursing/clinical-risk-management/Pages/report.aspx
Complete the risk assessment form on Datix/adding a new risk

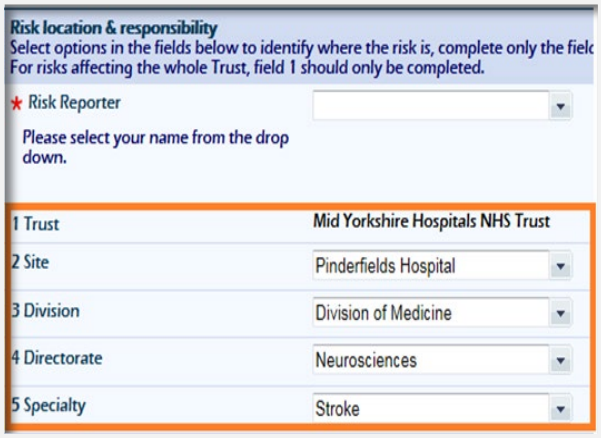
Details of the person reporting risk section

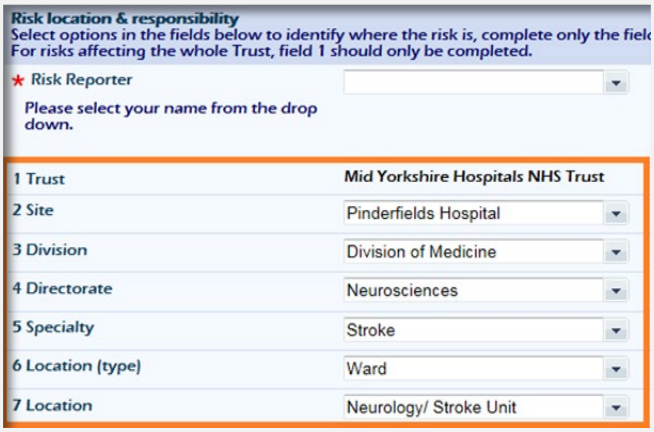
The Datix system will automatically populate the first 3 field section with your details as you are logged in.

Risk location and responsibility

* Select the risk reporter from the drop down list

* Complete the location fields relevant to the risk, e.g. if a risk is identified at directorate/specialty level then, then the fields only needs to be completed up to the directorate/specialty fields. If the risk is identified at location level then all the fields will need to be completed.





Risk description and rating (all of this section is mandatory)

* **Describe the issue/situation/activity that is being risk assessed** * (using a one line summary of the risk)

* **Enter the date of the risk assessment**

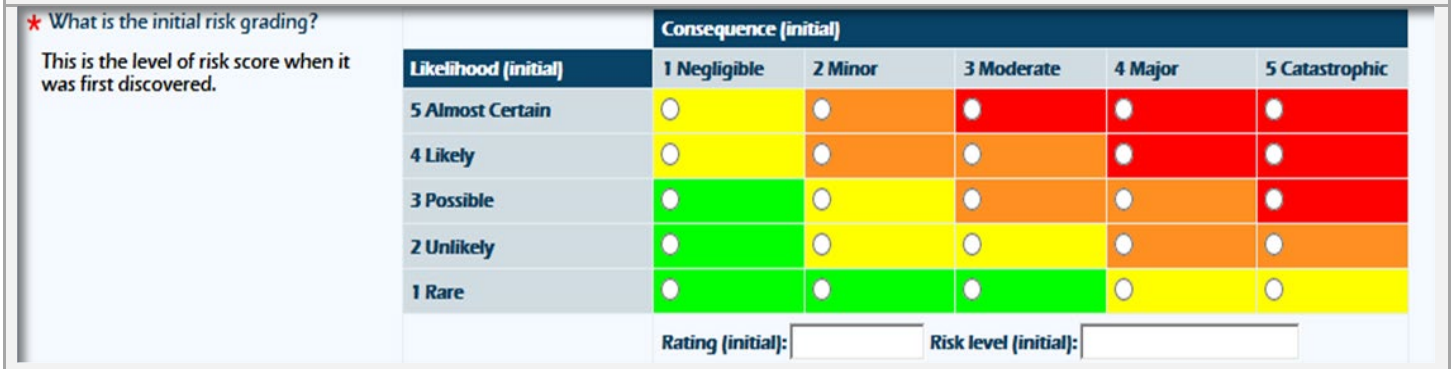
* **Type of risk**
Click on the drop down box and select one of the options.
Please note: you can only select one risk type from this section.

* **Risk Sub-Type**
Drop-down options to select sub-types.

* **Source of risk**
Select the option to show how the risk was identified. I.e. risk assessment/incident/complaint etc. You can only select one option.

* **Who is affected**
Click on the drop down menu and select all affected parties (You can select more than one). You will need to double click on the selected parties.

* **What is the ~~initial~~ Inherent risk grading?**
This is the level of risk score when it was first discovered.



An escalation email will automatically be sent to the relevant person for risk ratings:
0-6 – Dept/Ward Manager
8-12 – PSM/HOC/Matron
12+ - ADO/ADNs/DCD and Governance Manager/Clinical Director

* **Go to the bottom of the form and press submit**

This will generate a risk ID, notify relevant staff and take you back into the record to complete the risk actions (you will find the risk action plan section half way down the form)

Board Assurance Framework(BAF)

* Under the 'description' or 'control' section link to the relevant BAF priority, for example; "This risk aligns with the Trust BAF Strategic Priority 1: Keeping our patients safe at all times".

* State under the 'control section'…… "Control measures are in place to provide assurance that the risk is being managed effectively via the '……'(add name) project or improvement plan led by…… (add name) and monitored quarterly by……. (add group/committee monitoring).

* Under the 'description' or 'control' section link to the relevant National Guidance e.g. NICE, CQC, NHSE ….and include if a gap analysis has been undertaken to drive the improvement/action plan.

* This is a multi-code field-more than one option can be selected

~~* The BAF only applies to risk score (Initial) 15 +~~

* This will also allow you to pull through on reports e.g. you can pull a report for which of your risks sit under ~~with~~ which strategic objective~~BAF priority~~.

STRATEGIC OBJECTIVE		PRINCIPAL RISKS	
1	Keep our patients safe at all times	1	*Failure to maintain the safety of patients*
		2	*Failure to maintain and develop Trust Estate, and Equipment*
2	Provide excellent patient experience and deliver expected outcomes	3	*Failure to provide **excellent patient experience** including not meeting NHS Constitution Standards*
		4	*Failure to provide **expected outcomes***
3	Be an excellent employer	5	*Failure to recruit, train and sustain and engaged and effective workforce*
		6	*Failure to sustain an engaged and effective workforce*
4	Be a well-led Trust that delivers value for money	7	*Failure to achieve financial sustainability and VFM*
		8	*Failure to comply with targets, statutory and regulatory duties and functions*
5	Have effective partnerships that support better patient care	9	*Failure to have effective relationships with partnering organisations*
6	Provide excellent Research, Development and Innovation Opportunities	10	*Failure to support research, development, transformation and innovation for the benefit of patients and the NHS*

Actions

You **MUST** click on 'create a new action' to complete an action form. One form is required to be completed for each individual action. (This will open a blank action plan form) and will be allocated its own ID number.

* **Priority**
Click on the drop down box and choose an option of priority to be given to that action.

* **Description**
Brief summary of what action is required.

Start date – enter the start date of your action.
Due date – enter the date the action is due to be completed

* **Assigned by (from) / Responsibility (to) (mandatory)**
Complete this section by clicking on the drop down box and choosing the designated person to complete the action.

* **Complete the rest of the fields on the form where necessary**
Cost/cost type/synopsis/resource requirement/reporting and monitoring requirement/progress. (Then submit the action at the bottom of the page) this will take you back to the action section on the form.

* **This will generate an automated email to the person identified to complete the action**

Supporting documents

If you have documents to attach to the risk record, click on **attach a new document** – this will open a small section which is mandatory once you have clicked into it.

*Link as – click on the drop down box and select the type of document you are linking to the risk
* Description – add the description of the document
* Insert the file – click on the browse and attach your document

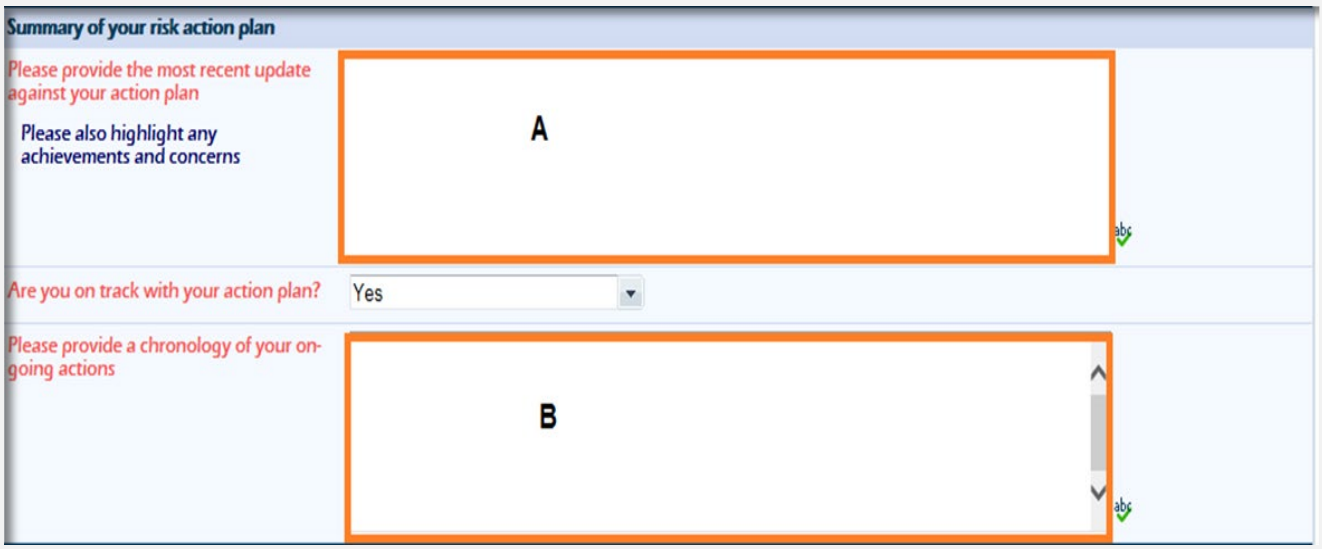
* Go to the bottom of this section and click on **SAVE**

Once you have completed this it will then take you back to the form (You will need to follow the above steps each time you want to add a new document)

Summary of your risk action plan

In this section please provide the mitigating actions for the risk.

* In **Box A** – in this section bullet point specifically what progress you have achieved against the improvement/action plan for that Quarter (or month), highlight any barriers or areas you are concerned about. This section is providing evidence of assurance or the gap in assurance. When you next do a risk review, you should cut & paste the documentation in this section into the 'Chronology of ongoing actions' (**Box B**) below and write your new update in the top box each time.
Please be aware that documents you have attached and actions created (as described above) are not visible on reports pulled from Datix so ensure your action progress is well documented in this section.



Residual risk rating -(Target)

* Please complete the residual risk score taking into account what the score would be if all the mitigating actions have been fully completed and implemented.

Monitor Risk

* **Enter the date when the risk will be reviewed**

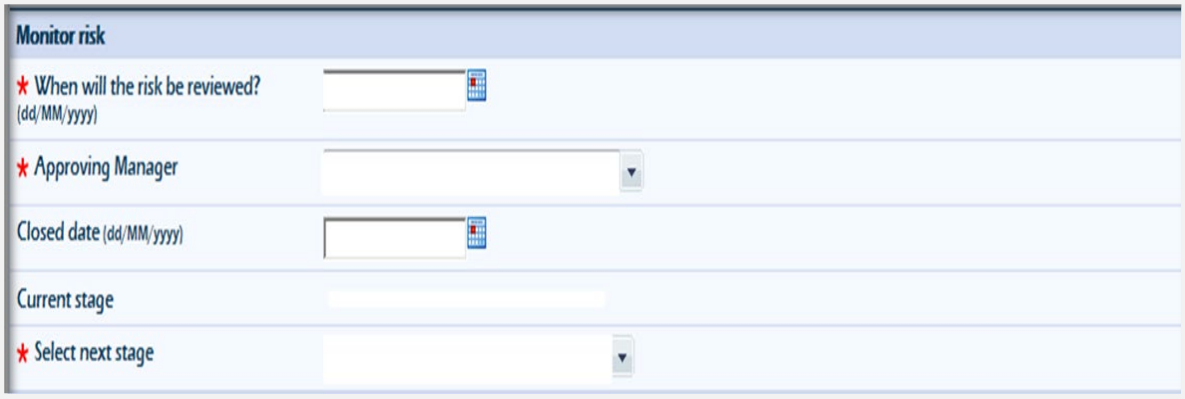
(This can be monthly/3 monthly/6 Monthly-depending on the status and score of the risk)

* **Select the appropriate manager**

This is the person who will approve/sign off the risk (The surname can be typed in the field to narrow your search)

* **Select next stage**

Click on the drop down box and select the relevant stage (see glossary of terms for explanation of status) – then go to the bottom of the page and select **SAVE**



ADDITIONAL INFORMATION – DATIX RISK MODULE FIELDS

Field	Further Guidance
Risk reporter	Mandatory field. Please enter your name as reporter of the risk.
Trust	This field is automatically populated/defaulted.
Site	Not mandatory field. Choose from the options list if required.
Division	Not mandatory field. Choose from the options list if required.
Directorate	Not mandatory field. Choose from the options list if required.
Specialty	Not mandatory field. Choose from the options list if required.
Location type	Not mandatory field/ Choose type of location of risk from the options.
Location	Not mandatory field. Choose precise location from the options list e.g. Ward 31
Exact location	Not a mandatory field. Free type box if risk has been identified in a particular bay/corridor etc.
Estates buildings	Not mandatory field. Choose from the options list if required.
Describe the risk	Mandatory field. Describe a one line summary of risk you are assessing.
Date of risk assessment	Mandatory field. Add risk assessment date.
Type of risk	Mandatory field. Choose from the options list.
Risk sub-type	Not mandatory. Choose the sub-type that matches with the type of risk.
Source of risk	Mandatory field. What led to the risk being reported?
Who is/could be affected?	Mandatory field. Choose from the options list. More than one option can be selected from this list.
Risk grading Matrix(~~Initial~~ inherent)	Mandatory field. Choose the appropriate risk rating from the Matrix to score the ~~initial~~ inherent ~~target~~ risk. (This will automatically populate the rating and grading below before submission.
Description	Mandatory field. What is the likelihood that the risk/issue will occur and what is the consequence/impact it would have? Please ensure that the risk is fully described.
Manage/control the risk	Mandatory field. What is currently in place to manage/ control/ reduce/ minimise the risk. Please list in full the current controls in place.
Risk grading Matrix (Current)	Mandatory field. Choose the appropriate risk rating from the Matrix to score the current ~~target~~ risk. (This will automatically populate the rating and grading below before submission.

Reference	Optional field. May be used for local purposes or left blank.
ID	This field is automatically populated.
Date risk reported	This field is automatically populated.
Designated risk reporter	This field is automatically brought forward previous information.
Risk description	This field has been automatically brought forward the previous information you have already entered.
Actions	You must click on create a new action to complete an action form for each new action you have identified. Complete the 3 mandatory sections on this action form. Also complete as much information in the other sections as possible before submitting the action.
Supporting documents	If any documents are to be attached click on Attach a new document and complete all 3 Mandatory sections.
Please provide the most recent update against your action plan	Provide the most recent update (Can be updated each time a risk is reviewed).
Are you on track with your action plan?	Select Y/N from the drop down
Please provide a chronology of your on-going actions	Chronology details of actions taken.
~~Residual~~ Target risk rating	Choose the rating of the risk score you are working towards when the actions you have identified are fully implemented and effective.
Is the risk score acceptable?	Choose from the Yes/No
Risk review date	Mandatory field. Enter the date when the risk is scheduled to be reviewed. This field must be updated after each review.
Approving manager	Mandatory field. Select the relevant manager who will be reviewing/approving the risk.
Select next stage	Mandatory field. Select the next stage.

Additional functionality (see option on the left hand side of the risk form)

Field	Further guidance
Progress notes	Optional field. This may be used as an aide memoir.
Communication and feedback	To be used for all communication around the risk. This will keep an audit trail of all communication – who/date/time.
Notifications	This will keep an automatic list of who has been notified about the risk.
Print option	Click on print to print of the risk form.
Audit trail	Click on audit trail which shows an audit of all movements within the risk.

Appendix 4 GLOSSARY OF TERMS

Risk assessment under development – the risk assessment has been completed on the first form. At this stage the person completing the risk assessment may need more time to complete any actions on the form.

Risk submitted for review by manager/reviewer – the risk has been completed and sent to the relevant manager/reviewer. If the risk has to be re- scored by the reviewer, the reviewer must inform the person who reported the risk, and a due date set. This must be done by manual email through the Datix communication and feedback section.

Risk score approved – actions ongoing – once the risk has been moved to this section, the risk cannot be closed as actions are still ongoing.

Risk ongoing – risk score tolerable – The action/s has/have been completed but the risk is still there.

Risk resolved – The risk no longer exists.

Likelihood - is the chance that something might happen. *Likelihood* can be defined, determined, or measured objectively or subjectively.

Consequence - A ***consequence*** is the outcome of an event

Level of Risk - is estimated by considering and combining consequences and likelihoods. A ***level of risk*** can be assigned to a single risk or to a combination of risks.

Risk Evaluation - is a process that is used to compare risk analysis results with risk criteria in order to determine whether or not a specified level of risk is acceptable or tolerable.

Control- is any measure or action that modifies risk. ***Controls*** include any policy, procedure, practice, process, technology, technique, method, or device that modifies or manages risk. Risk treatments become controls, or modify existing controls, once they have been implemented.

Target risk/Residual risk/Mitigated risk is the risk left over after you have implemented a risk treatment option. It is the risk remaining after you have reduced the risk, removed the source of the risk, modified the consequences, changed the probabilities.

Monitor - means to supervise and to continually check and critically observe.
It means to determine the current status and to assess whether or not required or expected performance levels are actually being achieved.

Review - ***Review activities*** are carried out in order to determine whether something is a suitable, adequate, and effective way of achieving established objectives.

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW			
Agenda item	2.5		
Paper title	Tier One Committee Proposal		
Responsible Director	Keith Ramsay, Trust Chair		
Author	Jen Beckett, Company Secretary		
Previously considered by	Strategy and Transformation Committee have reviewed the documents associated with it Membership has been reviewed at various committees and a summary provided for agreement and a summary provided for agreement Board seminar has considered the principles for establishing the Culture and People Committee		
The Board/Committee is asked to:			
Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

Section 5.1.1 of the Trust Standing Orders refers to delegation of functions to committees. In order to ensure that the delegations remain appropriate and relevant, changes to Terms of Reference (ToR) require Trust Board approval along with the establishment of any further committees.

This paper is presented to seek approval by the Trust Board for changes to the Tier One committee arrangements, specifically to establish the Strategy and Transformation Committee as a formal Tier one committee, to establish the Culture and People Committee and to agree the changes to membership of Tier one committees.

Trust Board are asked to approve:-

- Strategy and Transformation Committee being established as a Tier one committee, in line with the ToR and workplan presented.
- Trust Board delegation of the approval and monitoring of Enabling Strategies to Strategy and Transformation Committee.
- Establishment of the Culture and People Committee in line with the ToR presented.
- Executive and non-executive Tier one committee membership, noting changes, quoracy and attendance expectations.
- Approve the other noted membership changes to the committees.

Link to strategic objective(s)	*Highlight relevant box from the below:*
	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director

What is the financial impact?	There is no financial impact related to this paper

1. Information and Purpose

This paper is presented to seek approval by the Trust Board for changes to the Tier one committee arrangements, specifically to the establish the Strategy and Transformation Committee as a formal Tier one committee, to establish the Culture and People Committee and to agree the changes to the Board of Directors membership to Tier one committees.

2. Background

Section 5.1.1 of the Trust Standing Orders refers to delegation of functions to committees. In order to ensure that the delegations remain appropriate and up to date, changes to Terms of Reference (ToRs) require Trust Board approval along with the establishment of any further committees. The Board should consider the workplans for committees to ensure they meet the requirements of the ToR and are in line with the delegations agreed.

3. Proposed Committee Changes

3.1 Strategy and Transformation Committee (Shadow)

Following discussion at the private meeting of the Trust Board in November 2021, the Strategy and Transformation Committee has been meeting in shadow form. In line with the normal process undertaken for other committees at the end of the financial year, the members have completed a self-assessment, appendix 1. The outputs of this were reviewed and discussed at Strategy and Transformation meeting in July 2022.

The (shadow) committee recommended it be established as a full Tier one committee with the following changes to ToR:-

- Membership to be updated to reflect changing roles and titles
- Committee responsibilities in relation to the transformation work to be clarified.

These changes have been made and are attached, appendix 2.

The Committee also recommended Trust Board delegate the approval of Enabling Strategies to Strategy and Transformation Committee, with Trust Board receiving these for information and Trust Board maintaining the authority to approve the Corporate and Clinical Services Strategy. This is reflected in the proposed workplan, appendix 3.

The Trust Board are asked to consider and approve:-

- The recommendation to establish Strategy and Transformation Committee as a Tier one committee.
- The recommendation Trust Board delegate approval and monitoring of Enabling Strategies to Strategy and Transformation Committee.

3.2 Culture and People Committee

The Trust's workforce are an essential element of being able to deliver the strategic vision and objectives of the organisation. Staffing challenges have

been prevalent in the NHS nationally for many years and with the added burden on staff, both in and outside of work, created by the pandemic the Trust Board recognise the difficulties staff face on a daily basis. As well as delivering the strategy another key responsibility of any Board is the setting the culture of the organisation. In recognition of the increasing workforce challenges and the desire to support staff and make MYHT a place people want to come to work, the Trust Board agreed that additional focus on People and Culture was required through the establishment of a Tier one committee.

The Director of Workforce and Organisational Development led a seminar with the Board of directors in June 2022 to gain their views on the committee's role and purpose. Based on the feedback received and a review of various approaches, a ToR, appendix 4, has been developed for Trust Board to review and approve.

The proposal is the committee is a 'non-traditional' tier one committee with a cross-functional team of employees on the committee, formed to ensure that different voices within the Trust are heard when decisions that impact workers are made. The committee will ensure workforce members have the opportunity to assist and influence the development of the culture, values and Kind Life approach in the organisation, rather than it being a 'traditional' oversight and assurance committee. One of the roles of the committee will be to advise the Board on how the culture of the Trust feels. Setting the culture of the Trust will remain a key responsibility and duty of the Board. The Committee will support the work already underway on a Kind Life work, a culture of continuous improvement and distributed leadership models.

The Trust Board are asked to approve establishment of the Culture and People Committee in line with the ToR presented.

3.3 Board of Director Tier One Committee Membership

In line with the proposed changes to the tier one committee structure outlined above and Board membership changes, a revised overview of the Board of Directors membership of the Tier one committees is presented in table 1. Attendance against this membership will be reported in the Annual report for 2022/23.

Table one – Summary of proposed Board of Director membership of Tier one committees

NED / ED Committee Attendance		Remuneration and Terms of Service	Audit & Governance	Quality Committee	Resource and Performance	Charitable Funds	(Shadow) Strategy Committee	Culture and People Committee	Risk Committee (executive committee)	Total (excluding TB)
ED	LR									3
	TD								Chair	5
	TY									3
	KS									5
	AW									4
	PM									4
	MB									3
	DP									3
	JoW			(Karen Benstead)	(Karen Benstead)		(Mel Brown)			0
	PC									2
	EH									2
	Co.Sec									5
NED	KR	Chair				Chair	Chair			4
	SS							Chair		4
	JC				Chair					5
	DT			Chair						3
	GE		Chair							4
	NM									4
TERMS OF REFERENCE NOTE:										
Quoracy		50% of members	2 members (NEDs)	60% of members Chair Senior Div rep	2 NEDs 5 EDs or named deputies	1 NED 1 ED	2 NED 5 ED	2 NED 2 ED	50% of members	
Attendance expectation		It is expected that each member attends every meeting.	It is expected that each member attends every meeting.	75% of meetings	70% of meetings	70% of meetings	75% of meetings (inc named deputy)	75% of meetings (inc named deputy)	80% of meetings	

Key	
	Member
	In attendance

Further to the Board of Director changes the following membership changes are proposed for approval:-

- **Quality Committee**
  - Director of AHPs to be added as an attendee

- **Resource and Performance Committee**
  - Director of Operations ACS to be added as an attendee (instead of the Director of Adult Community Services)
  - Head of Finance improvement to be added as an attendee
  - Deputy Chief Operating officer to be added as an attendee

- **Strategy and Transformation Committee**
  - Director System Reform & Integration Wakefield System added as attendee (replacing the Director of Adult Community Services)

The Trust Board are asked to :-

- approve Board of Directors membership changes to Tier one .committees, noting the quoracy and attendance expectations.
- approve the other membership changes to the committees as outlined.

3. Conclusion and Recommendation

In summary Trust Board are asked to approve:-

- Strategy and Transformation Committee being established as a Tier one committee, in line with the ToR and workplan presented.
- Trust Board delegation of the approval and monitoring of Enabling Strategies to Strategy and Transformation Committee.
- Establishment of the Culture and People Committee in line with the ToR presented.
- The Board of Director changes to the Tier one committee membership, noting changes, quoracy and attendance expectations.
- Approve the other noted membership changes to the committees.

Jen Beckett
Company Secretary
August 2022

MEETING OF THE STRATEGY AND TRANSFORMATION COMMITTEE (SHADOW)
DATE OF MEETING: 21 JULY 2022

OVERVIEW			
Agenda item	5.2		
Paper title	Strategy and Transformation Committee (Shadow) Progress Assessment Report		
Responsible Director	Keith Ramsay, Trust Chair / Committee Chair		
Author	Sophie Johnson, Executive Assistant		
Previously considered by	Not applicable		
The Board/Committee is asked to:			
Approve	Receive	For Information	Take assurance
Executive summary			
The Strategy and Transformation Committee is asked to: • Receive the results from the Strategy and Transformation Committee (Shadow) Progress Assessment and discuss where action may be needed prior to establishing full Tier 1 Committee status.			

Link to strategic objective(s)	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	Not applicable.
Link to Board Assurance Framework risk(s)	Not applicable.

STRATEGY AND TRANSFORMATION COMMITTEE (SHADOW) PROGRESS ASSESSMENT REPORT

PURPOSE OF REPORT

The purpose of the report is for the Strategy and Transformation Committee (shadow) to receive and discuss the results from the progress assessment and proposed action plan before the Tier 1 status is approved at Trust Board.

1. RESULTS OF THE STRATEGY AND TRANSFORMATION COMMITTEE (SHADOW) PROGRESS ASSESSMENT

The Committee progress assessment was based on a National Audit Office Audit Committee checklist and the Committee Terms of Reference. It was created to review the effectiveness of the Strategy and Transformation Committee (shadow) prior to establishing full Tier 1 Committee status. The checklist covers the following areas:

Principle 1: The Role of the Strategy and Transformation Committee (shadow) – Does the Committee effectively support the Board and the Chief Executive by reviewing the comprehensiveness of assurances to satisfy their needs, and by reviewing the reliability and integrity of these assurances?

Principle 2: Membership, Independence, Objectivity and Understanding – Is the Committee suitably independent and objective, and does each member have a good understanding of the objectives, priorities, and risks of the Trust, and of their role on the Committee?

Principle 3: **Skills** – Does the Committee contain or have at its disposal an appropriate mix of skills to perform its functions well?

Principle 4: Scope of Work – Is the scope of the Committee suitably defined, and does it encompass all the assurance needs of the Board?

Principle 5: Communication - Does the Committee communicate effectively with the Board and other stakeholders

All Committee members and attendees were asked to complete and return a progress assessment questionnaire dealing with each category. 8 completed questionnaires were received giving a response rate of 44.44%, 2 responses were completed by Non-Executive Director members, 4 were completed by Executive members and 2 were completed by other members of the Committee.

The Executive Assistant has reviewed the results and provided comments for all exceptions including actions where necessary. Any exceptions or areas where members/attendees were not aware of particular items are explored in the below table.

The Committee are asked to **NOTE** the below comments and **APPROVE** the actions.

Issue	Question	Comment
Terms of Reference	Are the roles and responsibilities of the Committee been clearly defined and communicated to all Committee members, along with details of how the Committee supports the Board?	**Results:** Yes – 7 No - 1 Not Known - 0 **Comments:** The following comments were received and the Committee are asked to discuss. *"The roles have been defined and communicated as per the Terms of Reference, but I think further clarity on these is still required, in particular: -* • *The role of the Board versus the role of the committee in relation to strategy development (strategy will always need to be approved by the Board) clarity is required that the Strategy and transformation committee oversees the development and ensures it is meeting the timeframes agreed by the board and will be deliver in line with these.* • *The role of the committee in transformation programme is required, this should be to have oversight of the transformation plans and how they are aligned to the strategy and whether they will therefore deliver it, and where there are any gaps. Currently only highlight reports are being received. Given the role of the Resource and Performance committee in monitoring the performance and the waste reduction plan clarity is required as to whether highlight reporting and delivery of the programmes would be best reported through RAP or STC."* **ACTION REQUIRED – TO DISCUSS**
Terms of Reference	Do members think the timings of the Committee meetings are correct?	**Results:** Yes – 7 No - 0 Not Known – 1 **Comments:** The Committee are asked to discuss if they believe the timings of the Committee meetings are correct. **ACTION REQUIRED – TO DISCUSS**

Terms of Reference	Does the Committee meeting regularly and do meetings coincide with key dates in the Board meeting programme?	**Results:** Yes – 6 No – 0 Not Known – 2 **Comments:** The Committee are asked to discuss if the meetings are held regularly and coincide with key dates in the Board meeting programme. **ACTION REQUIRED – TO DISCUSS**
The Role of the Committee	**Conclusions** Do we achieve Principle 1: The Role of the Strategy and Transformation Committee – Does the Committee effectively support the Board and the Chief Executive by reviewing the comprehensiveness of assurances to satisfy their needs, and by reviewing the reliability and integrity of these assurances?	**Results:** Yes – 5 No – 0 Not Known – 3 **Comments:** The Committee are asked to note the following comments that were received: *"I think it is quite early to be able to answer the principle 1 at this stage. I'm assured by the development of the Strategy but at this stage, enabling strategies such as the Clinical Strategy have not yet been developed to a stage where they can be shared. From what we have seen to date, I'm assured but it is too soon for me to give an absolute yes."* **NO ACTION REQUIRED – TO NOTE**
Membership	Do members think the Committee has the right membership?	**Results:** Yes – 6 No – 2 Not Known – 0 **Comments:** The following comments were received and the Committee are asked to discuss. *"The committee has a large membership; it may be better for committee to have a reduced membership and more people in attendance."* *"Do we need an additional representative of the OD Team?"* **ACTION REQUIRED – TO DISCUSS**
Membership	Is the size of the membership correct for supporting the committee in achieving its purpose?	**Results:** Yes - 6 No - 1 Not Known – 1 **Comments:** The following comments were received and the Committee are asked to discuss.

		"*Consideration needs to be given to the role of the committee – if it is to oversee the delivery of strategy and agree the transformation plans, then these could be presented by directors / Programme SROs. If the committee is going to talk in depth about what should be in the strategy and the transformation plans then a wider group including divisions would be required, however if this is the case then the committee is probably an executive committee rather than a non-executive committee."* *"One to watch – inevitably a lot of members sit on this Committee and Board – we do need to be careful that we are not in effect "marking our own homework" or indeed repeating conversations in a Tier 1 Committee and then at Board."* **ACTION REQUIRED – TO DISCUSS**
Membership, Independence, Objectivity and Understanding	**Conclusion** Do we achieve Principle 2: Membership, Independence, Objectivity and Understanding – Is the Committee suitably independent and objective, and does each member have a good understanding of the objectives, priorities, and risks of the Trust, and of their role on the Committee?	**Results:** Yes - 7 No - 0 Not Known - 1 **Comments:** The Committee are asked to discuss whether Principle 2 has been achieved. **ACTION REQUIRED – TO NOTE**
Range of Skills	**Conclusions** Do we achieve Principle 3: Skills – Does the Committee contain or have at its disposal an appropriate mix of skills to perform its functions well?	**Results:** Yes - 7 No - 0 Not Known – 1 **Comments:** The following comments were received and the Committee are asked to discuss. *"It would be good to have some external review of this committee at some point and its effectiveness – probably when we have the new Trust Strategy."* **ACTION REQUIRED – TO DISCUSS**
Trust Board Annual Strategy Work Plan	Is the Committee developing a Strategy work plan to recommend to the Trust Board which	**Results:** Yes - 7 No - 1 Not Known – 0

	identifies timeframes for decision-making and key strategy and planning topics for inclusion in the Trust Board Development Plan and Trust Board meeting workplan?	**Comments:** The following comments were received and the Committee are asked to discuss. *"A timeline for production of the strategy has been shared but this has not led a structured milestone plan including the development of the Transformation plans and when time at board development sessions will be required."* **ACTION REQUIRED – TO DISCUSS**
Strategy Development and Alignment	Does the Committee through its workplan gain assurance that the future strategy aligns with (and assess the impact on the Trust's Strategy of the following): • National strategies e.g., NHS Long Term Plan • Regional strategies e.g., West Yorkshire and Harrogate ICS 5-year plan • Local strategies e.g., Health and Wellbeing Strategies	**Results:** Yes - 7 No - 0 Not Known – 1 **Comments:** The Committee are asked to discuss if assurance is gained through the workplan that the future strategy aligns with and assess the impact on the Trust's Strategy. **ACTION REQUIRED – TO DISCUSS**
National Planning Guidance	Does the Committee through its workplan receive and consider national planning guidance's impact on the Trust?	**Results:** Yes - 6 No - 0 Not Known – 2 **Comments:** The Committee are asked to discuss if through its workplan the Committee receive and consider national planning guidance's impact on the Trust. **ACTION REQUIRED – TO DISCUSS**
National Planning Guidance	Does the Committee through its workplan oversee the development of the Trust's response to planning guidance?	**Results:** Yes - 7 No - 0 Not Known – 1 **Comments:** The Committee are asked to discuss if through its workplan the Committee oversee the development of the Trust's response to planning guidance. **ACTION REQUIRED – TO DISCUSS**

National Planning Guidance	Does the Committee through its workplan consider and endorse the Trust response to national planning requirements?	**Results:** Yes – 5 No – 0 Not Known – 3 **Comments:** The Committee are asked to discuss if through its workplan the Committee consider and endorse the Trusts response to national planning requirements. **ACTION REQUIRED – TO DISCUSS**
National Planning Guidance	Does the Committee through its workplan gain assurance that the Trust is compliant with planning requirements?	**Results:** Yes - 5 No - 0 Not Known – 3 **Comments:** The Committee are asked to discuss if through its workplan the Committee gains assurance that the Trust is compliant with planning requirements. **ACTION REQUIRED – TO DISCUSS**
Understanding and Interpreting National and Regional Policy	Does the Committee through its workplan receive and consider briefings concerning National and Regional Policy?	**Results:** Yes - 6 No - 0 Not Known – 1 **Comments:** The Committee are asked to discuss if through its workplan the Committee receive and consider briefings concerning National and Regional policy. **ACTION REQUIRED – TO DISCUSS**
Transformation/ Breakthrough Programmes and Enabling Strategies	Does the Committee through its workplan gain assurance on the delivery of key Transformation Programmes (e.g., Planned Care), Breakthrough Programmes (e.g., Digital) and enabling Strategies (e.g., Workforce and Organisational Development?	**Results:** Yes - 6 No - 0 Not Known – 2 **Comments:** The following comments were received and the Committee are asked to discuss: *"Highlight reports are received but the key deliverable, benefits and timescales have not been shared and therefore it is difficult to know if they are delivering."* **ACTION REQUIRED – TO DISCUSS**
Committee Workplan	The Committee is currently developing a workplan, do members think this covers all relevant areas of work? is there anything else	**Results:** Yes - 6 No - 2 Not Known - 0

	members would like to see on the workplan?	**Comments:** The Committee are asked to discuss if the workplan covers all relevant areas of work. **ACTION REQUIRED – TO DISCUSS**
Scope of Work	**Conclusions** Do we achieve Principle 4: Scope of Work – Is the scope of the Committee suitably defined, and does it encompass all the assurance needs of the Board and Chief Executive?	**Results:** Yes - 4 No - 0 Not Known – 3 **Comments:** The Committee are asked to note the following comments that were received: "*As answered earlier, my view is that it is a little too soon to be able to answer all of these questions positively as work is still progressing."* **NO ACTION REQUIRED - TO NOTE**
Reporting to the Board	Does the Committee provide an Annual Report to the Board, timed to support preparation of the Annual Governance Statement?	**Results:** Yes (6) No (1) Not Known (1) **Comments:** The Committee are asked to note the following comments that were received: *"Committee only in shadow form and therefore full reporting not yet in place for the AGS but will be next year."* *"I assume as it moves out of shadow form, it will. Strategy is covered in the annual report anyway."* **NO ACTION REQUIRED – TO NOTE**
Agenda Setting	Are the meetings set for a length of time which allows all business to be conducted, yet not so long that the meeting becomes ineffective?	**Results:** **Yes – 6** **No – 0** **Not Known – 1** **Comments:** The Committee are asked to note the following comments that were received: *"As the meeting develops, the timings will sort themselves out."* **NO ACTION REQUIRED – TO NOTE**

2. ATTENDANCE

Attendance is included below for information. The Terms of Reference states that each member should attend a minimum of 75% of meetings the below chart assesses the performance of each member/attendee based on December to May meetings:

Name	16 Dec 21	27 Jan 21	7 Apr 21	19 May 22	Meetings attended	%
Members						
K Ramsay	✓	✓	✓	✓	4 /4	100%
J Charge	×	✓	✓	✓	3 / 4	75%
M Nawaz	✓	✓	✓	✓	4 / 4	100%
L Richards	×	✓	✓	×	2 / 4	50%
J Hazelgrave	✓	✓	✓	✓	4 / 4	100%
D Melia	✓	✓	✓	✓	4 / 4	100%
T Davies	✓	✓	✓	✓	4 / 4	100%
P Marshall	✓	✓	×	✓	3 / 4	75%
K Stone	✓	✓	✓	×	3 / 4	75%
M Braden	✓	✓	✓	×	3 / 4	75%
J Yarwood		✓	✓	×	2 / 3	66%
N Artis					0 / 0	N/A
R Robinson		✓		✓	2 / 2	100%
S Robertshaw					0 / 0	N/A
A Hodge					0 / 0	N/A
In attendance						
M England	✓	✓	×	✓	3 / 4	75%
J Beckett	✓	✓	×	✓	3 / 4	75%
M Lewis	✓	✓	✓	×	3 / 4	75%
M Brown					0 / 0	N/A

3. RECOMMENDATION

Members of the Strategy and Transformation Committee are asked to:-

i. Make a recommendation to Trust Board as the whether the Committee should be established as full Tier 1 Committee.

Sophie Johnson
Executive Assistant
July 2022

APPENDICES
Appendix A Terms of Reference
Appendix B Draft Work Programme 2022/23

STRATEGY AND TRANSFORMATION COMMITTEE

TERMS OF REFERENCE

1. Role of the Strategy and Transformation Committee

The role of the Strategy and Transformation Committee is :-

- to provide oversight and direction for the development and implementation of the Trust's strategy ensuring that enabling strategies are aligned to it.
- to provide oversight and assurance of the delivery of the Trust's annual business planning process ensuring alignment to the Trust's strategy.
- to gain assurance transformation workstreams are delivering the activity to enable the Trust's strategic objectives and business plan to be achieved.

The Tier 1 Committee will do this by:

- Taking assurance by appropriate methods to ensure the effective development and deployment of Trust strategies and business plan.
- Providing assurance to Trust Board concerning the development of Trust strategies and plans.
- Providing assurance to Trust Board on the delivery of key transformation programmes aligned to Trust strategies and plans.

2. Membership

The following are Board members of the committee:

- 3 Non-Executive Directors (one of whom is chair of the Committee)
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Chief Nursing Officer
- Chief of Planning, Partnerships and Strategy
- Director of Workforce and Organisational Development
- Medical Director
- Chief Clinical Information Officer
- Director of Estates, Facilities and IM&T

The following are Committee members:

- Divisional Clinical Directors
- Associate Directors of Nursing
- Director of Allied Health Professionals

The following people will be invited 'In attendance':

- Company Secretary
- Associate Director of Planning & Partnerships

- Head of Programme Management
- Programme Commissioning Director Integrated Care

3. Quorum

The Committee has no decision making authority unless at least 2 of the non-executives and 5 of the executive/corporate directors or their deputies are present. Named deputies will be registered on the attendance matrix. Deputies will count towards the quorum but may not exercise voting rights, unless formally appointed to act up in to Executive/ Corporate Director role during a period of incapacity or to temporarily fill an Executive / Corporate Director vacancy.

4. Attendance

It is expected that each member or named deputy attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy must be identified for core members of the Committee and must attend when a member is unable to be present. A named deputy will count towards quorum and members should ensure where possible 100% attendance through their deputy.

5. Changes to the Terms of Reference

Changes to the Terms of Reference, including changes to the Chair or membership of the Committee, are a matter reserved to the Trust Board.

6. Administration

The Chair of the Committee will set the agenda supported by the Associate Director of Planning & Partnerships. The Committee will be administered by the Corporate Governance Officer.

7. Establishment of sub-committees

The Committee may establish Sub-Committees or groups to support its work. The Terms of Reference of such Sub-Committees will be approved by the Committee and reviewed at least annually. The minutes of any such Sub-Committees will be presented to the Committee at the next available meeting. The Chair of each Sub-Committee will be expected to provide a Chair's report to the Strategy and Transformation Committee after each meeting.

8. Frequency of meetings

The committee will meet bi-monthly unless agreed otherwise by the Chair. Meetings will be expected to last no more than 2 hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Committee may be called by any member of the Committee, with the consent of the Chair.

9. Annual Plan

The Committee will develop an annual programme of work for approval by the Trust Board at its first meeting of the financial year. The programme will include a list of all reporting and accountable groups and Sub-Committees and when minutes or reports from those groups will be received.

10. Reporting to Trust Board

The Chair of the Committee will provide a Chair's Report monthly to the Trust Board on its proceedings after each meeting. The Chair of the Committee will draw to the Trust Board's attention any issues of significance, including issues where the committee is unable to provide a satisfactory level of assurance.

11. Status of the meeting

All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee.

12. Monitoring

The Committee will provide the Trust Board with an Annual Report setting out issues that have been considered by the Committee and details of assurance provided. This will include levels of attendance, delivery against the work programme and the management of identified risks.

13. Main duties and responsibilities

The Committee's main duties and responsibilities incorporate the following:

1. Develop the annual Strategic Work Plan for recommendation to Trust Board
2. Assurance of effective strategy development and alignment
3. Oversight and assurance of the Trust's Operating Plans
4. Oversee the development of the clinical service strategy
5. Understanding and interpreting national and regional policy
6. Assurance and oversight of transformation programmes, key Breakthrough Programmes and enabling strategies

13.1 Trust Board Annual Strategy Work Plan

The Committee will:

- Develop a Strategy work plan to recommend to Trust Board identifying timeframes for decision-making and key strategy and planning topics for inclusion in the Trust Board Development Plan.

13.2 Strategy Development & Alignment

The Committee will:

- Gain assurance on the development of the Trust's corporate strategy in line with the expectations of the Trust Board and to make recommendations to Trust Board considering:
    i. Key issues to be addressed within the strategy
    ii. Impact of changes in the internal and external environment on the strategy
    iii. Potential impact on and changes to the aspirations and view of the future for the Trust
    iv. The most appropriate measures of success
    v. The principal risks aligned to the delivery of the strategy as described in the Board Assurance Framework
    vi. Implementation and socialisation of the Trust strategy

- Gain assurance that the future strategy aligns with (and assess the impact on the Trust's Strategy of the following):
    i. National strategies e.g. NHS Long Term Plan
    ii. Regional strategies e.g. West Yorkshire and Harrogate ICS 5 year plan
    iii. Local strategies e.g. Health and Wellbeing Strategies

- Ensure that enabling strategies are aligned with the emerging Trust's overall strategy

- Gain assurance on the development of the sustainability strategy ensuring alignment to the overarching Trust Strategy

13.3 Clinical Service Strategy

The Committee will:-

- Assess the requirements and potential approaches to developing a Clinical Service Strategy:
    i. Making recommendations to Trust Board on the approach to developing a clinical service strategy
    ii. Gaining assurance on the roadmap for development of a clinical service strategy

13.4 Operating Plans

The Committee will:

- In relation to the operating plan:
    i. Oversee the approach and process to develop the Trust's Annual Operating Plan
    ii. Assure the Trust Board that the plan aligns with the Trust's strategy and addresses the annual planning priorities as agreed by Trust Board
    iii. Seek assurance the Annual Operating Plan is being delivered as agreed by Trust Board.

- In relation to national planning guidance:
    i. Receive and consider national planning guidance's impact on the Trust
    ii. Oversee the development of the Trust's response to planning guidance.
    iii. Consider and endorse the Trust response to national planning requirements
    iv. Seek assurance that the Trust is compliant with planning requirements

13.5 Understanding and interpreting National and Regional Policy

The Committee will:

- Receive and consider briefings concerning National and Regional Policy

13.6 Transformation/Breakthrough Programmes and Enabling Strategies

The Committee will:

- Seek assurance on the delivery of key Transformation Programmes (e.g. Planned Care), Breakthrough Programmes (e.g. Digital) and enabling Strategies (e.g Workforce and OD).
- Monitor the development and delivery of the Transformation and Improvement agenda, ensuring that these are in line and driven by the vision and values of the Trust.
- Gain assurance on the alignment/synergy of the Trust's transformation programmes with the Trust's corporate, clinical and enabling Trust strategies.
- Gain assurance on the alignment/synergy Trust's transformation programmes with the Trust's operating plan.
- Gain assurance on the delivery of the Transformation and improvement agenda, including the identification of any key risks to strategic delivery, an overview of the high- level milestone achievements, delivery of benefits and strategic considerations for stakeholder engagement across Place and System.

Document Control

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MEETING OF THE STRATEGY & TRANSFORMATION COMMITTEE
DRAFT - WORK PLAN 2022/23

	LEAD	FREQ	MAY	JUL	SEPT	NOV	JAN	MAR
SECTION 1 - ADMINISTRATION								
Chairs Report to Trust Board from the previous meeting	Chair	Bi-monthly						
SECTION 2 - STRATEGY								
Strategy Development Programme Update	Emma Hall	Bi-monthly						
Clinical Service Strategy Development	Emma Hall	Bi-monthly						
Enabling Strategies Review – Quality	Talib Yaseem	2						
Enabling Strategies Review – Workforce	Phillip Marshall	2						
Enabling Strategies Review – Digital	Mark Braden/Paul Curley	2						
Enabling Strategies Review – Research & Innovation	Karen Stone	2						
Enabling Strategies Review – MY Healthcare Estates	Mark Braden	2						
Board Assurance Framework - Risks against delivery	Jen Beckett	2						
SECTION 3 – PLANNING								
National Prioritises & Operating Planning 2023/24	Emma Hall	4						
Trust Annual Operating Plan 2023/24	Emma Hall	4						
SECTION 4 - TRANSFORMATION								
Unplanned Care – Highlight Report	Trudie Davies	Bi-monthly						
Planned Care – Highlight Report	Trudie Davies	Bi-monthly						
Ageing Well Programme – Highlight Report	Karen Benstead	Bi-monthly						
Transformation Exception Report*	Trudie Davies	Bi-monthly						
Digital Programme Board Exception Report	Paul Curley	Bi-monthly						
Delivery Against MY Green Plan Update	Mark Braden	Bi-monthly						
SECTION 5 -								
Chairs Report to Trust Board for the current meeting	Chair	Bi-monthly						
Year-End Report including: • Review of Terms of Reference • Work Programme 2022/23 • Self-Assessment Review • Committee Annual Report	Meeting Administrator	1						

*__Please note:__ The Programme Oversight Group will be fully established in July 2022 and therefore the Transformation Exception Report will replace the Unplanned Care, Planned Care and Ageing Well Programme Highlight Reports from this point onwards.

CULTURE AND PEOPLE COMMITTEE

TERMS OF REFERENCE - DRAFT

1. Role of the Strategy and Transformation Committee

The People and Culture Committee (the Committee) is a non-statutory Committee and has been formally constituted by the Board of Directors in accordance with its Standing Orders.

The role of the Committee will be to oversee the development and ongoing implementation of the Trust's Workforce Strategy and cultural improvements so that all staff enjoy a positive working experience and improved health and wellbeing. It will do this by monitoring, reviewing and reporting to the Board on the culture and organisational development of the Trust, providing advice on cultural improvements to Trust Board as part of being a listening organisation.

2. Membership

The following are Board members of the committee:

- 3 Non-Executive Directors including the Trust Chair (one of whom is chair of the Committee)
- 5 Executive/Corporate Directors (Chief Executive, Director of Workforce and Organisational Development, Deputy Chief Executive Officer, Chief Nursing Officer, Medical Director)

The following people will be invited as committee members:-:

- Freedom to Speak Up Guardian
- The 4 Chairs of the staff networks
- Head of EDI
- A staff-side union representative
- Company Secretary
- Deputy Director of Workforce and Organisational Development
- Assistant Director of Organisational Development
- Associate Director of Communications

One of the Non-executive Directors will be appointed by the Trust Chairman as the Chair of the Committee. A further Non-Executive member of the Committee will be appointed as Vice-Chair by the Committee Chair. In the absence of the Committee Chair, the Vice-Chair will chair the meeting.

The Chair of the Committee should ensure the membership promotes equality, diversity and inclusion.

Members of the Committee do not represent or advocate for their respective area of the Trust, but act in the interests of the Trust as a whole.

3. Quorum

The Committee has no decision making authority unless at least 2 of the non-executives and 2 of the Executive Board members (or their deputies) are present. Named deputies will be registered on the attendance matrix. Deputies will count towards the quorum but may not exercise voting rights, unless formally appointed to act up in to Executive/ Corporate Director role during a period of incapacity or to temporarily fill an Executive / Corporate Director vacancy.

4. Attendance

It is expected that each member or named deputy (for Executive Board members) attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy must be identified for Executive Board members of the Committee and must attend when a member is unable to be present. A named deputy will count towards quorum and members should ensure where possible 100% attendance through their deputy.

5. Changes to the Terms of Reference

Changes to the Terms of Reference, including changes to the Chair, Board members or committee members, are a matter reserved to the Trust Board.

6. Administration

The Chair of the Committee will set the agenda supported by the Director of Workforce and Organisational Development. The Committee will be administered by the Corporate Governance Team.

Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than five working days before the date of the meeting.

7. Establishment of sub-committees

The Committee may establish Sub-Committees or groups to support its work. The Terms of Reference of such Sub-Committees will be approved by the Committee and reviewed at least annually. The minutes of any such Sub-Committee will be presented to the Committee at the next available meeting. The Chair of each Sub-Committee will be expected to provide a Chair's report to the Culture and People Committee after each meeting.

8. Frequency of meetings

The committee will meet bi-monthly unless agreed otherwise by the Chair. Meetings will be expected to last no more than 2 hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Committee may be called by any member of the Committee, with the consent of the Chair.

The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

9. Annual Plan

The Committee will develop an annual programme of work for approval by the Trust Board at its first meeting of the financial year. The programme will include a list of all reporting and accountable groups and Sub-Committees and when minutes or reports from those groups will be received.

10. Reporting to Trust Board

The Chair of the Committee will provide a Chair's Report monthly to the Trust Board on its proceedings after each meeting. The Chair of the Committee will draw to the Trust Board's attention any issues of significance, including issues where the committee is unable to provide a satisfactory level of assurance.

11. Status of the meeting

All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee.

12. Monitoring

The Committee will provide the Trust Board with an Annual Report on the committee's performance. This will include levels of attendance, delivery against the work programme and the management of identified risks.

13. Main duties and responsibilities

The purpose of the Committee is to provide assurance and advise the Board of Directors that the Trust is making sufficient progress towards a Fair, Safe and Just Culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff.

The Committee will:

- ensure that the Trust's activities enable colleagues to feel supported in their work, and consistently experience civil and respectful behaviours
- oversee the development of a consistent culture where people feel safe and able to raise concerns and that concerns raised are suitably addressed;
- ensure the Trust's activities are systematically and effectively promoting health and wellbeing, and psychological safety.
- ensure the Trust is actively seeking to reduce inequalities in staff experience and is promoting equality, diversity and inclusion in a systematic and effective way.
- shape, approve and drive the Trust's People and Organisational Development Strategy and assure its implementation to ensure appropriate impact;

- ensure the Trust has a systematic approach to assessing culture, relationships and behaviours within teams and that where issues are identified, each team has a suitable action plan to address any findings.
- shape, approve and support implementation of improvements arising from the triangulation of feedback from staff surveys, exit interviews, Freedom to Speak Up Guardians and other sources.
- oversee the development of the Trust's engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;
- ensure engagement and consultation processes with staff, stakeholders and communities reflect the ambition and values of the Trust and also meet statutory requirements;
- review and drive performance improvement against key elements of the Workforce Strategy including:
    - Equality, Diversity and Inclusion reports and action plans – e.g. Gender Pay, WRES, WDES etc,
    - NHS Staff survey results;
    - GMC/HEE surveys.
    - Feedback from staff in training.
- ensure the Trust's values and appropriate standards of behaviour in accordance with the Standards of Business Conduct/Conflicts of Interest Policy and Professional Leaderships Behaviours, are being practiced throughout the organisation.

Document Control

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COMMITTEE REPORT TO TRUST BOARD – AGENDA ITEM 3.1

Meeting	**Resource and Performance Committee**
Date of meeting	**27 July 2022**
Completed by	**Simon Stone**
COMMITTEE AGENDA ITEMS	
Are there matters of concern or importance to escalate to Trust Board or another Committee?	The cost of the pay award and potential impact of funding it on capital budgets was explored – further clarification expected in September. The extraordinary resilience our staff showed during the extreme heatwave was noted and commended
Where has the Committee received assurance?	Assured that the Trust was still on target to deliver against elective targets but noted that the continued high levels of non-elective work may threaten delivery. Noted continued I&E balance but challenging delivery of CIP target Received the PFI Performance Management Report Reviewed the Annual Equality, Diversity and Inclusion Report, noted progress on the development of Carers Network, Armed Forces Network, Race Equality Network, LGBTQ+ Network and Disability and Long Term Conditions Network. Received the Cyber Security Report and proposed a report by exception approach to highlighting risks rapidly to Board Mrs Halliwell led a discussion on Super Stranded Patients and the new “Reason to Reside” (R2R) measure. The continued challenge of patients who have no Reason to Reside in a hospital bed being unable to get home or find a safe alternative form of accommodation is leading to significant waiting for beds in ED Received an analysis of the performance of our District Nursing Teams against the newly published QNI Workforce Standards. Further work is needed but some assurance was received that caseloads are broadly in line, but some variation needs exploring.
Has the Committee asked for any further action to be taken, if so, what action, by whom and within what timescale?	No
ANY OTHER MATTERS TO BE REPORTED TO TRUST BOARD	
COMMITTEE ADMINISTRATION	

Committee Self-Assessment for 2021/22 complete?	**Yes**
Terms of Reference up to date?	**Yes**
Workplan up to date?	**Yes**
Committee Annual Report due?	**No**

The Mid Yorkshire Hospitals
NHS Trust

Trust Board Performance Report

8th September 2022

Working together
making a difference

Table of Contents

Strategic Goals

The Trust has six strategic goals that support delivery of the Trust vision of an excellent patient experience each and every time. Each strategic goal has identified themes to describe delivery and also have identified metrics to track progress.

The Trust has also developed two Key Initiatives that will help monitor progress related to the NHS People Plan (MY Green Plan, which sets out the trust's decarbonisation journey and broader sustainability programme, and Health Inequalities).

Performance Overview – July 2022

Strategic Goal 1: Keep our patients safe at all times

Patient safety is of paramount importance, with the Trust committed to keeping patients safe at all times.

