York Teaching Hospital
NHS Foundation Trust

# Board of Directors (Public Meeting)

Wednesday 26 September 2018

York Teaching Hospital
NHS Foundation Trust

# BOARD OF DIRECTORS MEETING

**The programme for the next meeting of the Board of Directors will take place:**

On: Wednesday 26 and Thursday 27 September 2018

In: The Boardroom, Foundation Trust Headquarters, 2nd Floor Administration Block, York Hospital, Wigginton Road, York, YO31 8HE

| TIME | MEETING | LOCATION | ATTENDEES |
|---|---|---|---|
| **26.09.18 13.00 – 16.50** | **Board of Directors meeting held in public** | **Boardroom, Foundation Trust Headquarters** | **Board of Directors & Members of the public** |
| 27.09.18 9.00 – 12.40 | Board of Directors meeting held in private | Boardroom, Foundation Trust Headquarters | Board of Directors |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors (Public) Agenda

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| 1. | **Apologies for absence and quorum**<br><br>To receive any apologies for absence | Chair | Verbal | - | 13.00 – 13.10 |
| 2. | **Declaration of Interests**<br><br>To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders. | Chair | A | 9 | |
| 3. | **Minutes of the meeting held on 25 July 2018**<br><br>To receive and approve the minutes from the meeting held on 25 July 2018. | Chair | B | 15 | |
| 4. | **Matters arising from the minutes and any outstanding actions**<br><br>To discuss any matters or actions arising from the minutes | Chair | Verbal | - | |
| 5. | **Patient Story**<br><br>To receive the details of a patient experience. | Chief Executive | Verbal | - | 13.10 – 13.20 |
| 6. | **Chief Executives Update**<br><br>To receive an update from the Chief Executive | Chief Executive | C | 29 | 13.20 – 13.35 |

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| Strategic Goal: To deliver safe and high quality patient care | | | | | |
| 7. | **Quality and Safety Committee**<br><br>To receive the minutes of the July & August meetings for approval. | Committee Chair | D | 31 | 13.35 – 13.40 |
| 8. | **Chief Nurse Report**<br><br>To receive the Chief Nurse Report. | Chief Nurse | E | 41 | 13.40 – 13.55 |
| 9. | **DIPC Annual Report**<br><br>To receive the DIPC Annual Report for approval. | Chief Nurse | F | 51 | 13.55 – 14.05 |
| 10. | **Medical Director Report**<br><br>To receive the Medical Director Report. | Medical Director | G | 85 | 14.05 – 14.20 |
| 11. | **Performance Report**<br><br>To receive the Performance Report. | Chief Operating Officer | H | 95 | 14.20 – 14.35 |
| 12. | **Emergency Planning Report and Annual self-assessment against core standards**<br><br>To receive and approve the self-assessment. | Chief Operating Officer | I | 111 | 14.35 – 14.45 |
| | **Short Break** | | | | 14.45 – 14.55 |

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| 13. | **LIVEX**<br><br>To receive a report on the July 2018 LIVEX event. | Chief Operating Officer | J | 121 | 14.55 – 15.25 |
| 14. | **Director of Estates & Facilities Report**<br><br>To receive the Director of Estates and Facilities Report. | Director of Estates & Facilities | K | 153 | 15.25 – 15.40 |
| | Strategic Goal: To support an engaged, healthy and resilient workforce | | | | |
| 15. | **Workforce and Organisational Development Committee**<br><br>To receive the minutes of the July meeting for approval. | Committee Chair | L | 221 | 15.40 – 15.45 |
| 16. | **Director of Workforce Report**<br><br>To receive the Workforce Report and the Annual Equality, Diversity and Human Rights Report. | Acting Director of Workforce & OD | M<br>M1 | 229<br>239 | 15.45 – 16.00 |
| 17. | **Freedom to Speak Up Toolkit Gap Analysis**<br><br>To approve the gap analysis for submission. | Acting Director of Workforce & OD | N | 333 | 16.00 – 16.10 |
| | Strategic Goal: To ensure financial sustainability | | | | |

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| **18.** | **Finance and Performance Committee**<br><br>To receive the minutes of the July & August meetings for approval. | Committee Chair | O | 353 | 16.10 – 16.15 |
| **19.** | **Finance Report**<br><br>To receive the Finance Report. | Finance Director | P | 359 | 16.15 – 16.25 |
| **20.** | **Efficiency Report**<br><br>To receive the Efficiency Report. | Finance Director | Q | 377 | 16.25 – 16.35 |
| | Governance | | | | |
| **21.** | **Risk Management Framework**<br><br>To receive and approve the Risk Management Framework. | Chief Nurse | R | 395 | 16.35 – 16.45 |
| **22.** | **Reflections on the meeting**<br><br>• BAF 'at a glance' | Chair | S | 427 | 16.45 – 16.50 |
| **23.** | **Any other business** | Chair | | | 16.50 |
| **24.** | **Time and Date of next meeting**<br><br>The next meeting will be held on Wednesday 28 November 2018 in the Boardroom, Foundation Trust Headquarters, York Hospital. | | | | |

Items for decision in the private meeting:

The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to

issues concerning individual people (staff or patients). On this occasion the Chair will ask the Board to resolve:

*'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.*

# Register of directors' interests
# September 2018

York Teaching Hospital
NHS Foundation Trust

**Additions:**

**Lucy Brown, Acting Director of Communications**
**Polly McMeekin, Acting Director of Workforce and Organisational Development**

**A**

**Changes:**

**Deletions:**

**Libby Raper, Non-Executive Director**

| Director | Relevant and material interests | | | | | |
|---|---|---|---|---|---|---|
| | Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies). | Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS. | Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS. | A position of authority in a charity or voluntary organisation in the field of health and social care. | Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services | Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders |
| ***Ms Susan Symington (Chair)*** | **Non-executive Director—**Beverley Building Society<br>**Director** - Lodge Cottages Ltd | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | **Member—**the Court of University of York | Nil |
| ***Jennifer Adams (Non-Executive Director)*** | **Non-executive Director** Finance Yorkshire PLC | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Spouse is a Consultant Anaesthetist at the Trust | Nil |
| ***Professor Dianne Willcocks (Non-Executive Director)*** | **Member—**Great Exhibition of the North (2018) Board<br><br>**Director**—Clifton Estates Ltd (linked to JRF) | Nil | Nil | **Chair—Charitable Trustee**<br>**Act as Trustee** –on behalf of the York Teaching Hospital Charity<br><br>**Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust<br><br>**Member—**Executive Committee YOPA<br>**Patron—**OCAY<br><br>**Director**— York Media Arts Festival Community Interest Company | **Director—**London Metropolitan University<br><br>**Board Member**—York Museums Trust<br><br>**Chair of Steering Group** - York Mediale Festival | Nil |

| Director | Relevant and material interests | | | | | |
|---|---|---|---|---|---|---|
| | Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies). | Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS. | Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS. | A position of authority in a charity or voluntary organisation in the field of health and social care. | Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services | Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks |
| ***Michael Keaney (Non-Executive Director)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Jenny McAleese (Non-Executive Director)*** | **Non-Executive Director**—York Science Park Limited<br>**Director**—Jenny & Kevin McAleese Limited | **50% shareholder and Director**—Jenny & Kevin McAleese Limited | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity<br><br>**Trustee**—Graham Burrough Charitable Trust<br><br>**Member**—Audit Committee, Joseph Rowntree Foundation | **Member of Court**—University of York | Nil |
| ***Dr Lorraine Boyd (Non-executive Director)*** | Nil | Equity Partner Millfield Surgery | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | GP Providers Lead for North Locality of Vale of York CCG<br>GP Advisor to CAVA | Nil |
| ***Ms Lynne Mellor (Non-executive Director)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Position with BT (telecom suppliers) |

| Director | Relevant and material interests | | | | | |
|---|---|---|---|---|---|---|
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| ***Mr Mike Proctor (Chief Executive)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Spouse a senior member of staff in Community Services | Nil |
| ***Mr Andrew Bertram (Executive Director Director of Finance/ Deputy Chief Execu-tive)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | **Member** of the NHS Elect Board as a member representa-tive | Nil |
| ***Beverley Geary (Chief Nurse)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Mr James Taylor (Medical Director)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Mrs Wendy Scott (Director of Out of Hospital Care)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Mr Brian Golding (Director of Estates and Facilities)*** | **Acting Managing Direc-tor**—YTHFM LLP | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Spouse is Director of Strategy and Planning at HEY NHS FT | Spouse is a Director at HEY NHS FT and Trus-tee of St Leonards Hos-pice |

| Director | Relevant and material interests | | | | | |
|---|---|---|---|---|---|---|
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| ***Ms Polly McMeekin (Acting Director of Workforce & OD)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Mrs Lucy Brown (Acting Director of Communications)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Public Board Minutes – 25 July 2018

**Present:** **Non-executive Directors**

| | |
|---|---|
| Ms S Symington | Chair |
| Mrs J Adams | Non-executive Director |
| Mr M Keaney | Non-executive Director |
| Ms L Raper | Non-executive Director |
| Prof D Willcocks | Non-executive Director |
| Dr L Boyd | Non-executive Director |

**Executive Directors**

| | |
|---|---|
| Mr A Bertram | Deputy Chief Executive/Director of Finance |
| Mrs B Geary | Chief Nurse |
| Mr J Taylor | Medical Director |

**Corporate Directors**

| | |
|---|---|
| Mr B Golding | Director of Estates and Facilities |
| Ms P McMeekin | Acting Director of Workforce & OD |

**In Attendance:**

| | |
|---|---|
| Mrs L Provins | Foundation Trust Secretary |

**Observers:**

Margaret Jackson – Public Governor – York
Jeanette Anness - Public Governor – Ryedale and East Yorkshire
Michael Reakes – Public Governor – York
Gerry Richardson – Stakeholder Governor – University of York
Lesley Pratt – Healthwatch York
Mick Lee – Staff Governor
John Cooke – Public Governor – York
1 Member of Defend our NHS (York)
Vijay Jayagopal – Consultant
Peter Blackaby – Board Partner
Lindsay Smith – Member of the public
Jim Flannagan – Unite
Richard Maddalena – Unite
Nigel Smith – Unite Community
Dave Ferris – Unison
Nick Whitworth – Unite

Malcolm Richardson – Unison
Ian Craven – Member of the public
Megan Ollerhead - Unison
1 member of the public
1 member of Unison

Ms Symington welcomed everyone to the meeting and noted that Mr Bertram would be acting in his role as Deputy Chief Executive in Mr Proctor's absence.

## 18/32 Apologies for absence

Apologies were received from Mr Proctor (Chief Executive), Mrs Scott (Chief Operating Officer), Mrs Brown (Acting Director of Communications), Mrs Rushbrook (Director of Systems and Network), Ms Mellor (Non-executive Director) and Mrs McAleese (Non-executive Director).

## 18/33 Declarations of interest

Mrs Adams stated that her husband had taken up the role of Deputy Medical Director for Planned Care at Scarborough for a period of 6 months.

No further declarations of interest were raised.

## 18/34 Minutes of the meeting held on the 30 May 2018

The minutes of the meeting held on the 30 May 2018 were approved as a correct record.

## 18/35 Matters arising from the minutes

Action Log: item 17/012 – this will be discussed outside the meeting in order to find a resolution.

Action Log: item 17/104 – Ms Symington stated that good progress was being made to the Committee review and the changes would come into effect in September.

No further items were discussed.

## 18/36 Patient Story

The Matron for General Surgery, Urology & Critical Care, Harriett Lynch told the Board how, through teamwork, a patient who was terminally ill with cancer and wished to get married was able to with only approximately 12 hours notice. The story evidenced how staff from the Lilac Ward and various teams pulled together to provide a dress, service, cake, buffet and photos to make it a very special day just hours before the patient sadly passed away. Ms Symington stated that it highlighted the very best of care and teamwork that the NHS can provide.

**It was resolved that the Board were very moved by the patient story which set the tone of the meeting, reminding the board of its overall purpose.**

## 18/37 Chief Executive Report

Mr Bertram explained that Mr Proctor had written the report and that he would highlight a couple of key points.

**NHS 70** – Mr Bertram explained that the report described a number of events which had taken place in and around the Trust and he wished to put on record the Board's thanks to all those in the Trust and its communities who had helped the Trust celebrate.

The Trust had also been a finalist for a Parliamentary Award for the work to provide a mobile chemotherapy unit in conjunction with York Against Cancer (YAC). Mr Bertram noted sadly that the Trust did not win but wished to thank YAC for working with the Trust and supporting the project which had proved very successful.

**LIVEX** – Mr Bertram stated that the Trust, working in partnership with the Army, had put on a huge exercise to simulate a major incident, which included having a significant number of casualties. He thanked the Army at Strensall Barracks who had helped to co-ordinate and run the event which had been an enormous success and provided a huge amount of learning, which would feed into developments in the Trust's emergency preparedness.

**Aligned Incentive Contract** – Mr Bertram stated that the AIC was up and running and was already evidencing significant changes in relationships with Commissioners. It was providing changes to the way organisations were working and how funding flowed which was a very positive start.

**Scarborough Review** – Mr Bertram highlighted that a procurement exercise was taking place and that a number of organisations had shown interest. The review would look at sustainability of the clinical, financial and service model on the East Coast.

**Secretary of State** – Ms Symington stated that she and the Chief Executive had met with the Secretary of State before the NHS 70 Service at York Minister. They had discussed the difficulties facing Scarborough Hospital and been asked to provide him with more information about delivering sustainability in what was termed 'unavoidably small hospitals'. The information had been sent to him and was being forwarded onto the new Secretary of State, Matt Hancock.

Mrs Adams thanked the Governors for their help with LIVEX and the wonderful tea party that they had given for NHS 70.

**It was resolved that the Board noted and accepted the report.**

## 18/38 HYMS Academic Year

Ms Symington stated that in July the Board takes the opportunity to try to understand what has happened during the year at Hull York Medical School. She highlighted that recruitment is central to the Trust's sustainability and the strongest relationships are needed to maintain the provision of clinical services provided by medical staff.

The Board were provided with a presentation by Vijay Jayagopal, HYMS Clinical Dean.

Following the presentation Dr Jayagopal challenged the Board, saying it had teaching in the name so this should be part of it's core business.

Ms Symington stated that it was good to remind the Board that the sustainability of the Trust was linked to the work of the Medical School which was trying to increase the number of future doctors available.

Mrs Geary responded to the challenge stating that the Trust is a Teaching Hospital and reminded everyone that it was not just about medical students as the Trust also helped to train many other professions. However, she also stated that the Trust needed to be mindful when increasing the number of students it takes, as this requires capacity in the clinical areas and supervision requirements and the Board would need to be assured by the quality of the experience.

Ms McMeekin also highlighted the work which was trying to refresh the Trust Grade package as it was becoming more common for doctors to step off the training programme so the Trust needed to create more attractive Trust Grade roles.

It was noted that there is a perception in the STP that students from public schools are not encouraged as much as those from private schools. Dr Jayagopal stated that there are entry criteria and applications are followed up with interviews. It was noted that state school applicants are probably smarter as they achieve the same grades with less support. Dr Jayagopal highlighted his son's experience at a recent careers event and he stated that the way this is done needs to be changed to ensure a more engaging approach. He also noted that the HYMS still has chemistry as an essential requirement where some other schools have moved to biology or chemistry.

Prof. Willcocks loved the presentation and how it demonstrated the embeddedness and interlocked with all the things that matter to the Trust, however, she was concerned that there were no links to research as it was one of the Trust's ambitions to increase the amount of research to promote reputation and retention. Dr Jayagopal stated that research is a key part of the school, but he could have done a presentation on that element alone.

Ms Symington thanked Dr Jayagopal for a very comprehensive and informative presentation.

**It was resolved that the Board noted and accepted the presentation.**

## 18/39 Student Projects Presentation

A presentation was provided by Miss Lawford-Davis and Dr Laboi, Consultant Renal Physician

Dr Laboi stated that 6th Form students from All Saints School who were interested in a career in medicine come to the Trust one afternoon a week for 9 weeks to do a project and Miss Lawford-Davis would provide a presentation to the Board on her project which was about finding out the information patients wanted to receive when coming for renal treatment.

Ms Symington thanked Miss Lawford-Davis for the presentation which had been very informative.

Dr Boyd stated that the presentation had been really interesting and reminded the Board that what the patients want and what doctors and the staff caring for them think they want are not always the same.

Mr Bertram also thanked Miss Lawford-Davis noting that she had challenged the core of what the Trust provides and what it thinks it knows. He asked how she had got patients to open up to her. Miss Lawford-Davis stated that it was about letting patients speak as they were often eager to talk.

Dr Laboi stated that the shared care work was about an equal partnership and learning to empower patients to challenge. Miss Lawford-Davis' work would feed into a new patients pathway.

**It was resolved that the Board thanks both Dr Laboi and Miss Lawford-Davis for the very interesting presentation.**

## 18/40 Out of Hospital Care Report

Mrs Liley provided an overview of the report including the approach to home first which was driven by patient safety and the need to ask the question whether care be delivered at home or a place closer to home in order to reduce the harm caused by long lengths of stay in hospital and subsequent deconditioning. Sheffield are promoting conversations which are about 'why not home, why not today'. Mrs Liley noted that this also linked to the Trust's SAFER approach. The team were also working on trying to meet with the more difficult to reach groups.

Mrs Adams was pleased with the levels of engagement and also that the discharge process theme was identified which chimed with the adult inpatient survey comments that patients feel abandoned when discharged. She stated the joined up thinking would help to take away some of the fear of going home. Mrs Liley stated that the SAFER work started the discharge planning earlier.

Prof. Willcocks stated that when consulting groups like LBGT it may be useful to talk to another of their groups which was about people ageing without children which affects so many and is critical to the DToC issue.

Dr Boyd stated that there is a lot of information available which would help with discharge from lots of organisations and it is about how to bring it together in one place.

**It was resolved that the Board noted the report and accepted the recommendations.**

## 18/41 Finance and Performance Committee

Mrs Liley provided an overview of the month 1 performance including the ECS, the Ernst and Young work and that unfortunately due to last minute changes in the guidance, the Trust had not achieved 30% of the quarter one PSF funding. An appeal has been lodged with NHSI.

A second piece of guidance which has been received is around super stranded patients (those in for 21 days or more) and that trusts are required to reduce the number by 25% by December. The majority of this work sat within the SAFER agenda, but a number also related to system partners who were working through an action plan. The work also related to the winter plan.

Mrs Liley gave an overview of the cancer and RTT position. She also noted the 52 week breaches in Head and Neck and stated that the investigation had covered all the directorates as there were a number of process issues which related to all directorates. An SI had been raised and was in process of being investigated. The action plan will be shared with the regulators.

In relation to the recent diagnostic issues, Mrs Liley stated that the children on the MRI waiting list had all been offered MRIs at Sheffield. This had been taken up in 15 instances and the other families were happy to wait for slots at this Trust.

Mrs Adams asked about the DToC reporting in the Board data pack and Mrs Liley stated that work was being done on the data due to some internally generated delays over the Summer and further work was also being done with system partners. The work was also linked to the SAFER agenda being progressed in the Trust. Mrs Liley did note that as some of the reporting was tightened up the numbers would change. She also noted that there is a system wide partners workshop looking at refreshing a specific joint protocol of care and better coding.

Mr Bertram reminded the Board that the Trust had signed up to deliver a £14m deficit which would achieve a payment of £12m through the PSF, giving a balance position of a £2m deficit for the Trust. At the end of quarter one the Trust had delivered a £6.2m deficit against a plan of £6.3m which had delivered the £1.9m PSF payment. He highlighted the Income & Expenditure chart on page 75 of the Performance Report and gave an explanation as to how this was different from the financial issues last year. He stated that the position was incredibly tight. He noted the Trust had not met the ECS which meant it had not qualified for the full PSF and had lost the 30% tied to the ECS which amounted to £600k. This meant the Trust had posted an adverse £4.8m deficit due to the loss of the £600k.

Mr Bertram stated that the finances had been discussed in more detail at the Finance and Performance Committee. The run rate had been triangulated which for the last 6 months of last year had been an average of £40.6m against a current £41m run rate. He made the Board aware of some one off payments which had taken place in relation to the NHSR premium and that the Scarborough Community Contract loss.

In relation to the ECS it was agreed that the performance should be celebrated due to the progress made, but the loss of the £600k was due to changes in the rules. It was also noted that demand had increased significantly in ED which was another contributing factor so an appeal had been lodged with NHSI.

Mr Bertram highlighted that £7.3m CIP had been delivered at the end of quarter 1, £5.3 was recurrent, which put the Trust in a strong position. The position currently feels precarious and is a tight balance especially in light of staff challenges going forwards. Mr

Bertram stated that the Trust had a deficit of approximately £7m which was half the year end position so things needed to slow down. He highlighted the successful discussions with the CCGs which meant that cash was not currently an issue as payments were being profiled thanks to the AIC agreement.

Mr Golding asked if the Trust would need to borrow any money this year and Mr Bertram stated that the paper described a net borrowing of £2m due to the lack of cash reserves. Some of the issue will be about receipt of the sustainability funding and he highlighted that the quarter 1 funding would not be received until September.

Mrs Adams asked about the new ECS trajectory and PSF funding. Mr Bertram stated that further clarification was being sought. Currently the guidance is about improving on performance judged against the same quarter the last year and that is why the Trust missed quarter 1, however, if the Trust hits the submitted trajectory for quarter 4 this year, it will exceed last year's position. He noted that there was a meeting with NHSI on Monday when more information may be available. The amount of PSF at risk over the year is £4m which is 30% of the £12m available.

**It was resolved that the Board noted and accepted the report.**

## 18/42 Quality and Safety Committee

Mrs Adams stated that page 109 of the board pack provided a summary of the recent meeting and the items for escalation to the Board.

Mrs Geary stated that she wished to highlight the increase in C. Difficile cases and stated that her report on page 171 highlighted 18 cases, which had now increased to 19. The Trust's threshold for the year is 47 and that she would expect the Trust to be at about 12 at this time of year. The PIRs carried out did not show signs of an outbreak or cross infection and the nightingale wards at Scarborough had not seen an increase. Her concern was that this was due to lack of decant facilities to enable deep cleaning at York and the increase in outstanding backlog maintenance. Deep cleaning was currently more opportunistic and it had been approximately 2 years since the Trust had been able to use decant facilities to do remedial work and refurbishments. Mrs Geary stated that infections like C. Difficile can stay in the environment for a long period of time.

Mrs Geary stated that the IPC Steering Group had discussed this issue at some length and were looking at ways to proactively deep clean. Learning from other organisations was also being looked at.

Mrs Geary also highlighted the 6 month review Maternity Report and that it noted some fantastic work being carried out in the directorate including work with the STP on implementing the Better Births guidance and the digital maturity focus looking at mobile working for community midwives. She noted concerns around medical staffing, but that midwifery staffing levels were meeting national recommendations due to a decrease in the birth rate, although York may struggle to achieve the 80% one to one care due to the acuity levels. Mrs Geary stated that stillbirths remain below the national average, smoking in pregnancy rates were decreasing, the uptake of the flu vaccine had increased and there is a plan in place to extend the offer of the whooping cough vaccine this year. Other points of note were that there had been no SIs in the last 6 months, 3rd and 4th degree

tears rates were below the national average, but there was an increasing caesarean section rate which was being looked at.

Prof. Willcocks noted that there had been an astonishing story about midwifery care shared with the Patient Experience Steering Group which may be a useful patient story for the Board as it had highlighted a number of issues to be considered.

Mr Taylor noted that the Electronic Prescribing Management Administration system was due to be rolled out in Scarborough which was part of the process for controlling antibiotic stewardship which was linked to C. Difficile. Mr Taylor stated that there was a new WHO initiative which categorised antibiotics into 3, Access, Reserved and Specific.

Prof. Willcocks was disappointed to see that the Mortality Review had not come to the Quality and Safety Committee. Mrs Adams stated that it had been arranged for the Consultant Lead to attend the Committee Time Out in August. Mr Taylor noted that the Trust are ready to go with the Medical Examiner position, however, it keeps being delayed nationally due to training requirements. He stated that as soon as training is available the Trust will sign up. He stated that attendance at the Mortality Group is currently being reinforced.

Prof. Willcocks stated that she had done a recent patient safety walk round on Paediatrics and SCBU and the biggest complaint was still the lack of Wifi which has been discussed on and off for years. Mr Bertram noted that there is some Wifi available to patients in some areas and he was aware of a recent procurement exercise. Ms Symington noted that Ms Mellor is an expert on this topic and has been engaged in a number of conversations.

Ms Symington stated that she had had a very positive conversation with the new Deputy Director for Patient Safety, Becky Hoskins. Ms Symington had stressed how important the walkrounds were as it provided critical triangulation for the NEDs. Mrs Adams noted that Becky Hoskins had also attended the recent Quality and Safety Committee.

Mr Golding noted that CQC actions had been devolved down to Committees and in relation to the Children's Community Facilities a project initiation document was in the process of being prepared. Mrs Geary noted that a business case for the Children's Assessment Unit was being fast tracked in order to change the paediatric pathway as soon as possible. It was thought that this move would also reduce the number of paediatric admissions. Mrs Liley noted that this work would also help to support ECS delivery.

Mrs Adams asked about Children's Champions as there was concern about the number of children receiving treatment on adult wards. Mr Bertram stated that this piece of work had been picked up by the Executive Board for discussion and a number of clinicians had signed up to be Champions. Areas where there had not been any volunteers were currently being sorted.

**It was resolved that the Board noted and accepted the report.**

## 18/43 Adult In-patient Survey

Mrs Geary provided an overview of the Annual inpatient Survey and highlighted that the sample was from this time last year. The embargo on the report had just been lifted. The report noted that there was no change in the vast majority of questions. Mrs Geary stated that one of the responses ('were you bothered by noise at night?') despite improving was still an issue. The response which had deteriorated was about whether people had to wait to get onto the ward. The report had been split by site this year, but it did make the sample size small when considering the responses.

An action plan had been developed and signed off by the Patient Experience Steering Group last week. Mrs Geary noted that there were some particularly good comments about caring, nursing and medical staff and communication. Mrs Geary stated that the wards pull all their actions into one overarching plan so that nothing is missed. Mr Golding stated that the Trust had to be careful about setting itself actions that could not be delivered especially around things like noise as many wards were multi-occupancy. However, Mrs Geary stated that the Trust was engaged in the night owl project which provided patients with masks and ear plugs.

**It was resolved that the Board noted the In-patient Survey report.**

## 18/44 Environment and Estates Committee

Mr Golding stated that a decision had been taken to split the risk register between the Trust and the LLP and that work was in progress.

In relation to sustainable development he was pleased with the action plan progress and Andrew Bennett and his team had developed a sustainable development briefing document which set out what the Trust expected and would be shared with design teams.

Mr Golding stated the Committee had received a short briefing paper on a change in legislation which was about responsibility for regulating health and safety incidents. He noted that the CQC was now responsible for any incident within premises regulated by them and would have the same powers to prosecute as the HSE.

Mr Golding highlighted page 259 of the pack which detailed progress on the LLP. He noted that Paul Bishop would now be a regular attender of the Environment and Estates Committee and he had provided an overview of the activities being undertaken. The go live date remained as the 1 October and that he currently had no risks to flag with the Board other than the unions, who nationally still objected in principle to the set of up subsidiary companies. It was noted that the Trust had been informed of the protest by the unions and had worked with them which had been very helpful.

Mrs Adams asked about agenda for change element and it was confirmed that the Trust's position is that they will continue to be an agenda for change employer and will do whatever is possible to avoid having a two tier workforce.

**It was resolved that the Board noted and accepted the report.**

## 18/45 Workforce and Organisational Development Committee

Ms McMeekin highlighted the issue with medical staff vacancies at Scarborough, but also noted the many recruitment initiatives in place and that nationally the vacancy position had deteriorated across the NHS.

Mr Keaney asked what was normal and Ms McMeekin stated that 14 to 16% was normal now, although it had been about 3 to 4% 5 years ago.

Ms McMeekin stated that employer led recruitment had had its day and that it was about taking a fresh approach and working more like an agency and using networks. Work was also ongoing to make the Trust Grade role more attractive by providing continued development and investing in Masters CPD training.

Ms McMeekin also raised that the Board were required to complete a gap analysis from the National Guardians Office around the freedom to speak up agenda. She stated that Ms Smith had already started the work and the Trust was meeting about 50% of the recommendations. Both she and Prof. Willcocks would also provide some input.

Mrs Adams stated that she liked the detail in the report especially around recruitment on the East Coast. She asked about the small window around overseas visas. Ms McMeekin stated that this provided fresh impetus to look outside of Europe, but other Trusts would also be doing the same.

Ms McMeekin stated that there was concern that 41 of the junior doctors rotating in August still required certificates of sponsorship from HEE so the Trust was trying to get assurance from HEE that these would be forthcoming.

**It was resolved that the Board noted and accepted the report.**

## 18/46 Freedom to Speak Up/Safer Working Guardian Reports

**Safer Working Guardian** - Ms Smith stated that she had brought one of the Junior Doctors to talk to the Board as he was the Vice Chair of the Junior Doctors Forum. She noted that exception reports were down, which was also a national trend so she would focus on other elements. The key areas reporting around toil payments and extra hours were medicine in Scarborough and Surgery in York.

Dr Roper stated he worked as a Junior Doctor in ED and was the Vice Chair of the Junior Doctors Forum (JDF). He wanted to provide the Board with an overview of the work of the JDF which had increased attendance from 1 at the start of the year in August to 4 or 5 junior doctors attending every meeting. The JDF allowed juniors to gain a broader knowledge of what is wrong and what can be done better. He noted some of the barriers to exception reporting and that the JDF had been working on myth busting and highlighting that the Guardian is getting results. Dr Roper noted the differences of the Guardian role between the York Trust and Hull Trust, where he had previously worked, stating that it was better to have a full time Guardian as it allowed the time to do the job and get results. Dr Roper explained that some of the work being progressed was looking at how the culture could be changed especially in terms of high impact changes which could be done. The

challenge would be to engage with the new doctors so the meeting in August 2018 had been changed to a slightly more informal one to encourage attendance.

Mrs Adams asked about the issues in Surgery at York and Dr Roper stated that it sometimes had to do with the slightly more hierarchical system in surgery, however, he was pleased to say that the Clinical Director was engaging with the work which helped enormously. He noted that there were some sessions being held on culture and communication.

Ms Smith stated that a good starting point for the work was that issues were being discussed at both the Board and Executive Board so the Trust were starting to talk about and address issues that have been raised. She highlighted that she is also doing some joint work with the Organisational Development Department.

Prof. Willcocks stated that she would like to see some softer KPIs included in the report which captured some of this work.

Mr Bertram asked if there were any practical things the Board could do. Dr Roper stated that some of the issues were around engaging doctors with the work the Board did, but one of the good initiatives being taken forward was to pair doctors with managers so that they could learn about each others roles. This initiative was proving successful from both sides. He also noted that it was about the Board providing support for the work Ms Smith was doing.

**It was resolved that the Board noted and accepted the report.**

**Freedom to Speak Up** – Ms Smith highlighted that work had started on the self-assessment from the National Guardian's office which Ms McMeekin had raised earlier. The Board discussed the self-assessment. She noted that in relation to case reviews a number of equality and diversity issues had been raised by the Fairness Champions and would be worked through. The numbers of speak ups had increased recently from 12 to 18 per month, however, this month had already seen 28 speak ups being received and the first anonymous one had been received.

Ms Smith stated that the number of Fairness Champions was growing with another 10 applications being received, but this did mean that her workload in relation to training, managing and support was becoming more challenging. In relation to achievements, Ms Smith was pleased that she was being asked to support Directors and Clinical Directors to do sessions with staff to raise awareness and she was also being commissioned to do more listening events which was really positive and showed a level of embeddedness.

Ms Symington asked what the severity of the 28 approaches this month were and Ms Smith replied all were moderate. The top theme was still bullying and harassment which the Trust needed to be mindful of.

Ms McMeekin stated that she had discussed the evaluation with Ms Smith which appeared on page 309 of the pack in relation to the number not addressed and those who felt they had suffered unfair treatment. Ms Smith highlighted that it was stressful for staff to raise issues and it was about how the Trust addresses it. Ms McMeekin stated it was about how

the Trust could pull out slightly more constructive comments and also get some of the figures down.

Mr Bertram asked about the pan sector work. Ms Smith stated that she thought she had been invited as one of the first Guardians in post and that the work was interesting as all sorts of different organisations were involved, which also meant shared learning and practice. It was agreed that some of this learning and insight could be shared in the report in future.

Prof. Willcocks commended the work with the Fairness Champions stating that a substantial piece of work was being done with a very limited budget.

**It was resolved that the Board noted and accepted the report.**

## 18/47 Any other Business

**WRES Report** - Ms McMeekin asked the Board to note the WRES Report from the pack which was due to be submitted.

**Wifi** – Mr Taylor stated that he had received an update on the implementation of patient wifi. He stated that initial problems had been due to GDPR compliance which had now been sorted. Wifi had been installed and would go live in 8 to 10 weeks.

**BAF Alignment** – Ms Symington stated that on reviewing the discussions at both the private and public meetings all the critical risks to achieving the Trust's strategic aims had been covered.

Ms Symington stated that the meeting had been busy with visitors, but these discussions including the patient safety story about a wedding, the HYMS presentation and the presentation around the student project were absolutely what the NHS was about and should be protected.

**August Meeting** – this will be a private meeting at the Stensall Barracks which will be a workshop around partnership working and engagement.

**AGM** – Ms Symington advised that the AGM will take place on the 27 September.

**Mrs Rushbrook, Director of Systems & Network** – Ms Symington wished to record the Board's thanks to Mrs Rushbrook for her many years commitment to the Trust and the NHS and wished her a healthy, happy and long retirement.

**Ms Raper, Non-executive Director** – Ms Symington also wished to record the Board's thanks and best wishes to Ms Raper who had fulfilled her 9 years as a Non-executive Director and was leaving the Trust at the end of July.

## 18/48 Date and Time of next meeting

The next public meeting of the Board will be held on Wednesday 26 September 2018 in the Boardroom at York Hospital.

## Outstanding actions from previous minutes

| Minute No. and month | Action | Responsible Officer | Due date |
|---|---|---|---|
| 17/012 | Parity of other staff groups with junior doctors in relation to exception reporting criteria (20 mins) to be added to the work programme. | Mrs Provins | Jan 2018<br>Feb 2018<br>May 2018<br>tbc |
| 17/104 | Board Committee reporting changes to be reviewed in March. | Ms Symington | Completed |

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NHS Foundation Trust

# Board of Directors – 26 September 2018
# Chief Executive's overview

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

## Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

## Purpose of the Report

To provide an update to the Board of Directors from the Chief Executive on recent events and current themes.

## Executive Summary – Key Points

- Chief Executive Recruitment
- York Teaching Hospital Facilities Management LLP
- Industrial Action

## Recommendation

For the Board to note the report.

Author: Mike Proctor, Chief Executive

Director Sponsor: Mike Proctor, Chief Executive

Date: 26 September 2018

## 1. Chief Executive recruitment

As has now been widely briefed, we did not make an appointment as a result of the recent selection process for a new Chief Executive. We will be going out to recruit again, however in the meantime I will continue in the role and have been talking to our Clinical Directors and other members of the senior leadership team about the important work that we now need to progress. We are not in a position to tread water and I fully intend to make decisions that will help us to move forward in areas where we had initially opted to pause until an appointment was made.

## 2. York Teaching Hospital Facilities Management LLP

We are now a matter of days away from the launch of our estates and facilities company, which goes live on 1 October.

Throughout this process we made a commitment that staff who transfer to the new company will keep their NHS Agenda for Change terms and conditions, and I can confirm that this is the case. I can also confirm that staff will receive the pay increases that were announced earlier this year as part of the three year national pay award.

A commitment was also made that staff would not transfer in to York Teaching Hospital Facilities Management LLP until we had received confirmation from the NHS Pension Scheme that these staff will be able to remain members of the scheme.

We have now received formal written confirmation from the NHS Business Services Authority (the organisation that manages the NHS Pension Scheme) that our request to continue to offer the scheme to those transferring to the LLP has been approved. This was the final hurdle for us, and staff will transfer as planned on 1 October.

This has been a huge undertaking involving many staff and I want to thank all those involved in the project for their contribution.

Board colleagues may have seen coverage of NHS Improvement's announcement that they are asking organisations who are yet to form wholly-owned subsidiaries to pause any plans. I want to clarify that we have had confirmation from NHS Improvement that this does not affect us, and that we can proceed on 1 October as planned.

## 3. Industrial action

As part of the ongoing national opposition by trade unions to the creation of wholly-owned subsidiaries, at the time of writing we are expecting members of Unite the Union to carry out a strike from 6am on Thursday 27 September to 6am on Saturday 29 September.

This will mainly affect staff from our estates and facilities services.

We have reviewed our business continuity plans and are confident that we can continue to deliver a safe service with no significant impact on patients.

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Quality and Safety Committee Minutes – 21 August 2018

## Recommendation

| | |
|---|---|
| For information | ☒ |
| For discussion | ☒ |
| For assurance | ☒ |
| For approval | ☐ |
| A regulatory requirement | ☒ |

## Current approval route of report

The minutes are approved by the Quality and Safety Committee.

## Purpose of report

The purpose of the Quality and Safety Committee is to receive assurance and to provide challenge and scrutiny around matters of patient safety, patient experience and clinical effectiveness within the Chief Nurse and Medical Director's areas of responsibility. Each month a small number of items will be selected for escalation to the Board of Directors for information and/or debate.

Chair's Summary

1. Nurse staffing remains at the forefront of committee discussions, in particular, the lower number of new registrants than normal joining the Trust in this intake. The committee welcomed a number of new initiatives to reduce unfilled shifts.

2. The Mortality Review work was presented to the committee by Peter Wanklyn and the Trust is now in a good position to introduce the new Medical Examiner system when it finally goes live. Review rates amongst elderly medicine deaths are good but general medicine compliance is a challenge.

3. Within medical staffing, Radiology faces a number of issues across sites. The McKInsey review is awaited and will hopefully generate some options for the medical staffing shortages on the East Coast.

4. An update on the Trust Quality priorities for this year was received. Adoption of the SAFER patient flow system and achievement of the 7 day service targets are improving but still exhibit too much variation from site to site and ward to ward.

Reduction in Noise at night and still birth rates are showing good progress. Dementia screening remains a challenge.

5. Harrogate hospital hyper-acute stroke services will cease in October due to medical staffing shortages. York hospital has agreed to receive around one third of these patients onto its stroke unit.

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Key points for discussion

This month the Committee has selected the following for the particular attention of the Board:

1. Registered Nurse intake - BG
2. Harrogate Stroke Service changes - JT
3. Variation in success with Quality Priorities for 2018/19 JT/BG
4. Mortality Review successes and challenges - JT

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Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☐ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☐ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☐ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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Reference to CQC Regulations
(Regulations can be found here: http://www.cqc.org.uk/content/regulations-service-providers-and-managers )

Author: Liz Jackson, Patient Safety Project Support

Sponsor: Jennie Adams, Non-Executive Director
Date: 21 August 2018

# Quality & Safety Committee Minutes – 21 August 2018

**Attendance:** Jennie Adams, Lorraine Boyd, James Taylor, Beverley Geary, Rebecca Hoskins, Fiona Jamieson, Lynda Provins, Liz Jackson

The Committee had agreed to have a shortened meeting for August with minimal papers being provided.

## Minutes of the meeting held on the 17 July 2018

The notes from the meeting held on the 17 July were approved as a true and accurate record.

## Matters arising

Adult inpatient survey - The Committee questioned the actions identified from the adult inpatient survey and BG confirmed that there is an action plan in place which is monitored by the Patient Experience Steering Group.

Nurse Staffing - The Committee queried the data quality of the nurse staffing statistics. BH confirmed that the staffing report is being refreshed. The current rotas are based on seven hour shifts and much of the workforce actually work 12 hour shifts. The fill rate should therefore be better than we are currently reporting and SafeCare will also help with this. The report will become as accurate as possible and consistent over time, whilst being open and transparent. The Committee noted the difficulty in reflecting the changes to the skill mix on the wards.

Nursing appraisals - BG confirmed that nursing appraisal data has been discussed at Corporate Directors and Polly McMeekin has agreed to look in to using a consistent approach across the whole workforce.

Incident reporting - The previous discussion around incident reporting was revisited by the Committee. FJ advised areas, in particular General Medicine, are not reporting all incidents. FJ has attended the governance session in General Medicine and they have agreed to run a trial week where all incidents are reported on to datix; including those that are dealt with in the moment. This week will take place before December.

Sharps injuries - It has been noted that not all sharps injuries are being reported, which was identified through a discrepancy between occupational health and datix data. Occupational Health has been asked that when they are treating a member of staff for a

sharps injury they check if a datix has been completed. It is hoped that an improvement in reporting will be seen.

Patient Safety Walkrounds - The Committee thanked RH for the revised plan for patient safety walk rounds' going forward, RH confirmed that it is hoped that this plan will commence as a trial in October. JT will feed the plan back to Corporate Directors. The Committee agreed that the walk round reports are very helpful and welcomed the new approach.

## Action Log Items

Item 68 – The Trust strategy is going to Board this month, the Patient Safety strategy has an agreed, clear direction and the document is in development. RH has liaised with the communications team to arrange dates for the launch of the strategy and a programme of directorate meetings has been scheduled.

Item 88 – The Committee were scheduled to review the sentinel stroke audit this month but agreed to postpone this due to the shortened agenda. The selected audits for review will be picked up through the medical director and chief nurse reports going forward.

Item 93 – BG advised that the Safer Staffing Report will change when SafeCare is embedded and BG will provide an update in September. The Committee discussed the concerns around the current data not being up to date and agreed that the SafeCare report will provide assurance on day to day care.

Item 95 – The EPMA Board has not met since the last Committee meeting. JT confirmed that work is continuing behind the scenes and the launch of EPMA in Scarborough is scheduled to commence at the beginning of October. Additional development work continues to take place. The Committee requested an update on the increase in insulin errors that are being reported, which was noted at the July meeting. RH advised that the Diabetes Specialist Nurses have been conducting focused training on the wards and believe that the increased reporting is down to improved awareness rather than an increase in incidents. JT confirmed that a work stream for antibiotic prescribing has been agreed by the Executive Board.

Item 96 – The Mortality report had come to the Committee for review and is scheduled later in the agenda.

## Risk Register for the Chief Nurse

CRR Ref: CN2 – BG advised that the nurse staffing risk has been increased due to the number of new recruits dropping from 120 in 2017 to 68 in 2018. New terms have been agreed for new registrants including; relocation expenses and being paid a band 4 rather than a band 2 whilst awaiting their PIN number. It has also been agreed to increase the premium for bank staff. An increased cohort of Trainee Nurse Associates is being looked

in to for next year, as is an improved education programme. The current climate has the potential to increase Trust agency spend.

## Risk Register for the Medical Director

The strategy work around Medical staff on the East Coast being undertaken with McKinsey has been included in several of the Medical Director risks.

CRR Ref: MD7 – The Committee discussed the bed capacity in ICU following a letter that had been sent by staff. JT agreed to liaise with Brian Golding. The refurbishment of the Emergency Department is included in the estates programme and there is focussed strategic work planned for ICU. JT confirmed that the current capacity in ICU would not increase the risk score.
**Action:** JT to liaise with Brian Golding

CRR Ref: MD8 – JT advised that there will be some system changes in Radiology in October. There have been ongoing capacity issues across site and JT has recently reviewed data regarding unreported scans. Further recruitment to Radiology will commence imminently. There has been a delay in the build on the Scarborough site. The Trust will need to recruit staff to increase capacity; however the build was to ensure that a backup CT machine could be put in place.

## Quality Priorities

The Committee reviewed the quality priorities report, the priorities in which had previously been agreed by the Committee. LP advised that she has linked with the leads from these areas to agree the measures and leads will produce a nine and twelve month report. The Committee agreed that they were good priorities and measures and although they may not all be achievable, they are open and transparent.

SAFER – JT advised that there are areas within the Trust that are showing significant improvements with the safer initiative and are close to achieving and other areas that are behind and require further attention. The measures are prescribed actions as part of the project. The Committee discussed having an improvement trajectory and LP confirmed that anything above 50% is amber and a percentage could be defined each year. There is an opportunity for narrative in the final report.

Infection prevention and control - BG explained that the IPC measures were agreed when the care groups and governance structures were being developed. As the IPC measures are around processes and structures and the ownership of these within directorates the measures may no longer work. The Committee agreed that these can be changed next year and noted that IPC data is included in the priorities.

Maternity and still births – The data for this priority is included in the maternity quarterly reports and the reduction in still births is being clearly demonstrated.

Night owl initiative – BG advised that the inpatient survey had shown some improvement in noise at night; however, a number of complaints include noise at night as a secondary topic. The Committee suggested changing the measure to a reduction in complaints with noise at night as the primary complaint.

## Highlights form the Medical Director and Chief Nurse

Stroke Services - JT advised the Committee that Harrogate will no longer able to offer an acute stroke service from October as there is only one stoke physician. It has been agreed that the Yorkshire Ambulance Service will bring stroke patients to York and Leeds, dependent on which catchment area they are closest to. There is capacity on the York acute stroke ward which currently houses some outliers. Taking on these additional patients will impact on the general service and delivery within the organisation. Stakeholder discussions have agreed that this change in service will not follow the Scarborough Hospital model as the travel to York and Leeds is not a big issue. A fast track pathway though York Emergency Department will be looked in to.

Never Event - RH confirmed that the patient receiving air instead of oxygen was declared as a never event; however, is not currently showing on the performance report. RH to amend data.

Infection prevention - BG advised that there is a potential new MRSA bacteremia case which is being investigated. The Committee queried the Clostridium Difficile (CDIFF) rates in the performance report which BG advised were incorrect. For 2018 the Trust has had 23 incidences of CDIFF against a full year limit of 47, eight of which saw no lapses in care. The cumulative actual total and the cumulative trajectory have been transposed within the pack – which is giving an incorrect picture of the Trust position.

## Matters arising from the Performance Report

BH advised the Committee that she is working with Systems and Network Services to agree measures that will be included in the Medical Directors report going forward.

Dementia screening - The Committee noted that the compliance with dementia screening has reduced to 76.6% in July and advised that there needs to be increased awareness of this issue again. RH agreed to review a breakdown of this data by ward, directorate and site.
**Action:** RH to review data and possible actions.

Patient Safety Walk Round – The Committee discussed the feedback from the patient safety walk round on ward 25 and agreed that the issues were; the number of vacancies, the leadership and the input from the surgical team. BG advised that the ward had a cluster of CDIFF cases earlier in the year but these have not reoccurred following a deep clean. JT is in conversations with Orthopaedic colleagues regarding mandating the same standards as those on other surgical wards and there is an action plan in place. Orthopaedic work needs to be repatriated back in to the Trust; this will increase funding which could be used to recruit more middle grade doctors.

SHMI - The Committee reviewed the Trust SHMI data, and queried if the widening gap between the York and Scarborough site was cause for concern. JT advised that the SHMI is not a benchmarking figure, it is based on the quality of coding and the national averages are readjusted when new data is submitted. JT confirmed that the neither site within the Trust is alerting as an outlier. A more granular breakdown may help to highlight any areas of specific concern.

## Mortality

Peter Wanklyn introduced the mortality quarterly report, which is now in a new format, and explained that the national process is very clear with Trusts learning directly from deaths.

Consultants in charge of the patients care will undertake a simplified mortality review; this will produce an overall score which may trigger the need for a structured judgment case note review (SJCR). Complaints regarding deaths and some mandatory groups automatically trigger an SJCR to be completed. The Trust can also initiate a review of a group of patients. PW explained that an SJCR is not used to identify an avoidable death as this is very subjective.

National guidance suggests that 10% of deaths should have a SJCR and the Trust is currently at 3%. This is an evolving process and it is difficult due to under reporting. JT explained that the medical examiner roles will improve the process and take on the inaccuracies in the data, the governance work and learning and will be independent from the actual specialties.

Completion of initial mortality reviews and SJCRs within Elderly medicine directorate is well embedded; however, the other high mortality area of general medicine has a very low rate of mortality review completion and this needs to be addressed before we can be really confident that key lessons from deaths are being learned.

The Mortality Steering Group maintains the reports; however, the process needs to be embedded in the directorate structure. The minutes of the Mortality Steering Group and the quarterly reports are sent to the Clinical Directors and the Clinical Governance Leads. Clinical Governance Leads have been asked to supply reports to the steering group to provide assurance; however none have been received.

The completed SJCRs contain a useful amount of data filtered by an expert; this can be shared with the SI committee for use in an investigation when necessary and can also be presented so appropriate people can put changes in place. The process needs to be linked with complaints and inquests as these can lead to the SJCR being quite delayed. PW advised that the national SI process is being rewritten and will hopefully have some correlation.

The recurrent themes this quarter are; failure to escalate, delays in medical reviews and workload of junior doctors.

The Committee discussed the junior doctor's workload. JT explained that this is determined by the fill rate from the deanery. The number of doctors on the rota is historic and since this was determined the acuity and dependency of patients has increased. ACPs, specialist nurses, physician's assistants and other clinical alternatives are being put in place to mitigate for this.

PW highlighted that completing the SJCRs does incur additional work for clinicians and there is no additional resource to complete these. PW has presented the mortality work at governance days and grand rounds, there needs to be local engagement and acceptance of the process. JT advised that there is a new clinical director in General Medicine who he is confident will make progress on this project and the Committee suggested featuring and SJCR in the Nevermore publication.

BG explained that the SJCRs that come to the Quality and Safety meeting are very helpful and themes can be triangulated with other discussions and meetings such as; inappropriate ward moves, bed escalation, outliers and board rounds. These have triggered actions such as; cohorting elderly patients on one ward during winter to reduce outliers and reducing and restricting ward moves.

**Assurance -** The Committee were assured that the Mortality Report executive summary highlights topics that already feature in the Committees discussions
**Action –** RH to arrange for an SJCR to feature in Nevermore

## Any other business

The Committee discussed the work plan going forward, LP explained the items scheduled to go to the Committee will go on to the Board schedule. Reports will be taken as read and front sheets will include key themes for discussion. The process can be changed as it evolves. The Committee highlighted that the new structure of the Board must ensure that patients remain at the center of the discussions.

As this was her last meeting, the Committee thanked Liz Jackson for her secretarial support over the years and wished her well for the future.

**Next meeting of the Quality and Safety Committee: To be confirmed.**

**Quality & Safety Committee – Action Plan – August 2018**

| No. | Month | Action | Responsible Officer | Due date | Completed |
|---|---|---|---|---|---|
| 36 | Mar 17 | Foundation Trust Secretary to liaise with Medical Director for the Patient Consent Audit report | Helen Noble | May 17, Jun 17, Jul 17, Aug 17, Sept 17, Oct 18, Jan 18, Feb 18, July 18 | |
| 68 | Dec 17 | JT to bring amended Patient Safety Strategy | Medical Director | Feb 18<br>March 2018<br>May 18<br>Summer | |
| 73 | Feb 18 | Nursing appraisal data | BG | Mar 18, April 18, May 18, July 18 | Completed |
| 88 | May 18 | Audits for review;<br>Sentinel Stroke Audit<br>National Cardiac Arrest Audit<br>A local audit<br>Paediatric Diabetes Audit | FJ | <br>Aug 18<br>Sept 18<br>Oct 18<br>Nov 18 | |
| 93 | Jun 18 | To share SafeCare with board within the Chief Nurse report | BG | Aug 18<br>Sept 18 | |
| 95 | Jun 18 | Feedback from the EPMA Board | JT | Jul 18<br>Aug 18<br>Sept 18 | |
| 96 | Jun 18 | Mortality Report to come to the Committee for review | JT | Aug 18 | Completed |
| 97 | July 18 | Bed capacity in ICU following letter from staff. JT liaising with Brian Golding | JT | Sept 18 | |
| 98 | July 18 | Dementia screening compliance, RH to review breakdown of data | RH | Sept 18 | |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Chief Nurse Report

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

## Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

## Purpose of the Report

The Chief Nurse report provides assurance on progress towards the delivery of our quality priorities, and highlights any risks to delivery of the Nursing & Midwifery and Patient Experience Strategies. The four themes are:

- Experience and Communication
- Workforce
- Safe, quality care
- Partnerships and efficiency

The themes triangulate with the Patient Experience and Patient Safety strategies in order that priorities are aligned to ensure delivery of the key objectives.

In addition, the summary provides details of falls and pressure ulcer incidence for Q4, plans for improvement and priorities to reduce risk.

## Executive Summary – Key Points

a) Vacancies – the Trust continues to hold a RN vacancy position, bank and agency staff are being utilised to maintain patient safety. As previously reported a number of recruitment and retention initiatives are being employed, these are being reviewed to ensure best results.

b) Maternity Services are pleased to report the achievement of meeting 10 out of the 10 safety actions for 2017/18 Maternity Incentive scheme. The Trust will be receiving the return of its contribution into the incentive fund together with a share of unallocated funds.

c) The Trust will be part of a City of York Joint Targeted Area Inspection into Safeguarding Children (SAH) over 2 weeks commencing 17th September

d) Q1 2018/19 has seen an increase in the total number of falls

e) A full root and branch review of falls prevention and management has commenced, with an expected completion date of November 2018. This review will be multi-dimensional and explore how themes and learning from falls are shared.

f) 5 pressure ulcer SI investigations have been completed in the Quarter. Three of the five reports related to community settings.

g) A thematic analysis was undertaken to identify areas for improvement, a key finding was documentation, plans to address this are in place.

h) Pressure Ulcer Collaborative is an improvement project has been set up as part of the national NHS Improvement's Stop the Pressure initiative. Our focus in is on heel pressure ulcers, with an aim to reduce these by 50 per cent over the next six months

## Recommendation

The Board is asked to:

1. Note the RN and care Staff vacancy position at 31st July 2018
2. Commend the Maternity team for the work undertaken to achieve CNST
3. Note the JTAI

Author: Beverley Geary, Chief Nurse

Director Sponsor: Beverley Geary, Chief Nurse

Date: September 2018

## 1. Introduction and Background

The Chief Nurse report provides assurance on progress towards the delivery of our quality priorities, and highlights any risks to delivery of the Nursing & Midwifery and Patient Experience Strategies. The four themes are:

- Experience and Communication
- Workforce
- Safe, quality care
- Partnerships and efficiency

The themes triangulate with the Patient Experience and Patient Safety strategies in order to ensure delivery of the key objectives.

## 2. Progress on Strategic Themes

In line with the Nursing and Midwifery strategy, this report is aligned to the four key themes

### 2.1 Experience and Communications

The Friends & Family Test response rates for the end of July are detailed below with a comparison against May and June 2018.

| % likely to recommend | May 18 | June 18 | July 18 | National Av (June 2018) |
|---|---|---|---|---|
| Inpatient | 96.7% | 96.7% | 96.6% | 96% |
| Emergency Department | 84.5% | 85.7% | 84.6% | 87% |
| Maternity | 97% | 98.2% | 96.4% | 98% |

The inpatient response rate in June 2018 was 27% against a national average of 25%. The inpatient satisfaction rate in July 2018 remains stable and slightly higher than the national average. There were very few negative comments received in July.

The ED response rate increased to 10.5% in July but is slightly lower than the national average of 13%. The ED satisfaction rate was 84.6%, with the Scarborough ED rate decreasing slightly and York ED rate remaining stable.

Few concerns were raised in our EDs other than about long waiting times. There were a couple about not being offered pain relief while waiting at York ED, some at both sites about poor communication with the patient and poor communication between departments.

As always, the overwhelming theme across all comments in all areas is thanks and respect to our staff.

The PALS actively dealt with 152 enquiries, comments and concerns. The team also had 162 queries that were not formally logged. 1029 compliments were received.

77% of PALS cases were closed within the target timescale of 10 working days (up 6% from July 2018).

45 new complaints were received and 12 cases were reopened for further investigation. 28% of complaint cases closed in August met the Trust's 30 day response target. This is down from 40% in July but remains just above the 2017-18 annual average of 27%. Two cases were addressed using the next working day process, resulting in a quick resolution for the complainant.

The patient experience team provides the Chief Nurse, Deputy Chief Nurse and Directorate Managers with directorate-level performance reports on complaints management.

There were no new PHSO cases. However, the Trust is working with the PHSO to resolve 1 case without the need for formal investigation.

## 2.2 Workforce

### 2.2.1 Nursing Dashboards

The nursing dashboards at Trust and Site level for the period ending 31st July 2018 are attached at Appendix 1.

### 2.2.2. Vacancy Position

At the period ending 31st July 2018, the Trust overall RN vacancy position stood at 315.76fte, which represents 15.74% of the Trust's budgeted establishment. To date, 136.04fte RNs have been recruited into posts with their commencement dates in the next few months. However 78.22fte (3.89%) have resigned from their existing positions, leaving the unfilled RN position at 208.14fte (10.18%).

Chart 1 below provides the breakdown

Chart 1

| Site | Vacancies | | | Pending Starters | | | Pending Leavers | | | Unfilled Vacancies | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN | Band 4 | Care Staff | RN | Band 4 | Care Staff | RN | Band 4 | Care Staff | RN | Band 4 | Care Staff |
| Inpatient Wards | 214.43 | -23.68 | 54.11 | 76.31 | 1.00 | 49.12 | 37.74 | 0.00 | 15.17 | 176.86 | -24.68 | 20.16 |
| Other Areas | 101.33 | 5.67 | 44.52 | 59.73 | 0 | 10.67 | 40.48 | 2 | 9.97 | 31.12 | 7.67 | 21.96 |
| **TOTAL** | **315.76** | **-18.01** | **98.63** | **136.08** | **1** | **59.79** | **78.22** | **2** | **25.14** | **208.14** | **-17.01** | **42.12** |

The inpatient vacancy position is broken down by site below:

| Site | Vacancies | | | Pending Starters | | | Pending Leavers | | | Unfilled Vacancies | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Inpatients Areas** | **RN** | **Band 4** | **Care Staff** | **RN** | **Band 4** | **Care Staff** | **RN** | **Band 4** | **Care Staff** | **RN** | **Band 4** | **Care Staff** |
| Bridlington | 4.99 | 0.00 | 2.01 | 1.64 | 0.00 | 0.40 | 2.00 | 0.00 | 0.00 | 5.35 | 0.00 | 1.61 |
| Community | 7.61 | 0.00 | 4.47 | 2.20 | 0.00 | 3.00 | 0.00 | 0.00 | 0.00 | 5.41 | 0.00 | 1.47 |
| Scarborough | 74.83 | -10.80 | 20.03 | 11.60 | 0.00 | 14.20 | 7.40 | 0.00 | 3.97 | 70.63 | -10.80 | 9.80 |
| York | 127.00 | -12.88 | 27.60 | 60.87 | 1.00 | 31.52 | 28.34 | 0.00 | 11.20 | 95.47 | -13.88 | 7.28 |
| **TOTAL** | **214.43** | **-23.68** | **54.11** | **76.31** | **1.00** | **49.12** | **37.74** | **0.00** | **15.17** | **176.86** | **-24.68** | **20.16** |

Bank and Agency Usage has continued to be high during July with the equivalent of 170.47fte nurses (25,570.5hours) and 173.09fte Care Staff (25,963.5 hours) being utilized during the month.

We will be receiving 74 newly graduating nurses to the organisation between now and November 2018. Preparations are now being made to welcome these nurses with and final arrangements being made for their preceptorship programmes which will begin in mid-October 2018.

Recruitment of nurses is continuing Trust-wide and discussions are already taking place with universities on how we can engage further with students.

The first cohort of Trainee Nursing Associates will have completed their programme early next year and will be employed into substantive positions within the Trust from April 2019. These will be one of the first groups of Nursing Associates in the country to have completed the pilot since the role was introduced in January 2017, a national evaluation is ongoing and will continue post qualification.

Coventry University (CUSC) have agreed to support a Trainee Nursing Associate programme in Scarborough to start at the latest by February 2019, for 20 people this will it will be funded by the Apprenticeship Levy.

Coventry have also mapped the apprentice standards against the BSC so potentially the 15 current TNA's who will be qualifying shortly could move onto this and we could start to utilise the Levy for a professional qualification.

The Trust is continuing to explore its options for a further cohort of Trainee Nursing Associates during 2019.

## 2.3 Safe, Quality Care

### 2.3.1 Infection Prevention Update

The Trust's current status of infections since April 2018 is detailed below:

| Organism | Trust Annual Threshold | Trust attributed to end of August 2018 |
|---|---|---|
| Methicillin Resistant Staphylococcus Aureus **(MRSA)** | 0 | **3** |
| Methicillin Sensitive Staphylococcus Aureus **(MSSA)** | 30 | **13** |
| Clostridium Difficile **(C-diff)** | 47 | **24** |
| Escherichia Coli **(E-coli)** | 68 | **23** |

C.difficile awareness days have been held on York and Scarborough sites in July. The aim of these days was to raise awareness around Cdiff aetiology and management as well as incorporating learning from PIRs. The days were well attended by clinical staff and allied healthcare professionals. The days will be replicated in October.

A meeting for Seasonal Influenza Planning was held during the summer. The model for management is broadly based on the success of Ward 23 during last season; it is planned that ward 23 will continue to be designated Flu ward on York site. Further fit testing training days have been arranged in September on Scarborough and York sites and there are now lists of fit testers available on the Learning HUB for clinical areas to access.

A planned proactive HPV programme has begun on Scarborough site, undertaken by the Trusts HPV team over weekends. Innovative ways are being explored to deploy proactive HPV on the York site.

### 2.3.2 Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme

Maternity Services are pleased to report the achievement of meeting 10 out of the 10 safety actions for 2017/18 Maternity Incentive scheme. The Trust will be receiving the return of its contribution into the incentive fund together with a share of unallocated funds.

The CNST maternity incentive scheme is to support the delivery of the Department of Health and Social Care's maternity safety strategy and was developed in collaboration with national partners and with the assistance of the National Maternity Safety Champions.

The 10 standards that the Trust was required to comply with to be eligible for the credit are:

I. Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?
II. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
III. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?

IV. Can you demonstrate an effective system of medical workforce planning?
V. Can you demonstrate an effective system of midwifery workforce planning?
VI. Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?
VII. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?
VIII. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
IX. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
X. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme

### 2.3.3 Safeguarding Children's Update

The Safeguarding Team are working closely with our midwifery colleagues to develop electronic safeguarding information. By utilising a midwifery shared drive we are able to facilitate the storage of electronic copies of Cause for Concerns, Maternal Wellbeing and Holistic assessment forms. Ultimately we aim to have the whole maternity safeguarding record stored as an electronic document. Between 28 and 32 weeks of pregnancy, the safeguarding team will complete a written summary and, where appropriate, will also complete and store a Safeguarding Safety Plan. Currently paper copies of these documents are either in community or in hospital. This new process will enable information to be visible to both hospital and community staff in a timely manner. A standard operating procedure has been developed. Blank copies of safeguarding paperwork are also located here for the convenience of staff, the system went live in August.

Was Not Brought is being increasingly referred to in order to describe children not brought to appointments by parents or carers. Having tried unsuccessfully to introduce it within YTHFT, we presented a paper to the Children and Young People's Board. It was greeted with enthusiasm and a determination to recognise that children not attending at appointments have done so largely because they were not brought. A pathway has been ratified at the Operational Governance group and will now be shared across directorates. SNS will alter templates to assist in decision making and recording. Standard letters will reflect our commitment to consider the impact on the child of not being brought to an appointment.

We have received notification that the Trust will be part of a City of York Joint Targeted Area Inspection (JTAI). These are carried out jointly with CQC, OFSTED, National Probation Service and Her Majesty's Inspectorate of Constabulary and Fire And Rescue Services. This one is the first in the country to focus on Sexual Abuse in a Family Environment.

As with previous inspections we are required to submit policies, guidelines and procedures in addition, a number of cases for tracking. The review will take place over 2 weeks w/c 17 & 24th September when site visits to ED, Sexual Health Services and Maternity and Childrens services are likely. An update and any high level feedback will be given to the Board in due course.

On Friday, City of York local authority will put forward between 5 and 7 cases for tracking. We will have until close of business on Monday to complete chronologies for any children where we have had involvement. The chronologies will be for a period no longer than 6 months.

The Safeguarding Children Team continue to play an active role in the work of the local safeguarding children boards and the local network of health partners. We have had early discussions with partners re the use of tablets to capture information from Initial Health Assessments both for professionals and children.

### 2.3.4 Safeguarding Adults Update

The Mental Capacity (Amendment) Bill was introduced to the House of Lords on Tuesday 3 July 2018 and seeks to replace the current system known as 'Deprivation of Liberty Safeguards' (DoLs) which is assessment currently carried out on people who do not have the mental capacity to make their own decisions about their care, for example because they are living with dementia. It was criticised by a 2017 Law Commission review for being too complex and bureaucratic.

The government has now developed a new system, known as 'Liberty Protection Safeguards', which will become law through the bill.

The reforms seek to:

- introduce a simpler process that involves families more and gives swifter access to assessments
- be less burdensome on people, carers, families and local authorities
- allow the NHS, rather than local authorities, to make decisions about their patients, allowing a more efficient and clearly accountable process
- consider restrictions of people's liberties as part of their overall care package
- get rid of repeat assessments and authorisations when someone moves between a care home, hospital and ambulance as part of their treatment

The safeguarding adult's team will monitor the progress of the bill for impact on Trust processes and report through usual governance arrangements.

In March 2018, Safeguarding Ward packs were launched and to support these, the bitesize training programme began. The safeguarding adult's team have begun an audit of the training and the pack.

Early indications are that whilst there is increased awareness from nursing staff, in some cases mental capacity considerations are still not being documented appropriately. The key area of concern is the documentation regarding capacity in making medical decisions proposed by Doctors. This has been with the Medical Director and Director of Patient safety.

The local commissioning groups are now responsible for coordinating Learning Disabilities Mortality Review (LeDeR), reviews for patients who have died and have a learning disability. They have convened monthly "panel" meetings to review the cases submitted

and monitor actions from completed reviews. These will be fed into to the Trust Mortality review Groups.
The Trust continues to work in partnership with multi-agencies as per the Multi-agency safeguarding adults policy and procedures.

Safeguarding Adults Multi-agency policy and procedures have now been amended. The Trust Safeguarding Policy has now been reviewed to mirror the amendments.

## 3. Detailed Recommendation

The Board is asked to note the Chief Nurse report for September.

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Director of Infection & Prevention Annual Report

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

## Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

## Purpose of the Report

The Director of Infection Prevention Control annual report is to provide the board with IPC incidence for the year 12017-18. Identify key risks and give assurance around the keep workstreams of the IPC team to reduce risk of HCAI to patients.

In addition, to outline the proactive work undertaken to improve quality and safety.

## Executive Summary – Key Points

In year 2017-18 there were 45 cases of *C.difficile* infection, against a target of 48.

There were 39 MSSA bacteraemias (target 30) and 4 MRSA bacteramias (zero tolerance) – these represent an improvement compared with 2018-19, and work will continue to reduce these rates in 2018-19.

There were 87 *E. coli* bacteraemias, unchanged from last year. Work is ongoing to identify and address underlying causes.

2017-18 has seen success in:

- The management of influenza and formation of a cohort ward
- Meeting the C. difficile target
- Reduction in Surgical Site Infection rates in Bridlington hospital
- A late improvement in Staph. aureus bacteraemia rates
- Restructuring of the team and increasing engagement of staff across the organisation with the Infection Prevention agenda.

Challenges remain moving into 2018-19.

- MRSA and MSSA bloodstream infection rates remain high, but alongside the work of the S. aureus bacteraemia group, may be improved with
- Increasing compliance with aseptic non-touch technique training and use, especially in junior medical staff.
- Improving central line care pathways

Ageing infrastructure, including decontamination equipment and the fabric and layout of some clinical areas, increases opportunities for organisms to persist in the environment and can make maintenance of hygiene practice standards more difficult.

Focus on maintaining a clean environment will be needed to minimise the infection risk to service users.

Recommendation

Board of Directors is asked to receive the DIPC annual report for information; and to note the progress and challenges.

Author: Dr. Katrina Blackmore, Deputy Director of Infection Prevention Control

Director Sponsor: Beverley Geary, Chief Nurse & Director of Infection Prevention Control

Date: September 2018

York Teaching Hospital NHS
NHS Foundation Trust

# Director of Infection Prevention and Control

# Annual Report

# 2017-2018

| | |
|---|---|
| Author: | Dr Katrina Blackmore, Deputy Director Infection Prevention and Control |
| Owner: | Beverley Geary, Director of Infection Prevention and Control |
| Governance: | Presented to Quality and Safety Committee and Board of Directors |
| Date of Report: | September 2018 |

# 1. Executive Summary

Mandatory surveillance

There were 45 cases of *C.difficile* infection, against a target of 48.

There were 39 MSSA bacteraemias (target 30) and 4 MRSA bacteramias (zero tolerance) – these represent an improvement compared with 2018-19, and work will continue to reduce these rates in 2018-19.

There were 87 *E. coli* bacteraemias, unchanged from last year. Work is ongoing to identify and address underlying causes.

Orthopaedic surgical site infection

Continuous surveillance for total hip and total knee replacement has been undertaken since April 2017, following concerns regarding high infection rates in Bridlington hospital. An external review, and implementation of an action plan, has led to reduction in infection rates to below the national benchmark. Rates are higher in York, and work is ongoing to replicate the action plan on the York site.

Influenza

The winter season saw a high rate of winter respiratory viruses. Rapid local virus testing supported early diagnosis, and facilitated isolation or cohort nursing. On the York site, ward 23 became an influenza cohort ward, facilitating focused staff training and reducing side room pressures. Planning for next winter is underway to build on this work across York and Scarborough.

Antimicrobial Stewardship

CQUIN targets – A greater than 1% reduction in total antibiotic and Piperacillin-tazobactam consumption was met. This was not met for carbapenem use – this is challenging as the trust is a low user of carbapenems.

Since introduction fo EPMA in York, 100% compliance has been achieved for recording indication as this is mandated – however there has been a drop in recording of duration.

Cleaning services

An independent cleanliness monitoring team has been established, working with the 'Synbiotix' system. Its use will become established in 2018-19.

There have been significant challenges across the Trust with respect to domestic vacancies. This makes maintaining a clean and safe environment challenging, increasing the risk of infection transmission through persistence in the environment.

Hydrogen peroxide vapour (HPV) is used to disinfect sealed clinical areas, use has continued following discharge of patients with high risk infections (eg. *C. difficile*). We continue to try to implement a proactive HPV programme.

Decontamination

The Decontamination Steering group (DSG)successfully implemented the audit and surveillance programme, monitoring and acting on findings to improve processes and maintain compliance with the NHS Premises Assurance Model.

Investment is needed in the internal fabric and fixtures and fittings of the Sterile Services unit at the York Hospital site.

Sterilization and disinfection equipment is ageing and at risk of failure. A 10 year equipment replacement programme has been approved and will be monitored and supported by the DSG.

Aseptic Non-Touch Technique (ANTT)

At the end of 2017-18, compliance with newly mandated practical sign off for medical and dental staff is 4%, and 53% for nursing and midwifery staff. 89% of required staff have undertaken e-learning.

Conclusion and Recommendations

2017-18 has seen success in:

- The management of influenza and formation of a cohort ward
- Meeting the C. difficile target
- Reduction in Surgical Site Infection rates in Bridlington hospital
- A late improvement in Staph. aureus bacteraemia rates
- Restructuring of the team and increasing engagement of staff across the organisation with the Infection Prevention agenda.

Challenges remain moving into 2018-19.

MRSA and MSSA bloodstream infection rates remain high, but alongside the work of the S. aureus bacteraemia group, may be improved with

- Increasing compliance with aseptic non-touch technique training and use, especially in junior medical staff.
- Improving central line care pathways

Ageing infrastructure, including decontamination equipment and the fabric and layout of some clinical areas, increases opportunities for organisms to persist in the environment and can make maintenance of hygiene practice standards more difficult.

Focus on maintaining a clean environment will be needed to minimise the infection risk to service users.

## 2. Infection Prevention arrangements

Standards in Infection Prevention are set and guided by:

- The Health and Social Care Act 2009: Code of Practice on the Prevention and Control of Healthcare Associated Infections and Related Guidance
    - (The Hygiene Code)

- The NHS Commissioning Board, Everyone Counts 2013/14
- Monitor Licence – No: 130145 Issued 1/4/13 Version 2
- Monitor Risk Assessment Framework 2014/15
- CQC Registration CRT1 – 480230002 Issued 21/9/12
- NHS Outcomes Framework 2014/15 Domain 5
- Relevant DH Guidance and Recommendations
- NICE Infection and Prevention and Control Quality Standard 61, 2014
- Epic 3: National Evidence Based Guidelines for Preventing Healthcare Associated Infection in NHS Hospitals in England

In November 2017, the Infection Prevention nursing team underwent restructuring.

The new structure comprises:

Director for Infection Prevention and Control (DIPC) – Chief Nurse
Lead Nurse for Infection Control – Band 8A,(Vacant at time of report)
Specialist nurse – Band 7 x 3wte.
Specialist nurse – Band 6 x 3wte.
Staff nurse – Band 5 x 1wte.
Associate practitioner – Band 4 x 2wte.
Administrative assistant – Band 3 x 1wte.
Clerical officer – Band 2 x 1wte

The Infection Prevention nursing team work alongside the Consultant Microbiologists/ Infection Prevention doctor team
Katrina Blackmore (Deputy DIPC/ Decontamination)
Dave Hamilton (Microbiology Clinical Lead)
Damian Mawer (Infection Prevention Doctor)
Barry Neish (Water safety)
Neil Todd (Antimicrobial lead/ Ventilation)

The Trust Infection Prevention Steering Group provides oversight of Infection Prevention arrangements (Summary of Governance – Appendix 1). Full governance structure in appendix 2.

The DIPC has presented the following reports to the Quality and Safety committee and Trust Board during 2017/18:

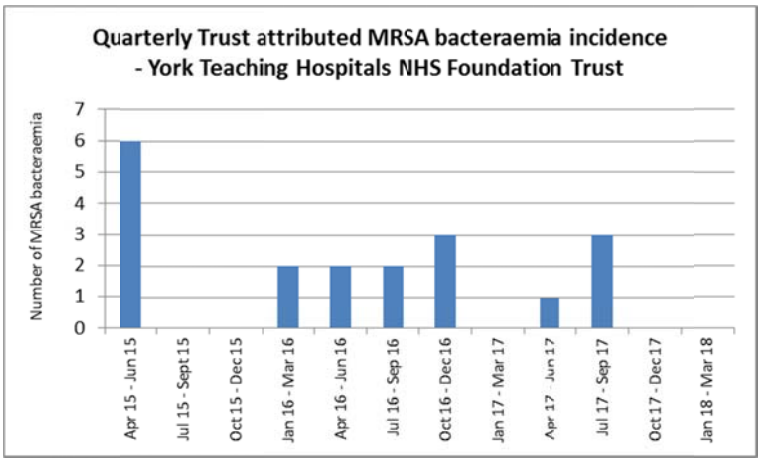
Quarterly DIPC reports
Annual DIPC report 2016/17
Monthly dashboards – mandatory surveillance reports
Infection Prevention risks on Corporate risk register

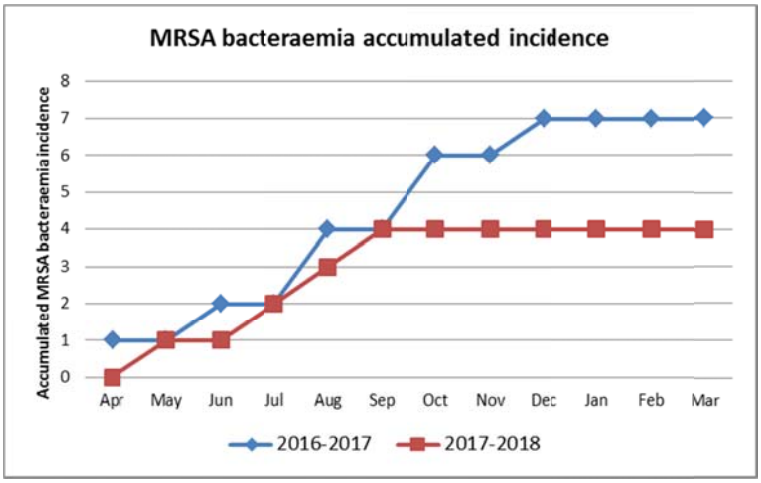
## 3. Mandatory reporting of Healthcare Associated Infection

In 2017-18, it was mandatory for trusts to report MRSA, MSSA and E. coli bloodstream infections (bacteraemias), and *C. difficile* toxin cases, to Public Health England.

In 2018-19, reporting of other Gram negative bloodstream infections will also be mandatory, although the Trust has been reporting these voluntarily since April 2017.

### 3a. Meticillin resistant *Staphylococcus aureus* (MRSA)



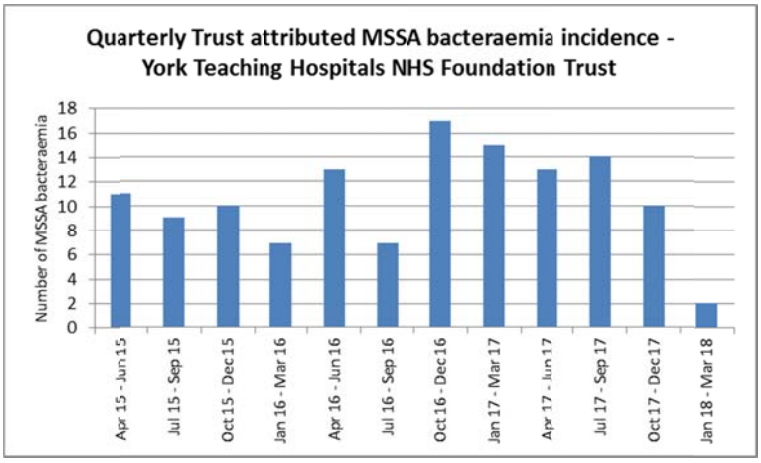



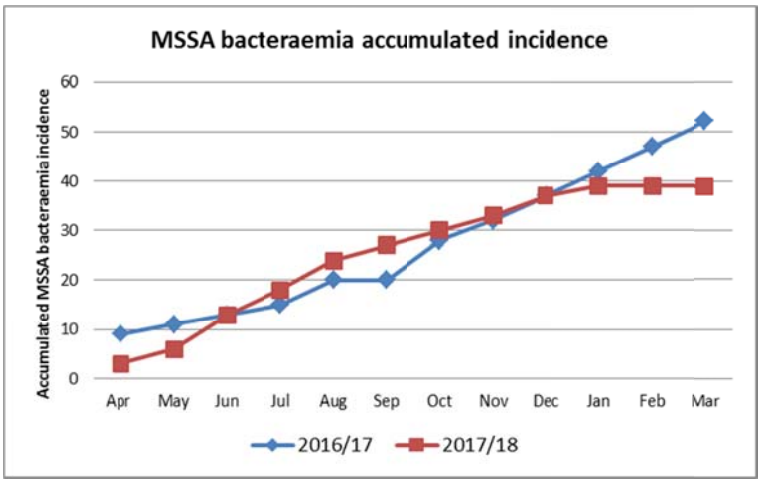

There were four Trust attributed MRSA bacteraemias, against a 'zero tolerance' target. Two were in a single patient, and two were thought to be contaminants.

Post infection review was held for all cases, and work is ongoing locally and across the trust to reduce risk of device related infection and blood culture contamination rates led by the MSSA bacteraemia reduction group.

| MRSA bacteraemia issues identified through Post Infection Review - 2017 to 2018 | | |
|---|---|---|
| **Case** | **Date** | **Issues identified** |
| Case 1 | 02-May-17 | Cannula related sepsis |
| Case 2 | 29-Jul-17 | Admission specimen but probable infection at pacemaker site secondary to infected cannula site (see case 1) therefore attributed to Acute Trust |
| Case 3 | 01-Aug-17 | Contaminated admission specimen taken in Emergency Department Scarborough Hospital |
| Case 4 | 29-Sep-17 | Contaminated specimen. |

### 3b. Meticillin susceptible *Staphylococcus aureus* (MSSA)



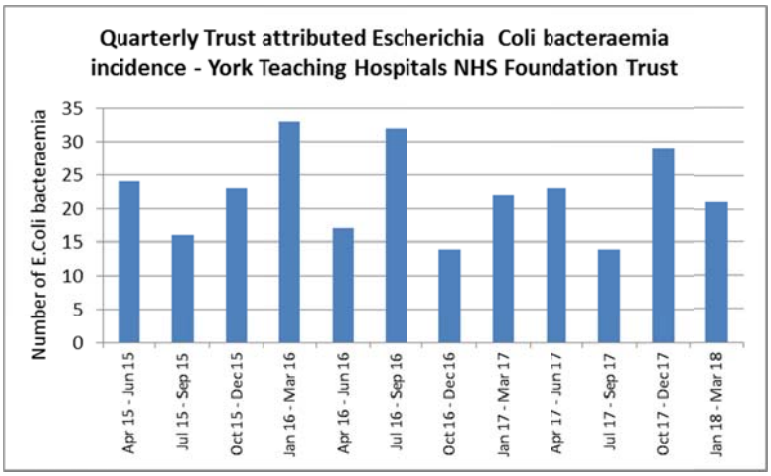



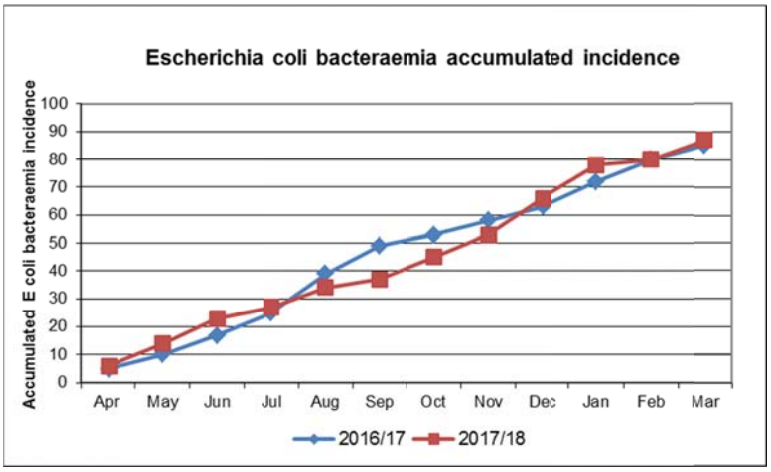

MSSA bacteraemia rates were similar to 2016/17 until Q4 when a reduction was noted, with a final total of 39 against a target of 30. The Staph aureus bacteraemia reduction group are working on a number of initiatives, to be introduced in 2018/19, which aim to further reduce the rate. These include: introduction of non-ported cannulas and cannula insertion packs, more regular monitoring of cannula sites, better documentation of cannula insertion and removal, reducing unnecessary cannulation of patients in

Emergency Departments, and introducing a flyer for patients with advice about their cannula. The group is also supporting a business case from Dermatology for a band 6 outreach nurse who will review chronic wounds / ulcers on the ward and provide support and education to nurses around appropriate dressings.

### 3c. *Escherichia coli* bacteraemia

There is a 50% reduction target for healthcare associated *E. coli* bacteraemia across the healthcare economy between 2017 and 2021, set as a CCG Quality Premium. The data presented are for cases defined as 'hospital onset'.




Microbiology notes and medical investigations were reviewed to identify an infection source for hospital onset *E coli* bacteraemias. The following were the most probable causes:

| | |
|---|---|
| Urosepsis | 24 |
| Catheter urosepsis | 15 |
| Biliary source | 13 |
| Other (wound, chest sepsis) | 7 |
| Unknown (no clear source, no investigations, patient died) | 27 |

A microbiologist and IPN reviewed full medical records for a smaller sample, to gain an understanding of recurring contributory factors in patients with *E. coli* bacteraemia in hospital onset cases. A number of themes were identified and actions to address these Include:

The team liaising with the CCG Infection Prevention leads to consider ways of introducing wider health economy solutions where recurring problems are identified.

A Trust clinical improvement project piloted a scheme to use coloured jug lids to assess oral fluid intake in inpatients and identify those who are not drinking sufficiently in hospital.

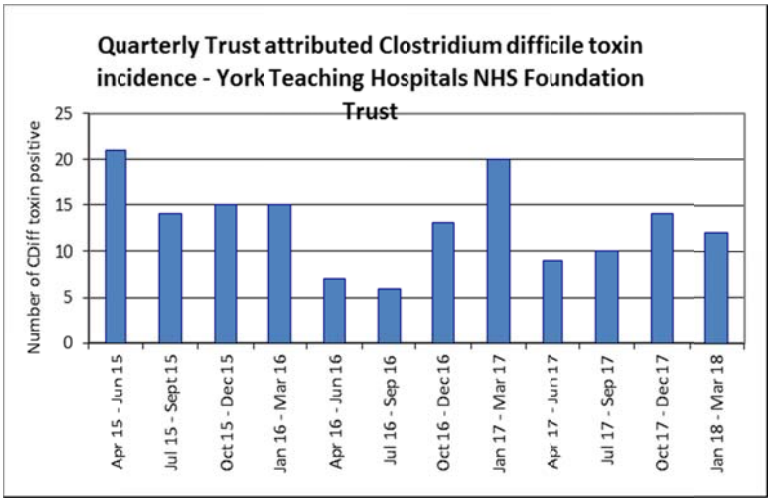
The catheter care pathway is to be added to CPD nursing investigations so that the paper copies can be discontinued. This will enable electronic reminders to staff to ensure regular reviews are documented, and audits to be undertaken to assess compliance. The move to CPD is dependent on the IT development team to complete.

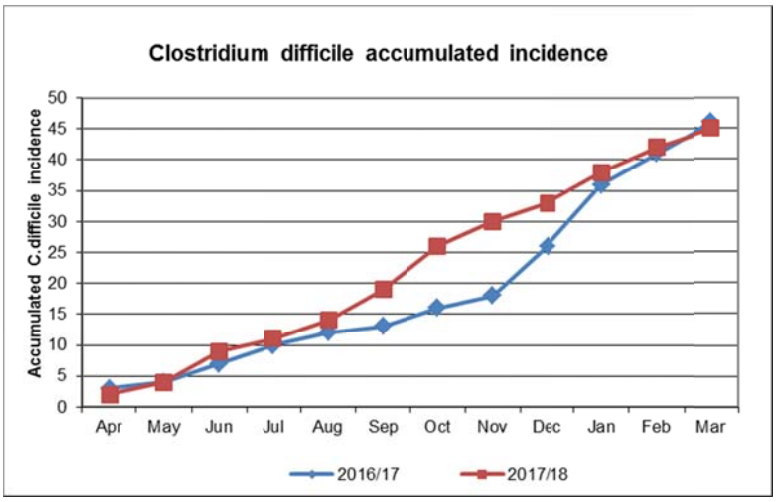
**3d. *Clostridium difficile***

The trust Trajectory for 2017 – 2018 was 48 cases of hospital acquired *C. difficile.* Our final total for the year was 45.
Following C difficile Post Infection Review meeting, and discussion with the CCG, it was agreed that 21 of these cases the trust had no lapses in care that had contributed to the patient acquiring *Clostridium difficile*.

When the lapses in care did occur, themes identified were:

- **Antibiotic prescribing:** EPMA was introduced at the end of 2017. This should make antibiotics easier to manage from a trust perspective.
- **Environmental concerns**: It was identified that a number of wards were looking tired and need refurbishment. These were highlighted as priority for refurbishment in summer of 2018.
- **Staffing issues**: Shortage of nursing staff is a continuous theme. The trust is managing this by ongoing recruitment campaign.
- **Hand Hygiene:** Bespoke hand hygiene training was undertaken in areas where it was identified hand hygiene scores were low.






## 4. Audit and surveillance

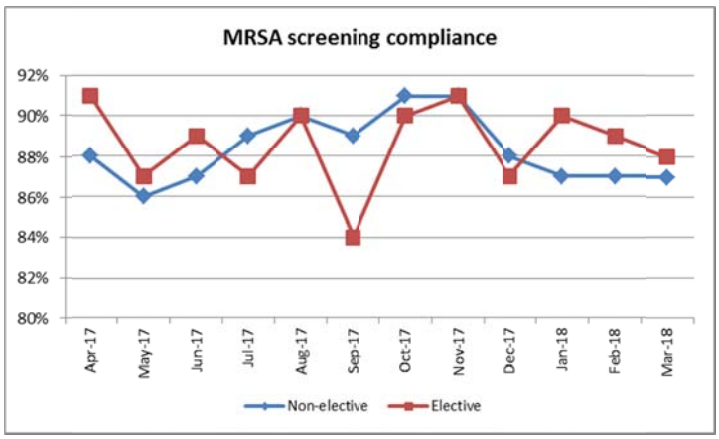
### 4a. CPE (Carbapenemase producing enterobacterales)

There were no Trust attributed cases of CPE identified.

These multi-drug resistant organisms continue to present a threat to patients and healthcare organisations in the UK and worldwide. Work continues to identify and screen possible carriers. Precautions are taken to prevent onward transmission from possible or confirmed carriers, in line with local and national guidance.

### 4b. MRSA screening

The directorate and ward compliance percentages for elective and non-elective MRSA screening were added to the Infection Prevention dashboards in March 2018 and will be included each month in future dashboards. In March 2018 IPNs met with areas with poor compliance to educate staff in understanding the reasons for MRSA screening and patient safety, identify barriers to taking screens and promote improvement in both elective and non-elective screening compliance.



## 4c. Surgical Site Infection - orthopaedics

Following concerns regarding higher than expected surgical site infection rates following arthroplasty in Bridlington hospital, work was initiated to ensure compliance with best practice standards, culminating in a visit and report from Professor Mike Reed early in 2017.

During 2017-18, a working group was formed to implement the recommendations from Professor Reed. Actions include:

- Post Infection review (PIR) of all SSI cases
- Continuous SSI surveillance
- Pre-operative optimisation
- Roll-out of Methicillin –susceptible Staph. Aureus (MSSA) screening and decolonisation
- Active warming to ensure normothermia

These recommendations are also being rolled out onto the York site

Continuous surgical site infection surveillance following Total Hip Replacement (THR) and Total Knee Replacement (TKR) surgery from April 2017, using the Public Health England (PHE) Surgical Site Infection Protocol (SSISS). This was the first year that the trust has participated in the scheme for all total hip and knee replacement surgery, but numbers of identified infections were higher in 2016-17.

| **Primary surgery** | Annual 2017/18 | Annual 2017/18 | Annual 2017/18 | Annual 2017/18 |
|---|---|---|---|---|
| | Trust to date | BRIDLINGTON | YORK | SCARBOROUGH |
| Number of THR and TKR primary operations | 1043 | 575 | 412 | 56 |
| Number of SSI | 6 | 1 | 4 | 1 |
| Percentage SSI against operations | 0.58% | 0.17% | 0.97% | 1.79% |

| **Revision surgery** | Annual 2017/18 | Annual 2017/18 | Annual 2017/18 | Annual 2017/18 |
|---|---|---|---|---|
| | Trust to date | BRIDLINGTON | YORK | SCARBOROUGH |
| Number of THR and TKR revision operations | 291 | 116 | 156 | 19 |
| Number of SSI | 4 | 1 | 3 | 0 |
| Percentage SSI against operations | 1.37% | 0.86% | 1.92% | 0.00% |

The national benchmark for surgical site surveillance rates is 0.6% for primary THR and TKR surgery and 1.3% (hip) and 1.4% (knee) for revision surgery. Any infection that occurs up to one year post surgery would meet the inclusion criteria set by PHE, so final figures remain subject to change. The patients will be assessed at one year using CPD and laboratory database records.

## 5. Serious Incidents

In 2016 an number of colonisations of MRSA were found on screening in the Special Care Baby Unit om the York site. Action taken as a result

- Deep clean and minor works programme initiated
- Admission and weekly MRSA screening were initiated for all babies on SCBU following the 2016 outbreak.
- There were three cases of colonisation with the outbreak strain over the period April 2017- March 2018, with no clinical infections
- These are sporadic cases developing with babies presenting as positive further into their hospital stay.
- The situation still being monitored and the Infection Prevention Team continue to work closely with SCBU. Public Health England have also provided assistance and guidance.

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### Influenza

The 2017 winter season saw the highest number of influenza cases across the organisation since the “swine flu” pandemic of 2009-10, reflecting the national picture. There were also been high numbers of other winter respiratory viruses (see graphs below).

The trust took a co-ordinated response to the epidemic. A new laboratory testing system for respiratory viruses was introduced in November 2017. This supported the earlier identification of respiratory virus cases, which helped ensure better use of side rooms, reduced the spread of these infections on the ward and facilitated more rapid treatment of patients.

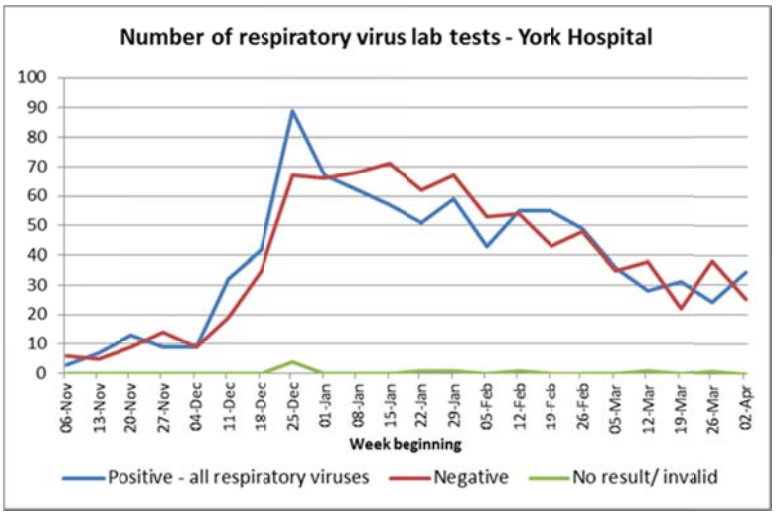
The Infection Prevention team worked closely with the Patient Flow and Operations teams at both sites to ensure identification and appropriate placement of patients with influenza and other respiratory viruses. In York ward 23 became a cohort ward for three months, during which they cared for more than 300 patients with respiratory viruses (mostly influenza). Concentrating cases on one ward ensured better care for patients and reduced the risk of transmitting the infection to other, vulnerable service users.

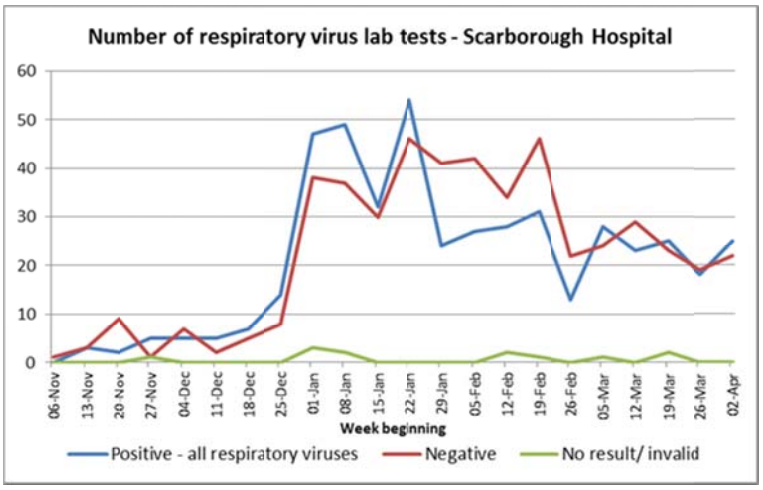
The Infection Prevention team also worked with community partners and the communications team to ensure dissemination of important public health messages around influenza.

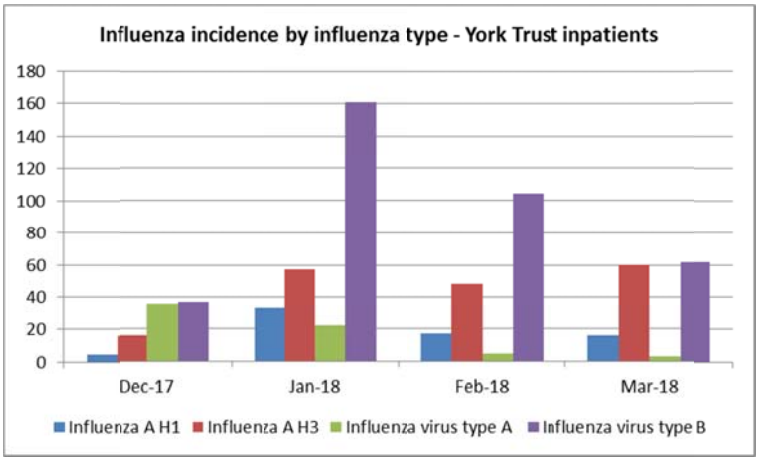
Despite this work there were a number of outbreaks of influenza around the organisation, including on Ward 39 Johnson Ward, Scarborough hospital CCU, Oak

Ward and St Helens due to transmission of the virus between patients. The most serious outbreaks were on Ann Wright ward, which had three in total. An SI investigation was undertaken for the first two outbreaks, the main findings of the investigation was that the 'Nightingale' layout of the ward, with patients in close proximity and no physical barriers (doors) between them, facilitated direct spread of virus between patients and made infection prevention very challenging for staff. The vulnerability of the frail and elderly patients on the ward exacerbated the situation. Scarborough hospital board has been asked to consider housing lower risk patients on Ann wright this coming winter.

There have also been closures of Ward 39, Johnson Ward, Scarborough hospital CCU, Oak Ward and St Helens due to respiratory virus transmission between patients.






**Viral gastroenteritis**

There were 12 full ward or unit closures due to suspected or confirmed norovirus, with a total of 75 days of full ward closure. This was a lower burden than previous years, and control measures prevented spread between wards

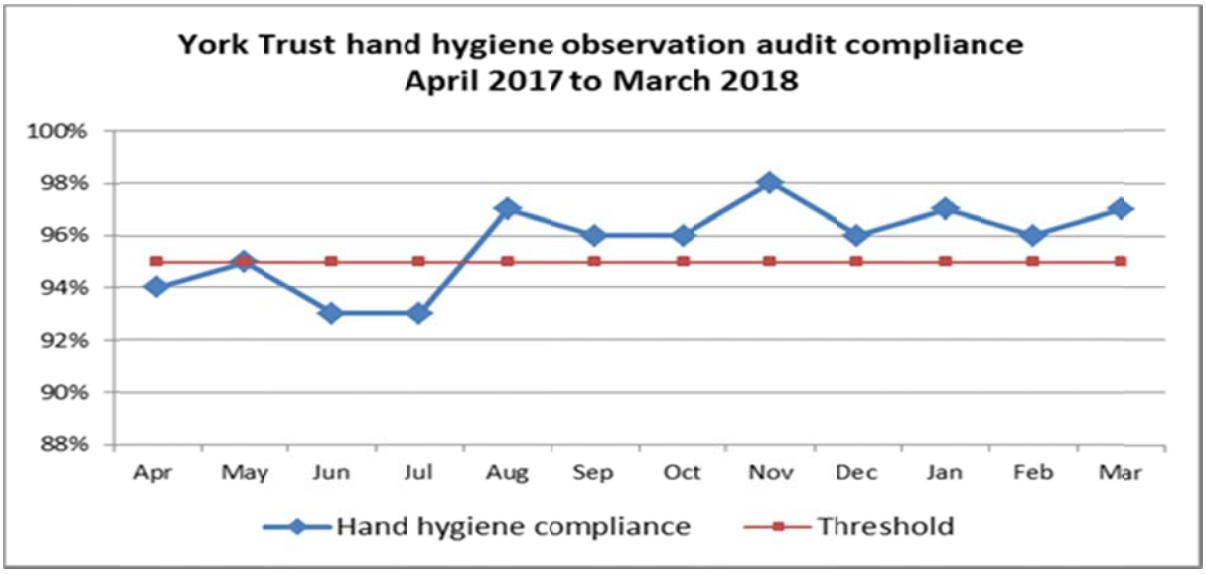
## 6. Preventing Healthcare associated infection

Hand hygiene

Monthly hand hygiene audits are carried out by clinical teams in all areas.

From April to July, audit scores fell below the 95% target, increasing to over 95% from August onwards. A number of interventions supported this improvement.

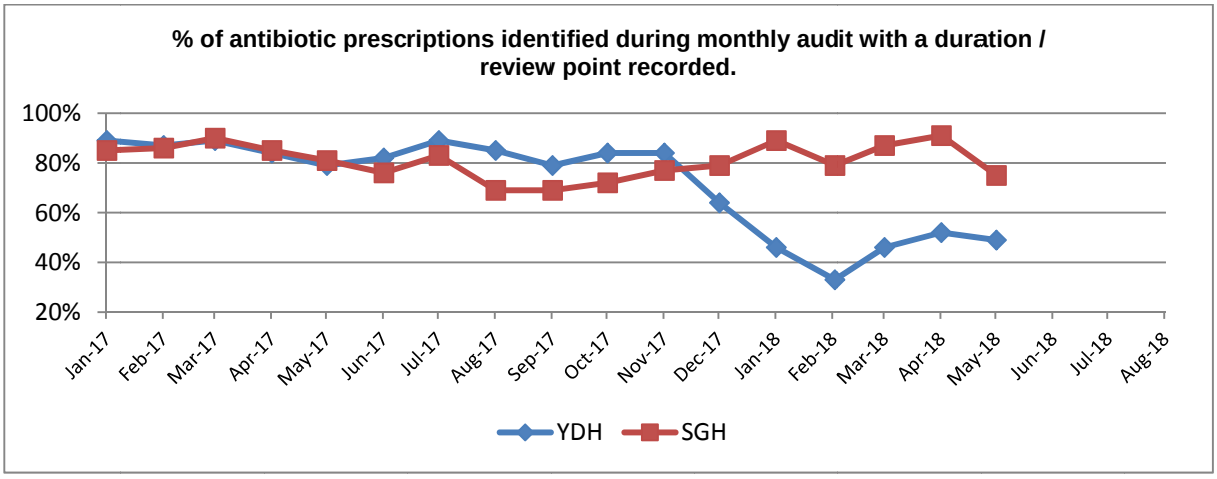
- Hand hygiene day 5th May across all sites working with Matrons helped to raise awareness and focus the importance of Hand hygiene.
- The hand hygiene policy was launched in April 2017, with an educational programme led by the Infection Prevention Team to engage ward staff at all levels, across acute and community sites. Ward managers now take responsibility for completing and acting on audit results within their clinical areas. This intervention has been followed by an improvement in hand hygiene audit scores.
- New hand hygiene signage was rolled out across sites.
- For community staff who are not observed as part of routine hand hygiene audits, an annual competency assessment was designed as an alternative compliance measurement.
- Opportunistic observation of hand hygiene, and challenge where necessary, by the Infection Prevention nurses is ongoing.
- The fall in compliance in June and July was addressed by individual areas and action planned.




## 7. Antimicrobial prescribing

Monthly antimicrobial audits in Scarborough have continued to show adherence to the prescribing standards which are as follows:

- All antimicrobial prescriptions shall have an indication recorded on the prescription
- All antimicrobial prescriptions shall have a duration or review date recorded on the prescription



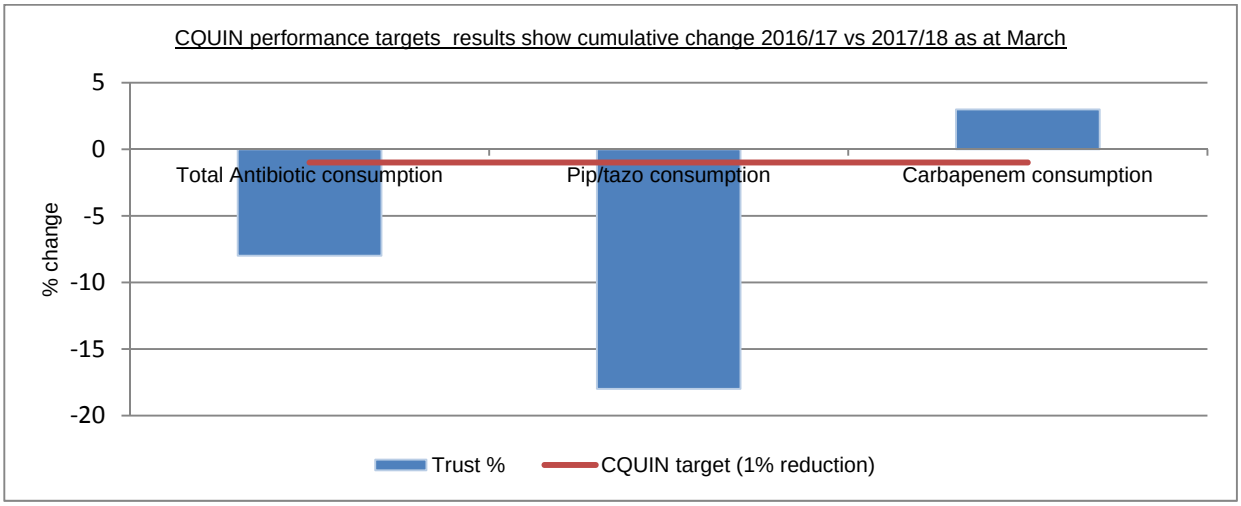

In York EPMA was introduced between October and November. In EMPA the indication is a mandatory field and so there is 100% compliance for that although some prescriptions have the indication of micro advice which is not a proper indication. Unfortunately there was a large drop off in recording either a review or duration beyond what is automated by the system.

There has been some reduction in the recording of the duration/review date on antimicrobial prescriptions. Results for individual directorates are shared with the

Clinical Directors and they are asked to encourage all staff to record indication and review dates on prescriptions. This is reinforced by pharmacy staff on the wards.

Last year there was a national antimicrobial stewardship CQUIN. This CQUIN had two parts; the first was aimed at reducing total antibiotic consumption and also consumption of certain broad-spectrum antibiotics by 1% whilst the second part focusses on antimicrobial stewardship and ensuring antibiotic review within 72 hours.

The CQUIN to reduce antimicrobial consumption is to continue for 2017/19 and an action plan is being drawn up to work towards these targets. Figures from quarter 1 show we have achieved a greater than 1% reduction in pip/tazo and total use of antibiotics has increased however the volume of carbapenems has increased.




The indicators for the new financial year 18/19 have changed. The pip/taz indicator has been dropped and replaced with a new indicator which is aimed at the total antibiotic prescribing being greater than 55% from the WHO access group of antibiotics. The trust already achieves in excess of 61%. The carbapenem prescribing is an even greater challenge of reducing by 3% given that we are very low prescribers of carbapenems.

Weekly antimicrobial stewardship ward rounds which include members of the pharmacy antimicrobial team together with microbiology consultants/registrars have proved very successful in reviewing inpatient antibiotic prescriptions and this ties in well with our new national CQUIN. Work continues to write and update prescribing guidance. We have recently issued new adult and paediatric and adult treatment poster. The Trust is also enrolled in the ARK study which is measuring whether including an intervention to grade the certainty the prescriber has about whether the patients has an infection i.e. whether it is possible or probable. The aim of this is to give the reviewer the confidence to stop or switch the antibiotics or decide on a new review date. This concept is very much in line with the review part of the CQUIN. If this is successful this will be rolled out to other areas of the Trust.

## 8. Infection prevention Policies

The relaunched Infection Prevention policies and procedures group oversees the writing, review, stakeholder consultation and update of policies to comply with local and national requirements.

## 9. Training and Education

The Infection prevention team face to face training for some staff groups required the depth of content to be revised and pitched at a suitable level, particularly for staff working in clinical areas. It was also identified that the e-learning was not aligned with the face to face training as required by the trust's Corporate Learning and development (CLaD) team; and there was no specific e-learning package for community staff to access.

The driving force for the infection prevention team in making improvements and progress was through working in collaboration with CLaD, Training developers in learning technologies, and Community Leads.

Four new e-learning packages have been developed and published on the learning hub. These include the Clinical, Non-clinical, Allied Health professionals, and Community e-learning packages. All the e-learning has been aligned to the face to face training respectively; with the content revised to suite staff levels based on clinical and non-clinical duties that they undertake. The community e-learning and face to face training have been developed specifically for community staff.