Theme:	Current Performance against key indicators within Theme	Direction of Travel
Safe Staffing	🟢 🟢 🟢 🟢	→
Incidents	🟢 🔴 🟢 🔴 🔴	↑
Safe Place	🔴 - - - -	→

Strategic Goal 2: Deliver excellent patient experience and expected outcomes

Achieving the Trust's vision means providing an excellent patient experience to the people we serve every time they encounter the care we deliver. Waiting times for services are a significant factor in excellent patient experience and have been severely affected by the Covid-19 pandemic.

Theme:	Current Performance against key indicators within Theme	Direction of Travel
Waiting Times	🟢 🔴 🔴 🔴 🔴 🔴 🟢 🔴 🔴 🔴 🔴 🟢 🟢 🟢	→
Improved Outcomes	🔴 🔴 🔴 🟢 -	↓

Strategic Goal 3: Be an excellent employer

The Trust values its staff and aspires to be an excellent employer: one which people choose to join, want to stay and where they can develop. The Covid-19 pandemic has seen Trust staff continuously go above and beyond to respond and provide patients with the best care possible.

Theme:	Current Performance against key indicators within Theme	Direction of Travel
Health and Wellbeing	🔴 🔴 🔴 🔴	↓
Full Staffing	🔴	→
Staff Experience	🔴 🔴 🔴	↓
Leadership & Development	-	-

Strategic Goal 4: Be a well led, sustainable Trust with sound finances

The Trust is an NHS organisation with the responsibility for providing the best value for the use of the public's money. The Trust will ensure its leaders support the vision, share the values and behaviours, and pledge to spend resources to meet the objectives.

Theme:	*Current Performance against key indicators within Theme*	*Direction of Travel*
Finance		
CQC	-	-
Clinical Service Strategy	-	-

Strategic Goal 5: Have Effective Partnerships that Support Better Patient Care

The direction of the NHS is to work more collaboratively with other providers and commissioners for the benefit of patients and to safeguard the sustainability of services. For example, the White Paper published in February 2021 on the future configuration of the NHS places even greater emphasis on collaboration and integration.

Theme:	*Current Performance against key indicators within Theme*	*Direction of Travel*
Collaboration	-	-

Strategic Goal 6: Provide Excellent Research, Development, and Innovation Opportunities

As a learning organisation with three acute hospitals and vibrant community services, the Trust is perfectly positioned to actively participate in research, development, and innovation opportunities. Enhancing the Trust's involvement in these will strengthen our offering to patients and staff.

Theme:	*Current Performance against key indicators within Theme*	*Direction of Travel*
Teaching Status	-	-
Research Facility	-	-
Innovation	-	-

Key Initiative 1: MY Green Plan

The Trust will have a board-approved Green Plan that responds to climate change and contributes towards us achieving net zero carbon emissions, by 2038 and 2045 for direct and non-direct carbon emissions respectively.

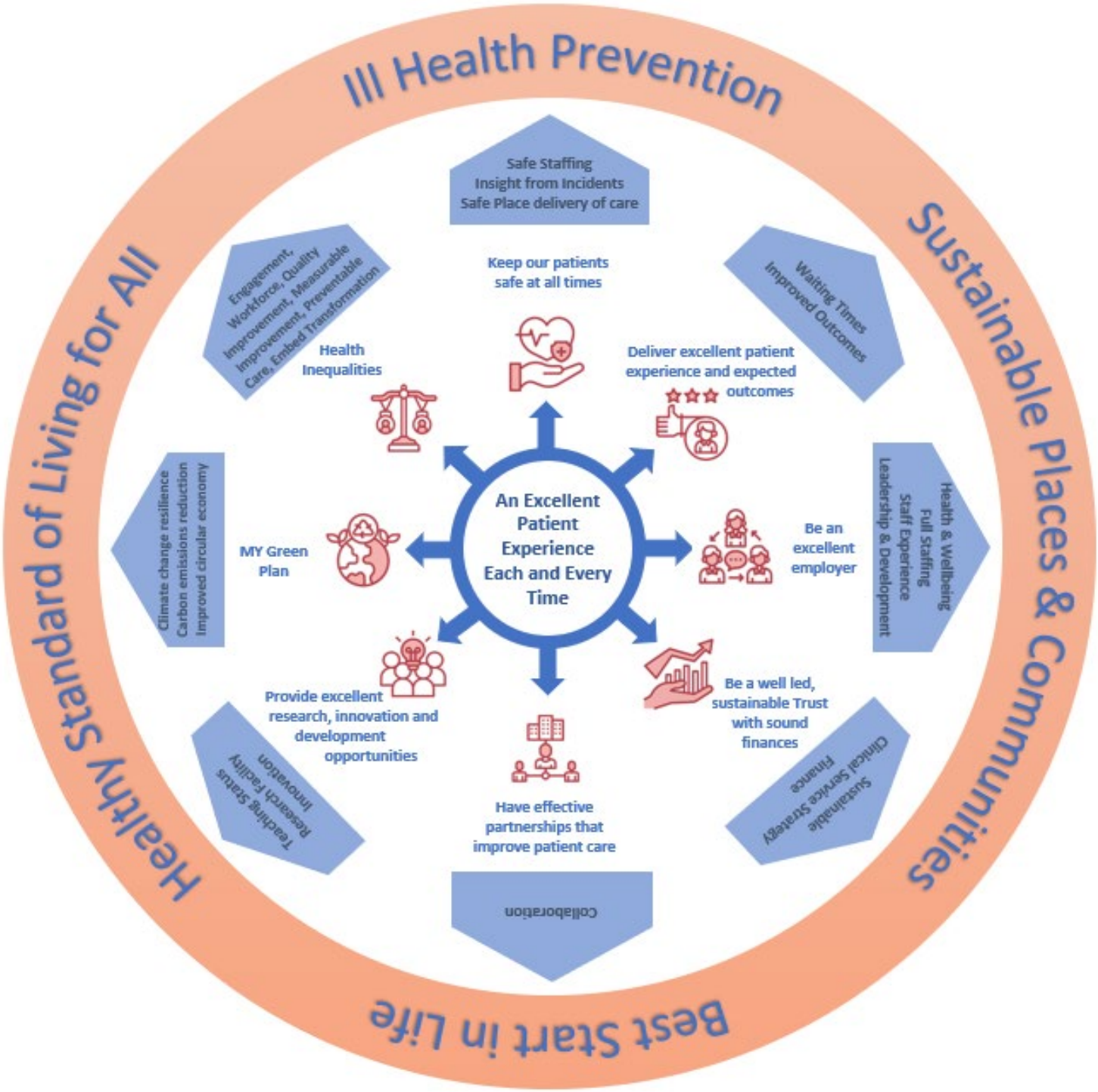
Theme:	*Current Performance against key indicators within Theme*	*Direction of Travel*
Sustainability/Green Plan	-	→

Key Initiative 2: Health Inequalities

The Trust will work with system partners to improve health and access to health and social care, ensuring inequalities are considered and addressed through access to, experience of, and outcomes from clinical services. The Trust will also maximise social value through employment, procurement, environmental impact, and facilities.

Key Initiative:	*Current Performance against key indicators within Theme*	*Direction of Travel*
Engagement	-	-
Workforce	-	-
Quality Improvement	-	-
Measurable Improvements	-	-
Preventative Care	-	-
Embed Transformation	-	-

Detailed Performance



Detailed Performance – Introduction

The following pages in the Detailed Performance section provides a month-by-month breakdown of performance dating back to April 2021 (where available). Where it's possible, a forecasted position has also been included to gain some insight into the potential direction of travel based on historic performance.

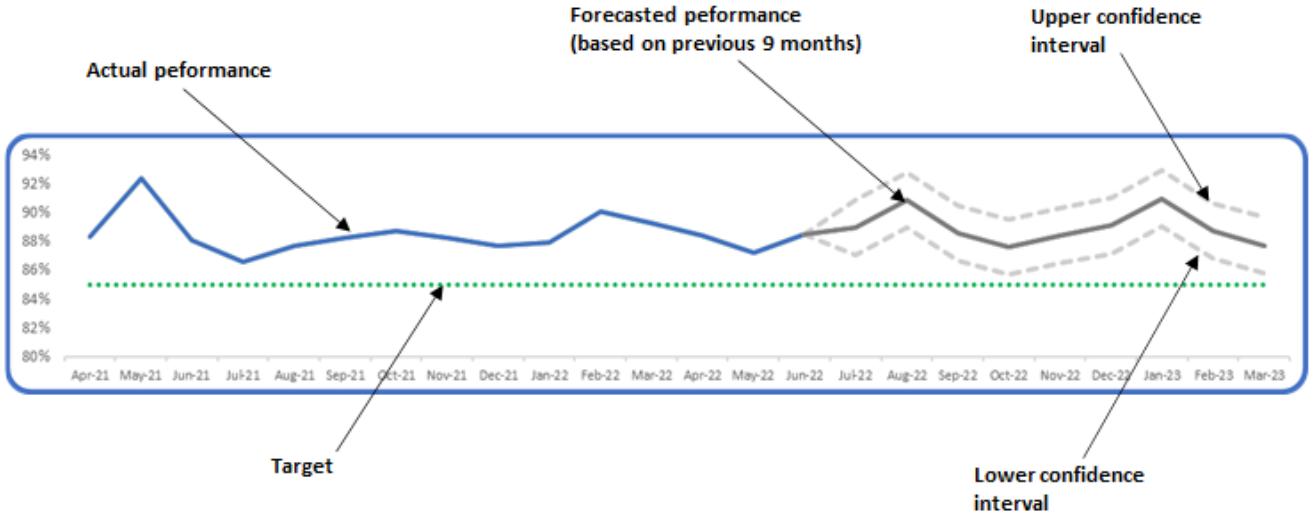
Current Performance Overview

Key Indicator achieving target (current month)

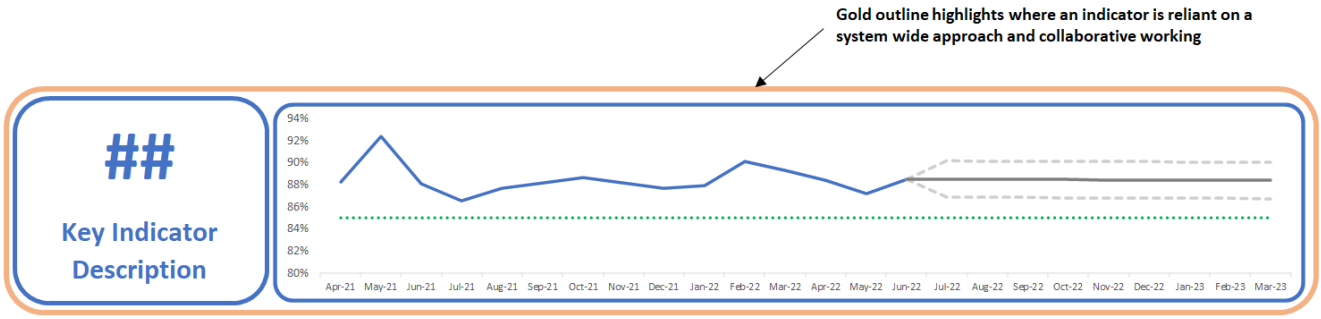
Key Indicator not achieving target (current month)

No target assigned

Month to date performance, including forecast to year-end



Identifying indicators that are reliant on a system wide approach and collaborative working



Strategic Goal 1: Keep Our Patients Safe at all Times

Theme 1.1 Safe Staffing

Nursing and Midwifery recruitment and retention remains a priority. Whilst the vacancy position is improving, the commitment to Domestic and International recruitment, and the investment in developing and retaining a skilled registered workforce remains crucial; especially acknowledging the risk associated with an aging workforce nearing retirement.

In view of the current Health Care Assistant (HCA) vacancy, a review of the HCA workforce, recruitment pipeline, training academy and pastoral support required to grow, retain, and sustain our HCA workforce has commenced. The current fill rates reflect the current vacancy position compounded by staff unavailability and the sustained requirement to staff extra capacity beds. In addition, patient acuity and dependency has significantly increased requiring enhanced care, placing additional demands on staffing.

Real time staffing decisions are managed utilising SafeCare data, ensuring staffing decisions pay due consideration to capacity, patient acuity, dependency, skill mix and live incident mapping (Red Flags). Annual workforce reviews adopt a triangulated approach to ensure staffing models meet the demand, acuity, and dependency of our patients, which includes a skill mix review and the use of alternative workforce models.

It is nationally recognised that the NHS in England has a shortage of medical workforce at consultant and senior-training grades, in addition there is a shortfall regionally between the number of training posts established within Trusts and the number of doctors working within HEE training programmes. This differential in numbers is also affected by the numbers of doctors in training who are now opting to undertake training on a less than full time basis.

Locally there are particular challenges at Consultant level in Emergency Medicine and Acute Medicine which mirror the national challenges in these particular specialties. Other challenges at this level include ENT and Ophthalmology where despite advertisement the Trust has been unable to fill all vacancies. The Trust has a number of vacancies across doctors in training grades with specific challenges being observed within Emergency Medicine and at Registrar level across the medical specialties. In addition, there are challenges at Registrar level in paediatrics and obstetrics & gynaecology.

It is in this national, regional, and local context that the medical workforce within the Trust is planned and managed.

The Trust and its services adopt proactive and innovative approaches to managing the medical workforce, to ensure that sufficient appropriately skilled medical staff are available to provide safe care and treatment and achieve good outcomes. This includes:

- Medical staffing is planned across sites
- Informed and innovative rota designs
- Promotion of the use of SAS doctors
- Development and implementation of the Trust's own internal training programme, aimed at doctors from overseas
- Successful use of international recruitment initiatives at all levels
- Recruitment pipeline with proactive engagement of senior-trading grade doctors
- Proactive and effective use of locums at all grades

Theme 1.2 Insight from Incidents

Infection Prevention & Control:

Implementation of the 'National Standards of Cleanliness' has commenced and will be ongoing throughout 2022/23.

- MRSA – The Trust has reported 1 MRSA blood stream infection against a trajectory of 0. Each case is reviewed, and the lessons learnt are included in the Trust MRSA Reduction Plan and are reported through the Patient Safety and Clinical Effectiveness Sub-Committee and the Infection Prevention and Control Committee.
- Gram Negative Blood Stream Infections – 16 cases were reported in the reporting period. These include cases of MSSA, E. Coli and Klebsiella. No cases of Pseudomonas were reported. Each case is reviewed, and the lessons learnt are included in the Trust Gram Negative Reduction Plan and are reported through the Patient Safety and Clinical Effectiveness Sub-Committee and the Infection Prevention and Control Committee.

Never Events:

The Trust takes the learning from never events extremely seriously. In each previous never event, a comprehensive investigation is undertaken using a human factors and systems-based approach, this informs the development and implementation of robust action plans to strengthen the systems to prevent a similar incident happening again. We continue to monitor these actions through our quality assurance process, with oversight at the Trust Never Event Group. The Trust's commissioners have oversight of completed investigations and action plans.

The Trust continues to work collaboratively with safety leads from across the region in the West Yorkshire Association of Acute Trusts (WYAAT) Learning Group. Learning from Never Events is shared with organisations across the WYAAT and internally through the Patient Safety Panel and Patient Safety Bulletin.

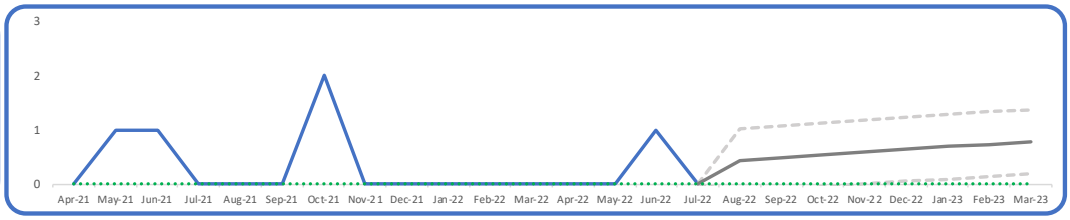
Incidents that are harmful:

The proportion of harm continues to be over the <27% trajectory, driven by a decrease in the reporting of 'no harm/near miss', incidents along with a slight increase in the reporting of 'low harm' and 'moderate' incidents. Additional contributing factors to the rise in incidents graded as harmful are Hospitals Onset Covid Infection (HOCI) incidents to be graded moderate/Severe or Death and are included within these figures. The Trust has a backlog in incident investigations on Datix, this is important as the investigation outcome informs if the incident is graded correctly.

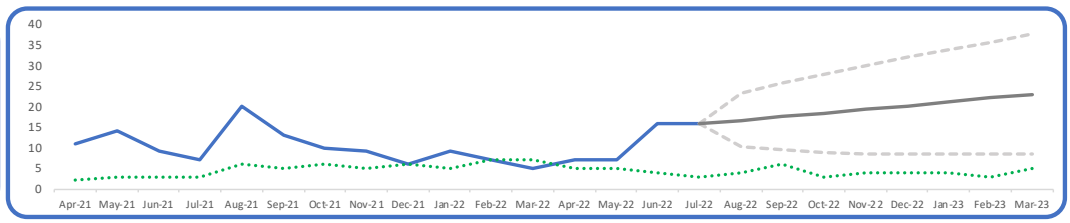
The Datix team circulate a monthly 'Incident Performance Report' to the Senior Leadership Team in all Divisions, to provide oversight of all incidents, including backlog of investigations, proportion of incident grading and hotspot Wards/Departments.

It is important to note that the 'incidents that are harmful' measure should not be viewed in isolation but utilised as a tool in triangulation of multiple patient safety measures. The National Reporting & Learning System (NRLS) is a system designed to support learning and reflect the reporting culture at the submitting organisations and understand how our Trusts reporting 'trend and patterns', measure up to other similar size Trusts.

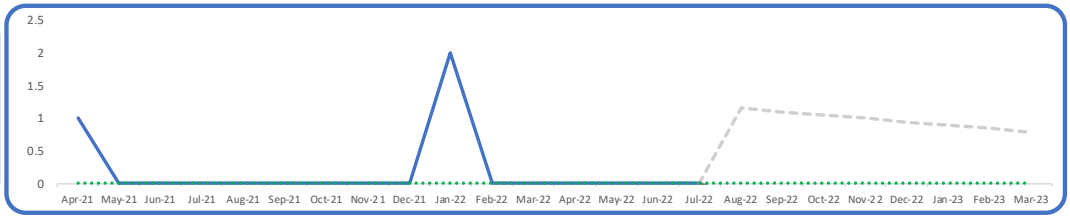
0
Preventable MRSA Cases



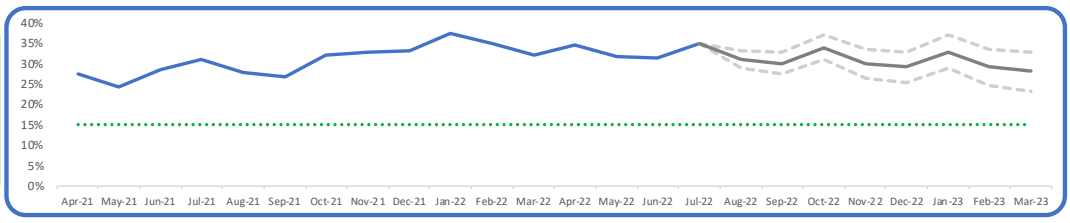
16
Gram-negative bloodstream infections



0
Never Events (2022/23)



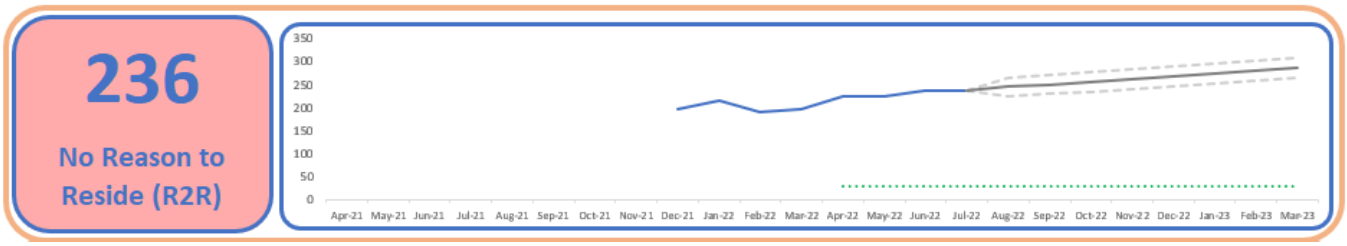
34.9%
Incidents that are Harmful



Theme 1.3 Safe Place Delivery of Care

A verbal update on Safe Place Delivery of Care will be available for the board, and written content in next month's report. This theme will be delivered by close and effective system working with partners.

Going forward the report will include information on Non-medical MH Admissions, Delayed MH Transfers (>24hrs), Virtual Ward Beds (Frailty) and Virtual Ward Beds (Respiratory).



Strategic Goal 2: Deliver excellent patient experience and expected outcomes

Theme 2.1 Waiting Times

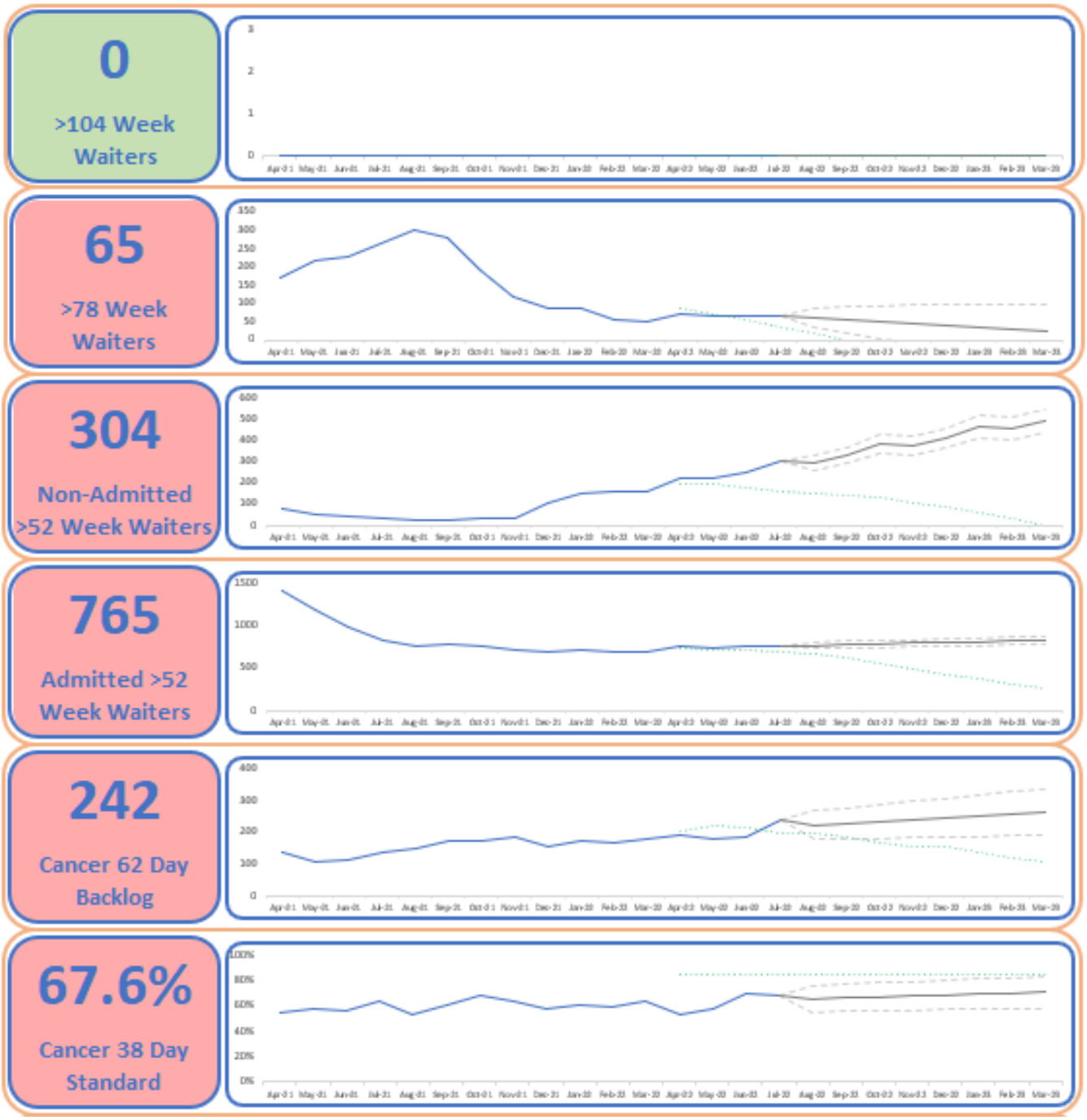
Delivery of planned care access targets including cancer and diagnostic services, is reliant on effective system working and strong partnerships with primary care colleagues. The focus of the planned care services at the Trust is to continue on the reduction of longest waiting patients and the treatment of cancer and clinically urgent patients. The System has a local target to have zero patients waiting over 78 weeks by the end of September. All services are concentrating on ensuring patients are booked and have a plan to receive treatment by that deadline; theatre capacity has been prioritised and the surgical management teams are working closely with clinicians to micromanage the booking and preparation for those operations. As of the end of August it is predicted that by the end of September there will be just up to 25 patients who will have waited over 78 weeks for treatment, these patients are in the services that are under the most pressure and have struggled significantly to reduce their waiting times or having to prioritise cancer patients ahead of the longest waiters.

The Trust has also committed to reducing waiting times to below 52 weeks by the end of March 2023. All services are working towards improvement trajectories to meet this standard however there are a small number of services with demand and capacity imbalance and workforce challenges who are raising a risk. The Trust is seeing increased demand for elective services this year and this has added additional pressure.

The Planned Care Redesign programme is assisting services to transform delivery models and address historical demand and capacity imbalances, as well as clear the backlog that was increased significantly through the pandemic. The programme will focus on 'back to basics' operational management as well as digital transformation and partnership working across health and social care, to transform the way people access healthcare.

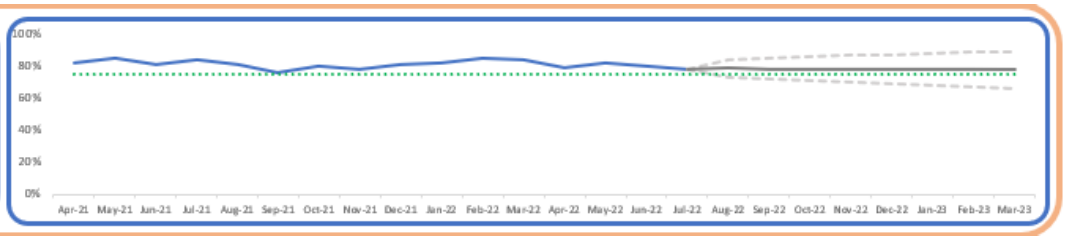
Delivery of urgent care access targets is reliant on system partners working together. Since the RPIW in May 2022 there has been an evidenced and sustained improvement in ambulance handover times. All of the >60 minute ambulance handover breaches referenced in this report occurred in a cluster on Friday 22 July (x6) and these were linked to significant system pressure, high conveyances within a very short period of time and poor hospital flow. A full review of causative factors and associated actions to recover was undertaken. Performance recovered quickly after this period with no further breaches during the month. An unintended consequence of prioritising ambulance handovers based on the system risk profile has seen an increased incidence of crowding within the ED at PGH specifically which is being closely monitored by the teams with associated extended waits in the department.

The number of patients in the ED > 12 hours is being monitored by Mid Yorkshire Hospitals as part of the suite of metrics linked to our national pilot status and does not yet form one of the key national standards. Nevertheless, this forms a key element of risk assessment linked to the evidenced adverse impact on patient outcomes following an extended stay in the Emergency Department. A 2% tolerance has been proposed nationally to reflect the complex patient management within Emergency Departments. At Dewsbury Hospital this standard is regularly achieved and there have been no breaches of the 2% since September 2021. All of the significant waits have occurred at the Pinderfields site. The principle reasons for this are a) high attendance and conveyance numbers resulting in significant numbers of patients within the ED at PGH (the department is formally crowded at more than 75 patients but regularly has extended periods with 100+), b) prioritisation of ambulance handovers increasing the patient numbers within the ED based on the system risk assessment, c) staffing gaps and associated delays in patient assessment and treatment planning / delivery and d) slow outflow from the department once a decision to admit has been made and the patient is ready to leave the ED following completion of ED related care and treatment. All of these elements are being addressed through the unplanned care programme at local, place and system level.



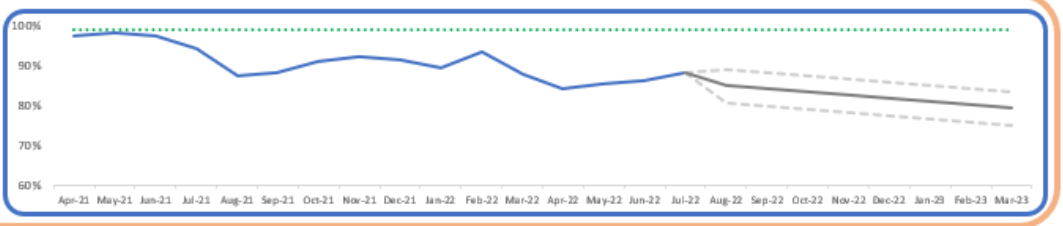
78.3%

Cancer 28 Day Standard



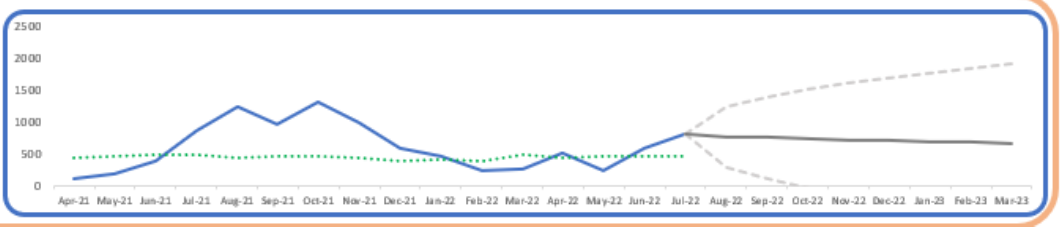
88.2%

Diagnostic >6wk Waiting Time



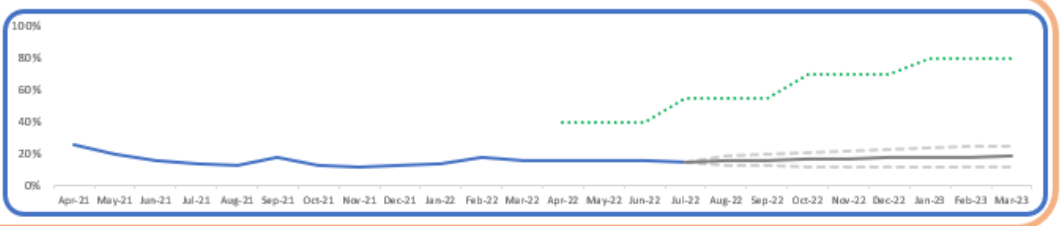
816

12hrs in Department (2% Allowable)



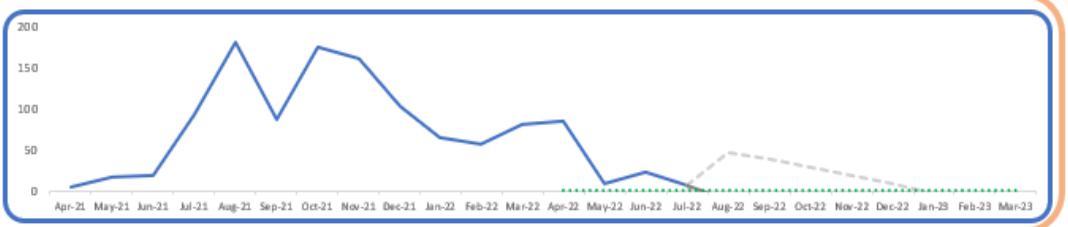
14.7%

Ready to Admit (RTA) Waiting <60mins



6

Ambulance Handovers >60mins

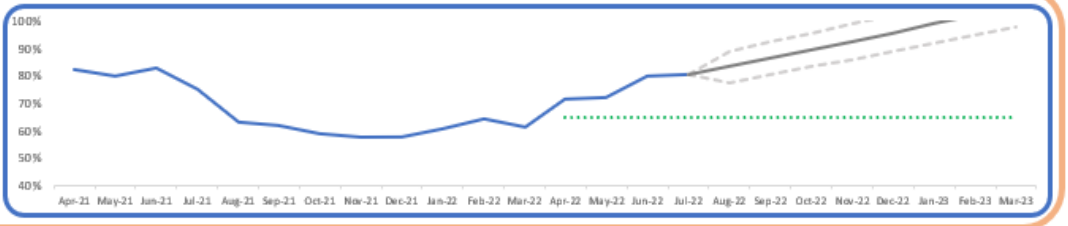


96.3%

Ambulance Handovers <30mins

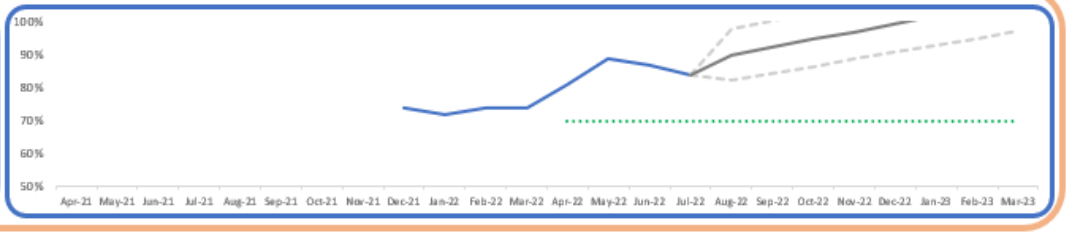
80.5%

Ambulance Handovers <15mins



84.0%

2hr Urgent Community Response



Theme 2.2 Improved Outcomes

Complaints

There has been an increase in the number of formal complaints received in July 2022 (103) compared to 68 received in June 2022. The increase in number is thought to be attributed to the number of patients attending hospital services and system pressures on capacity and demand. Key themes remain consistent; 'communication', 'clinical treatment' and 'respect and dignity'. Work continues on the planned care redesign programme with a key feature being personalised care and how this can be taken forward within the organisation.

Staff attitude

There has been a continual increase, month on month, in the number of formal complaints received that cite staff attitude as a cause for dissatisfaction. This increase has been shared at Divisional Governance meetings. The Patient, Carers and Families Experience and Engagement Framework has been refreshed, with a focus on positive communication. Improvement actions include; a 'Customer Care' training course has been developed by Organisational Development and rolled out across the organisation for staff to access which emphasises compassionate care and different communication models. The Trust is re-visiting the 'Hello My Name Is' and 'Please call me' initiatives. The Framework action plan and dashboard are monitored and reported on monthly at the Patient Experience Sub-Committee and Quality Committee

Patient FFT Response Rate

There has been an increase in the overall number of responses for June 2022, (9,222) compared to May 2022 (8,741) with Inpatient and Day case areas reaching the local target of 20%. The lowest area of achievement remains from Outpatient services (June 3.5%). SMS text messaging of FFT for Outpatient attendances has commenced August 2022 as an additional mode for completing the survey and should lead to an increase in response rates. All areas are being encouraged to continue to promote the offer of patient FFT via their ward/service improvement plans.

Going forward the report will include information on Inpatient Survey: Patient Discharge

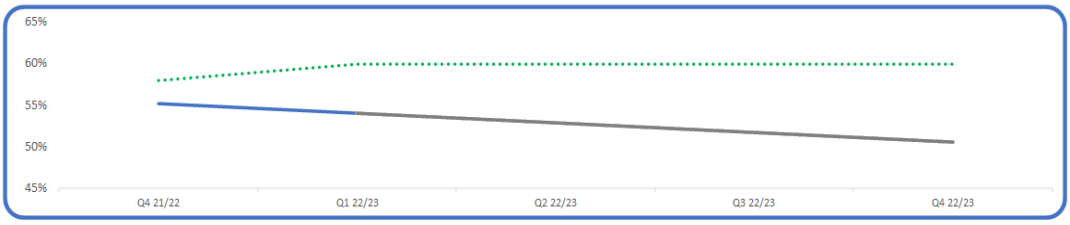
Strategic Goal 3: Be an Excellent Employer

Theme 3.1 Health & Wellbeing

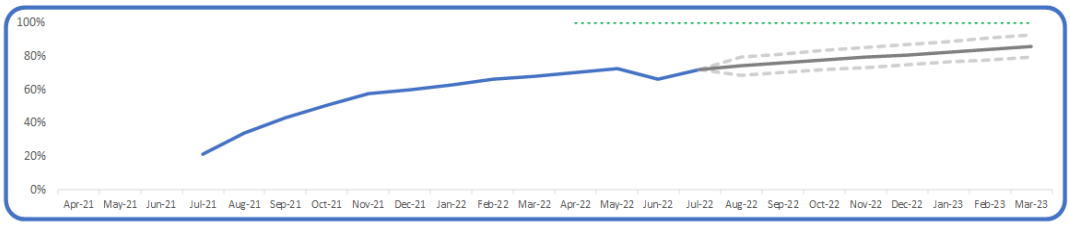
As one of the indicators for health and wellbeing our staff sickness rate continues to fluctuate in line with subsequent waves of covid infection affecting the workforce. Over and above ill health, with notable mentions for MSK, Stress, Anxiety and Depression; attendance levels are influenced by many factors including organisational culture/staff engagement. Work is underway to continue to promote Health & Wellbeing conversations and to develop the capability and capacity of line managers to support staff as effectively as possible. Linked to this we are also undertaking a root and branch review of some of our key policies – such as the managing attendance policy to have a greater focus on promoting health and wellbeing – recognising that the application of such a policy has greater potential impact if it helps to reduce illness and promote wellbeing.

Operating plans describe ambitions to expand Occupational Health to provide more preventative interventions for MSK related illness, subject to availability of resources. As a Trust we continue with our investment in the provision of mental health and psychological support services for staff (including but not limited to our Employee Assistance programme).

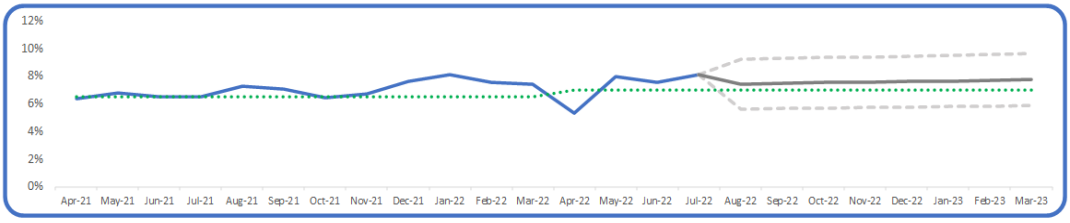
54.1%
Recommend place to work



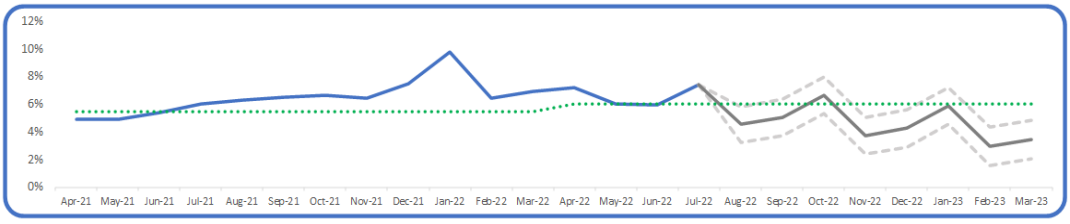
72.2%
Health & Wellbeing Conversation



8.10%
Vacancy Rate
(including Jnr Drs in training)

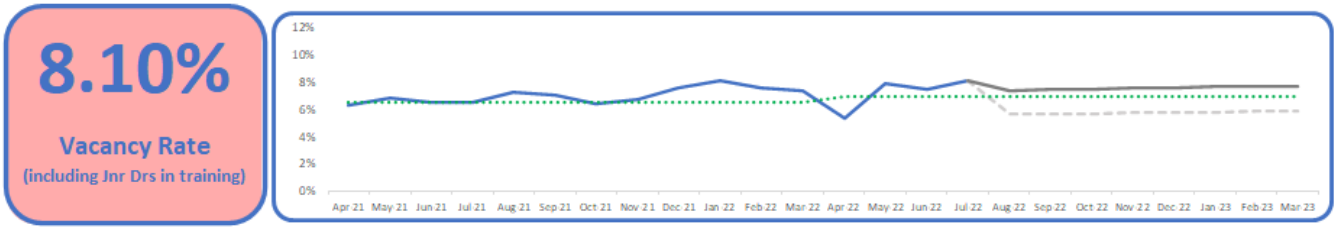


7.41%
Staff Sickness



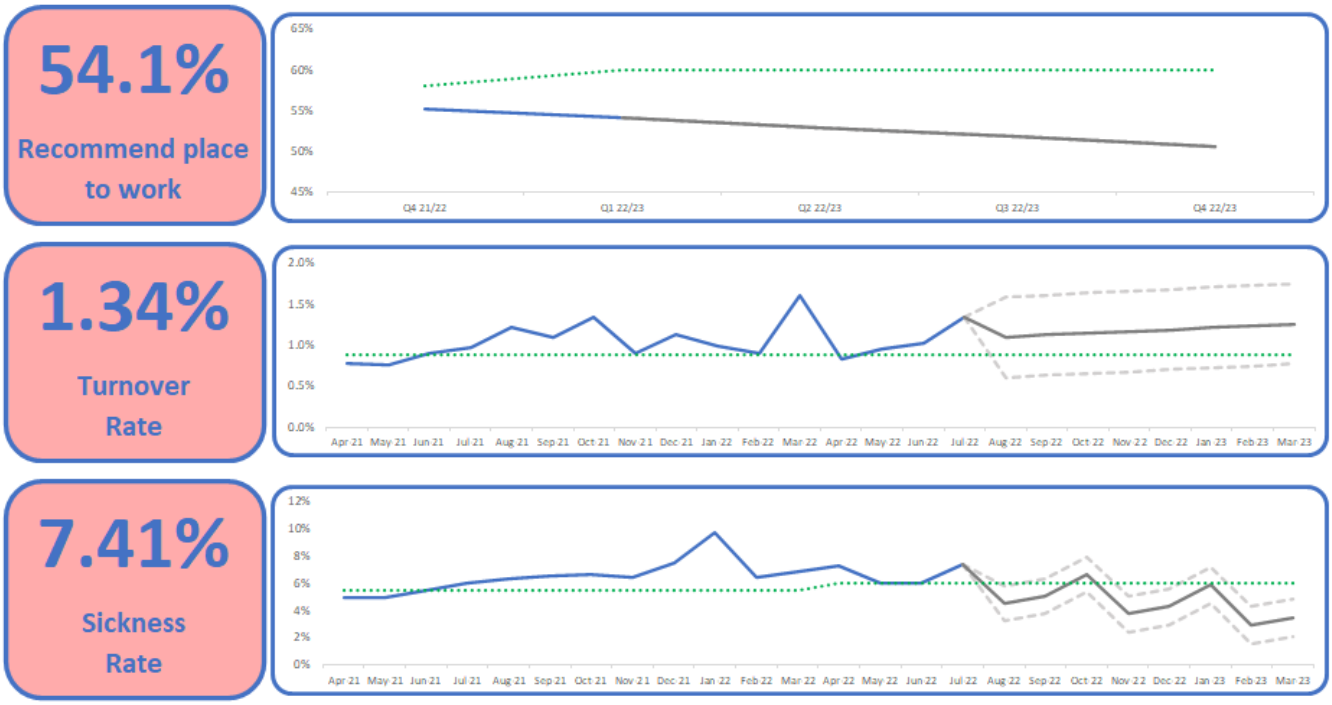
Theme 3.2 Full Staffing

Vacancy rates have fluctuated in recent months has the Trust has grown its funded establishment in various areas. The observable drop in April being best described as an anomaly as budgets and establishments were reworked and corrected. However, the beginning of a reduction in the vacancy rate can be observed. This can be primarily attributed to high recruitment activity across the organisation with specific campaigns for Health Care Assistants and large campaigns in EFIT and other administration and clerical teams. Our international recruitment work goes from strength to strength for Registered Nurses and we are increasing our numbers in other areas such as midwifery. We are also currently about to undertake a pilot to directly recruit nursing associates.



Theme 3.3 Staff Experience

It is important to recognise the absolute significance of retention and its links to delivering on vacancy reductions. The work underway with regard to cultural improvements (People and Culture Committee, A Kind Life, Scoping of a staff engagement platform) and initiatives to further improve staff engagement are essential to achieving that goal. Similarly making the case for embracing flexible working is a key project that is underway.



Theme 3.4 Leadership & Development

A verbal update on leadership and development will be available for the board and written content in next month's report.

Strategic Goal 4: Be a Well-led, Sustainable Trust with Sound Finances

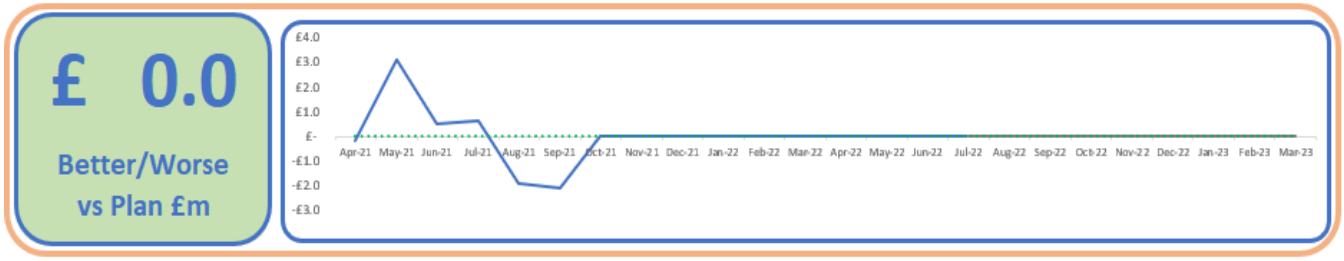
Theme 4.1 Finance

Following confirmation of additional national funding to support inflationary pressures a revised breakeven plan has been agreed by the Trust. YTD the Trust is achieving this breakeven position and forecasting delivery for year end. Key risks to delivery include non-achievement of waste reduction (£26m annual plan), increased costs from non-elective demand and increased bed capacity open above planned capacity. Additional national funding secured for Wakefield place (£3.2m) in August is to be managed through the winter boards; it is intended this will provide some mitigation for these increased costs.

Elective Service Recovery Funding (ESRF) is assumed to be secured in full for the first half of the year, this is fixed but for the latter half this will revert back to being dependant on delivery of the 104% activity target and presents the largest risk to financial delivery.

The trust is planning a non-recurrent £4m PFI change of Law risk transfer in year, this requires DHSC and NHSE approval, should this not be achieved it will present a risk to delivery of the plan.

Pay award funding is expected to flow in M5, including backdates to April 2022, the trust anticipates a £1.6m pressure on this which will need mitigating from further waste reduction schemes to deliver the trust plan.



Theme 4.2 CQC

The planned milestones for Quarter 1 were superseded by the unannounced CQC inspection of Trust services in March 2022 (Quarter 4, 2021/22) and April 2022 (Quarter 1, 2022/23). The inspection included re-inspection and rating of four core services across the Pinderfields Hospital and Dewsbury and District Hospital sites (urgent and emergency care, medical care, services for children and young people, and maternity services), in addition to well-led at trust level. The inspection cycle is on-going at the time of writing, although the on-site activity concluded in April 2022.

The Trust received the draft inspection report on 29 July 2022 and completed the factual accuracy checking process of the report on 26 August 2022 in line with the timescales agreed. The Trust is now awaiting the outcome of the factual accuracy checking process and final reports. On receipt of the final inspection report, the action planning process to address the improvement recommendations will commence.

As the re-inspection took place sooner than anticipated and given the findings of recent inspections of other providers, there is a risk of not achieving the overall trust rating of “good”.

Theme 4.3 Clinical Service Strategy

A verbal update on Clinical Service Strategy will be available for the board and written content in next month’s report.

Strategic Goal 5: Have Effective Partnerships that Improve Patient Care

Theme 5.1 Collaboration

The Patient Initiated Follow Up (PIFU) rollout within MYHT is due to complete its phase 1 delivery of "PIFU to Discharge" by October 2022, with this version of PIFU being available across all suitable outpatient clinics. Currently this is available across 80% of the acute specialities with the remaining few scheduled for delivery throughout September. This will enable all clinics to provide the PIFU pathway that results in a discharge from the Trust. In addition, long term/Chronic Conditions PIFU has been developed and successfully trialled within Rheumatology and is being rolled out across other suitable specialties. In July 2022, 2.1% of patients were placed on the PIFU Pathway from total outpatient appointments, in line with national targets. Given more specialities are now using PIFU and the increased number of eligible patients given the Chronic Conditions pathway, the PIFU numbers are forecast to continue to rise in line with targets.

Advice and guidance delivery via the Shared Referral Pathway remains consistently above the NHS England targets (July 2022 actual 24% vs national target of 12%). A national decision is anticipated that will incorporate clock stops generated via advice and guidance/ shared referral pathway will be included in Trust performance data; this would increase the Trust's referral to treatment completion position by 11% based on approximately 2,700 referrals.

Strategic Goal 6: Provide Excellent Research, Innovation and Development Opportunities

Theme 6.1 Teaching Status

The Medical Director and her team have been working closely with colleagues from the University of Leeds Medical School to take forward actions to support the Trust being in a position to apply during September 2022 for a change of its establishment in order to reflect the significant teaching commitment we make. This has included:

- The establishment of a Joint Partnership Board with the first formal meeting to be held in early October 2022 and further meetings scheduled during each of the University Trimesters.
- Carrying out an internal and external consultation on the proposed renaming of the Trust settling on Mid Yorkshire Teaching NHS Trust. Support for both the application for teaching status and the choice of name has been received from all external stakeholders.
- Identification of the University nomination for the initial role of Associate NED until formal teaching status is awarded whereby the post will convert to a full NED basis.
- Development of a portfolio of evidence which will be completed during early September to support the application for teaching status.

Once the formal application for a change to our establishment order has been submitted the timescales for consideration of this and the necessary legal process required is out with the control of the Trust and it is hoped that this will be completed by 31st March 2023.

Theme 6.2 Research Facility

The consultation with staff affected by the change has been completed and moves are scheduled to take place during the first two weeks of September.

An architect has been engaged to develop the plans for the conversion required to transform the facility from the current office usage to a mixed office and clinical space. This design has been completed and we are awaiting the costed programme for this conversion. Once this has been received a formal business case and phased work programme will be developed for presentation and approval. Until this costed plan has been provided the timing for the conversion work programme cannot be identified, it is there highly likely that the Clinical Research and Improvement Building will not be completed and open in its final configuration by 31st March 2023. The Research Team will be housed in the building by this date, and it is hoped that some limited clinical space will be available at that time. The Innovation Hub will be available at the same time as the Research Teams occupy the building in mid-September 2022 but will not occupy its final space until all the building works has been completed.

Theme 6.3 Innovation

There is good momentum in innovation in the Trust at the moment. We have had strategic meetings with innovation colleagues from the University of Huddersfield to discuss workforce development and leadership training, as well as NHS-focused innovations such as medicines, medical technologies, digital, diagnostics, and ways of working.

Building starts this autumn on the Health Innovation Campus at the University of Huddersfield, which will provide some excellent opportunities for joint appointments, education, research, and innovation. We have also been meeting with colleagues from the University of Leeds in relation to teaching hospital status. To mature innovation within the Trust, we will build innovation projects for grant submissions in collaboration with universities. The first Yorkshire Spread and Scale Academy is being hosted by Mid Yorkshire in September. Supported by our innovation colleagues from Cardiff and Vale Health Board, 24 teams and over 100 participants will attend the three-day event, which will boost innovation and help us to identify initiatives that will be eligible for external funding. The asthma health inequality project being led by Dr Llinos Jones, Respiratory physician is underway in collaboration with the University of Huddersfield. Results from the project will be available early in 2023.

Within the Trust, Innovation Clubs are being held once every three months, and the Innovation Review Group will hold its first meeting in September. The Trust has submitted projects to the Medipex NHS Innovation Awards and Showcase, which will be held in October. Risks to innovation as a strategic goal relate to staff resource. There is an urgent need for an innovation manager and dedicated administrative support, particularly with the innovation opportunities that the Mid Yorkshire Clinical Research and Innovation Building will provide.

Key Initiative 1: MY Green Plan

Theme 1.1 Carbon Emissions Reduction

The following table shows the current position from the perspective of charting the organisational net zero journey for emissions under the trust's direct control, with reference to the last three financial years. The figures show that whilst emissions have reduced – compared to the 2019/20 baseline year – the percentage decrease is not as pronounced as it needs to be as of yet, wherein the reduction should have been 10.5% by the end of March 2021 but was only 2.8%.

		Carbon Reduction Tracker			% emissions change to date against BY	Latest social cost of carbon (£)
Emissions categories	Units	2019/20 FY (BY)	2020/21 FY	2021/22 FY		
Scope 1 - Direct emissions	kgCO2e	12,371,398	12,050,308	12,509,303	1.1%	£863,142
Scope 2 - Indirect emissions	kgCO2e	8,085,990	7,423,937	6,745,782	-16.6%	£465,459
Scope 3 - Upstream/downstream emissions	kgCO2e	5,423,169	4,701,778	5,910,861	9.0%	£407,849
Total Emissions	tCO2e	25,881	24,176	25,166	-2.8%	£1,736,450

Theme 1.2 Sustainability/Green Plan

Progress has been made with the actions assigned against sustainability under the existing annual operating plan structure, and detail is available to the Board if required. The progress includes the development of a three year green plan which was requested by NHSEI. This is compliant with central requirements, was board-approved in March, and was shared with the ICS and Greener NHS as instructed.

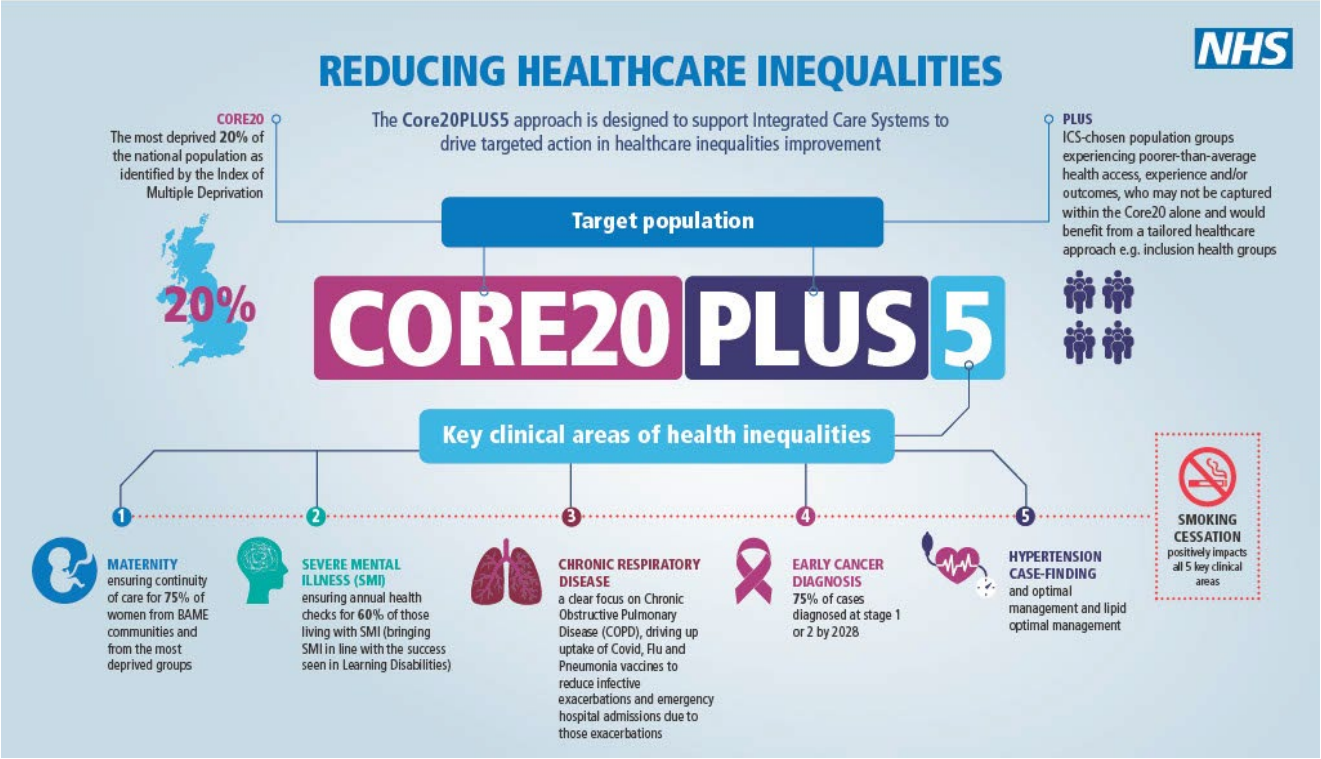
The plan for the next 6 months is to continue to lay the foundations for future success and to work towards the targets within the trust's AOP, whilst also broadening out the breadth of requirements to encapsulate the actions detailed in MY Green Plan. This establishes the full programme of work for this financial year, and the next two thereafter. The sustainability function should hopefully be fully resourced by early January 2023, which will allow work to be scaled up significantly. In the meantime, the immediate priority surrounds the Trust's attempts to bring capital grant funding into the organisation to help deliver energy efficiency improvements and deep heating-centric decarbonisation projects. To meet these ends we are preparing to submit a multi-million pound bid into the Salix Public Sector Decarbonisation Scheme (PSDS).