**Aseptic Non-Touch Technique (ANTT)**

The main objectives were to improve completion and compliance rates through provision of ANTT training to community staff; and to incorporate ANTT assessment tools into Objective Structured Clinical Examination (OSCEs) for the Clinical Development Team (CDT) and Continence teams' clinical procedures.

There was a very low percentage of ANTT practical completion rate in the community. It was acknowledged that ANTT training for community staff posed some challenges because of lone working where peer assessment was not always possible.

Community Leads played a fundamental role in organising groups of community staff to be trained in ANTT by members of the infection prevention team. Groups of community staff in four different community localities were trained in practical ANTT between November 2017 and March 2018.

It was also recognised that there was need to standardise ANTT assessment between that used for ANTT training and the OSCEs for clinical procedures held by CDT and the continence team across the trust.

By working closely with CDT and the continence team, ANTT assessment tools for various procedures were developed by the infection prevention team and amalgamated into the OSCEs for clinical procedures.

The ANTT assessment tools have also been placed on Staff Room for easy accessibility by ANTT assessors in both clinical and community settings.

### Training and Education

Information below shows % compliance 2017/18 of staff for whom IP is required learning

- IP Level 1 – 18938 (88%)
- IP Level 2 – 14773 (91%)
- IP ANTT theory – 12646 (89%) figures for practical for first quarter included with theory
- IP ANTT practical - 3147 (29%) figures for quarters 2, 3 and 4

The breakdown below demonstrates that at the end of quarter 4, having been made mandatory, only 4% of medical and dental staff, and 53% of nursing and midwifery staff had completed ANTT practical sign off. Improving compliance, and assurance around the use of aseptic technique when undertaking procedures, is an important area for improvement in 2018-19.

**End of Q4 ( April 2018)**

| | IPC L1 | | | IPCL2 | | |
|---|---|---|---|---|---|---|
| **Staffgroup** | **Staff required to complete** | **Staff Completed** | **% Compliant** | **Staff required to complete** | **Staff Completed** | **% Compliant** |
| **Add Prof Scientific and Technic** | 213 | 195 | **92%** | 88 | 83 | **94%** |
| **Additional Clinical Services** | 2136 | 1845 | **86%** | 73 | 73 | **100%** |
| **Administrative and Clerical** | 1920 | 1772 | **92%** | 10 | 9 | **90%** |
| **Allied Health Professionals** | 2 | 2 | **100%** | 642 | 611 | **95%** |
| **Estates and Ancillary** | 959 | 772 | **81%** | | | |
| **Healthcare Scientists** | 214 | 201 | **94%** | | | |
| **Medical and Dental** | 19 | 17 | **89%** | 751 | 623 | **83%** |
| **Nursing and Midwifery Registered** | 9 | 5 | **56%** | 2501 | 2335 | **93%** |

| | ANTT Theory | | | ANTT Practical | | |
|---|---|---|---|---|---|---|
| **Staffgroup** | **Staff required to comple** | **Staff Completed** | **% Compliant** | **Staff required to comple** | **Staff Completed** | **% Compliant** |

| | te | | | te | | |
|---|---|---|---|---|---|---|
| **Add Prof Scientific and Technic** | 88 | 81 | **92%** | 83 | 34 | **41%** |
| **Additional Clinical Services** | 77 | 75 | **97%** | 73 | 28 | **38%** |
| **Administrative and Clerical** | | | | | | |
| **Allied Health Professionals** | 225 | 215 | **96%** | | | |
| **Estates and Ancillary** | | | | | | |
| **Healthcare Scientists** | | | | | | |
| **Medical and Dental** | 751 | 625 | **83%** | 393 | 17 | **4%** |
| **Nursing and Midwifery Registered** | 2493 | 2264 | **91%** | 2389 | 1267 | **53%** |

## 10. Conclusion and Recommendations

2017-18 has seen success in:

- The management of influenza and formation of a cohort ward
- Meeting the C. difficile target
- Reduction in Surgical Site Infection rates in Bridlington hospital
- A late improvement in S. aureus bacteraemia rates
- Restructuring of the team and increasing engagement of staff across the organisation with the Infection Prevention agenda.

However, challenges remain moving into 2018-19 which will need consideration and integration into the annual workplan.

MRSA and MSSA bloodstream infection rates remain high, but alongside the work of the S. aureus bacteraemia group, may be improved with

- Increasing compliance with aseptic non-touch technique training and use, especially in junior medical staff.
- Improving central line care pathways

Ageing infrastructure, including decontamination equipment and the fabric and layout of some clinical areas, increases opportunities for organisms to persist in the environment and can make maintenance of hygiene practice standards more difficult.

Focus on maintaining a clean environment will be needed to minimise the infection risk to service users.

## 11. Contributing authors

**Infection Prevention team:**
Damian Mawer – Consultant Microbiologist/ Infection Prevention Doctor
Astrida Ndhlovu – Advanced Specialist Nurse
Anne Tateson – Advanced Specialist Nurse
Louise Dalby – Advanced Specialist Nurse
Jane Balderson – Specialist Nurse/ Surveillance
Annette Williams – Specialist Nurse
Lynn Stokes – Specialist Nurse
Gillian Leonard – Administrative assistant

**Antimicrobial stewardship team:**
Anita Chalmers – Lead Antimicrobial pharmacist

York Teaching Hospital NHS
NHS Foundation Trust

# Trust Infection Prevention Steering Group:

# Summary of Governance

Version 2
April 2018

## York Teaching Hospital NHS Foundation Trust

## Trust Infection Prevention Steering Group:

## Summary of Governance

## Table of Contents

## Trust Infection Prevention Steering Group (TIPSG)

Terms of Reference

| | |
|---|---|
| **1** | **Status** |
| | The Trust Infection Prevention Steering Group (TIPSG) is a sub group of the Quality & Safety Committee. Any issues of concern will be escalated to the Executive Board and the Board of Directors by the Director of Infection Prevention and Control via the Trust Infection Prevention Steering Group. |
| **2** | **Purpose of the Group** |
| | To set the strategic direction in relation to Infection Prevention practice.<br>To ensure the Trust maintains compliance with the required Legislation and Guidance and to provide assurance to Board of Directors via the Quality & Safety Committee in relation to:<br><br>- The Health and Social Care Act 2009: Code of Practice on the Prevention and Control of Healthcare Associated Infections and Related Guidance (The Hygiene Code)<br>- The NHS Commissioning Board, Everyone Counts 2013/14<br>- Monitor Licence – No: 130145 Issued 1/4/13 Version 2<br>- Monitor Risk Assessment Framework 2014/15<br>- CQC Registration CRT1 – 480230002 Issued 21/9/12<br>- NHS Outcomes Framework 2014/15 Domain 5<br>- Relevant DH Guidance and Recommendations<br>- NICE Infection and Prevention and Control Quality Standard 61, 2014<br>- Epic 3: National Evidence Based Guidelines for Preventing Healthcare Associated Infection in NHS Hospitals in England |
| **3** | **Authority** |
| | The Quality & Safety Committee has provided delegated authority to the Trust Infection Prevention Steering Group to provide assurance around Infection Prevention across the Trust. |
| **4** | **Roles & Functions** |
| | The Trust Infection Prevention Steering Group function is to set the strategic direction and provide assurance on Infection Prevention practices and mitigation of risks to the Board of Directors.<br><br>To discuss and agree escalation of any risks that may be considered sufficiently significant as to need discussion at the Quality and Safety Committee or Executive Board.<br><br>To approve and oversee implementation of the Trust's Infection Prevention Strategy and Annual Plan. |

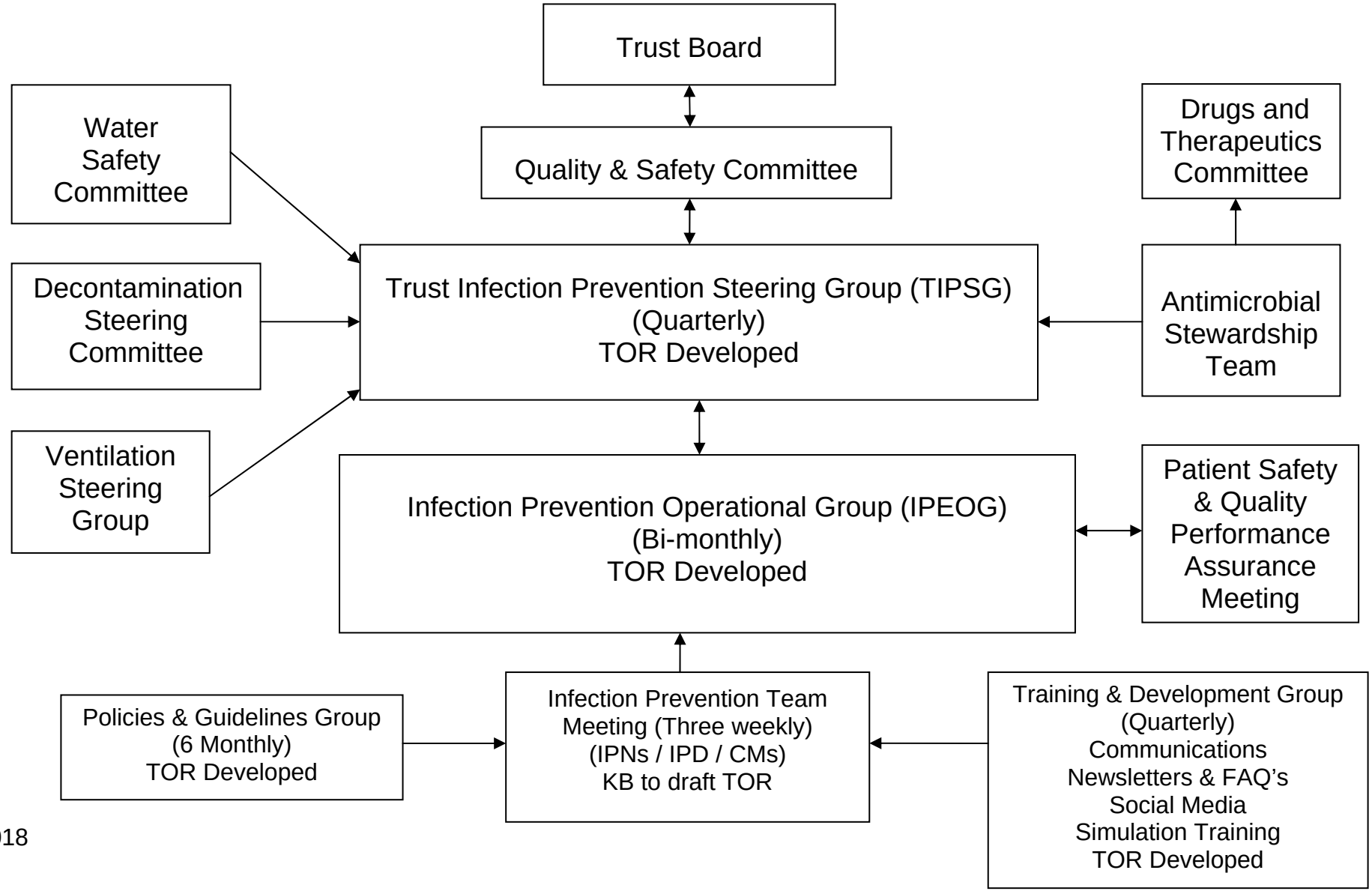
| | |
|---|---|
| | Advise the Trust on its statutory responsibilities in relation to Infection Prevention requirements under the assurance and regulatory frameworks outlined in 2.<br><br>Advise the Board of Directors on the accountability implications of the statutory requirements and regulatory frameworks through the Director of Infection Prevention and Control.<br><br>The Director of Infection Prevention and Control provide quarterly and annual reports to the Board of Directors and Executive Board as necessary for their consideration**.**<br><br>Provide expert advice and recommendations when variations in performance occur and manage the implementation of improvement strategies that are agreed.<br><br>In collaboration with internal audit approve the Trust Infection Prevention Audit programme for:<br><br>- NHS Outcomes Framework<br>- Policy Compliance<br>- Clinical Practice Standards<br>- The Clinical Environment<br><br>Advise the Trust on cleaning and environmental standards.<br><br>Advise the Trust on the designing in of infection prevention to Capital and minor works schemes.<br><br>With the Decontamination Lead, advise the Trust on decontamination standards.<br><br>In collaboration with the Risk and Legal Services Department, oversee the maintenance of the infection prevention and control risk register.<br><br>Provide advice and oversight from an infection control perspective with regard to the design and planning of community services.<br><br>To agree interventions for acceleration improvement initiations and receive updates on these to assure the Board of the safety of care delivered.<br><br>To agree recommendations for presentation to Board of Directors on any strategic Infection Prevention proposals.<br><br>To receive information on external strategic plans that impact upon Infection Prevention<br><br>To receive assurance from the Infection Prevention Operational Group.<br><br>Risk register management and to receive updates and exception reports. |
| **5** | **Membership** |

| | |
|---|---|
| | The membership of the Trust Infection Prevention Steering Group will comprise of representation from:-<br><br>• Deputy Chief Executive (Chair)<br>• Director of Infection Prevention & Control (Deputy Chair)<br>• Member of the Senior Operations Team – Melanie Liley<br>• Deputy Director of Infection Prevention<br>• Lead Doctor for Infection Prevention<br>• Lead Infection Prevention Nurse<br>• Director of Estates and Facilities<br>• Medical Director or representative<br>• Antimicrobial Stewardship Leads –Neil Todd/Anita Chalmers<br><br>Co-opt<br>• Community representative<br><br>Depending upon the work programmes, the Trust Infection Prevention Steering Group may request the attendance of other Trust staff in order to present their reports or to provide evidence in relation the agenda items. |
| **6** | **Quoracy** |
| | The Forum will be quorate with six members attending which must include the Chair and / or the Deputy Chair. |
| **7** | **Meeting Arrangements** |
| 7.1 | The Trust Infection Prevention Steering Group will meet a minimum of 4 times per year and all supporting papers will be circulated 7 days in advance of the meeting. Copies of all agendas and supplementary papers will be retained by the Infection Prevention Directorate in accordance with the Trust's requirements for the retention of documents.<br><br>The Infection Prevention Team will supply the Secretariat service to the meeting. |
| 7.2 | The Chair of the Trust Infection Prevention Steering Group has the right to convene additional meetings should the need arise and in the event of a request being received from at least 2 members of the group. |
| 7.3 | Where members of the Trust Infection Prevention Steering Group are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the group and provide a deputy. The deputy does not form part of the quorate group unless agreed with the Chair. |
| **8** | **Review & Monitoring** |
| | The Infection Prevention Team will maintain a register of attendance at the meeting. Attendance of less than 75% will be brought to the attention of the Chairperson of the Group to consider the appropriate action to be taken.<br>The annual report will be presented to the Board of Directors. |

| | |
|---|---|
| | |
| | The Terms of Reference will be reviewed every year. |

| | |
|---|---|
| **Author** | **The Chief Nurse / Director of Infection Prevention & Control** |
| **Owner** | **Chair of the Trust Infection Prevention Steering Group** |
| **Date of Issue** | **April 2018** |
| **Version** | **2** |
| **Approved by** | |
| **Review Date** | **April 2019** |

# Infection Prevention (IP) Governance Structure




July 2018

# Trust Infection Prevention Steering Group Work Programme

| Q1 | Q2 |
|---|---|
| Agree Infection Prevention Work Plan and<br>Audit and Surveillance plan for the following financial year<br><br>Report from Water Safety Committee<br>Report from Decontamination Committee<br>Report from Antimicrobial Stewardship Team<br>Report from Infection Prevention Operational Group<br>Audit and Surveillance Report<br><br>Review HCAI Incidence, Outbreaks and Incidents<br>Agree Risk Register | Agree Annual Report for preceding financial year<br><br>Report from Water Safety Committee<br>Report from Decontamination Committee<br>Report from Antimicrobial Stewardship Team<br>Report from Infection Prevention Operational Group<br>Audit and Surveillance Report<br><br>Review HCAI Incidence, Outbreaks and Incidents<br>Agree Risk Register |
| **Q3** | **Q4** |
| Winter Planning<br><br>Report from Water Safety Committee<br>Report from Decontamination Committee<br>Report from Antimicrobial Stewardship Team<br>Report from Infection Prevention Operational Group<br>Audit and Surveillance Report<br><br>Review HCAI Incidence, Outbreaks and Incidents<br>Agree Risk Register | Review Mandatory Training and Emergency Preparedness<br><br>Report from Water Safety Committee<br>Report from Decontamination Committee<br>Report from Antimicrobial Stewardship Team<br>Report from Infection Prevention Operational Group<br>Audit and Surveillance Report<br><br>Review HCAI Incidence, Outbreaks and Incidents<br>Agree Risk Register |

# Annual Report of the Decontamination Steering Group covering the period from 1 April 2017 to 31 March 2018

# (For inclusion in Infection prevention & Control Annual Report)

July 2018

## Introduction

The aims of this section of the report are to describe the current arrangements for the safe and effective decontamination of reusable medical devices across the Trust.

The Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 part 3 place a legal duty of care on NHS providers to ensure that through Regulation 15 all equipment should be appropriately cleaned and decontaminated.

This requirement is further detailed within Health Technical Memorandum (HTM) 01-01 and 06-01 which states the arrangements for the management and decontamination of surgical instruments and endoscopes.

The Trust has in place a Decontamination of Reusable Medical Devices Policy in place, this policy states the arrangements for the safe effective decontamination of reusable medical devices and surgical instruments in accordance with the legislative, essential quality and best practice requirements identified within Regulations 15 and Health technical memoranda.

The Trust has a Decontamination Steering committee in place which meets 6 times per year, the remit of the Decontamination steering group is to monitor the effectiveness of decontamination processes across the organisation with an annual audit and surveillance programme linked to the NHS Premises Assurance Model being a key component of the groups monitoring strategy.

The Trust has an executive Decontamination Lead in post, (Director of Estates & Facilities) and a Deputy Decontamination Lead, (Head of FM Compliance) and the appointment of these individuals is key to meeting the best practice requirements stated within HTMs.

## Audit & Surveillance Programme

The Decontamination steering group commissions an annual audit programme the purpose of which is to monitor the effectiveness of medical device decontamination processes being undertaken across the organisation primarily within Endoscope Decontamination Units and Sterile services units across the Trust.

The aim of the audit and surveillance programme is to provide assurance to the Decontamination steering group and Infection prevention Operational group on the effectiveness of decontamination processes and the environments in which decontamination takes place.

The Dashboard below shows the Trusts position at May 2018 against the audit and surveillance programme

**Decontamination of Reusable Medical Devices- Audit Dashboard** — Reviewed: 11th May 2018

| Audit Activity | Last Audit | Next Audit |
|---|---|---|
| Endoscopy SGH/BDH | Jul-17 | Aug-18 |
| Endoscopy -York | Feb-17 | Aug-18 |
| Sterile Services- SGH | Aug-17 | Aug-18 |
| Sterile Services- York | Aug-17 | Aug-18 |
| Outpatients- BDH | May-18 | May-19 |
| Outpatients-SGH | Jan-18 | Jan-19 |
| Cardio Unit- SGH | May-18 | May-19 |
| Cardio Unit- York | May-18 | May-19 |

| Last audit Scores | R | A | G/NA | |
|---|---|---|---|---|
| Endoscopy SGH/BDH | 4 | 3 | 167 | 174 |
| Endoscopy -York | 2 | 10 | 152 | 164 |
| Sterile Serv- SGH | 0 | 3 | 33 | 36 |
| Sterile Serv- York | 0 | 5 | 31 | 36 |
| Outpatients- BDH | 0 | 1 | 14 | 15 |
| Outpatients-SGH | 0 | 1 | 14 | 15 |
| Cardio Unit -York | 0 | 1 | 14 | 15 |
| Cardio Unit- SGH | 2 | 1 | 12 | 15 |
| | 8 | 25 | | |

Major Corrective Actions= Red Rated Risks

| Non Conformance By Category (Red Rated Only) | | |
|---|---|---|
| Decontamination Process (DP) | 1 | |
| Engineering/Maintenance (EM) | 0 | |
| Documentation (Doc) | 2 | |
| Tracking & Traceability (T&T) | 3 | |
| Governance (Gov) | 2 | |
| Training (TG) | 1 | |

| Annual Audits to date — Overall Compliance | 12/13 | 13/14 | 14/15 | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 | * KPI Met |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Endoscopy SGH/BDH | 4 | 1 | 2 | 3 | 5 | 4 | | | | | | | | No |
| Endoscopy -York | 0 | 0 | 5 | 5 | 0 | 2 | | | | | | | | No |
| Sterile Services- SGH | 2 | 2 | 0 | 0 | 2 | 0 | | | | | | | | Yes |
| Sterile Services- York | 0 | 2 | 2 | 1 | 0 | 0 | | | | | | | | Yes |
| Outpatients- BDH | 4 | 2 | 0 | 2 | 0 | 1 | 0 | | | | | | | Yes |
| Outpatients-SGH | 1 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | | | Yes |
| Cardio Unit- SGH | 2 | 1 | 1 | 0 | 1 | 1 | 2 | | | | | | | No |
| Cardio Unit- York | * | * | * | * | * | 2 | 0 | | | | | | | Yes |

| Audit Action Plan Submission | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Endoscopy SGH/BDH | | | | | | | | | | | | | | |
| Endoscopy -York | | | | | | | | | | | | | | |
| Sterile Serv- SGH | | | | | | | | | | | | | | |
| Sterile Serv- York | | | | | | | | | | | | | | |
| Outpatients- BDH | | | | | | | | | | | | | | |
| Outpatients-SGH | | | | | | | | | | | | | | |
| Cardio Unit -York | | | | | | | | | | | | | | |
| Cardio Unit- SGH | | | | | | | | | | | | | | |

*KPI=
NO Major Corrective Actions (Red)
Less Than 20% Moderate Corrective Actions(Amber)

The significant findings and recommendations of the 2017/2018 audit programme were:

- Investment is needed in the internal fabric and fixtures and fittings of the Sterile Services unit at the York Hospital site.

- Sterilization and disinfection equipment replacement at the York and Scarborough Sterile Services Sites requires planning through the equipment replacement programme commissioned by the Decontamination Steering group.

- Replacement of Endoscope Washer Disinfection equipment at the Scarborough & York sites is due and will be planned via the equipment replacement programme commissioned by the Decontamination Steering group and approved by the Capital Planning Executive group.

- The Organisation should move towards and electronic tracking and traceability system for Endoscope decontamination processes, a capital project is currently underway to achieve this.

- The organisation will look to condense endoscope decontamination units to 2 sites (York & Scarborough) and cease reprocessing at the Bridlington site as the equipment at the site is becoming unreliable due to age and obsolescence of parts and there is no robust business continuity as the installed equipment is stand alone.

## Key Successes

The group has successfully implemented the audit and surveillance programme and through careful monitoring of any audit findings and outcomes Endoscopy Decontamination and Sterile Services Managers have been able to improve both processes and to a lesser extent the environment in which decontamination of surgical instruments or endoscopes takes place, examples of this include:

- Implementation of cross site monitored action plans relating to audit and surveillance

- Recent approval of 10 year plant and equipment replacement programme

- Process improvement associated with water quality tests for automated endoscope washer disinfectors

- Identification and progression of the case for electronic tracking and traceability systems associated with endoscope reprocessing

- Implementation by EDU management teams of improved endoscope storage and transport arrangements via vacuum packed storage.

**2018-2019 Objectives**

The multidisciplinary team through under the leadership of the Decontamination Steering group should seek to further explore and implement the electronic tracking and traceability system for endoscopes across the organisation as a priority.

The group shall also oversee the concept of centralisation of Endoscope decontamination at the East coast sites by decommissioning the EDU at the Bridlington site and commissioning improved EDU facilities at the Scarborough site possibly through a re-design programme within the existing sterile services unit at Scarborough.

The Approved Capital replacement programme progression should be monitored and supported by the Decontamination Steering group.

The Estates team should ensure that evidence to support compliance with the NHS Premises Assurance Model in terms of decontamination is maintained.

The Trust Decontamination of Reusable Medical devices policy requires review by the Decontamination steering group in March 2019.

David Biggins
Deputy Decontamination Lead/Head of FM Compliance
York NHS Teaching Hospital Foundation Trust

July 2018

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Medical Directors Report

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

Purpose of the Report

This report provides an update from the Medical Director on salient issues related to patient safety, clinical effectiveness and patient experience.

Executive Summary – Key Points

**National Safety Standards for Invasive Procedures**

In September 2015 NHS England issued the National Safety Standards for Invasive Procedures (NatSSIPs). The NatSSIPs set out key steps necessary to deliver safe care for patients undergoing invasive procedures and are designed to support organisations in standardising the processes that underpin patient safety. Organisations are required to develop Local Safety Standards for Invasive Procedures (LocSSIPs).

The Trust formed the LocSSIPs project board in November 2017 and agreed specific terms of reference, roles and functions.

Initially scoping identified 97 procedures for which the criterion was met. Of these, 27 LoCSSIPs are completed and in use. A further 26 are awaiting approval and 21 are in development.

Further engagement and facilitation is still required to ensure that the remaining 23 procedures are LoCSSIP compliant. Directorate teams are asked to engage with the Patient Safety team for all outstanding procedures.

## Electronic Prescribing and Medicines Administration

EPMA has now been rolled-out to all in-patient areas at York Hospital with the exception of Paediatrics (Wards 17/18) and Obstetrics and Gynaecology. ICU is using EPMA for patients on 'regular' medicines with the exception of critical care drugs. White Cross Court and St Helens are complete.

Last month saw the deployment to ED for those patients pending admission. This had already been activated to allow drug histories to be completed in ED, prior to transfer to wards, but nurses are now able to record administration for those patients with delayed admission thereby reducing critical missed doses. This deployment also provided resolution for agency log-on which has been a significant governance issue for all aspects of CPD.

Go-Live in Theatres will take place week commencing 17 September and will last 2 weeks. This will be followed by a rapid deployment into Scarborough and Bridlington hospitals week commencing 9 October. This will include Theatres and ED.

Following deployment, the plan is to undertake a period of consolidation/benefits appraisal whilst assessing the priorities for future development. A potential key priority is outpatient prescribing, where there are likely to be significant patient safety gains through having access to a fully populated medication history for what are a complex group of patients.

## Sepsis

The recognition and timely treatment for Sepsis as well as rationalisation of antibiotics is a national CQUIN; Quarter 1 performance has been reported as follows:

Compliance with Emergency Department Screening across both sites in Q1 reached 88.66%.
Compliance with Inpatient screening across both sites in Q1 reached 84%.
Compliance with Emergency Department treatment within an hour across both sites in Q1 reached 35.55%.
Compliance with antimicrobial review reached 75% in Q1.

The sepsis steering group continues to lead the improvement programme with support from task and finish groups in both Emergency Departments. A sepsis Clinical Leadership Fellow has recently been appointed to support the continued work to achieve timely recognition and treatment of sepsis.

Recommendation

The Board of Directors are asked to note the Medical Directors Report for September 2018.

Author: Rebecca Hoskins, Deputy Director of Patient Safety

Director Sponsor: Mr. James Taylor, Medical Director

Date: September 2018

## 1. Introduction and Background

Patient Safety-

- Sepsis
- EPMA
- National Safety Standards for Invasive Procedures

Clinical Effectiveness-

- New consultants to the Trust

Patient Experience –

- Antibiotic prescribing audit

## 2. Patient Safety

### 2.1 Sepsis

The recognition and timely treatment of sepsis, as well as rationalisation of antibiotics is a national CQUIN and is reported as follows:

**a) Timely identification of patients with sepsis, in emergency departments and acute inpatient settings**

Compliance with Emergency Department Screening across both sites in quarter 1 reached 88.66%.

Compliance with Inpatient screening across both sites in quarter 1 reached 84%

**b) Timely treatment of sepsis in Emergency Departments i.e., percentage of patients who were found to have sepsis on screening and received intravenous antibiotics within one hour**

Compliance with Emergency Department treatment within an hour across both sites in Q1 reached 35.55%.

**c) Assessment of a clinical antibiotic review between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours.**

Compliance with antimicrobial review reached 75% in quarter 1.

The sepsis steering group continues to lead the improvement programme with support from task and finish groups in both Emergency Departments. A sepsis Clinical Leadership Fellow has recently been appointed to support the continued work to achieve timely recognition and treatment of sepsis.

### 2.2 EPMA – Escalated item from Patient Steering Group

EPMA has now been rolled-out to all in-patient areas at York Hospital with the exception of Paediatrics (Wards 17/18) and Obstetrics and Gynaecology. ICU is using EPMA for

patients on 'regular' medicines with the exception of critical care drugs. White Cross Court and St Helens are complete.

Last month saw the deployment to ED for those patients pending admission. This had already been activated to allow drug histories to be completed in ED, prior to transfer to wards, but nurses are now able to record administration for those patients with delayed admission thereby reducing critical missed doses. This deployment also provided resolution for agency log-on which has been a significant governance issue for all aspects of CPD.

Technical developments have provided a go-live for therapeutic Fragmin charts and the Insulin chart. Solutions for prophylactic Fragmin, multiple routes and suspensions will go live in the next 2 weeks alongside the deployment into Theatres, PACU and Ward 27. Work to deploy into Theatres has been significant and has been supported by the Anaesthetists.

Go-Live in Theatres will take place week commencing 17 September and will last 2 weeks. This will be followed by a rapid deployment into Scarborough and Bridlington hospitals week commencing 9 October. This will include Theatres and ED.

Following deployment, the plan is to undertake a period of consolidation/benefits appraisal whilst assessing the priorities for future development. A potential key priority is outpatient prescribing, where there are likely to be significant patient safety gains through having access to a fully populated medication history for what are a complex group of patients.

### 2.3 National Safety Standards for Invasive Procedures

In September 2015 NHS England issued the National Safety Standards for Invasive Procedures (NatSSIPs). The NatSSIPs set out key steps necessary to deliver safe care for patients undergoing invasive procedures and are designed to support organisations in standardising the processes that underpin patient safety. Organisations are required to develop Local Safety Standards for Invasive Procedures (LocSSIPs).

The Trust formed the LocSSIPs project board in November 2017 and agreed specific terms of reference, roles and functions.

Initially, scoping identified 97 procedures for which the criterion was met. Of these, 27 LoCSSIPs are completed and in use. A further 26 are awaiting approval and 21 are in development.

Other Completed Actions include:

- Development of a Trust wide NatSIPPs Policy
- Pathways in Endoscopy and VIU reviewed to ensure NatSIPP compliance
- Generic LocSIPP template approved for non-pathway procedures
- Specialist LocSIPPs developed at Directorate level
- WHO Surgical Safety Checklist reviewed
- Implementation of the amended WHO Surgical Safety Checklist
- Principles of safe site marking agreed

Next Steps include:

- Approval of Trust wide NatSIPPs Policy and site marking guidance via The Patient Safety Group
- Develop a database of all invasive procedures across clinical directorates
- Implementation of agreed principles for site marking across clinical directorates
- Assessment of training needs and development of Trust wide safety standards training
- Develop a LocSIPPs audit tool.

Further engagement and facilitation is still required to ensure that the remaining 23 procedures are LoCSSIP compliant. Directorate teams are asked to engage with the Patient Safety team for all outstanding procedures.

## 3. Clinical Effectiveness

### 3.1 Consultants new to the Trust

The following consultants joined the Trust in August:

Amanda Isdale
Locum Consultant Rheumatology
York

Priya Shanmugarajah
Locum Consultant Neurology
York

Kathryn Gracie
Locum Consultant Respiratory
York

### 3.2 Clinical Effectiveness Group

The minutes of the July Clinical Effectiveness Group meeting have not yet been approved and are therefore not available at the time of reporting.

## 4. Patient Experience

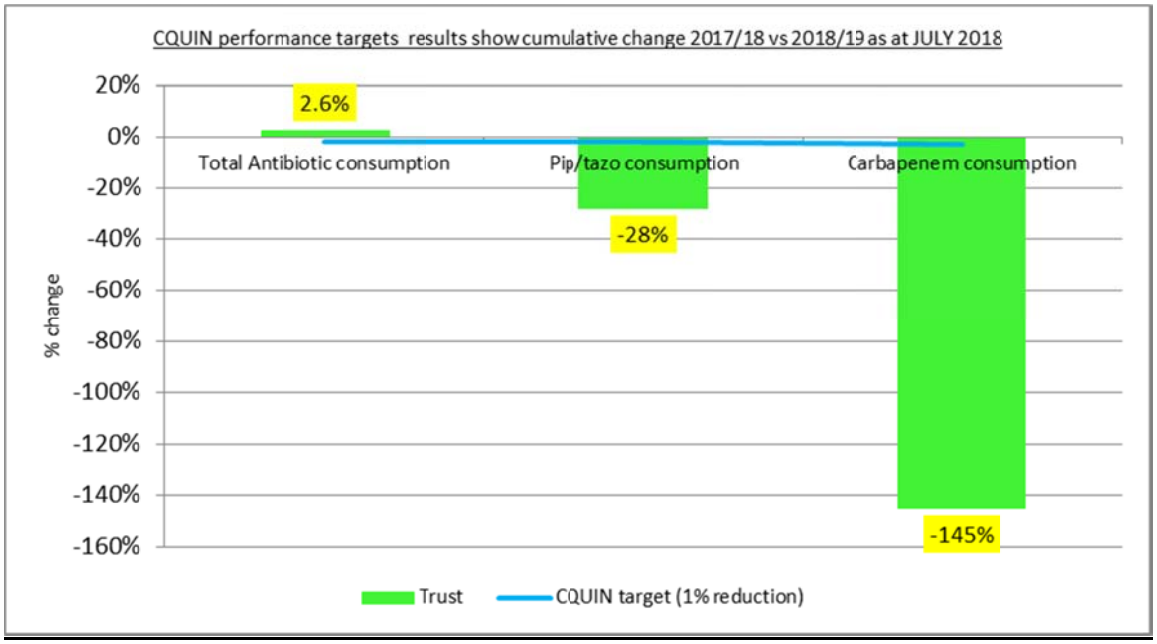
### 4.1 Antibiotic prescription audit results

The summary of the antibiotic prescriptions from the July prescription audit are presented below.

Unfortunately the prescribing data for August is not available at the time of compiling the report. Both August and September's data will be presented in the October report.

Consumption data % change of cumulative totals 2017/18 vs 2018/19 as at the end of July 2018

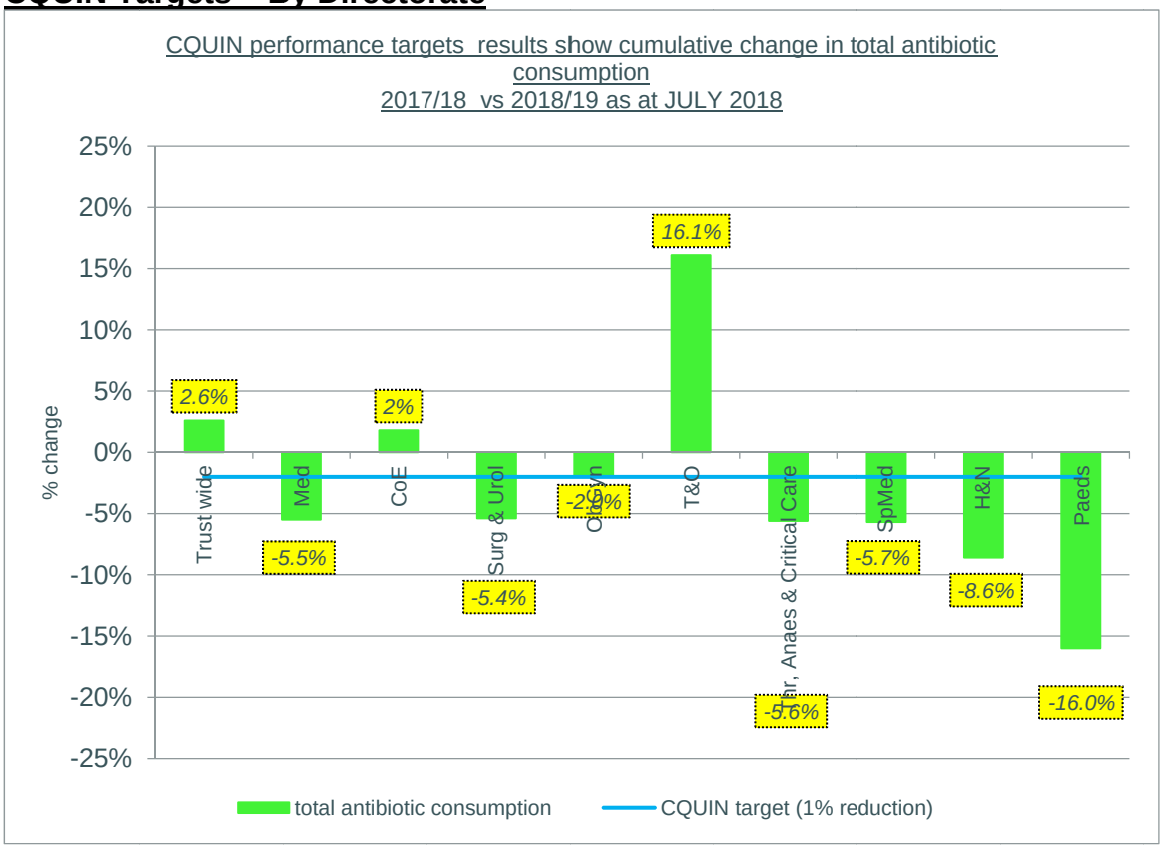
## CQUIN Targets – Trust wide



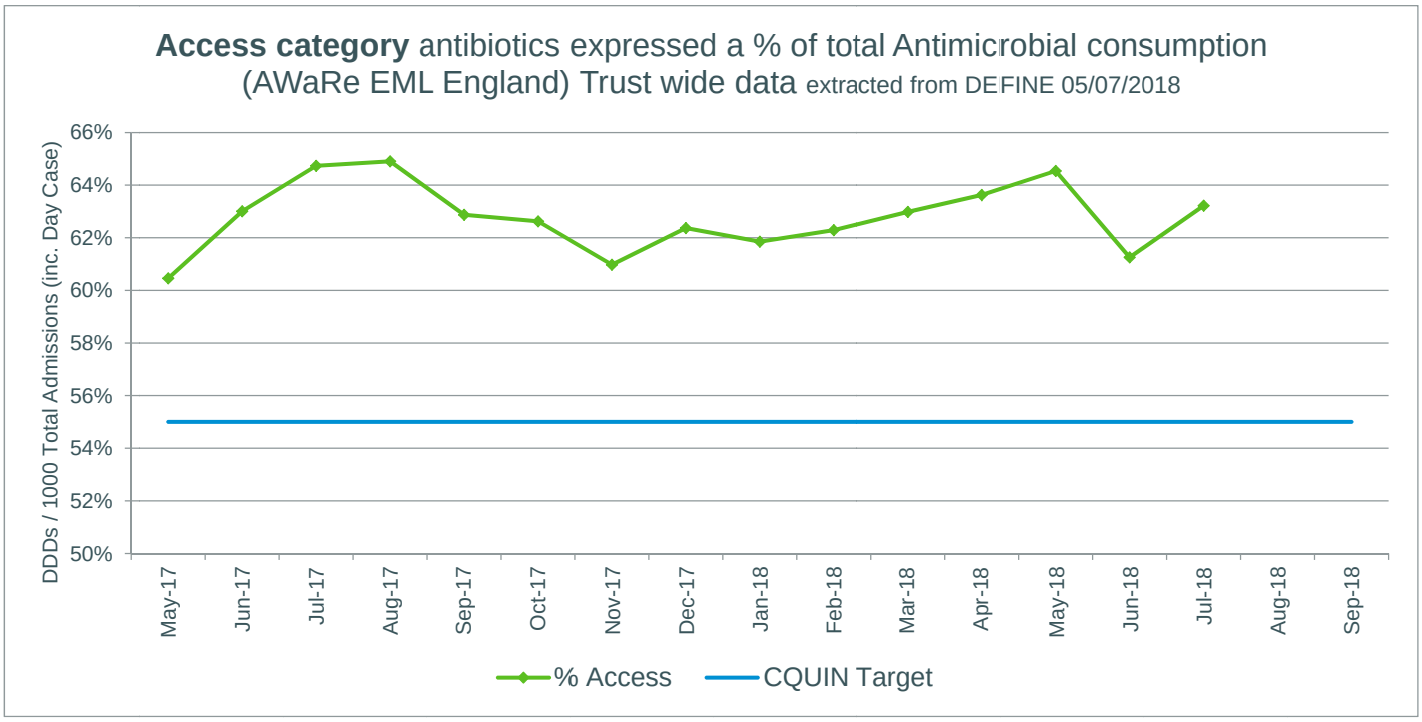

There is a huge percentage decrease in the use of the carbapenems, but this reflects the very low use generally in the Trust; one or two patients can have a great impact. Although pip/tazo (Piperacillin / Tazobactam, a broad spectrum IV antibiotic) consumption is no longer covered by a CQUIN a decrease in usage this month is noted. Both carbapenems and pip/ tazo are targeted on the antibiotic ward round, switching to narrower spectrum antibiotics where ever appropriate.

The Board of Directors has supported the proposition to mandate duration of treatment which will protect patients from unnecessary doses of antibiotics.

## CQUIN Targets – By Directorate



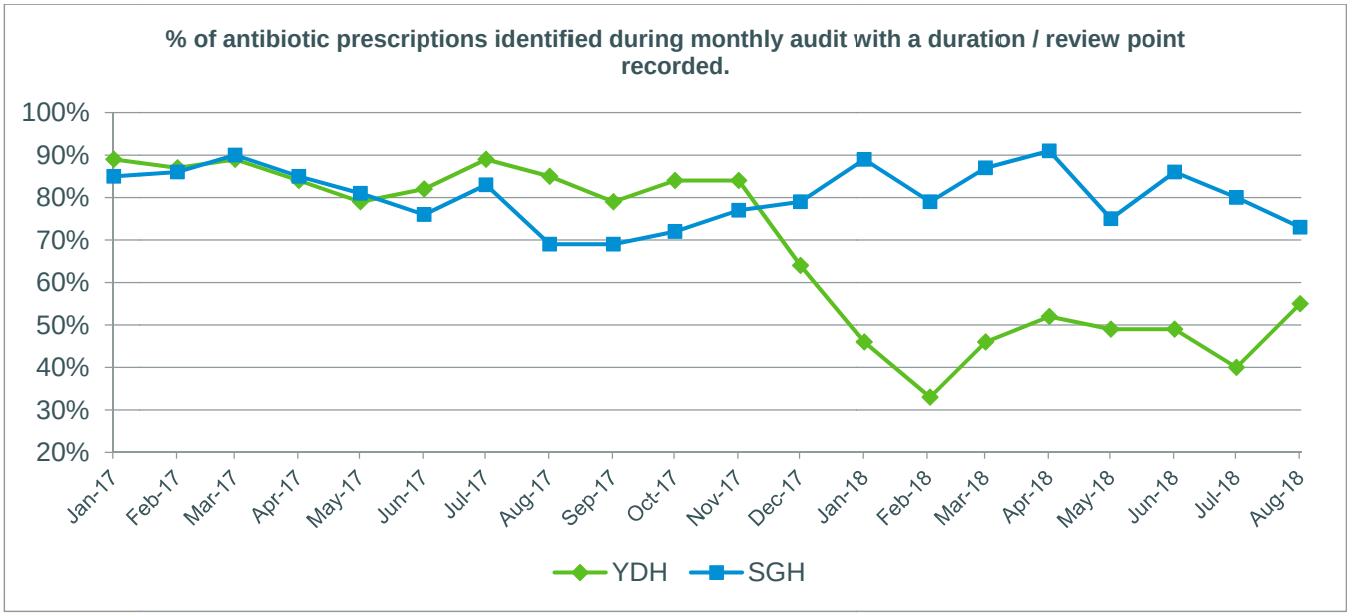

The Trust Pharmacy Antimicrobial Team continues to work closely with Clinicians and "Team Micro" on the York and Scarborough sites to actively promote the review of all antibiotic prescriptions. The increases in antibiotic consumption vary between Directorates; this may in part reflect the increase in prescribing of combinations of narrower spectrum antibiotics to target infections rather than using a single broad spectrum agent. While this approach may potentially increase the total volume of antibiotics consumed the more focused approach to targeting infections (combined with actively reviewing patients) promotes a more proactive approach to managing antibiotics and minimising resistance.




AwaRe EML England classifies antibiotics into 3 different categories: Access, Watch and Reserve. The Access list covers the majority of the antibiotics that feature on the Trust formulary and therefore those that are most frequently prescribed. The CQUIN target aims to encourage the balance of antibiotics used by an organisation to be in favour of the Access list and encourage a decrease in the use of Watch and Reserve antibiotics; these are antibiotics the Trust has described as restricted or to be prescribed only on the advice of "Team Micro".

Overall the Trust continues to be above target for Access antibiotics. Team Micro continue to monitor antimicrobial use and review empiric guidance.

The summary of the antibiotic prescriptions from the **August** prescription audit are presented below.



The recording of both an indication and a duration (or review point) on every antibiotic prescription is an important patient safety metric. The drive to promote switching from *IV to oral* antibiotics at the earliest appropriate time has been escalated as any initiative that promotes the active review of antibiotic prescriptions will help limit unnecessary doses where possible.

There has been a campaign on all wards promoting switches from IV antibiotics to oral, using screen savers and posters. This may indirectly also help to encourage recording course lengths.

In York the ARK study (in Medicine) is supporting this as it encourages regular review including justification as to why antibiotics must be continued. Interestingly in medicine there is the highest level of recording of duration on the York site.

**Key Indicator results for August 2018** (results based on Consultant Directorate as identified on audit day)

| Indicator % | Trust | Med | CoE | Surg & Urol | ObGyn | T&O | SpMed | H&N |
|---|---|---|---|---|---|---|---|---|
| pt Rx Abx | % | 40% | 21% | 49% | 7% | 27% | 59% | 53% |
| Indication recorded **YDH** | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| indication recorded **SGH** | 85% | 69% | 100% | 100% | NA | 100% | NA | NA |
| duration recorded **YDH** | 55% | 83% | 59% | 17% | 100% | 65% | 50% | 20% |
| duration recorded **SGH** | 73% | 63% | 79% | 85% | NA | 100% | NA | NA |

## 5. Recommendation

The Board of Directors are asked to note the Medical Directors Report for September 2018.

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# Performance and Activity Report

## August Performance 2018

Produced September 2018

### The Board Assurance Framework is structured around the four ambitions of the Trust:

**Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.

**Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.

**People and Capability** - The quality of our services is wholly dependent on our teams of staff.

**Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

**Assurance Framework Responsive**

# Performance Summary by Month – Trust level

| Operational Performance: Unplanned Care | Target | Sparkline / Previous Month | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Care Attendances | | ▼ | 17134 | 15979 | 16570 | 15158 | 16236 | 14712 | 13719 | 15845 | 16374 | 17985 | 17242 | 18903 | 18215 |
| Emergency Care Breaches | | ▼ | 2033 | 2697 | 2222 | 1263 | 2766 | 2728 | 2499 | 2983 | 2439 | 1786 | 1722 | 2266 | 1366 |
| Emergency Care Standard Performance | 95% | ▲ | 88% | 83% | 87% | 92% | 83% | 81% | 82% | 81% | 85% | 90% | 90% | 88% | 93% |
| ED Conversion Rate: Proportion of ED attendances subsequently admitted | | ▲ | 37% | 38% | 38% | 39% | 41% | 41% | 40% | 39% | 39% | 38% | 38% | 37% | 38% |
| ED Total number of patients waiting over 8 hours in the departments | | ▼ | 274 | 528 | 371 | 152 | 791 | 833 | 668 | 872 | 607 | 195 | 159 | 260 | 110 |
| ED 12 hour trolley waits | 0 | ◀▶ | 1 | 1 | 2 | 0 | 5 | 14 | 15 | 40 | 13 | 0 | 0 | 0 | 0 |
| ED: % of attendees assessed within 15 minutes of arrival | | ▲ | 69% | 68% | 67% | 69% | 57% | 63% | 61% | 57% | 64% | 67% | 63% | 62% | 70% |
| ED: % of attendees seen by doctor within 60 minutes of arrival | | ▲ | 44% | 35% | 35% | 42% | 41% | 45% | 43% | 40% | 41% | 42% | 40% | 41% | 50% |
| Ambulance handovers waiting 15-29 minutes | 0 | ▼ | 446 | 469 | 745 | 649 | 823 | 702 | 679 | 784 | 702 | 762 | 765 | 785 | 766 |
| Ambulance handovers waiting 30-59 minutes | 0 | ▼ | 258 | 331 | 368 | 172 | 537 | 424 | 360 | 471 | 325 | 317 | 260 | 355 | 342 |
| Ambulance handovers waiting >60 minutes | 0 | ▼ | 106 | 207 | 257 | 55 | 548 | 390 | 367 | 419 | 302 | 152 | 110 | 216 | 104 |
| Non Elective Admissions (excl Paediatrics & Maternity) | | ▼ | 4411 | 4251 | 4411 | 4304 | 4575 | 4515 | 4092 | 4525 | 4442 | 4791 | 4603 | 4840 | 4727 |
| Non Elective Admissions - Paediatrics | | ▼ | 495 | 673 | 790 | 800 | 934 | 736 | 654 | 844 | 703 | 734 | 639 | 668 | 537 |
| Delayed Transfers of Care - Acute Hospitals | | ▲ | 1238 | 965 | 932 | 958 | 865 | 660 | 885 | 1010 | 1134 | 1092 | 1020 | 1071 | 1336 |
| Delayed Transfers of Care - Community Hospitals | | ▼ | 234 | 445 | 312 | 439 | 506 | 483 | 357 | 266 | 464 | 358 | 262 | 307 | 301 |
| Patients with LoS >= 7 Midnights (Elective & Non-Elective) | | ▼ | 1015 | 1048 | 1057 | 1045 | 1130 | 1153 | 1034 | 1108 | 1002 | 1055 | 986 | 1056 | 1026 |
| Ward Transfers - Non clinical transfers after 10pm | 100 | ▼ | 70 | 84 | 67 | 57 | 113 | 99 | 106 | 94 | 106 | 58 | 71 | 73 | 38 |
| Emergency readmissions within 30 days | | ▼ | 745 | 712 | 738 | 796 | 876 | 771 | 765 | 807 | 780 | 884 | 814 | - | - |
| Stranded Patients | | ▼ | 390 | 413 | 367 | 333 | 402 | 474 | 412 | 430 | 413 | 377 | 366 | 385 | 369 |
| Super Stranded Patients | | ▼ | 137 | 128 | 129 | 99 | 126 | 161 | 139 | 157 | 150 | 123 | 118 | 125 | 118 |

| Operational Performance: Planned Care | Target | Sparkline / Previous Month | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatients: All Referral Types | | ▼ | 18427 | 17830 | 19668 | 19490 | 16186 | 19348 | 17399 | 19132 | 18985 | 20009 | 19350 | 20161 | 18465 |
| Outpatients: GP Referrals | | ▼ | 9737 | 9566 | 10440 | 10381 | 8247 | 10280 | 9220 | 10223 | 10065 | 10435 | 9923 | 10540 | 9679 |
| Outpatients: Consultant to Consultant Referrals | | ▼ | 2247 | 2014 | 2322 | 2216 | 1889 | 2145 | 1965 | 2062 | 2065 | 2183 | 2137 | 2244 | 1926 |
| Outpatients: Other Referrals | | ▼ | 6443 | 6250 | 6906 | 6893 | 6050 | 6923 | 6214 | 6847 | 6855 | 7391 | 7290 | 7377 | 6860 |
| Outpatients: 1st Attendances | | ▼ | 11741 | 11721 | 12797 | 12665 | 10091 | 12309 | 11116 | 11657 | 10919 | 12504 | 11988 | 12291 | 11728 |
| Outpatients: Follow Up Attendances | | ▼ | 26558 | 26826 | 28311 | 29312 | 24019 | 29717 | 25312 | 26855 | 26789 | 28852 | 27695 | 29075 | 26781 |
| Outpatients: 1st to FU Ratio | | ▼ | 2.26 | 2.29 | 2.21 | 2.31 | 2.38 | 2.41 | 2.28 | 2.30 | 2.45 | 2.31 | 2.26 | 2.37 | 2.28 |
| Outpatients:  DNA rates | | ▼ | 7% | 7% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% | 6% |
| Outpatients: Cancelled Clinics with less than 14 days notice | 180 | ▼ | 121 | 188 | 176 | 167 | 133 | 210 | 213 | 194 | 168 | 149 | 145 | 184 | 173 |
| Outpatients:Hospital Cancelled Outpatient Appointments for non-clinical reasons | | ▲ | 823 | 817 | 862 | 780 | 702 | 949 | 757 | 844 | 849 | 728 | 885 | 945 | 1070 |
| Diagnostics: Patients waiting <6 weeks from referral to test | 99% | ▼ | 99% | 99% | 98% | 98% | 97% | 98% | 98% | 97% | 96% | 96% | 96% | 96% | 94% |
| Elective Admissions | | ▼ | 721 | 683 | 790 | 790 | 597 | 568 | 604 | 531 | 636 | 781 | 759 | 741 | 612 |
| Day Case Admissions | | ▲ | 6047 | 5846 | 6254 | 6151 | 5179 | 6069 | 5538 | 5827 | 5549 | 6185 | 6135 | 6203 | 6206 |
| Cancelled Operations within 48 hours - Bed shortages | | ▼ | 12 | 38 | 27 | 2 | 74 | 118 | 129 | 168 | 59 | 18 | 7 | 10 | 4 |
| Cancelled Operations within 48 hours - Non clinical reasons | | ▼ | 57 | 84 | 91 | 65 | 169 | 191 | 189 | 205 | 117 | 103 | 89 | 98 | 75 |
| Theatres: Utilisation of planned sessions | | ▲ | 90% | 89% | 88% | 93% | 86% | 83% | 85% | 84% | 88% | 92% | 92% | 92% | 93% |
| Theatres: number of sessions held | | ▼ | 590 | 619 | 704 | 718 | 542 | 599 | 543 | 520 | 565 | 628 | 636 | 608 | 553 |
| Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc) | | ▼ | 56 | 77 | 57 | 54 | 76 | 74 | 50 | 105 | 76 | 60 | 61 | 74 | 63 |

**Assurance Framework Responsive**

# Performance Summary by Month – Trust level continued

| 18 Weeks Referral To Treatment | Target | Sparkline / Previous Month | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incomplete Pathways | 92% | ▼ | 88% | 87% | 87% | 87% | 86% | 85% | 85% | 83% | 84% | 84% | 84% | 85% | 84% |
| Waits over 52 weeks for incomplete pathways | 0 | ◀▶ | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 2 | 1 | 14 | 9 | 0 | 0 |
| Waits over 36 weeks for incomplete pathways | 0 | ▼ | 197 | 197 | 199 | 202 | 238 | 260 | 297 | 356 | 409 | 450 | 438 | 390 | 369 |
| Total Admitted and Non Admitted waiters | 26303 | ▼ | 26148 | 25526 | 25174 | 24894 | 25006 | 25185 | 25334 | 26303 | 26967 | 27480 | 27425 | 27796 | 27756 |
| Number of patients on Admitted Backlog (18+ weeks) | | ▼ | 1353 | 1457 | 1465 | 1448 | 1623 | 1818 | 1928 | 2223 | 2303 | 2334 | 2330 | 2273 | 2272 |
| Number of patients on Non Admitted Backlog (18+ weeks) | | ▲ | 1976 | 1884 | 1699 | 1761 | 1816 | 1880 | 1921 | 2179 | 2070 | 2002 | 2041 | 2023 | 2245 |

| Cancer (one month behind due to national reporting timetable) | Target | Sparkline / Previous Month | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer 2 week (all cancers) | 93% | ▲ | 83% | 85% | 87% | 93% | 93% | 94% | 95% | 94% | 94% | 94% | 94% | 87% | - |
| Cancer 2 week (breast symptoms) | 93% | ▲ | 98% | 99% | 97% | 95% | 94% | 95% | 99% | 99% | 96% | 96% | 94% | 95% | - |
| Cancer 31 day wait from diagnosis to first treatment | 96% | ▲ | 98% | 98% | 97% | 99% | 100% | 99% | 99% | 99% | 98% | 99% | 99% | 98% | - |
| Cancer 31 day wait for second or subsequent treatment - surgery | 94% | ▲ | 97% | 96% | 83% | 97% | 97% | 94% | 100% | 97% | 97% | 97% | 100% | 98% | - |
| Cancer 31 day wait for second or subsequent treatment - drug treatments | 98% | ▲ | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | - |
| Cancer 62 Day Waits for first treatment (from urgent GP referral) | 85% | ▲ | 83% | 76% | 74% | 86% | 87% | 85% | 81% | 86% | 78% | 78% | 82% | 72% | - |
| Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) | 90% | ▲ | 99% | 93% | 91% | 91% | 90% | 96% | 95% | 94% | 91% | 84% | 97% | 91% | - |

Assurance Framework
Responsive

# Commissioning for Quality and Innovation (CQUIN): 2018-19

| CQUIN Name & Description | Executive Lead | Operational Lead | Quarter 1 Outcome | Quarter 2 Risks & RAG | Quarter 3 RAG | Quarter 4 RAG |
|---|---|---|---|---|---|---|
| 1a: NHS Staff Health & Well-being | Mike Proctor | Polly McMeekin | Amber - due to partial achievement in 2017-18 | | | |
| 1b. Healthy Food for NHS Staff, Visitors and Patients Maintain a) ban on price promotions, b) advertisement of HSSF, C) ban on HSSF from checkouts & d) ensure healthy options available 24/7. | Brian Golding | Pierre Gomez | Achieved | No risks identified | Green | Green |
| 1c. Uptake of Flu Vaccinations<br>Improving the uptake of flu vaccinations for frontline clinical staff within Providers to 75%. | Mike Proctor | Polly McMeekin | No risks identified | | | |
| 2a. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)<br>Timely identification of patients with sepsis in emergency departments and acute inpatient settings | Jim Taylor | Rebecca Hoskins | Partially Achieved | Amber | Amber | Amber |
| 2b. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)<br>Timely treatment of sepsis in emergency departments and acute inpatient settings. | Jim Taylor | Rebecca Hoskins | Partially Achieved | Amber | Amber | Amber |
| 2c. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)<br>Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours. | Jim Taylor | Rebecca Hoskins | Achieved | No risks identified | Green | Green |
| 2d. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) | Jim Taylor | Anita Chalmers | Annual Return – no issues identified | | | |
| 4. Improving services for people with mental health needs who present to A&E<br>Where a 20% reduction in attendances to A&E was achieved in year 1 (for those within the selected cohort of frequent attenders) maintain this reduction.<br>Identify a new cohort of frequent attenders to A&E during 17/18 who could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19. | Beverley Geary | Sarah Freer & Jill Wilford | Achieved | No risks identified | Green | Green |
| 6. Advice & Guidance<br>The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. | Wendy Scott | Jenny Hey & Nicky Slater | Achieved | No risks identified | Green | Green |

Assurance Framework
Responsive

# Commissioning for Quality and Innovation (CQUIN): 2018-19

| CQUIN Name & Description | Executive Lead | Operational Lead | Quarter 1 Outcome | Quarter 2 Risks & RAG | Quarter 3 RAG | Quarter 4 RAG |
|---|---|---|---|---|---|---|
| **9a. Preventing ill health by risky behaviours - alcohol and tobacco Tobacco screening.** Rolled out into Acute 2018/19 | Beverley Geary | Melanie Liley | Community - Achieved | Community - No risks identified | Green | Green |
| | | | Acute - Achieved | Acute - No risks identified | Green | Green |
| **9b. Preventing ill health by risky behaviours - alcohol and tobacco Tobacco brief advice.** Rolled out into Acute 2018/19 | Beverley Geary | Melanie Liley | Community - Achieved | Community - No risks identified | Green | Green |
| | | | Acute - Achieved | Acute - No risks identified | Green | Green |
| **9c. Preventing ill health by risky behaviours - alcohol and tobacco Tobacco referral and medication.** Rolled out into Acute 2018/19 | Beverley Geary | Melanie Liley | Community - Achieved | Community - No risks identified | Green | Green |
| | | | Acute - Achieved | Acute - No risks identified | Green | Green |
| **9d. Preventing ill health by risky behaviours - alcohol and tobacco Alcohol screening.** Rolled out into Acute 2018/19 | Beverley Geary | Melanie Liley | Community - Achieved | Community - No risks identified | Green | Green |
| | | | Acute - Achieved | Acute - No risks identified | Green | Green |
| **9e. Preventing ill health by risky behaviours - alcohol and tobacco Alcohol brief advice or referral.** Rolled out into Acute 2018/19 | Beverley Geary | Melanie Liley | Community - Achieved | Community - No risks identified | Green | Green |
| | | | Acute - Achieved | Acute - No risks identified | Green | Green |

Assurance Framework
Responsive

# Commissioning for Quality and Innovation (CQUIN): 2018-19

| CQUIN Name & Description | Executive Lead | Operational Lead | Quarter 1 Outcome | Quarter 2 Risks & RAG | Quarter 3 RAG | Quarter 4 RAG |
|---|---|---|---|---|---|---|
| **10. Improving the assessment of wounds**<br>**The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.** | Beverley Geary | Melanie Liley | **Service and IT are working through a solution that will allow access to accurate data to facilitate analysis of the wound care work that is being undertaken.** | | **Amber** | **Amber** |
| **11. Personalised care and support planning**<br>**Personalised care and support planning which is; a) an intervention that supports people to develop the knowledge, skills and confidence to manage their own health and wellbeing and that leads to the development of a care plan and b) an enabler that supports patients to understand the local support mechanisms that are available to them.** | Wendy Scott | Melanie Liley | **No risks identified - Annual target** | | | |
| **CA2. Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)**<br>**Implementation of nationally standardised doses of SACT across England using the dose-banding principles and dosage tables published by NHS England (developed through the Medicines Optimisation Clinical Reference Group).** | Jim Taylor | Karen Cowley | **Achieved** | **No issues identified** | **Green** | **Green** |
| **GE2. Activation System for Patients with Long Term Conditions**<br>**CQUIN scheme therefore aims to encourage use of the "patient activation measurement" (PAM) survey instrument, firstly to assess levels of patient skills, knowledge, confidence and competence in self-management.** | Jim Taylor | Eleanor King | **Achieved** | **No issues identified** | **Green** | **Green** |
| **GE3. Medicines Optimisation**<br>**This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.** | Wendy Scott | Stuart Parkes | **Achieved** | **No issues identified** | **Green** | **Green** |
| **CSAAS. Child Sexual Assault Assessment Services**<br>**Implementation of the Sexually Transmitted Infections (STI) Pathway and referral to appropriate care** | Wendy Scott | Liz Vincent | **Achieved** | **No issues identified** | **Green** | **Green** |
| **Enhanced Armed Forces Covenant**<br>**Embedding the Armed Forces Covenant and utilising local Armed Forces resources and support services to enable improved health outcomes for Serving Personnel, veterans and their families** | Polly McMeekin | Katherine Quinn | **Achieved** | **No issues identified** | **Green** | **Green** |

**Assurance Framework Responsive**

# Emergency Care Standard and Unplanned Care

## Operational Context

The Trust has achieved the planned trajectory for the Emergency Care Standard (ECS), reporting 92.5% (89% plan), including the achievement of the national ECS target for the York locality for August at 96%. This is also above the national position of 89.7%. This was achieved despite attendances to the Trust being 5% (+910) above plan. This increase in attendances is reflected nationally.

York Hospital performance was particularly strong as a result of a focussed team approach, both clinical and operational, with the Transformation plan, building on the work of ErnstYoung report, delivering improved clarity of actions within the York Emergency Department (ED). Performance was also supported by lower bed occupancy levels at York Hospital. For August York Hospital bed occupancy at midnight was below 85% on all days. In contrast, Scarborough Hospital has experienced higher levels of bed occupancy throughout the month, with only 5 days below 85% and declaring severe pressure on one day. The seasonal profile for Scarborough Hospital sees the busiest months for the ED through the summer period, due to population increases. As a consequence of ongoing pressure in ED, the Trust has reported 104 ambulance handovers which took more than 1 hour (99 at Scarborough). This is a focus for the Action on A&E Programme and is a core priority.

Delayed Transfers of Care (DtOC) rose significantly at York Hospital during August. Delays have been affected by pressures in home care and nursing home capacity during August. This increase has been escalated to system partners.

## Targeted Actions in August

- Ongoing delivery of the ECS Transformation Plans at York Hospital. Clinical, Nursing and Managerial leads assigned to each project (targeting the Front Door & Handover, Assessment and Ambulatory Care and SAFER).
- Establishment of the ECS Transformation Group at Scarborough Hospital, with plan in development for September.
- Bed modelling refresh for Scarborough Hospital to improve flow as part of the winter planning process.
- Trust winter planning weekly meetings to refine the 2018-19 Winter Plan and support system preparations.
- Confirmation from NHSI of £950k winter capital funds to support the development of a trolley assessment area at Scarborough ED, with a planned completion date of 24th December.
- Refocus of the ECS performance weekly meeting at Scarborough Hospital to provide oversight and support to operational teams.
- Proposed Scarborough discharge hub review workshop held to inform next phase of development (to mirror the York Integrated Discharge hub).
- Local authorities identified additional workforce to support discharge hub.

**Assurance Framework Responsive**

# Emergency Care Standard

**Standard(s):**

Ensure at least 95% of attendees to Accident & Emergency are admitted, transferred or discharged within 4 hours of arrival. The Trust's operational plan trajectory for the August 2018 was 89%.

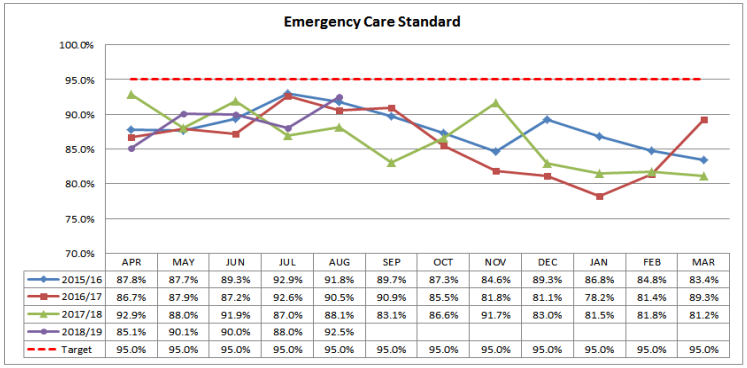
**Consequence of under-achievement**

Patient experience, clinical outcomes, timely access to treatment, regulatory action and loss of the Provider Sustainability Fund (Access Element).

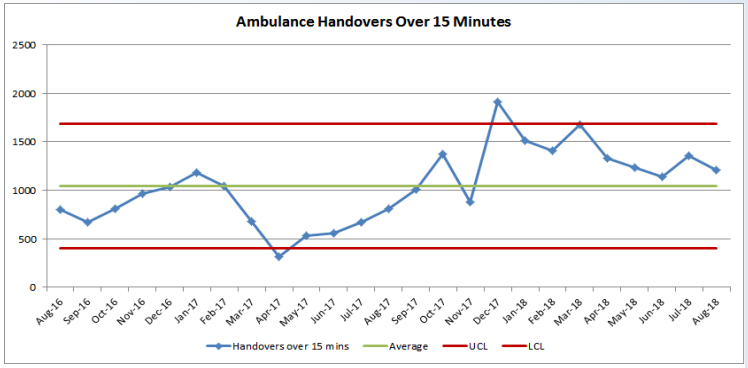
**Performance Update:**

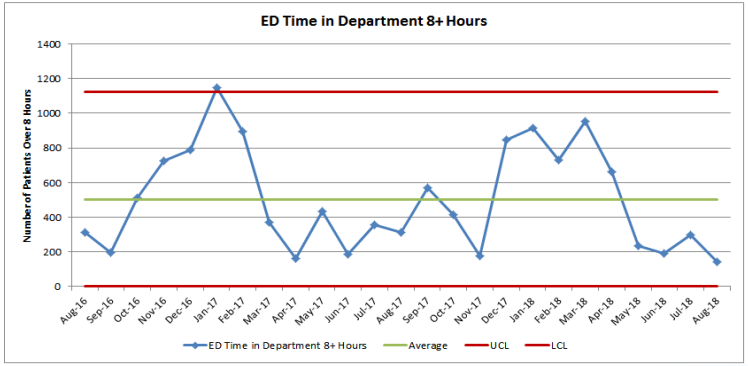
- The Trust achieved 92.5% in August 2018 against the planned trajectory of 89%; the best performance in August for the last four years.
- The number of Type 1 attendances was over 10,000 for the 3rd time this financial year (there were no months with attendances over 10,000 in 2017-18). This represents a 6.8% (+640) increase compared to August 17.
- The number and percentage of patients waiting over 8 hours has decreased by 219% (-170) compared to August 2017, and is most notable at York Hospital.
- Ambulance Handovers remain a challenge, with 104 handover over 1 hour, 99 of which were at Scarborough Hospital. This is comparable with August 17, but represents a 52% reduction from July 18.

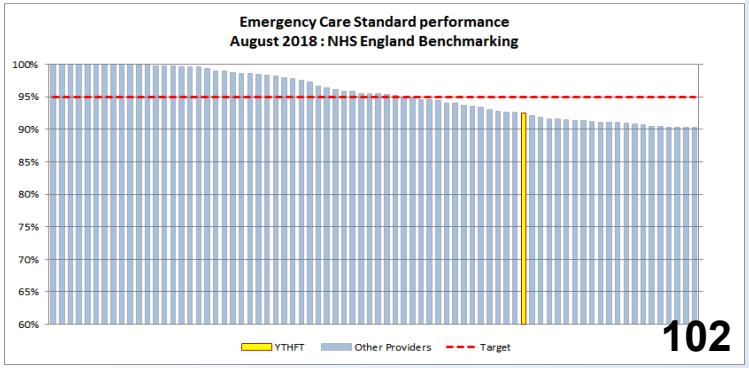
**Performance:**




| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 87.8% | 87.7% | 89.3% | 92.9% | 91.8% | 89.7% | 87.3% | 84.6% | 89.3% | 86.8% | 84.8% | 83.4% |
| 2016/17 | 86.7% | 87.9% | 87.2% | 92.6% | 90.5% | 90.9% | 85.5% | 81.8% | 81.1% | 78.2% | 81.4% | 89.3% |
| 2017/18 | 92.9% | 88.0% | 91.9% | 87.0% | 88.1% | 83.1% | 86.6% | 91.7% | 83.0% | 81.5% | 81.8% | 81.2% |
| 2018/19 | 85.1% | 90.1% | 90.0% | 88.0% | 92.5% | | | | | | | |
| Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |



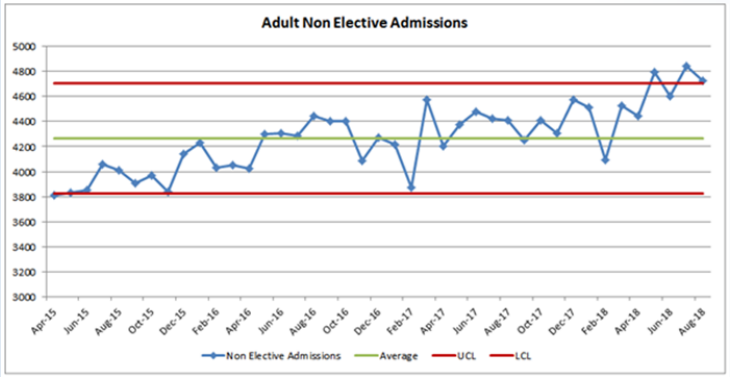
**Assurance Framework Responsive**

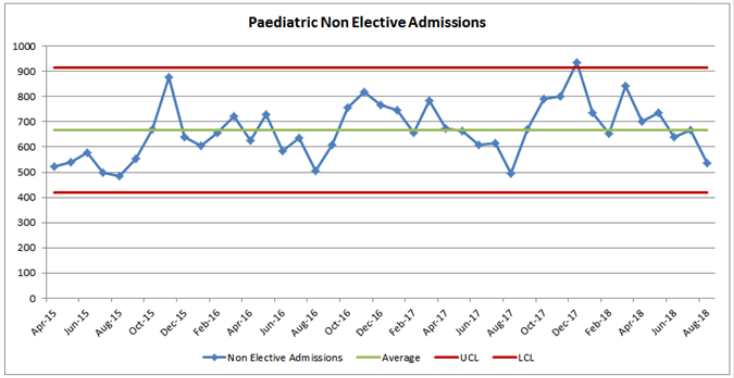
# Unplanned Care

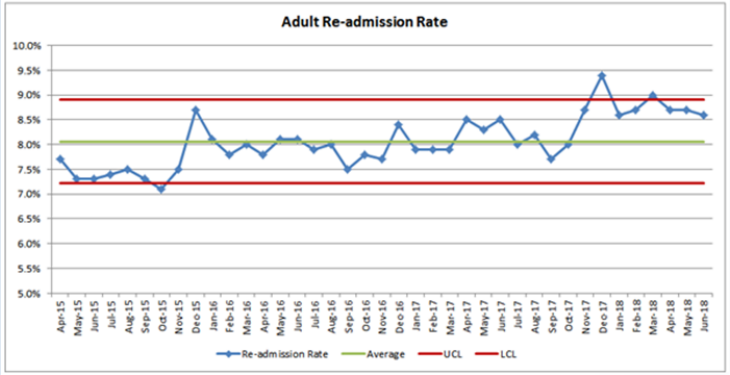
**Performance Update:**

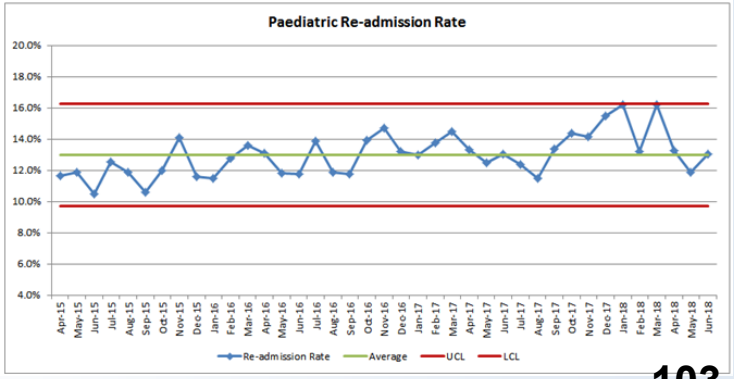
- The number of non-elective admissions in August 2018 of 4,727 shows an increase of 7.16% on August 2017 (4,411). It was also the 3rd highest number of non-elective admissions in a month in over 3 years, the other 2 higher months were also in 2018-19. The most notable increase was in General Surgery and Urology at Scarborough up 10% from July 18 and 11% compared to August 17.
- Non-elective GP admissions remained steady with only a slight increase over the previous month (+1.41%), though the increase on August 2017 showed a greater increase (+7.45%).
- The readmission rate of 8.6% for June 2018 was slightly lower than May (8.7%), but up on June 2017 (8.5%).
- Acute DTOCs have risen significantly in August: 25% (+265) increase from July 18, and 8% (+98) from August 17. This is most notable at York Hospital, up 58% (+359) from July 18.
- The number of beds occupied by super stranded patients (patients who stay more than 21 days) has seen a reduction (up to July) of 10%, against a target of 25% by December 2018.

**Performance:**



**Assurance Framework Responsive**

# Cancer Waiting Times

## Operational Context

The Trust has not achieved the 14 day Fast Track referral from GP target in July at 86.6% (reported a month in arrears) for the first time since December 17. Nationally the Fast Track performance was not achieved for July (91.9%). This is primarily due to clinic capacity pressures in Dermatology (Malton). Referrals into the Trust have remained high, and significantly higher (+19%) than July last year. This has put pressure on outpatients capacity, and resulted in some longer polling ranges for routine cases as clinic capacity is converted to provide additional fast track clinics. Referrals have notably increased compared to July 2017 in Colorectal, Head and Neck, Urology and Dermatology. In contrast to other local providers Urology, Dermatology and Lung have also seen increases in the conversion rate despite the increase in referrals, meaning that more cancers are being diagnosed from the referrals. Whilst from a clinical outcomes perspective this is positive, it continues to place pressure on the Trust's capacity.

The 62 day target from referral to treatment has not been met in July at 72% and is significantly lower than the Trust trajectory of 85%. Nationally the target was not met achieving 78.2%. The drop in Trust performance was anticipated as a number of long wait patients are being treated throughout July and August, in particular patients on Urological, Colorectal and Head and Neck pathways. For July East Coast patients have been particularly affected by capacity issues. For East Coast urological patients there have been specific delays in the diagnostic tests (TRUS) and treatments for some tumours, which have also affected other Trusts in the Humber, Coast and Vale Cancer Alliance. It has now been confirmed that Hull have secured funding for an additional robot to increase treatment capacity. NHSI are sighted on the challenges in relation to Cancer Waiting Times across the Number Coast and Vale Cancer Alliance.

All other Cancer Waiting Time targets have been met.

The Trust has nominated a strategic lead for Cancer, working alongside the Cancer Clinical Lead, Cancer Manager and Lead Nurse to refresh the Cancer Strategy and supporting action plans to improve timed pathways. The Trust is working through the Humber, Coast and Vale Cancer Alliance Board to develop and support a holistic 62 day recovery plan.

## Targeted Actions in August

- Trust Cancer Stocktake and refresh of actions to support 62 day performance .
- Review of the Standard Operating Procedure for removing surveillance patients from the waiting list at Cancer Board (in line with NHSI Elective Intensive Support Team advice).
- Ongoing implementation of the timed pathways .
- Review of the Clinical Harm Review process and reporting arrangements.
- Development of the Humber, Coast and Vale Cancer Alliance 62 day recovery plan.
- Closure report for the NHSI Elective Intensive Support Team, following on site support on cancer waiting times.
- Ongoing patient tracking management, including escalation management of diagnostic requests.
- Further release of detailed Business Intelligence to inform cancer planning and recovery.

**Assurance Framework Responsive**

# 14 Day Fast Track – Cancer Waiting Times

**Standard(s):**

Fast Track referrals should be seen within 14 days.

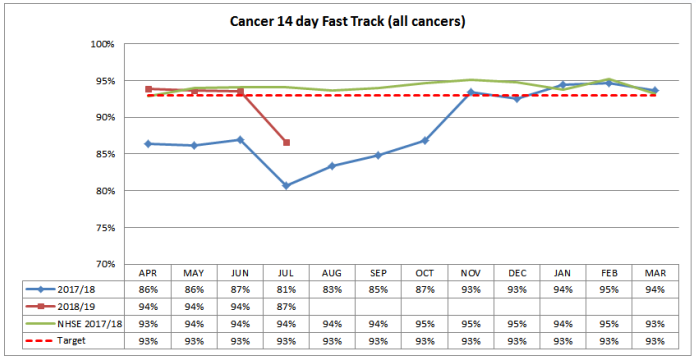
**Consequence of under-achievement:**

Patient experience, clinical outcomes, timely access to treatment and regulatory action.

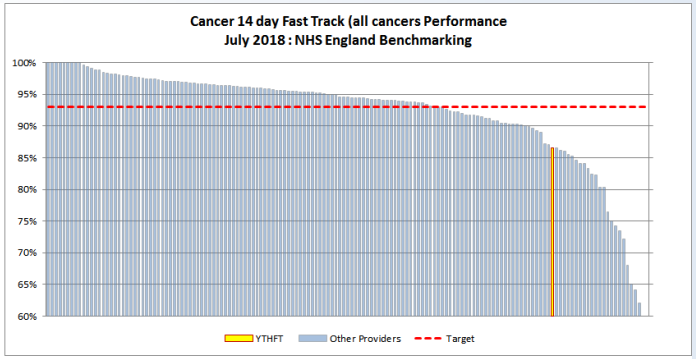
**Performance Update:**

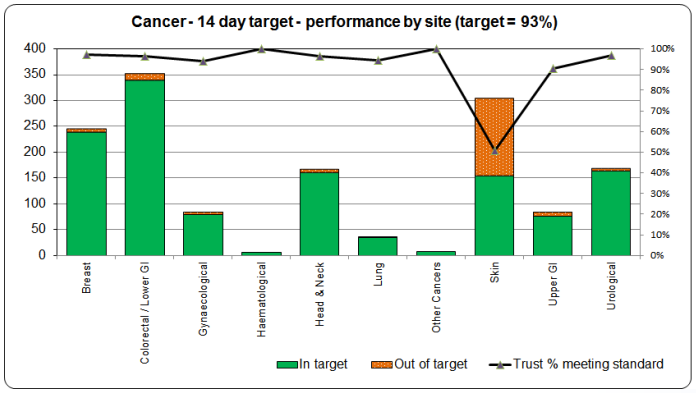
- The Trust achieved 86.6% against the 93% target in July 2018.
- Of the 201 patients in breach of target, 75% were Dermatology referrals. Of the delayed Dermatology Fast Tracks 81% had no reported cancer.
- 12% of the breaches were due to patient choice (e.g. did not attend or could not attend within target).
- 17.8% of referrals were seen within 7 days.
- Fast Track referrals were 19% (+235) higher than July 2017.

**Performance:**




| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 86% | 86% | 87% | 81% | 83% | 85% | 87% | 93% | 93% | 94% | 95% | 94% |
| 2018/19 | 94% | 94% | 94% | 87% | | | | | | | | |
| NHSE 2017/18 | 93% | 94% | 94% | 94% | 94% | 94% | 95% | 95% | 95% | 94% | 95% | 93% |
| Target | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% |



**Assurance Framework Responsive**

# 62 Day Fast Track – Cancer Waiting Times

**Standard(s):**

Ensure at least 85% of patients receive their first definitive treatment for cancer within 62 days of a Fast Track GP or Dental referral.

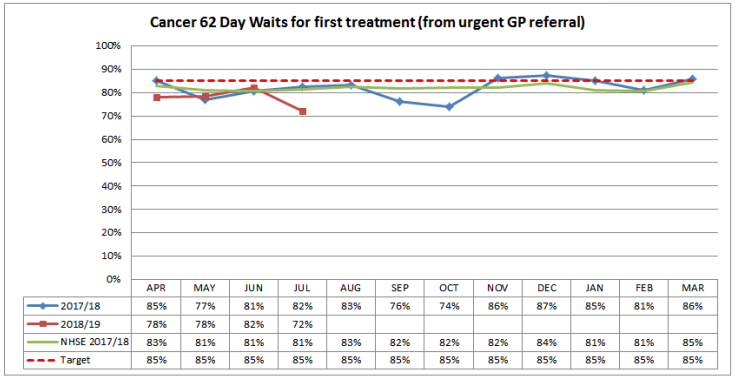
**Consequence of under-achievement:**

Patient experience, clinical outcomes, timely access to treatment, regulatory action and 62 day performance is linked financial allocation to the Humber, Coast and Vale Cancer Alliance.

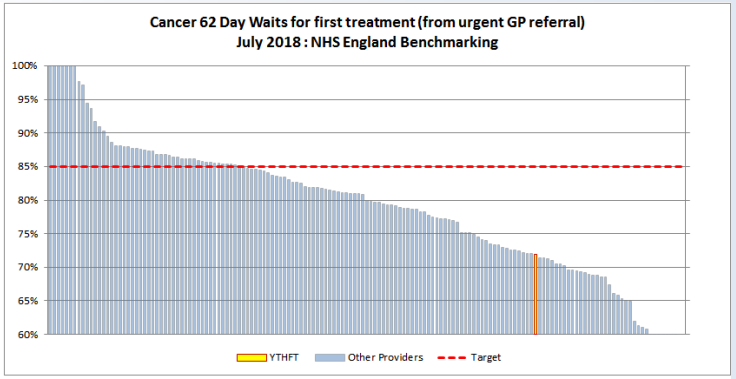
**Performance Update:**

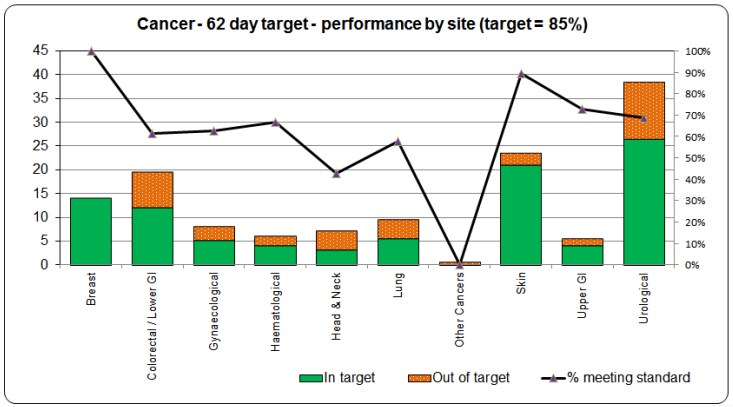
- The Trust achieved 72% against the 85% target for February, equating to 38 accountable breaches (56 patients).
- There were breaches across the majority of tumour sites with highest number of breaches in Urology,.
- Of the reported patient breaches, 38% relate to delays to diagnostic tests or treatment plans/ lack of capacity; 21% relate to complex or inconclusive diagnostics and 18% were due to patient not attending or unavailability.

**Performance:**




| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 85% | 77% | 81% | 82% | 83% | 76% | 74% | 86% | 87% | 85% | 81% | 86% |
| 2018/19 | 78% | 78% | 82% | 72% | | | | | | | | |
| NHSE 2017/18 | 83% | 81% | 81% | 81% | 83% | 82% | 82% | 82% | 84% | 81% | 81% | 85% |
| Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |



**Assurance Framework Responsive**

# Planned Care

## Operational Context

The Trust has seen a marginal reduction in the total incomplete waiting list for August, the first reduction this financial year to 27,756. This is due to a reduction in GP and total referrals into the Trust in August over the holiday period. However, the waiting list remains higher than required to achieve the target of 26,303 by March 2019. This is particularly notable for General Surgery, General Medicine, Dermatology, Rheumatology and Ophthalmology.

The number of long wait patients (over 36 weeks) has continued to decrease in August, down 10% from April 18, following targeted validation and weekly meetings with directorates. This still remains a concern however, with 195 patients over 40 weeks at the time of writing the report. The Trust received the national letter from NHSI requiring the achievement of the 2018-19 performance expectations for planned care . The Trust has responded confirming the internal recovery actions and quantifying the potential cost of additional capacity required to achieve the waiting list target, if demand continues to increase as anticipated.

The Trust continues to deliver the Theatre Productivity Programme, targeting Bridlington theatre utilisation in the first phase. This works seeks to increase the number of operations that can be delivered within existing capacity. The Trust is part of the national NHSI Outpatients Productivity and has identified senior managerial and clinical leads. The Trust elective plan is seasonally profiled and accounts for a reduction in elective activity in August.

The Trust has not achieved the national diagnostic target at 93.6%, against the standard of 99%. There are particular pressures in MRI, Non-Obstetric Ultrasound , Endoscopy at Scarborough and Sleep Studies (although this has seen significant improvement and recovery is anticipated for the end of September). The Trust is developing a comprehensive diagnostic recovery plan supported by NHSI Productivity Team and NHS Elect, along with the corporate teams.

## Targeted Actions in August

- Comprehensive Referral to Treatment Time (RTT) stocktake completed by speciality, including waiting list position, medical vacancies, premium cost work, referral changes, polling range for 1st Outpatient appointment and Follow-Up backlogs.
- Detailed analysis of progress against plan and pressures on the waiting list position.
- Identification of recovery actions for the waiting list position, including forecast models by speciality of the RTT position. This has identified a 'capacity gap' to meet increased demand. The Trust is working with commissioners to determine how any additional capacity would be funded.
- Short term actions identified to mitigate risks within Ophthalmology for Glaucoma patients, including using capacity at Harrogate District.
- Preparation for the Ophthalmology 'Deep Dive' with commissioners in September to identify a sustainable model for the medium term.
- Increased outsourcing of Radiology reporting to help mitigate risks in the radiology backlog.
- Commencement of the Radiology demand and capacity analysis to support a comprehensive recovery plan.
- Secured funding through the Cancer Alliance for the networked diagnostic STP procurement.
- PWC analysis of Endoscopy opportunities, and ongoing implementation of the Endoscopy recovery plan.

**Assurance Framework Responsive**

# 18 Weeks Referral to Treatment

**Standard(s):**

The total waiting list must not be more than 26,303 open clocks by March 2019. The Trust must not exceed 3 x 52 week breaches in 2018-19.

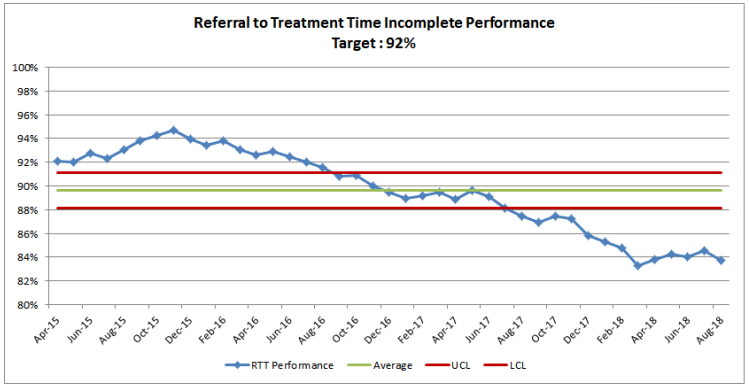
**Consequence of under-achievement:**

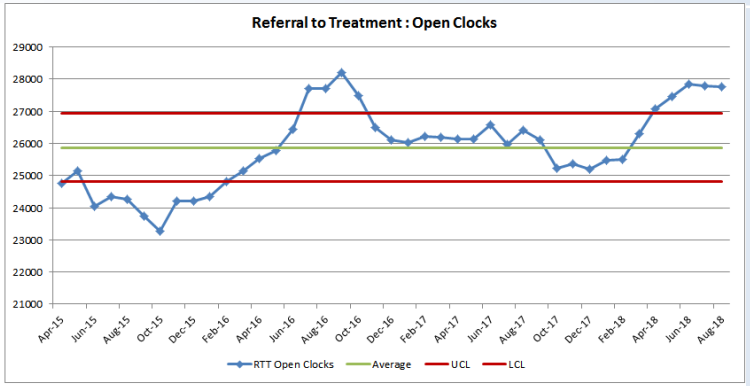
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

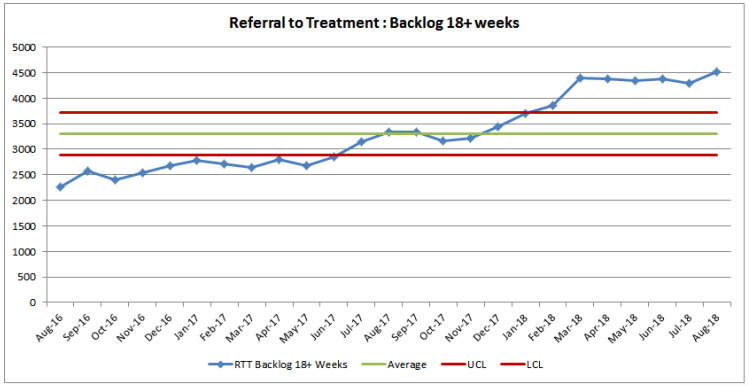
**Performance Update:**

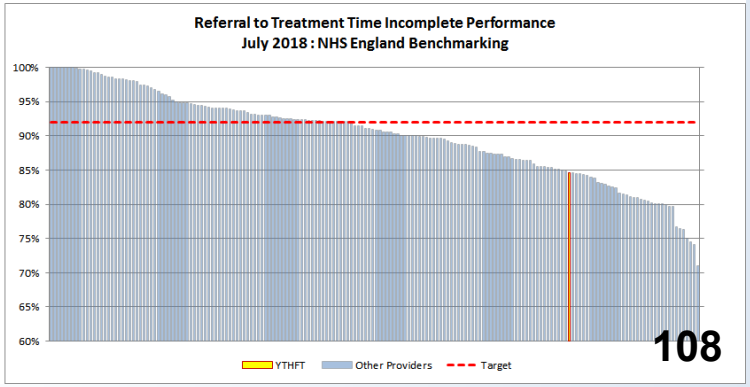
- The Trust achieved 84% RTT in August 2018, with 4,517 patients waiting over 18 weeks.
- The total number of patients on the RTT Incomplete pathway was 27,756 in August 2018, a slight improvement July's position (27,796). This remains 1790 clocks (6.9%) above plan for August.
- The Trust has declared 0 x 52 week wait patients.
- There were 16,407 referrals received in August 2018, a reduction of 10.5% on July and 3.5% on August 2017. GP referrals were over 1,000 less than July (-10.2%) , and over 200 less than August 2017 (-2.4%).
- Utilisation of planned sessions has improved at York Hospital to 95% in August.
- The Trust 'Did Not Attend/ Was Not Brought' (DNA) rate remains at 6%, although Scarborough Hospital DNA rate is higher at 8%.

**Performance:**



**Assurance Framework Responsive**

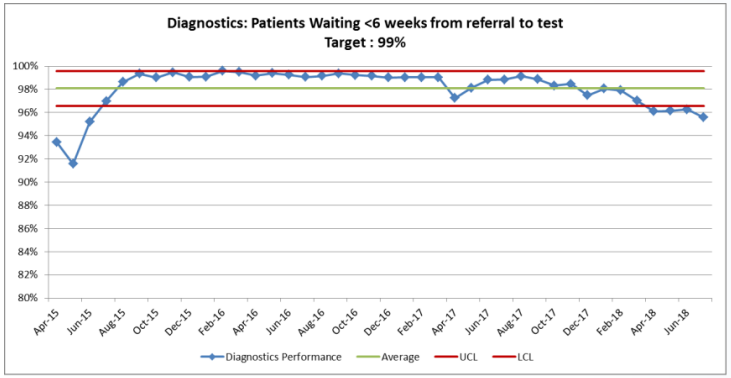
# Diagnostic Test Waiting Times

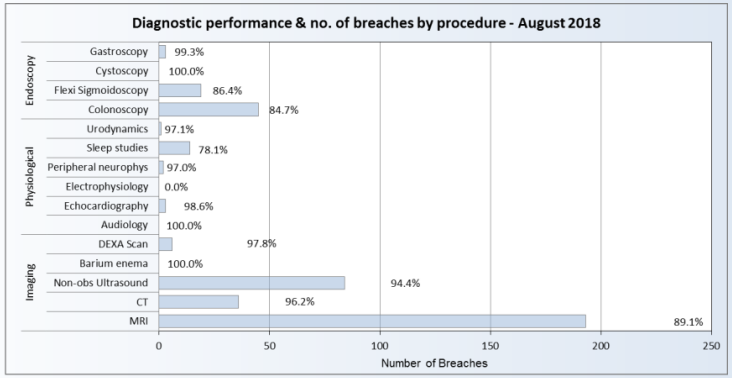
**Standard(s):** Ensure at least 99% of patients wait no more than 6 weeks for a diagnostic test.

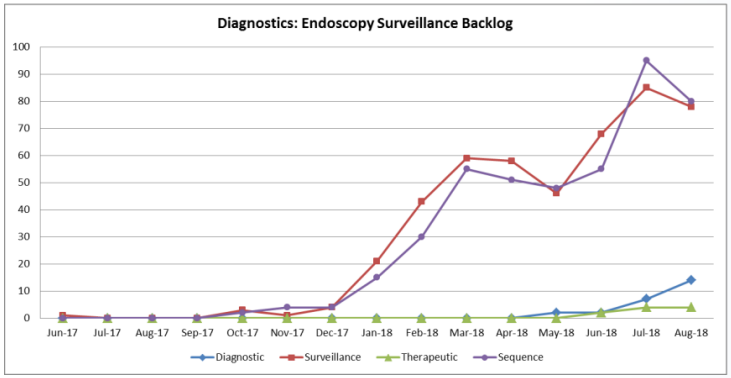
**Consequence of under-achievement:** Patient experience, clinical outcomes, timely access to treatment and regulatory action.

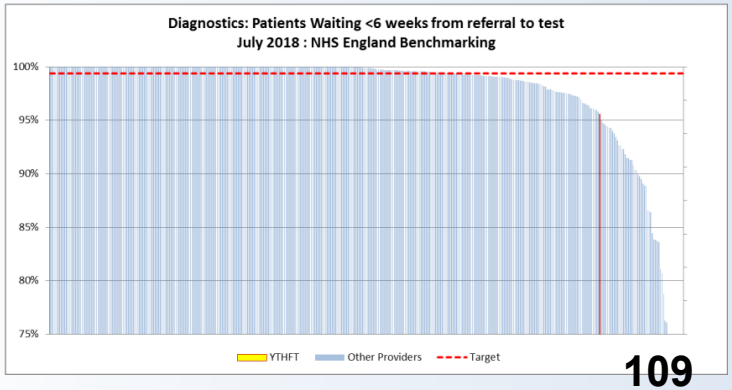
**Performance Update:** The Trust achieved 93.6% against the 99% target for August 2018,. The majority of diagnostic breaches were for colonoscopy, Non-Obstetric Ultrasound and MRI.

**Performance:**



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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# NHS England Emergency Preparedness, Resilience & Response Annual Assurance

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☒ |
| For discussion | ☐ | A regulatory requirement | ☒ |
| For assurance | ☒ | | |

Purpose of the Report

The Board is asked to:

- Note that following a self-assessment process against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Standards, the Trust has rated itself as "Substantially" compliant. This is an improvement on the "Partially Compliant" rating reported in 2016/17 and 2017/18.
- Note the progress with the EPRR agenda since the last update in September 2017.
- Note the key priorities and updated action plan for EPRR that will be implemented over the next 12 months.

Executive Summary – Key Points

The Board is asked to note that following a self-assessment process against the NHS England EPRR standards, the Trust has been rated as "substantially" compliant.

There have been a number of significant achievements and events of note in the last 12 months. In July 2018, two live mass casualty simulation exercises (known as LIVEX) were undertaken, which allowed over 200 front line staff from both acute sites to test the Trust Incident Response Plans. The Trust now has over 300 completed Business Continuity Plans, for a range of different scenarios and more than 60 trained staff (at both acute sites) who can enact the decontamination equipment and plans.

During the year, the Trust has also had to respond to a Summer Heatwave, where Met Office temperature thresholds were met on two occasions. Following on from this, and in response to learning the plan will be subject to review and improvements later this year.

The Emergency Planning Steering Group (EPSG) continues to manage all EPRR related risks, including that of another Cyber Attack. While the action plan produced following the incident of May 2017 has now been completed, the risk of another attack of this nature occurring remains high and so it remains a "red" risk on the risk register.

An audit of EPRR arrangements undertaken in March 2018, reported a "significant" level of assurance - which was an improvement on the "limited "assurance rating given in March 2017 when the same audit was undertaken.

Priorities for 2018/19 include following up actions from the LIVEX exercises, undertaking a live "Black Start" exercise and continuing to review, refine and update our risks and associated emergency planning policies.

Recommendation

To approve the report and assurance rating of "substantial" compliance with the NHS England EPRR Core Standards.

**Author:** Mark Hindmarsh – Joint Head of Strategy & Lead for Emergency Planning

**Director Sponsor:** Wendy Scott – Chief Operating Officer (Accountable Emergency Officer)

**Date:** September 2018

## 1. Introduction and Background

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

On an annual basis, The NHS England Core Standards for EPRR set out the minimum standards that NHS organisations and providers of NHS funded care must meet. The Trust is required to undertake an annual self-assessment against these standards and provide assurance to NHS England that robust and resilient EPRR arrangements are in place and maintained within the Trust. In 2016/17 and in 2017/18 the Trust reported that it was "partially" compliant with these standards – meaning it did not fully meet 10 of the core standards.

Following this year's self-assessment process the Trust is declaring a "Substantially" Compliant rating. **The Board is requested to note this compliance rating.** The action plan in the appendix to this report sets out the key actions required to further strengthen the Trust's compliance with these standards and will be addressed over the next 12 months.

## 2. Significant Incidents and Events of Note in the Last 12 Months

### 2.1 LIVEX

In the first week of July 2018, the Trust, supported by the Army, undertook two live mass casualty simulation exercises at the Army Medical Services Training Centre in York. The purpose of the exercises was to test the Trust Incident Response Plan (IRP) and associated Action Cards for both of our main two acute sites, and provide frontline staff with some experience of what working through a Major Incident may be like. LIVEX also acted as an important end-point and motivator for staff to look up the IRP and attend training sessions that were put on. Following LIVEX 80% of participants reported that they knew where to find the Trust IRP, and this is a significant achievement.

In totality, the exercises involved over 200 front line NHS staff, and are the only known example of the NHS working in this way and to this scale in the UK this year. The full report from LIVEX, which details the list of recommendations resulting from the exercises has also been completed and is being discussed at Trust Board today.

### 2.2 Chemical, Biological, Radiological and Nuclear (CBRN)

This agenda has continued to be given prominence in the national media following events with the Novichok Nerve agent in Salisbury in March 2018. The Trust has continued to receive clinical management updates from NHS England that set out best-practice clinical management for patients poisoned with this and other similar agents, and these have been sent on to clinical teams for information.

The Trust is subject to a bi-annual inspection of its decontamination equipment, polices and training schedules by Yorkshire Ambulance Service – with the next one being due in July 2019. Until then the Trust is officially rated as "prepared" (which is the highest possible rating for a Trust such as this). In preparation for any incident, the team have

continued to increase the number of staff trained in this area (more than 60 staff are now trained on both sites) and practice quarterly the process around erecting the decontamination tents and testing other equipment.

### 2.3 Business Continuity

Following extensive work, led by the Deputy Head of Performance, the Trust now has over 300 completed business continuity action cards for departments and areas across all sites. These cover the actions to be taken in the event of the loss of people, information/data, premises, suppliers and IT/infrastructure. The Business Continuity Group will oversee the on-going refinement of these plans, including a rolling testing schedule.

### 2.4 Summer 2018 Heatwave

During the summer of 2018, the Yorkshire and Humber region experienced an unusual spell of hot weather. In conjunction with the Met Office, NHS England have set agreed temperature threshold levels for each UK region (daytime temperatures of 29$^{O}$C or over for Yorkshire & Humber). If these thresholds are met over three consecutive days, it means that the Trust should activate its heatwave plan. This occurred on two separate occasions over the Summer, meaning that extra fans were deployed around sites, locked windows were opened to allow for additional airflow and that additional communications were circulated advising how best to ensure that patients and staff remained hydrated.

Following experiences this summer, a number of improvements have been identified that are needed to this plan. Implementation of these will be overseen by the EPSG.

### 2.5 Cyber Attack – May 2017

Following the Wanna-Cry Cyber Attack of May 2017 a detailed action plan was authored and submitted to Trust Board that was approved in July 2017. The report set out more than 50 actions to be completed and these included recommendations around strengthening arrangements for applying patch updates to the Windows systems and improving business continuity arrangements for the loss of IT systems. The Emergency Planning Steering Group (EPSG) was tasked with overseeing the implementation of these actions. All actions on this report have now been completed and The Cyber Attack Action Plan has now been stood down as a standing item on the EPSG agenda.

However, the risk of another Cyber incident remains high, and recent cyber-attacks on British Airways, Ticketmaster and TSB Bank have all served as a reminder to remain vigilant in this area. It is important to note that “Cyber Attack” remains on the EPSG Risk Register as a “high” risk, meaning that it is subject to quarterly review, updates and actions.

## 3. Internal Audit of EPRR

Following a request by the Chief Operating Officer, The Trust’s Internal Audit team undertook an audit of EPRR arrangements which reported its findings in March 2017. The report gave EPRR arrangements a rating of “limited” assurance. A 27 point action plan was produced as a result of the audit which was handed over to the EPSG in April 2017. Following a request, a repeat audit was requested, and was undertaken in March 2018. The report concluded that EPRR was now “significantly” assured and stated:

*The review confirmed that there has been significant progress towards implementing the recommendations raised in Y1760 [March 2017 Audit]: Emergency Preparedness, Resilience and Response (EPRR). Minor improvements have been recommended, but these do not impact on the overall effectiveness of the system.*

## 4. Governance and Leadership Arrangements for EPRR

Given the increasing and changing nature of the work in this area and the risk it presents, the Trust has decided to appoint to a new post, "Lead for Emergency Planning". The post has been banded at 8A level and will report to the Deputy Chief Operating Officer, with portfolio responsibility for EPRR. The post will work across all Trust sites and be responsible for the day to day delivery of the EPRR agenda, as well as chairing the EPSG. Interviews for this post are due to take place in October 2018.

## 5. Plans for 2018/19

### 5.1 Building on LIVEX

The LIVEX exercises have generated a significant programme of work to be taken forward in 2018/19. In all the report lists more than 60 recommendations, some of which can be resolved quickly and easily, while others may require small task and finish groups to be established to resolve. There are six main, Trustwide issues resulting from LIVEX that require resolution in the coming year, and these are:

- Command, Control and Communications training for individuals in leadership and command roles
- Work with The Police and Coroner to improve arrangements for the collection of forensic evidence and establish a casualty bureau
- There are three information/IT issues to resolve, relating to; speeding up the registration of patients, tracking patients through the hospital and the process around registering "unknown" patients.
- Staff would value further training around the management of some rarely seen trauma cases (such as blast injuries)
- The Trust is to review and improve its staff call-in process
- The Trust should review how to deploy staff differently across sites in the event of a major incident, especially if the incident occurred significantly closer to one of the main sites.

The NHS and Army team involved in LIVEX will also share their learning with the wider NHS through NHS England and the development of a "LIVEX in a Box" table top exercise.

### 5.2 Black Start Exercise

A "Black Start" is a procedure to restore power in the event of a total or partial shutdown of the electricity system. The Estates team and Business Continuity Lead are currently working with departments across the Trust that will allow them to safely shut down the Trust's main power supply at York Hospital. The purpose of the exercise would be to test directorate level business continuity action cards for the loss of power, while also testing that the back-up generators kick-in as they are intended to if the main electricity supply is

interrupted. The aim is to run this test before the end of the year, subject to the relevant governance arrangements being in place.

### 5.3 On-going Risks and Policy Reviews

There are currently 19 risks on the EPSG risk register. All risks are scheduled for review at least annually, with red risks being reviewed quarterly. There are currently four risks with a "red" rating. They are:

- Risk of surges in activity
- Risk of IT or communications failures (inc. Cyber Attacks)
- Risk of Utilities Failures
- Risk of Pandemic Influenza

Mitigating these risks will continue to be a high priority for the EPSG in 2018/19.

The EPSG also oversees another 20 separate policies that are related to the Emergency Planning agenda, this covers everything from the Heatwave Plan to the Site Lockdown Plan. All these policies are now on a schedule to be reviewed at least annually – or more frequently if the need arises. This work is also a high priority in 2018/19.

## 6. Conclusions

The enclosed report identifies progress made in the last 12 months and sets out the further work to be undertaken during 2018/19. There is a high level of commitment and engagement to the EPRR agenda across the Trust, particularly following LIVEX that will be harnessed in the coming year.

In addition to those areas discussed in this report, the attached work plan (in the appendix) sets out the main areas of focus for the next 12 months that have arisen following the NHS England Self-Assessment Process.