Key Initiative 2: Health Inequalities

The Trust is evolving its approach to reducing Health Inequalities to be more person-centred, proactive, and preventative. The aim is to create a Trust culture that considers health inequalities in all aspects of its delivery of care and empowers staff to develop projects and implement real change to the care, experience and outcomes of people using our services.

Although there remains a health inequality lens on elective waiting lists to minimise any variation that exists in time to first appointment, diagnostics and treatment that is incorporated in our key role as a care provider, the Trust approach is expanding to recognise how it can support our local partners to help to reduce inequalities and our role as an anchor organisation.

The delivery of our strategy will be underpinned by the Core20Plus5 approach to address the 20% most deprived of the national population, to reach out and include population groups with protected characteristic and address five clinical areas of focus.

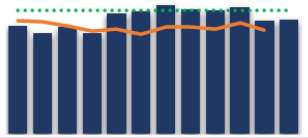
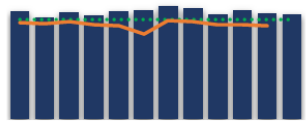
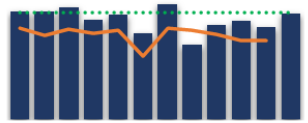
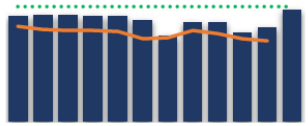


As a result, the terms of reference for the Trust's Health Inequalities Steering group have been updated to incorporate a membership that reflects a wider system view, such as stronger links to the voluntary sector, and has representation from operational leads who can deliver our shared strategy. It will aim to improve co-production, better communication, and raise overall awareness of the need to address this challenge.

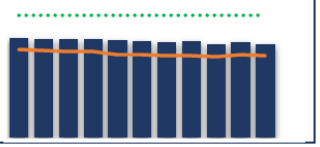
The Steering Group will also deliver an action plan based on the themes of Engagement, Workforce, Quality Improvement, Data Driven & Measurable, Preventative Care and Embedding into Operations and Transformation.

Benchmarking (England non-specialist Acute Trusts)

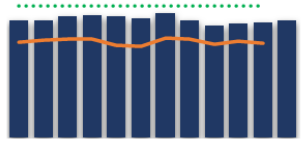
Cancer Pathways

Key Measure	Desired Direction	Target	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Financial YTD	National	ERP	Op. Plan	Local	Monthly Trend (National Avg. / Target)
Cancer 2 Week Performance	High ↑	93%	81.2%	75.8%	80.1%	75.3%	90.9%	92.3%	97.1%	93.4%	92.9%	95.6%	85.1%	85.8%	-	●				
	Direction of Travel		-	↓	↑	↓	↑	↑	↑	↓	↓	↑	↓	↑						
	National Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%						
	National Average		84.7%	84.1%	81.3%	77.4%	78.6%	75.0%	80.7%	80.6%	79.1%	83.2%	77.7%							
	National Ranking		104/134	113/134	91/132	91/132	49/133	29/132	16/133	37/132	29/128	24/131	65/130							
Cancer 28 Day Performance	High ↑	75%	80.7%	76.1%	80.2%	77.9%	80.7%	81.8%	85.1%	83.6%	78.6%	81.7%	79.4%	78.4%	-	●	●	●		
	Direction of Travel		-	↓	↑	↓	↑	↑	↑	↓	↓	↑	↓	↓						
	National Target		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%						
	National Average		72.6%	71.7%	73.5%	71.3%	70.5%	63.8%	74.1%	73.1%	70.8%	70.8%	70.4%							
	National Ranking		24/134	47/135	33/133	39/134	26/134	11/133	18/134	16/134	25/127	14/131	24/131							
Cancer 31 Day Performance	High ↑	96%	96.2%	96.2%	96.8%	95.0%	95.8%	92.9%	97.3%	91.3%	94.2%	94.8%	93.8%	95.9%	-	●	●	●		
	Direction of Travel		-	-	↑	↓	↑	↓	↑	↓	↑	↑	↓	↑						
	National Target		96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%						
	National Average		93.7%	92.6%	93.5%	93.0%	93.4%	89.6%	93.7%	93.4%	92.8%	91.8%	91.8%							
	National Ranking		65/135	57/135	56/133	76/134	69/133	64/133	53/135	104/135	71/130	64/133	77/134							
Cancer 62 Day Performance	High ↑	85%	78.3%	78.7%	78.9%	78.3%	78.3%	75.5%	64.0%	73.5%	73.6%	66.0%	69.8%	82.9%	-	●				
	Direction of Travel		-	↑	↑	↓	↔	↓	↓	↑	↑	↓	↑	↑						
	National Target		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%						
	National Average		70.7%	68.0%	67.8%	67.5%	67.0%	61.8%	62.1%	67.4%	65.2%	61.5%	59.9%							
	National Ranking		42/132	31/131	32/132	33/132	40/133	31/132	62/131	49/131	44/131	62/129	36/130							

Referral to Treatment (Incomplete Pathways)

Key Measure	Desired Direction	Target	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Financial YTD	National	ERP	Op. Plan	Local	Monthly Trend (National Avg. / Target)
RTT 18 Week Performance	High ↑	92%	74.8%	74.4%	74.6%	74.7%	73.2%	72.9%	72.2%	72.5%	70.2%	71.9%	70.8%		-	●				
	Direction of Travel		-	↓	↑	↑	↓	↓	↓	↑	↓	↑	↓							
	National Target		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%							
	National Average		66.8%	65.6%	64.7%	64.6%	62.9%	62.5%	62.2%	62.0%	61.1%	62.9%	61.6%							
	National Ranking		44/135	39/135	37/135	35/135	33/135	33/135	32/135	32/135	37/133	38/132	37/132							

Diagnostics

Key Measure	Desired Direction	Target	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Financial YTD	National	ERP	Op. Plan	Local	Monthly Trend
Diagnostic <6 Week Performance	High ↑	99%	87.6%	88.1%	91.0%	92.2%	91.4%	89.4%	93.5%	88.1%	84.4%	85.6%	86.3%	88.2%	-	●				National Avg. — Target ····· 
	Direction of Travel		-	↑	↑	↑	↓	↓	↑	↓	↓	↑	↑	↑						
	National Target		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%							
	National Average		72.0%	73.1%	74.1%	73.9%	69.6%	68.9%	74.9%	74.0%	70.3%	72.8%	71.3%							
	National Ranking		37/135	39/135	31/134	33/135	24/135	26/135	32/135	41/135	41/134	42/133	41/132							

Recommendations

It is recommended that the Trust Board:

a) Notes the information included in this report
b) Seeks assurance of actins to address underperformance identified

Strategic Goal images designed by surang | Flaticon

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW	
Agenda item	3.3
Paper title	Green Plan Annual Report 2021/22
Responsible Director	Mark Braden
Author	Peter Leighton-Jones
Previously considered by	This the first annual green report submitted for the trust board's consideration. However, it was a commitment set out within the previously agreed MY Green Plan and is dictated by central NHS requirements.

The Board/Committee is asked to:			
Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

All trusts are obligated to publish their progress made against board-approved green plans, under an 'annual sustainability report'. We selected the 2019/20 financial year as the baseline for our carbon footprint, with the rationale that this was the last 'normal' year that wouldn't be skewed by COVID-19 related effects. As such, we had two financial years to report against, and these are the subject of the MY Green Annual Report that forms the basis of this report. The report centres on the organisational carbon reduction tracker and providing a commentary around the findings so far, whilst also talking about efforts made to drive general sustainability work. The report shows that carbon emissions reduced by 6.5% in the first year affected by the pandemic, before rebounding by 4% during the most recent financial year, leading to a net reduction of 2.8% over those two years. Based on the net zero trajectory we need to follow to reach our initial 2038 target, we would have hoped for a drop of 10.5% so far. However, the performance observed is not unexpected, given that the green plan only went live in April this year, and before January 2022 there was no dedicated resource in place to drive this agenda forward. The principal catalyst needed to accelerate progress now is an influx of capital funding to support building retrofits, which the trust will be seeking via an application into the Salix Public Sector Decarbonisation Scheme (PSDS) in late September. This report seeks approval for the content of the MY Green Annual Report, with board members encouraged to note that the current version is a skeleton draft, which will be submitted to professional graphic design once approved, and where the structure and visuals will be improved to make the report into a glossy and appealing publication.

Link to strategic objective(s)	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	No financial impact.

The Mid Yorkshire Hospitals NHS Trust

MY Green Annual Report

2020/21 & 2021/22 Financial Years

Contents

[Placeholder – to be created during the design phase]

Foreword

[Placeholder – intros/thoughts from Len and/or Mark Braden to be added in the design phase]

1. Introduction

This is the inaugural MY Green Annual Report, which complements the MY Green Plan by aiming to transparently communicate the progress that's being made towards the decarbonisation targets and commitments set forth within that plan. At its heart, this report is a set of carbon accounts for the trust, and provides the evidence base for proving that we are on the right path – or else otherwise – towards our net zero targets. This first MY Green Annual Report is slightly unusual in the sense that it covers the last ***two*** financial years, whereas future iterations will deal with single financial years in isolation. The rationale for this peculiarity is simple; specifically, the trust wanted to avoid data skewing caused by the pandemic response when establishing the baseline carbon footprint that now forms the comparator against which our journey towards becoming a net zero organisation will be measured during the next 23 years. As such, all reporting of progress is made in comparison to the MY Carbon Footprint and MY Carbon Footprint Plus baselines, which were set against the 2019/20 financial year as the pre-pandemic reference point.

The report primarily discusses our on-going carbon emissions as an organisation, although some of the latter sections also tackle our non-carbon related sustainability actions, to reflect the fact that sustainability is about more than carbon tunnel vision alone, with broader environmental considerations, societal elements, and economic aspects being key determinants of any holistically ***sustainable*** organisation.

The annual reports linked to the green plan are separate to both the corporate annual plan – which covers the trust as a whole – and the existing annual Estates Returns Information Collection (ERIC) and Greener NHS data collection commitments. Annual reports are board-approved prior to publication and are shared with the Integrated Care System (ICS), who have scrutiny and oversight powers regarding how we are performing. All current and future iterations of the MY Green Annual Report will be published on the trust's intranet and internet sites to ensure that stakeholders have full transparency regarding the status of our decarbonisation work in relation to the targets we've pledged.

2. Reporting requirements & methodology

Health & Care Act 2022 – This new law underscores the importance of the NHS taking a strong approach to addressing its climate change impacts, placing new duties on NHS England & Improvement (NHSEI), and all trusts, foundation trusts, and Integrated Care Boards (ICBs) to contribute towards statutory national emissions and environmental targets. It specifically requires commissioners and providers of NHS services to address:

- the UK 2050 net zero emissions target;
- the targets within the Environment Act 2021; and,
- the need to adapt to any current or predicted impacts of climate change identified within the Climate Change Act and sequential Climate Change Risk Assessments (CCRAs).

Delivering a net zero NHS – To assist with the discharging of the duties under the Health & Care Act, the power was given to publish statutory guidance to support the system on its path towards net zero. As such, linked documents previously published by NHS England, in the form of the 'Delivering a Net Zero National Health Service' strategy and the 'Net Zero Supplier Roadmap', have now been re-published as statutory guidance. These provide the context for the carbon footprint of the NHS, the trajectories needed to reach net zero, and the steps required to deliver against these targets, whilst simultaneously improving the health of patients and the public.

NHS Standard Contract – Service condition 18 of the 22/23 Standard Contract obligates NHS providers to report on progress made in relation to their board-approved green plans, which in the trust's case, is the 'MY Green Plan': midyorks.nhs.uk/green-plan/.

Greenhouse Gas (GHG) Protocol – All carbon accountancy used by the trust makes best endeavours to follow the processes, logic, and rules set out by the globally recognised GHG Protocol, which is universally accepted as the *de facto* framework for all organisational carbon reporting.

Carbon conversion factors – Each year, the Department for Business, Energy, & Industrial Strategy (BEIS) publishes the UK Government Conversion Factors for GHG Reporting. These factors are suitable for UK-based organisations of all sizes, across every sector and industry. As a result, in preparing the carbon accounts for the trust as part of this report, the BEIS carbon conversion factors have been used in the vast majority of cases. When selecting the factors to use, the version of the dataset that best correlates with reporting periods should be used; for example, factors labelled as 2021 should be used for data from the 2021 calendar year. For organisations who report based on financial years – from April to March – the factors from the calendar year in which the greatest portion of their data falls should be applied; for instance, the 2021 factors would be applied to data for the reporting year that spans the 1st of April 2021 until the 31st of March 2022. This is the rationale that the trust is duly following for all of its annual sustainability reports.

Proxy carbon conversion values – Despite the applicability of the BEIS carbon conversion factors in most cases, the NHS has some complexities that aren't fully accounted for in the BEIS dataset. Specifically, there are gaps when it comes to estimating the fugitive emissions associated with medicines in use – such as volatile anaesthetic gases – and for clinical waste, which is routinely subjected to sterilisation and destruction processes far in excess of the norm during the course of its treatment. In such cases, alternative carbon conversion factors have been used in line with the latest academic research and consensus on the most representative estimates for carbon impacts across these more unique areas of waste disposal.

Treatment of GHG emissions – Carbon dioxide (CO_2) isn't the only GHG, with many other gases exerting a global warming potential (GWP) when emitted to the atmosphere, to varying degrees of severity and over different timescales; including methane, nitrous oxides, fluorocarbons, and water vapour. As such, whenever we are estimating the carbon emission impacts of our activities, we talk in terms of CO_2 'equivalents' (CO_2e), to account for the aggregated relative impact of all the gases that our operations release, in relation to comparable units of CO_2. This also supports ease of presentation and allows for like-for-like comparisons between different organisations. For example, every unit of methane has a GWP 86 times higher than the same unit (volume) of CO_2, when considered over a 20 year period.

3. MY net zero targets

The trust has committed to the following high-level decarbonisation targets:

1. Net zero by 2038 for the emissions we control directly – with an 80% reduction by 2028-2032 (the ***MY Carbon Footprint***); and,
2. Net zero by 2045 for our entire emissions profile – including supply chain and personal travel contributions – with an 80% reduction by 2036-2039 (the ***MY Carbon Footprint Plus***).

These targets broadly align with the central NHS mandate enshrined within the Health & Care Act and the specific NHSEI strategy that aims to deliver the world's first net zero national health service, which is fleshed out via other NHS obligations, within the Standard Contract, the Long-Term Plan, and other pertinent documentation. However, the goal for tackling emissions that the trust directly controls goes further, in terms of our net zero target being two years sooner than the national NHS requirement, where the 2038 date instead dovetails with what the sub-regional ICS is targeting, as well as the West Yorkshire Combined Authority (WYCA) and the local authorities serving the districts we operate in, i.e. Wakefield Council and Kirklees Council.

It should be noted that the trust is yet to set definitive year-on-year (YoY) carbon reduction targets. Whilst there is an aspiration to develop a comprehensive roadmap for decarbonisation, with quantifiable and SMART KPIs to guide this, it will take a few years as we first need to fully understand the timings and scale associated with things like vehicle renewals, plant equipment replacement and maintenance cycles, phasing of retrofit works, and so on. In particular, acute hospital estates are very complex and setting energy efficiency reliant carbon reduction targets at this stage – when future funding routes are still unknown – would be both arbitrary and hypothetical. Nevertheless, we aim to use sound science and data-led approaches – tied to fully approved, costed, and deliverable work – to get to the point required ASAP, and this will become clearer once we've had time to do the requisite baselining and robust planning.

4. Categorisation of emissions in scope

Chapter 4 of the GHG Protocol describes the definitions of the 'scopes' for GHG accounting and reporting purposes, and also includes a diagram – shown in figure X – to illustrate what the three scopes relate to in practical terms. The NHS has also created its own illustration of the emissions categories that form the scope of the net zero targets we are collectively working towards within the system, which is shown in figure X by way of comparison.

Scope 1: These are 'direct' GHG emissions occurring from sources that are owned or controlled by an organisation; for example, emissions from combustion of fossil fuels in natural gas boilers, coal or biomass burnt in furnaces, and petrol or diesel used in fleet vehicles. Scope 1 categorisations also include 'fugitive emissions', which come from gases or vapours with a GWP that leak, escape, or are released – intentionally or passively – due to organisational activities.

Scope 2: These are 'indirect' emissions from the generation of purchased electricity consumed by the company or organisation in question. Purchased electricity is defined as electricity that is bought or otherwise brought into the organisational boundary of the company, where the scope 2 emissions physically occur at the facilities where the electricity is generated.

Scope 3: This reporting category allows for the treatment of all other *indirect* emissions. These emissions are a consequence of the activities of the company, but which occur from sources not owned or controlled by the company. Some examples of scope 3 activities are extraction and production of purchased materials; transportation of purchased fuels or supplies; and use of purchased products and services, both upstream and downstream of the organisation's operations.

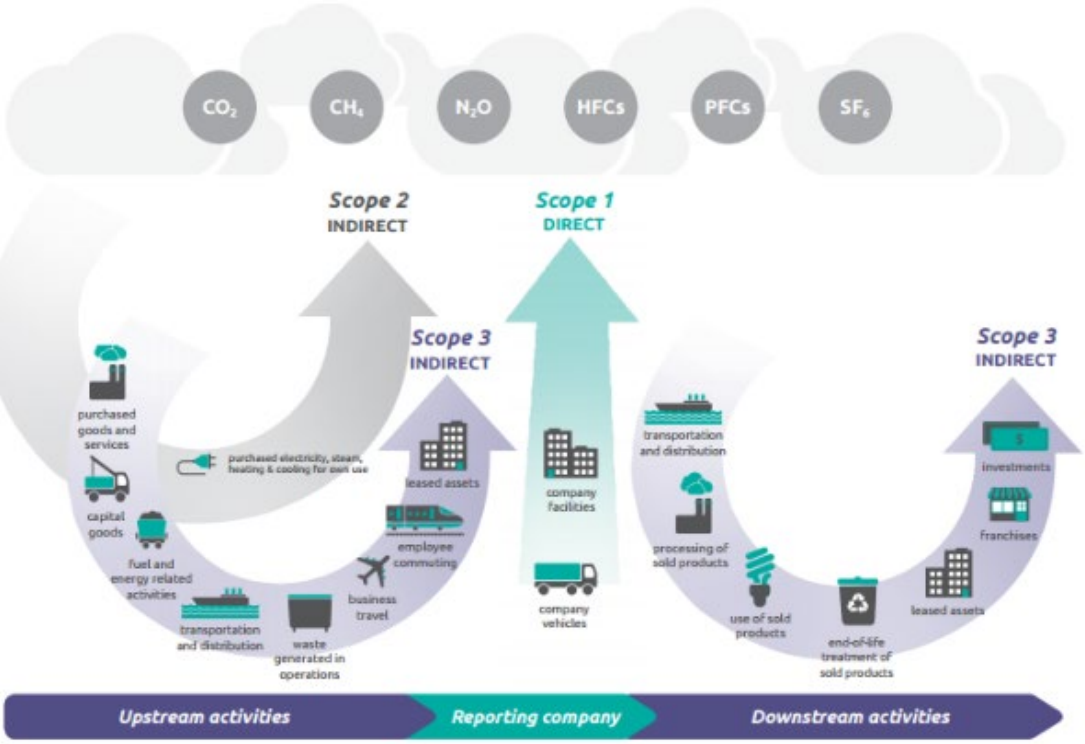


Figure X: *GHG Protocol emissions scopes*

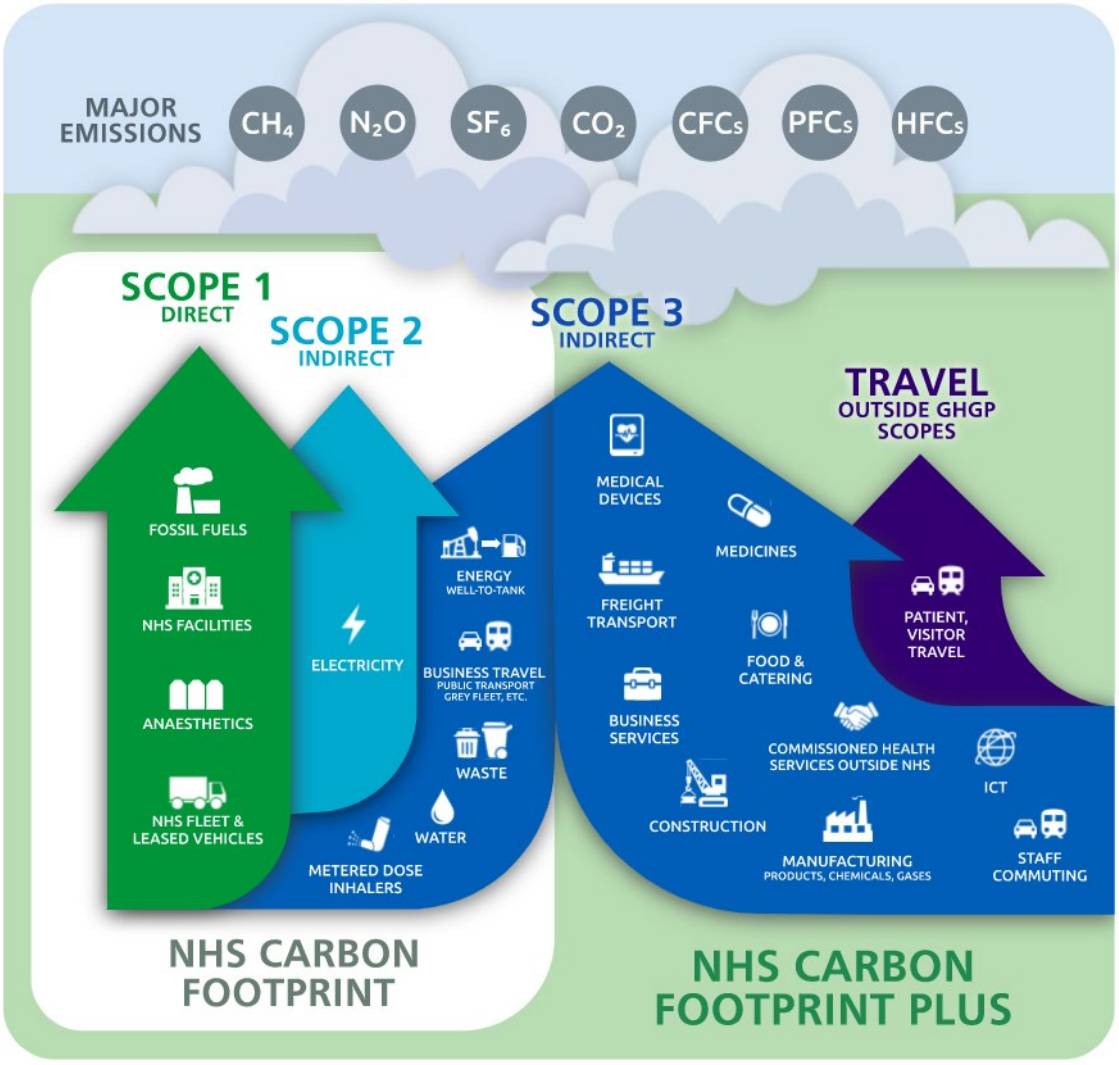


Figure X: *Scope of NHS carbon footprints & associated boundaries*

5. MY Carbon Footprint

Baselines

The baseline year that forms the yardstick for measuring the progress we make with our decarbonisation work is the 2019/20 financial year. The associated carbon footprints were set as part of our first official green plan, which was agreed in March 2022, and published shortly afterwards. MY Carbon Footprint includes emissions the trust is in control of – such as energy usage, waste, medical gases, fleet vehicles, and business travel – whereas MY Carbon Footprint covers a best approximation of supply chain and personal travel-based emissions as well, where we can influence the extent of those emissions but not exert total dominion over them.

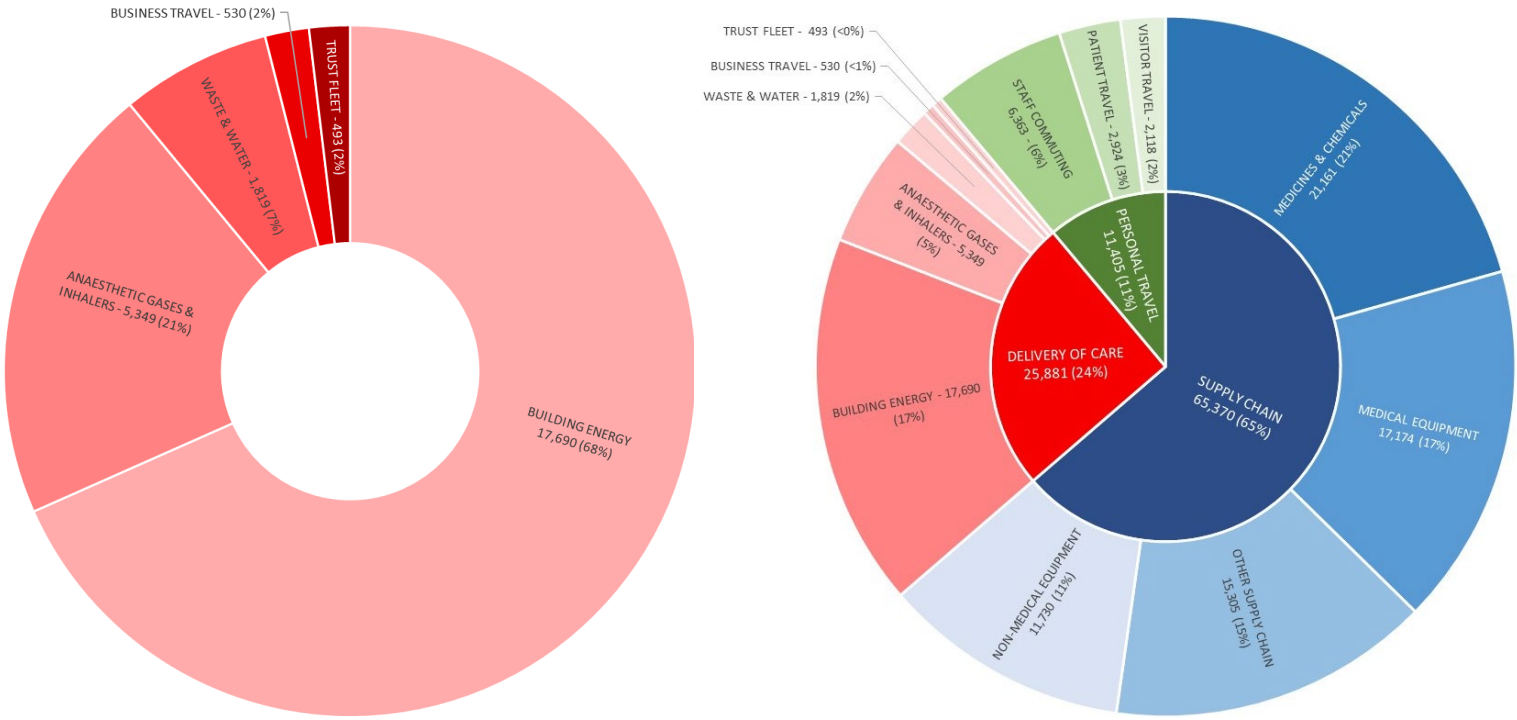


Figure X: *MY Carbon Footprint & MY Carbon Footprint Plus – baseline year 2019/20*

Re-baselining of MY Carbon Footprint

When MY Green Plan was written, the carbon footprint baselines were as follows:

- **MY Carbon Footprint** – 23,014 tCO_2e
- **MY Carbon Footprint Plus** – 99,789 tCO_2e

However, during the course of preparing this annual report, corrections have been made to reflect omissions made in the initial analysis undertaken 7 months ago. These alterations primarily refer to 'well-to-tank' ('WTT') emissions, and corrections for outdated carbon conversion factors relating to waste specifically. WTT emissions – also known as upstream or indirect (scope 3) emissions – are an average of all the GHG emissions released into the atmosphere from the extraction, production, processing, and delivery of a fuel, e.g. petrol, or an 'energy vector', such as electricity. WTT emissions were omitted from the original MY Carbon Footprint because there wasn't enough time to perform the appropriate levels of due diligence prior to publication. The impact of their inclusion at this stage is to add 2,336 tCO_2e to the MY Carbon Footprint baseline year.

After consulting the literature, it was determined that the BEIS carbon conversion factors for NHS waste applications were not fit-for-purpose. Specifically, they didn't take into account the specialised nature of NHS waste treatment. The latest thinking is that the carbon intensity of certain disposal and treatment methods in NHS settings is not adequately encapsulated by the BEIS factors, and hence it was felt that new conversion factors needed to be backwards-applied to our data. As such, the metrics calculated by a preeminent academic group have been used instead, taking inferences from a peer-reviewed study published in the Journal of Cleaner Production, titled 'The carbon footprint of waste streams in a UK hospital' (Chantelle *et. al* 2021). The impact of the revised waste figures is to contribute an extra 529 tCO_2e to the MY Carbon Footprint baseline year.

Some carbon conversion rounding up errors also contributed to a further deficit of 2 tCO_2e, meaning that ***the total impact of the baseline year additions is 2,867 tCO_2, which is a 12.5% increase.*** The published green plan will be updated to reflect this change accordingly, but it should be noted that the 'plus' elements of the carbon footprint baseline remain unaffected at this point.

The revised carbon footprint baselines are now as per the below:

- **MY Carbon Footprint** – 25,881 tCO_2e
- **MY Carbon Footprint Plus** – 102,656 tCO_2e

Tracking emissions over time

As described in chapter 5 of the GHG Protocol, recalculating base year emissions is key to ensuring consistent emissions tracking over time, and this needs to be undertaken whenever any of the following triggers occurs:

- **Structural changes** – where the transfer of ownership or control of emissions-generating activities or operations/services move from one organisation to another.
- **Changes in calculation methodologies** – or improvements in the accuracy of emission factors, which could result in a substantial impact on the baseline year emissions data.
- **Discovery of significant errors** – or a number of cumulative errors, which are collectively material.

We envisage the following to be the most likely organisational changes to impact upon our emissions calculations and these will be investigated in due course, and any re-calculations to be applied to the baseline year and the years since will be carried out on an annual basis hereafter:

- **Alterations to estate** – where various projects are underway currently and/or planned for the future to restructure and add to existing assets and in some cases, construct new buildings;
- **Fleet expansion and/or rationalisation** – which might involve reassessing the number of vehicles we need to deliver our services, leading to either less or more vehicles being required;
- **Electrification of fleet vehicles** – to move away from diesel and petrol; and,
- **Electrification of building heating systems** – to retrofit heat pumps into areas currently served by gas boilers, whether they use air, the ground, or water as the heat source.

6. Reporting assumptions and exclusions

Assumptions

- **BEIS indicators**: The BEIS carbon conversion factors have been used for the majority of carbon calculations within this report. An assumption is made that the datasets prepared and

published by BEIS are correct but regardless, they are the best resource currently available and are applied by most organisations across the UK for the sake of consistency and alignment with government reporting guidelines.

- **Data accuracy**: This is considered to be broadly accurate but there is one anomaly that hasn't been fully explained yet, which relates to oil usage specifically. In the baseline year, oil consumption was roughly 5 times higher than in the subsequent 2 financial years. Generally, oil 'burns' – to test contingency power generators – are pre-scheduled at regular junctures, so the more recent usage represents a marked step-down in usage, where the baseline year was perhaps anomalous or there was a procedural change within the trust or NHS, which changed the operational parameters. Further work is required to understand the true cause. In addition, and in the case of water supply and treatment emissions, the BEIS conversion factors more than halved between the 2020 and 2021 releases, with no explanation given for why this was the case. In the absence of any narrative, the trust can only assume that BEIS updated their methodologies and found a discrepancy, which was then corrected.
- **Fleet & business travel estimates**: As with the analysis of all scope 3 emissions, the figures underpinning both fleet vehicles and business travel are far from an exact science. There are a number of different methods that can be used, including BEIS conversion factors based on fuel usage in relation to mileages, BEIS conversion factors linked to actual fuel usage in vehicles, and Original Equipment Manufacturer (OEM) claims regarding vehicle performance in both laboratory and real-world scenarios. There is an argument that organisations should triangulate methodologies and then average them out to get a more holistic set of results. However, all 3 main ways of studying vehicle emissions have pros and cons. For example, OEM claims can be spurious, age plays a factor, substandard vehicle maintenance affects performance, and driver habits can wildly swing the emissions generated by certain vehicles when in use. As a result, the trust looked at BEIS factors applied to mileage and fuel use. The former came out higher so this was selected as the figure within our carbon footprint, in the interests of being conservative. In the case of business travel, it should also be noted that staff expense claims often span different financial years, in terms of the gap between the dates the claims relate to and the point in time the claims are actually lodged. For expediency's sake, the trust has taken the approach of using the date of the claim to determine the financial year for it to be included in.
- **Waste**: For the pandemic-affected period, recycling of domestic waste was assumed to be circa 1% and instead of landfill, the primary treatment method was taken to be medical waste low temperature incineration with associated energy recovery. The high-end estimate from the range quoted in the afore-mentioned Chantelle study was used as the conversion factor for this industrial waste process.

Exclusions

- **Supply chain emissions**: The trust calculated its supply chain emissions as part of the MY Carbon Footprint Plus baseline, which was included in MY Green Plan. This showed that our 3rd party emissions were around 66% of the overall carbon footprint, which was in line with central NHS estimates for the system as a whole. However, this was always predicated upon extremely crude approximations. We used the old NHS Sustainable Development Unit (SDU) carbon conversion factors for spend categories at the time, but this is obsolete – having last been updated in 2016 – and the approach is extremely broad-brush and somewhat subjective. As a result, little value is seen in reporting against supply chain emissions at this juncture as the only determinant of our relative impact in that area would be the comparative amount of expenditure we incur in any given year, which would tell us nothing about actual progress or reductions. The situation will only improve when NHS Supply Chain roll-out their heightened decarbonisation requirements within NHS contracts, which will place responsibilities on suppliers to have carbon reduction plans in place, proper reporting, and eventually, full carbon

footprinting of products offered into the system via buying catalogues. As such, we will initiate reporting of 3rd party emissions when we have the appropriate tools to do so.

- **Personal travel**: The emissions associated with staff commuting and visitor/patient travel are not ordinarily considered to be within an organisation's emissions boundary under the principles advocated by the GHG Protocol. However, the NHS decided to include them within the scope of the 'plus' element of the system-wide carbon footprint. In our case, they account for somewhere in the region of 11% of our overall 'plus' footprint. Due to a lack of recent travel plan survey data, we used the NHS Health Outcomes of Travel Tool (HOTT) as a proxy dataset to estimate the emissions associated with staff commuting and patient and visitor travel. The HOTT used national and regional datasets to generate generalised figures for transport mode, distances travelled, and emissions from a 2018 baseline, and projected these into the near future. Unfortunately, these figures are extremely indicative and need to be bolstered and verified by improved staff surveys, car park data, intel gleaned from appointment details, and patient feedback, which must be gathered and analysed in the coming years. As such, the personal travel section of MY Carbon Footprint Plus must be treated with some level of caution, notwithstanding the fact that it's the best estimate we had at the time of cementing our baseline. Furthermore, it makes little sense to report on personal travel at this time, until datasets are improved and proper inferences can be made.
- **Refrigerant gases**: These are exceptionally potent GHGs, some of which are thousands of times more damaging than CO_2 when emitted to the atmosphere. Pertinently, leaks of these gases can occur passively, over time, as well as due to incorrect maintenance. These scope 1 emissions were not included in our original baseline but should be going forwards, as well as for ongoing reporting. At this time, the backdated calculations have not been applied, pending the need for further scrutiny of estates' management information regarding the exactitudes of our air con and chiller assets. However, we will endeavour to quantify and include the carbon impacts of refrigerant gases in the next annual sustainability report, scheduled for publication in August 2023.
- **Non-car based business travel**: So far, the trust has not calculated the emissions impacts of non-car related business travel, with rail, bus, and taxi journeys currently missing as elements. The same logic applies to hotel stays and air travel. Overseas staff are also somewhat of a special case and 'grey area', wherein the NHS sponsors visa applications to bring in skilled healthcare staff to bridge workforce gaps. The trust pays for flights in the case of relocating overseas staff and their families to the UK ***[TBC]***, which should be included in business travel calculations. In addition, delegations are often sent abroad to recruit foreign workers into trusts and this is an extension of the same thing. Nevertheless, further work is required to fully understand the extent of these instances and there is also an exercise required to map out whether expense claimants are recording and evidencing full journey details when requesting bus, train, and taxi refunds.
- **Homeworking**: The BEIS carbon conversion factors now allow for homeworking impacts to be quantified as part of scope 3 emissions calculations. This uses a metric of 0.34075 $kgCO_2e$ per fulltime equivalent (FTE) working hour, drawing upon the methodology from the Homeworking Emissions Whitepaper, prepared by EcoAct in 2020. This reflects the fact that by allowing people to homework, organisations are effectively decentralising/outsourcing their own energy emissions into the domestic arena, where boilers and thermal performance will often be less efficient, and power draw for things like lighting will be increased compared to a situation where all staff are consolidated in environments such as offices. At present, we don't have the data to adequately quantify the impacts of this, and indeed, staff don't formally record instances of working from home, meaning that further thought is required on how we should capture this information in future.

7. Carbon emissions commentary

The below table summarises the trust's carbon reduction performance over the past two financial years, in comparison to the baseline year (BY). The full reference table – which splits up the various emissions scopes into their constituent parts – is included as appendix X. This is underpinned by a comprehensive spreadsheet version of the 'carbon reduction tracker', which holds all of the corresponding datasets and carbon conversion factors. The spreadsheet will be used henceforth to track, monitor, and report on carbon emissions reduction progress, whether this is positive or negative. This will be updated on a quarterly basis, wherever possible, so that reporting data is available on a more regular basis, operationally, to help us keep on top of any deviations from either the 'norm' or what we expect to achieve, target-wise.

		Carbon Reduction Tracker			% emissions change to date against BY	Latest social cost of carbon (£)
Emissions categories	**Units**	**2019/20 FY (BY)**	**2020/21 FY**	**2021/22 FY**		
Scope 1 - Direct emissions	kgCO2e	12,371,398	12,050,308	12,509,303	1.1%	£863,142
Scope 2 - Indirect emissions	kgCO2e	8,085,990	7,423,937	6,745,782	-16.6%	£465,459
Scope 3 - Upstream/downstream emissions	kgCO2e	5,423,169	4,701,778	5,910,861	9.0%	£407,849
Total Emissions	tCO2e	25,881	24,176	25,166	-2.8%	£1,736,450

The 2020/21 financial year saw a 6.5% reduction is carbon emissions, compared to the baseline year. This could have arguably been expected given that the 1st year of the pandemic led to some of the biggest structural changes ever seen in the way healthcare was delivered, with multiple lockdowns imposed. This resulted in a huge downturn in acute hospital activities relating to planned care and scheduled operations, with efforts channelled into responding to the immediate concerns presented by either COVID-19 or other emergencies connected to unplanned care.

The effects of COVID-19 countermeasures bear out in the numbers, where emissions from medical gases in use – e.g. anaesthetic gases and nitrous – dropped markedly. For example, the volume of inhaled anaesthetics reduced by 45% during the period. Things like business travel and fleet mileage also fell, which again would be predictable based on what was seen in the earlier stages of the pandemic.

Perhaps more surprising is that waste-related emissions reduced. This is because the change in the treatment of domestic waste away from the standard approach somewhat paradoxically led to a disposal method that had lower associated carbon impacts. Essentially, a large proportion of this commingled waste was previously sent to landfill, with only small amounts of circa 10% sifted and separated for onward recycling. During the pandemic, and to avoid the risk of operatives handling potentially COVID-infected materials, the landfilled and previously recycled components were almost entirely diverted to low temperature medical waste incinerators, where energy recovery was used to generate electricity for injection into the grid. This culminated in a carbon emissions reduction of circa 500 tCO_2e even though clinical waste volumes went up 11% in the first pandemic-affected year and a further 8.5% the year later (in the 21/22 FY).

The graph in figure X shows what's been achieved so far – from a carbon reduction perspective – versus what's needed in simplified terms, when it comes to YoY percentage reductions against the baseline carbon footprint, out towards the 2038 target for emissions under direct organisational control. It shows that whilst emissions dropped during the 1st year of the pandemic, they effectively 'bounced back' during the subsequent 12 months. The initial 6.5% reduction in emissions was partially reversed by a 4% rise in emissions between 20/21 and 21/22, with a resulting 2.8% net carbon emissions decrease against the baseline year, as things stand.

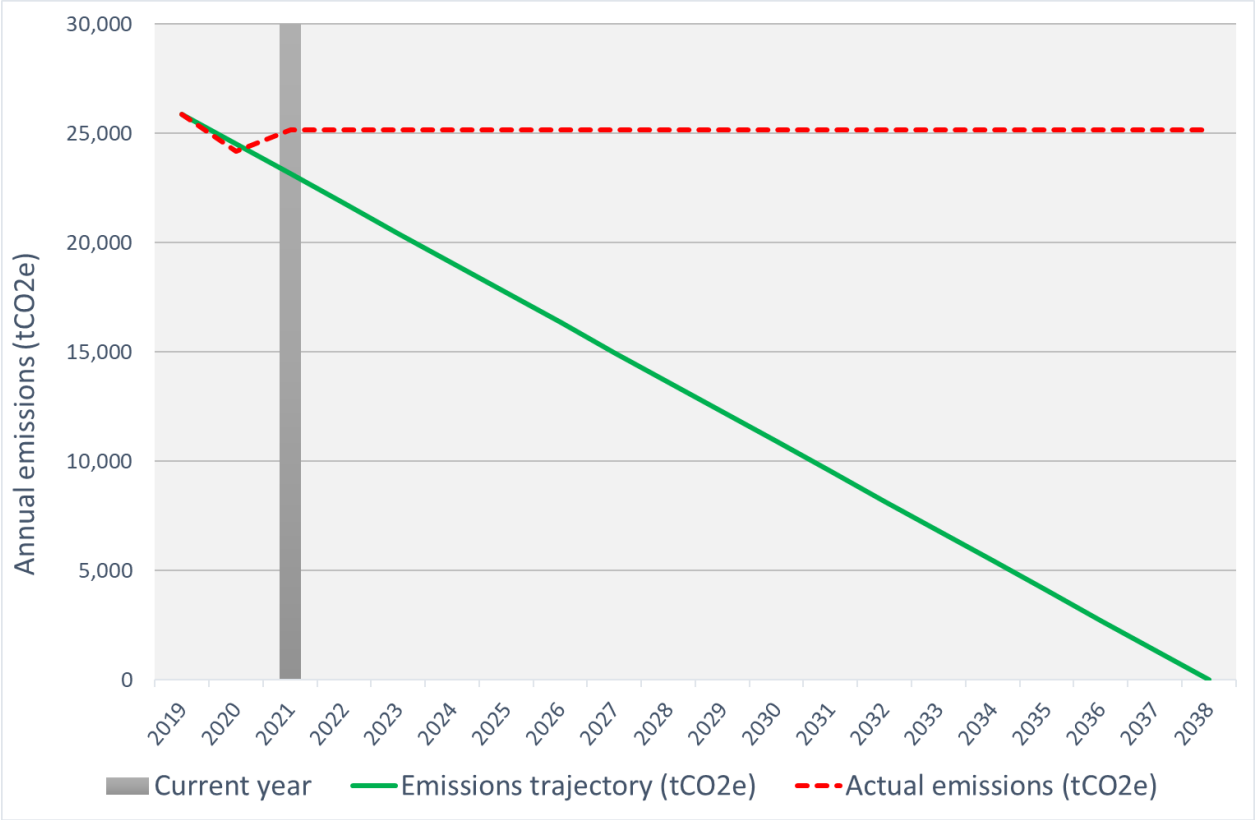


Figure X: *Actual emissions plotted against a simplified emissions reduction trajectory for MY Carbon Footprint*

The 2.8% decrease represents a relatively small cut in our emissions profile, and this most likely relates to a recent waning of medical activities, which are at least partially attributable to fallout from the pandemic. The balance of the residual reduction is mainly a result of passive gains made via the incremental decarbonisation of the UK power grid, as we move increasingly towards a mix where offshore wind contributes a large proportion of the baseload. This has caused a 17% drop in our relative emissions from electricity use. As an honest assessment, these two external factors mean that the corresponding reduction seen is not representative of proactively delivered decarbonisation work from the trust. Indeed, it is reasonable to assume that there could be a pronounced reversal in the superficial emissions declines once the 22/23 FY has been analysed, due to the efforts underway to address the backlog in planned hospital care, which was caused by delays and postponements of previously arranged procedures. The impacts will be felt when the frequency of carbon intensive acute activities, such as the use of theatres and imaging equipment, is rapidly increased to compensate for previous hiatuses.

To stay broadly on target with the 2038 net zero deadline tied to MY Carbon Footprint, the trust needs to cement 5.26% – or 1,362 tCO_2e – of YoY carbon emissions reductions, on average, against the baseline year, assuming we consider the journey for our decarbonisation work as a linear trajectory. In practice, reductions won't happen in a straight line and will instead be stepped and staggered, with some actions leading to disproportionately larger decreases, depending on the scale of particular retrofitting efforts and/or any organisational changes that lead to reduced carbon emissions. As two years have passed since our baseline was set, we might have expected/hoped for a 10.5% decrease in emissions by now, as opposed to the 2.8% reduction seen thus far.

There are two other phenomena worth noting when looking specifically at the carbon accountancy figures. One of these is that gas usage is up significantly when compared to the baseline year, with a 19% increase having been seen in 20/21 and a further 5% the year after. However, the trust did receive a Salix loan of close to £2m in 2020, and in 2021 a 425kW combined heat and power (CHP) system was installed at Dewsbury Hospital. This has likely added 8.5 GWh of gas consumption to the organisational profile, which roughly accounts for the increase observed, albeit the peripheral actions to change that

site to a low temperature hot water system for heating should have offset some of this, as should the efforts to improve plant room insulation. Nonetheless, those improvement measures seem to have been lost within the figures and delving deeper into the granularity isn't aided by gaps in the half hourly gas dataset at that site. Linked to this issue, there is also no weather normalisation applied to gas consumption currently at any of our sites, and we don't have the capacity to create predictive regression models yet to estimate anticipated gas usage based on degree days (external temperatures) because we are lacking the half hourly gas resolution required.

The other main observation is that our electricity consumption remains resolutely unchanged across all three years, and this is despite investment in LED lighting upgrades within that period. As such, it is fair to say that more needs to be done to reduce our electricity load and we know that our two PFI hospitals have limited LED coverage at present, with a figure of 15% speculated across those locations.

Finally, a social cost of carbon (SCC) has been calculated for our emissions, which comes out at £1.74m for the latest year in question. The SCC concept attempts to sum the quantifiable costs and benefits of emitting one tonne of CO_2, in monetary terms, utilising the concept of 'negative environmental externalities', where climate change can be viewed as the market's failure to adequately cost in the harmful impacts associated with given economic activities and 'growth'. The SCC can theoretically be used to weigh up the benefits of reducing future climate change impacts versus the costs of carbon emissions abatement and avoiding those risks. In effect, the SCC is the cost of the current and future damage caused by emissions to society, the economy, nature, and the planet. The current cost per tonne of CO_2 is pegged at £69 in the UK and this figure will rise incrementally over time. In an ideal world, these costs would be incorporated into business cases and financial models so as to favour decision-making that leads to proposals that lessen carbon impacts, but current accountancy practices don't generally lend themselves to such practices as indirect factors are rarely considered, from a budgetary viewpoint. However, if nothing else the SCC gives a rudimentary visualisation of the monetised costs associated with the environmental degradation brought about by ***our*** carbon emissions.

8. Commentary of progress and forward projection

High-level position statement

The following SWOT analysis gives a summary snapshot of current programme delivery within the trust, where the strengths and weaknesses are considered internal to the organisation and the opportunities and threats are outside factors:

Key updates

Dedicated lead & team expansion – A 'head of sustainability' was recruited in late 2021 and started in post in January 2022. This is a new position that sets the tone for the trust's future aspirations. Since

then, job descriptions have been drafted for two positions that will fall under the head of sustainability, as envisaged by the original structure for this nascent function within the trust; namely, for an 'energy & sustainability manager' and a 'resources & sustainability manager'. The 1st role will have a clear energy specialism but will also have more extensive duties than mere energy management responsibilities. The 2nd position will focus on more generalised sustainability work, but with a particular eye on waste reduction and recycling, transportation and mobility, and supply chain improvement programmes. It's hoped that both vacancies will be filled by January 2023, which will significantly improve resourcing and green skillsets within the organisation.

Green plan – The trust's first official 'green plan' – known as my MY Green Plan – was drafted in early 2022, before being board-approved in March 2022 and officially published two months later. This forms the bedrock of the trust's sustainability agenda and establishes the work plan for the next 3 years.

Sustainability Transformation Oversight Group (SusTOG) – The governance arrangements for managing the trust's sustainability programme have been drafted and finalised, and the first SusTOG meeting is anticipated to take place in mid-October. These meetings will take place every 3 months, to roughly coincide with financial quarters. The SusTOG will dictate and scrutinise all of the programme's workstreams and is therefore integral to the success of our linked initiatives.

Energy Savings Trust (EST) fleet electrification review – EST have completed their review and shared their findings with the trust. Their recommendations show that potential exists to transition our fleet across to EV cars and small to medium-sized vans in particular, with market developments soon to arrive in other more complex vehicle classes; for example, in respect of minibuses and heavy commercial vehicles. A stakeholder presentation is to be arranged imminently, to discuss next steps.

EV chargers – The trust recently installed EV charge-points at all three hospital sites. The chargers are now live, and available to use for staff and visitors. There are currently three 22kW dual chargers (6 bays) at Pinderfields Hospital, two 22kW dual chargers (3 bays) at Dewsbury Hospital, and one 22kW dual charger (2 bays) at Pontefract Hospital. In time, we hope to introduce more chargers for the use of staff specifically, although no decisions on this have been made as of yet. However, assuming this happens, the existing fast chargers will be re-allocated for the use of visitors and/or trust fleet vehicles only, who are more likely to need short-term charging provision. Any new chargers – once introduced – will be sized at 3.6kW or 7.2kW to allow more to be installed across our sites. This will also mean that staff members can charge their vehicles for an entire shift, without needing to move their vehicles during the working day, which is impractical for many, especially those working in busy clinical environments.

Plans crystallising for estates decarbonisation work – Previously, the trust submitted two unsuccessful Salix PSDS bids. However, a body of work has been developed, which is now being refined alongside a competent 3rd party, who will assist us in developing our latest bid, which should be submitted in late-September 2022. This is a vitally important opportunity to potentially bring a substantial, multi-million pound sum of money into the trust to kick-start and catalyse our decarbonisation work in earnest. Concurrent to this process, we are honing in on what's required to fully develop a formalised and specific heat decarbonisation plan, which is something all trusts must eventually have in place, given that gas-dependent heating is the most difficult area to retrofit with low carbon alternatives. Separately, we are poised to commission a technical advisor to ascertain what solar PV opportunities we have across our estate, especially for solar carports and ground-mounted arrays, as well as our larger roof spaces that will likely fall outside of any future Salix PSDS submissions.

Mine water heat – For our larger assets, like the main hospital building at Pinderfields, electric air source heat pumps are unlikely to be sufficient to provide what's required, without incurring unjustifiable costs. However, in close proximity to Pinderfields there are unique opportunities in respect of our district's legacy coal mining infrastructure. Essentially, the shafts and seams underground have now flooded and those bodies of water are heated, geothermally. The water can

be brought to the surface and used in buildings as a decarbonised and renewable source of energy, not just for heating in the winter but for cooling in the summer months as well, which then allows for climate adaptation in heatwave scenarios. We recently commissioned the Coal Authority to examine the viability of this, and we will also be using Sustainable Energy Ltd to feed the findings into a high level techno-economic feasibility assessment. This is potentially a very exciting avenue for the trust to explore over the next few years.

Key risks & escalations

Forward outlook – We anticipate no significant emissions reductions for the 2022/23 financial year given what is known at the point of publishing this annual report. Whilst this is perhaps disappointing, it's indicative of the situation we face, wherein no new capital has been brought into the trust to specifically address carbon emissions. Much of the work within 2022/23 has instead focussed on embedding organisational governance, defining processes and policies, and assessing infrastructure, which will then hopefully help breed future success. Real progress – from a quantifiable stance – is hoped for within the next financial year.

Systemic change isn't yet happening – The efforts to decarbonise the NHS appear to be static, with numerous trusts reporting little inroads being made so far, even at the more progressive and sector-leading side of the spectrum. Our collective net zero work runs the risk of being knocked off course if enabling support and money isn't made available soon. The central NHS has asserted that 85% of the capital needed to achieve net zero already exists within the funding envelope of the system, but this isn't the experience being felt on the ground and the trust is in the process of drawing up fully costed decarbonisation plans to help evidence this.

Funding uncertainty – There are no guarantees of success in respect of our upcoming applications into the Salix PSDS. The scheme is subject to a highly competitive process for what is a finite resource, wherein every public sector body in the country is fighting for a slice of what is ultimately a small pie. The fact that Salix funding cannot be planned for or relied upon – recognising that it isn't a given that we will be awarded anything – means that we have limited options open to us to fully unlock and enable the estates retrofitting work required to move us towards net zero emissions for the organisation. The problem is compounded by our inability to borrow money for spend-to-save schemes, even if a valid business case can be demonstrated, where 3rd party finance is also considered off-limits, because it compromises our overall capital envelope ceiling. If we don't get any Salix money the question remains as to how we will deliver against the pledges made within our green plan.

Drastic price increases for energy – Given the structural changes going on across energy markets, as well as the geopolitical tensions that are exacerbating the situation, cost avoidance relating to energy bills is crucial. The best way to do this is to avoid energy consumption at the source, through better building management systems, energy efficiency measures, and deep retrofits. Furthermore, self-generation has to be a part of the equation, and with energy costs rapidly increasing, in a way that can't be planned for or mitigated, the business cases for heat pumps, solar PV, and heat networks will only improve. However, in the short to medium term the trust faces substantial cost pressures, and the following extrapolated forecasts demonstrate the *lowest* prices we are likely to pay over the next 3 financial years for electricity and gas ***[TBC]***, whereby as a comparison we paid £5m during the baseline year:

22/23 - £7m **23/24** - £9.5m **24/25** - £12m

Essentially, our energy bills will have doubled in just 4 years, and beyond 24/25 the outlook looks even bleaker. Trusts are receiving no additional budgetary support to deal with these rising costs, and reliable funding routes – which are accessible to all without barriers – are still not forthcoming.

Non-compliance warning re. NHS REGO mandate – Within the NHS Standard Contract, it stipulates that all trusts must purchase Renewable Energy Guarantee of Origin Certificates (REGOs) to cover

every megawatt hour (MWh) of electricity they consume. The problem with REGOs is that they offer no additionality whatsoever and they have been squarely criticised as perpetuating and normalising greenwash by many industry observers and environmentalists. This issue is also exacerbated by the rising cost of energy bills in general, all of which places undue cost pressures on trusts, where REGOs provide no value from a carbon reduction perspective. Recent REGO cost inflation has been somewhat of a self-fulfilling prophecy, as the NHS policy to buy them has directly contributed to the elevation in what are market driven prices. For our retained (owned) estate we have bought REGOs to cover this financial year, but not on the PFI side, as it was going to be too expensive. The projected cost – for the PFI component – was going up from roughly £16K to around £155k, which equated to £6.20 per REGO. We felt that this uplift of nearly 1,000% was completely unreasonable and unjustified, and we are still of that opinion. At the current market rate for REGOs, if we had to pay for certs to cover our full consumption profile, the cost would be £240k and rising. Nonetheless, we are covered for REGOs up until March 2026 for our retained estate portfolio, based upon the current understanding given to us by our brokers, who forward bought the REGOs previously at more attractive prices than the prevailing market rate. For the PFI component, we have no current plans to purchase REGOs through the supplier we use, noting that the price has now increased to £180k (~£7.50), and will no doubt continue to rise. It's quite simply not sustainable for central NHS actors to expect trusts to purchase them anymore. We have raised a complaint with Greener NHS (NHSEI) regarding this matter, and many other trusts have followed suit. We hope to lobby for the requirement to be overturned, but stakeholders should be aware that we are technically outside of compliance as things stand.

9. Non-carbon related sustainability work update

Workforce development – When it comes to sustainability, there is a growing staff movement developing. A 2018 national survey of NHS employees showed that 98% of those surveyed thought it was important that the health and care system works in a way that supports the environment. Locally, we have found that the 'green' agenda within the trust has a high level of support and enthusiasm across both clinical and non-clinical staff, and the organisation sees huge merit in capitalising on this goodwill and energy across the workforce. Younger people are often the most engaged when it comes to these types of issues, and it's essential that sustainability is brought into curricula across the full suite of medical qualifications. In addition, climate change is here to stay and many of our staff will need to receive training to learn new skills that allow them to carry out their roles in a way that fits in with the Greener NHS mandate. For instance, fleet operatives will need to understand how to drive EVs efficiently, heating technicians will need to fix and service heat pumps and clinicians may need to use different instruments, products, medicines, or chemicals that might otherwise be alien to them without proper orientation and education. If we fail to teach our staff the new skills they will need, we won't be future proofing their vocational capabilities, which would do them a disservice. We have also recognised that it's probable that existing and new staff will increasingly ask more of us as an employer, with respect to our net zero action and associated environmental work. If we weren't fully committed, some staff might move to trusts who they felt do more. This realisation has shown us the importance of the trust being a leader in this field, and being a teaching hospitals trust would bolster this crucial work, which is a status we are now energetically seeking.

For an organisation with over 9,000 employees, different methods will be needed to upskill staff in a way that doesn't detrimentally impact on healthcare but still maximises our ability to change the workforce's attitudes to – and understanding of – the associated issues. As such, the trust has become a corporate member of the Institute of Environmental Management and Assessment (IEMA), to strengthen networks, learn lessons from peers, access training, and improve workforce productivity, resilience, and growth, against a backdrop of numerous sustainability and climate threats. Our students and broader staff base will benefit from opportunities that arise when we become an IEMA-affiliated training centre, including vocational accreditations that widen their skillsets into the sustainability arena, which will only serve to help the overall mission of the NHS to become the world's 1st net zero national health service.

The Mid Yorkshire Quality Improvement System (MYQIS) provides a toolkit that's designed to help maximise quality, implement improvements, solve problems collaboratively, and eliminate waste. This system helps improve the quality of our services by looking at existing ways of operating, identifying barriers and wastage, and removing them, to add increased value to everything we do. MYQIS projects have already identified potential avenues for decarbonising and/or minimising waste in clinical activities and there remain an array of possibilities to explore other approaches that might result in better environmental outcomes. This also links in with the Kaizen Promotion Office's (KPO's) work, which centres on continuous improvement. Given that carrying out clinical audits and QI projects is a requirement in all junior doctors' training, it is reasonable to expect that NHS trusts will do what they can to provide appropriate support to help them meet this requirement. We see SusQI as a cornerstone of both staff and organisational development and students and trainee doctors within the trust's tutelage have already worked on QIPs to look at the likes of reducing unnecessary cannulation to avoid waste, and barriers to Total Intravenous Anaesthesia (TIVA) as a precursor to increasing uptake to reduce carbon emissions from the use of volatile anaesthetic gases. The breadth of processes and procedures that could be made more efficient under a SusQI system is vast, and we want to be at the forefront of those efforts.

Recently, nominations were received for a maiden sustainability prize, under the trust's annual Celebrating Excellence Awards, which will champion staff and divisions who have gone beyond the call of duty to embed more environmentally-conscious processes, behaviours, and products. The submissions have been shortlisted and the judging panel's final decision is pending. This new award is seen as a way to raise the profile of our sustainability work – and the MY Green Plan itself – across the organisation, so that people ultimately become more engaged in helping to deliver our shared objectives. We see the 23/24 financial year as a year when workforce development in respect of sustainability will take centre stage.

Partnership working & community engagement – The trust is very actively involved in collaborative efforts to tackle local health inequalities. As part of the sustainability programme, the likes of social and green prescribing are in scope, as well as interventions aimed at encouraging plant-based diets, which can have multifaceted health benefits around health, carbon, and biodiversity. Concepts like social return on investment (SROI) and social bonds could be used too – and potentially paid for by acute trusts like ours – to justify investing in grassroots, primary care based initiatives that avoid escalation of costs up the system hierarchy into our realm by bolstering preventative care, i.e. applying spend-to-save style approaches to social initiatives that reduce the need for reactive (and costly) hospital care later down the road. This could be as esoteric as investing in local fuel poverty schemes led by partners – like domestic insulation and heating improvement works – to avoid respiratory problems posed by mouldy homes, as well as to alleviate the risks posed by people facing financial hardship that then impacts upon their mental health, especially in a cost of living crisis.

The trust is also working very closely with ICS partners as well as local authorities, especially Kirklees Council, who proactively reached out to us to forge stronger links in respect of climate action.

Adaptation & Resilience – The summer of 2022 has seen heatwaves the likes of which climate modelling had not projected within the UK until decades from now. The work required to address this global problem is no longer about mitigation and carbon abatement alone; instead, it requires acceptance of the fact that climate change is happening in the here and now.

Indeed, the unfeasibly hot and unprecedented weather in 2022 has focussed minds on the need for more cooling. Generally, there is very little ventilation and active cooling across hospital estates, but it's a very serious situation, which endangers the health of frontline staff and patients. The trust has recognised that we need to review our inventory of cooling assets to understand both the current coverage and the gaps. If we are to adapt to future climate change impacts, improved cooling will be essential, so taking stock of any deficiencies is now critical. We will also be undertaking retrospective analysis to better understand how hot our buildings got during the peak of the heatwaves, by

interrogating the data within building management systems. Whilst we have a heatwave planning group and a dedicated business continuity plan for severe hot weather, the latter was created for the world of yesteryear, and this now needs to be brought up-to-speed with the pace of change we are actually seeing on the ground.

Whilst cooling will add to our consumption profile, this should be balanced by the fact that less heating will be needed in the coming decades, meaning there will be a displacement effect. However, better insulation can also keep heat out of buildings and there are other things we can do to improve shading – i.e. reduce solar gain – that don't incur as much on-going expenditure of energy and cost/carbon by association, including external shading screens and facades, window shutters, window awnings, strategically-placed trees, green walls, and so on. Where we do install heat pumps in the years to come, care will be taken to ensure that they are future-proofed, in the sense that they will be capable of providing both heating and cooling at a later date, without the need for further costly retrofitting.

We are also mindful of the need to undertake a climate vulnerability assessment, to gain a fuller appreciation of the risks our organisation faces, and what we can do to address these. Some of the likely issues of the future – beyond extreme weather events – might be things like crop failure, drought, medicines supply disruptions, increased frequency of injuries caused by extreme weather (e.g. high winds), climate refugee pressures on the trust, and mental health problems caused by the adversity people will experience. We need to be equipped to respond to all of these challenges.

Biodiversity enhancement – Our extensive greenspace assets offer potential to academically explore and research initiatives like green prescribing as a testbed for innovation, *in situ*, with a view to reconnecting people with nature and improving the mental and physical wellbeing of patients by association. This can simultaneously have the same positive impacts for staff and students enjoying those spaces as well. In the spring and summer of 2022, around 10 acres of previously close mown grass fields were left to go to meadow at Pinderfields Hospital in Wakefield. With no seeding whatsoever, 50 species of wildflowers were recorded, without even considering grasses and sedges, which also add biodiversity value. A further peripheral edge of around 1 acre was also allowed to grow. These parcels of land will not be mowed until September 2022, to allow insects to complete their lifecycles.

The premise wasn't to start managing the grounds as a nature reserve per se, but rather to do all that we could to support nature recovery both within our grounds and on other land we own, even though it may eventually be developed. We also have extensive hedgerows onsite at Pinderfields, which are mostly composed of hawthorn and elder. These are dense and tall, with numerous birds nesting within them, including house sparrows, goldfinches, and long-tailed tits. In addition, a pied wagtail nest was discovered in a planter within a courtyard inside the hospital itself during spring 2022, and all three chicks fledged. We hope to create a new 700m double run of mixed native broadleaf hedging along the metal fence edge of the hospital during the coming winter in early 2023, which will involve planting approximately 5k trees. We also recently realised that we have two mature wych elm trees within the grounds of Pinderfields Hospital. These have been estimated to be 100-120 years old and have somehow escaped the ravages of Dutch Elm Disease so far. They could prove to be important specimens and may well be a haven for white letter hairstreak butterflies, which have an exclusive dependency on elms.

Appendix X – Carbon accounts for MY decarbonisation journey so far

		Carbon Reduction Tracker			% emissions change to date against BY	Latest social cost of carbon (£)
Emissions categories	**Units**	**2019/20 FY (BY)**	**2020/21 FY**	**2021/22 FY**		
Scope 1 - Direct Sources						
Gas consumption	kWh	35,229,893	41,940,449	44,101,350	24.7%	£557,355
Oil consumption	kWh	1,254,944	217,084	293,068	-76.6%	£4,990
Fossil Fuels - Emissions	**kgCO2e**	**6,786,673**	**7,765,136**	**8,149,924**	**20.1%**	**£562,345**
Anaesthetic gases	kgCO2e	2,133,388	1,189,464	1,842,506	-13.6%	£127,133
Nitrous & Entonox	kgCO2e	3,053,949	2,719,042	2,088,013	-31.6%	£144,073
Medical Gases In Use - Fugitive Emissions	**kgCO2e**	**5,187,337**	**3,908,506**	**3,930,519**	**-24.2%**	**£271,206**
Petrol - cars	kgCO2e	66,441	59,256	58,277	-12.3%	£4,021
Diesel - cars	kgCO2e	36,941	46,333	44,559	20.6%	£3,075
Hybrid electric - cars	kgCO2e	22,587	14,839	12,217	-45.9%	£843
Uncategorised - cars	kgCO2e	1,833	-	-	-100.0%	-
Diesel - vans	kgCO2e	268,685	117,210	151,092	-43.8%	£10,425
Electric - vans	kgCO2e	901	1,372	1,163	29.1%	£80
Shuttle buses	kgCO2e	-	93,140	93,690	-	£6,465
Heavy commercial vehicles (HCVs)	kgCO2e	-	44,516	67,863	-	£4,683
Trust Fleet - Emissions	**kgCO2e**	**397,387**	**376,666**	**428,861**	**7.9%**	**£29,591**
Refrigerants & other fugitive gases	kgCO2e	-	-	-	-	-
Refrigerants/Other - Fugitive Emissions	**kgCO2e**	**TBC**	**TBC**	**TBC**	**N/A**	**N/A**
Scope 1 - Emissions	kgCO2e	12,371,398	12,050,308	12,509,303	1.1%	£863,142
Scope 2 - Indirect Sources						
Electricity supply & consumption	kWh	31,635,327	31,843,258	31,770,272	-16.6%	£465,459
Electricity Supply - Emissions	**kgCO2e**	**8,085,990**	**7,423,937**	**6,745,782**	**-16.6%**	**£465,459**
Scope 2 - Emissions	kgCO2e	8,085,990	7,423,937	6,745,782	-16.6%	£465,459
Scope 3 - Upstream/Downstream Sources						
Asthma inhalers	kgCO2e	161,713	131,634	197,572	22.2%	£13,632
Asthma Inhalers - Emissions	**kgCO2e**	**161,713**	**131,634**	**197,572**	**22.2%**	**£13,632**
Domestic waste (landfilled %)	kgCO2e	778,890	0	0	-100.0%	£0
Domestic waste (incinerated %)	kgCO2e	15,438	287,844	297,172	1824.9%	£20,505
Domestic waste (recycled % assumption)	kgCO2e	2,797	320	0	-100.0%	£0
Alternative treatment (orange clinical waste)	kgCO2e	99,575	392,610	288,642	189.9%	£19,916
Offensive waste (tiger clinical waste)	kgCO2e	269,706	155,337	224,505	-16.8%	£15,491
Infectious waste (yellow, purple, & red clinical waste)	kgCO2e	394,158	177,640	345,044	-12.5%	£23,808
Confidential waste (recycled)	kgCO2e	1,068	2,196	1,946	82.3%	£134
Domestic & Clinical Waste - Emissions	**kgCO2e**	**1,561,632**	**1,015,946**	**1,157,309**	**-25.9%**	**£79,854**
Water supply	kgCO2e	83,596	84,244	36,461	-56.4%	£2,516
Water treatment	kgCO2e	173,386	173,386	66,560	-61.6%	£4,593
Water Supply & Treatment - Emissions	**kgCO2e**	**256,983**	**257,631**	**103,021**	**-59.9%**	**£7,108**
Petrol	kgCO2e	308,396	249,754	248,686	-19.4%	£17,159
Diesel	kgCO2e	104,165	94,813	106,381	2.1%	£7,340
Hybrid (standard & plug-in)	kgCO2e	2,014	2,009	5,407	168.4%	£373
Battery electric vehicle (BEV)	kgCO2e	-	16	138	-	£10
Uncategorised cars	kgCO2e	5,357	288	48	-99.1%	£3
Private Car Use - Emissions	**kgCO2e**	**419,932**	**346,880**	**360,660**	**-14.1%**	**£24,886**
Air travel	pass./km	-	-	-	-	-
Bus travel	pass./km	-	-	-	-	-
Rail travel	pass./km	-	-	-	-	-
Taxi travel	pass./km	-	-	-	-	-
Hotel stays	Room/night	-	-	-	-	-
Non-Car Based Travel - Emissions	**kgCO2e**	**TBC**	**TBC**	**TBC**	**N/A**	**N/A**
Well-To-Tank (WTT) - Fossil Fuels	**kgCO2e**	**906,725**	**1,013,933**	**1,382,577**	**52.5%**	**£95,398**
WTT - Electricity Generation & Losses	**kgCO2e**	**1,223,654**	**1,112,603**	**1,911,935**	**56.2%**	**£131,924**
WTT - Trust Fleet & Business Travel	**kgCO2e**	**206,042**	**184,694**	**200,824**	**-2.5%**	**£13,857**
Elec Transmission & Distribution (T&D) Losses	**kgCO2e**	**686,487**	**638,457**	**596,963**	**-13.0%**	**£41,190**
Scope 3 - Emissions	kgCO2e	5,423,169	4,701,778	5,910,861	9.0%	£407,849
Total Emissions	tCO2e	25,881	24,176	25,166	-2.8%	£1,736,450

COMMITTEE REPORT TO TRUST BOARD – AGENDA ITEM 4.1

Meeting	**Quality Committee**
Date of meeting	**5 August 2022**
Completed by	**David Throssell**
COMMITTEE AGENDA ITEMS	
Are there matters of concern or importance to escalate to Trust Board or another Committee?	
Where has the Committee received assurance?	The Safeguarding Group Exception Report was received and it was noted that: • The Dewsbury Hospital Emergency Departments and Child Assessment Units were inspected on 27 June as part of a Joint Targeted Area Inspection of children's services in North Kirklees. The inspectors required four actions to be taken in response to their findings, two of which were already under way at the time of the inspection. Progress in completing these actions will be reported back to the Quality Committee • MAYBO de-escalation, breakaway and clinical holds training was progressing with successful recruitment to two band 4 positions with a further two posts out to advert. The target date for implementation of the project was 1 October 2022. • The Complex Needs Team and the Division of Surgery had been shortlisted for both a Health Service Journal (HSJ) Patient Safety award and a Nursing Times learning disability achievement of the year award for their work on prioritisation for surgery of patients with learning disabilities • Due to its complexity, the Liberty Protection Safeguards (LPS) consultation had been extended until the 14 July 2022. At that point in time there was no confirmed start date for LPS, but the expectation is that the scheme will not commence until 2023/2024. The Committee received the Division of Adult Community Services Governance Review Report and it was noted that: • All ACS staff who were re-deployed during the pandemic have returned to work within their host teams and services. The Division of Surgery Governance Review report was received and the following was noted: • The Division provided a detailed report on its reflective review of pressure ulcers reported over the last 12 months,

	focusing particularly on ICU, which was the area of highest incidence • The Mid Yorkshire Breast Team had become one of the first in the country to adopt new Magseed and Magtrace technology • An update was provided about the prostate cancer pathway, when members of the committee were given assurance about the performance of the service based on a detailed discussion of audit findings. From the CQC Action Plan Exception and Insight Reports it was noted that: • Eight of the 57 improvement actions from the 2018 inspection remained open • In the last reporting period, the BRAG status of the must do action plan to improve compliance with core and role-specific mandatory training had improved from red to amber. On this basis, no open action plans were rated as red • Trust-level performance against four of the five key questions in the latest CQC Insight report remained stable, but declines continued to be seen in maternity, outpatients and critical care, for reasons that have been discussed previously • Based on November 2021 to April 2022 data, the median time to report incidents to NRLS was 62 days for the Trust, compared with 20 days for all trusts nationally and five days at MY previously. Further investigation had established that this delay was due to a new process of clinical validation of incidents graded moderate or above prior to submission. Discussions were ongoing to agree how the process could be streamlined. The Committee received the Learning from Deaths Committee Quarterly Report and noted that: • The rolling 12-month HSMR had been “as expected” since May 2021, and the rolling 12-month SHMI had remained “as expected” for the last six reported quarters • Due to significant staffing shortages within the Clinical Coding department, coding of patient records was being delayed, which spuriously raised the HSMR. Mitigations were being put in place, but it was predicted that the position would not recover fully for 6-9 months • The Medical Examiner function continued to embed, and for the last eight months 100% of deaths had been reviewed by the Medical Examiner Officers with 93%

	deaths in Q1 2022/23 receiving Medical Examiner scrutiny.
Has the Committee asked for any further action to be taken, if so, what action, by whom and within what timescale?	
ANY OTHER MATTERS TO BE REPORTED TO TRUST BOARD	
COMMITTEE ADMINISTRATION	
Committee Self-Assessment for 2021/22 complete?	**Yes - Reviewed**
Terms of Reference up to date?	**Yes – Approved**
Workplan up to date?	**Yes – 2022/23 work plan approved**
Committee Annual Report due?	**Yes – Approved**

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW	
Agenda item	4.2
Paper title	Maternity Services and Assessment Report – August 2022
Responsible Director	Director of Nursing & Quality and Maternity Safety Champion Mrs D Parkes
Author	Director of Midwifery and Women's Services, Families and Clinical Support Services Dr Anne-Marie Henshaw
Previously considered by	

The Board/Committee is asked to:

Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

Drawing on a range of sources of intelligence, this report offers assurance to Board that the safety and quality of maternity services continues to improve. Detailed information about activities undertaken in month to continually learn from experience and improve in the safety and quality of maternity services at Mid Yorkshire Hospitals NHS Trust is provided.

This month's report summarises progress with Ockenden report recommendations and NHS Resolution Maternity Incentive Scheme Year 4.

Sections to draw to the Board's attention to in this report are:

Section	Description
2	Update on progress with 7 Immediate and Essential Actions outlined in the Ockenden report
3	Maternity Staffing Update – Increased risk to service delivery due to medical workforce gaps and midwifery gaps (vacancy, sickness and maternity leave). Midwife to birth ratio in July 1:28 (Plan 1:24).
5.4	Stillbirth and Neonatal Death – there have sadly been 10 babies' stillborn year to date, with 4 cases in July. A thematic review has been undertaken into all cases. Findings: The number of reportable stillbirths for the period of April-July 2022 remains like that reported previously in 2021. The stillbirth rate for the trust remains static at approximately 2.89%, from a national average of 4.1 per 1,000 births in 2021.

Trust Board are asked to receive the August 2022 maternity services assurance report.

Link to strategic objective(s)	*Highlight relevant box from the below:*
	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances

	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	*Highlight one box from the below:*
	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	

Main Paper:

1. Introduction and Purpose

Drawing on a range of sources of intelligence, this report provides assurance to Board about work undertaken to continuously improve the safety and quality of maternity services at Mid Yorkshire Hospitals NHS Trust.

Following publication of the Ockenden Review in December 2020, NHS England Improvement challenged NHS providers, commissioners and Local Maternity Systems to reflect on whether existing assurance mechanisms for maternity services are effective and ensure poor care and avoidable deaths with no visibility or learning cannot happen in their organisations. To ensure Trust Boards strengthen their oversight of maternity and neonatal safety, and to provide for consistent and methodical oversight of all services, NHS England Improvement have set out minimum quality measures to assist Trust Boards to address any issues in a timely fashion without the need for external intervention. This paper has been produced in accordance with these requirements.

2. Update on progress with Ockenden report recommendations and NHS Resolution Maternity Incentive Scheme Year 4

2.1. Outcome of the Ockenden Insight Visit June 2022

The final report of the June 2022 NHS England and Improvement Ockenden Insight visit was received by the Trust on 27 August 2022.

The purpose of the visit was to assess compliance with the 7 immediate and essential actions from the first Ockenden report published December 2020. The visit was supported by West Yorkshire and Harrogate Local Maternity System, Wakefield and North Kirklees Clinical Commissioning Group teams and Maternity Voices Partnerships.

The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were in place and becoming embedded in practice. Full details of the findings are provided in Appendix 1.
The use of appendices is encouraged to ensure that the report is concise and focusses on only the most pertinent details in this section.

Summary:

- An open and honest culture was clearly evident and commitment to high quality compassionate maternity care was positive to see.
- The evidence submitted prior to the visit was of a very high standard.
- Open & honest staff, on the day of the visit a limited number of medical staff were available which would have supported further triangulation.
- Clear reporting structure evident.
- ‘BOSH’ prompts on ward to enhance safety showed a culture which is focused on improving safety, quality and experience for women, families and those working to support them.
- Governance processes are robust, with good examples of testing learning shared with the visiting team.
- Sharing of learning via different sources to include staff in all areas was observed, this was valued by the staff.
- Staff reported good visibility of senior leaders on labour ward. This was particularly valued in times of high acuity where staff felt supported.

- The support of the preceptorship midwife and newly introduced role of recruitment and retention and pastoral support midwife, was noted by staff as positive additions in respect of support for early career midwives and cultural change in teamworking and 'belongingness'.
- The work and input of an effective MVP team has enabled significant improvements in the past 12 months.
- The Insight Visit Team found the MY team demonstrated their commitment to improvement and innovation.
- The team were clear about their challenges, which includes recruitment/staffing, culture and morale and demonstrated a unified consistent approach to solution focused resolution of these challenges.
- Peer support mechanisms across the service with good psychological support for staff was apparent and valued.

The Insight visit considered progress against the 7 immediate and essential actions (49 questions)

- 46/49 questions were assessed as fully complaint with actions embedded.
- 3/49 questions were assessed as partially compliant.

Table 1: Summary of compliance with 7 immediate and essential actions

Partially compliant question	Comments from the Insight Visit Team
Is a RA review and discussion of place of birth recorded at every contact with a Personalised Care Support Plan	Audits articulated. Personalised care and support are not fully embedded, the service articulated ongoing work with the MVP to address this element.
Can women participate equally in all decision-making processes and make informed choices about their care?	The service refers to shared decision making. Professional discussion and debate explored the services understanding of informed choice and sharing of all evidence with women to enable them to make truly informed choices. It was clear that assurance around this element was given from a professional perspective rather than a lived experience perspective. The service was keen to consider and develop methods of gaining feedback around this element that reflected the lived experience perspective.
Are women's choices respected following informed discussion and decision made?	It was clear from discussion that this service is forward thinking in supporting women's choices and uses language within guidance which is considered and respectful. Audit of this needs to be strengthened so that the service can continue with this philosophy.

Table 2: Insight Visit Team recommendations and MY response

	MY response	Lead and timescale
Further embed coproduction by involving the MVP earlier and inviting them to maternity safety champion meetings bi-monthly.	To discuss further at August Maternity Surveillance Meeting to understand capacity of MVP (Currently 3 days – 1 day Kirklees and 2 days Wakefield) and prioritisation. MVP invited to attend Maternity Safety Champion meetings from September 2022.	DOM. End Q2.
Further coproduce the website & service user information so that it is made easier to navigate, access and understand.	This work is already in progress.	Maternity Development Manager. End Q3.
Evolve further methods of service user self-evaluation for example 'Did you feel you had informed choice?'	Recommendation shared with Personalised Care Group – awaiting feedback from their discussions.	Chair Personalised Care Group and patient experience lead End Q3.
Consider further training around language and communication with women & families	'Customer service' training currently being planned – curriculum team working with MVP and patient experience lead.	DHoM Patient Experience Lead End Q3
Consider doing '15 steps' on delivery suite and 'whose shoes'	Completed the week of the Insight visit – already arranged. Awaiting report from MVP.	Action complete.

2.2. Update on progress with recommendations of the final report of the independent review of maternity services at The Shrewsbury and Telford Hospitals NHS Trust

The final report of the independent review of maternity services at The Shrewsbury and Telford Hospitals NHS Trust (Ockenden report) was published in March 2022. Organisations were asked to benchmark against the recommendations, mindful that publication of the report of the Independent Inquiry into East Kent Maternity Services is due and that following this a national maternity improvement programme will be developed.

We RAG rated our position against the recommended actions; progress has been made against all actions rated red or amber.

Table 3: Summary of progress with RED RAG rated actions from the final report of the independent review of maternity services at The Shrewsbury and Telford Hospitals NHS Trust

Action	Summary of progress	Lead and timescales
All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Awaiting details of national training programme being developed by NHSEI. All MY coordintors have opportunity for coaching from WOD and have been encouraged to attend workshops on behaviour management – uptake has been variable, and this is being discussed in appraisals and team meetings.	Matron for Labour Ward End Q3 – assuming direction from national team
All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Review of clinical skills facilitators being undertaken as part of the midwifery workforce review. There is some provision across inpatient areas but currently no provision in community settings.	Deputy HOM End September 2022.
Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	To be confirmed	To be confirmed
Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Maternal Medicine Consultant has been appointed. Reviewing medical and midwifery workforce to understand what support is required to fulfil this action.	HOCS End Q3
There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Audit commenced. First report due end Q2.	Audit Midwife End Q2
Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Working with LMS to establish what is required to meet this action (specialist midwifery role or midwife with special interest)	Deputy HoM End September 2022

2.3. Update on progress with NHS Resolution Maternity Incentive Scheme Year 4

The service continues to work towards full compliance of all 10 Maternity Incentive Scheme safety actions.

A detailed summary of progress against each safety action is in Appendix 2.

The deadline for submitting declaration of compliance to NHS Resolution is 5 January 2023, 12.00.

As per requirements of NHS Resolution, the final assessment of compliance with the Year 4 scheme will be available for November Public Trust Board.

Outline of progress:

On track to compliance within timescale		7/10
Risk to compliance within timescale – mitigations in place		1/10
Risk to compliance – significant risk that mitigations will not deliver within timescale		2/10

Safety actions rated as being at significant risk that mitigations will not deliver within timescale are:

> ***Safety action 6:*** *Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?*
>
> ***Safety action 8:*** *Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day to include maternity emergencies. 90% of each relevant staff group to attend an in-house 1-day MDT day to include antenatal and intrapartum fetal monitoring and surveillance. 90% of the team required to be involved in neonatal resuscitation and management of the deteriorating newborn have attended in-house neonatal life support or NLS.*

This due to staff being required to work clinically to ensure safe staffing leading to cancellation of fetal monitoring and essential and role specific training.

A recovery plan has been developed; however, given continued staffing pressures across all professional groups the recovery plan is fragile.

3. Bronte Birth Centre Update

Bronte Birth Centre remains suspended temporarily to maintain safe care across the maternity service.

The Trust has been working in partnership with colleagues at Calderdale and Huddersfield NHS Foundation Trust towards the ambition of a single birth centre in Kirklees. A joint Birth Centre Advisory Group is being arranged with partners from the CCG, MVP and Public Health to advise and guide the project. The work will report the Partnership Board.

Timescales will be determined by recruitment of midwives to both organisations.

4. Maternity Workforce

4.1. Obstetric and anaesthetic cover on Labour Ward

Table 4: Medical Staffing

Requirement	Rota/ Compliance
Safer Childbirth/RCOG: The Future Workforce: Recommended minimum Consultant presence on labour ward per week: — <2500 births: 40 hours or based on risk assessments — 2500 – 6000 births: 40 hours — >6000 birth: 60 hours	98 hours of labour ward consultant cover per week
Safer Childbirth: There should be a minimum twice daily ward rounds, including bank holidays and weekends. They should be available within 30 minutes if required.	Compliant
A duty anaesthetist must be immediately available 24/7. There must be 12 consultant sessions per week to cover emergency work on delivery suite. Scheduled obstetric anaesthetic activities (e.g. elective caesarean section lists, clinic) require additional consultant sessions over and above the 12 for emergency cover.	Compliant
Day 08:00 – 18:00	No rota gaps
Twilight 12.30 – 22:00	No rota gaps
Night 20:00 – 08.30	No rota gaps

Gaps on the Consultant and Tier 1 and 2 rotas continue to impact on the governance function.

We have successfully recruited to the Maternal Medicine post with the new appointee expected to start working at the Trust in the next three months.

HOCS has met with a representative for our SAS doctors to look at ways of improving their work life and making them feel included and appreciated within the department.

4.2. Midwifery Staffing Update

Achieving safe staffing levels across all areas continues to be one of the service's highest risks (Risk ID:5869, Risk rating: Increased from 15 to 20).

- Vacancy, maternity leave, and sickness across all areas has meant that shift fill has been below planned workforce models despite robust roster management and use of Bank and Agency.
- Staff unavailability exceeds the planned roster allowance in all areas except outpatients and Pinderfields Birth Centre (Table xx)
- Reduced shift fill has had a negative impact on patient and staff experience as staff are moved from area to area to maintain safety following risk assessment by Matrons and Managers.
- Staffing gaps across the service have contributed to the continuing temporary suspension of Bronte Birth Centre.

- The Business Continuity Plan has been used throughout Quarter 1 and 2. This has resulted in the cancellation of some training and continuous professional development events. A recovery plan has been developed to 'catch up' during Quarter 4.
- The recruitment strategy continues to be implemented however the midwifery recruitment team report fewer applications for each vacancy than previously received.
- We expect 22.24wte midwives to join us in September and October. Approximately 15wte are newly qualified.
- We have offered posts to 10 international midwives and continue to recruit suitable candidates. We expect the first international midwife to join us October/ November, but it may be 2023-2024 before all 10 are in post.
- As a result, we forecast not meeting workforce model for the remainder of 2022-2023. This is consistent with other Trusts in the Local Maternity System and North of England.

Table 5: Vacancy Summary end July 2022

Staff Group	Workforce Model Requirement WTE	Workforce Model Actual WTE	Budgeted Variance WTE	Variance WTE (inc maternity leave)
Registered Midwives	238.46	214.79	23.67	35.7
RGN – Labour Ward	12.04	8.3	3.74	4.74
RGN – Gate 18	5.24	0	5.24	5.24
Total	255.74	223.09	32.65	45.68 (18%)

Unavailability - Sickness

- Rates of long- and short-term sickness continue to exceed uplift and impact on patient and staff experience, and quality of care.
- Pressures and stress at work due to staffing gaps is likely to have contributed, at least in part, to poor results in the 2021 CQC Maternity Survey and Friends and Family Test. Work is continuing to improve leadership capability and confidence to improve staff wellbeing (for example implementing BOSH) and address staff behaviour.
- Oversight of sickness management by Director of Midwifery, Matrons and HR Business Partners continues with a focus on ensuring timely return to work interviews and wellbeing calls.

Unavailability - Maternity Leave

- 12.02wte midwives are currently on maternity leave. 0.92wte midwives and 0.92wte nurses will return from maternity leave in August.

Key staffing metrics:

- The midwife to birth ratio has further deteriorated to 1:28 (based on 6000 births and excluding midwives on maternity leave and vacancy). Birthrate Plus recommended a ratio of 1:24 (This is reflected in funded establishment).
- The Labour Ward Coordinator was supernumerary 100% of the time.
- 46% of vacant qualified shifts were filled by Bank and Agency in July, 66% of unregistered shifts were filled by Bank.
- 99.5% of women received 1:1 care in established labour across all care settings.

Table 6: % women receiving 1:1 care in established labour (Source: Maternity Dashboard)

Indicator	Aim	Target Type	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	FYTD*
% of all women who receive 1:1 Care in Established Labour	100%	Nat	99.17%	99.22%	99.73%	99.74%	99.47%	99.50%	**99.61%**

5. Essential Training: Management of Obstetric Emergencies (PROMPT) and fetal monitoring training (Risk ID 5806, Risk score 15)

Achieving essential training targets across all staff groups is challenging because training sessions have had to be cancelled or postponed redeploying staff to work clinically to maintain safe care. Recovery plans are being redrafted to ensure compliance meets NHS Resolution requirements.

Table 7: Fetal Monitoring Training

Target 90%

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Online Training								
Doctors	71.10%	71.40%	92.70%	90.20%	86.70%	86.70%	84.10%	65.90%
Midwives	91.70%	88.30%	93.80%	93.70%	92.70%	91.10%	81.70%	88.70%
Study Day								
Doctors	18.92%	30.56%	35.71%	46.65%	47.80%	50%	50%	54.76%
(not including FY/GP)				56.25%	59.40%	62.50%	62.50%	65.51%
Midwives	25.71%	37.97%	60%	76.83%	81.85%	83.92%	83.46%	86.23%

Table 8: Monthly PROMPT and Resuscitation

Target 90%

	Obstetricians	Anaesthetists	ODPs	Nurses	Midwives	MSWs	NAs
Jul-22	82%	63%	78%	89%	83%	62%	100%
Jul-22				78%	84%	69%	33%

6. Risk and Safety

6.1. Risk Register Summary – Current Risk Rating 15 or above

Table 9: Risk Register Summary – Current Risk Rating 15 or above being actively managed.

Risk ID	Description	Current Rating	Target Rating	Update
4839	Risk of poor patient experience and clinical outcomes due to delays in induction of labour management plans of care	15	6	Further time out planned in September to review progress and improve flow.
5643	Risk of a poor neonatal outcome due to a failure to perform intermittent auscultation in line with local guidance	15	5	Continuous audit in place. Progress noted. 1:1's taking place when there is a deviation from guidance.
5878	Risk that the current and planned continuity of carer model is not sustainable due to midwife staffing gaps	15	6	Continuity of carer roll out paused as per guidance from NHSEI post publication of Ockenden report.
5898	Risk that a baby may be unlawfully removed from the maternity unit	15	2	Team continues to work with security to drill safe practice. Work progressing with baby tags project.
5682	The risk of adverse neonatal and maternal outcomes because of not embedding learning from previous incidents	16	4	Evidence this risk is not being adequately mitigated and so work continues to communicate and embed learning from experience via a range of routes.
5779	Risk to patient safety due to non-adherence to accountable items systems and processes	16	4	Evidence this risk is not being adequately mitigated and so work continues to communicate and embed learning from experience via a range of routes.
6006	Risk to the timely delivery of the governance function due to the impact of medical and midwifery staffing gaps	16	4	Workforce review has taken place and plans to backfill gaps for the next six months with additional admin support and professional governance support.
2243	Risk to the ability to deliver a safe and effective service due to obstetric and gynaecology staffing vacancies on the rota	20	8	
4627	Risk of failing to provide a consistently high-quality Maternity service	20	5	This risk has arisen as a result of the combination of all individual maternity service risks.
5778	Risk to continuous delivery of high-quality intrapartum care at Bronte Birth Centre due to temporary service suspension	20	3	Temporary suspension continues due to staffing deficits. All actions to reduce risk of women attending birth centre in labour continue.
5869	Risk of poor-quality patient care and poor staff experience due to midwifery staffing gaps against planned workforce model	20	9	Recruitment and retention strategy in place. International recruitment continues.

6.2. Incidents – moderate and above

17 incidents were graded as moderate harm.

Following rapid review:

- 3 incidents were downgraded.
- 12 remain moderate harm incidents. These include 9 cases of post-partum haemorrhage.
- 2 cases were upgraded to serious incidents.
- In line with guidance, 1 of the serious incidents was reported to HSIB.

Table 10: Summary of incidents graded moderate and above

Reference Number	Summary	Comments
WEB206177 SI 2022/16215	Retained vaginal pack	Case reported as a serious incident
WEB205370 MI-001439 (HSIB Ref) SI 2022/14983 82424 (PMRT Ref)	Intrapartum stillbirth	Case reported to HSIB and therefore a serious incident
WEB205575	Examination under anaesthetic with inadequate analgesia	
WEB207655	Postnatal readmission with wound cellulitis / infection	
WEB 205459	Admission to NNU with hypoglycaemia	This case was deemed an avoidable admission to the neonatal unit.

5.3. Perinatal Mortality Review Tool (PMRT)

Sadly 5 cases were reported to PMRT during the month of July.

- 4/5 cases will be reviewed using the PMRT process.
- 1/5 case was referred to HSIB (WEB205370, HSIB Ref MI-001439, SI 2022/14983, PMRT Ref 82424.
- 2/5 babies were less than 23 weeks gestation.

6.4. Stillbirth and Neonatal Death

6.4.1. Stillbirth

Sadly, four babies were stillborn in July.

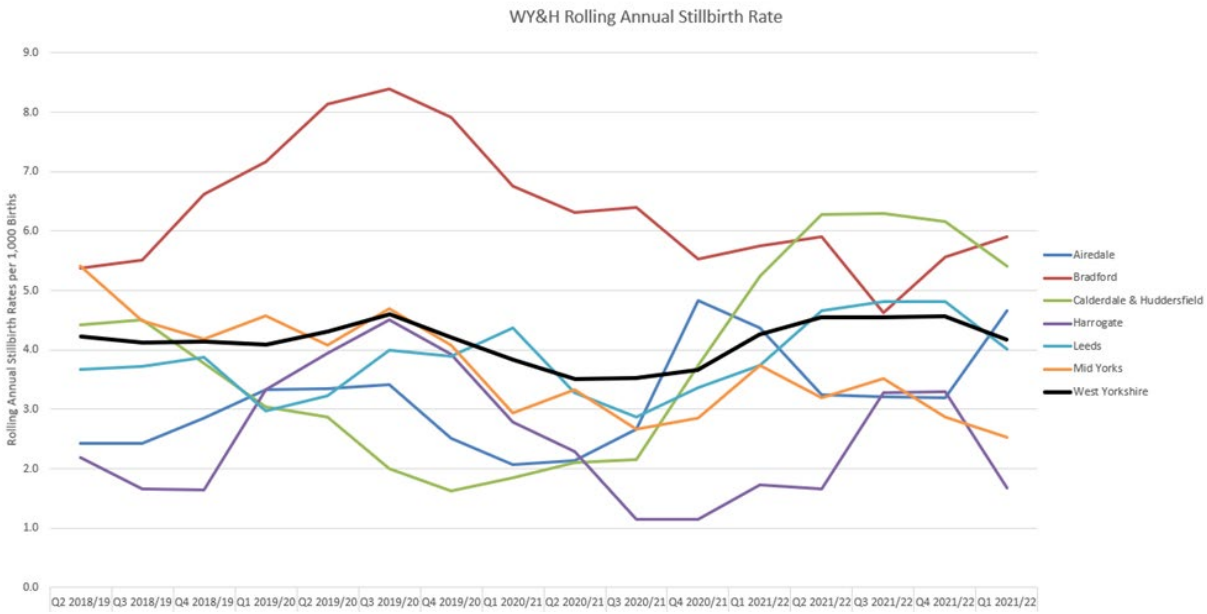
- Three cases are being examined using the PMRT tool; one case is being investigated by HSIB.

Between 1 April and 31 July, ten babies were stillborn at Mid Yorkshire Hospitals. During the same period there has been an increase in serious incidents declared for the maternity services (10) and consequently a thematic analysis of both was undertaken to analyse themes and trends of learning, to understand if they are possibly contributory to each other.

- The annual rate of all stillborn babies per 1000 births remains consistent when compared with the last two years

- Since Quarter 3 2019-2020, Mid Yorkshire Hospitals stillbirth rate per 1000 births has been consistently below the Local Maternity System average.

Figure 1: Rolling Annual Stillbirth Rate



Summary of key themes and trends

Overview:

- Of the 10 reported cases 4 occurred at >37 weeks gestation – on review the consideration of IOL to have expedited these births is only considered in one case and is an ongoing HSIB investigation.
- One case was a feticide for known abnormalities – the decision to terminate this pregnancy was made by the family for lethal fetal abnormalities.
- 4 cases (including the feticide case) had no identifiable learning during the 72-hour review. Learning may be identified during the more comprehensive PMRT reviews, but it is not anticipated there will learning that would have changed the outcomes.
- 6 cases were multiparous women and 4 primiparous women.
- 70% of cases were women receiving consultant led care.
- Only 2 women were known smokers at the time of the stillbirth confirmation
- Only 1 case is an intrapartum stillbirth. Learning around late booking guidance has been identified and the escalation of care for women who choose to have care outside of guidance has been shared. This case meets the criteria for referral to HSIB and is still under investigation.
- Late booking is only a theme in 2 of these cases, the national guidance for the care of women who book late is limited. The discrepancy in this guidance has been raised at the regional LMS safety forum with the hope for some standardisation in guidance and the care pathways advised for these women because of this incidence.
- Reduced fetal movements -
- In 6 cases the stillbirth was confirmed following an attendance to the maternity services with reduced fetal movements (RFM).
- In 4 of these cases, it was the woman's first attendance with RFM. In the other 2 cases it was the woman's 2nd attendance with RFM, the management of their previous episode of RFM was appropriate and followed guidance.

- In 1 case there was a delay in the woman presenting to the maternity services with RFM and on admission there was delay in her midwifery triage review when the stillbirth was confirmed. This case demonstrates a lack of learning from previous similar incidents and has consequently been declared a serious incident by the service.
- It is acknowledged that the concept of asking women to attend maternity services with reduced movements is to identify babies whose wellbeing is compromised. Therefore, the theme of women attending with RFM and having confirmation of a stillbirth is to be expected.

Covid-19 infection:

- 4 of these women (including the feticide) had conformed covid-19 at some point during their pregnancy but were not covid positive at the time the stillbirth was confirmed.
- It is not anticipated that the woman's covid positive status has directly impacted on the outcome in any of these cases, there was not delay in presentation to the service as a result and none required hospital admission during their infective period.
- The known association between covid-19 during pregnancy and stillbirths is still relatively unknown. Research to explore this is continuing, but to date there is no known identified causal link between covid-19 and stillbirths in women who do not require admission to hospital.

Vulnerable women:

- 3 women had ongoing safeguarding involvement to protect either the woman or the unborn baby.
- One of these women had mild learning difficulties.
- Two women did not attend appointments during the antenatal period – in both cases the management of these women followed local 'did not attend' guidance.
- None of the women were from a Black or Asian Minority Background (BAME).
- It is recognised in national literature that women from vulnerable backgrounds are at an increased risk of a stillbirth occurring.
- There were 4 women (40%) who met this vulnerable category, this figure would support the services continued work to adapt care provision to support and target these women primarily within a community setting.

Summary:

- The number of reportable stillbirths for the period of April-July 2022 remains like that reported previously in 2021.
- The stillbirth rate for the trust remains static at approximately 2.89%, from a national average of 4.1 per 1,000 births in 2021.
- There was an increase in cases during July (4), one of these was a feticide and two cases were identified on the woman's 1st attendance with RFM. The antenatal care in both cases has been deemed appropriate, within guidance and so far, there has been no identifiable learning. The fourth case is the HSIB case as discussed above.
- The trajectory for reportable stillbirths is following a pattern that has been seen in both 20/21 & 21/22. In both years there was a peak in stillbirth reporting during the month of September – further analysis to look at themes and trends for these cases would be beneficial to understand the contributory factors (if any) for the increase in reporting during this month.

- 50% of cases (including the feticide) had no identifiable learning (available at present) from the antenatal care these women received.
- Out of the remaining 5 cases, 2 cases have been declared SI investigations and 1 is an RCA investigation. There are no common themes between these cases and immediate learning has been shared with the multi-disciplinary team.
- Following analysis of the 10 cases there were no strongly linked themes and areas of learning.
- The analysis demonstrates that vulnerable women remain at a high risk of having a stillbirth at MYHT, as supported by national evidence. The continued implementation of service improvement initiatives to support these women will be beneficial.
- No women from a BAME background had a stillbirth during the period analysed.
- There are no significant themes that link with the themes identified during the serious incident review that has looked at the same period.

6.4.2. Neonatal Deaths

Sadly 5 babies were born in the Trust and died in the Neonatal Unit from 1 April 2021-31 March 2022.

The Trust mortality rate for the period was 0.87 per 1000 births. This is an improvement on the previous years.

6.5 Learning from SIs concluded in July 2022

No serious incident investigations were concluded in July 2022.

6.6. Impact of staffing shortfalls on business continuity – service suspensions

- Whist staffing levels have been challenging, staff movement from all areas including the deployment of managers, community midwives and specialist midwives and temporary suspension of Bronte Birth Centre has enabled safe care.
- There were no full-service suspensions in July or suspensions of the home birth service.
- Bronte Birth Centre remains suspended temporarily due to extreme staffing challenges. Work is in progress with colleagues at Calderdale and Huddersfield NHS Foundation Trust to explore the possibility of a joint Birth Centre initiative in Kirklees. CHFT have joined Mid Yorkshire colleagues and partners to develop a Birth Centre Advisory Group to progress conversations and review quality standards for Birth centres. The first meeting is planned for September 2022.

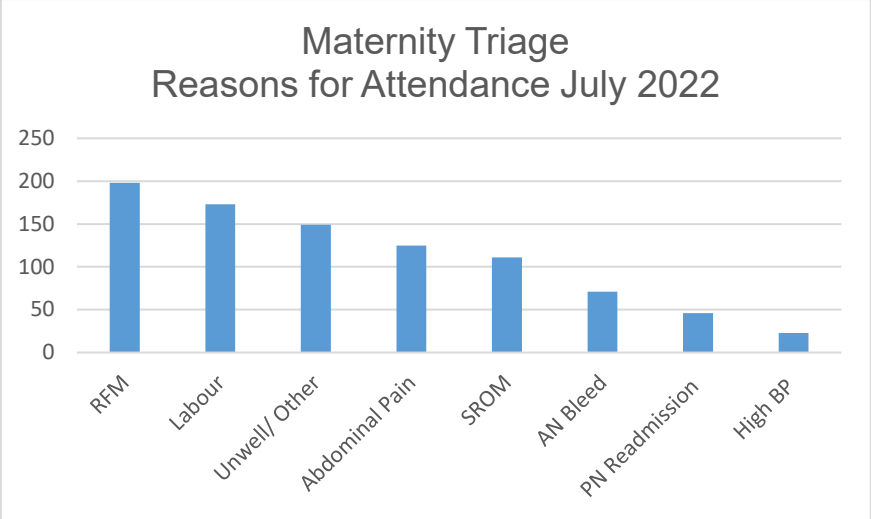
6.7. Maternity Triage

Maternity triage performance data demonstrates continued improvements against the Birmingham Symptom Specific Obstetric Triage System ambitions and the NICE Safer Staffing Red Flag guidance (Triage within 30 minutes).

In July:

- 896 women attended maternity triage.
- 836 women were triaged within 15 minutes of arrival.
- 60 women waited more than 15 minutes for initial triage (6.6%).
- The longest wait was 96 minutes.

Figure 2: Reasons for attendance to maternity triage July 2022



The Local Maternity System Triage Working Group has undertaken a scoping review of implementation of BSOTS across the LMS and made several recommendations currently being considered by the MY Triage Team.

Table 11: Triage best practice recommendations

Recommendation	MYHT response	Next steps, by who, by when
Staff triage 24/7 with 2 midwives for larger units	Compliant plus a telephone triage midwife 8 hours a day	Workforce model currently being reviewed to establish whether triage midwife also required to manage peaks of activity. Workforce Matron By end September 2022.
Develop LMS approved competency package for the following triage skills: Presentation scanning Preterm speculum training Antenatal CTG training	MYHT has in place competency training for all three triage skills – package to be shared with LMS	Trust lead for working group to be identified. Triage manager By end September 2022.

6.7. Delayed Induction of Labour and/or Acceleration (Risk Register ID 4839. Current Risk Rating Reduced to 15).

Staffing shortfalls have had a negative impact on patient flow for induction of labour with most women waiting more than 24 hours for transfer to Labour Ward.

Summary of findings of continuous audit for July:

- The leading indication for induction was diabetes, closely followed by reduced fetal movements
- 29% of women were admitted on their booked induction date for the outpatient service (balloon catheter) and only 26% of those women booked for Prostin were admitted on their agreed date of induction.

- 76% of women who had the balloon catheter birthed within 72 hours from the commencement of Induction of Labour. 62% of women who had Prostin/Propess as their 1st line IOL management birthed within the same period.
- There was more than double the number of Inpatient Inductions to outpatients, impacting on the availability of beds and subsequently increasing delayed admissions.
- The average time between admission and administration was higher than the 2-hour threshold in both non-pharmacological and pharmacological methods of Induction.
- 45% of the women who had a balloon induction had a normal delivery compared to 37% of those that had Prostin/Propess
- 56% of women who had the balloon method went on to have a LSCS compared to 43% of those who had the balloon method.
- The length of time which women waited to be transferred to labour ward continues to increase with 83% of women waiting over 24 hours (June 73% May 61% April 49%, March 25%)
- No women were transferred to Labour Ward at point of being deemed suitable for ARM and only 4% of women were transferred within the 4 hours before red flagging.

All cases of delay are continuously risk assessed by senior clinical staff; no poor outcomes were associated with delayed induction of labour.

A time out session has been arranged with clinical and operational teams to review arrangements for induction of labour and agree what further improvement actions are required to improve performance and experience.

6.8. Findings of reviews of perinatal deaths (PMRT)

Three cases were reviewed using the standardised PMRT process in July.

Table 12: Summary of PMRT cases July 2022

PMRT Reference Number	Summary findings
81150	Review Date – 27.07.22 Grading – B/A/A Awaiting HSIB investigatory report. No immediate learning that would have changed outcome identified.
81849	Review Date – 11.07.22 Grading – B (AN care only) To review process for counselling women about the importance of undertaking an ACTIM PROM test
82058	Review Date – 27.07.22 Grading – A (AN care only) No immediate learning that would have changed outcome identified.

6.9. Findings of reviews of referrals to Healthcare Services Investigations Branch (HSIB)

No HSIB reports were received in July 2022.

The HSIB Quarterly Review Meeting took place on 17 August.

Table 13: Status of open HSIB cases

Case Number	Date of referral	Type	Status
MI-006491	04/02/2022	Maternal Death	Awaiting PM report
MI-006885	24/02/2022	HIE / Cooling	For factual accuracy
MI-008649	27/04/2022	Neonatal Death	Awaiting PM report
MI-009261	12/05/2022	Neonatal Death	Interviews in progress
MI-011439	10/07/2022	Stillbirth	Scoping in progress

HSIB discussed findings of a secondary analysis of recommendations by category for Trust cases since 2019. The service is now considering ongoing improvement actions aimed at reducing the risk of harm – some actions are part of the Ockenden 2 response.

Table 14: Secondary review of recommendation categories for Mid Yorkshire Hospitals following HSIB investigation

Category	Number of recommendations
Clinical oversight	8
Escalation	8
Guidance	8
Clinical assessment (maternity)	7
No recommendations	6
Risk assessment	5
Fetal monitoring	4
Information	3
Staffing	2
Clinical assessment (neonatal)	2
MDT working	2
Observations	2
Documentation	2
Triage	1
Communication	1
Placentas	1

7. Requests for action from external bodies (e.g. HSIB, CQC, NHS Resolution)
No requests for action from external bodies were received in July 2022.

8. Response to Coroner regulation 28 reports
No Coroners cases and no Regulation 28 reports received in July 2022.

9. Service User Voice: Learning from feedback and complaints

9.1. Friends and Family Test

There was a significant deterioration in Friends and Family Test results in July. Wards and departments of most concern are:

- Home births
- Antenatal clinics
- Pinderfields Birth Centre
- Gate 18
- Labour Ward

Managers and Matrons are reviewing feedback, free text comments, complaint data and patient experience improvement plans to ensure improvement plans reflect feedback and have SMART actions.

Oversight of plans will be via the Personalised Care Subgroup of Maternity Governance with further updates to the Patient Experience Sub Committee and Board in September.

Table 15: Summary of FFT response rates and % negative experience

				Overall, how was your experience of our service?										
Site	Division	Print Room Code	Ward/ Area	Very Good	Good	Neither good nor poor	Poor	Very poor	Don't know	Total Responses	Patient numbers through service	% Response proportion	%Positive experience	% Negative experience
DDH	Families	FFT112	Antenatal clinic DDH	30	7	4	4	3	0	48	575	8.3%	77.1%	14.6%
PGH	Families	FFT113	Antenatal clinic 10b PGH	56	18	0	5	7	0	86	879	9.8%	86.0%	14.0%
PGI	Families	FFT115	Antenatal clinic PGI	26	6	3	3	3	0	41	557	7.4%	78.0%	14.6%
DDH	Families	FFT111	Community Antenatal DDH	66	20	6	2	2	0	96	945	10.2%	89.6%	4.2%
PGH	Families	FFT114	Community Antenatal PGH	172	15	7	5	1	0	200	1208	16.6%	93.5%	3.0%
PGI	Families	FFT116	Community Antenatal PGI	60	8	1	2	1	0	72	815	8.8%	94.4%	4.2%
PGH	Families	FFT195	Maternity Triage PGH	82	12	3	2	6	1	106	715	14.8%	88.7%	7.5%
DDH	Families	FFT117	Bronte Birth Centre	1	1	0	1	0	0	3	0	0.0%	n/a	n/a
PGH	Families	FFT120	Labour suite (G18a) PGH	48	9	2	2	6	1	68	405	16.8%	83.8%	11.8%
PGH	Families	FFT118	Pinderfields Birth Centre	18	4	3	2	3	0	30	48	62.5%	73.3%	16.7%
ALL	Families	FFT119	Home Births	1	0	0	1	1	0	3	9	33.3%	33.3%	66.7%
PGH	Families	FFT121	G18 (postnatal) PGH	75	25	6	5	9	1	121	494	24.5%	82.6%	11.6%
DDH	Families	FFT122	Community Postnatal DDH	63	14	6	1	1	0	85	251	33.9%	90.6%	2.4%
PGH	Families	FFT123	Community Postnatal PGH	78	19	2	1	1	0	101	199	50.8%	96.0%	2.0%
PGI	Families	FFT124	Community Postnatal PGI	20	3	1	1	0	0	25	207	12.1%	92.0%	4.0%
Maternity Totals				**796**	**161**	**44**	**37**	**44**	**3**	**1085**	**7307**	**14.8%**	**88.2%**	**7.5%**

9.2. Complaints

The number of complaints and PALS contacts about maternity services has increased in July compared with previous months.