## Yorkshire and the Humber Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019

## STATEMENT OF COMPLIANCE

York Teaching Hospital NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, York Teaching Hospital NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

| Overall EPRR assurance rating | Criteria |
|---|---|
| **Fully** | The organisation is 100% compliant with all core standards they are expected to achieve.<br><br>The organisation's Board has agreed with this position statement. |
| **Substantial** | The organisation is 89-99% compliant with the core standards they are expected to achieve.<br><br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| **Partial** | The organisation is 77-88% compliant with the core standards they are expected to achieve.<br><br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| **Non-compliant** | The organisation compliant with 76% or less of the core standards the organisation is expected to achieve.<br><br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.<br><br>The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance. |

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

17/09/2018

Date signed

| 26/09/2018 | 26/09/2018 | 01/09/2019 |
|---|---|---|
| Date of Board/governing body meeting | Date presented at Public Board | Date published in organisations Annual Report |

## EPRR Action Plan 2019

| Ref | Domain | Standard | Detail | Self assessment RAG | Action to be taken | Lead | Timescale |
|---|---|---|---|---|---|---|---|
| 15 | Duty to maintain plans | Pandemic influenza | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register. | Partially compliant | The Trust does have seasonal flu plans, but the Pandemic Influenza plans require an update. This is scheduled to be completed before the 2018/19 Flu Season in conjunction with the Trust IPC Team | Lead for EPRR | Nov-18 |
| 19 | Duty to maintain plans | Mass Casualty - patient identification | The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex. | Partially compliant | LIVEX demonstrated that there isn't a common process at either acute site for the registration of unidentified patients that present. This action therefore is already high priority to resolve. A small cross-department working group is needed to agree a process and roll it out across the Trust. | Lead for EPRR | Jan-19 |
| 20 | Duty to maintain plans | Shelter and evacuation | In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation. | Partially compliant | Although the Trust has evacuation policies it does not have arrangements in place to provide shelter following a whole site evacuation. Work will be undertaken with partners in the region to establish what can be done in this area. | Lead for EPRR | Apr-19 |
| 40 | Cooperation | LRHP attendance | The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum. | Partially compliant | This is a delegated responsibility to the Lead for EPRR, who routinely udates and briefs the AEO on relevant actions. | AEO | 2019 |
| 42 | Cooperation | Mutual aid arrangements | The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies.<br><br>These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA). | Partially compliant | Although the Trust has been through the process of completing a MACA this year as part of LIVEX, these isn't a formal, documented process around how this should happen, nor how mutual aid should be requested from other NHS organisations. This needs to be addressed in the EPRR policy document | Lead for EPRR | Mar-19 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **61** | **CBRN** | **PRPS availability** | The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment.<br><br>There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date. | Partially compliant | Recent delivery of 4 new suits received. However, due to national procurement issues, this is an on-going issue. Continue to work with NHS E and suppler to re-validate old suits. Ensure arrangements are in place to move suits between sites in the event of an incident occurring. | Lead for EPRR | Mar-19 |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# LIVEX – Final Report & Recommendations

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☒ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

Purpose of the Report

The Board is asked to:

- Approve the recommendations set out in this report to further strengthen the Trust's Incident Response Plan.
- Approve the proposed governance arrangements for the implementation of the recommendations.
- Support other on-going initiatives resulting from LIVEX, including the application for an NHS Employers Gold Award for supporting Military Personnel into the NHS and the development of "LIVEX in a Box".

Executive Summary – Key Points

During the week of the 2nd July 2018 York Teaching Hospital NHS Foundation Trust in partnership with the 2nd Medical Brigade, ran two live mass casualty simulation exercises – one for York Hospital and one for Scarborough Hospital. The exercises were held at the Army Medical Services Training Centre (AMSTC) in York and were known as "LIVEX".

As part of its legal requirements under the Civil Contingencies Act, the Trust is required to have an up to date Incident Response Plan (IRP), detailing how the Trust would respond in the event of a Major Incident occurring. The IRP was recently updated to incorporate new national guidance that was released following the Manchester Arena Attack – but the plan itself hadn't been rigorously tested. NHS England also require the Trust to run a live training exercise at least once every three years to test the IRP.

The principal purpose of LIVEX was to test the IRP and train staff in this uniquely challenging environment.

A scenario was devised that was essentially the same for both the York and Scarborough exercises, and involved the detonation of an Improvised Explosive Device (IED), plus

some gunfire taking place in close proximity to the hospital. This scenario then generated a large number casualties that presented to the hospital over the course of the seven hour exercise.

Around 100 frontline NHS staff were involved in each of the main exercises, and they were supported by around another 100 individuals (NHS and Army) who helped to facilitate the exercise or participated as a casualty actor.

Having completed the exercise, the IRPs for both hospital sites were deemed "fit for purpose." However, there were a number of issues that arose from LIVEX that require attention, the most pressing of which require a Trustwide response. They are:

- **Command, Control & Communications** – staff in leadership roles would benefit from improved training in this area, and new equipment is needed to facilitate this.
- **Forensics & Post Incident** Enquiry – Arrangements in this area are currently absent from the IRP. Work is required with The Police & Coroner to confirm arrangements.
- **Information & IT** – There are three separate elements to this issue:
    - It should be quicker to register patients in ED during an incident.
    - A common way is needed to register and track unidentifiable patients.
    - There should be a way to count patients presenting in the currency of P1, P2, P3 to facilitate situation reporting and liaison with the Ambulance Service.
- **Deployment of Staff** – Consideration should be given to how, in the event of a Major Incident, staff should be deployed to the site most in need of support.
- **Call-in Process** – The Trust needs a robust method of calling staff into its hospitals (especially out of hours) that isn't dependent on switchboard in the event of an incident
- **Trauma Training** – Frontline clinical staff should receive additional training around the management of trauma cases that rarely present at their hospital.

The media campaign around LIVEX was very successful, with LIVEX featuring on both BBC and ITV local news programmes and the "#LIVEX18" being seen over 91,000 on Twitter.

Overall responsibility for implementation of LIVEX recommendations sits with the Chief Operating Officer, but will be overseen by the Emergency Planning Steering Group. A table top version of LIVEX (called "LIVEX in a Box") is being developed in conjunction with The Army which it will be possible to share with other NHS Organisations to support their learning and preparedness.

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Recommendation

To approve the report and assurance rating of "substantial" compliance with the NHS England EPRR Core Standards.

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**Author:** Mark Hindmarsh – Joint Head of Strategy & Lead for Emergency Planning
**Director Sponsor:** Wendy Scott – Chief Operating Officer (Accountable Emergency Officer)
**Date:** September 2018

York Teaching Hospital NHS
NHS Foundation Trust

# LIVEX 2018

FINAL REPORT AND RECOMMENDATIONS

PREPARING FOR EMERGENCIES

| LIVEX 2018 Final Report | |
|---|---|
| **Author(s):** | Mark Hindmarsh – Joint Head of Strategy & Lead for Emergency Planning<br>Dr Phil Dickinson – Consultant Anaesthetist, Clinical Lead North Yorks & Humber Major Trauma Network<br>Lt Col Richard Chadwick – Chief Instructor, Army Medical Services Training Centre, 2nd Medical Brigade |
| **Contributors:** | Sarah Tomlinson – Head of EPRR, NHS England (Yorks & Humber)<br>Lt Col Jayne Cumming – Senior Nursing Officer, Army Medical Services Training Centre, 2nd Medical Brigade |
| **Owner:** | Wendy Scott – Chief Operating Officer and Accountable Emergency Officer |
| **Senior Responsible Officer:** | Wendy Scott – Chief Operating Officer |
| **Date of issue:** | September 2018 |
| **Version:** | v1.0 |
| **Review date:** | Recommendations should be reviewed quarterly from the date of approval |
| **Responsibility for review, distribution and testing:** | Emergency Planning Steering Group |
| **Consultation:** | LIVEX Participants<br>LIVEX Casualty Volunteers<br>LIVEX Enabling staff (York Trust & Army Medical Services Training Centre, 2nd Medical Brigade) |
| **Target audience:** | Trust Board<br>Trust Executive Board<br>Directorate Leadership Teams |
| **Publishing and distribution:** | This document is available to staff via the staff intranet.<br><br>The document also has a Government Security Classification of OFFICIAL |

# Contents

# 1. Foreword

Unfortunately, we live in times where the likelihood of another terrorist attack remains highly likely. There were no fewer than four separate incidents in the UK in 2017, and the Police continue to foil plots and arrest would-be attackers on a continuous basis. The attacks on Manchester Arena on 22nd May 2017 were the most deadly since the London bombings of 2005 – 22 people died, hundreds were injured and many of them continue to receive physical, mental and emotional support to this day. What we've been able to achieve at LIVEX is dedicated to and inspired by the families who lost loved ones in 2017.

We are not immune from this threat in York and North Yorkshire. York is one of the most popular cities in the UK for tourists (6 million in 2015), and throughout the year Scarborough hosts concerts and other events attracting tens of thousands of people. There are many other major events in our region throughout the year, all of which, sadly, could become targets for those who want to cause harm.

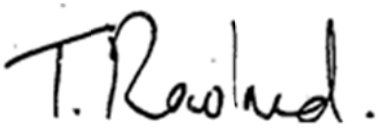
In July 2018 York Teaching Hospital NHS FT and 2nd Medical Brigade embarked on a unique series of training exercises to help prepare NHS staff to respond to a major incident. 2nd Medical Brigade are internationally recognised for the quality of their training and ability to prepare staff for challenging situations, and for the NHS, working with them in this way represented a fantastic opportunity.

The running of LIVEX18 was the culmination not just of a years' worth of planning and preparatory work, but a decade or more of partnership working between our two organisations. The purpose of the exercises was simple – to help train and prepare our staff to respond to a mass casualty major incident, whereby the Trust's hospitals had to manage a large influx of seriously injured people in a short space of time.

The approach taken at LIVEX was unique. Unlike the Military, the NHS does not regularly conduct large scale, multi-department, multi-organisation collective training exercises. The individual skills and knowledge of our NHS clinicians are well honed, but what is not routinely tested is how clinical and non-clinical teams come together, and how the response to an incident is led and co-ordinated. LIVEX aimed to correct this.

The opportunity to run LIVEX not only tested our plans, but also had unintended consequences, not originally considered during the preparatory phase. These included the boost to the morale and confidence of those taking part and the level of external interest in what we were doing. We have laid the foundations to support training and emergency preparedness across the NHS and we intend to share our learning and experience with others to support them in the future.

We are very proud of what was achieved at LIVEX and look forward to working closely together in the future.



Brigadier Toby Rowlands
**Commander**
**2nd Medical Brigade**

Wendy Scott
**Chief Operating Officer & Accountable Emergency Officer**
**York Teaching Hospital NHS FT**

# 2. Executive Summary

During the week of the 2nd July 2018 York Teaching Hospital NHS Foundation Trust in partnership with the 2nd Medical Brigade, ran two live mass casualty simulation exercises – one for York Hospital and one for Scarborough Hospital. The exercises were held at the Army Medical Services Training Centre (AMSTC) in York and were known as "LIVEX".

As part of its legal requirements under the Civil Contingencies Act, the Trust is required to have an up to date Incident Response Plan (IRP), detailing how the Trust would respond in the event of a Major Incident occurring. The IRP was recently updated to incorporate new national guidance that was released following the Manchester Arena Attack – but the plan itself hadn't been rigorously tested. NHS England also require the Trust to run a live training exercise at least once every three years to test the IRP.

The principal purpose of LIVEX was to test the IRP and train staff in this uniquely challenging environment.

A scenario was devised that was essentially the same for both the York and Scarborough exercises, and involved the detonation of an Improvised Explosive Device (IED), plus some gunfire taking place in close proximity to the hospital. This scenario then generated a large number casualties that presented to the hospital over the course of the seven hour exercise.

Around 100 frontline NHS staff were involved in each of the main exercises, and they were supported by around another 100 individuals (NHS and Army) who helped to facilitate the exercise or participated as a casualty actor.

Having completed the exercise, the IRPs for both hospital sites were deemed "fit for purpose." However, there were a number of issues that arose from LIVEX that require attention, the most pressing of which require a Trustwide response. They are:

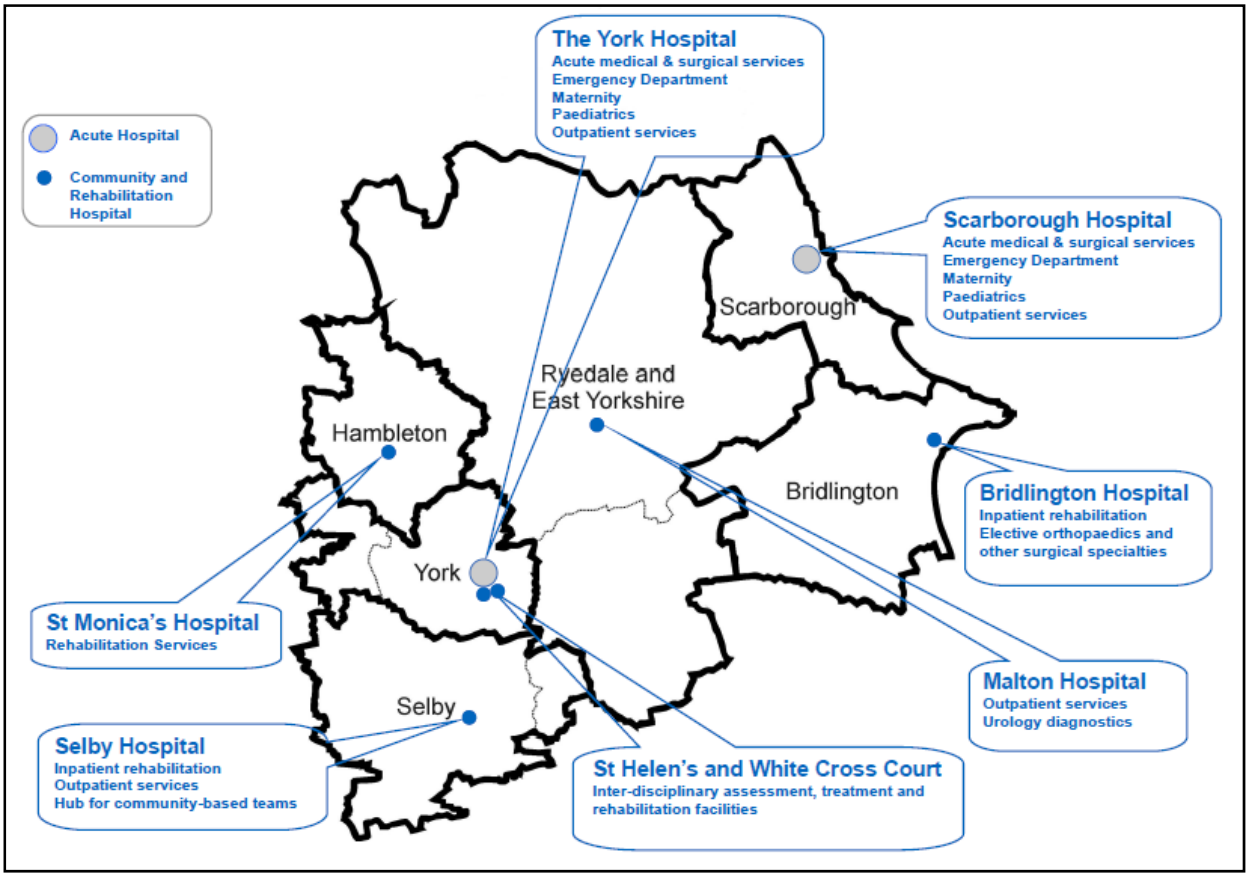
- **Command, Control & Communications** – staff in leadership roles would benefit from improved training in this area, and new equipment is needed to facilitate this.
- **Forensics & Post Incident Enquiry** – Arrangements in this area are currently absent from the IRP. Work is required with The Police & Coroner to confirm arrangements.
- **Information & IT –** There are three separate elements to this issue:
    - It should be quicker to register patients in ED during an incident.
    - A common way is needed to register and track unidentifiable patients.
    - There should be a way to count patients presenting in the currency of P1, P2, P3 to facilitate situation reporting and liaison with the Ambulance Service.
- **Deployment of Staff –** Consideration should be given to how, in the event of a Major Incident, staff should be deployed to the site most in need of support.
- **Call-in Process –** The Trust needs a robust method of calling staff into its hospitals (especially out of hours) that isn't dependent on switchboard in the event of an incident
- **Trauma Training –** Frontline clinical staff should receive additional training around the management of trauma cases that rarely present at their hospital.

The media campaign around LIVEX was very successful, with LIVEX featuring on both BBC and ITV local news programmes and the "#LIVEX18" being seen over 91,000 on Twitter.

Overall responsibility for implementation of LIVEX recommendations sits with the Chief Operating Officer, but will be overseen by the Emergency Planning Steering Group. A table top version of LIVEX (called "LIVEX in a Box") is being developed in conjunction with The Army which it will be possible to share with other NHS Organisations to support their learning and preparedness.

# 3. Introduction

Between the 2nd and 6th July 2017 York Teaching Hospital NHS FT, in partnership with the 2nd Medical Brigade, ran two live mass casualty simulation exercises – one for each of the Trust's two main acute hospital sites in York and Scarborough (depicted below). The exercises were held at the Army Medical Services Training Centre (AMSTC) in Strensall, just outside York.




The Trust's two main acute sites are 42 miles apart – at least an hours journey. Furthermore, Scarborough Hospital is particularly challenged, as it is over an hour away from any other major hospitals, resulting in its participation in several national initiatives to support the sustainability of acute hospitals in remote locations. These geographical and organisational challenges pose the organisation unique challenges in relation to how the sites would interact in the event of an incident, and how patients and resources might be deployed appropriately and effectively.

## 3.1. The Incident Response Plan (IRP) & NHS England Guidance

As part of the Trust's legal responsibilities under the Civil Contingency Act 2004, it is required to have a plan in place that sets out how it would declare and subsequently respond to an incident taking place in the vicinity of the organisation. NHS England require that plan, known as the Incident Response Plan (IRP), to be exercised at least once every three years.

The key features of the Trust IRP include:

- A description of how to assess any incident in the vicinity, and the process for making a decision around whether to declare a formal incident status.
- In the event of an incident being declared, a description of how the Trust would establish a formal Command and Control structure (i.e. establish Gold, Silver and Bronze commands).

- More than 50 Action Cards, setting out the tasks that individuals in a command role should undertake in the event of an incident declaration.
- How to record decisions, interact with external agencies and communicate effectively during an incident.
- How to establish a Recovery Working Group and de-brief following an incident.

**NHS England – Concept of Operations for Managing Mass Casualties**
The NHS England document "Concept of Operations for Managing Mass Casualties" was published in November 2017, in the aftermath of the Manchester Arena terrorist attack. The document required every region of England to have a pre-agreed plan as to how, in the event of a mass casualty incident occurring, casualties would be spread across the region's acute hospitals.

All acute hospitals were asked to state, in the first two hours, following an incident how many of each casualty "type" (i.e. Priority 1, 2 and 3) they would be able to accept. The hospitals in our Trust submitted the following numbers:

**Table 1. Numbers of Priority 1, 2 and 3 Casulaties that York and Scarborough Hospitals could Accept in the Event of Mass Casualty Incident in this Region**

| | Priority 1 (P1) Casualties | Priority 2 (P2) Casualties | Priority 3 (P3) Casualties |
|---|---|---|---|
| **York Hospital** | 6 | 6 | 30 |
| **Scarborough Hospital** | 4 | 4 | 30 |

These figures are then combined with the equivalent data from the other hospitals in the region. Yorkshire Ambulance Service refer to this as the "Casualty Distribution Framework".

The Concept of Operations for Managing Mass Casualties document also set out a number of other requirements that Acute Trusts need to be able to enact in the event of a Mass Casualty incident occurring. This includes:
- The ability to double critical care capacity for 96 hours following an incident.
- Ability to free up other acute inpatient beds.
- Manage major trauma patients normally transferred to other units for treatment.

The LIVEX exercise aimed to test not just the Trust IRP, but elements of this important NHS England document too.

## 3.2. Aims and objectives of LIVEX

The main aims of LIVEX were:
- To evaluate the Trust IRP, including all action cards at gold, silver and bronze levels, in order to make improvements and amendments as required.
- Exercise staff in ED and in Trauma teams, to develop their skills and give them some experience of functioning in a mass casualty scenario.
- Provide all participating staff with an environment to give them some experience of working in a formal command and control structure.
- To visually capture actions and procedures in order to contribute to future YTH training opportunities thereby disseminating the Major Incident plan across YTH.

## 3.3. Scope of LIVEX

The principal purpose of LIVEX was to test the Trust Incident Response Plan and its associated Action Cards in as realistic a way as possible. As part of that test, there were specific elements of the IRP that had a particular focus on them, namely;

- Whether or not each site would be able to cope with the number of P1, P2 and P3 casualties that had been designated to that site on the Yorkshire Casualty Distribution Framework.
- Whether or not each site would be able to double its ICU capacity in response to a mass casualty incident.
- Whether the full complement of Action Cards for both EDs worked as envisaged.
- Whether Gold and Silver Command teams would be able to manage the range of issues that arise as a result of having declared a Major Incident.
- How YAS would interact with the hospital site was included in scope.

There were several areas that were definitively out of scope at LIVEX. These included:

- LIVEX was a test of the Trust IRP, it was not a test of individuals and this was made clear to participants at every briefing session.
- There were several external agencies that were not involved as full participants at LIVEX, but would be involved in the response to a real mass casualty incident, they included:
  - The local CCGs, NHS England, NHS Improvement or Public Health England.
  - Local authorities.
  - Other category 1 responders, including Police and Fire Services.
- LIVEX was not a test of the entire Yorkshire Casualty Distribution Framework – it was only a test of the numbers of casualties assigned to either York or Scarborough Hospital.
- Although discussed during the exercise, LIVEX was not intended to test the transfer arrangements of patients around Yorkshire between hospital sites.

## 3.4. The Army Medical Services Training Centre (AMSTC)

The Army Medical Services Training Centre (AMSTC) was formed in 1989 and in 1999 it occupied what had been a vehicle workshop which had been converted into a Hospital Trainer. It is part of The 2nd Medical Brigade which delivers Deployed Hospital Care, including Battle Casualty Replacements and Individual Augmentees, for current and future operations.

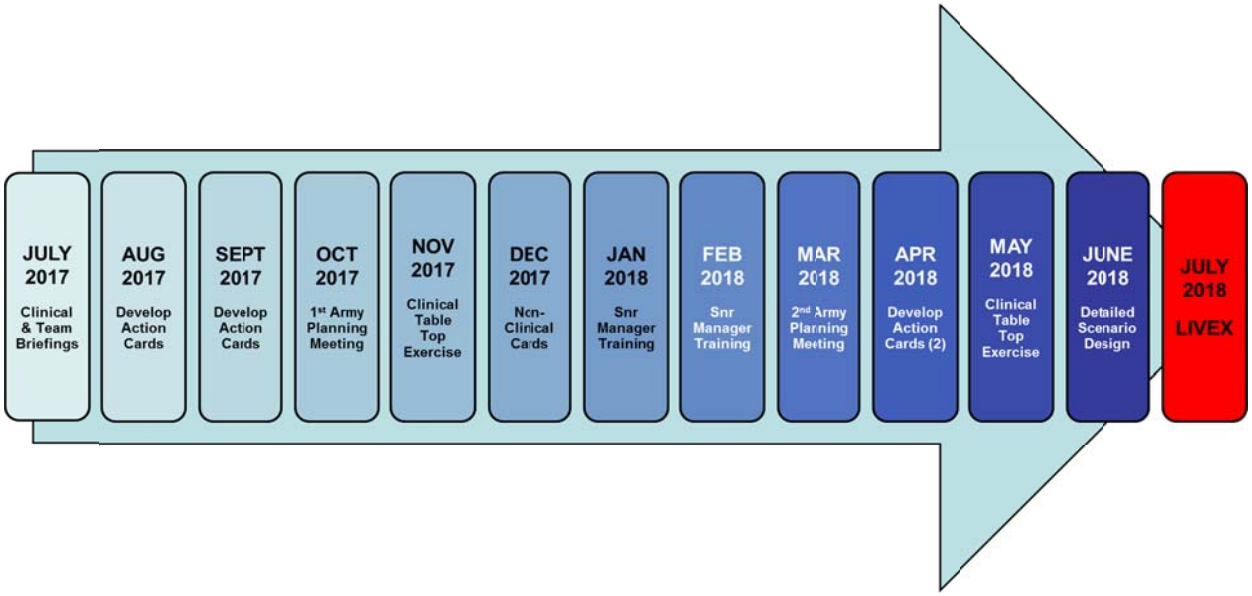
The normal role of AMSTC is validate and assure Deployed Hospital Care capabilities that are about to deploy on operations, or are about to be held at very short notice readiness to deploy anywhere in the world to provide medical care. The exercises use collective immersive simulation to re-create the hospital into which the teams will eventually deploy, and create the environmental conditions that the hospital will encounter on deployment.

Casualty actors are inserted into the hospital and the free play exercise allows objective evidence and data to be gathered against the military performance standards required of that unit. This methodology has been used to assess and validate hospitals that have successfully deployed to Iraq, Afghanistan, Sierra Leone and South Sudan. AMSTC is recognised by NATO partners as a world leader in collective macro simulation, and has been featured on national news programmes to demonstrate this world leading innovative facility.

## 3.5. Planning LIVEX – Adapting Army Methodology into the NHS

**Working upto LIVEX – July 2017 to June 2018**

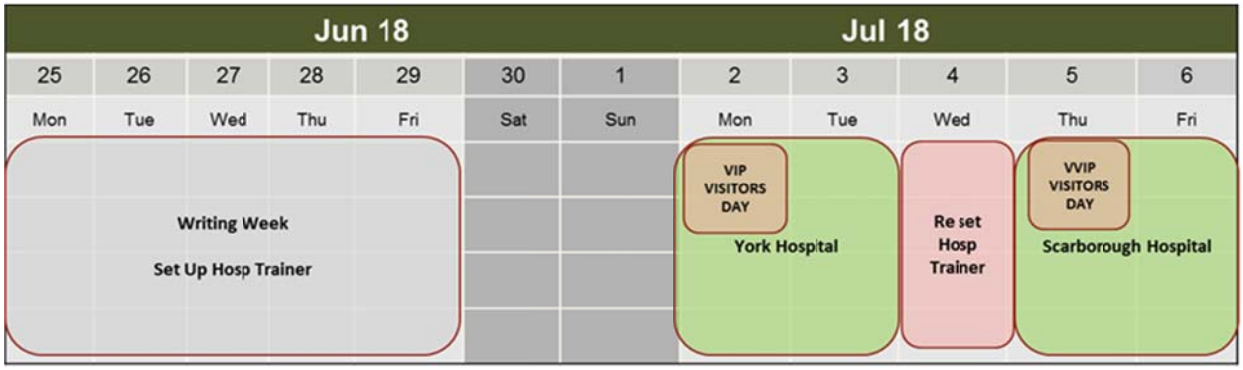
LIVEX was not simply two live exercises. The successful delivery of the exercises was the culmination of over 12 months of work, to document, test and train staff against the refreshed Trust IRP. The timeline is depicted below.




The LIVEX development plan, which was founded in the Army "Crawl-Walk-Run" training methodology, used briefings, table top exercises, and small group training to build ownership and awareness of the refreshed Trust IRP. The actual LIVEX exercises themselves served therefore as an important motivator and end-point for staff involved in the development work.

**The Structure of the LIVEX Fortnight**

The set-up, preparation and actual running of the LIVEX exercises took place over a ten day period at the end of June and start of July 2018. This is depicted below:




At the end of June the physical build of the York Emergency Department was finalised, and the IT and other relevant infrastructure was installed. Finishing touches were made to the exercise scenario and patient storyboards.

The following week, was divided into three parts as below:

- **Part 1 - 2nd & 3rd July –** This encompassed the York Hospital staff training day on the 2nd July and the exercise day on the 3rd July. There was a VIP visitors day also held on the 2nd July.
- **Part 2 – 4th July –** The York Hospital layout was taken down, and the Scarborough Hospital ED was built. Infrastructure testing also took place.
- **Part 3 – 5th & 6th July –** Scarborough Hospital staff were trained on the 5th July and then took part in their exercise on the 6th July. VVIPs visited the site on the 5th July.

## 3.6. The LIVEX Exercise and Scenario

**Running LIVEX**

The exercise was a blend of a real-time casualty simulation and table-top decision-making. The focus for the full immersive training were the main Emergency Departments (EDs), whose facilities and floor layout were accurately reproduced at AMSTC. A full "day shift" of ED staff took over the ED and received live "actor" casualties whose simulated injuries were created in line with clinical "stories" designed by the LIVEX planning staff. The ED staff assessed each casualty, just as they would in real life; made decisions on treatment and which hospital departments and services needed to be involved in their subsequent care.

Those supporting departments were represented in BRONZE Command, which was physically located next to the ED. They executed their part in the patient treatment pathway through a mixture of a conceptual "table top" exercise and being called forward to the ED to see and assess some of the casualty actors.

NHS and Military enabling staff accompanied casualty actors along the patient pathway to provide clinical information to Trust staff involved in care and decision making. They also served to observe the actions of all Command areas to provide feedback through pre-prepared Key Performance Indicator (KPI) data sheets.

**The Scenario**

The basic scenario was the same for both the York and Scarborough exercises, with the only real change being the location of the incident. The incidents were both terrorist in nature, and related to the detonation of an IED along with gunfire and took place in very close proximity to each hospital. The fictitious incident in York took place at York City Football Ground and in Scarborough the incident took place at the Cricket Ground. These locations were deliberately chosen to ensure that casualties presented quickly at the hospital following the incident to test the response to casualties arriving both on foot and by ambulance.

The number of casualties resulting from the incident, was deliberately designed so that both hospitals received slightly more patients than they had stated they would be able to manage on the Casualty Distribution Framework.

## 3.7. The Content and Structure of this Report

**Scope of this Report**

This report is not intended to be a blow by blow account of what happened during the week of LIVEX exercises. It is intended to be a report setting out the recommendations and actions emerging from the exercise, plus feedback from participants and observers about what we might do to improve the IRP and associated departmental Action Cards. Discussion around how LIVEX was run and how the exercise itself, including the training day could be improved is not contained within this report.

**Designing and Gathering Feedback and Intelligence for this Report**

There are three principal sources of information that were used to inform the recommendations in this report. They are:

- Observer Recommendations, based on their Key Performance Indicators (KPIs).
- Participant Feedback form both questionnaires and comments received following LIVEX (see appendix).
- Content from Hot-Debrief meetings held with exercise participants immediately following the conclusion of the exercise.

Draft versions of this report have also been shared with Trust Executives, department leads and LIVEX participants to gather further feedback and ensure that the recommended actions contained within this report are accurate.

**Development of Observer Key Performance Indicators**
Prior to LIVEX a joint team of NHS and Army staff worked together to create a series of Key Performance Indicators (KPIs) for each of the areas/departments that were participating in LIVEX. The KPIs were arrived at using a number of sources of information, including; the Trust Incident Response Plan (IRP), NHS England guidance and other nationally recognised Emergency Planning standards.

These KPIs were then used by observers at LIVEX to help ensure that their feedback was structured and focused around the areas that mattered most. There were ten domains against which observers gathered their observations (although not all ten domains were relevant to all areas). These domains were:

- Incident awareness and declaration
- Command, Control & Communication
- Incident Response – Other Bronze Areas
- Incident Response – Media Management
- Post Incident Enquiry (inc. Forensics)
- Incident Response – ED
- Incident Response – Theatres
- Incident Response – Critical Care
- Recovery from Incident
- Psychosocial Response & Recovery

In the detailed report that follows, in the sections relating to "Observer Recommendations and RAG", there is a Red-Amber-Green (RAG) rating against each of these ten areas (or fewer if there were some not relevant to a particular area). Some narrative explanation then follows justifying the RAG rating. The table below explains what is meant by each of these colours:

| Key | |
|---|---|
| Green | The incident response plan requires no, or very minor work in this area |
| Amber | The Incident Response Plan requires some work in this area |
| Red | The Incident Response Plan requires significant work in this area |

The RAG rating is not an indication as to the performance of individuals at LIVEX, rather an indicator as to the amount of work required on the IRP or Action Cards to address the issues identified as part of LIVEX.

## 3.8. Governance and Assurance

**Role of the Accountable Emergency Officer**
As per NHS England guidance, all Acute Trusts should nominate an Accountable Emergency Officer (AEO). This individual should be a Trust Executive Director, and is responsible for all Emergency Preparedness, Resilience and Response issues. The Chief Operating Officer acts at the AEO for this Trust, and so is ultimately responsible for the delivery of the recommendations arising from this report to the Trust Board of Directors.

**Role of the Emergency Planning Steering Group (EPSG)**
Where possible, actions arising from this report have been delegated to departmental heads and senior managers – and many of them have been involved in the writing of this report. Given the nature of some of the recommendations in this report, the membership of the group will be reviewed and it may be necessary to establish some short term task and finish groups to work up the detail of some of the recommendations.

Overall, the implementation of all LIVEX actions will be overseen by the EPSG, which meets quarterly and reports to the AEO.

**Sharing the Learning**

A version of this report will be placed on the Trust Website and intranet pages and will become a public document. It will also be shared with all local NHS and other relevant partner organisations through the “Local Health Resilience Forum”, which is supported by the NHS England regional team.

# 4. Trustwide Issues from LIVEX

The purpose of this section is to set out issues that were observed at both the York and Scarborough exercises and are therefore Trust-wide in nature and the most significant issues to address as priorities. Recommendations in this section are common therefore to both sites and the IRP as a whole. As they are organisation-wide issues, they also carry the most significant risk to the Trust and a priority to be resolved.

## 4.1. Command, Control and Communication (C3)

Across all command cells, Gold, Silver and Bronze it was apparent that staff would benefit from further training in how the command and control structures should function and how to communicate effectively within them. It was also clear that the Trust should invest in some materials to help command cells function optimally. Areas for improvement include:

- Establishing an appropriate “battle rhythm” during an incident.
- Structuring of meetings and briefings with clear agendas, specific outputs and the monitoring of actions.
- The Trust should invest in some visual aids (be it hard copy or electronic) to help maintain situational awareness and deadlines.
- Use of tools such as METHANE to disseminate and receive information.
- Confirming locations of command teams and equipping them appropriately.

## 4.2. Post Incident Enquiry and Forensics

The Kerslake Review into the Manchester Arena attack recommended that all NHS organisations should be aware of their role in the collection and preservation of forensic evidence[1]. Players and observers at both LIVEX exercises recognised that recognition of forensics related issues and post-incident requirements was poor and requires action to remedy.

It is to the credit of staff participating in LIVEX that some of them did pick this issue up and began acting upon it later on during the exercise itself, as there is no reference to this issue at all in the Trust IRP or Action Cards. This is therefore a significant gap in Trust plans.

The sorts of actions that should be included in the IRP include:

- A recognition of the Trusts requirement to maintain requisite documentation for any subsequent public enquiry.
- The establishment of a formal police casualty bureau that would ensure any casualties discharged from the incident were required to liaise with the police prior to leaving site.
- Clinician training around the need for forensic preservation of evidence, including the availability of the correct plastic evidence collection bags.
- Guidance around what needs to be done if the suspected perpetrator of any attack arrives at hospital requiring treatment.

## 4.3. Information and Core Patient Database (CPD)

CPD is the hospital patient administration system (or PAS system). It holds a version of the patient record and is the system used at the Trust to register patients upon admission and track their subsequent movements through the hospital.

There were three distinct issues identified relating to information and CPD that were observed at both exercises at LIVEX. These are addressed in turn below:

[1] The Kerslake Report: An independent review into the preparedness for, and emergency response to, the Manchester Arena attack on 22nd May 2017. (pg 221) https://www.kerslakearenareview.co.uk/

**Registering Patients at the ED Reception**
In the event of a major incident, CPD does not allow the timely booking in of patients at the ED reception desk resulting in a delay to treatment. This issue does not relate to the operating speed of CPD, rather the number and complexity of the mandatory data fields that have to be completed for every patient attending the department. The delay in the registration process resulted in delays to the commencement of treatment, a heightened sense of anxiety from those waiting to book in and pressure on ED reception staff.

**Common Patient Identifier for "Unknown" Patients**
There is no common process, across the Trust for the registration of "unknown" patients (e.g. a patient presenting at the hospital who is unconscious or isn't able to identify themselves for any reason). This led to confusion around how patients were being identified and could have, for example, easily led to the wrong diagnostic result being attributed to the wrong patient. A simple, consistent process is required, that works across all departments at both sites.

**Tracking of P1/P2/P3 Patients**
CPD does not provide a way of tracking casualties using the "currency" of P1/P2/P3. This resulted in the loss of situational awareness across commands, inaccuracies in reports and returns leaving the Trust and the distraction of key staff away from primary duties to attempt to gather this information using paper.

## 4.4. Strategic Deployment of Staff and Resources during an Incident

If an incident, on the scale of the scenario in LIVEX, occurred in our locality the Trust would need to consider how best to deploy staff and other resources across its sites to enable it to respond optimally. This issue would be particularly pertinent if the location of the incident was in the close vicinity of one of the main sites, resulting in a much greater number of casualties presenting at that site compared to the other.

NHS England guidance is clear that sites are required to be able to maintain their major incident response for at least 96 hours following the initial declaration of a major incident, and this too has implications for how staff will need to be deployed. There is a need therefore to set out in the IRP how resources might be used differently across sites in the event of a major incident.

## 4.5. Staff Call-In Process

Upon declaration of a Major Incident, the current process documented in the IRP for calling in staff is reliant on switchboard, plus individual departments and specialties getting in contact with colleagues independently.

Although not explicitly tested at LIVEX, many LIVEX participants expressed their concerns around this process, especially if an incident were to occur out of hours. There is a need to have a clear, agreed Trustwide process for calling in staff in the event of an incident that is not dependent on switchboard or individuals who would be better placed leading and responding to the incident itself. This requirement should include the process around calling in junior staff, those not officially "on-call" and loggists.

## 4.6. Clinical Skills Training - Trauma

LIVEX participants from both exercises that were involved in managing casualties reported they would value further clinical skills training, relating to the management of some trauma cases that they rarely see. Feedback showed that this was particularly around the management of penetrating trauma and casualties presenting with blast injuries.

## 4.7. Trustwide Recommendations

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 1 | Trustwide | Trustwide | Develop training package for those in command roles to improve their command, control and communications capability, knowledge and skills. | Chair EPSG |
| 2 | Trustwide | Trustwide | Work with the Police, CPS and Coroner to review requirements for ensuring Trust is able to contribute to any post-incident inquiry. This includes the establishment of a casualty bureau and that evidence is retained for future possible forensics work. | Chair EPSG |
| 3 | Trustwide | Trustwide | Develop a CPD solution for the timely booking in of patients during a major incident. | Chair EPSG & Head of IT Development |
| 4 | Trustwide | Trustwide | Develop and roll out a consistent process across all hospital departments for the registration of “unknown” patients on CPD. This process must meet the needs of ED, all diagnostic areas and all other possible destinations for patients. Consideration should be given to how this process functions at the regional Major Trauma Centres. | Chair EPSG & Head of IT Development |
| 5 | Trustwide | Trustwide | Review and modify CPD to identify appropriate processes for the tracking of casualties in the currency of (P1/2/3) across the patient pathway | Chair EPSG & Head of IT Development |
| 6 | Trustwide | Trustwide | The IRP should be updated setting out how staff should be strategically deployed across sites to enable an effective response to an incident, especially if the incident occurs closer to one site. | Chair EPSG |
| 7 | Trustwide | Trustwide | The process for calling in staff in the event of a major incident should be reviewed, a new process agreed and the IRP and training should be updated accordingly. | Chair EPSG |
| 8 | Trustwide | Trustwide | Participant feedback relating to future trauma training requirements should be reviewed and a new training package established to address this | Clinical Leads for Trauma and ED on both sites |

# 5. York Hospital Exercise

The York Hospital teams were trained on the 2nd July and undertook their exercise on the 3rd July. In all, 99 staff from York Hospital participated in the exercise. They came from a range of clinical and non-clinical areas including ED, Nursing, Therapies, Security and Portering to name but a few. Additionally, there were 41 different casualty actors and 7 members of staff from Yorkshire Ambulance who were directly involved in the scenario that played out.

## 5.1. Gold Command

**Observer Recommendations**

**Table 2. Observer RAG Ratings for York Hospital Gold Command**

| Domain | | RAG | Domain | | RAG |
|---|---|---|---|---|---|
| 1 | Incident awareness and declaration | A | 2 | Incident Response – ED | G |
| 3 | Command, Control & Communication | A | 4 | Incident Response – Theatres | A |
| 5 | Incident Response – Other Bronze Areas | G | 6 | Incident Response – Critical Care | G |
| 7 | Incident Response – Media Management | G | 8 | Recovery from Incident | G |
| 9 | Post Incident Enquiry (inc. Forensics) | R | 10 | Psychosocial Response & Recovery | A |

| Key | | |
|---|---|---|
| The IRP/Department Plan requires significant work | The IRP/Department Plan requires some work | The IRP/Department Plan requires no, or very minor work |

Observer feedback for Gold Command in York was collected against the KPI framework and resulted in the RAG rating as set out above. At the end of each bullet point below, numbers in brackets below indicate the domain reference number that the observation point relates to. Some of the areas highlighted for improvement included:

- There was some initial confusion around whether gold or silver command had declared an incident status and what that status was (1).
- A good “battle rhythm” was set by the gold team who had a good oversight of the incident (3).
- The awareness of the site Lockdown policy wasn’t fully understood and could have left the site vulnerable (1).
- The requirement to work with outside agencies was well understood, but contact detail and lists of those agencies are not documented in the IRP or Action Cards (3).
- Very clearly understood by Gold that the incident required careful media management (7).
- Given the limited Communications personnel available, there was a gap between Gold and Silver around what media/communications issues should be communicated up to Gold (3).
- Short term staff and casualty welfare was considered routinely, but there was limited discussion on the longer term psychosocial impact of the incident (10).
- The need to establish a Recovery team was identified early, but resources were not available at LIVEX to put it into operation and get it functioning properly (8).
- The need to work with the Police and be mindful of forensics issues was not recognised early enough and is completely absent from the IRP (9).

**Participant Feedback Questionnaires**

Only two members of the Gold Command team submitted feedback forms. Of those that responded they reported that they had attended training prior to LIVEX and reported that as a

result, they knew where the Incident Response Plan (IRP) was and had been briefed on it. Following LIVEX all of the respondents felt "well prepared" to respond to an incident.

**Hot Debrief Feedback**
In their hot-debrief session the team highlighted the importance of the Loggist role, and how well they had interacted with the Silver Command team and how important the interactions between those teams had been in getting a good situational awareness.

The team also felt that the Communications Team specialist would be better placed in the Gold rather than Silver Command team (a change that was subsequently tested in the Scarborough Exercise later in the week).

**Conclusions and recommendations for this area**

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 9 | Trustwide | Gold & Silver | Action Card/IRP to be amended setting out the process more clearly around incident declaration and dissemination. | Chair EPSG |
| 10 | Trustwide | Gold | In addition to the Gold Action Card, a list of the top 5 to 10 issues for the Gold team to consider should be set out, split by incident type (i.e terrorist, fire, CBRN or Cyber Attack). This would include issues such as; Public Health Issues, Media Plan, 96 hr plan etc | Chair EPSG |
| 11 | Trustwide | Gold & Silver | Additional training to be given around the site Lockdown policies and processes. The Lockdown process should also be tested and exercised annually. | Head of Security |
| 12 | Trustwide | Gold | Lists of relevant external agencies, including social care organisations, Air Ambulance and Public Health England (PHE) should be accessible to Gold Command | Chair EPSG |
| 13 | Trustwide | Gold | The location of the senior Communications expertise should be in Gold Command. | Communications Lead |
| 14 | Trustwide | Gold | A review of the emotional and pastoral support available for staff responding to an incident should be undertaken. This should include the role of the Trust Chaplain. | Chair EPSG |
| 15 | Trustwide | Gold | Training should include explanation of the function and make up of an Incident Recovery Team | Chair EPSG |
| 16 | Trustwide | Gold & Silver | Ensure all in a command and leadership role are trained and clear on how best to use the loggist role | Chair EPSG |
| 17 | Trustwide | Gold | The Gold Action Card should be updated stating that two loggists are required for the team | Chair EPSG |
| 18 | Trustwide | Gold | IRP should include information on the process around the administration of Hep B/Post Exposure Prophylaxis. This should then be incorporated into training. | Clinical Lead for Microbiology |

## 5.2. Silver Command

**Observer Recommendations & RAG**

**Table 3. Observer RAG Ratings for York Hospital Silver Command**

| Domain | | RAG | Domain | | RAG |
|---|---|---|---|---|---|
| 1 | Incident awareness and declaration | G | 2 | Incident Response – ED | G |
| 3 | Command, Control & Communication | A | 4 | Incident Response – Theatres | G |
| 5 | Incident Response – Other Bronze Areas | G | 6 | Incident Response – Critical Care | G |
| 7 | Incident Response – Media Management | G | 8 | Recovery from Incident | G |
| 9 | Post Incident Enquiry (inc. Forensics) | R | 10 | Psychosocial Response & Recovery | A |

| Key | | |
|---|---|---|
| The IRP/Department Plan requires significant work | The IRP/Department Plan requires some work | The IRP/Department Plan requires no, or very minor work |

Observer feedback for Silver Command in York was collected against the KPI framework and resulted in the RAG rating as set out above. At the end of each bullet point below, numbers in brackets below indicate the domain reference number that the observation point relates to Some of the areas highlighted for improvement included:

- There wasn't any formal use of the METHANE framework to convey information to staff and share situational awareness (3).
- The team would benefit from training on how best to use the loggist in their team and better understand which decisions and issues need to be logged (3).
- Early awareness of the need to track casualties through the hospital and issue was worked through by the team, but hampered by functionality in the systems available (1).
- Clear understanding of the need to create capacity, but more consideration in the plan needs to be given to the potential to receive casualties from other sites too (5 + 1).

**Participant Feedback Questionnaires**

Only three questionnaires from the Silver Team were received. However, they all reported that prior to LIVEX they had "limited" confidence in their role in a major incident and in the preparedness to play their part. Following LIVEX the team reported 100% of them were either prepared or well prepared to respond to a major incident.

The team also commented that LIVEX helped them to see how other departments operated and how their decisions could have a knock on effect on other areas. They also commented that Lockdown and security considerations needed further briefing and training.

**Hot Debrief Feedback**

The Silver team reported that the constant reassessment of the situation helped their understanding of the situation and that the senior medical and nursing roles in Silver gave real clarity and high quality information.

The team reported a number of issues that require further action and attention:

- A different location in York Hospital needs to be identified and resourced appropriately to house Silver Command. The current location (next to Operations Centre, 2nd Floor, Jct 5) is too small, isn't equipped properly and is not located close enough to the front of the hospital.

- There was a little confusion as to what the Yorkshire Ambulance Service (YAS) Hospital Advice and Liaison Office (HALO) role could be tasked with and which YAS related issues should be discussed with YAS remotely.
- Inclusion of the most recent Yorkshire Casualty Distribution Matrix in the IRP would be helpful.
- Further aids on how to manage some communications issues, such as twitter, would be useful.

**Conclusions and recommendations for this area**

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 19 | York | Silver | A new location, convenient to most is required at York Hospital to house Silver Command. This should include positioning of aids and equipment to support Silver, including signage that can by deployed in the Hospital so others can find Silver Command. | Chair EPSG |
| 20 | Trustwide | Silver | The role of Medical Lead in Silver Command should be taken only by individuals who have received specific training for this role (i.e. it should not default be a Deputy Medical or Clinical Director). It is likely this list will be made up of Medical Physicians. | Chair EPSG |
| 21 | Trustwide | Silver | A new Action Card for the Medical and Nursing Leads in Silver Command should not be developed. However, “hints, tips and questions to ask” should be added to the Silver Commander Action Card to help guide their work. | Chair EPSG |
| 22 | Trustwide | Silver | The YAS Hospital Advice and Liaison Officer (HALO) role should have an action card developed to clarify its function. | YAS Head of EPRR |
| 23 | Trustwide | Silver & Gold | Given YAS are an external organisation, clarity is needed as to who should liaise with the YAS Silver Command/incident based team. | YAS Head of EPRR |
| 24 | Trustwide | Silver | Further training and aids should be included in the IRP to support Silver Command in dealing with Communications (inc. Social Media) issues. | Trust Communications Lead |
| 25 | Trustwide | Silver | The IRP should have a copy of the site Action Cards structure, and Yorkshire Casualty Distribution Framework included in it. This should also be included in the incident box held in Silver Command | Chair EPSG |

## 5.3. Bronze Commands

In play at LIVEX, in addition to the ED, there were at least 16 other departments or hospital functions in play. Their role at LIVEX varied – some effectively ran a “table top” exercise, some were called forward and had to involve themselves with individual casualties in the ED, some ran a diagnostic or support service and others provided support and advice to other areas, for example around staffing issues. This section covers the significant observer feedback and resulting notable actions for some of these areas.

**Observer Recommendations – Notable Practice**
The placing of a consultant surgeon in both ED and main theatres (supported by an Anaesthetist) worked extremely well over the exercise – communication was excellent and patients were moved through the system without undue delay, prioritised in the correct clinical order.

The same was noted for the joint working of several other areas, including Acute Medicine, Elderly Medicine and Matron teams, Community teams with the Therapies services and Theatres and Critical Care.

The NHS England requirement to double Critical Care capacity was observed at LIVEX, and this is a significant achievement – however, it was not tested whether it could be sustained for 96 hours.

**Observer Recommendations – Areas to Improve**
None of the departmental action cards require the commander to establish how much follow up work is likely to result from the initial influx of patients, and what a departmental recovery plan might look like. This is key to understand to begin thinking about future staffing requirements.

There were issues in a number of areas, particularly in diagnostics and transfusion around not having a common unique patient identifier (see Trustwide issues).

In Pharmacy, there is no evidence that the volume of medication required to respond to an incident of this nature (e.g. Anaesthetics etc.) was considered by either the Theatres team or Pharmacy team – and this isn't an explicit action on their card. This also needs to be considered in the light of two acute receiving sites – so it might not be possible to shift medications from one site to bolster the other.

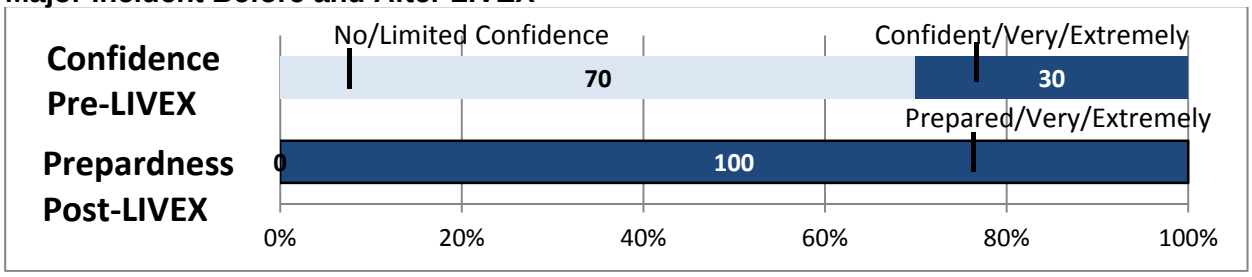
**Participant Feedback Questionnaires**
47% of participants who operated in Bronze Command roles hadn't received any training prior to LIVEX on the IRP or their role within it – however 89% said this didn't impact on their performance. This is reassuring as it means Action Cards were clear and briefings given on the day allowed staff to perform well.

Some of the comments included:

> *"Clear chain of command – good gold leadership"*

> *"A&E, Resus, and deploying staff to ED seemed to work well patients moved through swiftly and there was good spirit from everyone helping out"*

**Chart 4. Confidence and preparedness of Bronze Command Staff to participate in a Major Incident Before and After LIVEX**




3 months prior to LIVEX 70% of those operating in Bronze Command stated that they had no or limited confidence to play their part in a major incident. Following LIVEX 100% of respondents said they were prepared, well prepared or extremely well prepared for a major incident.

**Hot Debrief Feedback**
The teams highlighted the need to have resources in place prior to an incident being declared. This would include:

- Having Major Incident Packs in all relevant places across the Trust. These would include coloured tabards for those in command roles and versions of the most up to date IRP and Action Cards.
- Additional paper documentation specific for a major incident should be pre-prepared.

The teams also noted the importance for those not at LIVEX in understanding how departments/services other than their own would organise themselves in a major incident. One of the examples cited was around how well the transfusion service functioned, but that key to them being able to work well was all other areas understanding how to access them, the process for ordering and where they were going to be based.

**Conclusions and recommendations for this area**

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 26 | Trustwide | All Bronze | All Bronze level action cards should make reference to planning for the 96 hours following the incident, including planning for what activity is likely to be needed and the staffing resource to deliver that. | Chair EPSG |
| 27 | Trustwide | All Bronze | All other Bronze Commanders entering the ED should report to the EPIC upon arrival. This should be added to all Action Cards. | Chair EPSG |
| 28 | York | Pharmacy Bronze | The Pharmacy Command card should include reference to reviewing the relevant stocks at both sites soon after incident declaration. This should include Antibiotics, Control Drugs and Anti-virals. | Chief Pharmacist |
| 29 | Trustwide | All Areas | Each department should have a major incident box available, which includes all plans, tabards and some specialist equipment. | Chair EPSG |
| 30 | Trustwide | All Areas | A review should be undertaken of how to improve communication between all in Command roles. This should include consideration of radios, deck phones, use of wifi etc. | Chair EPSG |
| 31 | York | All Bronze | Future training for all departments should include an explanation of how other areas would function and organise themselves in a major incident. | Chair EPSG |
| 32 | Trustwide | Critical Care | The Critical Care Bronze Action Card should make more explicit the process around how capacity should be doubled, including location, staffing and how it will be maintained for 96 hours. | Clinical Lead for Critical Care |
| 33 | Trustwide | Surgery & Anaesthesia | Bronze Command Action Cards for Surgery and Anaesthesia should be updated to state that once directed, Directorate Management teams should be responsible for coordinating any | Clinical Directors for Surgery & Anaesthesia |

| | | | | |
|---|---|---|---|---|
| | | | cancellation of elective surgery (not the Bronze Commander themselves). | |
| 34 | Trustwide | Surgery & Anaesthesia | Contact details for the organisation that supplies External Fixators for patients who have undergone surgery to stabilise bone and soft tissue should be included in the Action Cards | Clinical Directors for Surgery & Anaesthesia |

## 5.4. ED Bronze - Resus, Minors, Majors & Triage

The feedback in this section includes both the ED staff plus other staff, from various other specialty backgrounds that were called forward and based themselves in ED for the majority of LIVEX – e.g. those that worked in trauma teams.