PALS contacts

- PE62341: Woman felt unsupported by staff and felt there was a lack of pain management

- PE62150: Missed community postnatal checks
- PE61965: Woman provided feedback following closure of BBC
- PE61712: Anonymous – unhappy with care provided, no further details given
- PE61813: Unhappy with lack of continuity
- PE61699: (Polish) woman requesting information about upcoming screening tests as couldn't remember what was said to her
- PE61375: Requesting a copy of surrogacy policy

Complaints

- 11 complaints were received by the Maternity service in July 2022.
- The average number of complaints being received in the previous 12 month rolling period is 6.
- 5 complaints were received about care and treatment on Gate 18. The manager and Matron are undertaking a thematic review which will be presented to September Personalised Care Group.

	Gate 18	Antenatal Clinic	Community Clinic	Community Midwives	Labour Ward	Triage/ PACU	Total
Clinical treatment	5	1	1	1	1	1	10
Staff attitude/behaviour	0	0	0	0	1	0	1
Total	5	1	1	1	2	1	11

Complaints Closed

3 complaints were closed in July (1 closed by telephone resolution).

- 1 upheld, 1 partly upheld, 1 not upheld

Learning from Complaints / Actions taken

- Woman in latent phase of labour felt that she should have had additional monitoring. Advised that during the latent phase of labour we would not recommend interventions– possible breakdown in communication
- Lack of communication when a woman was at home awaiting induction of labour
- Delay in transfer to LW which upset the woman
- Failure to weigh on day 3 which would have identified weight loss earlier
- Side rooms should be allocated where clinically appropriate. If these are unavailable it should be escalated
- Concerns regarding agency midwife – shared with agency

10. National priorities: Continuity of Carer

There is now one remaining continuity of carer team, Dewsbury based Brunswick team.

The team deliver continuity of carer across all maternity care pathways.
Approximately 6% of women booked to birth at MYHT receive continuity of carer from the team.

Plans for further roll out have been put on hold due to staffing shortfalls.

The midwifery rotation programme continues to support development of a flexible workforce able to confidently work across care settings. This should facilitate transition to continuity of carer teams in due course.

The Lead Midwife for Continuity of Carer ended her secondment with the Trust in August and has returned to her employing organisation.

11. Conclusion and Recommendations

Reduced staffing levels continue to affect women's and staff experience; however, outcomes remain stable, with slight improvement in several metrics. Rates of stillbirth, term admission to the neonatal unit and neonatal mortality remain below the Local Maternity System mean. The service continues to make progress against all Ockenden actions and the NHS Resolution Maternity Incentive Scheme safety actions.

Trust Board are asked to receive the August 2022 maternity services assurance report.

Appendix 1

Mid Yorks Ockenden KLOES next steps repc

Appendix 2

	Rating (August 2022)	Summary of Progress
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		Latest downloaded PMRT report (19 August 2022) confirms we are on track. New dedicated senior administrative support has improved case tracking and quality of reporting.
Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		A subgroup of the Maternity Data Oversight Group met on 18 August to review the July 2022 MSDS submission (on which the Year 4 compliance for safety action 2 is assessed). The group reviewed the data quality tools available and were able to provide assurance to the chair of the group that all six standards should be met. There is a further way to pass this standard if the Trust uses the NHD Digital data quality checking tool – we have evidence of completing this monthly.
Safety action 3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		Quarterly audit of TC pathway from Q1 22-23: audit report complete and due to be presented through September governance meetings. PMO have supported NNU team to create new audit tool and report. ATAIN action plan completed by 29 July 2022 deadline. Process required for sharing review findings and ATAIN action plan with required stakeholders: LMNS & ICS quality surveillance meeting. **Lead: CYP AND/ Neonatal Safety Champion**
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?		Neonatal nursing review in progress – due for completion September 2022.
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Midwifery workforce review in progress – due for completion September 2022. BR+ review planned for January 2023.
Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		**Element 1 smoking cessation:** Must achieve 80% compliance as an average over 4 months. Achieved this for the period 1 April to 31 July 2022. **Element 2 risk assessment for fetal growth restriction** Wording of standard requires FGR risk status to be assessed at booking and at 20 weeks. Have asked for NHS Resolution guidance on further definition of the requirements for 20 weeks. A proposed method for auditing against the 20 week standard, with timescales,

	Rating (August 2022)	Summary of Progress
		has been proposed – awaiting HOCS approval. [Action HOCS] Achieved standard for risk assessment at booking. Achieved standard for risk assessment at 20 weeks (taking proposed approach) **Element 3 raising awareness of reduced fetal movement** June 2022 SBLCBv2 audit demonstrated the required level of compliance. **Element 4 fetal monitoring training** 1-day fetal monitoring training underway. Current compliance, July 2022 (90% required): Midwives: K2 = 81.7%; face-to-face session = 83.5% Doctors (including GP trainees): K2 = 84.1%; face-to-face session = 50%. Risk escalated to HOCS. **Element 5 reducing preterm birth** The June 2022 SBLCBv2 audit reviewed all pre-term births in month. The 80% target for receiving a full course of antenatal corticosteroids within seven days of birth, and 80% target for receiving $MgSO_4$ within 24 hours prior to birth were not met but there were valid exceptional factors why this could not be achieved. The ongoing audit and communication with staff is adequate to meet the standard. **Lead: Maternity HOCS**
Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?		Positive relationship with MVPs and evidence of engagement in place. Working with MVP to collate the required evidence of approved work programme, ToR and remuneration.
Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day to include maternity emergencies. 90% of each relevant staff group to attend an in-house 1-day MDT day to include antenatal and intrapartum fetal monitoring and surveillance. 90% of the team required to be involved in neonatal resuscitation and management of the deteriorating newborn have attended in-house neonatal life support or NLS.		**PROMPT compliance, 1 August 2022 (90% required)** Midwives: 83% MSWs: 62% Obstetricians: 82% Anaesthetists: 63% ODPs: 78% Nurses: 89% NAs: 100% **Fetal monitoring compliance (90% required)** See safety action 6: below standard **Neonatal resuscitation (90% required)** Consultants: 83% (5 of 6) Midwives: 84% MSWs: 68% Neonatal nurses: 72% **Lead: Director of Midwifery and HOCS**

	Rating (August 2022)	Summary of Progress
Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		Maternity Quality Surveillance reporting Maternity Safety Champion and Board walk rounds to triangulate data and sources of information.
Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?		No escalations

The Mid Yorkshire Hospitals NHS Trust

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW			
Agenda item	4.3		
Paper title	Infection Prevention and Control Annual Report 2021-22		
Responsible Director	Mrs D Parkes Acting Director Nursing and Quality Dr J Sarma Director of Infection Prevention and Control		
Author	Mrs C Cruise Mrs A Watson		
Previously considered by	The Trust Infection Prevention and Control Committee The Patient Safety and Clinical Effectiveness (PSCE) Sub-Committee Quality Committee		
The Board/Committee is asked to:			
Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

The Infection Prevention and Control Annual Report details the activities of the infection prevention and control agenda in 2021/22 to improve and sustain patient, staff and visitor safety across all our services.

Key achievements include:

- Supporting the Trust response to the COVID-19 Global Pandemic.
- Delivery of the Annual Infection Prevention and Control Work Programme 2021/22.
- Significant assurance against the Infection Prevention and Control Board Assurance Framework.
- Infection Prevention and Control Nurse 7 day working during the reporting period.
- The work of the Antimicrobial Stewardship Team.
- Maintenance of the high visibility of the Infection Prevention and Control Team to facilitate effective infection prevention and control across the Trust.
- The work and commitment of our Estates and Facilities Teams in keeping our premises clean and fit for purpose and our water systems safe and wholesome.
- The work of the Occupational Health and Wellbeing Team keeping our staff safe.
- Internal Audit of Infection Prevention and Control concluded significant assurance was received.
- Duty of candour completed for all patients assessed as suffering a moderate or above level of harm due to hospital onset COVID-19 infection.
- Zero infections were reported in the Orthopaedic mandatory three-month surveillance, which is below the national average of 1%.

The Trust reported 98 Clostridiodes difficile infection cases and the national objective was not achieved

The Trust reported 4 MRSA bloodstream infections, 2 of these were deemed to be blood culture contaminants.
The Trust Board are requested to review and approve the report for publication on the Trust Website.

Link to strategic objective(s)	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director

The Mid Yorkshire Hospitals
NHS Trust

ANNUAL REPORT FROM THE INFECTION PREVENTION AND CONTROL COMMITTEE TO THE QUALITY COMMITTEE FOR THE PERIOD 2021/22

Executive Summary

The Trust has a statutory responsibility to be compliant with Health and Social Care Act 2008 (Regulated Activities) regulations 2014. A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report details Infection Prevention and Control activity from 1 April 2021 to 31 March 2022, noting our key achievements and performance against national healthcare associated infection objectives for the year.

The prevention and control of infection has remained a high priority for the Trust with a strong commitment to preventing Healthcare Associated Infections.

This report details the activities of the infection prevention and control agenda in 2021/22 to improve and sustain patient, staff and visitor safety across all our services.

The Trust reported 4 MRSA bloodstream infections, 2 of these were deemed to be blood culture contaminants; this was a decrease on the outturn in 2020/21 where 6 Trust attributed cases were reported.

The national objective for Clostridioides difficile infection cases was no more than 50 Trust attributed cases; the Trust reported 98 cases hence the national objective was not achieved. Additional actions were incorporated into the Clostridioides difficile infection reduction plan in quarter 4 in response to the increase in cases.

In addition, the main achievements in the reporting year include:

- Supporting the Trust response to the COVID-19 Global Pandemic.
- Delivery of the Annual Infection Prevention and Control Work Programme 2021/22.
- Significant assurance against the Infection Prevention and Control Board Assurance Framework.
- Infection Prevention and Control Nurse 7 day working during the reporting period.
- The work of the Antimicrobial Stewardship Team.
- Maintenance of the high visibility of the Infection Prevention and Control Team to facilitate effective infection prevention and control across the Trust.
- The work and commitment of our Estates and Facilities Teams in keeping our premises clean and fit for purpose and our water systems safe and wholesome.
- The work of the Occupational Health and Wellbeing Team keeping our staff safe.
- Internal Audit of Infection Prevention and Control concluded significant assurance was received.
- Duty of candour completed for all patients assessed as suffering a moderate or above level of harm due to hospital onset COVID-19 infection.
- Zero infections were reported in the Orthopaedic mandatory three-month surveillance, which is below the national average of 1%.

It must be noted the Global COVID-19 Pandemic has continued to present significant challenges to the NHS and the Trust in the reporting year which cannot be underestimated.

Mrs C Cruise
Head of Infection Prevention and Control

Mr D Melia
Director of Nursing and Quality/Director of Infection Prevention and Control

Mrs D Parkes
Deputy Director of Nursing and Quality/Deputy Director Infection Prevention and Control

Dr J Sarma
Consultant Microbiologist and Infection Control Doctor

July 2022

Contents

Introduction

This report details the activities relating to infection prevention and control (IPC) in Mid Yorkshire Hospitals NHS Trust (MYHT) during the reporting period 1 April 2021 to 31 March 2022 and has been discussed at the Trust Infection Prevention and Control Committee and the Patient Safety and Clinical Effectiveness Sub Committee.

The Infection Prevention and Control Committee (IPCC), chaired by the Director of Infection Prevention and Control, Mr D Melia or the Deputy Director of Infection Prevention and Control, Mrs D Parkes, has met five times in the reporting year. The usual bimonthly schedule was upheld with the exception of July when the scheduled meeting was held in August and the November meeting, which was cancelled due to operational demands.

The membership of the IPCC comprises of:

- Director of Nursing and Quality /Director of Infection Prevention and Control (Chair)
- Deputy Director of Nursing and Quality /Deputy Director of Infection Prevention and Control (Deputy Chair)
- Consultant Microbiologist/Infection Prevention and Control Doctor
- Head of Infection Prevention and Control
- Consultant in Communicable Disease Control/ HCAI Nurse Lead Yorkshire Region – United Kingdom Health Security Agency (UKHSA)
- Divisional IPC leads – Medicine, Surgery, Families and Clinical Support Services and Adult Community Nursing
- Consultant Pharmacist Antimicrobials
- Facilities –Trust and PFI Monitoring Team representative
- Estates Trust and PFI Monitoring Team representative –quarterly attendance
- Head of Health Protection Commissioning, Public Health and Adult Social Care
- Decontamination Lead- quarterly attendance
- Occupational Health and Well Being Practitioner-quarterly attendance

The Head of Infection Prevention and Control is a member of the Trust Patient Safety and Clinical Effectiveness Group and has delivered a monthly exception report on the activities, issues and the position of infection prevention and control.

The IPC Annual Work Programme for 2021/22 was approved at the IPCC meeting in May 2021 and based on the criterion of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 and the IPC Board Assurance Framework. Delivery of the IPC Annual Work Programme 2021/22 has been monitored through the IPCC in line with the Committee Business Programme.

Criterion 1: Systems to Manage and Monitor the Prevention and Control of Infection

The Infection Prevention and Control (IPC) Team

The Director of Infection Prevention and Control (DIPC) role continues to be within the portfolio of the Director of Nursing and Quality. This role is supported by the Head of Infection Prevention and Control (IPC), who has continued to provide leadership on the IPC agenda within the Trust and management to the IPC nursing and administration team, reporting to the Deputy Director of Nursing and Quality. The Matron for IPC has continued to support the Head of IPC in the operational management of the team and IPC service.

The deputy arrangement for the DIPC has been provided by the Deputy Director of Nursing and Quality.

The Head of IPC continues to have overall accountability for the delivery of the activities associated with infection prevention practice which is guided by the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. The Consultant Microbiologist has provided support to the Infection Control Doctor role in the reporting year with the support of an additional Consultant Microbiologist and a Locum Consultant Microbiologist.

IPC services are commissioned by Wakefield and North Kirklees Clinical Commissioning groups (CCG's) which includes the provision of community services to Wakefield residents.

The Head of IPC together with the Trust EPRR Lead has continued to provide support to the Strategic COVID-19 Executive Group in the Trust response to the COVID-19 pandemic, with Divisional Bronze Groups reporting directly to Strategic COVID-19 Executive Group. The Strategic Group was chaired by the Chief Operating Officer.

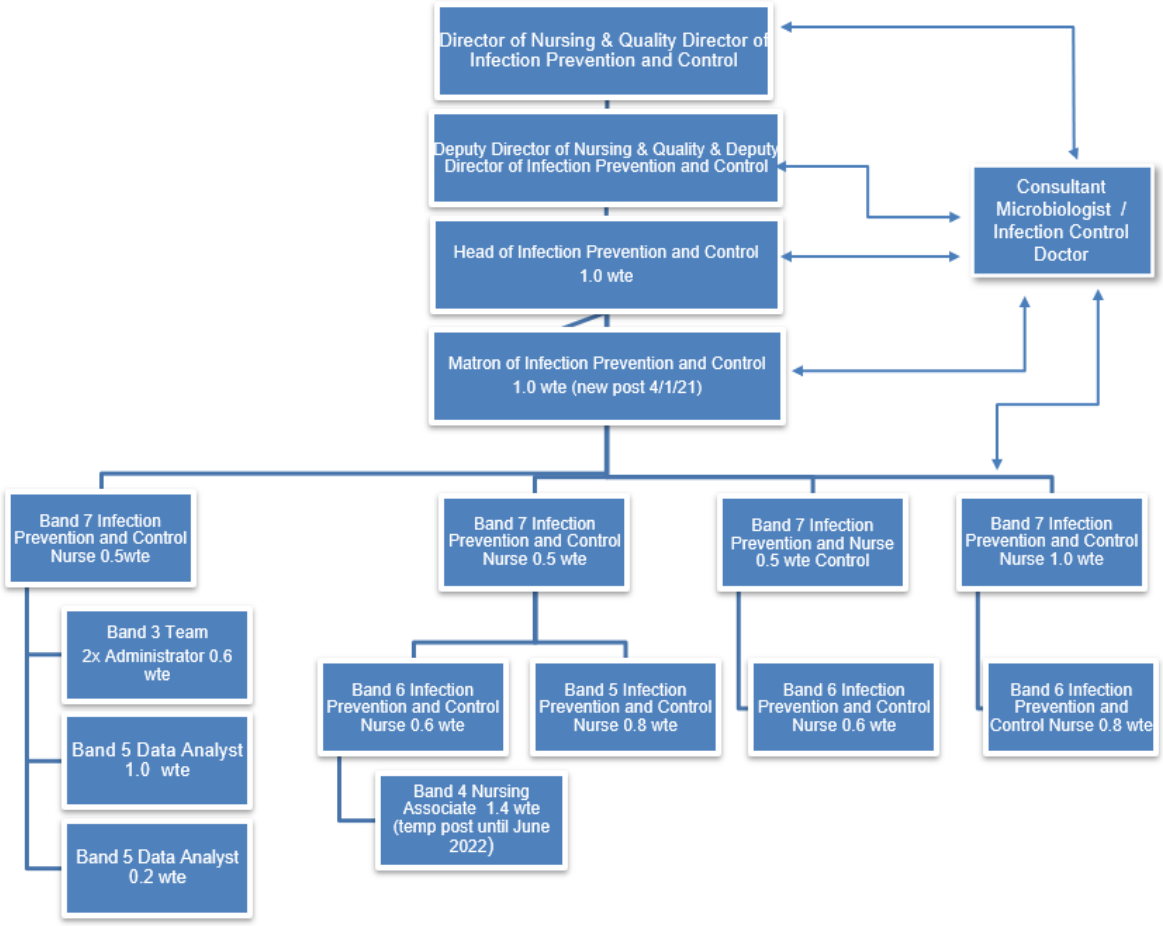
The IPC nursing team have worked alongside Divisional Bronze Groups and clinical colleagues to implement National IPC guidance relating to COVID-19, enhance IPC knowledge and facilitate compliance with IPC policies and guidelines 'every patient, every time'. The responsibilities and reporting structure are demonstrated in figure 1.

The nursing structure detailed in figure 1 facilitates effective and focused infection prevention strategies and actions across our services by:

- High visibility of the IPC nursing team in clinical areas developing close working relationships to facilitate the development of bespoke infection prevention guidance to meet the needs of the service.
- Maintaining working relationships with colleagues at divisional, ward and department level to embed infection prevention practice into everyday practice.
- Recognising opportunities to deliver ad hoc training.
- Supporting clinical colleagues in ensuring that patients are cared for in a safe and appropriate environment and where required post infection reviews (PIRs) are undertaken by clinical teams.

The Infection Prevention and Control Nursing Team have provided 7 day working until 31 March 2022, to support the COVID-19 response, outbreak management and the on call Consultant Microbiologist in infection prevention and control issues that have arose out of routine working hours.

Figure 1: Infection Prevention and Control Team Reporting Structure

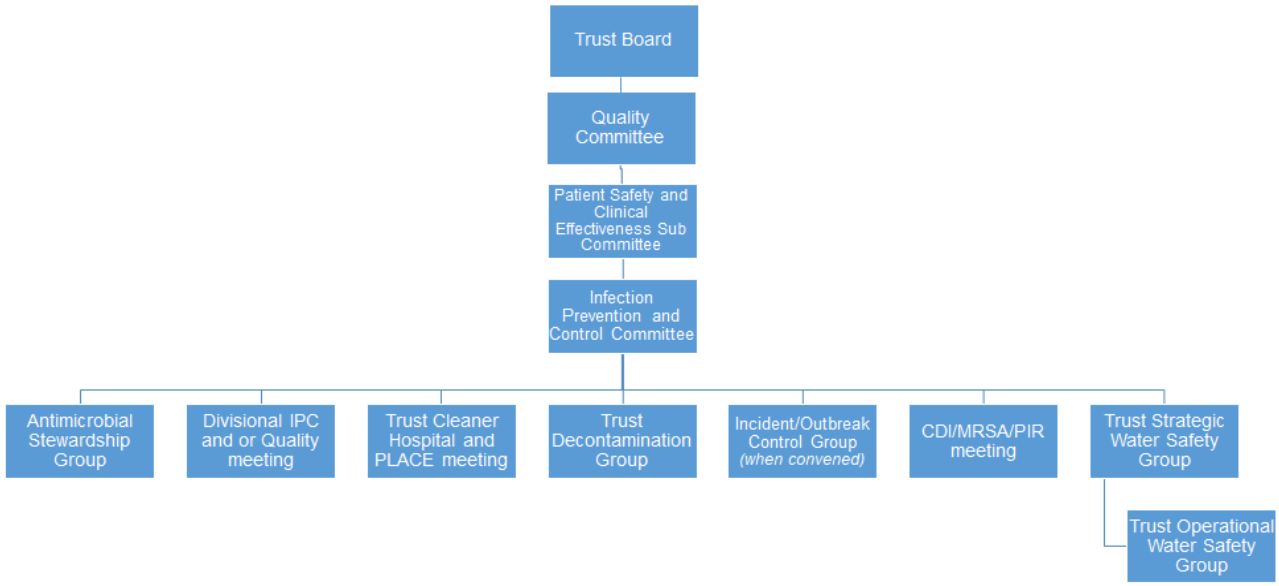


The Infection Prevention and Control Committee (IPCC)

The Trust IPCC has met five times during the reporting year, the meeting planned for November 2021 was cancelled due to operational pressures. The Terms of Reference for the Infection Prevention and Control Committee were reviewed January 2022, with the committee meeting bi-monthly. The Divisional infection prevention and control risks have been monitored through the Divisional Quality and Infection Prevention and Control Meetings and the Divisional Bronze Command Meetings. The IPCC monitored and discussed the activity and risks associated with infection prevention across the Trust.

The Head of Infection Prevention and Control submitted monthly reports to the Trust Patient Safety and Clinical Effectiveness Sub-Committee. The IPC Annual Report for 2021/22 will be presented to the Trust Quality Committee and Trust Board in August 2022. Figure 2 details the reporting structure of the IPC Committee.

Figure 2: Infection Prevention and Control (IPC) Committee Reporting Structure



Internal Audit of Infection Prevention and Control

Internal Audit of Infection Prevention and Control took place in March and April 2022. The objective of the audit is to provide assurance that the Trust's infection control systems ensure risks arising from infections are minimised by implementing robust monitoring and reporting mechanisms. The audit concluded significant assurance was received.

Surveillance of Healthcare Associated Infections

Alert Organism Surveillance

Alert organism surveillance continued in the reporting year, which involves daily review of microbiology results, facilitated by IC Net NG (clinical software surveillance programme). This allows prompt recognition of patients with infection/colonisation of alert organisms/drug resistant organisms, COVID-19, and subsequent initiation of control measures to reduce the risk of transmission and improve the health outcome for the patient.

A daily report is produced and shared with the Divisional Assistant Directors of Nursing, Divisional Clinical Directors, Heads of Clinical Service, Matrons, the Clinical Site Management Team and the Infection Prevention and Control Team Kirklees and Wakefield Council for information.

Mandatory Surveillance

The Trust has continued to report specific organisms, identified by the Department of Health (DH) as part of the mandatory surveillance scheme for acute trusts that was established in 2001.

United Kingdom Health Security Agency (UKHSA) manages and develops the scheme on behalf of the DH and includes the following organisms:

- Meticillin Resistant Staphylococcus aureus (MRSA) blood stream infections.

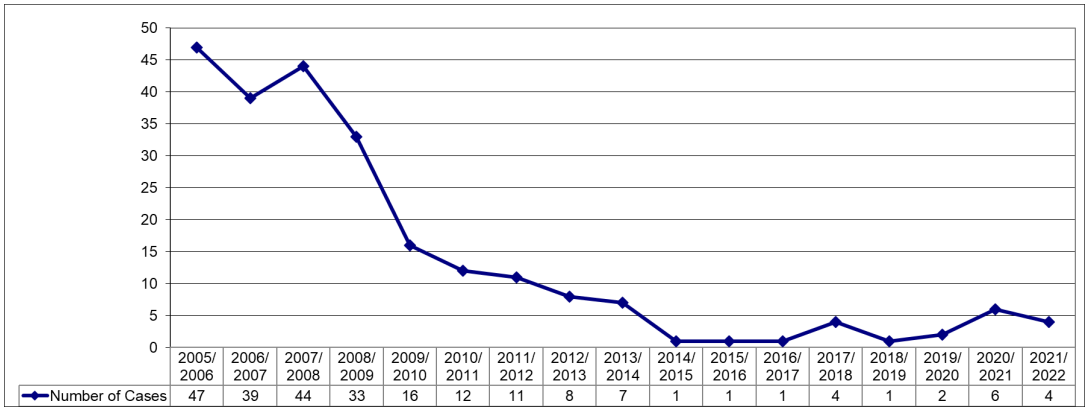
- Meticillin Sensitive Staphylococcus aureus (MSSA) blood stream infections.
- Clostridioides difficile toxin positive cases in patients two years old and above.
- Escherichia Coli bloodstream infections.
- Klebsiella bloodstream infections
- Pseudomonas bloodstream infections
- Glycopeptide Resistant Enterococcus (GRE) blood stream infections.
- Surgical site infections following orthopaedic surgery.

Meticillin Resistant Staphylococcus Aureus (MRSA) Bloodstream Infection

Staphylococcus aureus is a bacterium commonly found on human skin, which can cause infection if there is an opportunity for the bacteria to enter the body, in serious cases it can cause blood stream infection. MRSA is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

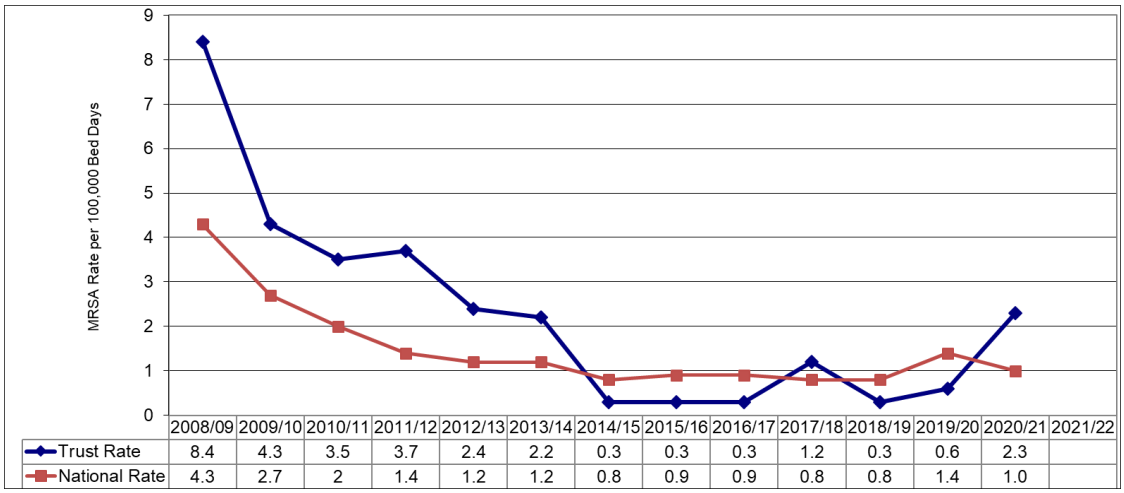
The MRSA blood stream infection objective is divided into two parts; those, which are Trust, attributed and those which are Clinical Commissioning Group (CCG) attributed. The national objective is a zero tolerance to preventable infections. The Trust's performance in relation to MRSA bloodstream infection is monitored against the Trust attributed cases. There were four Trust apportioned MRSA bloodstream infection cases see figures 3 and 4.

Figure 3: Total Number of Trust Apportioned MRSA Bloodstream Infection (BSI) Cases 2005/06-2021/22



	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Number of Cases	47	39	44	33	16	12	11	8	7	1	1	1	4	1	2	6	4

Figure 4: MRSA Bloodstream Infection Rate (Trust Apportioned Cases) 2008/09-2021/22



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Trust Rate	8.4	4.3	3.5	3.7	2.4	2.2	0.3	0.3	0.3	1.2	0.3	0.6	2.3	
National Rate	4.3	2.7	2	1.4	1.2	1.2	0.8	0.9	0.9	0.8	0.8	1.4	1.0	

The rates for 2021/22 are currently not available

All Trust attributed MRSA bloodstream infections are subject to a post infection review to identify the learning and determine preventability. The post infection reviews have been led by the Clinical Teams with support from the Trust IPC Team, Consultant Microbiologist, Consultant Antimicrobial Pharmacist, and the CCG IPC Team. Two cases were deemed to be blood culture contaminants, one case a preventable infection and one cases a non-preventable infection. Figure 5 details the Trust learning and action to address the learning.

Figure 5: Learning from Trust Attributed MRSA Bloodstream Infection Cases

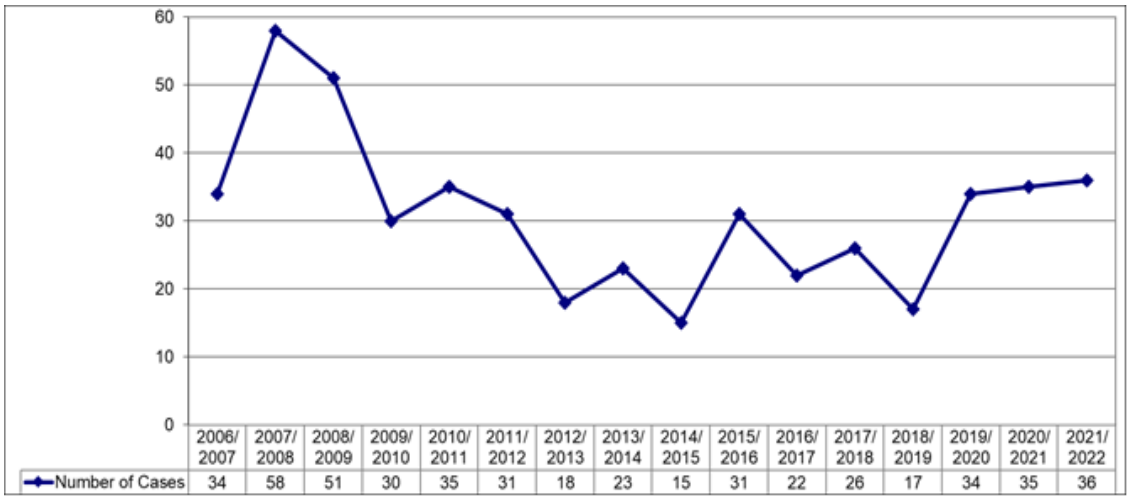
Learning	Action to address learning
Trust guidance on blood culture taking was not followed.	IPC Team supported the clinicians involved in updating education and the trust guidance.
Suboptimal hand hygiene audit compliance in the clinical areas.	IPC Team supported education and re-audit which demonstrated improved compliance.
Patient concordance with treatment: patient confused and agitated and removed own peripheral venous cannula several times.	Education and resource available to ward staff for 'specialling' patients who are non-concordant due to confusion and agitation.
MRSA Policy not followed in relation to prescribing and administering MRSA decolonisation treatment	Education to clinical teams re the Trust MRSA policy and MRSA decolonisation treatment patient group directive on eMeds
Suboptimal management of the peripheral venous cannula (PVC)	PPM+ being developed to support daily observational management of patient's peripheral venous cannula.
Antimicrobial prescribing not in line with Trust guidelines for patients with MRSA colonisation.	Trust prescribing guidelines discussed with prescribers.

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bloodstream Infection

MSSA is a strain of Staphylococcus Aureus that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases, it can cause blood stream infections.

There is no national objective for MSSA bloodstream infection cases. The Trust reported 36 MSSA bloodstream infection cases. This was an increase of only 1 case from the previous year. Enhanced surveillance has identified line and skin infections to be a common source.

Figure 6: Total Number of Post 48 Hour MSSA Bloodstream Infection Cases 2006/7-2021/22



	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Number of Cases	34	58	51	30	35	31	18	23	15	31	22	26	17	34	35	36

Clostridioides difficile Infection (CDI)

Clostridioides difficile is a bacterium that is found in the gut of around 3% of healthy adults and seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However, certain antibiotics can disturb the bacteria of the gut and Clostridioides difficile can then multiply and produce toxins, which cause symptoms such as diarrhoea.

The Trust objectives for 2021/22 are set using the two categories, “Healthcare Onset Healthcare Associated”, cases detected in the hospital three or more days after admission and “Community Onset Healthcare Associated” cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust in the previous four weeks.

The national objective for CDI for 2021/22 was set at no more than 50 cases. The number of CDI cases reported in 2021/22 was 98 cases: 78 health care onset, healthcare associated cases and 20 community onset, health care associated cases. The Trust did not achieve the national objective. It is important to note the Trust is not an outlier in reporting a rise in CDI cases, this is a national picture thought to be due to increased antimicrobial use and reduced opportunities for antimicrobial stewardship during the COVID-19 pandemic.

All Trust cases have been subject to a case review by the Consultant Microbiologist, Trust Infection Prevention and Control Team and Antimicrobial Stewardship Team. The panel deemed 85 cases were not preventable and 13 cases were preventable. The lessons learned from any lapses in care have been shared with the clinical teams.

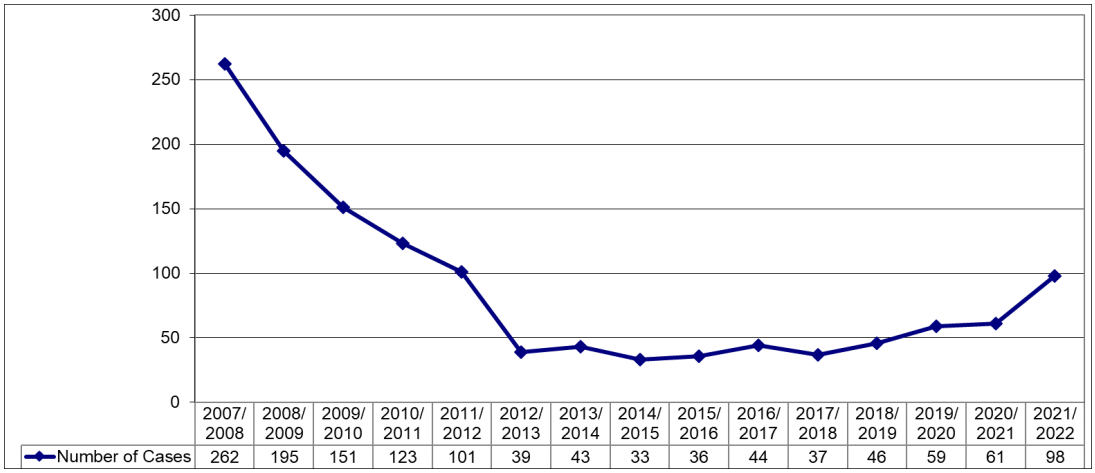
Learning	Actions to address learning
Delay in: • isolating patients with diarrhoea • sampling on admission to hospital	Education provided to clinical teams on CDI prevention and management.
Suboptimal documentation on the stool chart.	Education to clinical teams on the importance of accurate clinical records.
Cleanliness of the environment and clinical equipment.	Education to clinical staff and facilities staff. HPV business case in development for an in-house HPV service.
Suboptimal antibiotic management: not adhering to Trust guidelines, antibiotics not required, community antibiotic prescribing.	Feedback to prescribers regarding antimicrobial stewardship and the trust guidelines.

A spike in CDI cases was noted in quarter three. A deep dive of cases was undertaken, and the Clostridioides Difficile reduction plan was amended to include additional improvement actions, which included:

- Audits of hand hygiene, personal protective equipment (PPE), and commodes with feedback and education.
- Ribotyping of all positive samples.
- Environmental decontamination using Hydrogen Peroxide Vapour (HPV) of five wards at Pinderfields Hospital with the highest incident of CDI.
- CDI management and education to ward staff.

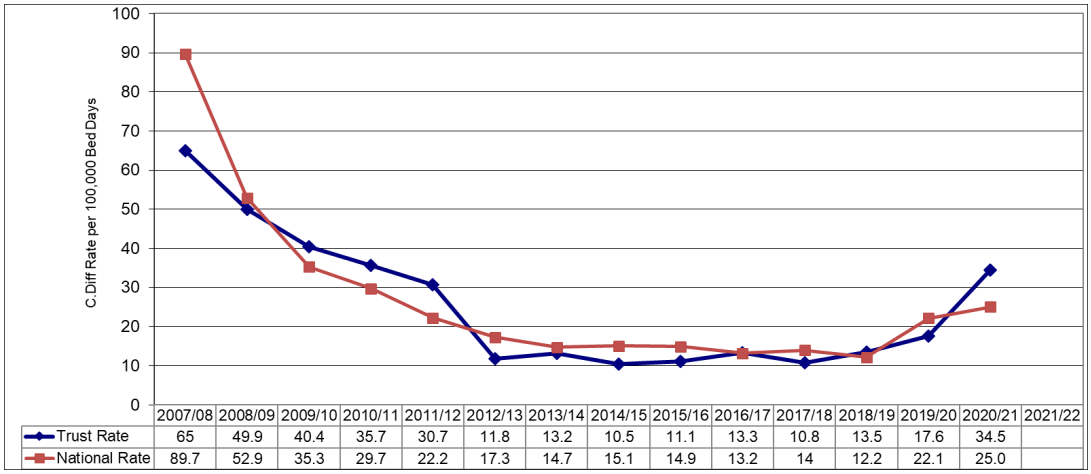
The reduction plan was shared with the Regional Consultant Microbiologist UKHSA, and IPC Leads NHS England / Improvement.

Figure 7: Total number of Trust Apportioned Cases of Clostridioides difficile Infection 2007/08-2021/22



	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Number of Cases	262	195	151	123	101	39	43	33	36	44	37	46	59	61	98

Figure 8: Clostridioides difficile Infection Rates *Trust Apportioned Cases 2007/08-2021/22



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Trust Rate	65	49.9	40.4	35.7	30.7	11.8	13.2	10.5	11.1	13.3	10.8	13.5	17.6	34.5	
National Rate	89.7	52.9	35.3	29.7	22.2	17.3	14.7	15.1	14.9	13.2	14	12.2	22.1	25.0	

The rates for 2021/22 are currently not available

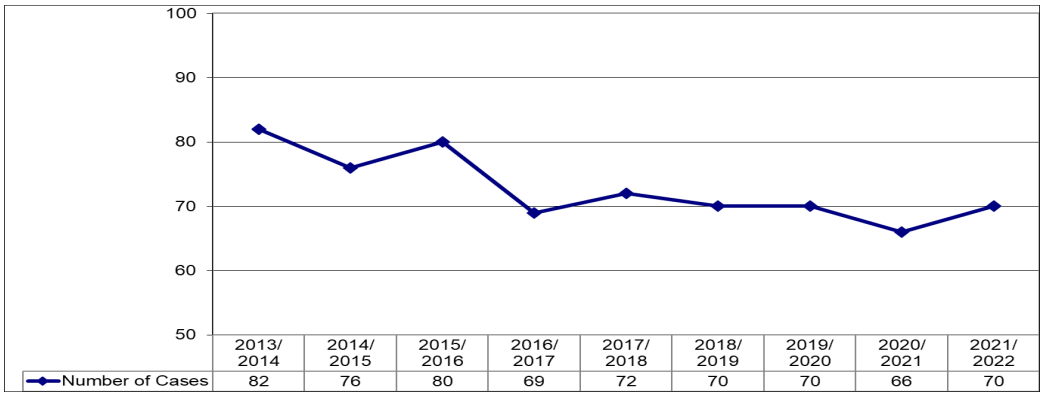
Gram Negative Bloodstream Infections

Escherichia Coli (E. coli) Bloodstream Infection

E. coli is a very common bacterium found in the human gut, which can cause serious infections such as blood poisoning.

The Trust has been mandated to report E. coli bloodstream infection cases since 2013/14. The national objective for E. coli bloodstream infections was no more than 152 Trust cases. The Trust reported 70 E. coli Trust attributed cases. This objective was achieved.

Figure 9: Escherichia Coli (E. coli) Bloodstream Infection Cases 2013/14-2021/22



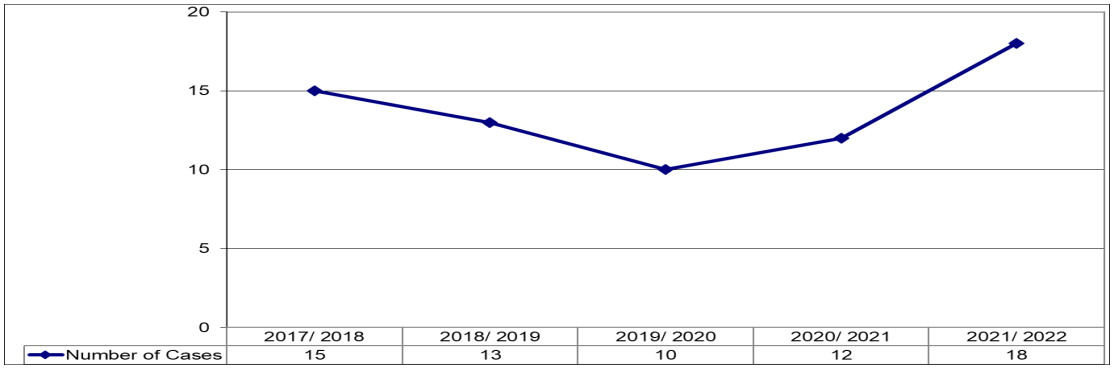
	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Number of Cases	82	76	80	69	72	70	70	66	70

Pseudomonas Bloodstream Infection Cases 2017/18-2021/22

Pseudomonas Aeruginosa is a bacterium often found in soil and ground water. It rarely affects healthy individuals but can cause a wide range of infections particularly in those with a weakened immune system. Pseudomonas Aeruginosa is resistant to many commonly used antibiotics.

The national objective for Pseudomonas bloodstream infections was no more than 21 Trust cases. The Trust reported 12 Pseudomonas Trust attributed cases. This objective was achieved.

Figure 10: Pseudomonas Bloodstream Infection Cases 2017/18-2021/22

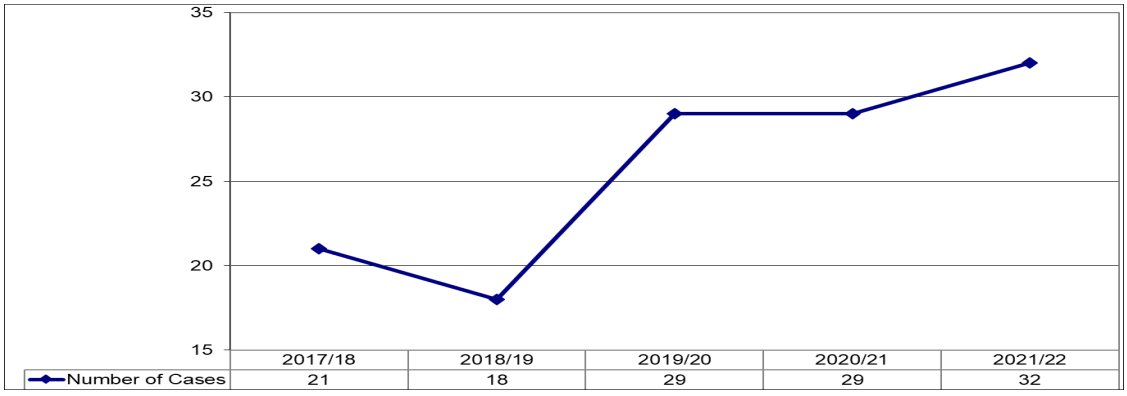


Klebsiella Bloodstream Infection Cases 2017/18-2021/22

Klebsiella species are a type of bacteria that are found everywhere in the environment and in the human gut, where they do not usually cause disease. These bacteria can cause pneumonia, bloodstream infections, wound and surgical site infections and can be associated with invasive procedures such as venous cannulation or urinary catheterisation.

The national objective for Klebsiella bloodstream infection cases was no more than 32 Trust cases. The Trust reported 32 Klebsiella bloodstream infection cases. This objective was achieved.

Figure 11: Klebsiella Bloodstream Infection Cases 2017/18-2020/21



The Trust has a Gram-Negative Bloodstream Infection reduction plan which is approved through the IPC Committee. Actions within the reduction plan include:

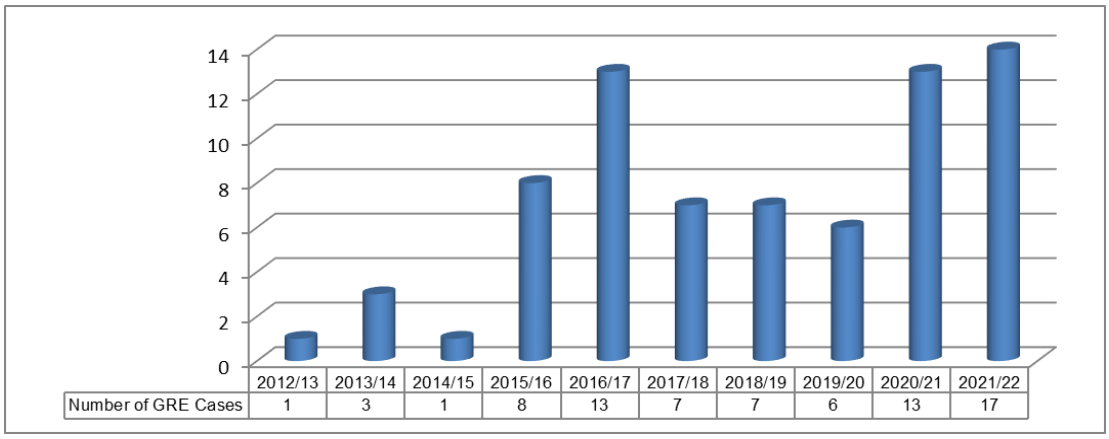
- Education and awareness for clinical staff of the national reduction agenda, hand hygiene and PPE.
- Enhanced surveillance of Gram-Negative bloodstream infections and monthly data included in the Trust and divisional dashboards.
- Improve Public Health awareness e.g., hydration, patient hand hygiene, patient personal hygiene.
- Education to clinical staff on a consistent approach to diagnostic investigation for a urinary tract infection, excluding urine dipstick for >65years.
- Antibiotic improvement project in the Care of the Elderly with the use of procalcitonin testing to identify a bacterial cause of infection.
- Consultant Microbiologist, AMS and IPC ward round in the Care of the Elderly Division.
- Improve clinical practice in relation to patients with invasive devices such as a peripheral venous cannula and urinary catheter using Aseptic Non-Touch Technique (ANTT).
- Improve Antimicrobial Stewardship specific to the treatment and management of patients with a Gram-Negative bloodstream infection.
- Consultant Microbiologist, AMS and IPC team review of complex Gram-negative bloodstream infection cases.

Glycopeptide Resistant Enterococci (GRE)

Enterococci are normally found in the gut and are part of the normal human gut flora. Although a common cause of urinary tract, infections they can also cause serious infections such as endocarditis and can be a particular risk to immunocompromised patients.

The Trust reported 13 cases, GRE is linked with high use of Glycopeptide the Antimicrobial Stewardship Team are working on reducing this type of antibiotic usage.

Figure 12: GRE 2012/13-2021/22

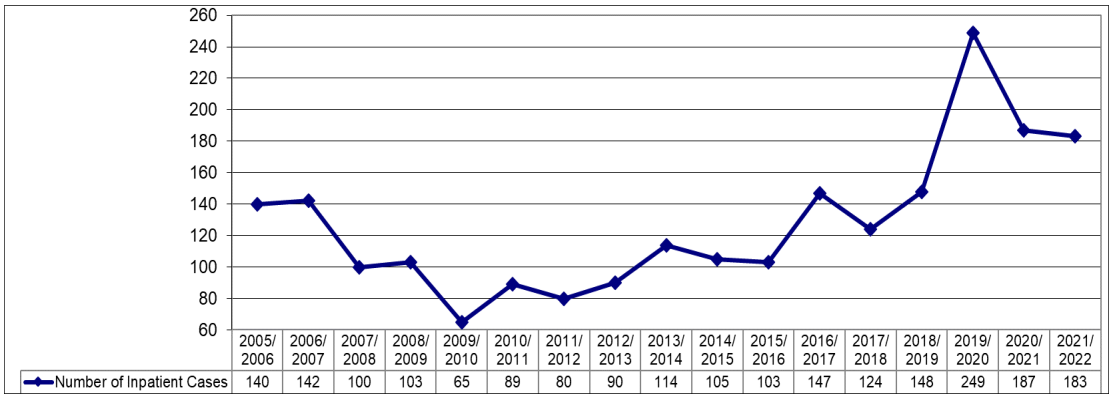


Extended Spectrum Beta Lactamase (ESBL)

ESBLs are enzymes that can be produced by bacteria making them resistant to groups of antibiotics. Some of the ESBL producing bacteria can resist penicillin and

cephalosporins, which are the most commonly used antibiotics in hospitals. This can complicate and/or delay optimal treatment. It is for these reasons that the numbers of ESBL producing bacteria cases are monitored to establish trends.

Figure 13: Number of ESBL Producing Bacteria 2005/06-2021/22



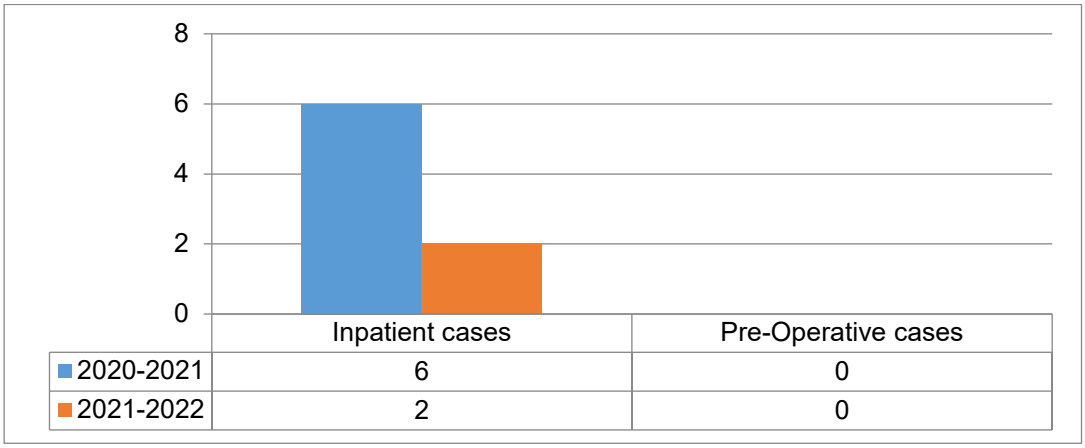
Carbapenamase Producing Enterobacteriacea (CPE)

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals and are some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections.

Carbapenems are a valuable family of antibiotics normally reserved for infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae).

Resistance to these antibiotics can complicate and /or delay treatment, hence the need to monitor these cases.

Figure 14: CPE Cases 2020/21-2021/22



Surgical Site Infection Surveillance Scheme (SSISS)

The Trust participated in the three-month mandatory orthopaedic surgical site surveillance. No infections were reported in the three-month surveillance period, which is below the national average of 1%.

Figure 15: SSISS Results from Surveillance Period Q2

The Mid Yorkshire Hospitals NHS Trust		Repair of Neck of Femur July - September 2021		
		Dewsbury	Pinderfields	Pontefract
Number of Operations		N/A	68	N/A
Total Surgical Site Infections (SSI)		0	0	0
SSI	Inpatient & Re-admissions	0	0	0
	Other Post Discharge:	0	0	0
	Patient Reported	0	0	0
Hospital Site SSI Rate		N/A	0.0%	N/A
National SSI Rate			1.0%	

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Environment Cleanliness

The Facilities teams have continued to maintain high standards of cleanliness during the reporting period and prepared for the introduction of the new National Standards of Cleanliness 2021. The standards will be implemented throughout 2022.

The pandemic required the Trust to designate several higher risk areas including ward areas supporting COVID-19 patients, admission areas and the Emergency Department which were additional to the Facilities Service Teams employed to work in our high acuity areas such as Intensive Care (which was expanded during the pandemic to treat the increased number of patients) and the Trusts Acute Respiratory Medical Units. Additional staff were required to facilitate this. These additional staff were trained to achieve a high standard of cleaning practice.

The Facilities service investment in electronic cleaning audit tools has supported improvements and maintenance of the necessary standards of compliance. These electronic measurement tools were further developed in 2021/22 by the introduction of new software that supported staff to meet the prescribed standard of cleanliness in all areas, during a prolonged time of high service demand in the patient bed base.

Patient Led Assessment of the Care Environment (PLACE)

The National PLACE assessments were suspended in 2021/22. The Trust decided to commence preparation for a series of PLACE Light Audits, several trial audits were undertaken in 2021/22.

The PLACE Light Audit maintains the principles that are present in the full PLACE audit but does not have to be undertaken as a full hospital audit and gives the PLACE team the opportunity to sample individual units over a longer timescale. Results from the PLACE Light, which is supported by volunteer patient representatives, the Facilities Matron and the Infection Prevention and Control Team are reported back on completion to the ward team. Any areas of improvement identified from the PLACE

Light Audits were added to ward improvement plans and the audit outcomes shared within divisions.

It is understood that the National PLACE Audit programme will recommence in September 2022.

Waste Management

Waste Management during the COVID-19 pandemic has followed national guidance which has prompted numerous changes to ward and department guidance. The focus of this guidance was to ensure that waste produced from clinical areas who cared for patients with COVID-19 infections was appropriately segregated and handled in a secure and safe manner.

To support staff a new ward and department waste handbook was produced to highlight the necessary waste segregation changes. This included waste segregation and management in our adult community services and the vaccination hub. The Trust has work closely with our external waste contractors to ensure safe disposal of waste.

Frontline Ownership (FLO) Audit

Front Line Ownership (FLO) Audits were introduced in April 2015 and are performed monthly in each clinical area. The FLO audits assess compliance with 9 Key elements of infection prevention and control in all clinical areas. The 9 key elements audited monthly are:

- General environment
- Patient's immediate area
- Dirty utility and waste disposal
- Linen management
- Storage areas and clean utility/treatment room
- Patient equipment
- Sharps safety
- Hand hygiene facilities
- Standard precautions

Part two of the audit data is gathered for: Hand Hygiene, Bare below the Elbows, Peripheral Venous Cannula insertion and ongoing care, Central Venous Cannula insertion and ongoing care, Urinary Catheter insertion and ongoing care, Isolation Practice, Surgical Site Infection and Ventilator Associated Pneumonia compliance.

FLO audits are completed monthly by ward/department managers. Key environmental IPC elements were also monitored via the Ward Health Check and Ward Accreditation audits completed by the Corporate Team.

The data from the audits is visible by the auditor at the time of audit and FLO dashboards are produced for the Divisional Infection Prevention and Control Group meetings and Infection Prevention and Control Committee where action plans are monitored by senior nurses within the divisions.

Decontamination of the Environment with Hydrogen Peroxide Vapour (HPV)

Hydrogen Peroxide Vapour (HPV) decontamination of five clinical areas at Pinderfields Hospital was required due to an increased incidence of patients acquiring Clostridioides difficile infection. The hypotheses to this increased incidence was thought to be an environmental burden of Clostridioides difficile spores in the environment as the spores are inherently difficult to remove with conventional cleaning methods and research demonstrates HPV to be the preferred method of environmental decontamination following cases of Clostridioides difficile infection.

The IPC team worked with representatives from the Division of Medicine, Facilities, and an external HPV provider. This work was supported by the Programme Management Office to oversee and coordinate the project. A three-week HPV decontamination programme provided by the external contractor on the identified wards commencing on the 1st of March.

There is now a business case progressing to provide an in-house HPV service.

Water Safety Management

The Trust has continued to manage water safety through a structure of a Strategic Water Safety Group (SWSG), meeting quarterly and a monthly meeting of the Operational Water Safety Group (OWSG).

There is a multi-disciplinary membership of the groups with representatives from IPC, Consultant Microbiologist, Estates, Facilities, Medical Physics, PFI Monitoring, ENGIE and Consort. The Trust's Authorised Engineer (AE) for Water is also a member of the SWSG. All SWSG members are required to be trained to an agreed level and the AE Water authorises them as appropriate members.

The Trust has in place a Water Safety Policy and a Water Safety Plan which are reviewed on a regular basis.