**Observer Recommendations & RAG**

**Table 5. Observer RAG Ratings for York Hospital ED**

| Domain | | RAG | Domain | | RAG |
|---|---|---|---|---|---|
| **1** | Incident awareness and declaration | **G** | **2** | Incident Response – ED | **G** |
| **3** | Command, Control & Communication | **G** | **4** | Incident Response – Theatres | |
| **5** | Incident Response – Other Bronze Areas | | **6** | Incident Response – Critical Care | |
| **7** | Incident Response – Media Management | **G** | **8** | Recovery from Incident | **G** |
| **9** | Post Incident Enquiry (inc. Forensics) | **R** | **10** | Psychosocial Response & Recovery | **A** |

| Key | | |
|---|---|---|
| The IRP/Department Plan requires significant work | The IRP/Department Plan requires some work | The IRP/Department Plan requires no, or very minor work |

At LIVEX ED were not allocated a dedicated loggist to record actions or decisions - ED Action Cards should be updated to include this requirement. The department would have benefitted from having a clear, visual way of identifying other sector commanders, i.e. in Resus, Majors, Triage etc and there should be regular team huddles and tabards should be used to ensure the department remains coordinated.

The lack of functionality in CPD to track casualties in the currency was a re-current issue, pulling staff in clinical and leadership roles away from their core duties. This was resolved (partially) once the ED Bronze Command had a senior manager allocated to them to attend briefings and take a lead role on establishing what had been through the department thus far and this role should be formally established on an Action Cards for ED.

**Participant Feedback Questionnaires**

As has already been recognised, some updates to CPD may help the ED response in the future. However, despite this the manning and re-organisation of the team on the front reception desk is also important, and staff thought that a practice run through of the front desk response plan would have been good preparation prior to the exercise.

Feedback indicated that staff would benefit from further training around the clinical management of trauma, and this is addressed in the Trustwide recommendations section.

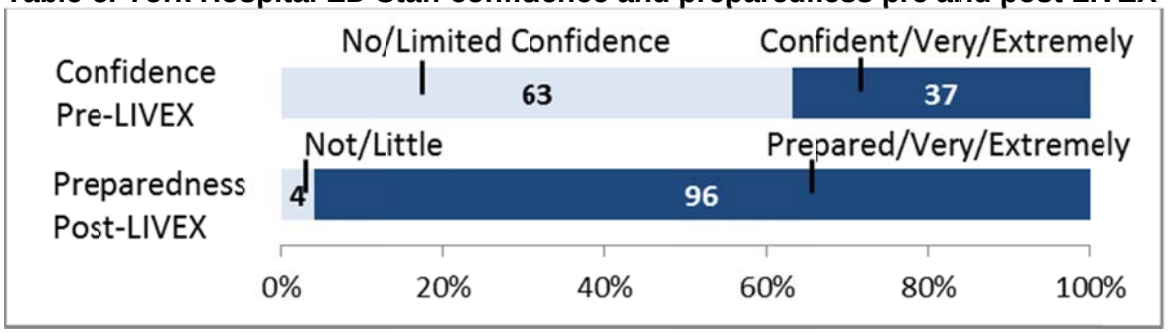
*"Needed more experience with trauma patients"*

Other feedback from this cohort highlighted the importance of updating the Trust call-in plan. While the scenario was in-hours, staff reported concern about how this would function out of hours. This is also addressed in the Trustwide recommendations section. Comments included:

*"Update call-in systems"*

*"Need a better plan for cancelling elective work…and a better staff call in plan."*

**Table 6. York Hospital ED Staff confidence and preparedness pre and post LIVEX**




3 months prior to LIVEX 63% of staff reported that had limited or no confidence in their knowledge and understanding of their role during a major incident. Following LIVEX, 96% said they were prepared, well prepared or extremely well prepared to respond.

**Hot Debrief Feedback**

Participants reported that communication was good, that Action Cards helped and that teamwork was excellent. There were several comments relating the how the front of house was organised. They included:

- A liaison role should be developed and based in the waiting room.
- The booking in processes both for YAS and walk-in patients could be improved, and resourced differently.

**Conclusions and recommendations**

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 35 | York | ED | The ED Bronze Commander should have a liaison officer to shadow them, to attend briefings and gather information on behalf of the ED Bronze. An action card should be developed (in line with the Scarborough one) for this. | Directorate Manager – Acute Medicine/ED |
| 36 | York | ED | The front reception desk plan for a major incident should be explicitly document and exercised with front line staff. This should include where extra staff could be sourced from. | Directorate Manager – Acute Medicine/ED |
| 37 | York | ED | Consideration should be given to having a single point of entry and triage for ambulances and walk-in patients during a major incident (as per Scarborough) and all Ambulances should book in, as per normal upon arrival at ED. | Clinical Director for Emergency Medicine |
| 38 | Trustwide | ED | The department should have pre-prepared major incident packs ready to use. These should contain; trauma booklet, blood forms, | Directorate Manager – Acute |

| | | | | |
|---|---|---|---|---|
| | | | bottles, labels, consent forms, transfusion forms ID bracelets etc | Medicine/ED |
| 39 | Trustwide | ED | Personal Protective Equipment (i.e. gloves, masks and aprons) were not routinely worn when managing patients. This should be addressed in future trauma training. | Clinical Leads for Trauma – York & Scarborough |

## 5.5. Conclusions - York Hospital

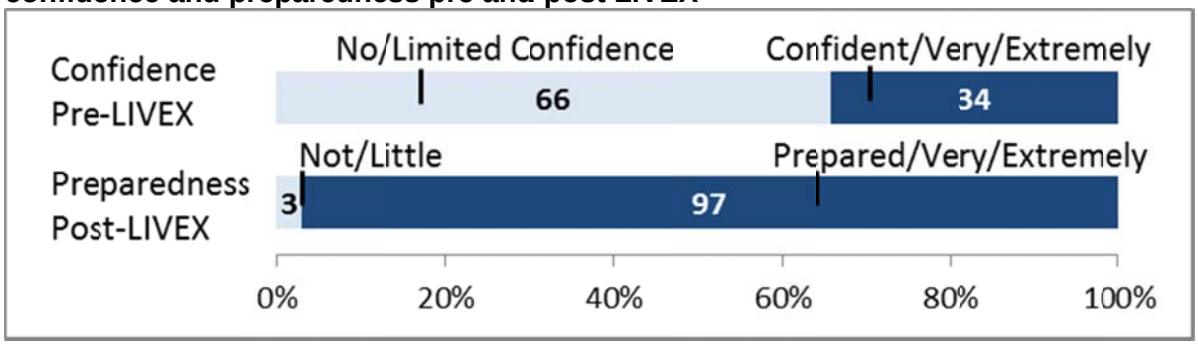
The IRP is generally fit for purpose for the York Hospital site. The main Trustwide issues (see section 4) clearly impacted on the ability of the team to respond to the incident as effectively as they would have liked. However, due to the significant work undertaken by staff in the last 14 months, only relatively minor updates and amendments are required to further refine the hospital response to an incident.

One of the issues to be addressed in all areas, including in Silver and Gold Commands is the establishment of an Incident Recovery Team and consideration of how the hospital will continue to effectively respond to the incident in the 96 hours following the incident. At the core of this is the development of a picture of the clinical work that needs to be completed and then the staff needed to support this. This is especially important in areas such as surgery, critical care and theatres.

The location in York Hospital of the Silver Command team, and possible Police presence (to establish a casualty bureau) was something that came up repeatedly in feedback. Confirming this new location and ensuring it is equipped appropriately is a priority action for the York site.

When the feedback for the participants in the York exercise is collated, it demonstrates more than a 60% increase in how confident participants felt about being able to respond to an incident. This is depicted in the chart below.

**Chart 7. Collated feedback from all participants at the York Hospital exercise, showing confidence and preparedness pre and post LIVEX**




The staff of York Hospital understandably approached LIVEX with a degree of apprehension. They quickly overcame their concerns, worked incredibly hard and produced an excellent collective response to a challenging situation. Their desire to learn and interact with external agencies was particularly impressive and a credit to the Trust.

# 6. Scarborough Hospital Exercise

The Scarborough Hospital teams arrived and were trained on the 5th July and did their exercise on the 6th July. In all 89 members of staff participated in the exercise itself, from surgery to radiology, from therapies to communications. There were also a further 8 members of staff from YAS who participated and over 35 casualty actors throughout the day.

In reviewing the feedback from the Scarborough exercise, there were several issues identified that were common to both York and Scarborough sites. For brevity's sake, these have not been repeated, but will be reported on the final action logs as needing to be addressed at both sites.

## 6.1. Gold Command

At the Scarborough Hospital exercise a notable change from the York exercise was that the Gold Command cell was physically located in a building separate from the main Hospital Trainer that hosted the exercise. This was to simulate that in the event of an incident occurring around Scarborough, it is likely that those that the Gold Command team would be based in York.

**Observer Recommendations & RAG**

**Table 8. Observer RAG Ratings for Scarborough Hospital Gold Command**

| Domain | | RAG | Domain | | RAG |
|---|---|---|---|---|---|
| **1** | Incident awareness and declaration | **G** | **2** | Incident Response – ED | **G** |
| **3** | Command, Control & Communication | **R** | **4** | Incident Response – Theatres | **A** |
| **5** | Incident Response – Other Bronze Areas | **A** | **6** | Incident Response – Critical Care | **A** |
| **7** | Incident Response – Media Management | **A** | **8** | Recovery from Incident | **A** |
| **9** | Post Incident Enquiry (inc. Forensics) | **R** | **10** | Psychosocial Response & Recovery | **G** |

| Key | | |
|---|---|---|
| The IRP/Department Plan requires significant work | The IRP/Department Plan requires some work | The IRP/Department Plan requires no, or very minor work |

Some areas of notable good practice included:

- The declaration of the incident was timely as was communication to other parts of the hospital (1).
- Early recognition of the need to consider staff psychological welfare and requirement to work with NHS partners to deliver this (10).

The remote location of the Gold Command team demonstrated several areas in which the Trust IRP needs to be amended and updated. These included:

- Robust communications (phone, data and video conferencing) between the Gold and Silver teams is essential for Command, Control and Communication (C3) to function efficiently (3).
- Consideration should be given to the establishment of a Gold "forward" team. This is, a team based on the site nearest the incident that shadow the roles of the Gold Team and report directly back to them for decisions (3).
- A communications lead both in the Gold team and based within the Silver team nearest the site of the incident would also aid C3 (3).

- The Gold Action Cards should require the establishment of a Recovery Working Group early (9).
- The embedding of Joint Emergency Services Interoperability Principles (JESIP) and joint decision making principles more generally should be incorporated into Gold Command team training (1).

The coordination with two Silver Command cells was not properly tested at LIVEX, and so this could be subject to further training in future for Gold Command teams. This needs to include plans for rapid discharge and transportation of staff, equipment and patients.

At the Scarborough exercise, a decision was made to locate the Lead for Communications in the Gold team. Observers reported that this seemed to work better than locating it in the Silver Team (as had been done for the York exercise). However, there was not a good understanding from the participants in the exercise that the Gold team need to be made aware of incidents that were likely to be of media interest.

**Participant Feedback Questionnaires**
Participants in the Gold team recognised the need to improve communications and the connectivity between sites in the event of an incident, and also reported that resources such as pre-populated charts and papers should be available to the Gold team to aid their management and oversight of the incident.

All respondents were aware of the location of the IRP and had read it.

**Hot Debrief Feedback**
The Gold team felt that Silver was responsive to their requests and there was the right level of experience and knowledge based within the Gold team. There was also suggestion that access to TV news in Gold command would have been helpful to keep abreast of unfolding events.

The teams also suggested that media training be given to a wider pool of people, who could find themselves in a Gold Command position and that video conferencing facilities should be installed in the base for Silver Command.

**Conclusions and recommendations**

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 40 | Trustwide | Gold & Silver | The locations of all Command cells on all sites should be confirmed. All locations should have video conferencing, access to TV news and at least two phone lines available. These locations should be equipped with a major incident box, containing all relevant information and visual aids. | Chair EPSG |
| 41 | Scarborough | Gold | Consideration should be given to how a Gold “forward” team might function. This may include a liaison officer role. | Chair EPSG |
| 42 | Trustwide | Gold | The Gold Card should make explicit the requirement to establish a Recovery Working Group early on in the incident | Chair EPSG |
| 43 | Trustwide | Gold | Training around JESIP principals should be incorporated into future Gold Command training | Chair EPSG |
| 44 | Trustwide | Gold & Silver | Media training should be given to a wider pool of individuals who may be needed to | Trust Communications |

| | | | | |
|---|---|---|---|---|
| | | | speak to media outlets. Emergency lines to take (holding statements) should be included in the IRP. | Lead |
| 45 | Trustwide | Gold & Silver | The format of the Trust loggist book should be confirmed and communicated to all loggists. | Chair EPSG |
| 46 | Trustwide | Gold & Silver | In addition to loggists, a pool of individuals willing to act as "runners" should be developed. | Chair EPSG |

## 6.2. Silver Command

**Observer Recommendations & RAG**

**Table 9. Observer RAG Ratings for Scarborough Hospital Silver Command**

| Domain | | RAG | Domain | | RAG |
|---|---|---|---|---|---|
| **1** | Incident awareness and declaration | **G** | **2** | Incident Response – ED | **G** |
| **3** | Command, Control & Communication | **A** | **4** | Incident Response – Theatres | **G** |
| **5** | Incident Response – Other Bronze Areas | **G** | **6** | Incident Response – Critical Care | **G** |
| **7** | Incident Response – Media Management | **G** | **8** | Recovery from Incident | **A** |
| **9** | Post Incident Enquiry (inc. Forensics) | **R** | **10** | Psychosocial Response & Recovery | **G** |

| Key | | |
|---|---|---|
| The IRP/Department Plan requires significant work | The IRP/Department Plan requires some work | The IRP/Department Plan requires no, or very minor work |

Good practice included:

- A clear understanding of the need to create capacity across the site, and organise Bronze Command teams to enact that (1).
- Initial briefings, following incident declaration were promptly brought together which aided the understanding of the incident across the organisation (3).

Areas that were identified for improvements included:

- There was no formal use of the Joint Decision Making model or the METHANE structure of reporting to aid reporting or situational awareness. This should be incorporated into future training (3).
- The agreement from Silver Command to stop new cases going to theatre was not taken as early as it could have been meaning that a number of cases had started at the time of the incident (4+6).

**Participant Feedback Questionnaires**

Three months before LIVEX 72% of respondents in the Silver team reported no or limited confidence in their understanding of their role in a Major Incident. Following LIVEX, 86% of respondents reported being prepared, well prepared or extremely well prepared to respond to a Major Incident.

The role of the loggist was highlighted as being essential to the team, but although the loggist had been trained, the Silver team hadn't been trained on how to best interact with them, including understanding which issues should be logged.

Some of the roles in Security and Estates & Facilities that were based in the Silver Team didn't have pre-authored Action Cards, and this should be addressed.

**Hot Debrief Feedback**
The team felt that the team worked well and that they were quick to understand the situation. Working with the security team seemed to work well, but they were aware that in a real incident they would need to link with the main office in York.

The Silver team also reported that a 2nd loggist would have been welcome in the team and more clarity on what the role and function of NHS England in a Major Incident might be

**Conclusions and recommendations**

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 47 | Trustwide | Silver | Use of the METHANE structure of reporting incidents should be built into training. | Chair EPSG |
| 48 | Trustwide | Silver | Silver Action Card should be updated to state that Silver should work with medical and nursing leads in Silver, ED and Critical Care to establish what the remaining capacity is for P1 and P2 patients for sitrep reports. | Chair EPSG |
| 49 | Trustwide | Silver | Silver Command should have a list of extra posts that need to be filled across the site in the event of a major incident being declared, e.g. booking in clerks, runners, loggists etc. | Chair EPSG |
| 50 | Trustwide | Silver | A laminated A1 poster should be included in the designated Silver Command room that allows the Silver Command to record who is in each of the bronze command roles and what their contact details are. | Chair EPSG |
| 51 | Scarborough | Silver | Action Cards for those in Silver Command representing Estates & Facilities and Security should be developed. | Chair EPSG |

## 6.3. Bronze Commands

**Observer Recommendations – Notable Practice**
Critical care team noticed early on that they needed a loggist and that they should be recording their decisions and actions. There is a definite requirement to have a loggist alongside anyone in a command role.

The surgical, anaesthetics and theatres teams worked slickly through the incident. Patients were prioritised and sent from ED without significant delay. Given the volume of surgical work presenting in ED, there was one suggestion to base an additional senior surgeon in ED.

**Observer Recommendations – Areas to Improve**
The plan to double critical care capacity was enacted, however these actions were not logged (see above) and no consideration was given to maintaining this increase for 96 hours.

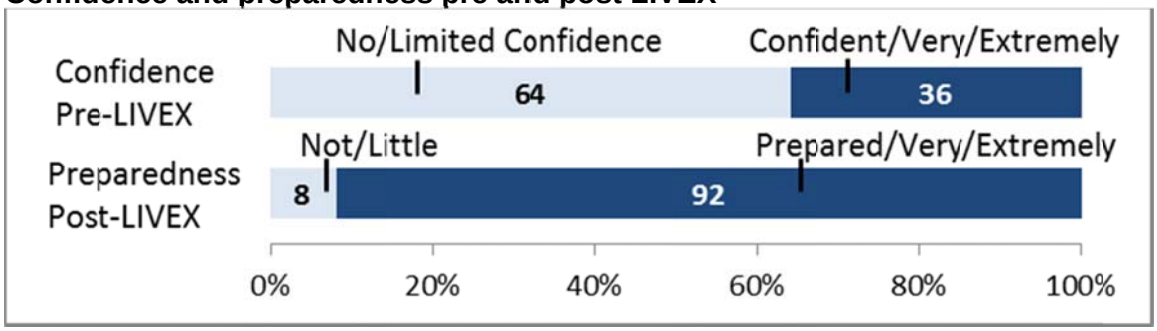
Overall the Scarborough Theatres team responded well, but they would benefit from having reference in their Action Card to the need to check for availability and stock levels of blood products and access to the One Hour Damage Limitation Surgical Guidance.

The Radiology team highlighted that a number of patient notes, including the patient trauma booklet were left in the ED when the patient had been sent for a CT. This needs to be resolved in future ED training.

**Participant Feedback Questionnaires**
The teams highlighted the need to focus on more pastoral care for staff and also on support for relatives of those that had been involved in the incident itself. Some of the staff also felt that they weren't properly briefed on the bed and critical care capacity, that may had hindered some of their decision making.

It was also highlighted that as the provider of Community Healthcare services in Scarborough is now provided by Humber NHS FT our Action Cards need to link to theirs – particularly from Medicine, Elderly and Therapies areas.

**Chart 10. Participants in Bronze Command Roles for Scarborough Hospital. Confidence and preparedness pre and post LIVEX**




Following LIVEX 92% of this staff group reported themselves being prepared, well prepared or extremely well prepared to manage in a major incident scenario. This contrasts with only 64% of staff, in the 3 months before LIVEX having no or limited confidence in their ability to respond to an incident.

**Hot Debrief Feedback**
Staff in Bronze Command roles reported that roles were well defined and that there was an effective command structure. They reported that the communication around the declaration of the major incident status could have been clearer, as could clarity on the lockdown arrangements.

There was only minimal consideration given to the issue of secondary transfers to other providers, which is an issue that wasn't addressed at LIVEX. Some concern was also expressed about the call-in process for off duty staff.

**Conclusions and recommendations**

| No. | Site | Area/ Dept | Action Required | Proposed Owner |
|---|---|---|---|---|
| 52 | Trustwide | Bronze | All Bronze Command roles should also be accompanied by a loggist and this should be documented on their Action Card. | Chair EPSG |
| 53 | Trustwide | All Command Roles | Given the difficulty of obtaining loggists for all in command roles, consideration should be given to obtaining Dictaphones and video recording equipment for all in command roles to record decisions on. | Chair EPSG |
| 54 | Scarborough | Bronze | The ability at Scarborough to maintain a doubling of Critical Care capacity for 96 hours should be reviewed. | Clinical Lead for ICU at Scarborough |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Director of Estates and Facilities Report – September 2018

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☐ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☒ |
| For discussion | ☐ | A regulatory requirement | ☐ |
| For assurance | ☒ | | |

Purpose of the Report

The purpose of this report is to provide updates and assurance to the Board of Directors relating to the corporate responsibilities of the Estates and Facilities Directorate. This report will highlight issues to the Board of Directors which have historically been raised with the Environment and Estates Committee; a sub-Committee of the Board.

Executive Summary – Key Points

The Director of Estates and Facilities would like to present the following documents to the Board of Directors for approval:

- Annual Report of the Environment and Estates Committee
- Annual Health and Safety Report incorporating Annual Fire Report and Fire Statement
- Terms of Reference of the Sustainable Development Group

Monthly updates will be provided on the following areas for information and assurance:

- Health, Safety and Security
- Sustainability
- Facilities Management Compliance

Annual updates will be provided on performance against Lord Carter metrics.

Recommendation

The Board of Directors is asked to approve the documentation listed above and to note the updates and assurance provided.

Author: Brian Golding, Director of Estates and Facilities

Director Sponsor: Brian Golding, Director of Estates and Facilities

Date: September 2018

## 1. Introduction and Background

In addition to operational duties and functions, the Director of Estates and Facilities is accountable for a number of the Trust's corporate responsibilities. These responsibilities have previously been monitored and reviewed by the Environment and Estates Committee; a sub-Committee of the Board of Directors. The Environment and Estates Committee has prepared an Annual Report for 2017/18 and a copy of this is attached (Appendix 1). This report will provide Board members with information and assurance regarding the activities of the Environment and Estates Committee over the reporting period.

The last meeting of the Environment and Estates Committee was held on 15th August 2018; the minutes of this meeting are attached for information purposes (Appendix 2).

**Summary Note: Board members are asked to approve the Annual Report of the Environment and Estates Committee and to note the minutes of the last Environment and Estates Committee meeting.**

## 2. Health, Safety and Security

This section of the report will typically provide Board members with a monthly update regarding key health, safety and security issues and offer assurance in relation to the measures being taken by the Trust to ensure compliance with health and safety legislation.

### 2.1 Health and Safety Annual Report

The Trust's Annual Health and Safety Report for 2017/18 has been prepared; a copy of this is attached (Appendix 3). The Annual Fire Report for 2017/18 and the annual Fire Statement are included as an appendix to the Annual Health and Safety Report. These reports are provided to the Board of Directors for information and for final approval.

**Summary Note: Board members are asked to approve the annual Health and Safety report, annual Fire Report and Fire Statement.**

## 3. Sustainable Development

The Trust has a commitment to integrate sustainable development throughout the organisation and deliver progress in line with the mission statement "*The York Teaching Hospital Foundation Trust strives to actively encourage, promote and achieve environmental sustainability in all that it does".*

Following the completion of the Sustainable Development Assessment Tool, a Sustainable Development Management Plan (SDMP) has been created detailing the actions identified to improve performance. The SDMP will coordinate the social, environmental and financial elements of sustainable development, ensure integration and provide assurance of sustainability for all areas of Trust business.

The SDMP is overseen by the Sustainable Development Group; a sub-group of the Environment and Estates Committee. Following discussions at the last Sustainable Development Group meeting on 1st August 2018, the Terms of Reference for the group have been approved. The Terms of Reference were reviewed at the August meeting of the Environment and Estates Committee however the meeting was not quorate and could not grant final approval. A copy of the Sustainable Development Group Terms of Reference are attached for approval by the Board of Directors (Appendix 4).

**Summary Note: Board members are asked to approve the Terms of Reference for the Sustainable Development Group.**

The Director of Estates and Facilities requests that the Board of Directors note the following updates regarding ongoing sustainability engagement activities and the sustainable catering initiative:

### 3.1 WRM Programme update

The work with consultants WRM intends to address carbon reduction whilst achieving cost savings for the Trust and it will address other areas of weakness too, including the Board commitment to integrate the principles of sustainability throughout the Trust.

Negotiations are close to completion with verbal agreement by WRM to commence the Phase 2 project work with the Trust subject to sight of the draft contract (which has now been issued).

Corporate Directors have approved the funding arrangements for Phase 2 of the project. The job descriptions for the new posts required to support this work have been drawn up and are with the HR team for banding and recruitment. It is anticipated that this project will start in the New Year following completion of the recruitment process.

### 3.2 Sustainability Engagement Activities

Sustainable Transport - A Sustainable Travel event is planned for Wednesday 19th September at Ellerby's,York Hospital. This will involve representatives from the Trust promoting the benefits of car sharing; First Buses, who will have details of the latest staff offers; Enterprise with information on the Trust Pool and Hire car scheme, and Wheels to Work, a new scheme which allows hiring a moped for those not able to use public transport. As the pressure on parking spaces is expected to increase, the event provides an opportunity to look at alternatives to driving, or to join the car share scheme where people travelling together can park for free or use other travel options available to them. Currently the Trust Liftshare scheme has 475 members and those Trust staff who actively share are jointly saving over £31000 per annum. This event will also launch a new Travel and Transport area on Staff Room, bringing together information on all aspects of staff travel and transport. A similar event is planned to take place on 3rd October at Scarborough Hospital.

In June, activities included work around National Clean Air Day (21st June) when the Trust promoted "no idling" to drivers of stationary vehicles, targeting Trust Estates and Delivery drivers, and via general staff through email and intranet communications.

In NHS Sustainable Health and Care Week (25th – 29th June), the Trust provided sustainability displays at York and Scarborough Hospitals and staff and visitors had the opportunity to see posters and discuss the work of the Trust in the areas of energy, waste (with support from Yorwaste who run the Allerton Park Waste Recovery Plant) and sustainable travel (with support from North Yorkshire County Council at Scarborough who were promoting their sustainable travel work and also a Wheels to Work subsidised moped hire scheme throughout the whole of North Yorkshire.

**3.3 Sustainable Catering** - A sustainable catering sub-group has been working towards the removal of a number of single use plastic waste items. This includes offering a 10p incentive for people to bring re-useable hot drinks cups at Ellerby's in York as a means of discouraging use of plastic coated non-recyclable disposable hot drinks cups. Posters and leaflets have been issued. Further work is underway to introduce the removal of catering polystyrene boxes, plastic straws, plastic sandwich wrapping and salad boxes. Corporate Directors have approved this work stream.

### 3.4 Unbleached 100% Recycled Paper Introduced

The Trust has recently changed its supply to environmentally friendlier paper as switching from virgin to 100% recycled paper will have a positive impact on the environment as it is an ecologically sound alternative.

Here are some examples of sustainability statistics which show the comparative annual savings based on the 3,275,940 reams / 8,150 tonnes of virgin copier paper supplied into the NHS by NHS Supply Chain:

| Resource | Resource Saving | Comparative Saving |
|---|---|---|
| Wood | 24,485,754kgs of wood | 16,600 European Spruce pine trees |
| Water | 353,882,894 litres of water | 141 Olympic size swimming pools |
| Energy | kwh 63,117,834 kwh of energy | 11,517 average family home energy consumption |
| Co2 | 5,222,429kgs of Co2 | 1,024 cars removed from the road a year or a Boeing 747 could fly for 6.87 days non-stop |

The paper has been trialed at the hospital and to date we have experienced no printer issues with the product change. In addition, it has been used in central government departments such as the Cabinet Office, Department for Work and Pensions, and HMRC for over 15 years. NHS Scotland switched to using the recycled paper in 2011.

This NCP activity was designed to mitigate the 21% cost increase on virgin fibre copier paper, and to deliver savings of 3.67% against the annual total cost of virgin fibre copier paper. This will deliver a 1st year saving of £256,000 (3.67%) and a cost avoidance to the NHS of £1,410,000 (21%).

**Summary Note: Board members are asked to note the update regarding ongoing sustainability work.**

## 4. Facilities Management Compliance

A major focus of the Environment and Estates Committee is the monitoring of performance and compliance against the legal, statutory and mandatory requirements relating to our premises and equipment in order to provide assurance with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 part 3 and general Health and Safety and Estates Buildings Management guidance.

The NHS Premises Assurance Model, (NHS PAM) Trust Assessment of Patient Experience (TAPE) and PLACE Assessment form part of the Board Assurance Framework and in order to provide assurance, audit and surveillance of the Directorate's progress in making achieving continuous improvement against these initiatives is in place.

A copy of August's Monthly FM Compliance Report is attached for information purposes (Appendix 5). The Director of Estates and Facilities requests that the Board of Directors note the following updates regarding the current compliance position (August 2018):

1. The organisation has not met the national average scores against PLACE Assessment requirements for 2018 with the exception of Selby Hospital site. The PLACE Report for 2018 will be provided in readiness for the next meeting of the Board of Directors.

2. The Directorate is not meeting many of the agreed KPIs associated with Hard & Soft FM performance including those indicators in place against the NHS Premises Assurance Model and TAPE Assessment process.

3. The organisation is not consistently achieving National Specification for Cleanliness in the NHS cleanliness scores. The infection prevention and control teams have been made aware of the issue and additional surveillance has been introduced.

**Summary Note: Board members are asked to note the update regarding ongoing compliance measures.**

## 5. Performance Against Carter Metrics

The Director of Estates and Facilities will provide the Board of Directors with annual updates in relation to performance against Carter metrics. A detailed overview will be provided to the Board of Directors at the next meeting.

## 6. Capital Projects Update

The Environment and Estates Committee previously received regular updates regarding ongoing Capital Projects; these updates are reported to the Board of Directors via the Finance and Performance Committee and this will be covered under a separate agenda item.

## 7. Next Steps

A further report will be prepared for the Board of Directors in October 2018.

## 8. Detailed Recommendation

The Board of Directors is asked to approve the documentation listed above and to note the updates and assurance provided.

APPENDIX 1

York Teaching Hospital NHS
NHS Foundation Trust

# Annual Report of the Environment & Estates Committee 2017/18

## Introduction

The Environment & Estates Committee (EEC) is a sub-committee of the Board of Directors (BoD). The EEC ensures the BoD receives assurance about the Trust's ownership, operation and maintenance of the built environment and associated services. The EEC has delegated authority to seek assurance around the suitability and safety of the Trust's assets and services provided by the Estates & Facilities Directorate.

The Group receives highlight reports from other committees:

H&S/NCRG (Health Safety & Non Clinical Risk Group),
Sustainable Development Group,
Space Management Group
Premises Assurance Group (Compliance)
Out of Hospital Care

in line with the governance structure, copy attached. **(Appendix 1a).**

## Overview of the year 2017/18

The Committee is continuing to function well and is well attended.

A table of attendance is attached. (**Appendix 1b)**.

## Work of the Group

During this reporting period, the Group approved, endorsed or noted the following policies, plans and reports:

- H&S Annual Report (including Fire Safety)
- Sustainable Development Management Plan (SDMP) + Action Plan
- Smoke Free Policy
- Travel Plan
- Heatwave Plan
- H&S Policy
- Premises Assurance Model (PAM) Annual Report
- PLACE Report
- Cleaning Policy
- Review of Building Regulations and Fire Safety Report (Grenfell)
- NHS Protect
- Estates Strategy
- Health & Safety Strategy

and routinely received information on:

- RIDDOR reportable incidents, new claims and settled claims, incidents, complaints and PALS information

- Finance, performance & efficiency report against Lord Carter recommendations (including space utilisation)
- Premises Assurance Model (PAM)
- Estates Condition Survey
- Risk Register assurance (introducing a routine review of red/amber risks and all risks)
- Internal Audit Reports
- Any new legislation, CQC, HSE information

**Update on Audit Work**

During the reporting period the Committee were assured that the following audits received a “high or significant assurance” rating:

- Y1746 – Pool & Hire Car scheme follow up final report
- Y1745 – H&S follow up final report
- Y1762 – Medical Equipment Management final report
- Y1809 – Water safety
- Y1816 – Compliance with Statutory Regulations
- Y1828 – Lone Workers
- Y1811 – Capital Planning
- Y1812 – Capital Project appraisal & selection
- Y1838 – Energy management

The Committee also discussed the action plans arising from those reports that received a “limited assurance” rating:

- Y1801 – Car Parking
- Y1749 – Residential accommodation follow up

**New Legislation**

The Committee was apprised of related legislative changes including HSE and CQC.

**2018/19 Work Programme**

Work for the forthcoming year will include:

Transition into YTHFM LLP
Monitoring progress towards Lord Carter targets
Continuing to review risks and BAF
Monitoring improvements in PAM compliance
Building a comprehensive Estates and Facilities Risk Register
Promote sustainable development throughout the Trust
Estates Condition Survey

It is noted that the BoD is trialling a new structure and reporting Committees will be suspended until January 2019.

## Meetings

During 2017/18 the Committee met on the following dates:

11th April
7th June
16th August
4th October
6th December
7th February 2018

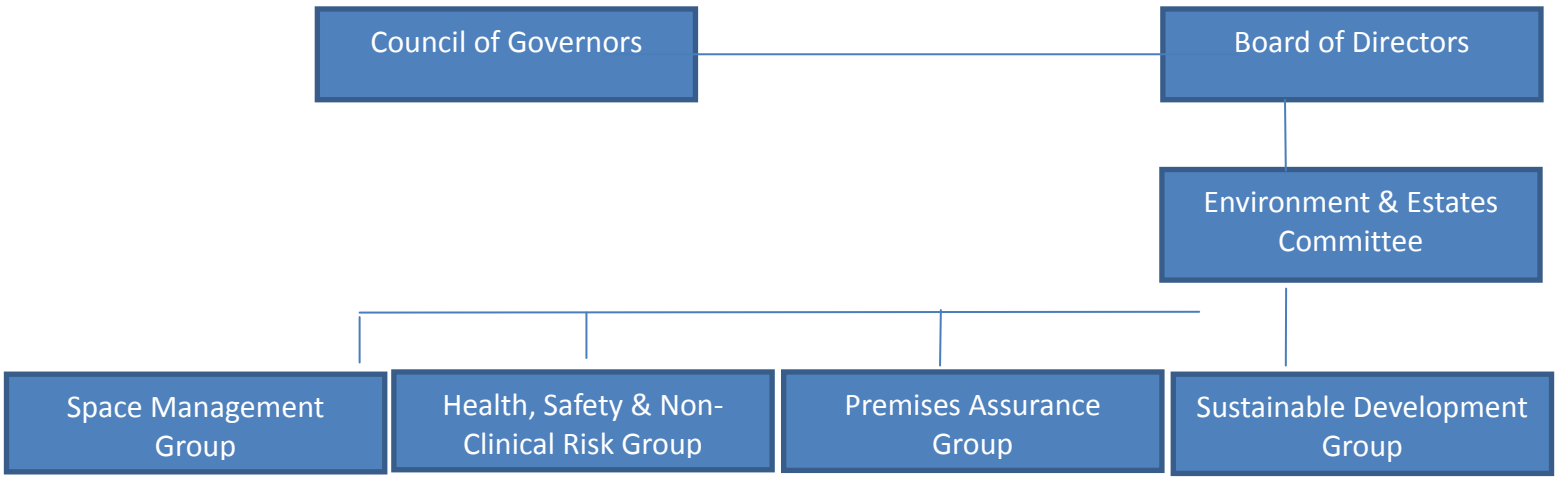
## Conclusion

Over the last 12 months the Committee has developed an understanding of the key issues and risks across the breadth of services that support the Trust's property and infrastructure.

Brian Golding,
Director of Estates & Facilities

**Appendix 1a**

Governance Structure
Environment and Estates Committee



**Appendix 1b**

## Environment & Estates Committee

## Attendance Record Apr ’17 to March ‘18 Meetings by current members

| | Apr 17 | June | Aug | Oct | Dec | Feb 18 | Total (x6) |
|---|---|---|---|---|---|---|---|
| **Michael Sweet, NED - Chair** | √ | √ | √ | √ | √ | √ | 6 |
| **Jenny Adams, NED** | √ | √ | √ | √ | √ | √ | 6 |
| **Brian Golding, Director of E&F** | √ | √ | x | √ | x | √ | 4 |
| **Andrew Bennett, Head of Capital Projects** | √ | √ | √ | √ | √ | √ | 6 |
| **Colin Weatherill, Head of Health, Safety & Security** | √ | √ | x | √ | √ | √ | 5 |
| **David Biggins, Head of E&F - Compliance** | √ | √ | √ | √ | √ | √ | 6 |
| **Jane Money, Head of Sustainability** | x | x | √ | √ | √ | √ | 4 |
| **Lynda Provins, Company Secretary** | x | √ | x | √ | √ | √ | 4 |
| ***Steve Reed, Joint Head of Strategy** | x | √ | √ | x | x | x | 2 |

York Teaching Hospital
NHS Foundation Trust

# Minutes - Environment & Estates Committee meeting – 15th August 2018 – York Hospital

**Attendance:** Brian Golding (BG), Andrew Bennett (AB), David Biggins (DB), Colin Weatherill (CW), Lynda Provins (LP), Jacqueline Carter (JC) (Minutes)

In attendance: Paul Bishop (PB), Mike Keaney (MK)

## 1. Apologies for absence

Apologies for absence were received from Jane Money (JM).

BG welcomed everyone to the meeting. It was noted the Committee Chair had left the organisation and the position had not been filled as yet. A decision had been made that whilst the Committee was not quorate, the August meeting would go ahead as planned but in an informal capacity. The BoD has agreed to postpone all sub committee meetings between September and December '18 and, therefore, this was an opportunity to work through the papers during this transitional period that will require to go directly to the Board of Directors. This was noted.

## 2. Minutes of last meeting

The minutes of the last meeting held on 6th June 2018 were agreed as a correct record subject to the following correction on page 7 of the minutes:

***SMG – minutes of last meeting dated 16th January 2018***

*With regards to the current unmet space needs and opportunities, the first floor of the administration block, YH, highlights an unusually large space becoming available once the endoscopy work is complete.*

## Governance

## 3. Matters Arising and Action Log:

**Corporate Risk EF02** – fire alarm replacement system. A question was raised at the last meeting as to whether the risk rating could be downgraded. It was confirmed this would be reduced once both main panels were installed and live.

**Directorate Risk EF36** – structural survey SGH. AB assured the Committee the necessary checks had been undertaken and the walkway was safe to use.

**Directorate Risk EF47** – Closure of ward doors. CW confirmed a protocol had been written however, the implementation of that will take time and he would need to agree how the work was phased and rolled out into the Trust. **Action: CW.**

**YTHFM LLP Risk Register** - As E&F transitions into a Wholly Owned Subsidiary of the Trust a mechanism will be required to manage the RR and the split between the Trust and

the LLP. CW confirmed he was in discussion with PB about progressing this piece of work. This was noted.

Disposal of offensive waste (no. 57 Action Log) – CW confirmed he was in discussion with Hugh Stelmach regarding this piece of work. He explained there had been some issues with our waste contractor who removes our clinical waste and their ability to be able to continue to remove it due to incineration capacity. This was a national concern and the Environment Agency was involved. The Trust is part of a region wide consortium and it was being managed through that Group. However, it has highlighted that we require a business continuity plan to be in place and, therefore, HS was in the process of producing a policy in response to this immediate crisis and this would then become our procedure going forward. BG asked to be kept informed of the situation. **Action: CW/BG.**

Definition of sustainability and level of priority in Trust (no. 62 Action Log) – JM and BG are in discussion regarding the production of a new Mission Statement. This was noted.

## 4. Directorate Risk Register

The Directorate Risk Register was reviewed by the Committee in line with its work programme.

The Register is split into 2 areas: corporate risks and directorate risks.

Corporate Risks EF01 and EF49 had been separated out to aid transparency and understanding following discussion at previous meetings. They are both associated with the risk in having available capital to deliver essential repairs or any future repairs. BG explained the benefit of Board sub committees being disbanded and the BoD operating in a different way would mean that this topic would be discussed directly by the Board of Directors.

The Committee noted the Red and Amber risks on the schedule.

## 5. Committee Annual Report

The Committee reviewed its Annual Report in line with governance arrangements in particular noting the future work programme contained within it.

The Report was endorsed by the Committee and would proceed to BoD for approval.

## 6. Board Assurance Framework (BAF)

LP presented the latest BAF schedule to the Committee which was received for noting and comment. The purpose of the report was to review the controls, assurance and gaps columns.

She explained the BoD have now refreshed the Trust Strategy including goals and have agreed strategic risks and the reformatting of the BAF going forward.

Work continues in populating the controls, assurance and gaps columns of the BAF in readiness for the BoD to be able to provide a score against each of the risks.

BG is the lead for the 2 elements of the newly presented BAF:

- Strategic Goal: "To deliver safe and high quality patient care"
- Strategic Goal: "To ensure financial stability"

It was agreed to update the schedule in line with the meeting discussion. **Action: LP.**

## Operations

### 7. FM Compliance Monthly Report

DB presented to the Committee the latest combined compliance report for the period ending July '18. The purpose of the report was to set out the Trust's position against the audit and surveillance activities in line with the PAM process.

Key items to note from the Report included:

- An improved Policy & Procedure Register position although it was noted there were still a number of policies outstanding. BG asked that outstanding Policies are approved by end September '18. **Action: DB.**

- The Trust Assessment of Patient Environment (TAPE) process is a quarterly assessment which follows a similar theme to the annual national PLACE assessments examining areas such as cleanliness, condition & appearance, accessibility and privacy & dignity and is in response to feedback from governors whereby there was a general feeling of "tick box" exercises taking place with no processes or action plans thereafter. Currently York and Selby sites are performing well with Selby meeting the 80% key performance indicator set. However, since the last quarter it was noted every site has seen improvement.

- The areas where the Trust was "non-conforming" associated with the condition & appearance and accessibility of our Estate. It was noted an audit action plan is produced and checked in line with the TAPE process.

- NHS PAM position by site measures 5 distinct domains the main one being the safety domain. It was noted that as E&F moves into the LLP they will be expected to provide to the Trust a quarterly position again the NHS PAM Safety domain and so it is essential that E&F Managers now engage with this process more fully.

- The Safety domain was currently showing control mechanisms as "inadequate" however, it was noted that the current position was better than shown; the information has not been populated onto PAM which why engagement with the E&F Managers is important. This information is also linked to business continuity procedures.

- FM KPI Dashboard on page 10 of the report sets out all the indicators we are currently measuring and going forward, these will be transferred to the new LLP.

The Committee noted the contents of the Report and the need for better engagement with the process by E&F Managers.

### 8. PLACE Results

PLACE assessments are undertaken in the 4th quarter of the annual cycle of business. It was noted that the latest national PLACE results will be available from 17th August.

## Sustainability

### 9. SDMP Update

BG presented an update to the Committee in the absence of JM. The purpose of the report was to provide an update on the 2nd phase WRM consultancy work and to update the Committee on the work of the SDG.

Key highlights from the report included:

- Recent sustainability engagement activities include promotional work undertaken around the National clean air day and the NHS sustainability week both held in June.

- The Trust is working with WRM Consultancy to progress the 2nd phase of work of the WRM Project to reduce carbon emissions and improve internal communications. The 2nd phase also requires the consultancy fees to be recoverable in the first year out of the savings achieved and includes the recruitment of 3 new staff posts.

Other Progress updates included:

- the updating of the SDMP Action Plans to be completed by October.

- In relation to waste the percentage of waste being sent to landfill has decreased and the percentage of waste recycled has increased.

- A sustainable catering sub group has been created to implement the removal of a number of single use plastic waste items. This includes the removal of catering polystyrene boxes, coffee cups, straws, sandwich and salad boxes. Corporate Directors has approved this work stream. BG asked the sub group to consider public relations and advertising as a matter of urgency.

- Sustainable care models – report to Board July 18 on Home First engagement process and proposals for next steps encompassed engaging local people which would be built into cancer strategy

- Adaptation – The heat wave plan had been tested out recently. This matter would be raised at the next EPSG meeting to confirm understanding of the level at which point triggers the involvement of the EPSG to meet as a requirement of the Policy. This was noted.

The Committee noted the contents of the report and in particular the urgent delivery of the sustainable catering actions.

### 10. SDG Terms of Reference

The Committee received the SDG Terms of Reference for noting and approval in line with governance arrangements.

Following discussion it was agreed to explore the membership of the Group further.
**Action: LP.**

## Capital and Property

### 11. SMG – minutes of last meeting dated 5th June 2018

The EEC received the latest SMG minutes for noting and comment.

Key points highlighted to the Committee were as follows:

- Item 3.9, the intention is to submit a paper to CDs proposing to increase rents charged for sessional use of Trust space/facilities.
- Item 4 relates to the need for a more formalised/robust process for dealing with space requests.
- Item 6, anticipated a rent increase to the Trust by NHS Property Services for the Trust's occupation of properties they own which the Trust will be challenging.
- Item 11, references work at BDH to optimise the Trust's use of the accommodation and best use of facilities.
- Harrogate Licences, Harrogate Trust has 7 Licences with the Trust. Currently they only pay for occupation of 1 property. This is being addressed. An indication of what fees the Trust would receive for all properties had been identified.

The Committee were assured of the work being undertaken around space utilisation and in particular against the Lord Carter recommendations.

## Health, Safety & Security

### 12. H&S Annual Report including Annual Fire Report

CW presented the Trust's H&S Annual Report for information which had been prepared in line with governance arrangements. The report highlighted the work undertaken in the last 12 months including:

- HSE intervention/RIDDOR reportable incidents which had seen a downward trend.
- Noting the Trust manages its risks on the HSE improvement model based on the Plan Do Check Act approach.
- H&S Self-Assessment internal audits achieved a 94% compliance rating. CW was intending to revisit this, as there may have been some misinterpretation in terms of how some departments have scored. Training in completion of the audit tool was suggested.
- H&S training for staff was highlighted as a concern particularly in the areas of needlesticks, medical gas and radiation. However, CW assured the EEC that all staff were properly trained and this concern was around the frequency of training.

- The link and collaborative working with other risk and safety functions in the Trust continues to be a challenge in forging closer working links. To be discussed further with Beverley Geary. **Action: CW/DB.**

- In terms of presentation the Fire Annual Report section required to be improved prior to submission to BoD.

- Regarding the annual servicing of fire extinguishers DB informed the EEC there were a considerable number that were overdue. **Action: CW.**

- In relation to Fire Doors DB asked that a Register is kept. **Action: DB/A.Betts.**

The Annual Report would proceed to BoD for approval.

### 13. H&S/NCRG – minutes of last meeting held on 13th June 2018

The EEC received the latest H&S/NCRG minutes for noting and comment. There were no issues for highlighting to the Committee.

### 14. Fire Safety update – general

CW provided a verbal update to the EEC in the following areas:

- Fire Alarm replacement scheme
- Fire Doors
- National Building Regulations update.

### 15. H&S Quarterly Report

The EEC received the latest Quarterly H&S report for noting and comment. The purpose of the report is to review reported incidents in regards to health, safety and non-clinical risk and features trend analysis for assurance to the Committee.

No issues were highlighted to the Committee.

### 16. Heat wave Policy

See item 8.

## Finance and Efficiency

### 17. Carter Recommendations – bi-monthly report

DB presented the latest report to the EEC. The purpose of the paper was to set out the Trust's current position against the NHS Improvement Model Hospital data for E&F.

Key highlights were as follows:

- Appendix 1 of the report showed the total trust performance against national trends associated with E&F costs per sq. mtre. The Trust was doing well against the national averages.

- Table E within Appendix 1 identified how many sq. mtres of occupied floor space each WTE is cleaning based on a set formula. The Trust is performing below the national benchmark which impacts on other targets associated with cleanliness through the PLACE Assessments which can be achievable. This was noted.

BG thanked DB for this update.

## Out of Hospital Care

### 18. Quarterly Report

The Committee received the latest report from the Out of Hospital Care Directorate. The purpose of the paper is to provide the Board sub committees with an overview of activities within the Out of Hospital Care Directorate and note any issues appertaining to the EEC.

With regard to providing intravenous antibiotics closer to home - The Trust has made a number of developments in this area including the development of ambulatory care for those requiring long courses over several weeks and working with private providers to deliver a service in patients' homes. A BC is currently being developed for a full service that could commence in time for winter 2018/19. The preferred option is for a Trust delivered model as the current private providers are costly and unable to provide a robust service to the east coast.

## YTH FM LLP

### 19. LLP update

The EEC received a progress report for noting and comment in relation to the formation of an LLP to deliver Estates & Facilities services to the Trust. The purpose of the paper was to apprise the EEC of the timetable, risks and progress towards the formation of the LLP.

The date of commencement of the LLP is 1st October 2018.

A copy of the current programme was attached at Appendix A.

Paul Bishop and DB are currently working through the reverse SLAs and KPIs.

Engagement with the staff and Union reps is continuing.

The Project Board has established and is maintaining a risk register, a copy of which was attached at Appendix B. It was noted these were not LLP risks. A separate piece of work separating out the LLP risks from Trust risks will be undertaken. This was noted.

### 20. Agree scope of reporting to Board of Directors for September to December

BG to agree with BoD in September.

### 21. Any Other Business

- DB raised concerns, on behalf of the Facilities Management team, around the difficulties they were experiencing in providing the required level of cleanliness across the organisation. DB suggested he could relax compliance monitoring in

administrative areas to help ease the situation. BG was in agreement with this in principle but asked DB to contact the Infection Prevention team. **Action: DB.**

- CW reported to the Committee that a gap in process had been identified within the Catering department and he was currently working with the Catering teams on ensuring a plan based on the HACCP principles was in place and being applied as a matter of course. This was noted.

## 22. Time and Date of Next Meeting

~~Wednesday 10th October 2018, 10.30am.~~ To be confirmed.

APPENDIX 3

York Teaching Hospital NHS
NHS Foundation Trust

# Health, Safety & Security in York Hospital NHS Foundation Trust

**(Encompassing Fire Safety, Security Management and Non-Clinical Risk Management)**

# Annual Report 2017/18

## Foreword

York Teaching Hospital NHS Foundation Trust (the Trust) recognises that promoting a positive safety culture is vital in protecting the health, safety and welfare of our employees, those who use our services and in protecting our environment.

The Trust is committed to promoting an environment which actively supports a safety culture and awareness by recognising health, safety and environmental management of risk as being key in the way the Trust operates and critical to the Trust's success.

In achieving this, the Trust has a developed risk strategy, based on risk profiling and assessment of risk to prevent any incidents before they occur, to ensure any residual risk is mitigated to as low as is reasonably practicable and is actively managed.

The report has been produced with the Health & Safety Executive (HSE) guidance managing for health and safety (HSG65) in mind; our aim is to continually improve on what we already have in place, by making the management of safety an integral part of good management and not a stand-alone system.

In the coming year, the Trust will continue to take a proportionate and pragmatic approach to management of health, safety and non-clinical risk across the organisation, by focusing on what really matters in delivering a safe environment and service for all.

On behalf of the Trust, we would like to thank all of the various teams involved in the management of risk across the organisation for their efforts in ensuring we have in place robust and effective safety management systems, structures and processes for achieving this aim.

Brian Golding

*Director Health Safety & Non-clinical Risk*

Mike Proctor

*Interim Chief Executive Officer*

## 1. Executive Summary

It is a requirement of the Trust's Board of Directors (BoD)[1] to have in place formal procedures for auditing and reporting on health and safety performance. This annual Health and Safety (H&S) report covers the Trust's H&S activities from 1 April 2017 to 31 March 2018; providing assurance on the H&S performance and management of risks.

As in previous years, the Trust has continued to meet the requirements of health and safety legislation throughout the year. A significant achievement was the reduction of 'serious' RIDDOR incidents reported in the Trust. The continued development and embedding of a robust framework for reporting groups will assist in monitoring our governance of Health Safety and Non-Clinical Risk concerns.

The Trust will continue to progress its management of health, safety and environment across the Trust with a focus on:

- prevention of injury to patients, staff and visitors;
- maximising staff morale, reducing absence levels, improving staff retention and productivity;
- mitigation of reputational damage to the Trust by preventing enforcement action and any resulting criminal or civil action being taken against the Trust or its officers;
- avoiding the damaging effects of financial penalties through uninsured losses;
- providing assurance against NHS and Care Quality Commission standards;
- continued review of existing health and safety arrangements to ensure continued compliance with relevant health and safety legislation and applicable safety standards;
- assessing, monitoring and providing assurance all premises are 'so far as is reasonably practicable' fit for purpose;
- review and assurance of the results and addressing issues identified by the self-assessment health and safety audit;
- identification of required health and safety training courses;
- monitoring of policy compliance and addressing any resulting issues related to health, safety and the environment;
- effective and safe management of waste and environmental matters and concerns.

## 2. Environment and Estates Committee

The reporting of corporate health, safety and non-clinical risk to the Board is via the Environment and Estates Committee. The Committee is responsible for overseeing the management of health, safety and non-clinical risk.

Summary overview of Committee business:

- receiving quarterly reports from the Estates and Facilities Premises Assurance Model (PAM) for monitoring standards and compliance of the physical environment in the Trust;
- approval of Trust health and safety strategy;
- exception reports from reporting sub-committees and groups for management of specific H&S and Environmental risks, monitoring specific topic risks for key areas set against the NHS Premises Assurance Model framework;

[1] *INDG 417 – Leading Health and Safety at Work*

- summary reports quarterly and annual on H&S performance, on non-clinical risk management, incident reports;
- Estates and Facilities patient experience, concerns, complaints and compliments;
- summary reports on the Trust sustainability and environmental agenda;
- property, capital and asset management (Carter compliance);
- monitoring key Estates and Facilities risk via the Directorate aggregated risk register, reporting significant risk to the Trust Corporate Risk Committee;
- specified Trust non-clinical, Estates and Facilities and health and safety policy and procedure final approval;
- approve the setting and review of and monitoring outcomes and actions of relevant internal audit reports;
- receive in year topic reports such as out of hospital care, PLACE, financial performance and specific risk, H&S and environmental matters;
- oversee the development and introduction of the Trust Assessment of Patient Environment inspection (TAPE) and wider compliance reporting and monitoring of the Trust Estates and Facilities performance.

In the reporting period, the Committee has met on 6 occasions (11 April 17, 7 June 17, 16 August 17, 4 Oct 17, 6 Dec 17 and 7 February 18), this is an increase on 16/17 when the Committee met on 4 occasions, when it was decided, due to the workload of the Committee, to move from quarterly to bimonthly meetings. The Committee has been successful in its remit of monitoring and reporting on non-clinical risk management performance on behalf of and to the Board and in identifying areas where the Committee required action to address any specific topics or items of concern.

## 3. Health Safety and Non-Clinical Risk Group (Committee Annual Summary)

The Health & Safety/Non-Clinical Risk Group (H&S/NCRG) brings together key Trust leads with responsibility for health and safety and non-clinical risk.