There are independent 6-monthly audits undertaken by the Trust's water safety advisors, 'Hydrop'. These now consist of a full audit in January and a checklist audit undertaken in July each year.

The Trust's AE carries out a governance audit of the management system on an annual basis. The report produced is presented by the AE to the SWSG for their information and action; the latest report gave substantial assurance on water management across the Trust.

The Trust capital programme for water safety management for 2021/22 included the replacement of Chloring Dioxide (CLO2) system at Dewsbury Hospital, installation of water meters to assist in understanding water storage capacity at Pinderfields and Pontefract Hospital, replacement of clinical wash hand basins to meet current HTM requirements at Dewsbury Hospital and minor works within the existing water system, e.g. removal of dead legs. Work will continue to 2022/23 on the water system.

Criterion 3: Provide suitable and accurate information on infections to service users and their visitors

Infection Prevention and Control mandatory training has been delivered in the form of a virtual presentation or E Learning during the reporting year. The Trust achieved 96.4% compliance with IPC mandatory training. Figure 16 details the compliance for all services and clinical divisions. It is pleasing to note all services and divisions achieved over 90%.

Figure 16: IPC Mandatory Training Compliance 1 April 2022

Topic	Adult Community Services	Chief Nurse	Clinical Support Services	Company Secretary	Division of Medicine	Division of Surgery	Finance & Corporate Services	Medical Director	Site Services	Womens & Childrens	Workforce & OD	Overall % Compliance
	Total Staff = 402	Total Staff = 130	Total Staff = 960	Total Staff = 51	Total Staff = 1876	Total Staff = 1592	Total Staff = 182	Total Staff = 262	Total Staff = 1158	Total Staff = 819	Total Staff = 129	Total Staff = 7561
Infection Control	98% 394 of 402 Staff	100% 130 of 130 Staff	98.5% 946 of 960 Staff	100% 51 of 51 Staff	94.7% 1777 of 1876 Staff	97.9% 1558 of 1592 Staff	99.5% 181 of 182 Staff	98.9% 259 of 262 Staff	92.1% 1067 of 1158 Staff	97.7% 800 of 819 Staff	97.7% 126 of 129 Staff	96.4% 7289 of 7561 Total

COVID-19 Monitored and Recorded Training (MART)

Personal protective equipment donning and doffing, education has continued in the reporting year with support of Practice Development and Education Unit colleagues and a 'roving team' of Corporate Colleagues from the Quality Team.

Monitored and recorded training (MART), developed in the first wave of the Global Pandemic, has continued in relation to Personal Protective Equipment (PPE) and Social Distancing, PPE Donning and Doffing and COVID-19 Screening. Figure 17 details the Trust compliance.

Figure 17: MART Personal Protective Equipment (PPE) and Social Distancing, PPE Donning and Doffing 1 April 2022

MART Training	Trust compliance
PPE and Social Distancing	93.3%
PPE Donning and Doffing	86%

World Health Organisation (WHO) Hand Hygiene Day

'World Hand Hygiene Day' is promoted by the World Health Organisation and is on the 5th May every year. Due to the global COVID-19 Pandemic, there were no active campaigns undertaken by the Infection Prevention and Control (IPC) team. The IPC team re-enforced the importance of hand hygiene through education and screensavers.

International Infection Prevention and Control Week (IIPW)

The third week in October every year, is an international celebration of infection prevention, and promotes the crucial role infection preventionists play in keeping our services and community safe and healthy.

The Trust was experiencing another wave of COVID-19 during this week, and therefore, the celebration was understated. Working collaboratively with the Trust Communications Team, an article was published in the Trust Bulletin around the theme for the year, which was a celebration of IPC. It also reiterated the 'hands, face, space' message. Screensavers were designed for all trust computers, detailing the social distancing guidance, and reminding staff of other seasonal organisms, such as Norovirus and Influenza.

Criterion 4: Provide suitable and accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion

The Trust Infection Prevention and Control dashboard has been produced monthly in the reporting year which details the infection prevention and control key performance indicators and includes mandatory reporting of organisms, MRSA elective and non-elective screening compliance, blood culture contamination, Carbapenamase producing Enterobacteriacea, ANTT compliance and cleanliness monitoring. The Trust Infection Prevention and Control dashboard containing divisional data, has been produced monthly.

Frontline Ownership (FLO) audit dashboards are produced for the divisional Infection Prevention and Control Group meetings in order for the groups to analyse the data, identify and share areas of good practice and required improvements. Part two of the audit data is gathered for identifying compliance with Hand Hygiene, Bare below the Elbows, Peripheral and Central Venous Cannula insertion and ongoing care, Urinary Catheter insertion and ongoing care, Isolation Practice, Surgical Site Infection and Ventilator Associated Pneumonia.

Criterion 5: Ensure that people who have or develop an infection are identified properly and receive appropriate treatment and care to reduce the risk of passing on the infection to other people

Hierarchy of Controls Risk Assessments

The Infection Prevention and Control Team have supported clinical leaders to develop COVID-19 hierarchy of control risk assessments for all inpatients wards, departments and emergency care areas. These multi-factorial risk assessments review each ward individually and aim to reduce the environmental, equipment and person specific risks of transmission of infection, considering elimination controls, substitution controls, engineering controls, administrative controls and control of personal protective equipment.

Infection Risk Assessment

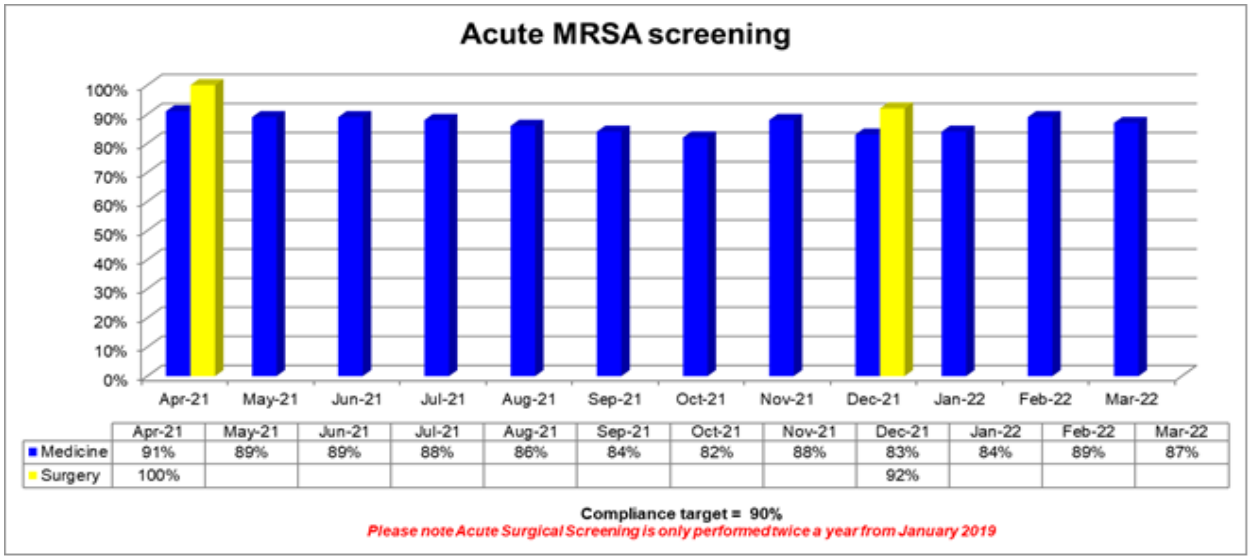
Clinical staff are required to complete an infection risk assessment of patients on admission to facilitate safe patient placement and reduce the risk of transmission of infection. Figure 18 details compliance with the infection risk assessment – this data is collected via the monthly Ward Health Check. The health checks were suspended during January and February 2022 in response to the potential COVID-19 wave in January 2022 – this was approved by Executive Directors.

Figure 18: Infection Risk Assessment Compliance Data

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Mar-22
63%	56%	84%	86%	86%	86%	94%	85%	82%	92%

MRSA Screening

Figure 19: MRSA Acute Screening Compliance, Division of Medicine and Surgery



Influenza Point of Care Test (POCT)

The Trust deployed the Standard Q SD Biosensor point of care test for Influenza A and B in the reporting period. The point of care test result is available within 15 minutes, which facilitated rapid diagnosis and safe placement of patients with influenza. Five Influenza A cases have been reported in the reporting year.

Winter Vomiting Virus Outbreaks

The IPC team supported the management of 20 outbreaks of diarrhoea and vomiting in the reporting year. 10 at Dewsbury Hospital affecting 49 patients and 10 at Pinderfields Hospital affecting 47 patients. Norovirus was confirmed as the causative organism in 1 outbreak at Dewsbury Hospital and 1 outbreak at Pinderfields Hospital.

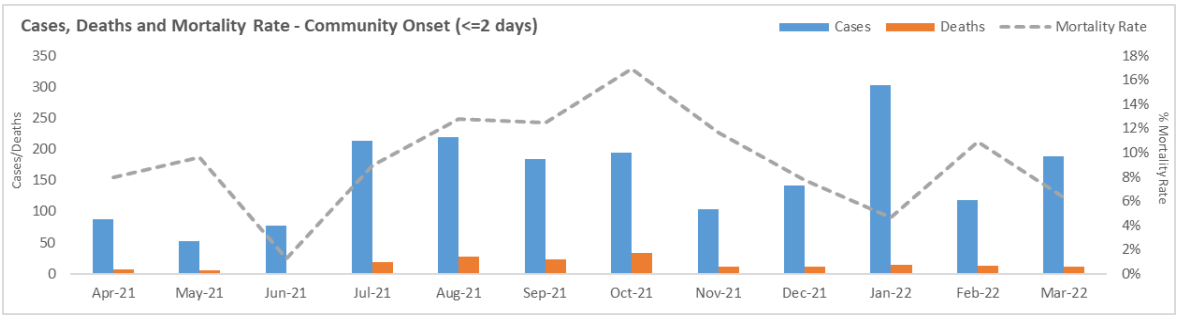
COVID-19 Pandemic 2021/22

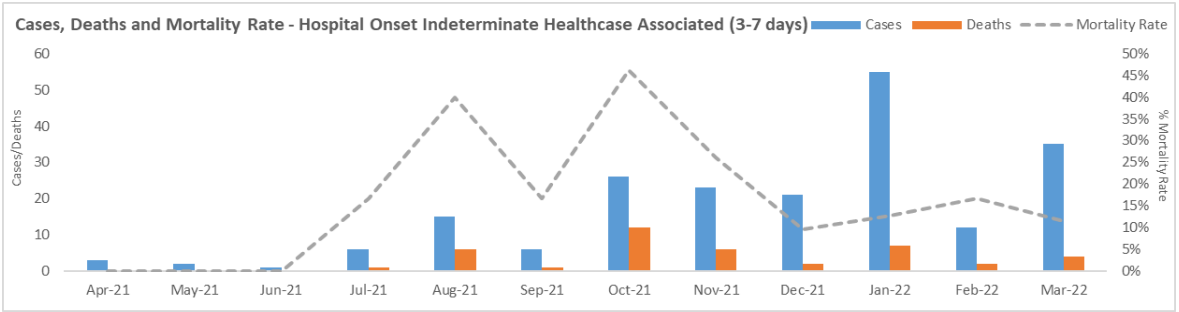
The Trust has adhered to and implemented HM Government, United Kingdome Health Security Agency and NHS England /Improvement Guidelines through the COVID-19 Global Pandemic through the aforementioned command and control structure.

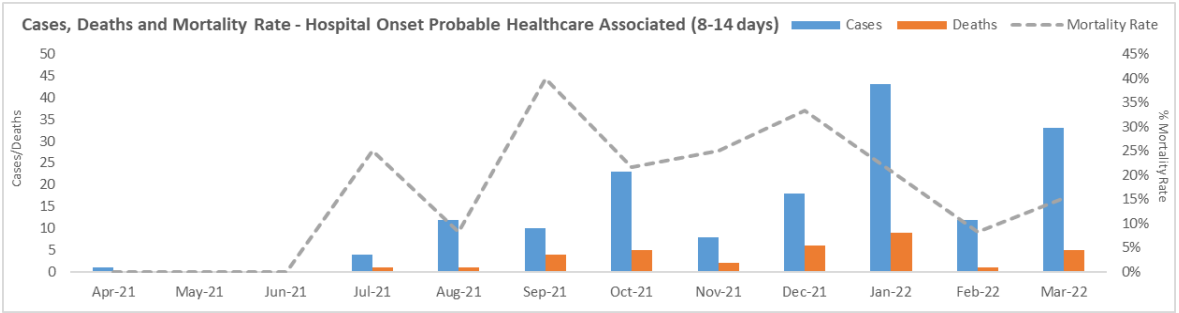
NHS England and NHS Improvement published definitions of COVID-19 in respect of patients diagnosed within hospitals, in a letter to NHS Trusts 19 May 2020. The definitions Trusts are required to apportion cases are:

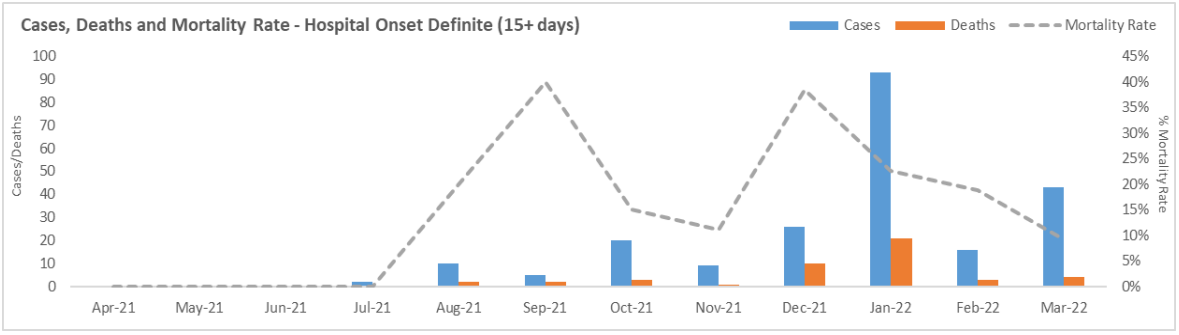
- Community-Onset (CO) - positive specimen date <=2 days after hospital admission or hospital attendance
- Hospital-Onset Indeterminate Healthcare-Associated (HOiHA)- positive specimen date 3-7 days after hospital admission
- Hospital-Onset Probable Healthcare-Associated (HOpHA)- positive specimen date 8-14 days after hospital admission
- Hospital-Onset Definite Healthcare-Associated (HOdHA)- positive specimen date 15 or more days after hospital admission

Figure 20: Confirmed COVID-19 cases and deaths by category to 1 April 2021-31 March 2022









COVID-19 Outbreaks 2021/22

The Trust declared 36 outbreaks during 2021/22. The total number of days spent in outbreak was 1656 days (this doesn't include any wards still currently in outbreaks at 31/03/2022). Dewsbury Hospital reported 10 outbreaks with a mean duration of 64 days and Pinderfields Hospital reported 26 outbreaks with a mean duration of 39 days.

Outbreaks have been monitored in weekly incident meetings with the Director of IPC, Head of IPC, IPC Matron, Senior IPC nurse, Divisional Assistant Directors of Nursing, Divisional Matrons, Ward Managers, Domestic Supervisors, and CCG colleagues in attendance. Good practice and learning are identified and shared in the Trust. A weekly outbreak summary has been provided to Executive Director colleagues.

Infection Prevention and Control Incidents within the Clinical Divisions

Division of Family Services and Clinical Support Services

Gate 19 Pinderfields Hospital Neonatal Unit, Serratia Incident

In July 2021, Leeds Neonatal Unit (NNU) notified the Trust that they had a Serratia issue on the unit. 2 of the babies involved in the incident at Leeds had been transferred to Gate 19 at Pinderfields. Both babies were screened on admission and found to be negative, however 3 days post admission one of the babies developed symptoms which was found to be due to Serratia.

The sample antibiogram was the same as Leeds, but it could not be determined if the sample was the same strain. Admissions into the room were temporarily paused as a precaution. A series of actions were agreed including enhanced cleaning of the unit, audit of practices and daily support from an infection prevention and control nurse. No further cases were identified.

Division of Surgery

Nasoendoscope Incident – Gate 26 ENT Outpatients

The Trust commissioned OMNES Healthcare Ltd to undertake ENT clinics to support with backlog waiting lists. During an OMNES ENT clinic in quarter 3 a nasoendoscope that had been used on another patient and was awaiting decontamination was used on another patient. An incident Control Group meeting was convened to investigate the incident. Duty of candour was completed for the affected patient. The risk to the patient was discussed with UKHSA Public Health Registrar and Trust Consultant

Microbiologist who both deemed this was low risk infection exposure and that no further action was required.

OMNES instigated a root cause analysis and a thorough review of processes was undertaken. The incident was confirmed to have been caused by failure to follow agreed processes. It was confirmed that OMES have undergone retraining and the learning shared throughout both organisations.

Division of Medicine

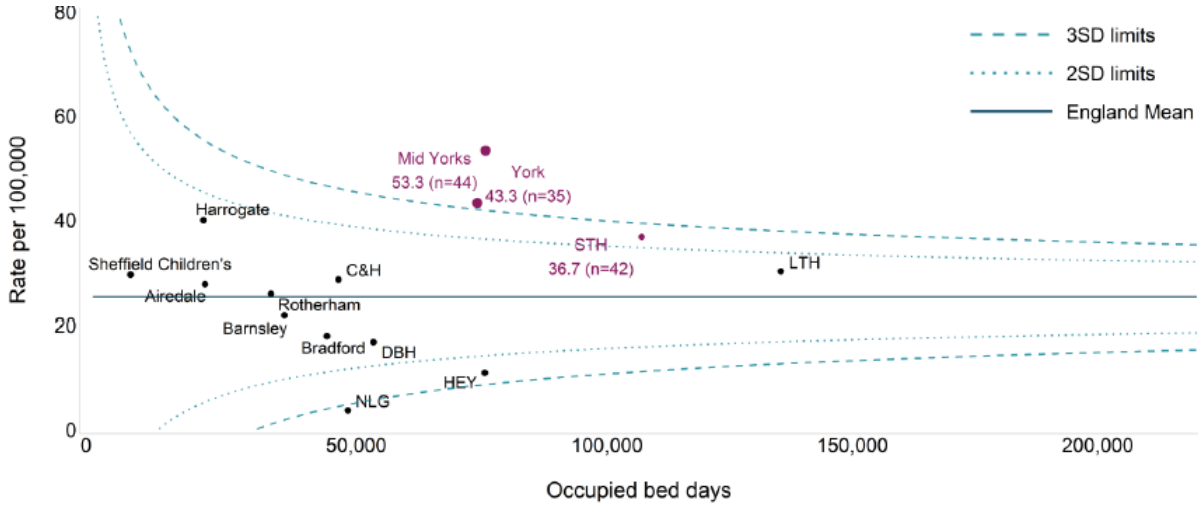
Scabies

The Trust had 4 Scabies incidents during the reporting period within 3 of our elderly care areas: 2 at Dewsbury Hospital and 2 at Pinderfields Hospital affecting 4 patients and 21 staff. Occupational Health supported the IPC Team in managing the staff cases.

Clostridioides difficile infection (CDI) increased incidence

During October 2021-December 2021 the Trust reported an increased incidence of CDI, 44 cases (53.3 per 100,000 bed days) were reported, this was significantly higher than the national average of 25.2 per 100,000 bed days and an outlier with Yorkshire and Humber acute Trusts, see figure 21.

Figure 21: Healthcare associated CDI rates in patients over 2 years of age per 100,000 bed days for Yorkshire and Humber acute trusts in comparison to England October 2021-December 2021



Organisations with rates significantly higher than the national average are shown in red and labelled with the rate per 100,000 and number of cases (n) reported this quarter. C&H = Calderdale and Huddersfield; DBH = Doncaster and Bassetlaw; HEY = Hull and East Yorkshire; LTH = Leeds; NLG = Northern Lincs and Goole; STH = Sheffield

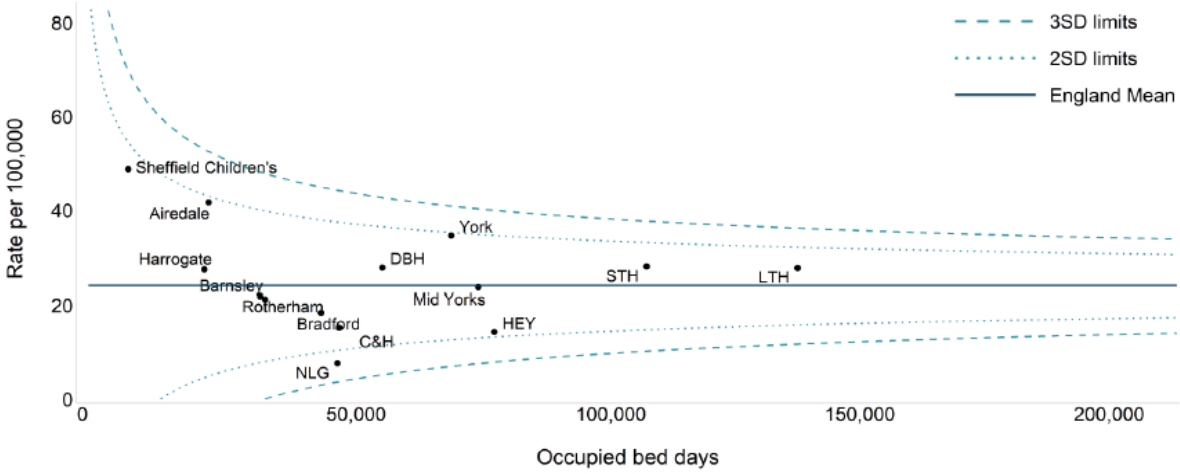
Data from UK Health Security Agency Healthcare Associated Infections quarterly report Yorkshire and Humber October- December 2021.

Following a post infection review of the cases, 10 were deemed preventable due to antimicrobial prescribing. Learning from the cases included delay in or inappropriate sampling in the hospital and community, antimicrobial management, and stool chart documentation.

The Trust CDI reduction plan was strengthened with additional actions which included: weekly review of cases with emphasis on antimicrobial stewardship and the introduction of an Elderly Medicine Ward Round with the Antimicrobial Pharmacist, Consultant Microbiologist and an Infection Prevention and Control Nurse. Hydrogen Peroxide Vapourisation (HPV) to 5 clinical areas with an increased incidence of CDI, education to clinical staff, CDI sampling algorithm and a review of the pathology sampling algorithm.

It is pleasing to report an improved position in quarter 4 (January-March 2022), with the Trust reporting 19 cases and now below the national average of 23.9 per 100, 000 bed days (see Figure 22). CDI reduction will continue to be a focus in 2022/23.

Figure 22: Healthcare associated CDI rates in patients over 2 years of age per 100,000 bed days for Yorkshire and Humber acute trusts in comparison to England January 2022-March 2022.



Organisations with rates significantly higher than the national average are shown in red and labelled with the rate per 100,000 and number of cases (n) reported this quarter. C&H = Calderdale and Huddersfield; DBH = Doncaster and Bassetlaw; HEY = Hull and East Yorkshire; LTH = Leeds; NLG = Northern Lincs and Goole; STH = Sheffield

Data from UK Health Security Agency Healthcare Associated Infections quarterly report Yorkshire and Humber January -March 2022.

Antimicrobial Stewardship

The Antimicrobial Stewardship Group (AMSG) has met bimonthly in 2021-22. AMSG reports to the Medicines Optimisation Group and the Trust Infection Prevention and Control Committee. Key achievements:

- Publication of AMS strategy in line with the National Antimicrobial Resistance (AMR) Plan
- Establishment of a COVID Medicines Delivery Unit in January 2022 to provide medicines for highly clinical vulnerable patients with COVID in the community
- Ongoing support for clinical teams during the COVID-19 pandemic, particularly new COVID medicines
- Clinical ward rounds / MDTs: intensive care, haematology, sepsis, endocarditis, elderly medicine, orthopaedics, *C. difficile* infections, burns, neonates, home intravenous antibiotics

- Point prevalence audit restarted post-COVID
- 2500 bed days saved by using elastomeric pumps for home intravenous antibiotics
- Rolling program of education and audit feedback to specialty governance meetings
- Journal article publications:
    - 21-Yusef-ICHE(letter)-Analysis of antimicrobial consumption to identify targets for antimicrobial stewardship.
    - 21-Yusef-ICHE(letter)-Impact of antimicrobial stewardship interventions on reducing antifungal use in hospitals in Jordan.
    - 21-Powell-Antibiotics-Use of procalcitonin during the first wave of COVID-19.
    - 21-Ahmad-PJ-How to evaluate the clinical appropriateness of an antimicrobial.
    - 21-AlTaani-Antibiotics-Pharmacists' knowledge, attitudes, behaviours and information sources on antibiotic use and resistance in Jordan.
    - 21-Khan-ExpRevAntInfectiveTher-Antimicrobial consumption in patients with COVID-19 – a systematic review and meta-analysis.
    - 22-Stone-JHI-Outbreak of livestock-associated MRSA in a regional burns centre.
    - Contributor – RECOVERY and QIST trials; co-investigator – PEACH Study.
- Rolling program of education and audit feedback to specialty governance meetings

Criterion 6: Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

Frontline Ownership Audits

Frontline Ownership (FLO) audit data is collected monthly on 10 key elements of infection prevention assurance. In addition, data on ANTT compliance, hand hygiene and bare below the elbow, isolation, peripheral venous cannula insertion and ongoing care, central venous cannula insertion and ongoing care urinary catheter insertion and ongoing care, surgical site infection and ventilator associated pneumonia.

A FLO report has been produced and distributed monthly along with a divisional breakdown report in the reporting year.

Criterion 7: Provide or secure isolation facilities

The Trust aims to isolate patients within the Trust with MRSA colonisation and infection, Clostridiodes difficile and diarrhoea to reduce the risk of transmission to other vulnerable patients in the clinical location.

Isolation of infected patients is monitored as part of the Frontline Ownership Audits – this is audited by ward managers via Part 2 of the audit tool on a quarterly basis. Trust compliance was 99% in Q1, Q2 and Q4 and 95% in Q3.

Virtual patient review (VPR) meetings with Operational and IPC colleagues took place at least daily during the COVID-19 Pandemic waves to support in safe patient placement.

Criterion 8: Secure adequate access to laboratory support as appropriate

The Microbiology Laboratory for the Trust is based in the Pathology Building at Pinderfields Hospital. The laboratory provides a consultant led diagnostic and screening service to all the hospitals within the Trust, Primary Care providers and Occupational Health services.

The laboratory is staffed and managed by a team of Health and Care Professions Council (HCPC) registered Biomedical Scientists and Support Workers and is accredited by United Kingdom Accreditation Service (UKAS).
The laboratory provides a seven-day service and offers an on-call service out of normal working hours that is accessed by contacting the hospital switchboard.

The laboratory utilises the DXC iLab IT system for all of its laboratory reports and is linked to the ICNet system used by the IPC Nursing Team. ICNet is updated regularly with data from the laboratory iLab system.

Criterion 9: Have and adhere to policies designed for the individual's care and provide organisations that will help to prevent and control infections

Infection Prevention and Control policies are reviewed with key stakeholders and discussed at the Infection Prevention and Control Committee before final approval through the Joint Executive Directors and Clinical Forum. See figure 23 for the policies reviewed in the reporting year.

Figure 23: Policies reviewed in 2021/22

Policy	Date of review
Prevention and Management of Clostridiodes Difficile Policy	January 2022
Isolation Policy	November 2021
Rabies Policy	October 2021
Scabies Policy	October 2021
MRSA Prevention, Management, Screening and Decolonisation Policy	September 2021
Management of Infection Prevention and Control Policy	May 2021
Prevention, Detection and Control of Multi-Drug Resistant Organisms including CPE, ESBL, GRE and Pseudomonas sp Policy	May 2021
Tuberculosis (TB) Management, including Multi Drug Resistant TB Policy	April 2021

Criterion 10: Ensure that as far as reasonably practicable that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care

Occupational Health and Wellbeing Report 2021/22

Immunisation and Vaccination

During 2021/2022 Occupational Health and Wellbeing Service (OHWBs) provided 16,166 (excluding influenza vaccines) episodes of care relating to immunisation and vaccination including:

- Provision of vaccine under a Patient Group Directive (PGD) or a Written Instruction (WI)
- Taking of blood samples to check immunity to disease
- BCG scar checks

This equates to a mean average of 1347 episodes each month which is an increase of episodes each month compared to the previous year. This number does not include seasonal influenza vaccination

The national streamlining agenda around immunisation and vaccination for Doctors in Training (DiT) has been completed in the West Yorkshire and Harrogate area. All NHS Occupational Health providers are now working to an agreed Standard Operating Procedure (SOP) based on the National Standards for Occupational Vaccination.

The plan for all OHWBs providers to move vaccination records onto ESR was delayed by the increased OHWBs activity in relation to COVID-19. The plan for Mid Yorkshire is that all immunisations and serology records will remain on the individual OHWBs record as part of the whole IT system upgrade. This new upgraded system allows individuals to access their own records and share information as they move between employers.

Skin Health Surveillance.

Skin health surveillance remains an annual requirement under COSHH for all employees who undertake regular handwashing and occlusive glove use. During 2021/2022 there were 124 episodes of care relating to skin surveillance: 79 were for face-to-face assessments.

No employees were temporarily excluded from clinical work due to skin problems. All remained in their substantive posts.

During the last 12 months in the areas where staffs occlusive glove use, hand washing and use of hand sanitiser has increased. OHWBs have provided some proactive support which included: offering a skin assessment in the workplace and providing access to emollients.

Sharps Injury Management

There was a total of 177 reported sharps injuries in the reporting period.

OHWBs continue to monitor all DATIX reports relating to sharps injuries to ensure all employees reporting such injuries are appropriately followed up. The Sharps Injury Group has not met during the reporting year.

Information on the devices being used during such incidents is reported to the Trust Health and Safety Committee.

Staff Contact Tracing Episodes

OHWBs continue to work proactively with colleagues in Infection Prevention and Control in any contact tracing exercises involving employees.

Seasonal Influenza Vaccination 2021/22

The Trust adopted a co-administration model of delivering COVID-19 vaccination and flu vaccination following approval by the Joint Council for Vaccination and Immunisation. This commenced in September 2021 and ended after a 4-week period. During this time 46.2% of staff agreed to have their flu vaccine at the same time as their Covid-19 vaccination. OHWBs then activated their peer to peer vaccination model and roaming vaccination team.

The annual seasonal influenza target was to vaccinate 90% of identified frontline staff. This target was not met. The final total submitted to Immform was 61.5%.This year there was also a request from PHE/NHSE/I to submit data via NIVS and NEYUEC as well as Immform. Uptake has been disappointing, but this is a picture replicated across the region.

Staff COVID-19 Response

Occupational Health has supported the Trust COVID-19 response by:

- Providing advice to employees and managers regards workers returning from overseas when quarantine measures have been in place
- Performing PCR testing on employees and their family index cases – 6649 swabs in total completed during 2021/22
- Providing support to FFP3 fit testing – 5550 fit tests in total have been carried out during this period.
- Providing support to the Outbreak Incident Control Group regarding outbreaks amongst staff.
- Undertaking vulnerable worker assessments and reviews including BAME risk assessment
- Providing advice to employees on returning to work from shielding

This work is ongoing, but the Occupational Health Service has now reverted to pre pandemic operating hours of 8am-4pm Monday to Friday.

Infection Prevention and Control Training and Education

Aseptic Non-Touch technique (ANTT®)

ANTT is a framework for a technique that maintains asepsis based on the best available evidence. The principles can be applied to any procedure where asepsis is required, for example: wound care, insertion of intravenous cannula, urinary catheterisation. Clinical colleagues who perform these procedures are required to be ANTT trained and competent.

The Trust training materials have been updated during the reporting year and uploaded onto the intranet for ease of access, whilst a self-assessment competency has been developed by the Infection Prevention and Control Team and approved for use across the Trust. Use of the competency framework has been supported by the Clinical Educators.

Figure 24 details the percentage of staff that is trained and competent. Compliance improved in March 2021 and has been sustained during the reporting period.

Figure 24: Aseptic Non-Touch technique (ANTT®)

Indicator Description	Month	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Doctors (all grades) Aseptic Non-Touch Technique (ANTT)	Target	90%	90%	90%	90%
	Actual	68%	71%	73%	75%

Indicator Description	Month	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Clinical Staff Aseptic Non-Touch Technique (ANTT)	Target	90%	90%	90%	90%
	Actual	83%	83%	89%	90%

Band 2 Care Certificate

Facilitated by Organisational Development, the Care Certificate programme supports Band 2 practitioners, to develop their key skills, knowledge, and confidence. One element is the infection prevention and control principles and how these are applied practically within the workplace.

Due to the COVID-19 pandemic limited training was completed in the reporting year as sessions were suspended. Training sessions were facilitated as required for staff to meet learning needs. Education was provided in other ways such as specific PPE training for certain areas.

Mid-Yorkshire Clinical Orientation Programme

The Infection Prevention and Control team have been working with colleagues within Professional Educational Development Unit to deliver the infection prevention and control training on the Midyorks clinical orientation programme. This programme is

aimed at qualified staff and those who are new to the trust. Infection prevention and control education has been delivered by a member of the Infection Prevention and Control team monthly throughout the year. Due to the global pandemic, this training has been delivered via Microsoft Teams.

International Nurses Training

The international nurses are required to attend a 10-week OSCE programme where on passing, they will receive their Nursing Midwifery Council (NMC) registration after four weeks. At this point, the international nurses receive their Infection Prevention and Control training via the Midyorks Clinical Orientation Programme.

Infection Prevention and Control Team Development

Attendance at face-to-face external study events has been limited in the reporting year due to the NHS response to the Global Pandemic, however the team have attended several short webinars. Figure 25 details the continuing education of members of the IPC Team.

Figure 25: External study events

Date	Study Event	Colleague attended
April 2021	Legionella and Pseudomonas General Awareness - Hydrops	9 members of the IPC Team
April 2021-July 2021	Cornerstone Leadership Course	AW – Matron IPC
June 2021	Learning from COVID-19 Pandemic Response in Northeast and Yorkshire Webinar – NHSE/I	CC – Head of IPC
June 2021	Risk Assessment and Hierarchy of Controls in IPC – Knowlex Webinar	AW – Matron IPC DB - Senior IPC Nurse LH – Senior IPC Nurse
June 2021	COVID-19 Joint Working – Knowlex Webinar	LH – Senior IPC Nurse
June 2021	Northeast and Yorkshire Region Standards of Cleanliness Webinar – NHSE/I	CC – Head of IPC AW – Matron IPC
September 2021	Nosocomial inquests and prevention of future death reports- Capsticks Webinar	CC – Head of IPC AW – Matron IPC
April 2021-September 2021	Business and Administration Apprenticeship – Skills Training UK	EC – Administrator
March 2022	Surgical Site Infection Surveillance System – UKHSA	CJ – Staff Nurse IPC MP – Nursing Associate IPC
March 2022	Airborne and droplet transmissibility of the SARS-COV-2 virus and implications for practice – Infection Prevention Society	LH – Senior IPC Nurse

Conclusions

The content of this report details the broad spectrum of activity associated with Infection Prevention and Control across the Trust. The report highlights that preventing and reducing the risk of preventable infections/harm has remained a priority for the Trust in the reporting period.

The Director of Infection Prevention and Control recognises and acknowledges the breadth and depth of work undertaken by all our staff and clinical leaders across the Trust working together to reduce harm associated with the COVID-19 Global Pandemic and the incidence of preventable healthcare associated infections and enhancing patient safety.

It must be noted that the reporting year has brought significant challenges to the NHS and Trust in the response to the COVID-19 Global Pandemic. However, our key achievements in 2021/22 include:

- Delivery of the Annual Infection Prevention and Control Work Programme 2020/21.
- Significant assurance against the Infection Prevention and Control Board Assurance Framework.
- Infection Prevention and Control Nurse team 7 day working throughout the reporting period.
- The work of the Antimicrobial Stewardship Team.
- Maintenance of the high visibility of the Infection Prevention and Control Team to facilitate effective infection prevention and control across the Trust.
- The work and commitment of our Estates and Facilities Teams in keeping our premises clean and fit for purpose and our water systems safe and wholesome.
- The work of the Occupational Health and Wellbeing Team keeping our staff safe.
- Internal Audit of Infection Prevention and Control concluded significant assurance was received.
- Duty of candour completed for all patients assessed as suffering a moderate or above level of harm due to hospital onset COVID-19.
- Zero infections were reported in the Orthopaedic mandatory three-month surveillance, which is below the national average of 1%.

Many challenges remain in the year ahead with the COVID-19 Global Pandemic and maintaining services across our Trust. The Trust priority will be to continue to improve our performance in relation to the national key performance indicators, be the best we can be and work within our finances to continue with a zero tolerance to preventable healthcare associated infections and keep patients, staff and visitors safe.

Mrs C Cruise
Head of Infection Prevention and Control

Mr D Melia (Chair of the IPCC)
Director of Nursing and Quality/Director of Infection Prevention and Control

Mrs D Parkes (Chair of the IPCC)
Deputy Director of Nursing and Quality/Deputy Director of Infection Prevention and Control

Dr J Sarma
Director of Infection Prevention and Control

July 2022

Glossary

Word/Phrase	Acronym	Definition
Antimicrobial Stewardship	AMS	A coordinated program that promotes the appropriate use of antimicrobials
Aseptic Non-Touch Technique	ANTT	Used during clinical procedures to identify and prevent microbial contamination of aseptic parts and sites by ensuring that they are not touched either directly or indirectly
Bare Below the Elbow	BBE	A requirement for all staff to be bare below the elbow in all clinical areas.
Bloodstream Infection	BSI	Infections caused by bacterial or fungal microorganisms being present in the bloodstream.
Central Venous Cannula	CVC	A central venous catheter is a thin, flexible tube that is inserted into a vein It is used to give intravenous fluids, blood transfusions, chemotherapy, and other drugs.
Clinical Commissioning Group	CCG	Clinically led NHS bodies responsible for the planning and commissioning of health care services for their local area.
Consultant Microbiologist	N/A	Provides services to aid the diagnosis and management of infectious diseases and help ensure the safety of those at risk of acquiring infectious diseases
Control of Substances Hazardous to Health	COSHH	The law that requires employers to control substances that are hazardous to health
Covid-19	NA	New strain of coronavirus , formerly known as 2019 novel coronavirus or 2019-nCoV
DATIX	N/A	Electronic incident reporting system
Department of Health	DH	A department of Her Majesty's Government, responsible for government policy on health and adult social care matters in England.
Frontline Ownership Audit	FLO	A monthly environmental and clinical practice audit undertaken by ward/department staff to assess compliance and competence.
Gram-Negative bacteria		Causes infections including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis in healthcare settings.
Healthcare Associated Infection	HCAI	Infections identified within the healthcare sector (e.g., hospital, GP etc.)
Hydrogen Peroxide Vaporisation	HPV	A deep clean used in hospitals that destroys all forms of microbial in the environment
Infection Prevention and Control Nurse	IPCN	A specialised nurse within the Infection Prevention and Control team
Infection Prevention and Control team	IPC	The team whose objective is to control and prevent infection across the Trust
International Infection Prevention Week	IIPW	An international campaign to raise awareness of the critical role infection prevention plays in improving patient safety

Word/Phrase	Acronym	Definition
Isolation		Placing patients in a single room
Link workers		Ambassadors who aim to raise awareness of the importance of Infection Prevention and Control in the clinical environment
Micro-organisms		A microscopic organism, e.g. Bacterium, virus, or fungus.
National Health Service Improvement	NHSI	Responsible to overseeing foundation trusts and NHS trusts. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable
National Institute for Health and Care Excellence	NICE	Provides national guidance and advice to improve health and social care
Outbreak		An isolated incident of two or three cases of infection or communicable disease associated in time and place
Patient Led Assessment of the Care Environment	PLACE	An annual audit involving local people visiting hospitals to assess how the environment supports the provision of clinical care
Peripheral Venous Cannula	PVC	A flexible tube containing a needle device which provides access for the purpose of intravenous hydration, feeding, and administration of medication and blood products.
Personal protective equipment	PPE	Equipment which protects oneself from infection e.g., mask, apron, gloves
Point of Care Test	POCT	Medical testing at or near the site of patient care
Post Infection Review	PIR	An investigation undertaken after a patient has contracted specific infections e.g., C-diff.
Private Finance Initiative	PFI	Refers to our PFI partners - a way of funding capital projects within the Trust
Public Health England	PHE	Protect and improve the nation's health and wellbeing, and reduce health inequalities
Royal College of Nursing	RCN	The world's largest nursing union and professional body
Sharps Safety		A system used to prevent sharps injuries
Surgical Site Infection	SSI	An infection that may occur post-surgery in a surgical wound
Surgical Site Infection Surveillance Scheme	SSISS	Mandatory monitoring and investigating surgical site infections within the hospital
United Kingdom Accreditation Service	UKAS	UKAS is the UK's National Accreditation Body, responsible for determining, in the public interest, the technical competence and integrity of organisations such as those offering testing, calibration and certification services.
Urinary Catheter		A device used to drain the bladder.
Ventilator Associated Pneumonia	VAP	A pneumonia that develops 48 hours or longer after mechanical ventilation is given by means of endotracheal tube or tracheostomy.
Visual Infusion Phlebitis scores	VIP	A scoring tool to assess early signs of phlebitis and prompt removal of peripheral intravenous cannulae.

Word/Phrase	Acronym	Definition
West Yorkshire Association of Acute Trusts	WYAAT	Acute Trusts based in the West Yorkshire region
World Health Organisation	WHO	A global organisation directing international health within the United Nations' system and to lead partners in global health responses.
Post-exposure Prophylaxis	PEP	A treatment that can stop a HIV infection after a person has potentially been infected.

MEETING OF THE PUBLIC TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW	
Agenda item	4.4
Paper title	Annual Report on Learning from Deaths – 2021/22
Responsible Director	Dr Karen Stone, Medical Director
Author	Dr Allison Grove, Associate Medical Director
Previously considered by	Learning from Deaths Group

The Board/Committee is asked to:

Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

This report provides members with a summary from the collated quarterly reports presented to the Quality Committee on deaths of patients under the care of The Mid Yorkshire Hospitals NHS Trust.

Date presented demonstrates that 2021/22 saw 440 less deaths in hospital than 2020/21 and an improving picture across all indictors when comparing annual rates between the two years. The Trust's relative risk for those diagnoses in the Hospitalised Standard Mortality Rate (HSMR) bundle and for all diagnoses was slightly higher than the national average for the year with rates of 102.8 and 101.9 overall. Emergency weekend and emergency weekday admissions across both the HSMR and all diagnoses groups have seen a reduction when compared to the previous year.

During the year the Trust's medical examiner service scrutinised 1533 deaths which represented 70% of deaths which occurred in the Trust, 306 of these resulted in referrals to HM Coroner.

The report further identifies learning from the carrying out of Structured Judgement Reviews and confirms that HSIB reports into maternal and neonatal deaths are received, reviewed and considered appropriately within the Trust.

It is recommended that members:

i. Note the contents of the report, and
ii. Receive assurance that the Learning from Deaths Group are appropriately managing mortality processes within the Trust.

Link to strategic objective(s)	*Highlight relevant box from the below:*
	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment	*Highlight one box from the below:*
	Initial assessment only

(select one)	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	*What is the financial impact associated with the paper? Is this recurrent or non-recurrent?*

Main Paper:

1. Introduction and Purpose

This report provides members with a summary from the collated quarterly reports presented to the Quality Committee on deaths of patients under the care of The Mid Yorkshire Hospitals NHS Trust. These quarterly reports are required by the National Guidance on Learning from Deaths.

2. Background

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work. In March 2017 the National Quality Board published a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care. As previously reported the Trust has adopted the use of the Structured Judgement Review (SJR) methodology as the basis for the review of cases. SJR is a validated, standardised method which scores the overall care given to deceased patients on a score of one to five. It is the nationally accepted tool for the review of adult deaths in England. Scores of one to two are low scores and are described as “very poor” or “poor” care respectively. Any case which receives a score of one or two is further investigated to determine if the death was more likely than not due to a problem in care. Across all scores there are valuable learning opportunities for the organisation.

3. Mortality

3.1 Mortality Data Set

The table below presents the high-level mortality data for the Trust and compares 2021/22 with 2020/21 data.

	2020/21	**2021/22**
Total Numbers of Deaths in year	2529	2089
Summary Hospital Mortality Indicator (SHMI) - rolling 12 month April to March (deaths due to Covid are excluded from SHMI)	1.0735 (within national average)	1.0422 (within national average)
Crude Death Rate (HSMR)	3.6%	3.5%
Crude death rate (All Diagnoses)	2.2%	1.5%
Overall (HSMR)	107.1	102.8
Overall (all diagnoses)	108.4	101.9
Emergency Weekend (HSMR;%resulting in death)	112	102
Emergency Weekend admissions (All Diagnoses)	110.2	102.7
Emergency Weekday (HSMR;%resulting in death)	106.2	104.5
Emergency Weekday (All Diagnoses)	108.3	103.4

Figure 1 below shows the HSMR trend from April 2020 to March 2022 and demonstrates the improvement the Trust has shown over this period.

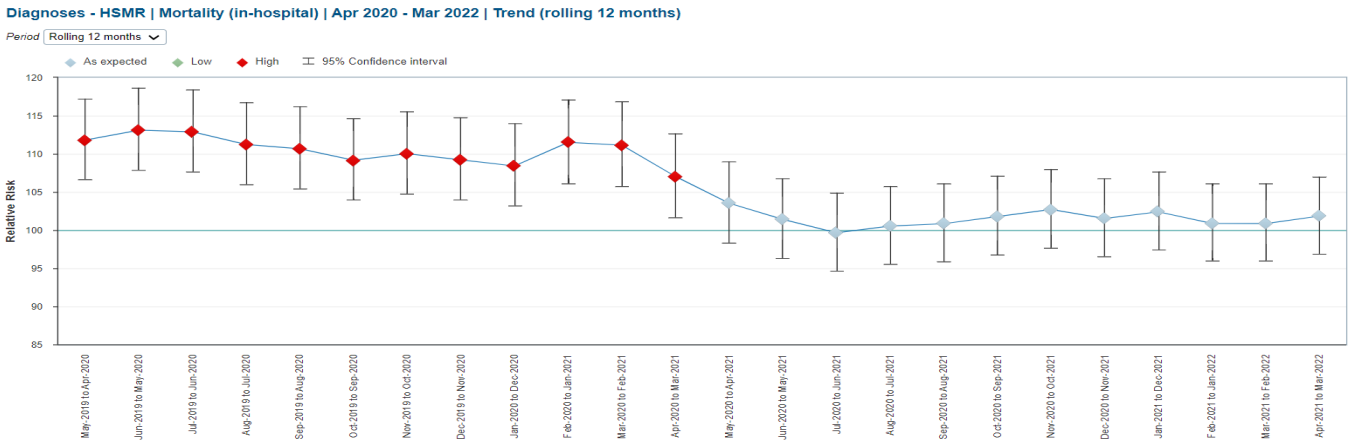


Figure 1 - Rolling 12 month HSMR from April 2020 to March 2022

Figure 2 compares the Trust's rolling 12 month HSMR with other Trusts regionally and demonstrates that the Trust compares favourably within the region. Mid Yorkshire Hospitals NHS Trust is represented by the large blue square in the plot.

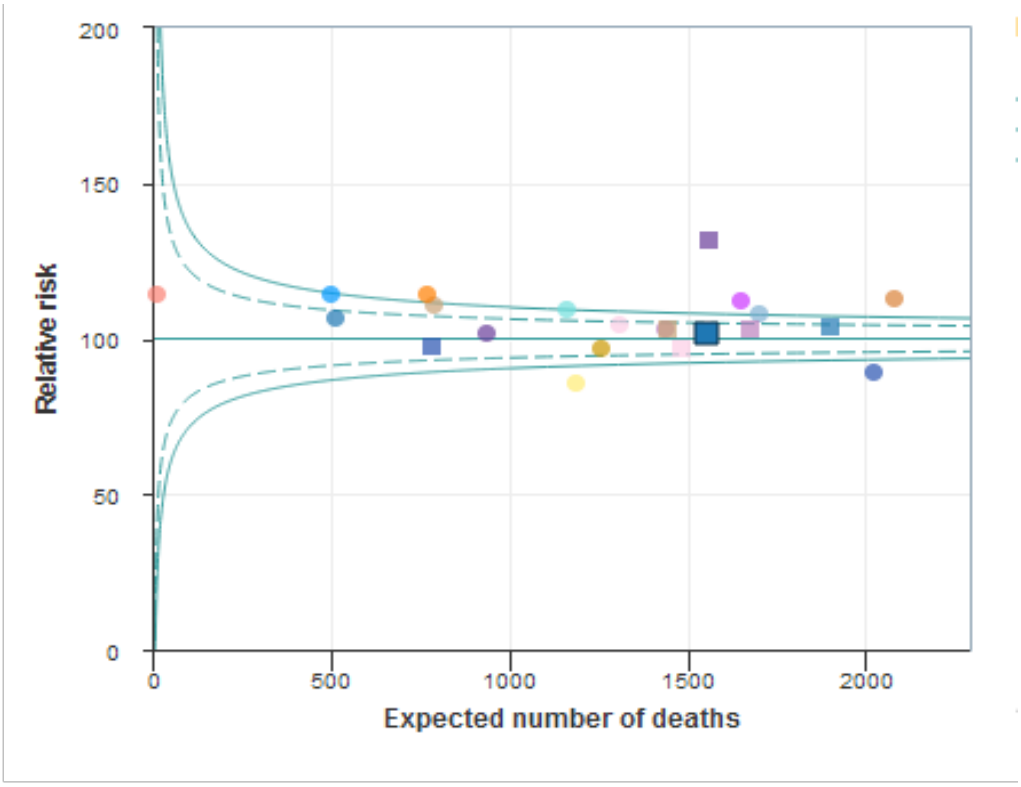


Figure 2 – Funnel Plot regional 12 month rolling HSMR

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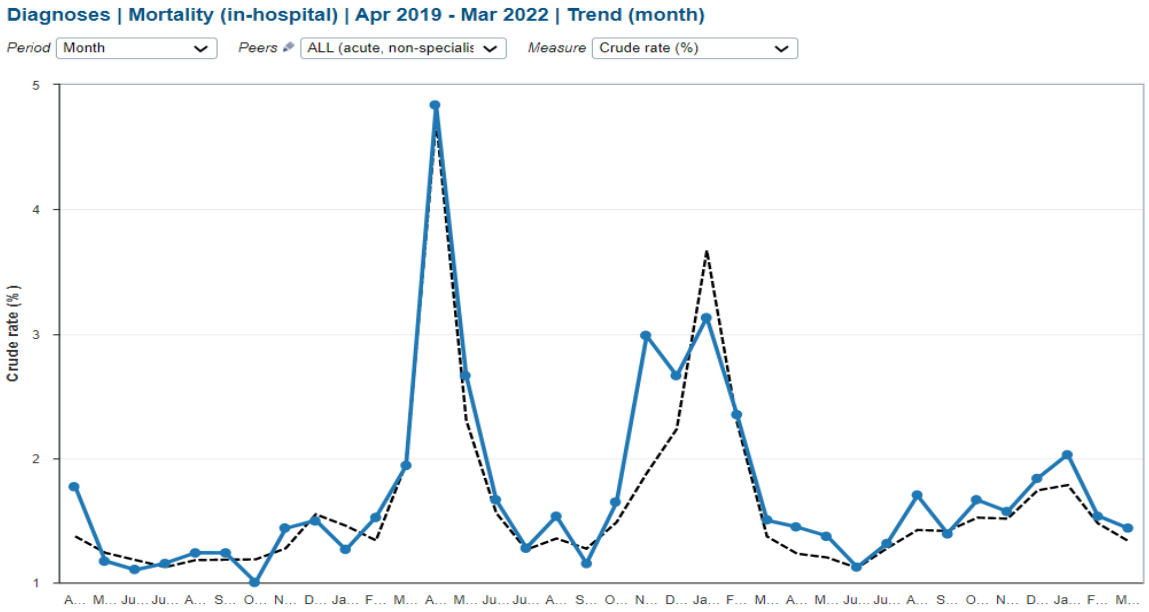


Figure 3 – Crude Death rates

Figure 3 represents the Crude death rate for last 3 years compared with national crude death rates and demonstrates that the crude death rate experienced by the Trust mirrors national death rates and demonstrates the peaks of deaths. The Apr 2020 peak is in line with national trend indicative of the first wave of Covid19 infection. The double peak in November 2020 and April 2021 mirrors the regional double peak in Covid19 deaths within the second wave of Covid.

3.2 Alert Flags

Negative alerts are issued when observed deaths in month are statistically significantly higher than expected deaths. Negative alerts are monitored via the Learning from Deaths group and the cases are reviewed. Covid 19 cannot be coded in HSMR data so removing deaths from Covid frequently eliminates the specific alert for a particular condition or group of conditions.

Other alerts are often received due to a small increase in number of deaths in conditions with a low expected number of deaths such an increase in deaths by 1or 2 has a marked increase on the relative risk.

- "Aortic, peripheral and visceral artery aneurysms" were newly alerting for October 2021. This related to 7 patients. A review of these cases, presented to March Learning from Deaths, identified no concerns or problems with care.
- "Acute and Unspecified Renal Failure" previously alerted predominantly in relation to a peak of 13 deaths in in January 2021 and continued to alert on 12 month rolling mortality relative risk up to Dec 2021. Since January 2021 in month relative risk for "Acute and Unspecified Renal Failure" has remained "as expected" such that for the period of this report April 2021 to March 2022 "Acute and Unspecified Renal Failure" 12 month rolling mortality relative risk remains within "as expected".

- "Sepsis" flagged twice in the year in December 2021 and February 2022. The identification and management of sepsis has been an area of focus for the Trust, monitored via the Deteriorating Patient Group. The ward improvement project focussing on detection of sepsis has shown significant improvements in the use of the Sepsis Screening Tool and in addition, there has been a Trust-wide focus on the timely prescription and administration of antibiotics for suspected sepsis. Overall sepsis mortality shows an improving picture compared with regional trusts for 2021/22 compared with 2020/21 as demonstrated by the funnel plots below. Mid Yorkshire NHS Trust is large blue square in both funnel plots

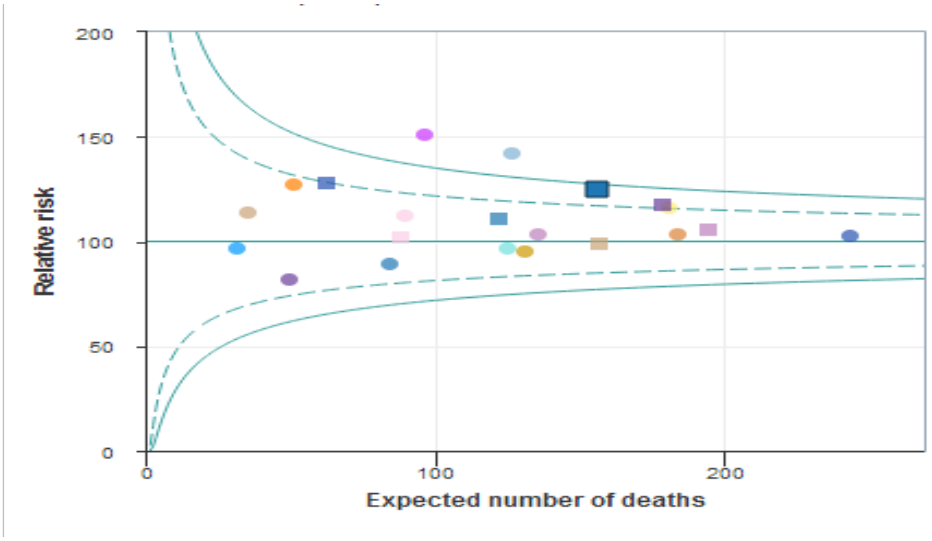


Figure 4 – Funnel Plot Septicaemia Mortality (except in labour) 2021/22

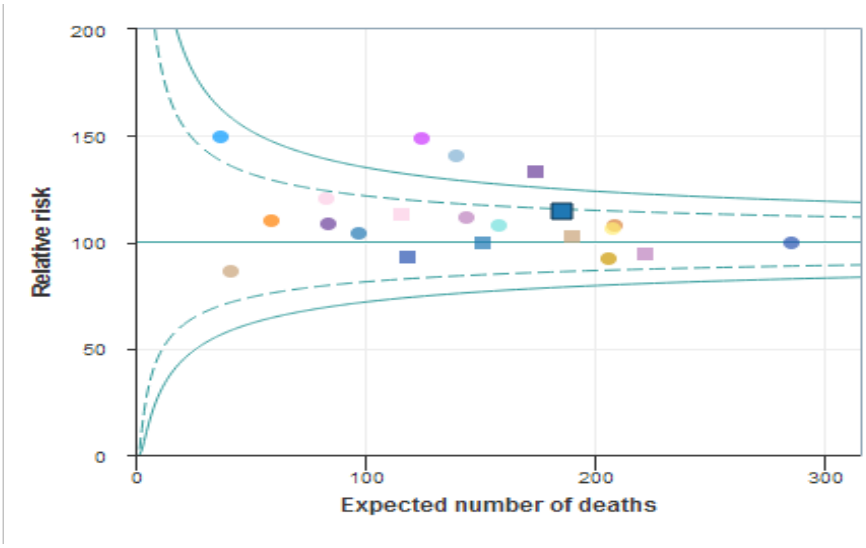


Figure 5 – Funnel Plot Septicaemia Mortality (except in labour) 2022/23

3.3 Healthcare Safety Investigation Branch Investigations

The Healthcare Safety Investigation Branch carried out investigations into three maternal and one neo-natal death during 2021/22. Reports relating to two of the maternal deaths and the neo-natal death have been received and considered by the service with appropriate action plans being developed. The third death remains under investigation.