The Group continued to function in line with the Group's Terms of Reference; a summary of key topics discussed by the Group in 2017/18 included: lone worker devices, ward level patient storage, needle stick injuries, safety training, safety programmes & plans, non-clinical CAS alerts, non-clinical incidents, sub-committee risk registers, review of safety policy and procedures and any specific items brought to the Group's attention by direct reports or via sub-committee or group.

As part of the Trust's governance arrangements the Group received highlight reports from the Trust's Health and Safety Committees and their sub committees and groups.

Meeting dates for 2017/18 were:
- 24th May 2017
- 14th September 2017
- 22nd November 2017 (cancelled)

**Meeting Attendance Record 2017-18:**

**H&S/NCRG Attendance record from April ’17 to March ‘18 by current members**

| | 24.5.17 | 14.9.17 | 22.11.17 cancelled | Total (2) |
|---|---|---|---|---|
| Brian Golding, Chair | √ | √ | | 2 |
| Adam Bassett, Community | √ | √ | | 2 |
| Staff Side rep | √ | √ | | 2 |
| Anne Devaney, Corporate Learning | | x | | |
| Andrew Millman, OH | | √ | | 1 |
| Kingsley Needham, H&S | √ | | | 1 |
| HR Manager | √ | | | 1 |
| Colin Weatherill H&S | √ | √ | | 2 |
| Helen Hey, Nursing | √ | √ | | 2 |
| Fiona Jamieson, Healthcare Governance | x | x | | 0 |
| Dave Biggins, Compliance | | √ | | 1 |
| DM rep | | | | |
| Jacqueline Carter - Minutes | x | √ | | 1 |

Meeting dates for 2018/19 have been agreed. A Work Programme will be developed and the following topics will be included for discussion for the forthcoming year:

- H&S Directorate self-assessment internal audits commencing October ’17;
- The development of a H&S training needs programme;
- Water Safety & Legionella Policy;
- Medical Devices Management Policy;
- Pest Control Policy;
- Waste Management Policy;
- Heatwave Policy;
- Asbestos Policy

## 4. HS&E Interventions, Legislation and Guidance Monitoring

In 2017/18 the Trust had the following communications with the UK Health and Safety Executive:

1. April 2017 – A routine inspection of the class 3 pathology laboratory at York Hospital was undertaken. The inspection identified a series of minor improvements which were addressed by the department.

2. May 2017 - Following a RIDDOR report in regards to a staff member having symptoms of contact dermatitis. The HSE commenced an investigation and made a site inspection in regards to the Trust management of COSHH / H&S; this intervention was made under HSE fees for intervention. The Head of Safety and Security met with the inspector and provided information and documentation that demonstrated the Trust had robust management in place in this area. No further action was taken as no material breach was identified.

3. October 2017 - Sharps - The HSE inspected in regards to the Trust management of Sharps under the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. Following a site inspection and review of documentation, the Trust was found to be in contravention of health and safety law namely the use of medical Sharps, information and training and arrangement in the event of an injury and required to pay a fee of £1556.40. The Trust put in place an action plan and actions have been undertaken to address the items identified.

4. March 2018 - Routine inspection of the class 3 pathology laboratory at Scarborough Hospital was planned. This inspection has not taken place to date and is expected later in 2018.

Occupational Health and Safety (OH&S) legislation and guidance that will or is likely to impact the Trust is reported via the Health, Safety & Security department and Estates competent persons. Where an amended or new legislative requirement or guidance is identified by the Trust, the relevant legislation, guidance, audit and inspection reports are reviewed, retained and disseminated to the relevant operational area or across the Trust as required with summary of applicable changes reported to the Environment and Estates Committee.

In year examples of this review process:

- Year-end review of Reported Incidents under the Reporting of Diseases and Dangerous Occurrence Regulations 2013;
- December 17 - Memorandum of Understanding Care Quality Commission (CQC), Health and Safety Executive and Local Government Association and potential impact of this on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and general health and safety legislation;
- Health and Safety Self-Assessment Audit 2017 results;
- Estates and Facilities Risk Register review of key risks.

## 5. Health and Safety Requirements

Health and safety legislation requires that the Trust has a system in place to proactively manage and control risks. As in previous years, in order to meet these legal requirements, the Trust manages its risks based on the HSE's model 'Successful Health and Safety Management' (HSG65[2]) based on the continuous improvement model based on the approach of **Plan, Do, Check, Act**.

### Plan

During this reporting period, the H&S and Risk Committees and groups have developed, approved or noted policies, procedures, plans and reports. As part of the Trust governance structure, specialist groups and Committees review, provide specialist advice and oversee policy and procedure development. Once approved at each specialist group, policies and procedures are promulgated through the appropriate parent group or Committee with final oversight by the Environment and Estates Committee acting on behalf of the Board.

The Trust continued to review health and safety strategy alignment with existing corporate risk management strategy to improve closer working synergy of the Trust non-clinical risk systems.

### Do

Work has continued on specific aspects of safety management, with risk based evaluation of topics which present the greatest health and safety risks to the organisation. Risks which are identified as medium or high have specific measures taken to address and effectively manage the risk. By adoption of this approach, resource can be identified and prioritised action taken, with less priority given to low risk activities.

H&S and Non-Clinical risk topics have identified specialist leads and specialist committees/groups to ensure and monitor compliance. Where significant risks are identified, control measures are put in place to mitigate the risk to an acceptable level. Where further action is deemed required, these risks are escalated to Directorate and corporate risk registers for risk treatment, management or acceptance.

Lead by the Head of Compliance, the Trust has continued with embedding the NHS Premises Assurance Model (PAM) standards. In this year the focus in this area of work has been focussing on compliance monitoring and reporting.

### Check

[2] *HSG65 (Third edition, published 2013)*

Proactive Monitoring - Health & Safety Self-Assessment Audit & EEC Quarterly Reporting

Each year in the Trust, a Health & Safety Self-Assessment audit is undertaken. The audit is shared with operational Directorates. Directorates are required to complete the audit against prescribed criteria proving assurance of adherence to Trust policy and guidance. The scores from each Directorate assessment are aggregated and a final Trust-wide score is obtained.

The Health and Safety Self-Assessment Audit tool is electronic. It is formed in two parts. This first part is a mandatory section made up of eight sub sections:

- Safety and Risk Management
- Incident Reporting
- Fire Safety
- Slips, Trips and Fall Prevention
- Work Related Stress
- Infection Prevention (All areas and staff)
- Learning from Experience
- Incident Investigation

The second part is made up of fifteen risk specific standards:

- Infection Prevention
- Moving and Handling People
- Lifting and Moving of Objects
- Human Tissue Act
- Control of Substances Hazardous to Health (COSHH)
- Violence and Aggression
- Clinical Waste Handling and Disposal
- Display Screen Equipment
- Laser Radiation and Artificial Optical Radiation
- Ionising Radiation
- Safety in Patient Areas
- Safe Use and Disposal of Sharps
- Latex
- Medical Equipment
- Resuscitation

Each sub section is awarded marks for a range of key questions asked; when totalled up, they are averaged to produce a mark across all criteria, with the overall percentage mark over time, providing an indicator by which an area can see its safety performance / compliance develop and improve. Linked to the self-assessment tool are numerous sub departmental audits and inspections to provide assurance and inform the final result.

The audit for 2017/18 was commenced in August 17 for return and completion October 17.

The result of the report was **94% compliance** with the standards.

*(Appendix 3a – H&S audit 2017 summary report)*

Health, safety and non-clinical risk performance has been reported on a quarterly basis to the Environment and Estates Committee and on a meeting by meeting basis to the Trust Health and Safety Committee and Health Safety and Non-Clinical Risk Group.

Reactive Monitoring - Health and Safety Accident and Incident Reporting System (AIRS) Reports; 2017/18

The Trust has in place a comprehensive system to collect information from accident and incidents which occur in the Trust's Datix reporting system.

As part of the Datix reporting system, the Trust captures significant harm incidents (Non-Clinical). The Trust has a duty to report these incidents to the HSE under the Reporting of Diseases and Dangerous Occurrence Regulation 2013.

Summary of RIDDOR Incidents for year 01 April 2017 – 31 March 2018

Total RIDDOR reports for the year was 8. This figure is significantly less than the Trust reported in 2016/17 which was 18.

Records of RIDDOR reports for the last 7 years (*this data is by calendar year*) across the Trust give a longer term comparison on performance. This shows RIDDOR reported in 2017 is 61.9% less than 2016. A better indication of longer term performance is to look at the average that the seven years data has recorded; for 2017 this represents a 31.11 % reduction compared to the average for the years 2011 to 2017[3].

Review of RIDDOR reportable incidents has identified that the most significant factor leading to the drop in RIDDOR is related to a drop in staff slips trips and falls and manual handling as a cause.

*(Appendix 3b – Full summary RIDDOR 17/18)*

**Act**

Health and Safety performance review - Working with the Trust's legal department, routine reviews of Employee and Public Liability claims are undertaken to identify any significant trends/risks and to identify potential lessons to be learnt to prevent reoccurrence.

It is Trust policy for investigations to be carried out into incidents to identify root causes and put in place measures to either eliminate any potential risk or mitigate the risk so that it is effectively managed. The Trust also has in place a robust policy for the management of serious incidents.

The Trust has in place a Central Safety Alert System managed through the Risk Department. This system collates any alerts which enter into the Trust from an external source or are raised internally. Once an alert has been entered onto the system, a process is followed to ensure the alert is addressed and signed off. Once this has been completed, the alert is closed and advised as appropriate to the informing organisation.

In addition to this, the Trust monitors complaints which may have a specific non-clinical safety element. These complaints are reviewed by the operational responsible department and via quarterly reports to the Environment and Estates Committee.

[3] *Some of the significant difference in RIDDOR reports can be accounted for by changes to RIDDOR reporting in 2013 effecting reports 2014 forward, prior to this higher number of reports were seen i.e. 3 day absence from work reporting was changed to 7 days .*

## 6. Health and Safety Executive's Key Topics in Health and Social Care

The HSE is the national independent regulator for health and safety in the workplace; this includes publicly and private owned health and social care settings, working in partnership with co-regulators in local authorities to inspect investigate and where necessary take enforcement action.

The HSE leads on employee health and safety and will, in conjunction with the Care Quality Commission, consider investigation of staff, public and patient or service user deaths or serious injuries. Where there is an indication of a specific breach of health and safety law which has been a probable cause or a significant contributory factor in meeting specific health and safety legislation, the HSE will be lead on securing justice or necessary improvement in standards.

With the introduction of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (CQC fundamental standards) and supporting Memorandums of Understanding and agreements between the authorities on the lines of regulatory responsibility in the healthcare, general health and safety and patient injury reporting rests in the main with the CQC, with the HSE focus being the regulator for topic specific health and safety legislation, environmental & equipment harm.

The HSE Health and Social Care Sector identified key topics:

Moving and Handling;
Sharps Injuries;
Slips Trips and Falls;
Workplace Violence;
Equipment Safety;
Dermatitis;
Legionella;
Falls from Windows;
Bedrails;
Scalding and Burns.

## 7. Staff Training

The Trust provides a range of in-house training that contains elements of health and safety. The move to the Learning Hub will allow the organisation to analyse the numbers of staff trained in more detail.

There still remains an identified gap in regards to specific health and safety training with continued improvement and progress required in the areas of Risk Assessment, COSHH Assessment, First Aid and general health and safety qualifications for staff tasked with specific health and safety responsibilities (e.g. IOSH). A business case has been developed to address this and a time of this report the case is in progress via the Trust Business Case panel.

## 8. Fire Safety Annual Report and Annual Fire Statement

*Appendix 3c - Fire Safety Report.*

*Appendix 3d – Annual Fire Statement.*

## 9. Security Management Annual Report

On 1 April 2017, NHS Protect responsibilities for security management in the NHS ceased, for the year the NHS standard (security management) remained applicable for commissioners and providers until 1 April 2018.
To maintain effective management and reporting, the Trust Head of Security put in place processes to ensure continued reporting in line with the principals of NHS Protect requirements.

In the last year, we have focussed on officer safety, and one measure we have taken is to introduce Body Worn Video. This has been extremely successful and we have seen complaints and V&A drop from implementation.

We have developed our CCTV system, which now runs more efficiently and cost effectively. Our Senior CCTV Programme Officer has also undertaken training which now allows for install works to be completed in-house, cutting out costs from external suppliers and contractors.

We have taken the lead on our Security Management Specialist regional meetings and currently chair the meetings which are held quarterly throughout the region. We have also built vital networking links with NHS England in the Security Management field.

We have continued to work on our access control strategy across the organisation; this has included implementation in high risk areas such as Duke of Kent Ward, Medical Gas stores, Endoscopy and Pathology.

The Security Department has continued to work closely with external agencies such as North Yorkshire and Humberside Police, National Counter Terrorism Police and Counter Terrorism Security Advisors. We have also made links and are part of the Cross-Sector Safety and Security Communications both receiving highly relevant National Security data and Information and being able to feed back in on a national level.

We are working hard as a department to make sure skills are enhanced in different areas within; as part of this NEBOSH training is been provided to staff so contingencies and forward planning are actively adopted moving forward to make sure the organisational objectives are met.

## 10. Conclusion

2017/18 has a continued focus on the wider health, safety and security risks of the Trust and how the safety function interacts with other aspects of safety management, with on-going work on improving the health and safety systems and processes, striving to embed these systems into the operational management across the organisation.

Work in this year continued in developing a health and safety strategy and key stakeholders and functions linked to the management of health safety and non-clinical risk to further address this.

The changes in the Trust's governance arrangements in this area in 2016 forward (NHS PAM's) is now delivering comprehensive reports in ensuring robust senior management

review at the Environment & Estates Committee and providing assurance on safety and non-clinical risk to the BoD.

The link and collaborative working with other risk and safety functions continues to be a challenge in forging closer working links, providing synergy and efficiency.

It is noted that, with the current Trust structures for management of risk, it is not always clear as part of the operational management structure, when the responsibilities lie with the Directorate for management of risk or where this is reported through to the health safety and non-clinical risk function.

On-going work with the various Trust functions is underway to define this structure and responsibilities.

For the Health and Safety Department to continue to support the Trust effectively, a review of the resource availability within the Trust is ongoing to allow for improvements to be made to health and safety systems already in place and to develop additional systems to allow for efficiency at an operational level.

**Owner:**

Brian Golding, Director of Estates and Facilities

**Contributors to the report and author:**

Kingsley Needham, Trust Health and Safety Manager
Janet Mason, Head of Security and Accredited Local Security Management Specialist
Darren Miller, Security Manager
Mick Lee, Fire Safety Officer – York
Kevin Hudson, Fire Safety Officer - Scarborough

Colin Weatherill, Head of Safety and Security (Report Author)

September 2018

# Health and Safety – Self Assessment Audit 2017

In August 2017 the Health and Safety Department circulated the self assessment audit tool for completion by the end of October 2017. This shift from processing submissions in late Q1 recognised that a number of Directorates were experiencing difficulties with conducting their audits. Following discussions within the Health and Safety Group, it was agreed that the audits would now take place in Q3.

As with previous years, larger Directorates were encouraged to split down into smaller sub groups in order to achieve a better representation of health and safety compliance.

Prior to the audit taking place, the most notable change to the usual structure was the new group 'Out Of Hospital'. This new group effectively replaces what would normally have been the community group. This will see further changes in the 2018 audit as a number of changes are already in the process of being made known; this will include Malton Hospital transfers to Humberside NHS.

The audit tool continues to evolve and improve by virtue of the feedback we receive. The results received are a simple indicator of where a Directorate/Department may be in the opinion of the auditor and meeting compliance; or conversely may identify areas where attention may be required.

Prior to the 2017 audit commencing, a full review of the questions being asked was undertaken, ensuring that links to Trust policies and legislation were current and in place with any software errors being removed.

The audit tool still remains an electronic tool based in Microsoft Excel, with two parts; a mandatory section made up of eight sub sections.

- Safety and Risk Management
- Incident Reporting
- Fire Safety
- Slip, Trip and Fall Prevention
- Work Related Stress
- Infection Prevention (All areas and staff)
- Learning from experience
- Incident Investigation

The second part is made up of fifteen risk specific standards;

- Infection Prevention
- Moving and Handling People
- Lifting and Moving of Objects
- Human Tissue Act
- Control of Substances Hazardous to Health (COSHH)
- Violence and Aggression
- Clinical Waste Handling and Disposal
- Display Screen Equipment
- Laser Radiation and Artificial Optical Radiation
- Ionising Radiation
- Safety in Patient Areas
- Safe Use and Disposal of Sharps
- Latex
- Medical Equipment
- Resuscitation

Each sub section is awarded marks for a range of key questions. When totalled up, they are averaged to produce a mark across all criteria. The document also enables the user to generate a Directorate/Departmental Action Plan from which improvements can be made and monitored.

The overall percentage mark can, over time, provide an indicator by which an area can see its safety performance/compliance progress. It can also be a benchmark against other areas of the Trust.

The 2017 audit received a total of 68 responses, an increase of 7 when compared to the last audit, an increase of almost 10%.

This audit has highlighted there may have been some misinterpretation as they returned zero marks. This should not be the case within the mandatory standard section. It may well be that a short training exercise take place in order to ensure you have the required understanding and consistency.

Generally the marks awarded still allow us to make changes that will improve our health and safety performance.

The lower marks were against the categories indicated below;

| | | | |
|---|---|---|---|
| Trust (all services) | **2017** | 88% | Learning from experience |
| | | 93% | Work related stress |
| | | 94% | Slips, Trips and Falls |

Interestingly the three lowest marks in the 'Risk Specific Standards' are as follows: –

| | | |
|---|---|---|
| Trust (all services) | **2017** | 70% Human Tissue Act<br>72% Laser Radiation and Artificial Optical Radiation<br>88% Display Screen Equipment |

Both DSE and Lasers have been worked on in 2017 so it is possible these areas may see improvement in 2018. DSE has had a new policy, guidance and a new self-assessment form. There is a small team looking at the whole issue of lasers, both ionising and non-ionising.

The Human Tissue Act had only 6 returns out of 68 so represented a small group therefore the result may give a false impression.

Overall results were as follows

| | |
|---|---|
| Trust (all services) | **2017** – 94%<br>2015 – 92%<br>2014 – 83%<br>2012 – 84% |

This continues the improvement seen since 2014.

Recommendations:-

- Ensure the evidence streams and questions used within the audit are linked to and in line with current legislation, Trust policies and documentation.

- The timing of the audit in Q4 has proved problematic for some Directorates/Departments due to manning levels and year end commitments. It is proposed that the anniversary date for the audit moves to Q2. Therefore the 2018 audit will commence in Q1 2019 with a view to the audit report being made available late Q2 2019.

  It has been suggested to Committees, by the authors of this report, they are encouraged to monitor their evidence and the questions asked in the audit, in effect continually updating their data and evidence such that the audit doesn't cause too much disruption whenever it takes place. This would in effect exhibit best practice.

- During the lead up to the 2017 audit Directorates and Departments were reminded of the action plan and the fact it is partially

generated by the software. It is an important part of the audit process to produce the action plan as it clearly highlights where improvements can be made, timescales and when the actions have been addressed.

- It has been noted, from a number of areas, that training in completion of the audit tool would be advantageous. Understanding the legislative evidence to prove compliance as well as understanding some of the terms used may well prove beneficial. Therefore, during 2018, training and awareness sessions for completing the audit will be arranged for those who require it.

- In a number of areas there have been significant improvements. Some of these improvements can be attributed to the contribution made by the Learning Hub in delivering e-learning packages and recording training. Improved attendance on courses has also helped.

Kingsley Needham
Health & Safety Manager
York

Colin Weatherill
Head of Safety & Security/ LSMS
Scarborough

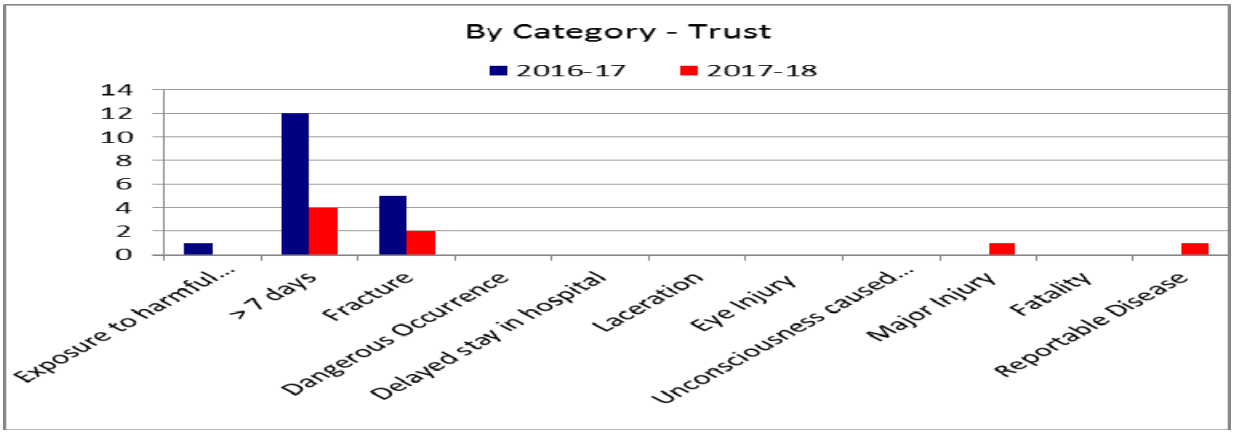
May 2017

# Year End Summary RIDDOR report - 2017/2018

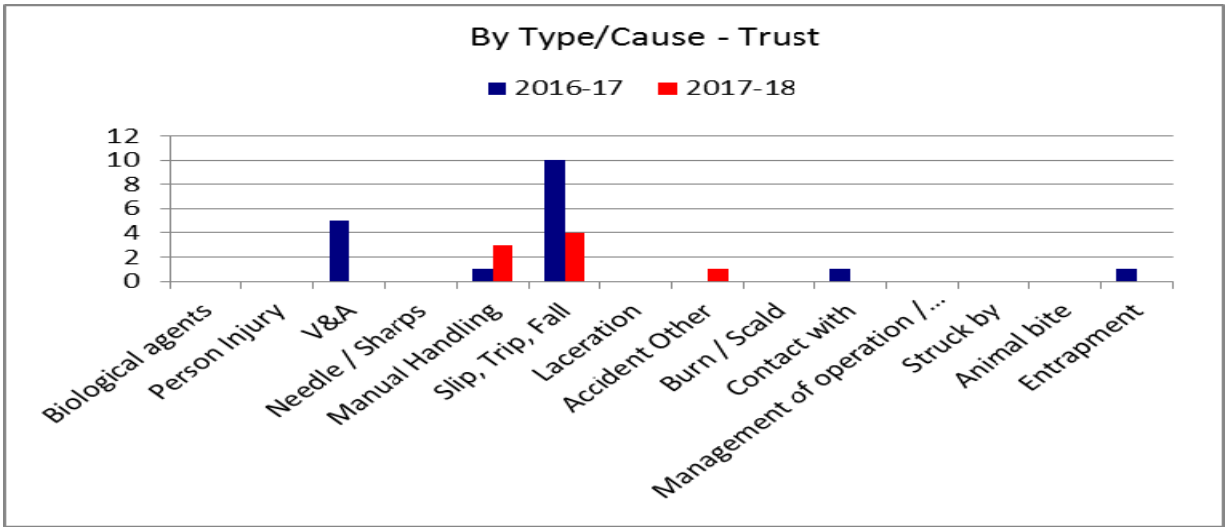
For the period 01 April 2017 to 31 March 2018, **EIGHT** RIDDOR reportable incidents were confirmed on Datix across the Trust.

The total number of RIDDOR reportable incidents for **2017/18** was **EIGHT**, compared to **EIGHTEEN** for the same period **2016/17** representing a 55.6% fall in RIDDOR's reported across the Trust.

**Summary of total Trust Reportable Incidents**




| RIDDOR Category to period | 2016-17 | 2017-18 |
|---|---|---|
| Exposure to harmful substance | 1 | 0 |
| > 7 days | 12 | 4 |
| Fracture | 5 | 2 |
| Dangerous Occurrence | 0 | 0 |
| Delayed stay in hospital | 0 | 0 |
| Laceration | 0 | 0 |
| Eye Injury | 0 | 0 |
| Unconsciousness caused by head injury | 0 | 0 |
| Major Injury | 0 | 1 |
| Fatality | 0 | 0 |
| Reportable Disease | 0 | 1 |

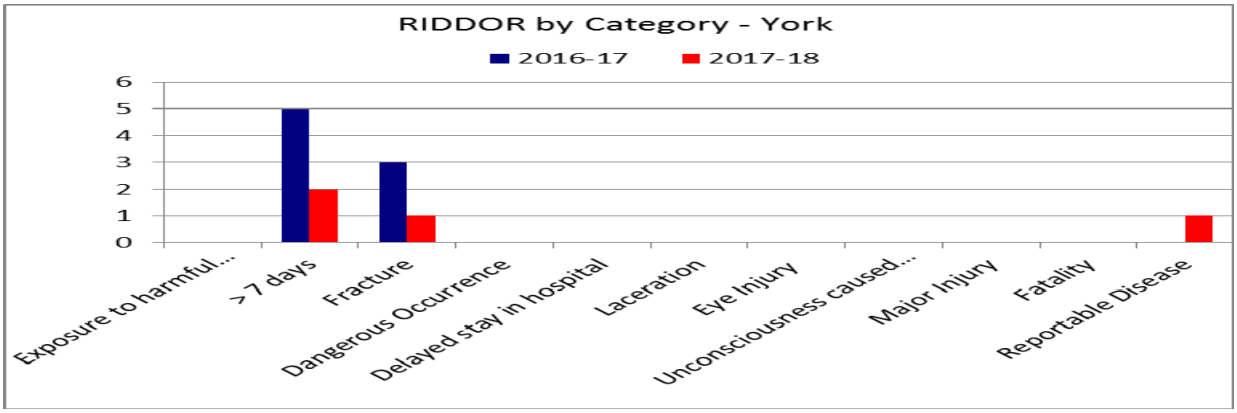


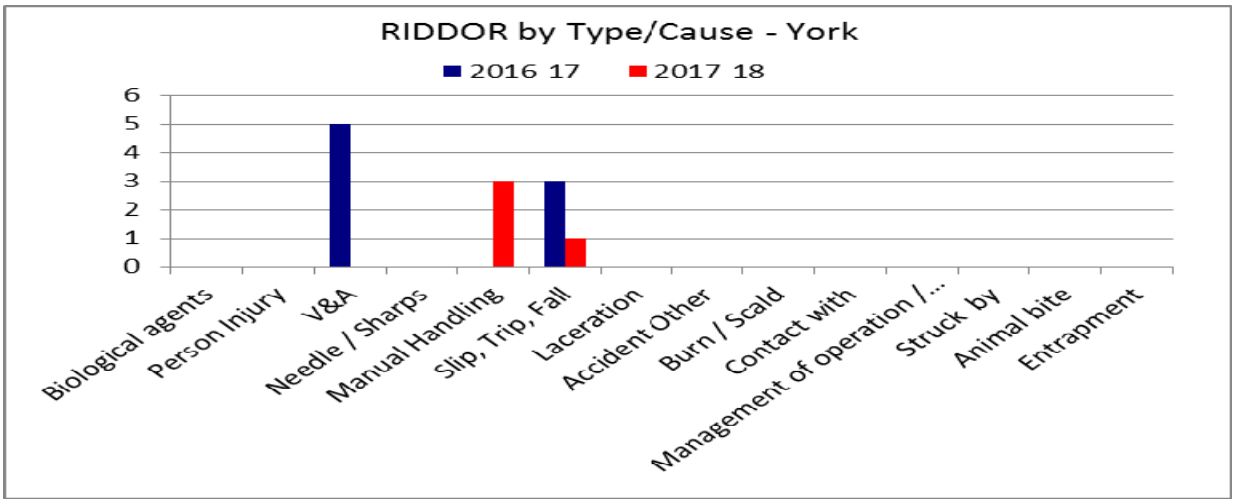
| RIDDOR TYPE / CAUSE | 2016-17 | 2017-18 |
|---|---|---|
| Biological agents | 0 | 0 |
| Person Injury | 0 | 0 |
| V&A | 5 | 0 |
| Needle / Sharps | 0 | 0 |
| Manual Handling | 1 | 3 |
| Slip, Trip, Fall | 10 | 4 |
| Laceration | 0 | 0 |
| Accident Other | 0 | 1 |
| Burn / Scald | 0 | 0 |
| Contact with | 1 | 0 |
| Management of operation / adverse event | 0 | 0 |
| Struck by | 0 | 0 |
| Animal bite | 0 | 0 |
| Entrapment | 1 | 0 |

The most significant differences between 2016-17 and 2017-18 was the change in causation, with the number of RIDDOR incidents involving slips trips and falls dropping across the Trust and manual handling incidents reported at York seeing a slight increase on 2016/17.

## By Site - York

The total number of RIDDOR reportable incidents for **2017/18** was **FOUR** compared to **EIGHT** for **2016/17** representing a 50% reduction of RIDDOR reportable incidents on 2016/17 for the York Hospital site.

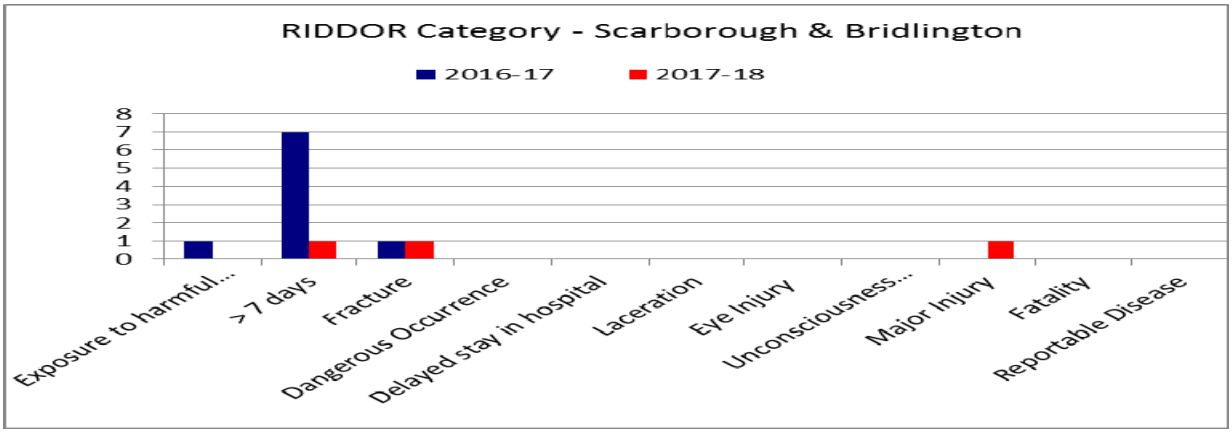


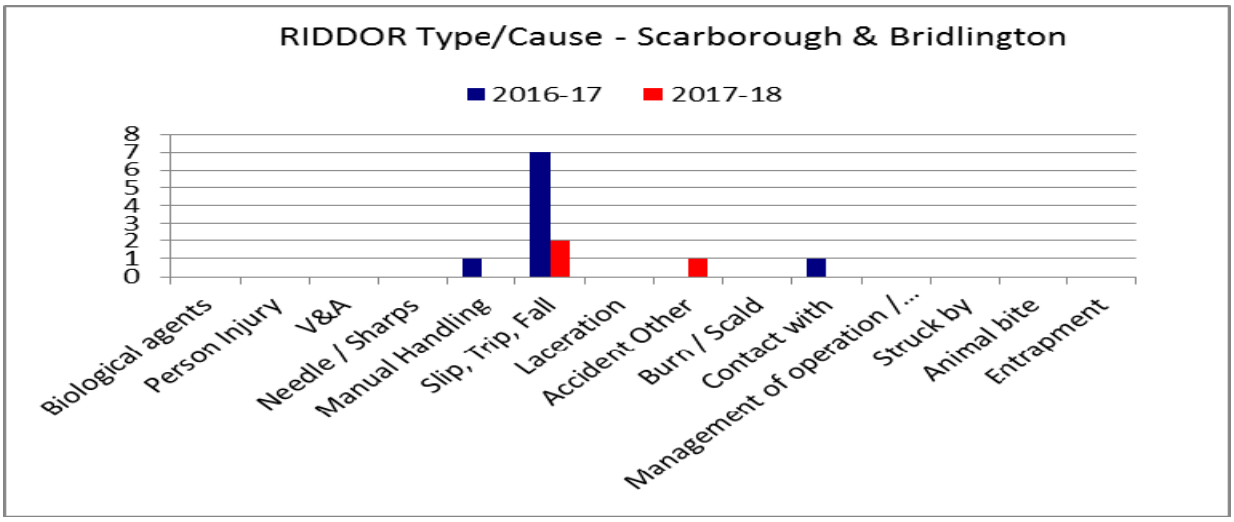



## By Site – Scarborough & Bridlington

The total number of RIDDOR reportable incidents for **2017/18** was **THREE** compared to **NINE** for **2016/17**.

This represents a 66.7% reduction in RIDDOR reportable incidents on 2016/17 for the Scarborough & Bridlington Hospitals sites.

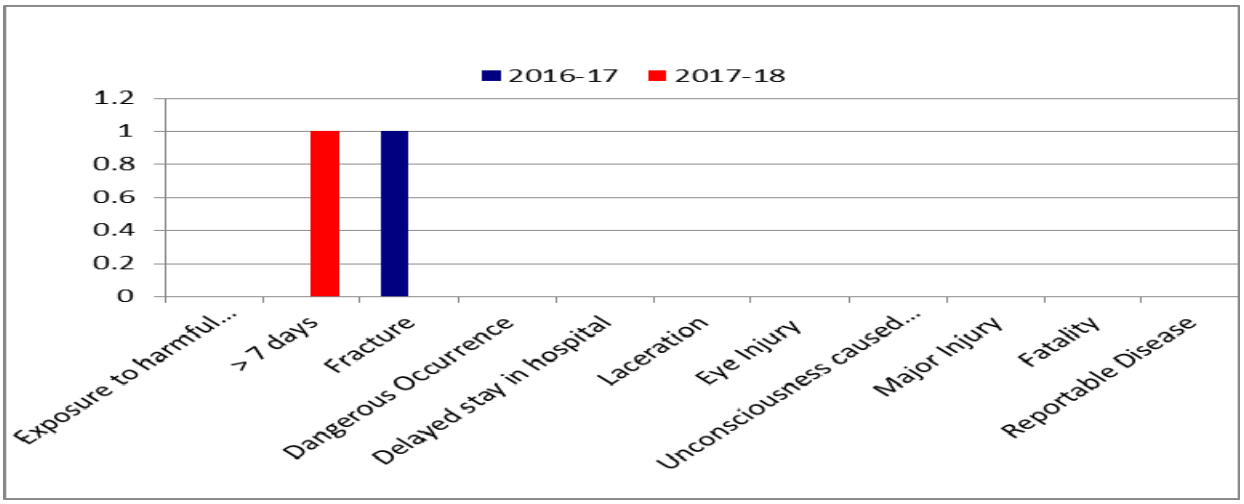


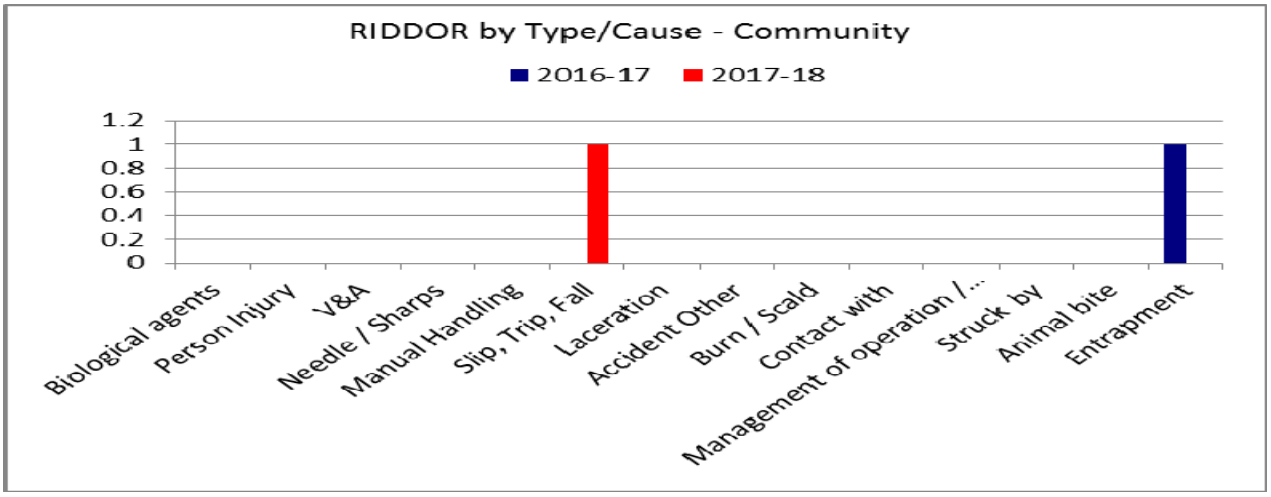




## By Site - Community

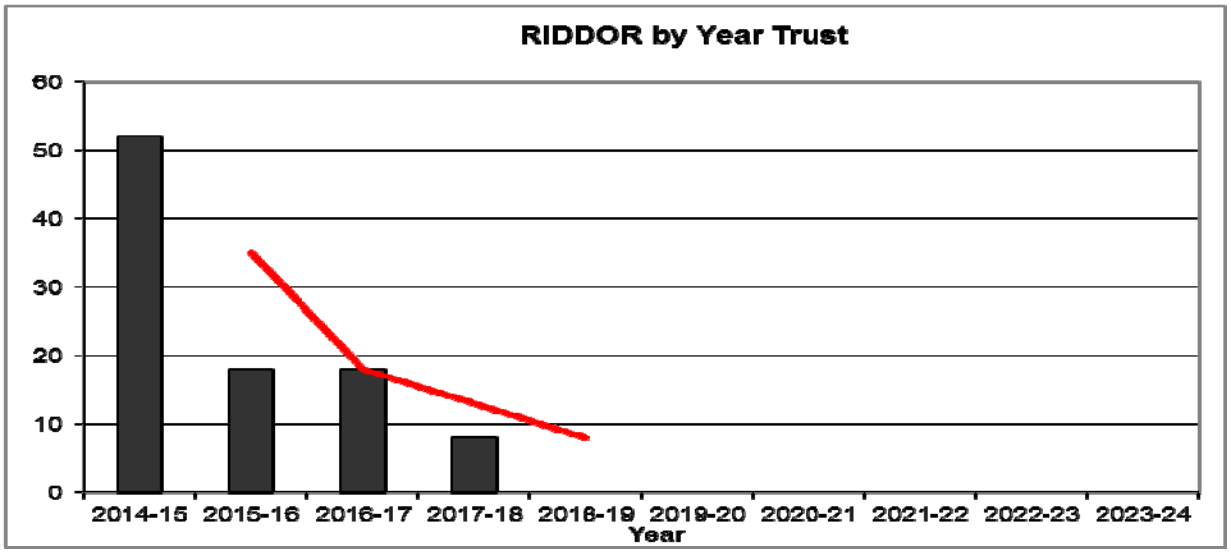
The total number of RIDDOR reportable incidents for **2017/18** was **ONE** compared to **ONE** for **2016/17**.

This represents no change in the number of RIDDOR reportable incidents on 2016/17 for the Community Hospitals & Clinics.



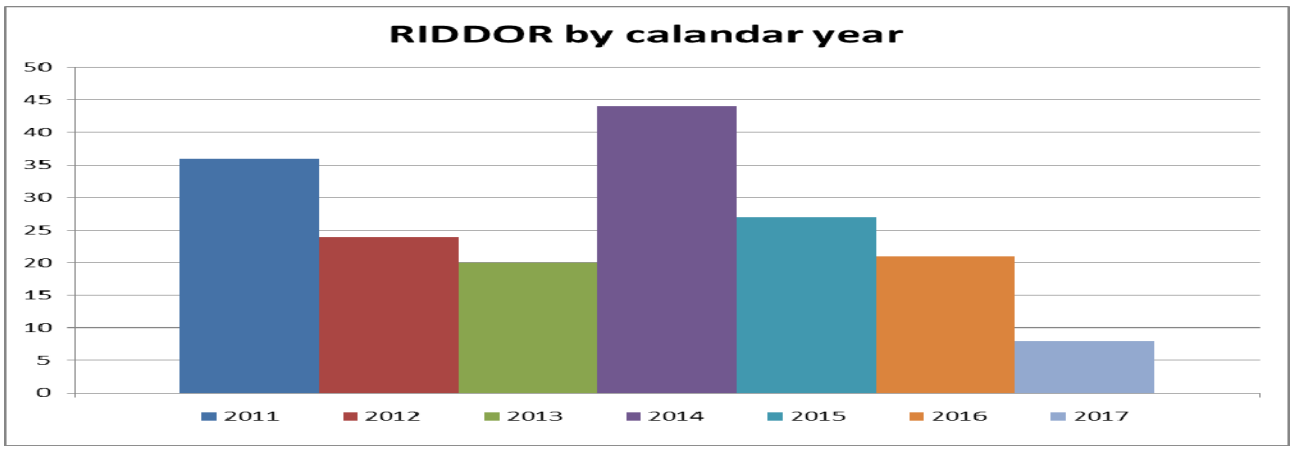



**RIDDOR reportable Incidents 2014/15 to 2017/18 (Financial year)**




RIDDOR reported for the last 4 financial years continues to show a significant downward trend in reported incidents from 2014/15 to 17/18.

**RIDDOR reportable Incidents 2011 to 2017 (by calendar year)**




The Trust 7 Year average for RIDDOR reported incidents is 25.7 per year therefore for the number of incidents reported for 2017 is 68.89% less than the 7 year average.

**END**

**Executive Summary:**

During the 2017 calendar year and continuing into and throughout 2018, the Trust will continue to meet its obligations under all current legislation and remain broadly compliant in maintaining those standards.

As part of the continuing commitment to make good/upgrade breaches to the structural/passive fire protection across all sites, work continued during the above reporting period and this will remain an ongoing commitment during the FY2018/19.

All work will continue to be carried out by third party accredited contractors, which ensures a standard of work satisfying current legislation and will serve to ensure a robust level of quality assurance and compliance for the Trust.

Remediation work was carried out and completed in the following areas at York:

Selby War Memorial Hospital (SWMH)

Work planned for the FY18/19:

St Monica's Hospital

Hospital wards (those undergoing refurbishment and which are un-occupied).

**Fire Alarm Replacement** (York/Scarborough)

A comprehensive survey and design initiative took place across the 2 main hospital sites during the early part of 2015 with a view to replacing the fire alarm systems at York and Scarborough. Work is now progressing on schedule across both main hospital sites. Work at the York site is due for completion by the end of 2018.

**Portable Fire Extinguishers**

Annual servicing of these items across all premises will be undertaken by a suitably trained individual employed by the Trust. Historically this has been a member of the Estates maintenance team based at Scarborough.

**Fire Safety Training**

This continues to be delivered across all sites by the relevant fire safety advisors. Face to face sessions are delivered as required with no Trust employee going more than 3 years without this type of training. There remains in place a requirement under the Statutory & Mandatory training policy, for fire training to be undertaken annually, on induction and through face to face or e-learning via the Learning Hub as applicable.

*During the course of 2017 it was pleasing to see that 19 consultants, all NEDs together with the Medical Director, Director of Estates and Facilities, Chairperson, Trust Secretary and the Chief Operating Officer all undertook fire safety training. (See Table 1)*

**Fire Alarm Activations**
There were a number of fire alarm activations across the main hospital sites during this reporting period, details of which can be seen in table 2 on page 4 of this report.

Unfortunately the data shows a small increase over the 2016 figures for the same sites. It is however pleasing to report that there were no activations from SWMH, Malton or St Monica's hospitals, nor from any of our other satelite sites.

It is expected that, upon completion of the fire alarm replacement across the two main hospital sites, the number of false alarm activations resulting in the attendance of the LAFRS (Local Authority Fire and Rescue Service) and therefore the needless disruption to personnel, departments etc will be greatly reduced. *(See Table 2)*

**Fire Safety Risk Assessments**
Regular reviews continue to be undertaken by the relevant fire advisors across all sites, thereby providing the Board of Directors with assurances that we meet all current statutory duties placed upon us by current legislation. *(See Table 3)*

**Fire Service Audits**
The Western region was subject to 1 local authority fire safety audit carried out at Malton Hospital by officers of the North Yorkshire Fire & Rescue Services. The premises received a broadly compliant/satisfactory rating.

**Trust Fire Safety Group(s)**
The Fire Safety groups are now well established across both Eastern & Western regions, with both groups meeting 4 times per year. Transparency is served through accessible folders held on the Trusts Q-Drive which are then subject to audit/scrutiny upon request. The Trust Fire Safety Manager, Kingsley Needham, has the responsibility of being Chairperson for both groups.

**Training:** *(Table 1)*

| **Approx. Total Manpower Figures:** | **9200** |
|---|---|
| York Staff trained (face to face)<br>Period Jan – Jun 2017 | 235<br>(down 672 on 2016) |
| York Staff trained (face to face)<br>Period Jul – Dec 2017 | 88<br>(down 363 on 2016) |
| York Fire Wardens trained<br>Period – 2017 | 41<br>(up 20 on 2016) |

| | |
|---|---|
| *Corporate Induct. - *Delivered at York Post Grad Cent* | 1,193 |
| *Stat/Mand Refresher – *York* | 1,175 |
| *HCA Induction – *York* | 151 |
| Jr Dr's Induction – *York* | 187 |
| Total York Staff Trained (2017 Calendar Year) | 3,070 |
| *Scarborough Staff (Stat/Mand)<br>Jan - Dec 2017 | 707 |
| *Scarborough Fire Wardens Trained<br>Period – 2017 | 9 |
| *HCA Induction – (*S'Boro)* | 70 |
| Total Scarborough Staff Trained (2017 Calendar Year) | 786 |
| *E-Learning/Learning Hub | 135 |
| **APPROXIMATE TOTAL TRAINED** | **3,991** |
| *Approximately 9,200 Trust personnel are required to undertake fire safety training over a 3 year period. With face to face training now being a 3 yearly cycle, we would expect to train approximately 3000 every year (face to face). The current CLaD figures as at Sep 2018 show a compliance of 77% (Low Risk) & 90% (High Risk) across the Trust.* | |

*** Figures Supplied by Corporate Learning and Development**

**Fire Alarm Activations 2017**

*(Table 2)*

| Location | Cause | 2017 | Comparison to 2016 Figures |
|---|---|---|---|
| York | Steam Leak | 3 | Up by 2 |
| York | Toasters | 5 | Up by 2 |
| York | Unknown Cause | 2 | Down by 6 |
| York | Accidental | 10 | Up by 3 |
| York | Contractors | 3 | Down by 1 |
| York | Aerosols | 8 | Up by 5 |
| York | Electrical Faults | 1 | Down by 1 |
| York | Water Leak | 1 | New 2017 |
| York | Smoking | 1 | Down by 1 |
| York | Microwaves | 2 | New 2017 |
| | **Total (Western Region)** | **36** | **Up by 5 on 2016** |

| Location | No. of Alarms | Comments |
|---|---|---|
| Scarborough | 16 | Down by 5 on 2016 |
| Bridlington | 10 | Down by 8 on 2016 |
| **Total (Eastern Region)** | **26** | Down by 13 on 2016 |

The above figures cover the period 1st Jan 2017 – 31st Dec 2017

**Fire Risk Assessments/Reviews**

The Fire Advisors across both Eastern and Western regions continue to carry out assessments and reviews over this reporting period. The breakdown for which is as follows:

**For the Calendar year 2017**
*(Table 3)*

| Region | Number |
|---|---|
| Eastern | 63 |
| Western | *62 |
| (Includes 7 assessments in premises occupied by the Trust but owned by NHSPS Ltd) | |

** Down on 2016 due to a 3 month sickness absence of the York Fire Safety Advisor*

**Annual Statement of Fire Safety 2017**

| | | |
|---|---|---|
| **NHS Organisation Code: RCB** | **NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST** | |
| **I confirm that for the period 1st January 2017 to 31st December 2017, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):** | | |
| **1** | **There are no significant risks arising from the fire risk assessments.** | **N/A** |
| **OR 2** | **The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessments. (Fire Alarm Replacement across York & Scarborough sites)** | ✓ |
| **OR 3** | **The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks.*** | **N/A** |
| ***Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date: N/A** | | |
| **4** | **During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? (Delete as appropriate) If Yes - Please outline details of the enforcement action in Annex A – Part 1.** | **No** |
| **5** | **Does the organisation have any unresolved enforcement action pre-dating this Statement? (Delete as appropriate) If Yes Please outline details of unresolved enforcement action in Annex A – Part 2.** | **No** |
| **AND 6** | **The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.** | √ |
| **Director (Trust Fire Safety)** | **Name: B GOLDING Director of Estates & Facilities** | |
| | **E-mail: brian.golding@york.nhs.uk** | |

*/*

| | | |
|---|---|---|
| **Contact details:** | **Telephone:** | **01904 72 5149** |
| | **Mobile:** | **N/A** |
| **Chief Executive** | **Name:** | **M PROCTOR** |
| **Signature of Chief Executive:** | | |
| **Date:** | **26 September 2018** | |

**Completed Statement to be forwarded to the Health & Social Care Information Centre No longer required**

**The above certificate is to be attached as an Appendix/Annex to the Annual Fire Safety Report.**

**(as recommended by the Internal Audit Report 2014)**

**ANNEX A**

| **Part 1 – Outline details of any enforcement action during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.** |
|---|
| **N/A** |
| **Part 2 – Outline details of any enforcement action unresolved from previous years, including the original date, and the action the organisation has taken so far. Include any outstanding proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.** |
| **N/A** |

**NHS Organisation Code RCB**

**NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST**

**Date: 26 September 2018**

APPENDIX 4

York Teaching Hospital NHS
NHS Foundation Trust

# Sustainable Development Group: Summary of Governance

**Version 4**
**August 2018**

## York Teaching Hospital NHS Foundation Trust

## Sustainable Development Group:
## Summary of Governance

## Table of Contents

# DRAFT
# SUSTAINABLE DEVELOPMENT GROUP
# TERMS OF REFERENCE

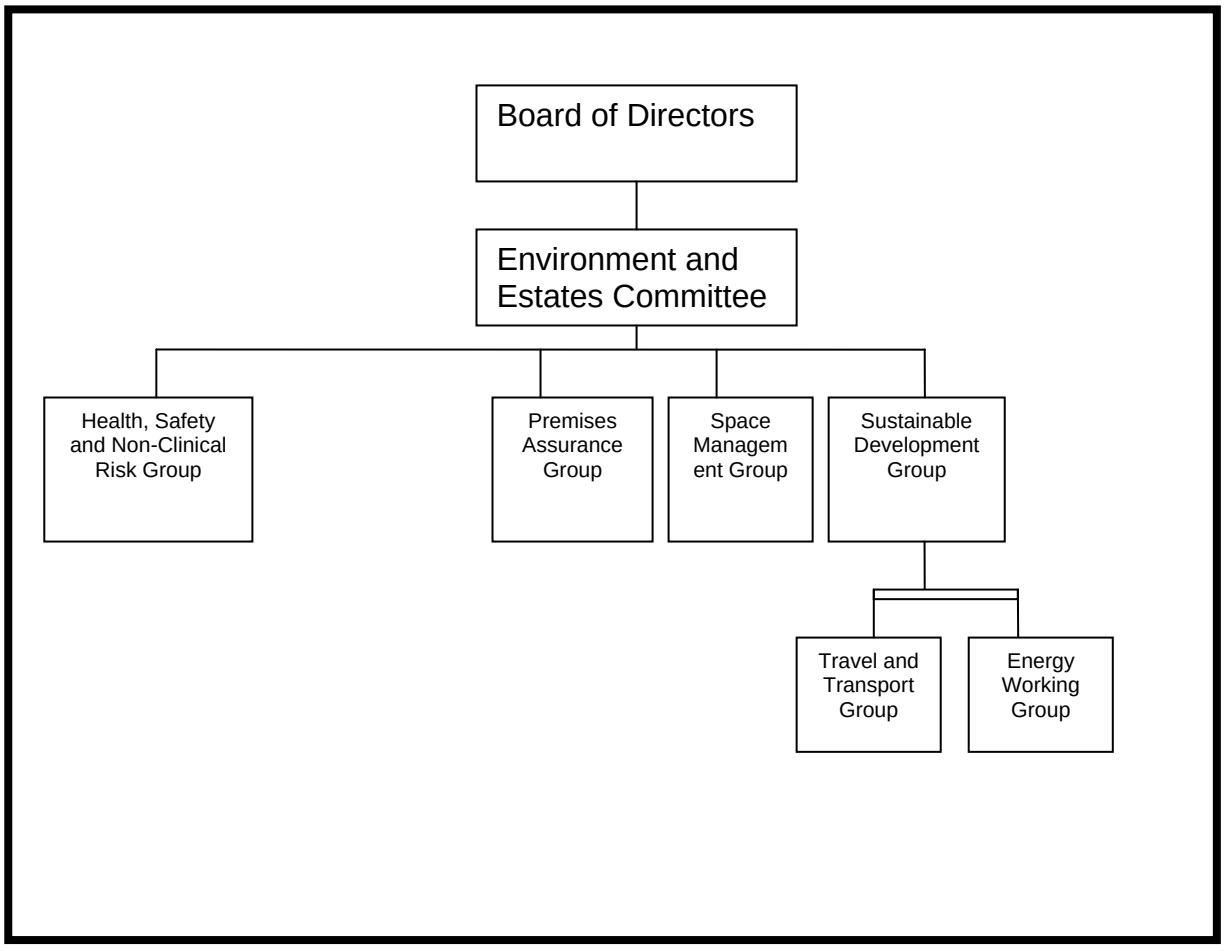
| | |
|---|---|
| **1** | **Status** |
| 1.1 | The Sustainable Development Group is a sub group of the Estates & Environment Committee who report to the Board of Directors. The minutes of the Sustainable Development Group will be received by the Estates & Environment Committee. |
| 1.2 | The Group will have a core membership receiving assurance. Other named parties will be in attendance and provide assurance to the Group. |
| **2** | **Purpose of the Group** |
| 2.1 | The Sustainable Development Group will ensure the establishment and maintenance of a Sustainable Development Management Plan (SDMP). The Management Plan will coordinate the social, environmental and financial elements of sustainable development and will ensure integration and provide assurance of sustainability into all areas of Trust business. The SDG will monitor and ensure the Trust is working towards the Trust agreed SDMP mission statement that: *The York Teaching Hospital Foundation Trust strives to actively encourage, promote and achieve environmental sustainability in all that it does*. It should be noted that whereas the Trust appreciates that sustainability is achieved when social, economic and environmental needs are met, our SDMP mission statement is aimed at ensuring that sustainability goes beyond that and is not focused solely on the financial and social aspects of "sustainability" as defined in the context of the Sustainability and Transformation Plan Guidance. |
| **3** | **Authority** |
| 3.1 | The Sustainable Development Group is a formal sub group of the Estates & Environment Committee. |
| **4** | **Legal requirements of the group** |
| 4.1 | The Sustainable Development Group must ensure that all legal requirements with regard to any new, or amended, legislation are reviewed on behalf of the Trust and addressed accordingly. |
| 4.2 | The Sustainable Development Group will prepare an Annual Report addressed to the Estates & Environment Committee and will be shared with the Board of Directors. |
| **5** | **Roles and functions** |
| 5.1 | The Group will establish and maintain the Trust's Sustainable Development Management Plan to include:<br>• Compliance with relevant environmental legislation and regulatory requirements |

| | |
|---|---|
| | • Include climate change in the Trust's Risk Register, specifically climate change mitigation risk, climate change adaption risk and associated climate change financial risk<br>• Develop emergency preparedness strategies for climate change risk and adaption risk. |
| 5.2 | The Group will coordinate the Trust's commitments to undertaking the Good Corporate Citizenship Assessment and developing action plans to improve performance and also to achieve the carbon reduction targets in accordance with the Climate Change Act 2008 and NHS Sustainability Guidance and Carbon Reduction guidance including target setting, monitoring and reporting on the *nine* thematic areas:<br>• **Corporate Approach**<br>• **Asset Management & Utilities**<br>• **Travel & Logistics**<br>• **Adaptation to Climate Change/Resilience**<br>• **Capital Projects**<br>• **Green Space & Biodiversity**<br>• **Sustainable Care Models**<br>• **Our People**<br>• **Sustainable Use of Resources**<br>• **Procurement**<br>• **Carbon/GHGs** |
| **6** | **Membership** |
| 6.1 | Membership of the Sustainable Development Group will comprise the following staff:<br>• Chair – Director of Estates & Facilities<br>• Vice Chair – Head of Sustainability<br>• Head of Estates and Facilities)<br>• Lead for Travel and Logistics<br>• Lead for Transport Air Pollution and Health Impacts (Head of Safety and Security)<br>• Lead for Waste Management<br>• Facilities Manager to advise on Sustainable Food and Catering<br>• Lead for Energy Management<br>• Estates Manager to advise and lead on Green space management opportunities<br>• Head of Capital Projects<br>• Head of Procurement<br>• Sustainable Care Model Lead<br>• Lead for Resilience<br>• Senior Finance Manager<br>• Senior HR Manager/Workforce lead<br>• Local authority sustainable development lead – tbc<br>• Secretariat Service<br>Further officers of the Trust may be asked to attend the Group when appropriate. The Sustainable Development Group will maintain a register of attendance at the meeting. Attendance of less than 50% will be brought to the attention of the Chair. |

| | |
|---|---|
| | The attendance record will form part of the Annual Report. |
| **7** | **Quoracy** |
| 7.1 | The meeting will be quorate with 7 members; this must include either the Chair or Vice Chair. |
| **8** | **Meeting arrangements** |
| 8.1 | The Sustainable Development Group will meet quarterly and all supporting papers will be circulated 7 days in advance of the meeting. Copies of all agendas and supplementary papers will be retained by the Director of Estates & Facilities Office in accordance with the Trust's requirement for the retention of documents. |
| 8.2 | The Chair of the Sustainable Development Group has the right to convene additional meetings should the need arise, and in the event of a request being received from at least 2 members of the Group. |
| 8.3 | Where members of the Sustainable Development Group are unable to attend a scheduled meeting, they should provide their apologies in a timely manner to the Secretary of the Group and send a nominated deputy. |
| 8.4 | <u>Reporting:</u><br><br>The Estates & Environment Committee will receive the minutes from the Sustainable Development Group in line with governance arrangements. |
| **9** | **Review and monitoring** |
| 9.1 | The Terms of Reference and membership of this group will be reviewed and monitored at regular intervals on the instruction of the Chair and will be reviewed in their entirety at an interval of not less than two years. |

| | |
|---|---|
| **Author:** | **Brian Golding, Director of Estates & Facilities** |
| **Owner** | **Brian Golding, Director of Estates & Facilities** |
| **Date of Issue** | **August 2018** |
| **Version** | **4** |
| **Approved by** | **Estates & Environment Committee** |
| **Review date** | **August 2020** |

## Governance Structure



York Teaching Hospital NHS Foundation Trust

# Estates & Facilities Directorate

# Monthly FM Compliance Report

| | |
|---|---|
| Month | **August 2018 (5)** |
| David Biggins | Head of FM Compliance & Performance |
| (Quarter) /Year | (2) 2018/2019 |
| Version | 1.0 |

## 1. Policy and Procedure Compliance- Directorate

There has been a 10% reduction on compliance with this Key Performance Indicator against the previous month, portering and travel and transport policies or procedures are now overdue review and there are still a number of policies organisation, procedures which are outstanding including ventilation and air conditioning, asset management and catering.