4. Medical Examiner Scrutiny and Coronial Referrals

4.1 Medical Examiners

Acute trusts in England were asked to set up medical examiner offices to initially focus on the certification of all deaths that occur in their own organisation on a non-statutory basis. Locally this service commenced in May 2020. In June last year Trusts were asked to extend the role of these offices to include all non-coronial deaths, wherever they occur. In 2020/21 the Trust's medical examiner service scrutinised 692 deaths which represented 26% of deaths that occurred in the Trust. During the last financial year (2021/22) the service scrutinised 1533 deaths which represented 70% of deaths which occurred in the Trust.

4.2 Coronial Referrals

The Notifications of Deaths Regulations 2019 and nationally issued guidance to medical examiners identify the circumstances when the death of an individual should be referred to the Coroner. During 2020/21 108 (15.6%) of the deaths scrutinised by the Trust's medical examiner service were referred to the Coroner. In 2021/22 306 (19.9%) of deaths scrutinised were referred.

5. Learning from Deaths

5.1 Structured Judgement Reviews

Structured judgement reviews, which are a nationally recognised standardised case note review methodology, are carried out on deaths which meet a nationally agreed set of criteria.

These local reviews have identified areas of good practice in some SJRs and areas for improvement in others, these include:

- evidence of good care for Sepsis, AKI and DNACPR,
- evidence of good communication with families
- timely review and escalation recognition and treatment of sepsis,
- documentation, communication
- examples of good involvement of patient/family in decisions about care and DNACPR
- timely recognition of End-of-Life care
- Identification of falls risk

In addition areas for improvement noted on some SJRs include:

- Delay in recognition, escalation and treatment of deterioration
- Multiple, and in some cases inappropriate, ward moves
- Good management of head injury but sepsis (possible cause of head injury) was missed
- Requirement to record postural blood pressure – as per policy
- Better attention to nutritional status of patient
- Earlier recognition of AKI
- Lack of routine medical review for patients on discharge lounge or MOFD.

6. Conclusions

6.1 The Trust's Learning from Deaths group is sighted on mortality data and has functional processes to receive appropriate information on a monthly basis. This data demonstrates that 2021/22 saw 450 less deaths in hospital than 2020/21 and an improving picture across all indictors when comparing annual rates between the two years. The Trust's relative risk for those diagnoses in the Hospitalised Standard Mortality Rate (HSMR) bundle and for all diagnoses was lower than the national average for the year with rates of 91.1 and 88.6 overall. Emergency weekend and emergency weekday admissions across both the HSMR and all diagnoses groups have seen a reduction to rates below the national average. The Trust can evidence the robust use of Structured Judgement Reviews to review deaths in hospital and that learning from these reviews is being disseminated across the organisation. It can also be confirmed that HSIB reports into maternal and neonatal deaths are received, reviewed and considered appropriately within the organisation with learning identified being implemented where necessary.

6.2 The Trust can confirm that the medical examiner service is operational and both the roles of Medical Examiner and Medical Examiner Officer are embedded within the Trust. Medical Examiner scrutiny of community deaths commenced in April 2022, starting with review of deaths in the local hospices, and preparation for the statutory basis of the service from April 2023 is at an advanced stage.

7. Recommendation

It is recommended that members:

iii. Note the contents of the report, and

iv. Receive assurance that the Learning from Deaths Group are appropriately managing mortality processes within the Trust.

Dr Allison Grove
Consultant Paediatrician and Associate Medical Director
11th August 2022

NHS
The Mid Yorkshire Hospitals
NHS Trust

The Mid Yorkshire Hospitals NHS Trust

Innovation Strategy

The Mid Yorkshire Hospitals NHS Trust
Innovation Strategy

Document Reference No.	CORP009
Version No.	2.0
Issue Date	August 2022
Review Date	Review date is 2 years 9 months after issue date
Document Author	Director of Innovation
Document Owner	Director of Innovation
Accountable Executive	Medical Director
Approved by	Trust Board
Approval Date	
Document Type	Strategy
Scope	
Restrictions	

VERSION CONTROL/REVIEW AND AMENDMENT LOG

Version No	Date	Description of change
0.1	4.2.2019	First draft
0.2	13.2.2019	Revised draft
0.3	19.2.2019	Revised draft
0.4	4.5.2019	Revised draft
0.5	7.6.2019	Revised draft
1.0	29.7.2019	Final
2.0	21.07.2022	Version 2.0, revision of original version V1.0 Inclusion of plans for Clinical Research and Innovation Building; addition of Chief of Planning, Partnerships and Strategy and Head of Sustainability
2.1	22.07.2022	Version 2.1, review by Strategy and Transformation Committee. Section 4 – “patient experience” added to patient outcome Section 5 – “patient experience” added to patient outcome Section 5 – add “reduce health inequalities” Section 8 – add “inclusively” Section 11 – add “patient experience” Section 17 – “patient experience” added to patient outcome Section 19 – add “staff and patient” innovation champions Annex 3 – remove screenshot

Innovation Strategy: MYHT

Why does the Trust need to develop its innovation capacity and capability?

One of the six strategic objectives of the Trust is to 'provide excellent research, development and innovation opportunities'. Among other things this means that the Trust will:

- Make it easy for staff to present ideas and innovation
- Support staff to realise ideas quickly and efficiently

We will know we are achieving because:

- More staff are involved in research, development and innovation
- Staff suggestions for innovation increase and more opportunities are considered and approved
- Staff receive support quickly and effectively to realise their ideas
- Faster adoption of evidence-based innovations

1. To improve the quality and value of the services the Trust provides, and to enhance the attractiveness of the Trust as a place to work, the Trust needs to increase its capacity and capability to support innovation by being an encouraging and supportive culture. This includes an enhanced ability to support staff who have new ideas about doing things better and solving problems.

2. The Institute of Medicine promotes the concept of readiness "to think in radically new ways about how to deliver healthcare services". Ultimately, healthcare innovation should be centred on patient care and their experience of that care.

3. In 2014, Professor Tony Young was appointed as the NHS National Clinical Director for Innovation. He emphasised the importance of becoming "early adopters" of the latest innovations in order to answer some of the challenges of the health service has.

4. Supporting innovation across the healthcare system is more important than ever, and is central to securing transformation and improving patient experience and outcomes. Creating the conditions for more collaborative approaches to innovation and enabling the fast adoption of cost – effective new technologies is very important.

Expected Benefits

5. The expected benefits include:

- Improve patient experience and outcomes (new, better or more efficient ways of doing things)
- Improve any other aspect of work of the Trust (new, better or more efficient ways of doing things)
- Reduce health inequalities
- Create a workplace where innovation is embraced – staff feel empowered to make a difference – improve recruitment and retention/improved care is given

- Create new opportunities to work on clinical 'problems' with external partners
- Raise the positive profile of the Trust – patients and staff and potential staff
- Build capacity in the organisation to engage with innovation – new skills, new ways of doing things
- Develop networks with innovation organisations – new opportunities e.g. learning, ideas and resource
- Opportunity to generate income to self-fund the Trust's Innovation infrastructure, thus building innovation capacity and expertise (grant funding, intellectual property in the long term)
- Contribute to national/regional strategies which encourage health care innovation as an economic driver for our region and country

What is meant by the term "innovation?"

6. Innovation is the process by which ideas can be developed to solve problems, make life easier, improve existing methods or provide new ways of doing things. An important part of any invention is its application in a cost-effective commercially successful way. Examples of innovation include medical devices, medicines, digital, ways of working and diagnostics.

7. Innovation is not simply about encouraging staff who have new ideas although this is of crucial importance on how we can do things better, or inventing new "products" that eventually are brought to market.

8. Innovation is also about identifying difficulties with current approaches to care and treatment of patients and identifying partners (for example companies or academic partners) who may be able to help us to inclusively solve those problems – matching some of the problems that staff come across with relevant partners.

National Context for Innovation in the NHS

9. "Innovation Health and Wealth" is the NHS Chief Executive's report on the identification, adoption and spread of innovation in the NHS. Launched by the Prime Minister in December 2011, it sets out the contribution that the NHS can make to the Government's "Plan for Growth". It defines innovation as "an idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied".

10. Linked with this report is the Department for Business Innovation and Skills – Strategy for UK Life Sciences. Both reports give similar messages confirming that the demand, nationally and internationally, to do more health care with less resource means that "business as usual" is no longer an option and that innovation should be utilised to solve the problems we face both now and in the future.

11. "Innovation Health and Wealth" outlines three reasons why innovation and adoption at pace are important not just to the NHS but to society and the economy as well:
    - Innovation can transform patient experience and outcomes;

- Innovation can simultaneously improve quality and productivity;
- Innovation is good for economic growth.

Innovation has been at the heart of the NHS since its creation.

12. "Innovation Health and Wealth" also describes the gap between the invention of new ideas and identification of best practice and their adoption and spread. Great innovations are often implemented quickly in one or two places but in the NHS, as in other health care systems, diffusion is slow, often taking many years.

13. Despite the drivers for the adoption of innovation, there are important regulatory safeguards and requirements in place that help to protect against the injudicious introduction of systems or products. This is exemplified by the concern and litigation that has surrounded the use of some surgical implants that were inadequately evaluated before widespread adoption. It is clear that the introduction of innovative processes and products must take place within a framework of expertise that is able to progress valuable new approaches while ensuring that patients and the public are safe.

14. There is a national structure to support innovation in the form of regional Academic Health Science Networks (AHSNs). These focus on:
    - Leading local work in the NHS on innovation
    - Supporting knowledge exchange networks
    - Timely embedding of research findings
    - Supporting links to facilitate development of industry and technology research
    - Pump-priming innovation projects
    - Providing consistent advice on intellectual property, management to the local NHS and Universities
    - Identifying and supporting the development, testing and commercialisation of ideas that have the potential to become best practice
    - Work with Trust procurement teams, clinicians and managers to support systematic adoption and spread across partners

Local context for innovation

15. The Trust (MYHT) is a partner organisation of the Yorkshire and Humber Academic Health Science Network (Y&H AHSN). The Y&H AHSN maps functionally and geographically to the same area as the Y&H Clinical Research Network and is responsible for "Health Improvement" and "Wealth Creation" Practically this includes embedding clinical research findings rapidly into practice, as well as developing links between local industry and NHS organisations.

16. The Y&H AHSN is tasked with building on existing collaborations and bringing together the commissioners and providers in the local NHS, higher educational institutions, and other partners including public health and social care, to work with industry and deliver innovation. Identifying and supporting the development,

testing and commercialisation of ideas that have the potential to become best practice.

- Work with procurement teams to support systematic adoption and spread across partners.

17. By working in partnership with local Trusts we may strengthen our ability to attract companies to work with the Trust to help us solve problems and or overcome existing limitations of know-how on treatment illness/injuries to improve patient experience and outcomes.

18. The Trust has a relationship with Medipex – the healthcare innovation hub for NHS organisations across the Yorkshire and Humber and East Midlands regions and industry and academia internationally. Medipex is a not for profit company that connects the NHS with industry and academic, sharing its knowledge of the NHS and commercialisation processes to facilitate the innovation cycle.

Innovation Specific Engagement

19. Through the introduction of staff and patient innovation champions we aim to broaden our engagement with innovation in clinical and non-clinical areas. Working with existing communication routes we will let staff know how to raise any "bright ideas". Submitted ideas will be submitted through an Innovation Review Group.

20. We will establish an Innovation Review Group as an organised and streamlined system for the identification and harvesting of ideas from staff in the Trust.

21. We will host a series of "unmet needs" workshops, harnessing the collective strengths of a multidisciplinary workforce to come up with innovative solutions to problems in the workplace.

22. We will work closely with the Y&H AHSN to improve the identification, adoption and spread of innovative healthcare not only across the Trust but across our regional network. We will build on technology transfer activities and actively play a role in the Y&H AHSN Innovation Pathway.

23. Innovations will be developed in line with the Trust Intellectual Property Policy.

How does innovation relate to MYQIS?

24. The Trust has embedded many components of the Mid Yorkshire Quality Improvement System. MYQIS is based on the world leading "Virginia Mason Production System". In 2014, Paul Plsek, the Chair of Innovation at Virginia Mason Hospital in Seattle, USA, published a book entitled "Accelerating Health Care Transformation with Lean and Innovation - the Virginia Mason Experience". In the book he very clearly explains how innovation relates to the Virginia Mason Production System, demonstrating their close compatibility and complementary effect.

How does innovation relate to research?

25. There are synergies between innovation and research – both give the Trust the opportunity to consider new approaches to help us to improve patient care. While research brings our patients opportunities to try new treatments that otherwise wouldn't be available and help to generate the evidence base for better care, innovation offers a chance to rethink the way we do things and support new ways of thinking.

26. Led by the Trust Research Director the Trust has a well-established research team with responsibility for expanding opportunities for research participation for patients and staff. The team work in partnership with academic, industry and the national health research partners to deliver high quality research and broaden opportunities for research involvement for patients and staff across the Trust.

27. Where innovations lead to new products that would benefit from being tested, the research team will support the development of research studies to gather the evidence to support these innovation products.

28. Research and innovation are different but overlapping activities. Research is centred on the acquisition of new knowledge without a strict requirement to apply that knowledge in any particular way. On the other hand, innovation is a more focussed process that seeks to apply knowledge in order to improve ways of working and/or generate commercial profits. There are significant benefits to be gained by ensuring that there is a close porous interface between research and innovation that benefits researchers, practitioners and innovators. The creation of the Mid Yorkshire Clinical Research and Innovation Building (MY CRIB) will further strengthen research and innovation in the Trust.

Priorities Year 1

29.

a) Appoint Director of Innovation (job description, Annex 1) - completed
b) Develop an innovation operational plan to proactively deliver against four priorities;
   - To ensure the Trust has an approach to adopting innovation which arises elsewhere
   - To promote and support 'home grown' innovations from our staff (training/encourage ideas/make aware of funding/support opportunities through already existing organisations/routes)
   - To develop and maintain productive partnerships with industry/academia to develop innovations within our setting/context
   - To identify and set out the Trust's unmet needs and develop and maintain productive partnerships with industry/academia to develop solutions to the clinical and non-clinical problems that are identified by staff, patients or regulators
c) Consider inviting staff in each Division to be an Innovation Champion – invites sent through Chief Executive's message and through innovation clubs
d) Establish an "Innovation Club" for interested staff to attend - completed

e) Establish an Innovation Review Group (Annex 2 refers) to consider how best to support ideas from staff and how best to take forward problems that staff highlight that a commercial partner may be able to help us solve.
f) Establish innovation links with the AHSN, Medipex and WYAAT Trusts.
g) Encourage staff to engage in innovation and to be involved in tackling challenges and solving problems in their work.
h) Review the publication "Creating the Culture for Innovation" published by the NHS Institute for Innovation and Improvement to identify further actions the Trust should take to create the right climate for innovation. - done
i) Promote and facilitate partnerships with industry that will benefit the Trust – in progress
j) Establish a 'virtual innovation hub' – website up and running, "new ideas" e-form, linkage with AHSN Innovation hub
k) To identify training needs regarding innovation – e-learning opportunities
l) To work with communications to establish an Innovation go to place for staff on the Trust Intranet - completed

30. There are severe constraints on the resources that the Trust can provide to develop innovation related to the adverse financial position of the Trust. However, there is an opportunity to further develop the innovation strategy and to develop deeper relationships with regional and national innovation organisations.

Innovation Resources

31. In Year 1, a part-time Director post will be established. The Trust's Director of Research has agreed to provide some support as has the Chief Executive.

32. The current lack of a physical Innovation Hub in the Trust, along the lines that exist at Alder Hey Hospital means that we will emulate the approach taken by the Royal Cornwall Hospital. They have established an "Innovation Club" that meets monthly hosted by the Director of Innovation and Chief Executive.

33. As the amount of innovation increases and partnerships with companies develop it is likely that more funds will be available to increase or core capacity to support innovation in the Trust. The aspiration will be to move to a half time Director with a full time Band 7 and admin support, as a minimum – but this will depend on steady progress taking place over the next year or two.

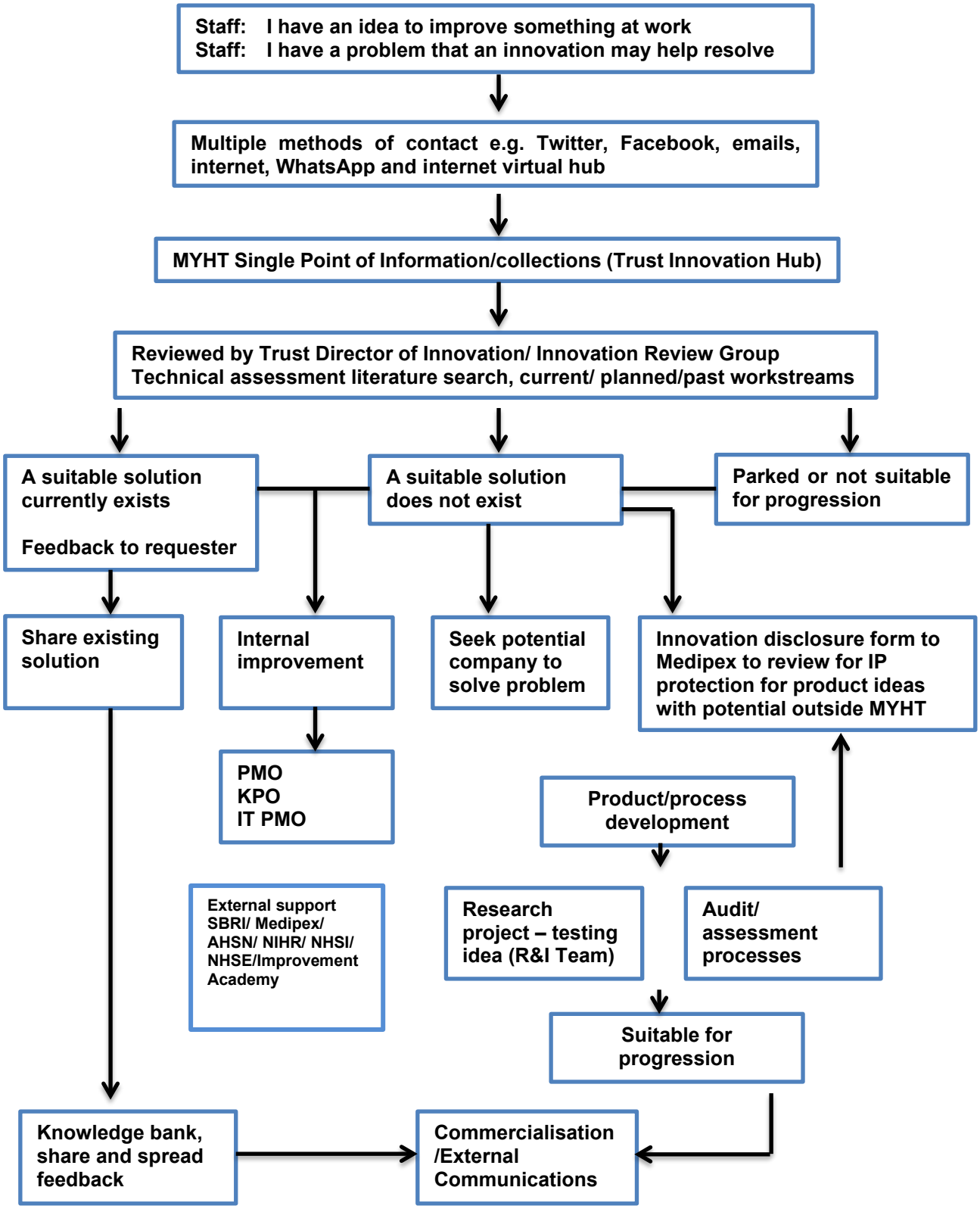
Physical infrastructure for Innovation and Research

34. The Trust has an important strategic aim to increase research activity and in particular, the numbers of patients who can benefit from enrolment in research trials. There is a need to improve the facilities for such activity by providing patients and research staff with a modern, fit for purpose research building on the Pinderfields site.

35. Approval for the development of the Clinical Research and Innovation Building (MY CRIB) will enable the Trust's commitment to innovation and encourage external partners to work with the organisation.

Staff Ideas for Innovation

36. Annex 3 sets out a possible approach for considering and supporting ideas from staff. This is also summarised in the possible detailed process flow chart below. The final detailed process will be developed with the Director of Innovation.



ANNEX 1

Role Description

Director of Innovation

Accountable to: Medical Director

Reports to: Medical Director

Base: Trust HQ

Time allocation: 1.5 days per week

Key working relationships:

Heads of Clinical Services, Innovation Champions, Yorkshire and Humber AHSN, Medipex, Commercial Companies, local NHS Trusts, Directors, Trust Research and Development Leadership Team.

Role summary:

To promote a climate of innovation in the Trust, supporting staff who have ideas to improve the quality and value of what the Trust does and how it does its work, working with relevant commercial companies to develop ideas as well as help the Trust and its staff solve problems.

Key duties and responsibilities:

1. To implement the Trust's Innovation Strategy
2. Actively engage in the 'entrepreneurial process' within the Trust and integrate concepts of entrepreneurships and innovation as synergistic components rather than individual areas
3. Link innovation to the Trust strategy
4. Lead the development of a climate in the Trust that encourages staff to develop ideas and be receptive to innovation
5. Establish and sustain a virtual Innovation Hub
6. Assist with staff engagement, enabling staff to be part of change in an 'innovation workplace'
7. Establish and sustain an Innovation Club
8. Responsible for the development, governance and management of the virtual Innovation Hub and Innovation Club
9. Be an effective member of the Joint Executive Directors and Clinical Forum which meets fortnightly
10. Establish relationships with fellow Directors of Innovation (or equivalent) in Yorkshire and beyond where appropriate, i.e. Cornwall
11. Be an agent for positive change within the Trust offering long term support

12. Establish relationships with relevant commercial companies which have the expertise to help the Trust resolve problems through innovation – to be the 'match-maker'
13. Responsible for developing and promoting the Trust's Innovation interests through local and national innovation networks as required
14. To secure income from external sources to support and expand the Trust's innovation support infrastructure
15. To ensure the Trust identifies exploits and commercialise innovations in partnership with external stakeholders
16. To be aware of adoption of relevant innovations from outside the Trust and promote
17. Manage the budget effectively
18. Create a management framework/operational plan/feed into Directorate Operating Plan in consultation with the Medical Director for the effective completion of these responsibilities, including reporting via established Trust governance frameworks
19. To ensure the development of effective partnerships with local and national academic institutions
20. To develop and manage a register of innovations activity across the Trust
21. To write a quarterly update/progress report and Annual Report for the Executive Directors meeting and Trust Board respectively
22. Ensure financial and ethical probity in all innovation projects
23. To work with Divisions and Directorates to ensure Innovation potential is encouraged and identified
24. To effectively disseminate innovation appointments and knowledge to relevant colleagues and partners
25. Ensure that appropriate innovation educational training exists to support and develop innovations across the Trust signposting to external training where relevant

Standard duties:

1. To work in accordance with the Trust standards of business conduct. Standing Orders, Schemes of Delegation and Standing Financial Instructions
2. To work in accordance with Trust policies and procedures

ANNEX 2

THE MID YORKSHIRE HOSPITALS NHS TRUST (MYHT)
INNOVATION REVIEW GROUP
TERMS OF REFERENCE

1. Role of the MYHT Innovation Review Group

The role of the MYHT Innovation Review Group is to make it easy for staff to present ideas and innovation and to support staff to realise their ideas quickly and efficiently. The group will consider how best to support ideas from staff, how best to take unmet needs highlighted by staff and patients forward with external partners and how to support innovation in the Trust. The group is responsible for supporting the Trust's streamlined system for the identification and harvesting of ideas from staff in the Trust.

2. Membership

Medical Director
Chief of Planning, Partnerships and Strategy
Director of Innovation
Director of Research
Head of the Programme Management Office
Director of Finance or nominee
Head Librarian
Director of Nursing
Clinical Innovation Champions (to include at least 1 medic, 1 nurse and 1 advanced health practitioner)
Head of Research
Head of Sustainability

Proposed new members of the group are to be appointment by the Innovation Review Group. The group will be chaired by the Director of Innovation.

The group will co-opt staff with appropriate skills and experience to consider innovation projects in the Trust.

3. Quorum

Five members or their nominated deputies, to include the Director of Innovation constitutes a quorum.

4. Attendance

It is expected that each member or named deputy attends a minimum of 60% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy will not count towards the quorum.

Membership of the group is to be reviewed at least bi-annually. Individual membership to be reviewed if three successive meetings are missed.

Observers may attend the groups by agreement with the chair.

5. Authority

The group holds authority to consider and provide permission (or otherwise) for innovation activity.

The group delegates the authority to the Director of Innovation where the review identifies no more than minimal risk.

6. Voting

Each member will be entitled to one vote. Any resolution of the group will require a simple majority of those present and voting. In the event of an equal number of votes, the chair will have the casting vote.

7. Administration

The Chair of the group will set the agenda.

Members of staff of the Trust wishing to raise matters with the group may approach any group member.

Minutes of the meeting will be published on the Trust's intranet.

8. Changes to the Terms of Reference

Changes to the terms of reference of the group, including changes to the chair or membership, are a matter reserved to the Executive Team.

9. Establishment of sub-groups

The group may establish sub-groups or groups to support its work. The terms of reference of such will be approved by the Innovation Reference Group and reviewed at least annually. The minutes of any such sub-groups will be presented to the Innovation Review Group at the next available meeting.

10. Frequency of meetings

The committee will meet every three months.

11. Annual Plan

The group will develop an annual programme of work for approval by the Trust Board at its first meeting of the financial year. The programme will include a list of all reporting and accountable groups and Sub-Committees and when minutes or reports from those groups will be received.

12. Reporting to Trust Board

The group will provide the Trust Board with an Annual Report setting out issues that have been considered by the group and details of assurance provided. The report will enable the Trust Board to monitor the effectiveness of the group, this will include innovation activity by clinical service group, staffing and financial information, delivery against work plan and management of risk.

13. Main duties and responsibilities

The group will:

- Assure the Executive Team that innovation activity in the Trust is managed and monitored according to applicable laws, policy and guidance
- Assure that Intellectual Property in the Trust is managed and monitored according to applicable laws, policy and guidance
- Develop plans and arrangements to support innovation activity in the Trust
- Provide annual report to the Trust Board on innovation activity
- To consider and evaluate ideas received from staff.

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ANNEX 3

Innovation Ideas – process for considering and supporting ideas

Innovation is the process by which ideas can be developed to solve problems, make life easier, improve existing methods or provide new ways of doing things. An important part of any invention is its application in a commercially successful way. Examples of innovation include training packages or manuals, best practice guidelines, new uses for drugs, diagnostic tests, and modifications to equipment, new or improved medical devices, software and databases. These innovations can be protected by intellectual property rights. An example of which is written information and diagrams, these can be protected by copyright, and inventions can be protected by patents.

If you have an idea for a novel invention or innovative new service, it is very important that you are aware of what you should do to protect it and keep your rights. Here are some useful tips and important facts that you should know;

- Make sure that you do not disclose the details of your idea to anyone, especially at conferences or meetings or in clinical papers. any of these activities will be seen as putting your idea into 'the public domain' and this can harm or completely eliminate the potential for your idea to be protected and eventually commercialised, limiting or removing the chance of it bringing any financial benefit to you or your NHS organisation.
- As an employee of the NHS you will be subject to the MY Intellectual Property Policy, which is included as part of your employment contract. You should speak to the Director of Innovation or Medipex to help you clarify the position regarding ownership of your idea.
- In most cases, your idea will automatically be the financial return from its department, the nature of that arrangement being specific to each individual Trust.

Developing your idea

Idea

The initial idea may come from anyone within the Trust and can be submitted to the Director of Innovation by completing a form using the "Submit an Idea" button on our website. This information and subsequent discussions are then used to quickly establish a "balanced scorecard" that provides an objective view of the relative merits of all projects and is used to help make decisions about the most appropriate next steps. The nature of the clinical need or problem that the idea addresses is assessed, as well as the effectiveness of the proposed solution and its potential for further development and possible commercialisation.

- Once you have your idea and have taken appropriate initial steps to protect it, you will need to establish what its true potential is, whether it is unique and offers real benefits over existing products or procedures and what you need to do to turn your idea into reality. This is where Medipex can help you.
- Mid Yorkshire and Medipex will take a structured approach to help you establish the way forward. We can get advice and peer review, find an appropriate partner

for prototyping; assist with protecting the intellectual property and get appropriate regulatory advice. Where appropriate we will also advise you on the best opportunities for obtaining support funding and ultimately can help broker a commercial licensing agreement with a suitable commercial partner.

Protecting your idea

Copyright
Patent
Design right
Trademark

Market Assessment

The potential usage and size of the market opportunity is established by utilising links with Medipex, accessing incidence data e.g. Hospital Episode Statistics, and assessment of what other competitor products there are already in the market and general searches. In addition, assessment of competitor products and/or treatments is carried out in order to assess the novelty of the innovation and its possible commercial appeal. This information and the core details of the invention are then used to start to build a business case in order to support further investment by the originating department /or to help secure other funding via appropriate grant schemes e.g. i4i, Biomedical Catalyst Fund, etc.

Intellectual Property

An assessment is made to establish ownership of any IP that may arise from the project through Medipex, as well as what existing IP there is on similar ideas/devices. This will involve various searches and if necessary, experienced patent lawyers are used to provide a formal assessment of "freedom to operate" and the potential for protection of any IP that arises. A cost benefit model is then established and where appropriate, IP protection activity is then commenced.

Proof of Concept

Medipex and the AHSN then assists with identification of suitable partners where needed, in order to provide CAD drawings, simple and working prototypes, research input, etc. and works closely with the innovator and any collaborators to manage the project towards regulatory approval and clinical trials. The evidence that the idea works and demonstrates benefit is then worked up into a case study that can be used to facilitate discussions with possible commercial partners and to secure any further investment that is required to progress to commercialisation.

On completion of the business case and proof of concept, further funding for clinical trials will be sought via grants and/or a potential commercial partner, in order to build a full regulatory and evidence package to achieve commercialisation and take the idea and diffuse it across the NHS and other healthcare markets globally. Having identified a suitable commercial partner, appropriate licensing agreements will then be developed and put in place that ensure the Trust receives royalty payments and revenue starts to flow back into the Trust to support further innovations.

Need to link to national and regional information:

- NHS England Innovation: https://www.england.nhs.uk/ourwork/innovation/nia/
- National Innovation portal: http://www.innovation.england.nhs.uk/
- Innovation roadmap: http://www.innovation.england.nhs.uk/road-map?p_p_id=122_INSTANCE_WwZPEtvVecnD&p_p_lifecycle=0&p_p_state=normal&p_p_mode=view&p_p_col_id=column-2&p_p_col_pos=2&p_p_col_count=3&p_r_p_564233524_resetCur=true&p_r_p_564233524_categoryId=126314&#p_122_INSTANCE_WwZPEtvVecnD n

This Road Map provides an overview of organisations, groups and teams that support innovation, innovators and entrepreneurs and highlights how they can get support for their ideas and innovations that support priorities in the NHS Five Year Forward View. The organisations, groups and teams outlined in this section provide unique and specialised support in a range of areas from clinical and technical advice, funding for pre commercial development through to implementation advice.

The Road map offers:-

- A reference point for information about the organisations, groups and teams that support innovation at a local and national level.
- The Road Map is intended to signpost users to the most appropriate support by identifying organisations which can provide help in progressing an innovation through its development journey.
- It identifies the kinds of support that these organisations can offer (in general terms) to transformational priorities of the Five Year Forward View.
- It is updated periodically to reflect any changes in the landscape.

- Medipex: http://www.medipex.co.uk/

Medipex is a healthcare innovation hub for NHS organisations across the Yorkshire and Humber and East Midlands regions and industry and
academia internationally. We connect the NHS with industry and academia, sharing our knowledge of the NHS and commercialisation processes to facilitate the innovation cycle.

- AHSN including monthly funding opportunities and innovation exchange hub:

http://www.yhahsn.org.uk/

Academic Health Science Networks were given licence to operate by NHS England in May 2013. The Yorkshire and Humber AHSN is one of 15 innovative health networks set up to create and harness a strong, purposeful partnership between patients, health services, industry, and academia.

The aim of the Yorkshire and Humber AHSN is to create significant improvements in the health of the population by reducing service variability and improving patient experience in the health care system. The Yorkshire and Humber AHSN will assist in ensuring new innovative products and services that have the potential to transform lives become part of routine clinical practice. The Yorkshire and Humber AHSN will

also assist in providing economic growth for the region, supporting inward investment projects and industry that support the health sector.

http://www.yhahsn.org.uk/funding/

External funding and investment are often the key to unlocking innovation in the NHS. However, there are a wide range of potential sources and types of funding depending on factors such as who is seeking funding (e.g. NHS organisation, academia, industry, voluntary sector), the amount of funding sought, the purpose of funding sought (e.g. research, development, demonstration, commercialisation, or evaluation), the size and stage of business growth (e.g. early stage or established), and whether the applicant is seeking grant funding, match funding, or investment with intention to payback with a return.

The Yorkshire and Humber AHSN is constantly horizon scanning to identify funding opportunities for industry and NHS organisations in order to facilitate collaboration and accelerate innovation in healthcare and as new initiatives are launched they will be included in the key opportunities sections below. If your organisation requires bespoke support for identifying funding and investors for developing innovative products and services for NHS organisations please provide your details via our online portal in order to work with our Commercial Team

http://www.yhahsn.org.uk/hie/

Innovation Exchange Portal

The Yorkshire and Humber Academic Health Science Network is delighted to unveil our new Health Innovation Exchange portal. Health Innovation Exchange provides a platform for NHS staff and industry innovators across the Health and Care sector to connect and share innovative solutions, projects and products which support the ambition of providing world-class patient care in a cost-effective, efficient manner. The portal will act as a forum for innovators to openly showcase products and solutions that can improve patient outcomes and experiences, as well as improve the efficiency in which services are provided. Richard Stubbs, Commercial Director of the Yorkshire and Humber AHSN said “Our staff and our patients are the biggest assets of the NHS. We also have a wealth of talent and ideas within the UK’s strong life science industry. To create a sustainable NHS for the future we need to better harness the expertise in these groups.”

“Nearly everyone has a great idea to share about how we can improve the care we give. But all too often they have no way of sharing these great ideas. The Health Innovation Exchange is a simple, accessible way for us to share what works, create communities with common interests, and grow a database of innovation for the benefit of Health and Social Care.”

“The portal will provide innovators the platform they require to showcase their solutions to the health care sector, whilst acting as a single point of entry into the AHSN. Meanwhile, for the first time, our members have the opportunity to view all the products and solutions that are available to support their strategic and operational needs in one place.”

Health Innovation Exchange is a product of the Yorkshire and Humber Academic Health Science Network, and is available for all AHSNs to use.

- Research - NIHR Portfolio studies – biannual search of: https://www.report.nih.gov/ using research team log of studies for all portfolio research hosted at MY
- Innovations successfully developed via MY innovation hub, through Medipex awards, Dragon's Den competition etc.
- Shortlisted innovation award from 'celebrating success' annual awards.
- QI (quality improvement) programmes. In embarking on any improvement something tangible has to be created – a poster, presentation, report, and document.
- Junior doctors projects – all CMTS have to do a project – this is a national requirement.
- RCN – compassionate care competition – if staff get involved with this then they have to produce something at the end of it – they may have to present their entry, document/write it up – this is added to the database (NB often the nursing staff involved are in communication with the library at the literature searching stage and so it is a good idea to ask/follow up where they are at with it)

ANNEX 4

Innovation Strategy Scorecard	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Number of Innovation ideas received				
Number of Innovation ideas actioned/developed				
Income received				
Number of trained innovation champions				
Good reputation with ahsn for adoption of innovation				
Innovation club meetings attendance				
'Partnerships' established with leeds city region innovation organisations				
Commercial links established				
Number of problems solved through connections with commercial and/or partner organisations				

ANNEX 5

EQUALITY IMPACT ASSESSMENT SUMMARY

Directorate: Corporate	**Area:** Company Secretary
Policy/Project Summary: .	
What are you seeking to achieve with this work? *What has prompted this change? What are the intended outcomes of this work?*	See paragraph 5 of the strategy
Who will be affected by it and why? *(e.g. Public, patients, service users, staff, etc.)*	Staff and patients
Information	
What information is available about the current situation to assist decision making? *(e.g. data, intelligence, research or national guidelines; staff and patient experience)* See paragraphs 9 to 18	
Impact Analysis	
Based on the information available, an assessment of the current situation and the changes being proposed is there the possibility of a differential impact (positive or negative) on the groups listed below? *(Enter Y/N against each characteristic and a rationale with evidence)*	

	Y/N		**Y/N**
Disability	N	**Gender Reassignment & Transgender**	N
Gender/Sex	N	**Religion or Belief**	N
Race	N	**Pregnancy and Maternity**	N
Age	N	**Marriage & Civil Partnerships:**	N
Sexual Orientation	N	**Carers**	N

Rationale for Answers Above: *(Explain for each characteristic, why it is considered that there may or may not be an impact)* The approach to innovation is inclusive
Summary of Actions Planned as a Result of the Assessment *(Indicate timescales and lead officers for each action)* None
Assessed By Karen Stone, Medical Director

MEETING OF THE TRUST BOARD
DATE OF MEETING: 08 SEPTEMBER 2022

OVERVIEW	
Agenda item	5.2
Paper title	Teaching Hospital Application
Responsible Director	Dr Karen Stone, Medical Director
Author	Ian Carr, Associate Director – Medical Directorate
Previously considered by	

The Board/Committee is asked to:

Highlight relevant box from the below, see overleaf for guide

Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

This report provides members with an update on progress relating to the Trust's desire to seek a change in our Establishment Order to reflect the significant teaching commitment it makes and be formally recognised as a Teaching Trust.

Following an assessment process carried out by the University we are pleased to be able to confirm that the University of Leeds confirmed their support for our application in July. The Trust has also consulted with a range of stakeholder organisations who have all indicated their support for our application and proposed change of name to Mid Yorkshire Teaching NHS Trust.

We are aiming to submit our formal application to the Department of Health and Social Care by 30th September 2022 and it is hoped that the formal processes will be completed by the end of this current financial year.

Achieving teaching status is the first step in a long-term programme towards our ultimate ambition of securing university hospital status. As we go forward we will continue to embed collaborative research, education and training into ways of working across the whole organisation to support delivery of our Trust strategy and ensure that the Trust continues to provide safe, high quality patient care

It is recommended that members:
i. Note the update

Link to strategic objective(s)	*Highlight relevant box from the below:*
	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	*Highlight one box from the below:*
	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)

Quality Impact Assessment	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	There is no direct financial implication from this report but a successful change in establishment order would require some indirect costs relating to the change of signage etc.

Main Paper:

1. Introduction and Purpose

This report provides members with an update on progress relating to the Trust's desire to seek a change in it's Establishment Order to reflect the significant teaching commitment it makes and be formally recognised as a Teaching Trust.

2. Background and update

The National Health Service Act 2006 states that the first NHS trust order made in relation to an NHS trust must specify that "where the NHS trust has a significant teaching commitment, a provision to secure the inclusion in the non-executive directors…a person from a university with a medical or dental school specified in the order".

The Mid Yorkshire Hospitals National Health Service Trust (Establishment) and the Pinderfields and Pontefract Hospitals National Health Service Trust and the Dewsbury Health Care National Health Service Trust (Dissolution) Order 2002 does not make any reference to a "significant teaching commitment".

If an NHS trust supports medical or dental training or research, it can apply to the Department of Health for an amendment to its Establishment Order to recognise this status. In order to apply for a change of our Establishment Order we require the support of the University of Leeds and colleagues within the Trust have been working with the University through the year to secure this support.

Following an assessment process carried out by the University we are pleased to be able to confirm that the University of Leeds confirmed their support for our application in July. The Trust has also consulted with a range of stakeholder organisations who have all indicated their support for our application and proposed change of name to Mid Yorkshire Teaching NHS Trust.

We are aiming to submit our formal application to the Department of Health and Social Care by 30th September 2022 and it is hoped that the formal processes will be completed by the end of this current financial year.

3. Benefits of Teaching Status

Achieving teaching status is the first step in a long-term programme towards our ultimate ambition of securing university hospital status. This programme will enhance current research partnerships to drive innovation and develop new treatments more quickly, as well as investing further in academic partnerships to strengthen the future workforce. This is important, as studies have found that hospitals which are actively involved in healthcare research and educating care professionals achieve better outcomes for patients.

Hopefully it will enable the recruitment and retention of high-quality staff across the nursing and medical professions and many other important functions. Securing teaching status will also support the local economy in the long term by

supporting and creating more opportunities for local people to train locally and, crucially, develop their careers locally.

As we go forward we will continue to embed collaborative research, education and training into ways of working across the whole organisation to support delivery of our Trust strategy and ensure that the Trust continues to provide safe, high quality patient care

4. Recommendation

It is recommended that members:

i. Note the update

Ian Carr
Associate Director – Medical Directorate
30th August 2022

MEETING OF THE RESOURCE & PERFORMANCE COMMITTEE
DATE OF MEETING: 27 JULY 2022

OVERVIEW	
Agenda item	6.1
Paper title	Equality Diversity and Inclusion Annual Report 2021-22
Responsible Director	Phillip Marshall, Director of Workforce and Organisational Development
Author	Brian Chiyesu, Head of Diversity and Inclusion and Angie Colvin, Diversity and Inclusion Manager
Previously considered by	Not applicable

The Board/Committee is asked to:

Shade in grey relevant box from the below, see overleaf for guide

Approve	**Receive**	**For Information**	**Take assurance**

Executive summary

This Equality, Diversity and Inclusion Annual Report 2021/22 provides a summary of the key equality, diversity and inclusion activities undertaken throughout 2021/22.

The Committee is asked to consider the report and note its content.

The Chair of the Committee is asked to assure the Board that the Trust has met its obligations under the NHS Standard Contract and in line with the requirements of the Equality Act 2010 Public Sector Duty. This Annual Report will be published on the Trust's website.

Link to strategic objective(s)	*Shade in grey relevant box from the below:*
	Keep our patients safe at all times
	Provide excellent patient experience and deliver expected outcomes
	Be an excellent employer
	Be a well-governed Trust with sound finances
	Have effective partnerships that support better patient care
	Provide excellent research development and innovation opportunities
Equality Impact Assessment (select one)	Not applicable
	Initial assessment only
	Further assessment (negative impact identified and equality impact assessment attached for Board approval)
Quality Impact Assessment	Not applicable
	Initial assessment and no further assessment required
	Further assessment to be signed off by Director of Nursing and Medical Director
What is the financial impact?	None

Main Paper:

1. Introduction and Purpose

This paper presents the Equality, Diversity and Inclusion (EDI) Annual Report 2021/22 for consideration by the Resources and Performance Committee (RPC).

2. Background

Updates on EDI activities are submitted to the RPC on a bi-annual basis to provide assurance of continuing progress in achieving the equality objectives set out in the EDI Strategy.

Following a delay in reviewing the EDI Strategy 2016 – 2020 (reported to RPC in October 2021), the Trust published its interim EDI Strategic Plan 2022/23 in April 2022.[1] This plan will be reviewed and refreshed in 2023 in light of the development of a wider Trust Strategy.

The ambitions set out in the plan reflect the Trust's commitment to ensure that equality, diversity and inclusion is at the heart of everything we do, and these are supported by four key priority work streams, as detailed below:

1. To promote leadership that is inclusive, welcoming and compassionate for all staff to be able to be their authentic self at work.

2. To progress key actions towards being an excellent employer and building a representative and supported workforce.

3. To review and progress the actions associated with the Trust's BAME Staff Experience Improvement Plan.

4. To actively engage with stakeholders - 'we each have a voice that counts'.

3. Assessment

The detail provided in this report shows significant progress throughout a challenging year. It demonstrates that the Trust has met its obligations under the NHS Standard Contract and in line with the requirements of the Equality Act 2010 Public Sector Duty.

4. Conclusion and Recommendation

The Committee is asked to consider the report and note its content.

The Chair of the Committee is asked to assure the Board that the Trust has met its obligations under the NHS Standard Contract and in line with the requirements of the Equality Act 2010 Public Sector Duty this Annual Report will be published on the Trust's website.

DEFINTIONS FOR ACTIONS REQUIRED FROM BOARD OR COMMITTEE (for reference)

Approve	**Receive**	**For Information**	**Take assurance**
To formally receive and discuss a report and approve its recommendations or a particular course of action.	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

BOARD ASSURANCE FRAMEWORK – PRINCIPAL RISKS KEY (for reference)

STRATEGIC OBJECTIVE		**PRINCIPAL RISKS**	
1	**Keep our patients safe at all times**	1	*Failure to maintain the safety of patients*
		2	*Failure to maintain and develop Trust Estate, and Equipment*
2	**Provide excellent patient experience and deliver expected outcomes**	3	*Failure to provide **excellent patient experience** including not meeting NHS Constitution Standards*
		4	*Failure to provide **expected outcomes***
3	**Be an excellent employer**	5	*Failure to recruit, train and sustain and engaged an effective workforce*
		6	*Failure to sustain an engaged and effective workforce*
4	**Be a well-led Trust that delivers value for money**	7	*Failure to achieve financial sustainability and VFM*
		8	*Failure to comply with targets, statutory and regulatory duties and functions*
5	**Have effective partnerships that support better patient care**	9	*Failure to have effective relationships with partnering organisations*
6	**Provide excellent Research, Development and Innovation Opportunities**	10	*Failure to support research, development, transformation and innovation for the benefit of patients and the NHS*

EQUALITY, DIVERSITY AND INCLUSION ANNUAL REPORT 2021-22

1. INTRODUCTION

The Trust is committed to ensuring that equality, diversity and inclusion (EDI) is at the heart of everything we do. We respect the value of difference and continue our focus on employing a diverse and representative workforce. We continue to ensure that all our services are fair and equally accessible to everyone regardless of age, gender, mental or physical disability, marital status, gender identity, maternity status, race, ethnic origin, religion or belief, sexual orientation or social class.

The Trust published its interim EDI Strategic Plan 2022/23 in April 2022.[1] This plan will be reviewed and refreshed in 2023 in light of the development of a wider Trust Strategy.

The ambitions set out in the plan reflect the Trust's commitment to ensure that equality, diversity and inclusion is at the heart of everything we do, and these are supported by four key priority work streams, as detailed below:

1. To promote leadership that is inclusive, welcoming and compassionate for all staff to be able to be their authentic self at work.

2. To progress key actions towards being an excellent employer and building a representative and supported workforce.

3. To review and progress the actions associated with the Trust's BAME Staff Experience Improvement Plan.

4. To actively engage with stakeholders - 'we each have a voice that counts'.

2. NATIONAL REPORTING REQUIREMENTS

In compliance with the Public Sector Equality Duty, as part of the Equality Act 2010, and as mandated within the NHS Standard Framework, NHS organisations are required to submit data and publish reports each year for the following:

- Gender Pay Gap Reporting
- The Workforce Race Equality Standard (WRES)
- The Workforce Disability Equality Standard (WDES)
- The NHS Equality Delivery System (NHS EDS2)

The Trust has submitted the required data as specified by NHS England and Improvement within the national timeframes.

2.1 Gender Pay Gap

The Trust submitted the 2021/22 Gender Pay Gap data by 30 March 2022 and details can be found on the UK Government and Trust's website:

https://gender-pay-gap.service.gov.uk/Employer/MgJzNw2a

A summary of the data is as follows:

- Women earn 83p for every £1 that men earn when comparing median hourly pay. Their median hourly pay is 16.7% lower than men's.
- When comparing mean (average) hourly pay, women's mean hourly pay is 26.8% lower than men's.
- In this organisation, women occupy 67% of the highest paid jobs and 84.8% of the lowest paid jobs.
- In this organisation, women earn 30p for every £1 that men earn when comparing median bonus pay. Their median bonus pay is 69.9% lower than men's.
- When comparing mean (average) bonus pay, women's mean bonus pay is 32.8% lower than men's.
- Who received bonus pay -
  1.5% of women
  10% of men

The Trust is committed to ensuring equity in the workforce and a range of actions which aim to achieve this, including:

2.2 The Workforce Race Equality Standard (WRES)

Improving the Workplace Experience for Black, Asian and Minority Ethnic (BAME) Colleagues

The WRES data is to be submitted to NHS England and Improvement (NHSE/I) before the national deadline of 31 August 2022. Prior to this it will be signed off by the Director of Workforce and OD. The WRES Annual Report and Improvement Plan is to be published on the Trust's website before the national deadline of 31 October 2022. Both these submissions will then be approved by the Executive Team and Trust Board prior to publication

The Trust developed a WRES Improvement Plan 2021/22 to continue improving the workplace experience for our BAME colleagues and addressing inequalities highlighted by the WRES indicators.

The WRES submission in August 2021 demonstrated an improvement across the majority of the WRES indicators, and across the following three indicators with the best percentile rankings against other Trusts and where the Trust performs in the best quarter of Trusts nationally:

- Indicator 3: The overall likelihood of entering formal disciplinary has decreased by 50 % but not by the same proportion for BAME staff
- Indicator 4: likelihood of undertaking non-mandatory training.
- Indicator 8: discrimination from a manager/team leader or other colleague in the last 12 months.

The Trust does however, acknowledge inequalities identified by the WRES in relation to career progression and in the relative likelihood of BAME applicants being appointed after shortlisting. As a result, an overhaul of the Trust's recruitment and exit interview processes was included within the WRES Improvement Plan and in line with the national NHS People Plan.

NHS Improvement Targets

As part of their national initiative "A Model Employer: Increasing Black and Minority Ethnic Representation at Senior Levels Across the NHS" NHS Improvement set the Trust, a number of key performance indicators providing a trajectory for the number of BAME staff that should be employed by the Trust in bands 8a and above.

The table below and supporting narrative from the report highlights NHSI's ambition for the Trust in 2019 compared to its actual position.

Table 4. 2019 staff in post compared to 2019 trajectory ambition for Mid Yorkshire Hospitals NHS Trust

	2018 actual	2019 actual	2019 ambition	Gap
Band 8a	15	21	16	5
Band 8b	4	4	4	0
Band 8c	1	1	1	0
Band 8d	1	1	1	0
Band 9	0	0	0	0
VSM	1	1	1	0

There has been an increase in the number of BME staff in AfC band 8a. The trust is on track to deliver equity by 2028 for all AfC bands 8a to VSM.

A Model Employer: Increased BAME Representation at Senior Levels across the Trust.

NHSI have proposed a trajectory, within the context of the above, in order to deliver equity across MYHT by 2028. The table opposite provides the trajectory set by NHSI for the number of BAME staff in each Band and covers clinical and non-clinical.

The following table highlights the performance trajectory set by NHS Improvement.

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Band 8a	15	16	17	18	19	20	21	22	23	24	25
Band 8b	4	4	5	5	5	6	6	6	7	7	7
Band 8c	1	1	2	2	3	3	4	4	5	5	6
Band 8d	1	1	1	1	1	1	1	1	2	2	2
Band 9	0	0	0	0	0	1	1	1	1	1	1
VSM	1	1	1	1	1	2	2	2	2	2	2

The Trust's performance against the trajectory up to the end of 2021 is provided in the table below:

Band	2020 Trajectory	2020 Actual	Gap	2021 Trajectory	2021 Actual	Gap
8a	17	21	4	18	21	3
8b	5	4	-1	5	4	-1
8c	2	2	0	0	2	0
8d	1	0	-1	1	0	-1
9	0	0	0	0	0	0
VSM	1	0	-1	1	0	-1

The table above shows that the Trust is just slightly behind trajectory. It should be noted however, that a data quality audit in 2020 identified a number of records on ESR that do not have an entry for ethnicity. Consequently, a data cleansing exercise was instigated in early 2021 to seek to rectify this deficiency.

MYHT Strategic Key Performance Indicators - BAME Clinical Staff

As part of the Trust's approach to taking positive action, two strategic key performance indicators were developed to identify the progress made in increasing the representation of BAME clinical staff in Agenda for Change Band 3 and Band 6.

The table below indicates the Trust's performance as at 31 March 2022 and provides comparison with the previous year:

KPI	2020/21 Target	End of Year Position	2021/22 Target	End of Year Position
Increase the representation of BAME	Band 3 = 5.0%	6.2%	Band 3 = 7.0%	6.53%
	Band 6 = 11.0%	11.1%	Band 6 = 14.0%	13.03%

As can be seen above, the Trust's performance continues to improve despite COVID 19 delaying some of the planned initiatives. The 21/22 targets revised and set higher than 1% target earlier projected. The disparity ratio published in December also indicates good performance among clinical staff ahead of its peer Organization. While the trust shows consistent improvement on the lower bands in non-clinical, the disparity ratio that was published indicates it is still lagging behind its peers on WRES 1a indicator

WRES1a - Clinical Staff lower to middle disparity ratio

The Race Disparity Ratio is the difference in proportion of BAME clinical staff at various AfC bands in a Trust compared to proportion of White clinical staff at those bands. It is presented at three tiers. Bands 5 and below ('lower'). Bands 6 and 7 ('middle'). Bands 8a and above ('upper')
The following table indicates what the targets meant in headcount terms based on staffing levels as at December 2021

Workforce Race Equality Standard Indicator 1a: Clinical Staff disparity ratio

	WRES1a - Non-Clinical Staff lower to middle disparity ratio 2021	WRES1a - Non-Clinical Staff middle to upper disparity ratio 2021	WRES1a - Non-Clinical Staff lower to upper disparity ratio 2021
Provider Value	1.4	1.2	1.7
Peer median	1.9	1.1	2.4
National median	2.0	1.5	2.9

Workforce Race Equality Standard Indicator 1a: Non-Clinical Staff disparity ratio

	WRES1a - Non-Clinical Staff lower to middle disparity ratio 2021	WRES1a - Non-Clinical Staff middle to upper disparity ratio 2021	WRES1a - Non-Clinical Staff lower to upper disparity ratio 2021
Provider Value	0.9	3.9	3.5
Peer median	0.9	1.5	1.4

National median	1.1	1.5	1.4

MY Race Equality Network (MY REN)

The network now has a membership list of around 100 members. There are also 'informal' members who prefer to hear what the network offers and provides, however choose not to be formal members, but will seek informal advice as and when necessary. The network has rebranded following a discussion with network members – it was previously known as "MY BAME Network" and is now the "MY REN". This has been reflected in our communications, and we are currently working on a logo.

Strategic discussions with the Integrated Care System (ICS) REN remain, and MY REN have led the conversation to establish place based REN at Wakefield, in line with the move to place-based partnership working. This continues at present, and we hope that the structure and benefits of such working can be established soon. MY REN continues with quarterly update meetings, which provides staff the opportunity to attend, network and hear of updates which are of interest to network members. This continues over MS Teams at present, with the intention that meetings will move to face to face once Covid-19 allows.

In celebrating events, the network supported National Day for Staff Networks and has played a key role in organising celebrations for South Asian Heritage Month, 18 July – 17 August 2022. We have worked closely with Communications, Design and Print and the catering team to establish a South Asian menu to be offered throughout the month, along with narrative detailing the history of this region in the world.

We have supported Communications with the development of a logo demonstrating all the nationalities that work within the Trust. This is something we are proud of, as it demonstrates the rich variety of nations that exist within our Trust.

The network has been a base for support and the members have played a vital role in, consultations, directors' appointments, cultural education, mentoring etc.

Each of the executive team members has chosen a protected characteristic to champion. The Chief Executive has chosen to champion race inequalities. Throughout the year, he has addressed matters that are race related whether it involved staff internally or national issues.

BAME STAFF EXPERIENCE IMPROVEMENT PLAN

When in November 2020 the Board requested that the Trust to instigate a BAME Staff Experience Improvement Plan for 2020/23, the priorities for action identified by colleagues via the 'Call to Action' were used as the basis for designing the plan. The plan was approved by Trust Board at its December 2020 meeting and reviewed in 2021.

The plan, together with an update on progress is attached at Appendix A. As a consequence of the delays that occurred as a direct result of the COVID pandemic, some of the original targets had to be revised and the plan attached reflects these changes.

Cultural Ambassadors

Thirty members of staff (two cohorts) have now completed the Royal College of Nursing (RCN) Cultural Ambassador training. Members of staff from a Black, Asian and Minority Ethnic background were invited to attend and the second cohort was opened up to members of the LGBTQ+ Staff Network.

A Standard Operating Procedure (SOP) is currently being developed to scope the role of the Cultural Ambassador and how they can provide support to identify and explore further issues of culture and behaviour where staff may be being treated less favourably, potential discrimination and unconscious or conscious cultural bias. There will be a visit to other Trusts who have successfully integrated cultural ambassadors in their organisations.

The EDI team are currently creating a directory of Cultural Ambassadors to help manage the requests for support.

Reciprocal Mentoring

In 2019/20 the Trust progressed the Executive Mentoring Programme aimed at members of staff from a Black, Asian and Minority Ethnic background, at band five and above. The programme was made up of six sessions and each member of staff was paired with an Executive Director. Feedback confirmed the programme was beneficial to all participants.

The EDI team is currently developing a new Reciprocal Mentoring Programme; a programme with aims for people from diverse backgrounds to feel fully included, engaged, respected and recognised and well-represented in leadership which in turn benefits individuals, organisational performance, service-user outcomes, innovation and better problem-solving.

The vision for this programme is to commence in the autumn and to be accessible to a wider group of individuals representing all protected characteristics with support and engagement from the executive team and senior leaders.

BAME Coaching and Mentoring

BAME Coaching and Mentoring courses Cohort 1 started in May 2021 and teaching session now completed in May 2022. The trainee Coaches have started the practical part of the course by coaching colleagues in the trust irrespective of their ethnicity. The Trust offers coaching courses every year but there has been less uptake from BAME staff. Following Trust Board approval of the BAME Staff Experience Improvement plan, nine participants enrolled on the

BAME Coaching and Mentoring course from across a variety of disciplines. Expression of interest for next year's cohort are gathering momentum, which is a positive development.

Stay & Thrive

Stay & Thrive is a community of action to help people recruited from overseas to thrive, build a career in the NHS and to stay at Mid Yorkshire Hospitals NHS Trust (MYHT). This is an NHS England initiative to support key elements of the 'We are the NHS People Plan', which sets out a clear need for more people, working differently, in a compassionate and inclusive culture and working across our systems. It started on September 2021 with a roll out of 12 months. It enables sharing, testing and implementing ways to support colleagues who are internationally recruited, creating the conditions where these colleagues feel a strong sense of belonging, can do their best work and build their careers.

From August 2020, 146 new International Educated Nurses (IENs) have joined the Trust. This offered diversity to our workforce with nurses coming from different ethnical backgrounds:

- Philippines
- Indian
- Nepalese
- Nigerian
- Ghanian
- Somalian
- Pakistani
- Zimbabwe
- Kenyan
- Sri Lankan
- Uganda
- Palestinian

To date, Stay and Thrive has since embarked on:

- Listening In Events to understand the experiences of the IENs and to shape positive work streams.
- Feedback surveys
- A Celebration Event to formally celebrate the IENs careers at Mid Yorkshire.
- Board level support for the improvement of Stay & Thrive.
- A range of initiatives established to provide timely support, i.e. a buddy system, Clinical, Pastoral and Objective structured clinical examination support, WhatsApp forum, family events
- Plans are currently being developed for other initiatives following the Listening Events.
- Promotional platforms including Trust intranet and local induction.

Celebrating National Campaigns

Black History Month, October 2021 -

The theme for the campaign was “Proud to Be,” and the Trust acknowledged the successes of our minority ethnic colleagues by celebrating the contributions they make to the NHS and to the wider communities we serve. The month also gave us the chance to educate one another on the inequalities experienced by people from minority ethnic backgrounds and to inspire all of us to maintain and further develop an inclusive and diverse culture which is supportive and welcoming for all.

2.3 The Workforce Disability Equality Standard (WDES)

The WDES data is to be submitted to NHS England and Improvement (NHSE/I) before the national deadline of 31 August 2022. The WDES Annual Report and Improvement Plan is to be published on the Trust’s website before the national deadline of 31 October 2022. Both these submissions will be approved by the Director of Workforce prior to submission and an update will be provided at Executive Team prior to Trust Board approval in September and publication by 31st October 2022.

The Trust developed a WDES Improvement Plan 2021/22 to seek to improve the workplace experience of colleagues with Disabilities and address inequalities highlighted by the WDES metrics.

There are some areas of improvement across the WDES metrics submitted in 2021 including staff feeling valued and receiving adequate adjustments however, there is still work to do to improve the workplace experience for staff with disabilities.

Similar to data identified within the WRES, the WDES identified inequalities in relation to career progression and the relative likelihood of applicants with a disability being appointed after shortlisting. The overhaul of the Trust’s recruitment and exit interview processes detailed earlier will aim to reduce the inequalities experienced by both BAME and Disabled applicants.

Review of Recruitment Processes

Following the release of the NHS People Plan, the Trust pulled together the BAME Improvement Plan and also put together an action plan that was submitted to the ICS which has been used to put together an ICS level plan Key actions were highlighted by the action for the Trust to work towards and the Trust set out how to achieve these,

Reasonable Adjustments

The Diversity and Inclusion Service (DIS) will continue to provide advice to managers and staff on ‘reasonable adjustments’ in the workplace and the role of the national ‘Access to Work’ agency.

However, following a number of issues being raised around this topic with the

Trust's Freedom to Speak-Up Guardian, plans are underway to look at how processes can be improved.

This work in consultation with the Disability Network will look at how communications and cooperation between the member of staff, their line manager, the Occupational Health and Wellbeing Service and Access to Work might be improved to eliminate some of the tensions that can develop between the parties under current arrangements.

Data Improvement Project to Improve Disability Declarations

Following an initiative in 2020 to contact all colleagues whose record on the Electronic Staff Record (ESR) did not indicate whether they had a disability or not, additional data collection has had a positive impact on Disability ESR declarations which have gone from 3.5% to 4.06%. Further discussions will take place with the Disability and Long-Term Conditions Staff Network to look at how we can further encourage and support colleagues to self-declare.

Disability and Long-Term Conditions Staff Network

The Disability and Long-Term Conditions Staff Network was launched on National Day for Staff Networks in May 2022. Expressions of interest from colleagues across the Trust were sought and the first meeting will take place on Wednesday 27 July 2022 (both face to face and via MS Teams).

The network will be open to all MYHT employees who have a positive interest in driving forward equality, diversity and inclusion, and a commitment to support the aims of the network. This includes all MYHT employees with a disability, long-term condition, or none.

The network will focus on key workstreams including the WDES and the Disability Confident Employer Scheme; driving a culture in which all members of the workforce and community are able to participate and fulfil their potential in an environment where they are valued and respected.

Disability Confident Scheme

The UK Government Disability Confident scheme supports employers to make the most of the talents disabled people can bring to our workplace. It helps employers recruit and retain great people, and:

- Draw from the widest possible pool of talent.
- Secure high quality staff who are skilled, loyal and hard working.
- Improve employee morale and commitment by demonstrating that you treat all employees fairly.

The scheme has 3 levels designed to support employers on their Disability Confident journey. The Trust is currently at level 2 (Disability Confident Employer) and the Certificate is due for renewal in mid-August 2022. With the support of the Disability and Long-Term Conditions Staff Network, the aim is to work towards Disability Confident Leader within the next three years.

Project SEARCH

The Trust is one of two national host businesses that run the Project SEARCH programme across 2 sites - Pinderfields site (PGH) and Dewsbury (DDH).

First launched at the Trust on 1 September 2017, the Project SEARCH Programme provides real life work experience combined with training in employability and independent living skills, to help young people make successful transitions from school to productive adult life.

The trainees are matched to their placements in terms of skills, abilities and interests, and this differs for each student. The trainees are supported by their local mentors who work alongside them in each department, helping them to learn the skills required in each placement, until they can perform the tasks independently.

Pinderfields

This year at PGH 11 interns joined the programme and 6 of these went on to complete and graduate. Five of the interns from the same cohort are now in payed employment.

The PGH site is also supporting year 2 Occupational Therapy students from the University of Wakefield.

Dewsbury (DDH)

The DDH site reflects the PGH site in relation to interns and graduates. There has also been 2 interns who are now in paid employment.

The DDH project SEARCH site is a growing site but with challenges which are determined by the size of the hospital which impacts the placements.

2.4 The NHS Equality Delivery System (EDS2)

The Equality Delivery System (EDS2) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

The main purpose of the EDS2 is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

Due to the challenges of the COVID-19 pandemic, the partnership worked together to develop a new online delivery model for the EDS2 events. This collaborative working group was made up of representatives from Calderdale, Kirklees and Wakefield Clinical Commission Groups (CCGs), Calderdale and

Huddersfield NHS Foundation Trust, The Mid-Yorkshire Hospitals Trust and Locala. This raised some significant challenges around accessibility, as members of the public needed to have access to internet to participate. Whilst it was not possible to overcome all the barriers to digital exclusion, we made sure that the presentations and supporting information were provided in an accessible format to the participants prior to the meeting and any reasonable adjustments were made to support participation on each of the days.

The leads for Equality and Diversity in the CCGs set up a series of events in Wakefield, Kirklees and Halifax in December 2021 and January 2022. A number of Voluntary, Community and Social Enterprise (VCSE) and Patient Participation Group (PPG) representatives, plus members of the public attended both of the events. The format for each EDS2 area events was as follows:

- **Pre-event Briefing** – a briefing to all the participants explaining what the EDS2 is, how the session will flow and the actual assessment process we were going to follow.

- **EDS2 Grading** – where local healthcare organisations presented their information. Using the EDS2 assessment criteria, participants listened to the NHS organisations, asked questions, scrutinised their evidence and then graded the equality performance of each of the healthcare organisations.

The Trust presented the implementation of a personalised care plan in maternity services including:

- How the service encompasses the principles of equality and diversity.
- The aims to achieve better health outcomes for all.
- The aims to improve individuals, birth partners, families and friends experience.
- Focus on upskilling staff to deliver more personalised care.
- Demonstration of how a local multi-agency approach benefits individuals, their babies and families.

The Trust maintained a 'Developing' status on the EDS2 from local community group feedback. The aim is to work towards reaching an 'Achieving' status next year.

In terms of our self-assessment of performance, we took account of the range of engagement opportunities and work we had undertaken with different communities and as such, using the EDS2 Grading System we scored ourselves as Amber – **Developing** (*Doing well for some protected groups*)' against the chosen EDS2 Outcomes for the services at Pinderfields and also those at Dewsbury.

The grading's achieved by MYHT at the EDS2 events is summarised below:

Goal & Outcome	Trust Self Assessment	Grading Panel Assessment
Goal 2: Outcome 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing	Developing

The full EDS2 Report is available on the Trust website and is attached at Appendix B

3. ACCESSIBLE INFORMATION STANDARD (AIS)

1. The Standard is a legal requirement for all providers of NHS and social care services. They have to have arrangements in place to provide information in accessible formats for patients, relatives and carers who have a need as a result of disability or long-term condition. The Standard came into effect in April 2016.

2. Prior to 2020/21 progress in applying the standard in MYHT has been slow for a variety of reasons, including inter alia the following:

- Arrangements to ensure GPs inform the Trust on referral, if patients have accessible information (AI) needs undocumented
- Only a small number of our many patient information systems have the facility to record details of patients' AI needs in a structured way and even then, they do not have the functionality to create alerts meaning that the needs often go missed due to work pressures on staff
- In terms of our main PAS (eCaMIS), AI needs can be recorded but Access Booking and Choice rely on the Trust's Central Alerts Management System (CAMS), a system that has significant limitations, to produce the alerts for them to work on

3. As services and patient administration systems change and develop, the processes that support delivery of accessible information require constant reviews that were perhaps not factored in the developments

4. During the past year the Trust has strengthen the AIS governance structures in order to monitor the progress and compliance, leading to a significant progress in applying the standard more effectively. Actions taken to facilitate this included:

- Develop a governance structure reporting to Patient Experience Sub Committee (PESC)
- Reconstituting the AIS Project Steering Group chaired by the Head of EDI to include many different services
- Several workstreams were developed to address areas of improvement

- Updated and extended the AIS Action Log to cover the actions agreed by the services involved
- Developed a communications plan to raise staff awareness about AIS
- Drafted AIS Guides for Staff and an MYHT AIS Policy in consultation with our key stakeholders at Place i.e., Wakefield Deaf Society and Wakefield District Sight Aid.
- MYHT adopting the 'Purple Promise' which is a commitment to continue to strive for an excellent patient experience each and every time, by continually improving our Communication and Accessibility for those patients who require additional access needs to our services.

5. Going forward the 'patient portal', being developed under the 'Patient Knows Best' work-stream, with its facilities for patients to obtain their letters resized to their desired font, or read out loud, will start to resolve some of the challenges applying the standard across MYHT.

4. HEALTH INEQUALITIES

In response to the inequalities exposed by the pandemic, the trust has formed a Health Inequalities Subcommittee to address these disparities. All the work the trust is doing in seeking to improve representation and experience for all such groups in the workforce and in access to services will undoubtedly support the broader efforts to reduce heath inequalities. The Director of Nursing and Quality, who is the lead for Diversity and Inclusion from a service perspective, is actively involved in progressing this agenda as chair of the sub-committee and EDI Team contribute to that.

5. SUPPORT FOR LGBTQ+ PATIENTS AND COLLEAGUES IN OUR WORKFORCE

NHS Rainbow Badge Scheme

Originated at Evelina London Children's Hospital, part of Guy's and St Thomas' NHS Foundation Trust, the NHS Rainbow Badge scheme was introduced as a pledge-based model. The Rainbow Badge is a visual symbol which identifies its wearer as someone with whom an LGBTQ+ individual can feel comfortable talking to about issues relating to sexual orientation or gender identity. It shows that the wearer is there to listen without judgement and can signpost to further support, if needed.

The scheme was launched in MYHT in May 2019 and to date over 2500 members of staff across the organisation have signed up to wearing a Rainbow Badge.

During LGBT+ History Month in February 2022, we promoted the NHS Rainbow Badges on a stand at each hospital site and we will continue to actively promote the badges with support from the LGBTQ+ Staff Network.

Phase 2 - NHS England have commissioned a collaboration, consisting of the LGBT Foundation, Stonewall, the LGBT Consortium, Switchboard (LGBT+ telephone helpline) and GLADD (The Association of LGBTQ+ Doctors and Dentists), to deliver Phase 2 of the NHS Rainbow Badge scheme.

This next phase has moved to an assessment and accreditation model and allows Trusts to demonstrate their commitment to reducing barriers to healthcare for LGBT+ people, whilst evidencing the good work they have already undertaken.

The assessment structure will involve the following processes:

- Policy review
- Staff survey
- Patient survey
- Services Survey
- Assessment document

The information from all aspects of the assessment process will be reviewed and the Trust will receive a graded award reflecting their current LGBT inclusion work. This will be either Bronze, Silver or Gold.

In addition to the award the Trust will also receive a comprehensive feedback report and action plan, this is designed to help Trusts achieve the next level and should facilitate meaningful change.

Following the submission of an expression of interest form, MYHT has successfully been allocated a place on the programme which will commence in August 2022.

Lesbian, Gay, Bisexual, Transgender, Queer and others (LGBTQ+) Staff Network

The LGBTQ+ Staff Network was officially launched during LGBT+ History Month in February 2022 and to date has met on three further occasions (both face to face and via MS Teams)

The network is open to all MYHT employees who identify as LGBTQ+. Membership is also extended to MYHT employees who have a positive interest in driving forward diversity and inclusion, and a commitment to support the aims of the network as allies

The network has agreed their Terms of Reference and some key priority workstreams to focus on over the first 6-12 months, including:

- The network's logo and branding.
- Reviewing the Trust's Transgender Policy.
- LGBTQ+ education/raising awareness, e.g., articles in MY News and on MY Bulletins, use of pronouns and LGBTQ+ training.
- NHS Rainbow Badge Scheme.

- Celebration of LGBTQ+ related key dates in the annual calendar.
- PRIDE 2022, participation in the march and a Trust stall at Wakefield PRIDE.

Currently, the network has 37 members and is chaired by the Diversity and Inclusion Manager on an interim basis.

In addition to the workstreams above, the network has been active since its launch in February. It has provided advice, LGBTQ+ representation and engaged in consultation on a number of initiatives and Trust queries, including:

- The interim EDI Strategic Plan 2022/23.
- The new Menopause Policy.
- Directors' recruitment process.
- Multiple LGBTQ+ related queries.

The network collaborated with other MY Staff Networks in celebrating National Day for Staff Networks in May 2022, focussing on the importance of sharing good practice and intersectionality.

The network also collaborates with local, regional and national LGBTQ+ related stakeholders including other Trust LGBTQ+ Staff Networks, LGBTQ+ organisations and the national Health and Care LGBTQ+ Leaders Network.

LGBT+ History Month, February 2022

Celebrations throughout the month included:

- Launching the LGBTQ+ Staff Network.
- Promotion of the NHS Rainbow Badge – promoting the Trust as an open, non-judgemental and inclusive place to work and receive care.
- Transgender Awareness training sessions.
- Pop-up stands promoting LGBT+ History Month across all three hospital sites at Pinderfields, Pontefract and Dewsbury.
- Trust Staff Library and Knowledge Service promotional stand and resources.
- Rainbow flags flying proudly at all three hospital sites.
- Wide range of communications, including screen savers, bulletins, social media and videos.

6. OTHER INITIATIVES

Board Championing Protected Characteristics of the Equality Act 2010

The nine protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity

- Race
- Religion or belief
- Sex
- Sexual Orientation

We continue to progress Executive and Non-Executive leads for each of the characteristics protected under the Equality Act 2010, recognising the need to ensure visible and accountable leadership at Board level.

The Kickstart Scheme

The Kickstart scheme is a £2 billion pound government scheme that began in September 2020, with the aim of offering young people, aged between 16 and 24, currently claiming Universal Credit, the opportunity to gain a six-month quality work placement. The aim is to develop the young person's employability skills, by not only offering a work placement, but also improve understanding of entering the job market, assisting in producing a quality CV and practicing interview skills.

Mid Yorkshire joined the Kickstart Scheme in December 2021 and have had 12 kickstart candidates in total. These candidates come from a range of backgrounds, with varied skills and abilities. They have received placements across a number of areas including Grounds and Gardens, Facilities, IT services, EDI, Chaplaincy and Finance.

Of the 12 candidates, six have disclosed having a disability or long-term condition, five are from a Black, Asian and Minority Ethnic background and seven identify as male.

Since the scheme began at MY, four of the candidates have completed their six-month placements. Two of them have secured substantive employment at MY, one has secured an apprenticeship, and the fourth one is currently applying for various roles. Two candidates left the programme early, one for personal reasons and the other secured substantive employment outside of the Trust. The remaining six candidates are all progressing well and are looking at their career options at present. One candidate has applied to start university in September.

The Kickstart scheme not only improves the work based skills of the young people involved, but also develops their life skills. Some of the candidates had never previously interacted with adults as peers and so they have undertaken a huge transformation over the past six months.

7. THE EDI TEAM

Following a review of the structure of the EDI team, the following is currently in place:

- Head of EDI - three days per week (0.6 WTE) until 31 March 2022 in the first instance. Now extended to 30 September 2022.

- Diversity and Inclusion Manager (Governance), full time post.
- Diversity and Inclusion Manager (Operations), full time post.
- EDI-REN Network Lead (7.5hrs p/w of Community Digital Manager Role)
- Diversity and Inclusion Project Manager, full time post.
- Kickstart Project Co-ordinator, fixed term contract (up to September 2022)
- Kickstart - Trainee Administration Assistant – three days per week until September 2022.

A further business case developed in 2022/23 to secure permanent funding for the new structure with a whole time equivalent(1WTE) Head of EDI.

The EDI team provides a wide range of support and guidance across the Trust in relation to the equality, diversity and inclusion agenda for service delivery and workforce. We have established a process to ensure that any support, advice or guidance is logged and monitored, and the team actively engages with the wider Workforce and Organisational Development (W&OD) team and the Freedom To Speak Up (FTSU) Guardian to discuss trust-wide EDI related issues.

Both the Head of EDI and the Diversity and Inclusion Manager (Governance) are qualified as NHS WRES Experts.

The team actively engage with local, regional and national networks to share good practice and work collaboratively on EDI related topics.

8. STAFF EQUALITY, DIVERSITY AND INCLUSION INTERNAL AUDIT

In May 2022, Internal Audit carried out an audit to provide assurance to the Trust on the progress in addressing the requirements outlined in NHS guidance on Staff Equality, Diversity and Inclusion.

The full audit report is attached at appendix A.

The Overall Opinion received was as follows:

Significant	The Trust launched its BAME Staff Experience Improvement Plan and this document sets out the Trusts Equality, Diversity and Inclusion (EDI) priorities for the period 2021-22 and includes the key initiatives the Trust is working on. The EDI agenda has become much more visible throughout MYHT since the start of the COVID-19 pandemic; the EDI team, whilst still small, has grown; and the staff networks are an integral part of the Trust. Progress in addressing workforce inequalities has been hampered by COVID-19 pressures, it is acknowledged that timescales in the delivery plan may need to be reset. The impact of EDI measures is primarily monitored by triangulating information from sources such as the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) with assurance reported to the Resource and Performance Committee and the Trust Board.

	This review confirmed that the Trust is either actively addressing or has plans to address all of the nine areas highlighted for action in the 'Belonging in the NHS' section of the NHS People Plan in order to create a fair and compassionate culture where everyone feels that they belong, are included, valued and respected and can progress as a unique individual.

9. FURTHER INFORMATION

For further information about anything in the report that follows or any other EDI issues you can email the Trusts EDI Lead: Brian.Chiyesu@nhs.net

Appendix A

AUDIT YORKSHIRE
The journey to excellence

Significant	The Trust launched its BAME Staff Experience Improvement Plan and this document sets out the Trusts Equality, Diversity and Inclusion (EDI)

	priorities for the period 2021-22 and includes the key initiatives the Trust is working on. The EDI agenda has become much more visible throughout MYHT since the start of the COVID-19 pandemic; the EDI team, whilst still small, has grown; and the staff networks are an integral part of the Trust. Progress in addressing workforce inequalities has been hampered by COVID-19 pressures, it is acknowledged that timescales in the delivery plan may need to be reset. The impact of EDI measures is primarily monitored by triangulating information from sources such as the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) with assurance reported to the Resource and Performance Committee and the Trust Board. This review confirmed that the Trust is either actively addressing or has plans to address all of the nine areas highlighted for action in the 'Belonging in the NHS' section of the NHS People Plan in order to create a fair and compassionate culture where everyone feels that they belong, are included, valued and respected and can progress as a unique individual.

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
The Trust has addressed the letter sent by the NHS Chief Executive ensuring than an action plan is in place to put in place the requirements outlined in The NHS: People Plan for 2020/21 as outlined below:	✓ Covid created a delay in implementing and working the 2020/21 people plan but the same plan was set out for 2021/2022 and the Trust have included key points and actions in their Annual Operating Plan for 2021/22 ✓ The Trust had an annual operating plan in place for 2021/22 which was approved by the Trust Board in May 2021 ✓ Section 5.3 Strategic Goal Three: Be an Excellent Employer includes a number of the people plan initiatives with '3.4 Identify and take the necessary actions associated with the implementation of the	High	0	0	0

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	Trust's BAME Staff Experience Improvement Plan' focusing on BAME staff with the metrics identified as; ✓ Increase the representation of BAME Clinical staff at Band 3 5.48% >5.5% SS ✓ As of March 2022, the current percentage of BAME clinical staff at Band 3 was 6.65% ✓ Increase the representation of BAME Clinical staff at Band 6 10% >12% SS ✓ As of March 2022, the current percentage of BAME clinical staff at Band 6 was 12.65% ✓ Increase the number of Black and Ethnic Minority staff in management positions An increase of 4 ✓ From the BAME Experience plan, a number of initiatives have been put into place in the last year in order to meet these metrics, these included; ✓ Executive Mentoring Scheme ✓ Training for BAME staff to become				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	coaches/mentors ✓ Board Equality, Diversity and Inclusion training sessions ✓ Wakefield Moving Forward Programme ✓ Celebrating festivals etc. – range of internal and external communications, social media, training, stands, etc. – LGBT+ History Month February 22, Ramadan, Eid, Staff Networks, Black History Month, International Women's Day. ✓ Guidance on dealing with discrimination – Zero Tolerance campaign and regional initiative around anti-racism – Board pledges. ✓ Cultural Ambassadors – Cohort 1 of 16 ambassadors trained in Nov 21 with second cohort to be trained in April 22.				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	✓ Race Equality Network – continued progression of the Trust network resulting in over 80 members. Co-chair afforded protected time of one day a week to focus on network relate work				
Recruitment and promotion practices: By October 2020, employers, in partnership with staff representatives, should overhaul recruitment and promotion practices to make sure that their staffing reflects the diversity of their community, and regional and national labour markets. This should include creating accountability for outcomes, agreeing diversity targets, and addressing bias in systems and processes. It must be supported by training and leadership about why this is a priority for our people and, by extension, patients.	✓ Following the release of the NHS People Plan, the Trust pulled together the BAME Improvement Plan and also put together an action plan that was submitted to the ICS which has been used to put together an ICS level plan ✓ Key actions were highlighted by the action for the Trust to work towards and the Trust set out how to achieve these ✓ The actions highlighted were; ✓ Two metrics, which are reported monthly to the Resources and Performance Committee as follows: the percentage of the Band 3 and Band 6 clinical workforce who are BAME ✓ Cultural Ambassadors are now being trained. Next step is to create a	**Significant**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	network of individuals who are able to support interview panels and to define their remit ✓ The trust is part of a collaborative bid for a scheme run in partnership with the Princes' Trust ✓ Role profiles for recent Director appointments include requirements regarding EDI in the person specification. This will be replicated in the Trust template job description for Band 8a+ roles ✓ Line Manager recruitment and selection training includes training on EDI and values based selection ✓ As well as the actions set out in the above, the Trust is also working through other actions such as; ✓ The International Stay and Thrive group- this group is looking at the experiences of our international				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	nursing and midwifery workforce in the Trust from advertising roles right through the employment cycle. ✓ Undertaking some research in the community regarding the barriers to employment specifically in our BME community ✓ Planning to go out and hold listening events in our community to understand how the Trust is perceived and the accessibility of recruitment processes ✓ Human Resources has put a case to Exec Team to purchase some recruitment software which will also support our overhaul work in the following ways: ✓ A careers website which will enable more inclusive advertising as information will be available in over 100 languages ✓ An Applicant Tracking System which will allow a focus on situational judgement				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	tests to reduce bias ✓ An on boarding system that would allow the Trust to customise the on boarding process and amend the "trust welcome" depending on the role/staff group				
Leadership diversity: Every NHS Trust must publish progress against the Model Employer goals to ensure that at every level, the workforce is representative of the overall BAME workforce.	✓ One of the metrics identified as part of the People Plan is to increase the number of BAME staff in senior management positions ✓ The Trust has number of initiatives in place to improve the level such as; ✓ Executive Mentoring Scheme ✓ Cultural conversations: (Reciprocal Mentoring) ✓ RCN BAME Leadership Programme & Follow up SIPP Course ✓ Wakefield Moving Forward Programme ✓ Equality, Diversity and Inclusion (EDI) Mandatory and Statutory Training ✓ Guidance on dealing with discrimination and prejudice by patients,	**Significant**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	relatives, carers ✓ WRES Ambassadors ! A review of reports by Internal Audit showed that the Trust is making good progress on increasing representation at a senior level, there is still work to do in order to meet the goals set within the Trust ! The Trust set a trajectory of having a total of 27 BAME staff at Band 8a and above and as of March 2022, the Trust had 25 members of BAME staff above band 8a				
Tackling the disciplinary gap: The Trust must close the ethnicity gap in entry to formal disciplinary processes by the end of 2020.	✓ The Trust has a Disciplinary policy in place which was approved in 2018 with a review planned for June 2022 ✓ The policy includes the Trust Equalities Statement: ✓ *Mid Yorkshire Hospitals NHS Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients, population and workforce, ensuring that none are placed at a disadvantage.* ✓ *We therefore strive to ensure that in both employment and service provision no individual is discriminated against by reason of sex, race, disability, age, sexual orientation, religion/belief, Transgender, marital*	**Significant**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	status, civil partnership or pregnancy. ✓ The trust has introduced cultural ambassadors which has been fed into the disciplinary process to ensure representation during the process ✓ This has also fed into the Trust strategic objectives; ✓ Rescue the amount of formal incidents full stop ✓ Reducing grievances as well as disciplinary ✓ Learning from Mersey Care – learning principles ✓ Recognising that the incident could be a learning opportunity ✓ Don't go straight down the formal route without considering the learning principals ✓ The Trust has recently introduced a Fact Finding Policy which encourages managers and others reviewing incidents to review before labelling the incident as formal. The purpose is to find out as much as possible before making a determination and moving forward ✓ Employee relations have put together a checklist which is used to work through the learning principles.				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	This focuses questions and staff on asking the right questions while determining the level of the incident				
Governance: By December 2021, all NHS organisations should have reviewed their governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes. Staff networks should provide a supportive and welcoming space for staff, have deep expertise on matters related to equality, diversity and inclusion, which boards and executive teams need to make better use of.	**Staff Equality Network Groups** ✓ The Trust has a number of staff networks in place with the aims of these groups including; ✓ To discuss and determine how MY can be a supportive employer for particular groups/all; ✓ To raise awareness of the support MY has in place (which may be particularly relevant to certain groups); ✓ To raise awareness around various diversities and reduce stigma; ✓ To act as a confidential, safe space for colleagues to share stories and network with colleagues who may have had a similar experience to them; ✓ To share knowledge and experience; ✓ To help provide guidance to	**High**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	managers re EDI issues; ✓ To discuss how MY can best support particular patient demographics and ensure compassionate care for them; ✓ To assist with identifying development needs; ✓ To influence and support MY policy and practice by giving colleagues a voice; ✓ To provide a forum to highlight common workplace issues for the organisation to address; ✓ To increase the volume of recruitment of particular demographics into CHFT. ✓ The MY Race Equality Network (REN) was established in December 2019 and has made good progress to date, delivering BAME Board seminar, Supporting staff, supporting COVID risk assessment, vaccination, wellbeing and other events. And championing inclusion. ✓ The Trust has also recently set up the LGBTQ+ Network which aims to create a				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	supportive space for LGBT+ colleagues that raises the visibility of the LGBTQ+ community at the Trust and that can influence decision making with the main three aims being; ✓ to create a supportive space for the LGBT+ community ✓ to raise the visibility of the LGBT+ community at the Trust ✓ raise awareness of LGBT+ staff issues ✓ **General Governance** ✓ In recent years and during covid the Trust ensured a BAME expert or a member of BAME staff was included in all exec meetings and strategic command during Covid ✓ This has included a recent hiring of a new BAME Non-Exec director ✓ The organisation also signed a memorandum of understanding with BAPIO (The British Association of Physicians of Indian Origin) which is a non-profit organisation open to all healthcare professionals, promoting diversity, equality and inclusion ✓ A number of webinars have been held and presented to the Trust board in recent years and there is a regular training course on religious and cultural				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	awareness which is available to all staff				
Information and education: From October 2020, NHS England and NHS Improvement will publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff. These resources are being utilised by the Trust.	✓ EDI training is available through a number of means with the Trust ✓ EDI has a slot on the corporate induction which is attended by all new starters within the Trust. It also forms part of mandatory training in the trust ✓ As well as these, other sessions such as religion and cultural awareness and held as well as written and e-learning materials which are available to all staff ✓ There are also Ramadan and transgender awareness sessions made available to staff ✓ A review of the Core and MAST Training Compliance as of March 2022, confirmed that all areas within the Trust have a compliance level above the target of 90% with a overall Trust compliance level of 95.2%	**High**	**0**	**0**	**0**
Accountability: It is the explicit responsibility of the chief executive to lead on equality, diversity and inclusion, and of all senior leaders to hold each other to account for the progress they are making, this is taking place at the Trust.	✓ The Trusts statement on the website is *'The Trust is committed to promoting equality, diversity and human rights in its day to day treatment of all patients, visitors and staff regardless of race, ethnic origin, sex, gender identity, marital status, maternity and pregnancy, disability, religion or belief, sexual orientation or age' and senior leaders*	**High**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	have taken steps to promote this. ✓ As part of the root out racism campaign that was held within the Trust, all directors took a pledge to set out what they would like to do to fight racism in our workplace and in our communities ✓ Regular communications are shared by the SLT including the weekly MY Bulletin sent to all staff, which in recent months has included has included detailed articles on Ramadan awareness, black history month and LGBTQ+ history month				
Regulation and oversight: Over 2020/21, as part of its 'well led' assessment of trusts, the Care Quality Commission (CQC) will place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion. The Trust is able to demonstrate the progress made on equality and diversity.	✓ A review of reports and meeting minutes does show that new initiatives have been brought in over the last few years since the last CQC report such as the BAME network and also the start of the LGBTQ+ network ✓ Disability Network establishment is in progress. Staff have already registered interest and date of first meeting already circulated ✓ The annual EDI report taken to the RPC in July 2021 reviewed the performance of the Trust and showed on that KPIs identified in previous years, the Trust has made progress on these compared to previous years ✓ Senior directors receive information to measure diversity on	**Significant**	**0**	**0**	**1**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	both a regular and annual basis ✓ Each of the nine protected characteristics has a Executive Director assigned as a champion within the Trust ✓ AIS Governance structure aligned with Patient experience Sub - Committee with Executive Support.. Insuring both patients and staff are equitable experiences and reasonable adjustments are made ✓ A number of senior directors attend the monthly RPC meetings which include BAME figures as part of the Workforce and OD Performance Report ✓ Each month this looks at the number of BAME staff at a Senior level and also reports on number of BAME staff at bands 3 and 6 ✓ The Trust also receives annual reports on; ✓ WDES Annual Report ✓ WRES Annual Report ✓ The EDI annual report looks at the KPIs for the previous year with the most recent one looking at figures from 2020/21. Figures showed that the Trust is making good improvements in band 3 and 6 representation with both figures ahead of targets. However the Trust is still falling short of targets on the number of BAME staff at a senior level (Band 8 and above). ✓ The WDES and ARES annual reports are also				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	taken to Trust board on an annual basis and again provide information on key metrics such as the number of disabled and BAME staff within the trust compared to full workforce ! Both figures improved for 2021 but there are still some data quality issues as ESR still has a number of employees with null under disability or ethnicity meaning it is hard to provide a fully accurate figure, especially as the WDES report suggests there is a large number of staff with a disability who do not have a disability on the system.				
Building confidence to speak up: The Trust has Freedom to Speak Up Guardians/Champions/Groups in place in line with the composition of the workforce. Appropriate policies / strategy are in place	✓ Trust employs a Full Time Freedom to Speak Up Guardian. ✓ They have a further 9 FTSU Associate Guardians (Champions) covering areas around the Trust ✓ The Associate Guardians cover a wide area of staff across all bands ✓ The Trust provides the FTSU Guardian with a designated office and a protected space where staff can speak to the Guardian in confidence that their conversation is confidential and as anonymous as they wish it to be ✓ The Trust has a Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy in place which is	**High**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	available to all staff through the intranet ✓ The policy was approved in August 2020 by the executive directors with a review date planned for May 2023 ✓ The Trust uses a number of forums and media to promote FTSU such as; ✓ Staff inductions ✓ Training sessions ✓ Freedom to Speak Up Month ✓ Staff intranet				
Overall		**Significant**	**0**	**0**	**1**

Draft	Final	Recipient Name	Recipient Title
✓	✓	Brian Chiyesu	Head of Diversity and Inclusion
✓	✓	Angie Colvin	Diversity and Inclusion Manager
✓	✓	Phillip Marshalll	Director of Workforce and OD
	✓	Jane Hazelgrave	Director of Finance
	✓	Jen Beckett	Company Secretary
	✓	Lisa Robson	Corporate Governance Officer

Finding	Risk	Recommendation	Priority	Management Response	Responsible Officer	Target Date
ESR Completion Reporting and monitoring on BAME and disabled staff is carried out a regular	Reported figures do not give an accurate representation of the workforce	1. The Trust should ensure the data quality exercise is continued to ensure data in the ESR system is as complete as possible to allow more	**Minor**	WDES work to improve disclosure on ESR has been carried out and improvement is reflected in the new WDES results while	Brian Chiyesu, Head of Diversity & Inclusion	Complete

Finding	Risk	Recommendation	Priority	Management Response	Responsible Officer	Target Date
basis. These reports rely on ESR being fully complete in order for the Trust to give an accurate picture of the key metrics and other reports. A review of reports by Internal Audit confirmed that there are still a number of cases of 'null' on ESR. The annual WDES report showed a gulf in number of staff who have indicated they have a disability on the Trusts system compared to the annual NHS Staff survey.		accurate monitoring		work still continue to improve BAME Disclosure recording.		

Opinion Level	Opinion Definition	Guidance on Consistency
High (Strong)	High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.	The system is well designed. The controls in the system are clear and the audit has been able to confirm that the system (if followed) would work effectively in practice. There are no significant flaws in the design of the system. Controls are operating effectively and consistently across the whole system. There are likely to be core controls fundamental to the effective operation of the system. A High opinion can only be given when the controls are working well across all core areas of the system. For example with 'Debtors' the controls over identifying income, raising debt, recording debt, managing debt, receiving debt, etc. are all working effectively – there are no serious concerns. Note this does not mean 100% compliance. There could be some minor issues relating to either systems design or operation which need to be addressed (and hence the report may include some recommendations) – however these issues do not have an impact on the overall effectiveness of the control system and the delivery of the system's objectives.
Significant (Good)	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas	The system is generally well designed - but there may be weaknesses in the design of the system that need to be addressed. In addition most core system controls are operating effectively – but some may not be. Whilst any weaknesses may be significant they are not thought likely to have a serious impact on the likelihood that the system's overall objectives will be delivered.

Opinion Level	Opinion Definition	Guidance on Consistency
Limited (Improvement Required)	Limited assurance can be given as whilst some elements of the system of internal control	The system is operating in part but there are notable control weaknesses. There are weaknesses in either design or operation of the system that may mean that core system objectives are not

	are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives	achieved. In terms of what differentiates a borderline Significant Opinion to a borderline Limited opinion – the main factors are the scale and potential impact of weaknesses found. Multiple weaknesses across a range of core areas would suggest a Limited Opinion level is applicable. However it also true that ONE weakness can suggest a Limited Opinion if it is fundamental enough to mean that a number of core system objectives will not be achieved.
Low (Weak)	Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the system's objectives.	The audit has found that there are serious weaknesses in either design or operation that may mean that the overall system objectives will not be achieved and there are fundamental control weaknesses that need to be addressed. It should be borne in mind that Low Assurance is not 'No Assurance.' The key point here is that there is a good chance that the system may not be capable of delivering what it has been set up to deliver – either through poor systems design or multiple control weaknesses. The report will clearly state if 'No Assurance' is actually more applicable than low assurance.

Grading	Definition	Guidance on Consistency
Major (High)	Recommendations which seek to address those findings which could present a significant risk to the organisation with respect to organisation objectives, legal obligations, significant financial loss, reputation/publicity, regulatory/statutory requirements or service/business interruption.	These are recommendations which aim to address issues which if not addressed could cause significant damage or loss to the organisation. The expectation is that these recommendations would need to be taken as a matter of urgency. These recommendations should have a high corporate profile – with a clear implementation tracking process in place, overseen by the Board or a Board level committee.
Moderate (Medium)	Recommendations which seek to address those findings which could present a risk to the effectiveness, efficiency or proper functioning of the system but do not present a significant risk in terms of corporate risk.	These are recommendations which if not addressed could cause problems with the safe or effective operation of the system being reviewed. The recommendations should have appropriate profile within the division or business area in which the system being considered sits and some profile at Board /Audit Committee level also. These recommendations should be carefully tracked to ensure that action reduces the risks found
Minor (Low)	Recommendations which relate to issues which should be addressed for completeness or for improvement purposes rather than to mitigate significant risks to	All other recommendations fall into this category. This includes recommendations which further improve an already robust system and housekeeping type issues.

	the organisation. (This includes routine/housekeeping issues)	

Appendix B

EDS2 Report 2021-2022 (005) (2)1

The Mid Yorkshire Hospitals NHS
NHS Trust

NHS Equality Delivery System (EDS2) Report 2021/22

1. Introduction

This report describes how the Trust used the NHS Equality Delivery System (EDS2) to assess its performance on items within its equality, diversity and inclusion work programme for 2021/22.

2. Background

Use of the NHS Equality Delivery System 2 (EDS2) is mandatory for providers of NHS services as part of the NHS Standard Contract. EDS2 requires that the performance of NHS providers be assessed on an annual basis against selected Outcomes within the four EDS Goals.

The EDS2 is a tool designed to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for individuals and groups protected by the Equality Act 2010, and to support them in meeting the Public Sector Equality Duty (PSED). The protected characteristics include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation. EDS2 can also be applied to groups not covered under the Equality Act 2010, for example carers, homeless people and people on low income.

Two of the four EDS2 Goals relate to service issues, with the other two relating to workforce issues. Details of the EDS2 Goals and Outcomes are provided at Appendix A. Performance is assessed using a grading system based on a RAG^{plus} framework, which is also summarised in Appendix A

A key principle of EDS2 is that the assessment of the provider's performance against the chosen Outcomes in the two service focused Goals should involve local community groups and patient representatives. EDS2 also requires that the provider services to be assessed are agreed in discussion with commissioners.

Performance against the two workforce focused EDS2 Goals should be conducted internally by providers involving relevant stakeholders.

3. EDS2 SERVICE GOALS

3.1 The Engagement Process

As per previous years, the CCGs and some providers across Wakefield, North Kirklees, Calderdale and Greater Huddersfield agreed to work together to design a process to engage with the local community groups and patient representatives to assess performance and gain feedback on the two EDS2 service focused Goals for 2020/22. Over the past two years, all the health and care partners have been subjected to unprecedented and unique challenges due to Covid 19 pandemic.

Covid 19 has shone a very bright light in highlighting the health inequalities that persist in our communities. It has become clear that those worst affected by the virus are often those who had worse health outcomes before the pandemic, particularly including people from Black Asian Minority Ethnic communities, older people, those with disabilities and those living in poorer areas. The trust, our partners and the commissioner are committed to reducing these inequalities and improving people's health.

During the planning process for the previous event, the NHS partners agreed a different format to previous years which was in direct response to the feedback received from the community organisations and participants who previously attended. As a result, the format of the EDS2 Events for the previous year for both Kirklees and Wakefield were changed from the previous format of formal presentations to a more relaxed 'market place' style. This format worked really well at the Kirklees event which was held at the Huddersfield Mission and the Wakefield event was held at the Wakefield Trinity Wildcats. At both events the CCG's and NHS Providers each had a 'stall' (stand) that attendees were encouraged to visit to have conversations about the services that had been chosen for each organisation. The theme for that year was Patient Experience and Complaints and the Mid Yorkshire team attending the events included the Diversity & Inclusion Service (DIS), Lead Matron for Patient Experience and Patient Experience Project Manager, Patient Liaison Improvement Lead and representation from the Learning Disability and Complex Needs team.

Without engagement with local people and communities, it would not be possible to deliver EDS2 effectively. However, the pandemic created significant challenges for us in terms of engaging with stakeholders. Our preferred option was always to deliver face-to-face events. However, as the pandemic progressed, it became increasingly clear that this was not a safe or

practical option. The partnership worked together to help the CCG develop a new online delivery model for the EDS2 events. This collaborative working group was made up of representatives from Calderdale, Kirklees and Wakefield CCGs, Calderdale and Huddersfield NHS Foundation Trust, The Mid-Yorkshire Hospitals Trust and Locala.

In response to the need to protect the public and colleagues from infection particularly with fluctuating transmission rates, a decision was made to hold the events remotely. This raised some significant challenges around accessibility, as members of the public needed to have access to internet to participate. Whilst it was not possible to overcome all the barriers to digital exclusion, we made sure that the presentations and supporting information were provided in an accessible format to the participants prior to the meeting and any reasonable adjustments were made to support participation on each of the days.

The CCG's established an assessment panel with membership being invited from the voluntary, community and social enterprise sector (VCSE) representing a range of protected characteristics (see Appendix 2 for a list of invited organisations). These included members of the Community Voices programme, Members, local equality forums and groups, Practice Patient Participation Groups (PPPGs) and the Voluntary Community and Social Enterprise (VCSE) sector, representing a range of protected groups. As part of adapting the approach to the process this year, Wakefield CCG also invited members of their public assurance group, the Patient and Community Panel, to participate.

The Leads for Equality and Diversity in the CCGs set up a series of events in Wakefield, Kirklees and Halifax. The format followed at each of these EDS2 area events was as follows:

- **Pre-event Briefing** – a briefing to all the participants explaining what the EDS2 is, how the session will flow and the actual assessment process we were going to follow.

- **EDS2 Grading** – where local healthcare organisations presented their information. Using the EDS2 assessment criteria, participants listened to the NHS organisations, asked questions, scrutinised their evidence and then graded the equality performance of each of the healthcare organisations.

Grading explained

The key question attendees needed to focus on when grading performance for each healthcare organisation is: how well do people from protected groups fare compared with people overall?

There are four grades; these are explained in the table below:

Excelling	**We are doing very well** People from **all** protected groups fare as well as people overall
Achieving	**We are doing well** People from **most** protected groups fare as well as people overall
Developing	**We are doing ok** People from **some** protected groups fare as well as people overall
Undeveloped	**We are doing badly** People from all protected groups fare poorly compared with people overall or there is not enough evidence to make an assessment

The initial EDS2 planning meetings amongst the CCGs and NHS Providers were held on an ongoing basis during 2021 and the programme of the actual EDS2 events took place in December 2021 and January 2022.

3.2 EDS2 MYHT Approach

The Trust proposed to focus on the service transformation work undertaken by the Maternity Service as part of their approach towards greater inclusivity. The title was 'Maternity – Implementation of Personalised Care Plan'. It had been chosen to be shared as part of the EDS2 work as it encompassed the principles of equality and diversity, aimed to achieve better health outcomes for all, aimed at improving individuals, birth partners, families and friends' healthcare experience, involved upskilling of staff to deliver more personalized care and this in turn would help to demonstrate how a local multi-agency approach benefits individuals, their babies and families.

We were also keen to feature examples of other good practice in relation to providing high quality patient care across the different protected characteristics. Other reasons for choosing this approach included:

- MYHT covers many areas of high deprivation and has a service user community that includes patients with particular access needs. It was with this in mind that the Diabetic Eye Screening Programme (DESP), developed a screening model that strived to remove barriers that may have previously prevented the most vulnerable accessing screening which in turn helps to address health inequalities.

- Reducing health inequalities means giving everyone the same opportunities to lead a healthy life, no matter where they live or who they. Under the Equality Act 2010 health services are required to make reasonable adjustments to address the additional needs of people with a learning disability or mental health diagnosis. Evidence is compelling that people with a learning disability or mental health diagnosis often face barriers in accessing and using health services.

- MYHT has a legal duty to offer equitable access. So for instance this involves collecting information on any individual's special needs, such as the need for a longer appointment slot if a carer will be in attendance, when a translator is needed or when a telephone call is needed rather than a letter for individuals with a visual impairment.

- We chose this service because we believed it would be a good opportunity to share with community groups, patient representatives and the voluntary and community sector, the work we have been doing through the pandemic. It would enable us to describe how as a Trust we were proactively making positive service changes. For example:

    - The pregnancy risks for BAME women are different to that of women with white ethnicity so it was an opportunity to enlighten the different maternity pathways in place for BAME women to identify early any issues which might otherwise result in a poorer outcome for the baby.

    - It is recognised within maternity services that there is an increasing reliance on digital information. This could potentially discriminate against those women that do not have access to digital devices. We could share that a programme has been established to provide mobile phones to pregnant asylum seekers who will be accessing services at Mid Yorkshire. This

enables each woman to access information, electronic notes and also maintain contact with midwives.

- Our underlying goal was to seek to ensure that we improve the experience of all patients regardless of age, gender, disability, ethnicity, sexual orientation, transgender, marital status or religion/belief and especially for those who may currently report lower levels of satisfaction with our services than the wider population.

The EDS2 Outcome the CCGs agreed that partners would use were:

- **Goal 2 Improved patient access and experience**
  Outcome 2.1: People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds

In terms of our self-assessment of performance, we took account of the range of engagement opportunities and work we had undertaken with different communities and as such, using the EDS2 Grading System we scored ourselves as Amber – **Developing** (*Doing well for some protected groups*)' against the chosen EDS2 Outcomes for the services at Pinderfields and also those at Dewsbury.

3.3 EDS2 Events (Wakefield and Kirklees)

The half day Wakefield and Kirklees events were held during December 2021 and January 2022. The NHS Providers that were involved at the events in showcasing their work were MYHT, CHFT, Kirklees and Wakefield CCG's and Locala. Both SWYPFT and YAS decided not to participate and instead hold their own events, while MYHT chose to continue with the format of engagement and to review future stakeholder engagement.

Using the EDS2 assessment criteria, the attendees at both events graded the equality performance of each of the healthcare organisations. A number of Voluntary, Community and Social Enterprise (VCSE) and Patient Participation Group (PPG) representatives, plus members of the public attended both of the events.

3.4 EDS2 Grading – Wakefield

Information about the community and patient groups who attended the Wakefield Grading Panel on 6th March is provided in appendix B.

Previously at the start of the event a sheet of flipchart paper would be pinned to the wall for each of the services to be graded and the stakeholders would then be asked to use red, amber, green or purple sticky labels to indicate the grade they thought should be allocated for the EDS2 Outcomes. A plenary session would then follow in which the groups were asked to explain their grading's and at the end of the feedback an overall grade was agreed.

In the revised format, to enable people to participate in the event and to gather views from others they represent a summary of the presentation was shared in advance. At the event itself Anne-Marie Henshaw, Director of Midwifery & Women's Services and Brian Chiyesu, Head of Equality Diversity and Inclusion delivered the MYHT presentation. Afterwards Anne-Marie and Brian answered questions and took feedback from the panel.

An anonymised online polling tool was then used to allow participants to grade the organisation against the EDS2 criteria. These scores were collated for the trust and have been used to determine the final grade. Using the EDS2 grading criteria (above), the table below provides the trust self-assessed grade and the grade awarded to the trust by local stakeholders based on the evidence presented.

The grading's achieved by MYHT at the Wakefield EDS2 event is summarised below:

Goal & Outcome		
	Trust Self Assessment	**Grading Panel Assessment**
Goal 2: Outcome 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing	Developing

As can be seen above, the overall level achieved by each service matched the self-assessment grade of 'Developing' that the Trust allocated itself. This meant that people from some protected groups fare as well as the general population covered

by the programme. This was a validation of our self-assessment. It should be noted that some of the participants scored as 'Achieving', however the overall score was moderated to 'Developing' in view of all scores allocated and based on the discussion in the plenary session. It's also worth acknowledging that the Wakefield Panel was generally positive about the presented processes and services.

3.5 EDS2 Grading – Kirklees

Information about the community and patient groups who attended the Kirklees Event is provided in the appendix.

The process for grading provider services used at Wakefield event was also used at the Kirklees event and it produced the following results for MYHT:

Goal & Outcome		
	Trust Self Assessment	**Grading Panel Assessment**
Goal 2: Outcome 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing	Developing

As in Wakefield, the overall level awarded to the service was 'Developing'. This means that the participants graded that some people from protected groups who use our service fare as well as the general population.

The Kirklees participants as did Wakefield recognised the ongoing efforts. The panels felt that overall, the service was able to demonstrate that some protected groups had been involved.

4. Conclusions

Continuing to use EDS2 within the Trust provides a useful mechanism for engaging and involving a range of stakeholders and staff in considering the Trust's performance on the equality, diversity and inclusion agenda and monitoring our progress. It has also provided invaluable feedback that will be used to inform future planning and engagement activities. The planning and engagement process also highlighted some of the work required for MYHT to progress to the next stage of achieving.

The joint working with the CCGs and other providers across West Yorkshire to engage community and patient groups around the service Outcomes proved particularly successful. Though the process has its own limitations, it offered a joint approach and enabled us to maximise the impact with limited resources during the pandemic.

Appendix A

The EDS2 Goals and Outcomes

GOAL		OUTCOME DESCRIPTIONS
Patient Focused	**Better Health Outcomes**	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities 1.2 Individual people's health needs are assessed and met in appropriate and effective ways 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse 1.5 Screening, vaccination and other health promotion services reach and benefit all local communities
	Improved Patient Access and Experience	2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care 2.3 People report positive experiences of the NHS 2.4 People's complaints about services are handled respectfully and efficiently

Workforce Focused	**A Representative and Supported Workforce**	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations 3.3 Training and development opportunities are taken up and positively evaluated by all staff 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source 3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives 3.6 Staff report positive experiences of their membership of the workforce
	Inclusive Leadership	4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations 4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

The EDS2 Grading System

The system is based on a RAG^{plus} framework as follows:

- ▲ Purple - Excelling (For all protected groups)
- ▲ Green – Achieving (For most protected groups)
- ▲ Amber - Developing (For some protected groups)
- ▲ Red - Undeveloped (For few or none of the protected groups)

Appendix B

List of Organisations Invited to the Wakefield Event

- Wakefield District Sight Aid
- Citizens Advice Bureau
- Well Women Centre Wakefield
- Carers Wakefield
- City of Sanctuary
- Wakefield Deaf Society
- Together Advocacy
- Members of the Patient and Community Panel
- South West Yorkshire Partnership NHS Foundation Trust
- Wakefield CCG
- Mid Yorkshire Hospitals NHS Trust

Appendix C

List of Organisations Invited to the Kirklees Event

- Oasis Care
- Gwennies Gateways
- KCMHF
- Healthwatch
- Kirklees Visual Impairment Network
- Parkview Surgery PPG
- Kirkwood Hospice
- Connecting Communities - RVS
- Kirklees Wellness Service
- Elmwood Surgery PPG
- Simbas Friends and Kirklees Activities (PALS)
- CHART Kirklees
- Age UK Kirklees
- Women's Centre
- Happy Moments
- Kirklees Involvement Network
- Carers Count
- Kirklees Dementia Hub
- New Methodist Church
- Streetbikes
- Locala
- Calderdale and Huddersfield NHS Foundation Trust

Kirklees CCG