It was agreed at August Premises Assurance Group Meeting that the Lifts and LOLER Policies for the organisation can be merged into a single policy which reduces the Directorate's policies/procedures on the register to 24.

The absence of an approved Ventilation Policy has been raised as a non- conformance by the Trust Independent Authorising Engineer (AE) Ventilation as part of an annual report of 2017 and should be addressed as a priority.

| | |
|---|---|
| **Number of Procedures on Register** | **24** |
| **Number Approved/in date -Last Review** | **14** |
| **Number not approved or overdue review** | **10** |
| **Policy & Procedure Compliance** | **58.00%** |

**Estates & Facilities Directorate Policies & Procedure Register**

| | Title | Format | Current Status | Policy in date or outstanding | Next Review Date | Authors | Approving Group/Committee |
|---|---|---|---|---|---|---|---|
| 1 | Asbestos Management | Policy | Approved | | Oct-20 | K Needham | Health & Safety Committee |
| 2 | Asset Management & Maintenance | Procedure | DRAFT | | TBC | J Dickinson | Premises Assurance Group |
| 3 | Environmental Cleaning Policy | Policy | Approved | | Oct-19 | D Biggins/C Birch | Environment & Estates Committee |
| 4 | Health & Safety Policy | Policy | Approved | | Mar-19 | C Weatherill & K Needham | Health, Safety & Non Clinical Risk Group |
| 5 | Catering | Procedure | DRAFT | | TBC | A Betts | Environment & Estates Committee |
| 6 | Medical Gas Management Policy | Policy | Approved | | Oct-19 | D Moon | Medical Gas Committee |
| 7 | Non Piped Gas | Procedure | DRAFT | | TBC | J Nicholls | Health & Safety Committee** |
| 8 | Water Safety & Legionella | Policy | Approved | | Sep-18 | D Moon | Water Safety Group |
| 9 | Electrical Safety | Plan | Approved | Under review | Feb-18 | P Johnson | Electrical Safety Group |
| 10 | LOLER/Lifts | Procedure | DRAFT | | TBC | J Dickinson | Health & Safety Committee |
| 11 | Ventilation & Air Conditioning | Procedure | DRAFT | | Apr-17 | J Nicholls | Ventilation Steering Group |
| 12 | Pressure Systems | Procedure | DRAFT | | TBC | J Dickinson | Health & Safety Committee** |
| 13 | Decontamination | Policy | Approved | | Jun-19 | D Biggins/J Brockway | Decontamination Steering Group |
| 14 | Fire Safety | Policy | Approved | | Jan-19 | M Lee & K Hudson | Environment & Estates Committee |
| 15 | Waste Management | Policy | Approved | | May-21 | C Weatherill. | Health, Safety & Non Clinical Risk Group |
| 16 | Medical Device Management | Policy | Approved | | Mar-20 | J Wilsher | Medical Device Management Group |
| 17 | Security | Policy | Approved | | Sep-19 | J Mason | Security Committee |
| 18 | Travel & Transport Policy | Procedure | Approved | | Jun-18 | J Money | Transport & Travel Committee |
| 19 | Pest Control | Policy | Approved | | Jul-20 | J Knott | Health & Safety Committee |
| 20 | Switchboard & Patient Multimedia | Procedure | Approved | | Jul-19 | L David | Premises Assurance Group |
| 21 | Portering | Procedure | Approved | | Jul-18 | J Louth/H Stelmach | Premises Assurance Group |
| 22 | Premises Assurance Procedure | Procedure | Approved | | Sep-18 | D Biggins | Environment & Estates Committee |
| 23 | Heatwave | Plan | Approved | | Mar-19 | C Weatherill. | Health & Safety Committee |
| 24 | Capital Projects Policy | Policy | None | | TBC | A Bennett | CPEG |

# 2. Decontamination of Reusable Medical Devices- Site

## Decontamination of Reusable Medical Devices- Audit Dashboard

Reviewed: 15th August 2018

| Audit Activity | Last Audit | Next Audit |
|---|---|---|
| Endoscopy SGH/BDH | Aug-18 | Aug-19 |
| Endoscopy -York | Aug-18 | Aug-19 |
| Sterile Services- SGH | Aug-18 | Aug-19 |
| Sterile Services- York | Aug-17 | Aug-18 |
| Outpatients- BDH | May-18 | May-19 |
| Outpatients-SGH | Jan-18 | Jan-19 |
| Cardio Unit- SGH | May-18 | May-19 |
| Cardio Unit- York | May-18 | May-19 |

| Last audit Scores | R | A | G/NA | |
|---|---|---|---|---|
| Endoscopy SGH/BDH | 0 | 3 | 162 | 165 |
| Endoscopy -York | 0 | 3 | 162 | 165 |
| Sterile Serv- SGH | 0 | 1 | 35 | 36 |
| Sterile Serv- York | 0 | 5 | 31 | 36 |
| Outpatients- BDH | 0 | 1 | 14 | 15 |
| Outpatients-SGH | 0 | 1 | 14 | 15 |
| Cardio Unit -York | 0 | 1 | 14 | 15 |
| Cardio Unit- SGH | 2 | 1 | 12 | 15 |
| | 2 | 16 | | |

Major Corrective Actions = Red Rated Risks

| Annual Audits to date | No of Major Corrective Actions at Last audit | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall Compliance | 12/13 | 13/14 | 14/15 | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 | * KPI Met |
| Endoscopy SGH/BDH | 4 | 1 | 2 | 3 | 5 | 4 | 0 | | | | | | | No |
| Endoscopy -York | 0 | 0 | 5 | 5 | 0 | 2 | 0 | | | | | | | Yes |
| Sterile Services- SGH | 2 | 2 | 0 | 0 | 2 | 0 | 0 | | | | | | | Yes |
| Sterile Services- York | 0 | 2 | 2 | 1 | 0 | 0 | 0 | | | | | | | Yes |
| Outpatients- BDH | 4 | 2 | 0 | 2 | 0 | 1 | 0 | | | | | | | Yes |
| Outpatients-SGH | 1 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | | | Yes |
| Cardio Unit- SGH | 2 | 1 | 1 | 0 | 1 | 1 | 2 | | | | | | | No |
| Cardio Unit- York | * | * | * | * | * | 2 | 0 | | | | | | | Yes |

| Audit Action Plan Submission | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Endoscopy SGH/BDH | | | | | | | | | | | | | | |
| Endoscopy -York | | | | | | | | | | | | | | |
| Sterile Serv- SGH | | | | | | | | | | | | | | |
| Sterile Serv- York | | | | | | | | | | | | | | |
| Outpatients- BDH | | | | | | | | | | | | | | |
| Outpatients-SGH | | | | | | | | | | | | | | |
| Cardio Unit -York | | | | | | | | | | | | | | |
| Cardio Unit- SGH | | | | | | | | | | | | | | |

| Non Conformance By Category | |
|---|---|
| Decontamination Process (DP) | 1 |
| Engineering/Maintenance (EM) | 0 |
| Documentation (Doc) | 2 |
| Tracking & Traceability (T&T) | 1 |
| Governance (Gov) | 0 |
| Training (TG) | 0 |

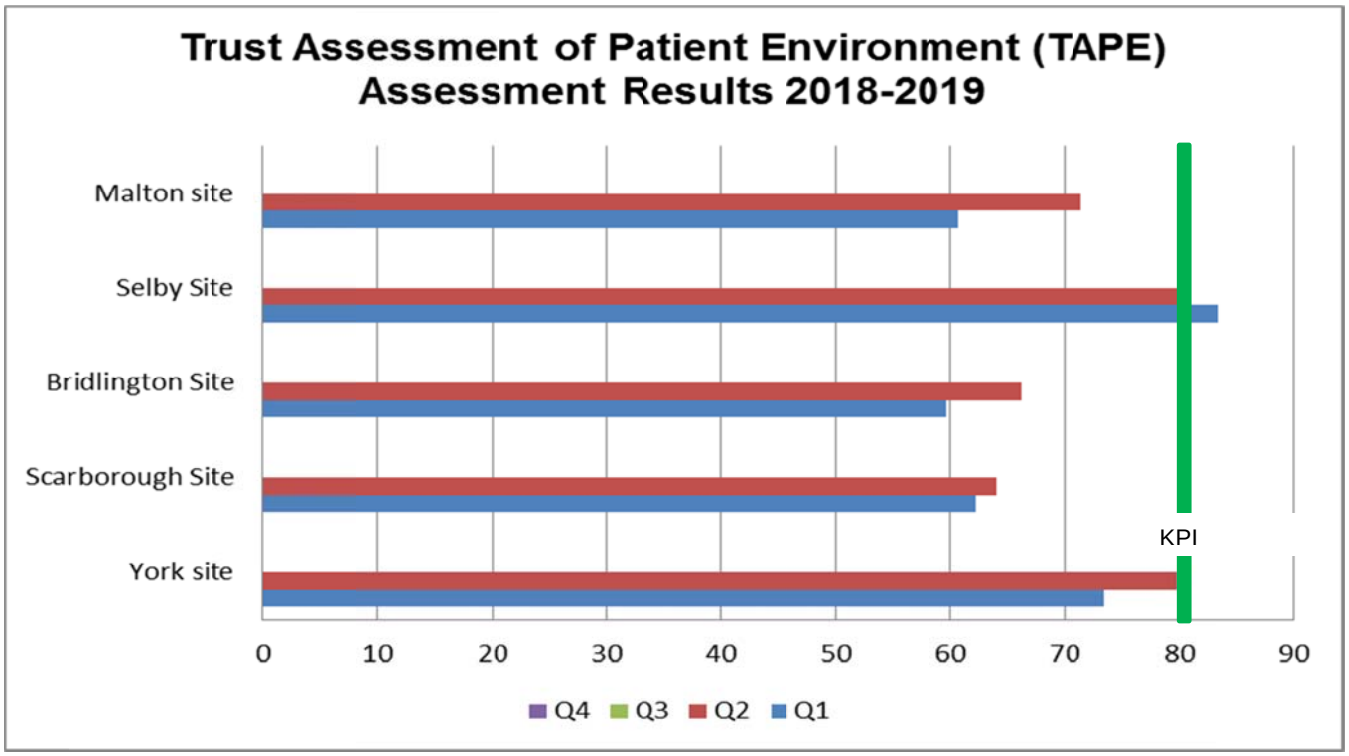
*KPI=
NO Major Corrective Actions (Red)
Less Than 20% Moderate Corrective Actions(Amber)

**KPI= no Major corrective actions required**

## 3. Trust Assessment of Patient Environment (TAPE) - Site

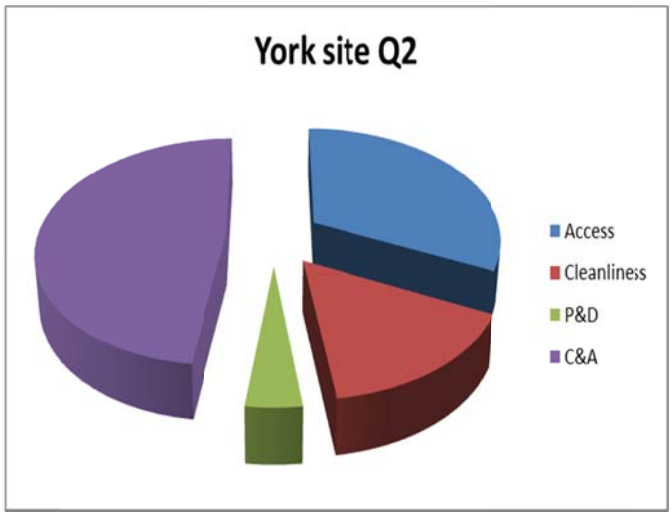
The Trust Assessment of Patient Environment (TAPE) process is a quarterly assessment which follows similar lines of enquiry to the Annual National PLACE Assessment process and examines elements of cleanliness, conditon and appearance, accessibility and privacy and dignity associated with our sites.

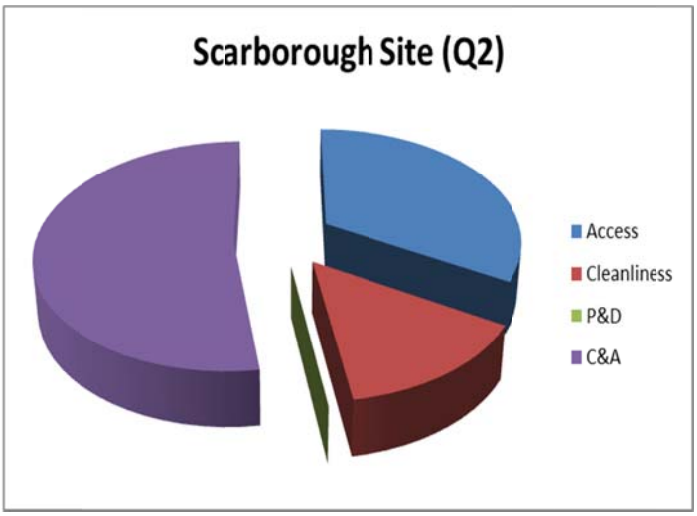
Currently one site is meeting the 80% key performance indicator set, however over the past 9 months and at the last 2 quarterly assessments site scores are generally improving as issues are identified and then subsequent corrective actions taken by Estates & Facilities teams.

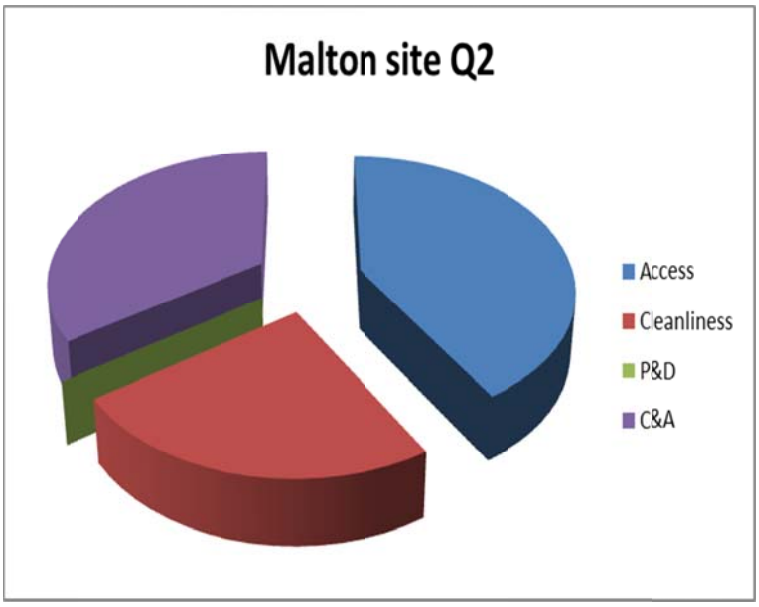


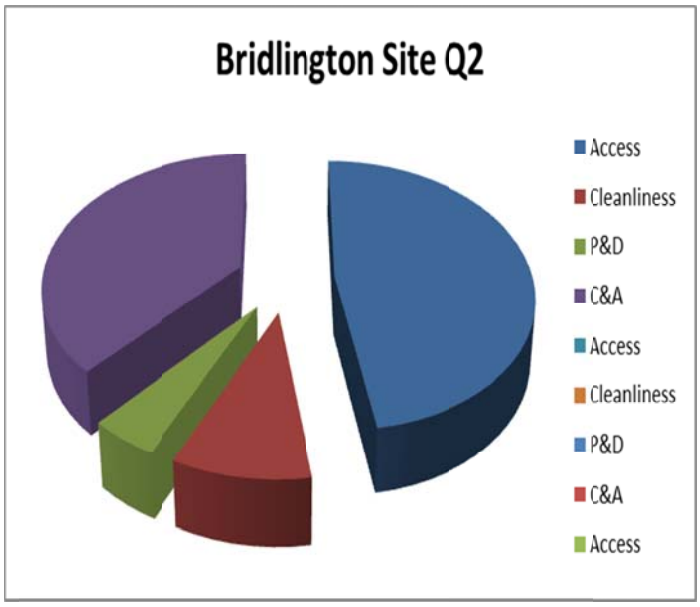

### TAPE- Non- Conformances- By site

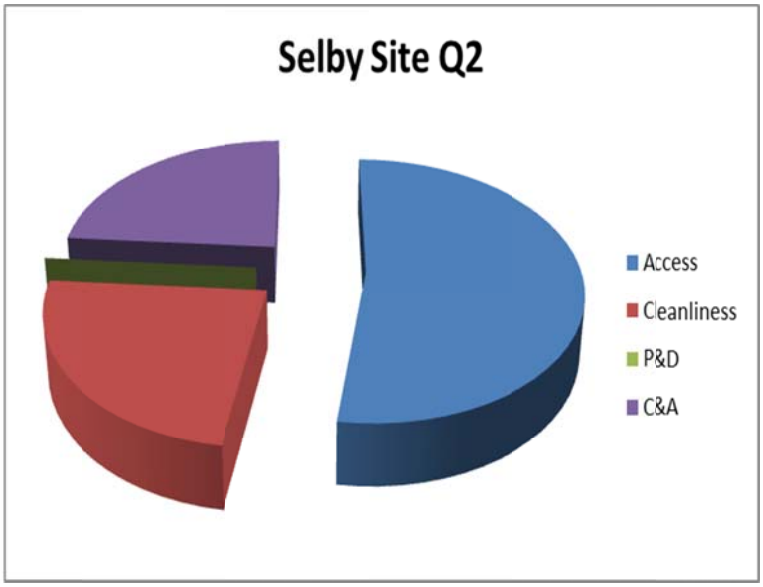
**Accessibility, Cleanliness, Privacy & Dignity (P&D)** **Condition & Appearance (C&A)**






It can be seen from the non-conformance information above that a high number of non-conformances identified are associated with the condition and appearance and accessibility of our Estate, the findings of the recent condition survey should allow a risk based approach to rectifications to be taken and this in turn should reduce some of the condition and appearance issues.

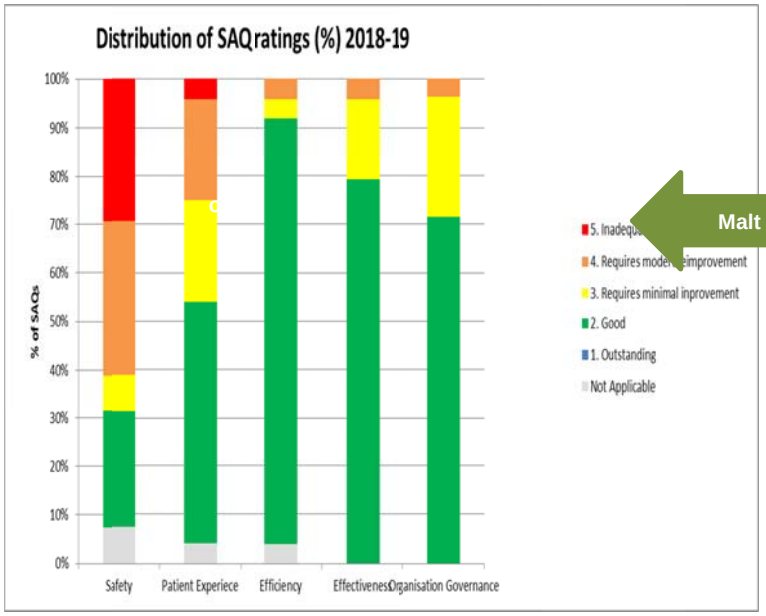
Accessibility is more complex in that the design and specification of the built environment will determine how accessible the environment is.

For existing buildings detailed accessibility audits will be undertaken by the FM Compliance team once fully resourced, beginning in in autumn so that a fuller picture of compliance with Building Regulations Approved Document M and NHS Wayfinding guidance can be evaluated.

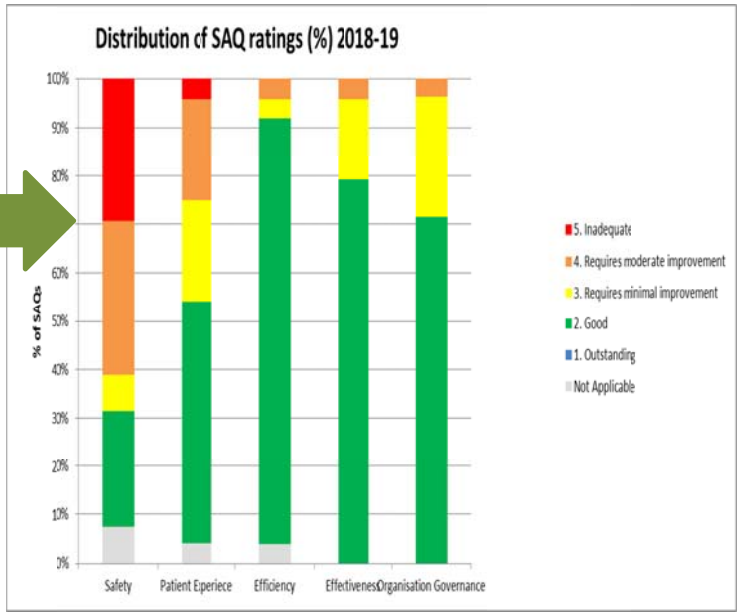
# 4. NHS Premises Assurance Model Position (By site)

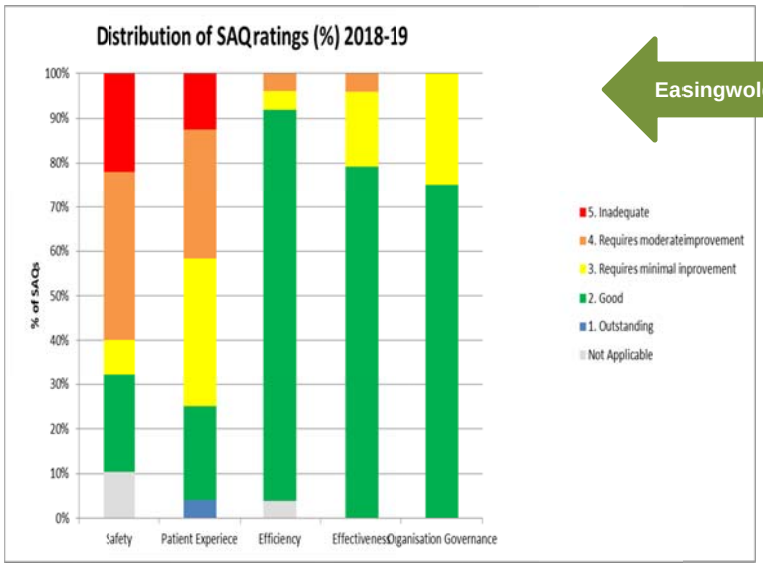
## 25th July 2018

## 31st August 2018

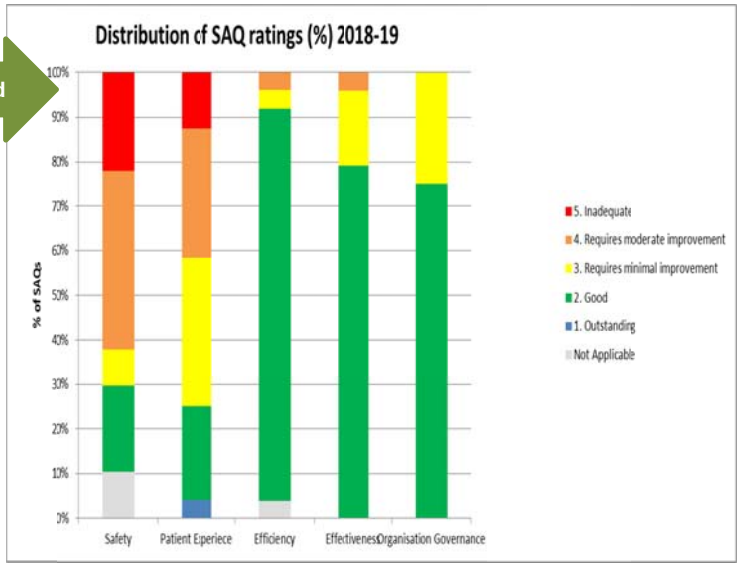


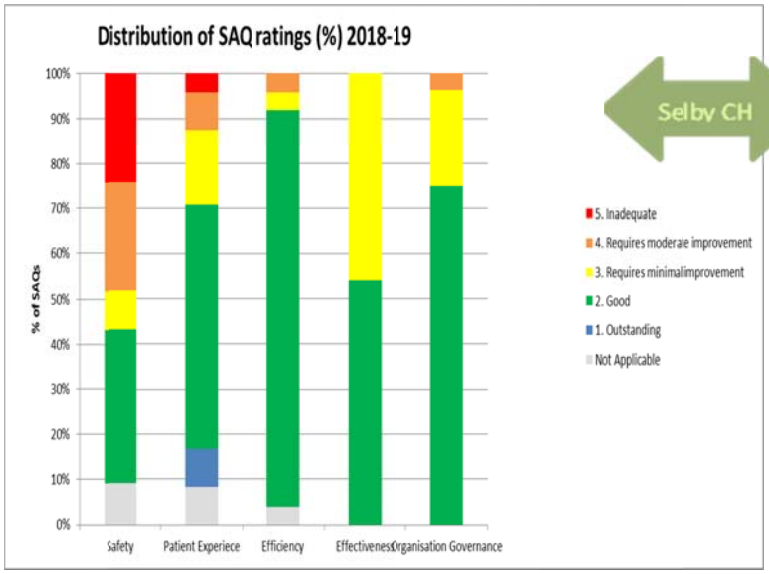

Malt



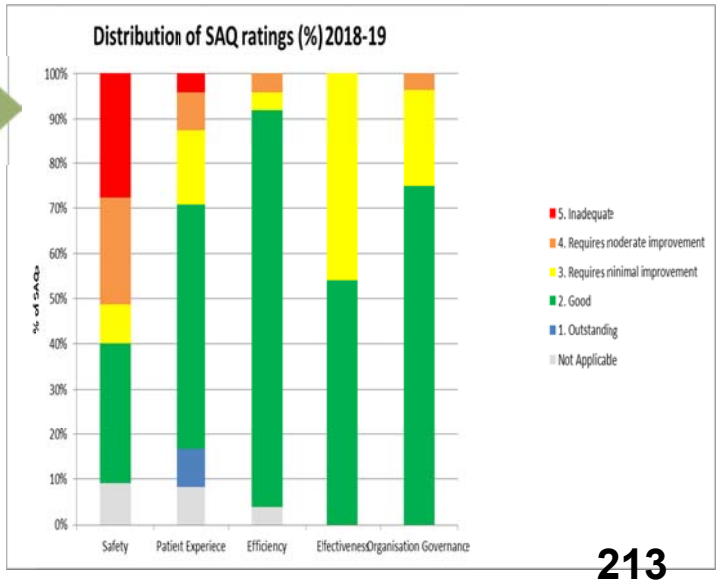




Easingwold

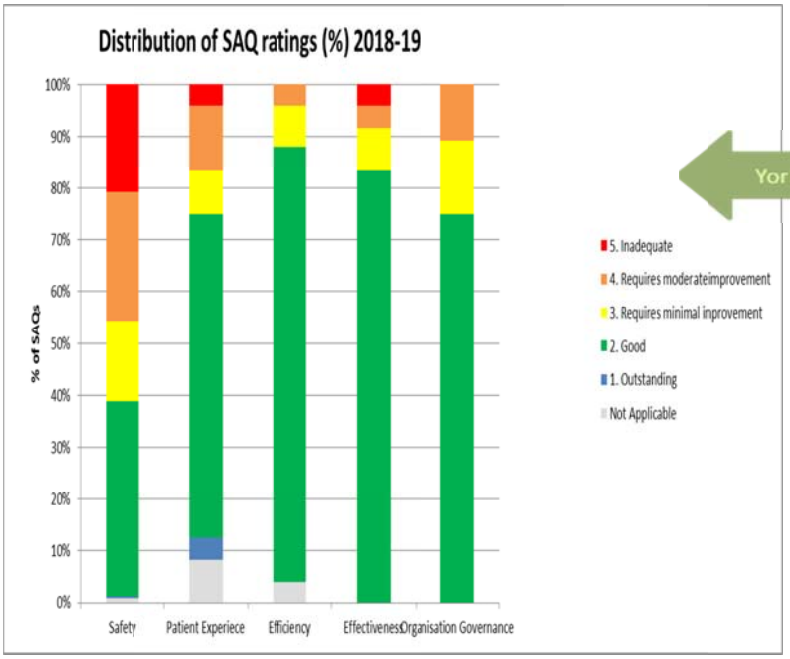


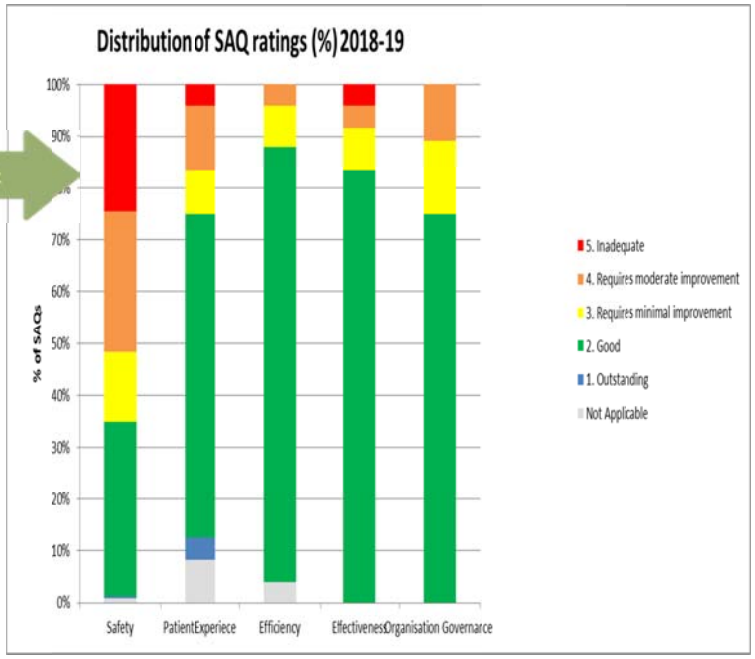

Selby CH

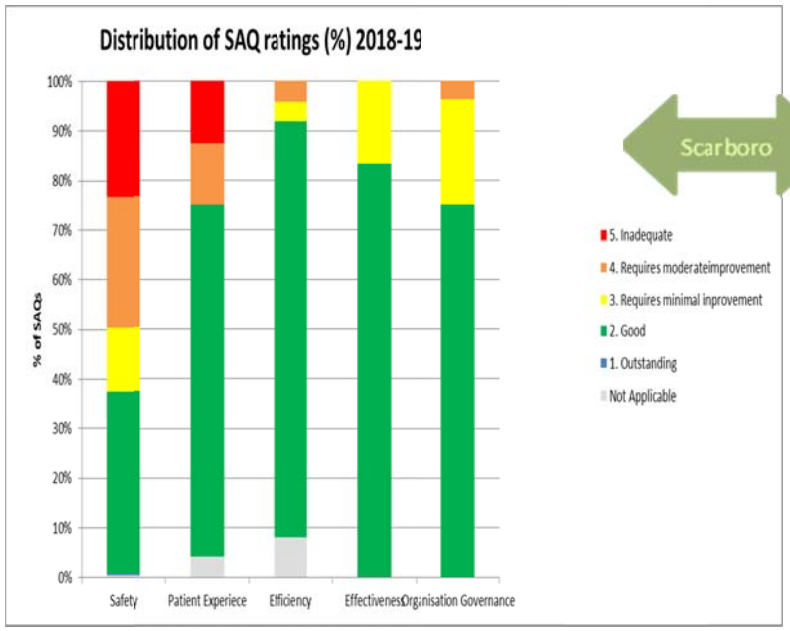


| 25th July 2018 | 31st August 2018 |
|---|---|

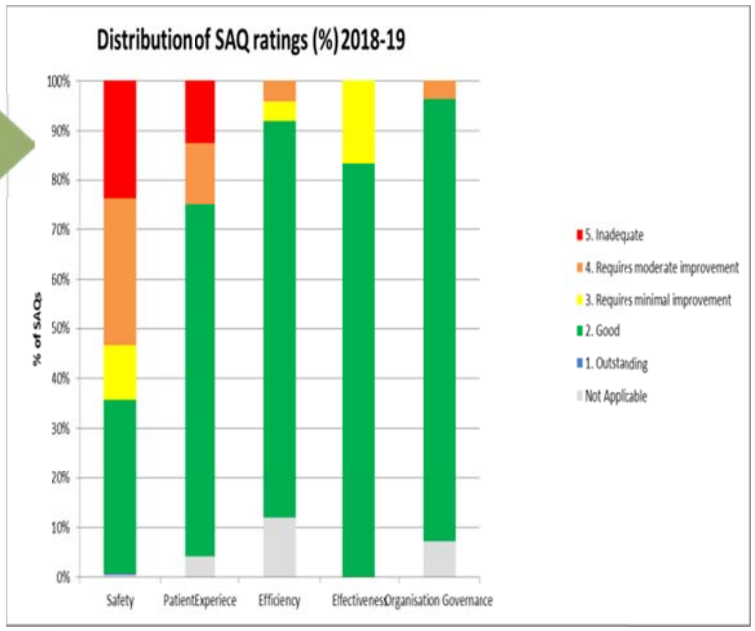


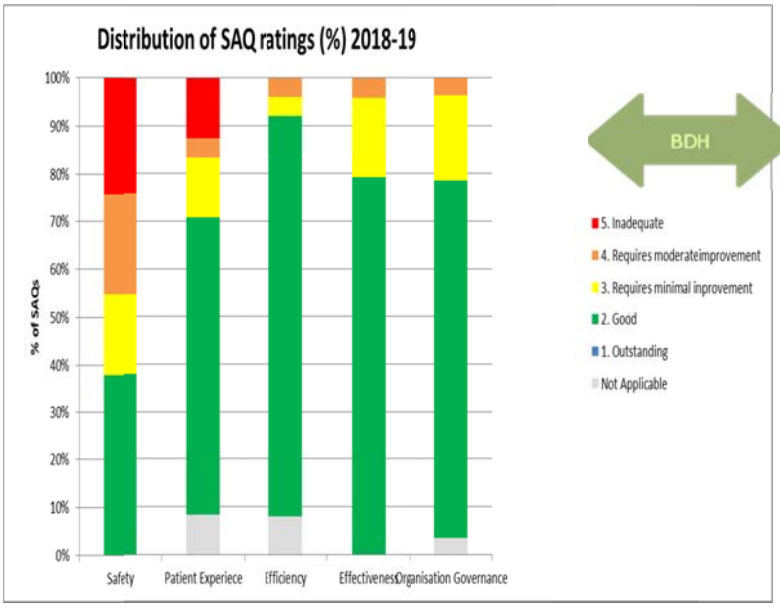

York




Scarboro

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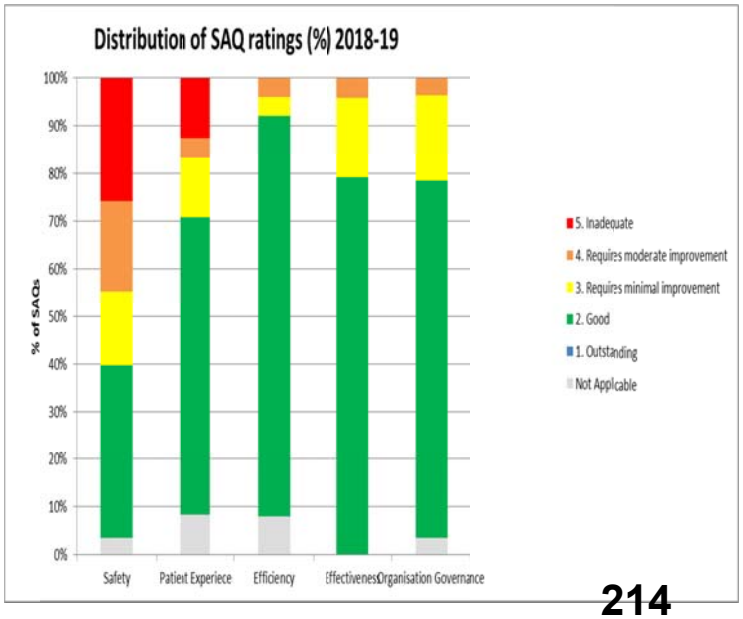


## 4. NHS Premises Assurance Model Position

The organisation's performance in demonstrating compliance with the NHS Premises Assurance Model has again reduced with all sites not achieving the 80% Key Performance Indicator, both safety and patient experience domain assurance is affected.

It should be noted that as Estates & Facilities functions move into the alternative delivery model that the new delivery model formed will be expected to provide to the Trust a quarterly positon against the NHS Premises Assurance Model Safety and Patient Experience domains so it is essential that Estates & Facilities Managers now engage with this process more fully including both assessment and formation of action plans.

Safety domain elements of NHS PAM Model require particular focus including the continuing absence of approved policies associated with asset management, maintenance and ventilation Current compliance with regards to Ventilation systems is as low as 25% at some sites.
Action plans for corrective actions to improve the management arrangements around Premises Assurance should be formulated as a priority.

It should also be noted that the Trust has a low number of Authorised Persons (APs) and Responsible Persons (RPs) in some engineering disciplines, an issue that has also been identified through Authorised Engineer Annual reports.

Surveillance has also identified that Authorised Engineers that the Trust employs as a method of independent scrutiny of engineering disciplines are not routinely providing the organisation with Annual reports or assurance on the engineering systems and arrangements. HTM 00 Best practice guidance for healthcare engineering describes one of the AE duties as provision of an annual audit/report.

## 5. PLACE ASSESSMENT 2017 & 2018 RESULTS

The organisation's PLACE Scores for 2018 have been published by NHS Digital and are now in the public domain, the organisation's performance against this annual assessment has led to a positon where the Trust is not meeting the national average in terms of PLACE Assessment scores.

Although it is acknowledged that nationally the bar has been raised in terms of National average scores, the Trust's local indicators such as TAPE and Cleanliness monitoring audits also demonstrate limited assurance.

The tables on the next page compare the organisations positons in 2017 and 2018 and a detailed report of the organisation's performance against PLACE assessment will be published later in the autumn.

PLACE Scores can be found at: https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place

## PLACE Assessment 2017- Site Scores

| | | CLN Score % | Food Score % | PDW Score % | Condition Score % | DEM Score % | DIS Score % |
|---|---|---|---|---|---|---|---|
| RCB55 | YORK HOSPITAL | 98.5 | 83 | 79.5 | 93.8 | 56.9 | 65.2 |
| RCBCA | SCARBOROUGH HOSPITAL | 96 | 73.4 | 75.6 | 90.4 | 61.8 | 68.3 |
| RCBNH | BRIDLINGTON HOSPITAL | 99.2 | 73.7 | 70.8 | 95.7 | 75.7 | 74.9 |
| RCB05 | ST MONICAS HOSPITAL | 100 | 98 | 80.7 | 99.4 | 82.4 | 86.4 |
| RCB07 | THE NEW SELBY WAR MEMORIAL | 100 | 93.2 | 92.4 | 99.6 | 79.6 | 87.3 |
| RCBL8 | MALTON AND NORTON HOSPITAL | 99.1 | 77 | 90.8 | 93.7 | 70.1 | 75 |

## PLACE Assessment 2018- Site Scores

| | | CLN Score % | Food Score % | PDW Score % | Condition Score % | DEM Score % | DIS Score % |
|---|---|---|---|---|---|---|---|
| RCB55 | YORK HOSPITAL | 95.27% | 78.84% | 76.41% | 85.66% | 58.98% | 67.21% |
| RCBCA | SCARBOROUGH HOSPITAL | 92.98% | 81.36% | 70.94% | 86.67% | 58.74% | 68.71% |
| RCBNH | BRIDLINGTON HOSPITAL | 96.87% | 70.12% | 77.11% | 87.10% | 52.45% | 50.20% |
| RCB05 | ST MONICAS HOSPITAL | 97.68% | 78.03% | 73.17% | 92.26% | 78.12% | 80.94% |
| RCB07 | THE NEW SELBY WAR MEMORIAL | 100.00% | 83.81% | 85.45% | 98.46% | 78.00% | 78.43% |
| RCBL8 | MALTON AND NORTON HOSPITAL | 85.85% | 79.25% | 69.08% | 87.80% | 63.23% | 66.73% |

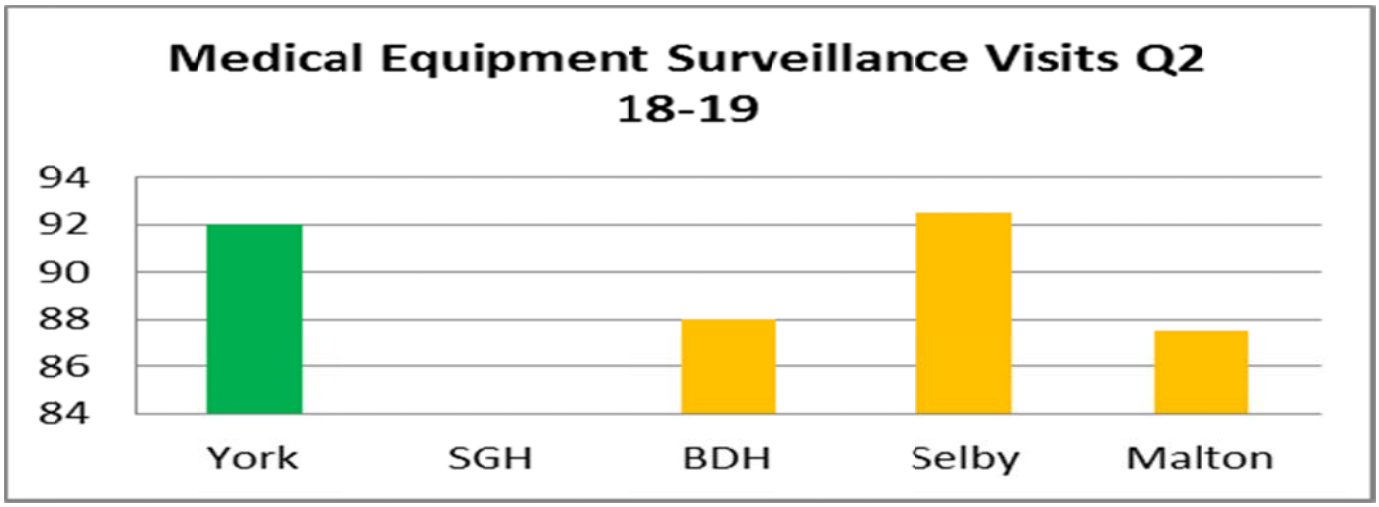
## PLACE Assessment Organisation Scores 2018

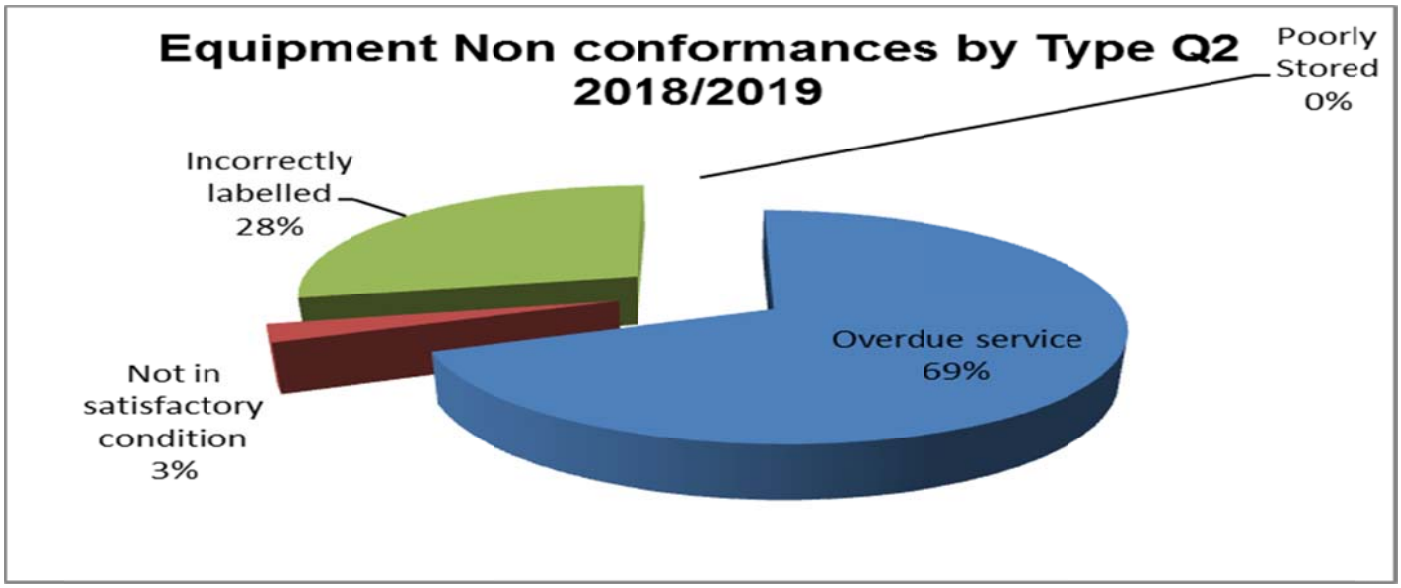
| Cleanliness | Food | Privacy,Dignity | CAM | Dementia | Disability |
|---|---|---|---|---|---|
| 94.82 | 79.21 | 74.62 | 86.64 | 59.12 | 66.74 |

| National Average Benchmark 2018 | |
|---|---|
| Cleanliness | 98.5 |
| Food & Hydration | 90.2 |
| Privacy, Dignity & Wellbeing | 84.2 |
| Conditon & Appearance | 94.3 |
| Dementia | 78.9 |
| Disability | 84.2 |

- Not meeting National Average
- Meeting national average
- Not meeting national average but improvement on previous year
- Not meeting National average and worse positon than previous year

## Medical Equipment Surveillance Results




Equipment Non- conformance percentages are attributable to the 200 Medical devices audited during the **Quarter 2** period

## 7. Facilities Management Key Performance Indicator Dashboard- Month 5- August 2018

| *Metric Description* | KPI | York Site | Scarbrgh Site | Bridlingtn Site | Selby Site | Malton Site | AV Position against Previous Month |
|---|---|---|---|---|---|---|---|
| *All Directorate Policies and procedures described on the Directorate Policy and procedure Register are approved by relevant groups or committees and up to date* | 100% | 58% | 58% | 58% | 58% | 58% | ↓ |
| *All sites are achieving 80% or greater against The Trust Assessment of patient Environment audit tool* | 80% | 79.8 | 64.9 | 66.2 | 80.5 | 71.4 | ↔ |
| *All sites are demonstrating less than 20% moderate improvement or inadequate compliance ratings against the NHS Premises Assurance Model* | <20% | >34% | >40% | >33% | >37% | >45% | ↓ |
| ***All sites are achieving the National average against all PLACE Assessment domains (2018)*** | | | | | | | |
| *PLACE -Cleanliness* | 98.4 | 95.2% | 92.9% | 96.8% | 100% | 85.8% | ↔ |
| *PLACE-Food* | 90 | 78.8% | 81.3% | 70.1% | 83.8% | 79.2% | ↔ |
| *PLACE-Condition & Appearance* | 94 | 85.6% | 86.6% | 87.1% | 98.4% | 87.8% | ↔ |
| *PLACE-Privacy, Dignity and wellbeing* | 84.2 | 79% | 75% | 70% | 92% | 90% | ↔ |
| *PLACE-Dementia* | 78 | 58.9% | 58.7% | 52.4% | 78% | 63% | ↔ |
| *PLACE-Disability* | 84 | 67% | 68% | 50.2% | 78.4% | 66.7% | ↔ |
| ***Cleanliness Technical Audits*** | | | | | | | |
| *Very High Risk (av)* | >98% | 93.72 | 95.20 | 97.84 | 95.39 | NA | ↓ |
| *High Risk (av)* | >95% | 84.79 | 92.12 | 93.96 | 90.86 | 83.56 | ↓ |
| *Significant Risk (av)* | >85% | 79.78 | 81.4 | NA | 93.45 | 93.64 | ↓ |
| ***Medical Equipment Surveillance (Regulation 15)*** | | | | | | | |
| *90 % of a Sample of 50 medical devices to demonstrate compliance against KLOES of Regulation 15 of HACSCA 2008.* | 90% | 92 | 89.5* | 88. | 92.5 | 87.5 | ↔ |
| | KPI | York Site | Scarborough | Bridlington | Selby | Malton | |

| Total Number of KPIs in place =65 | York Site | Scarborough Site | Bridlington Site | Selby Site | Malton Site | Total |
|---|---|---|---|---|---|---|
| Last Month/This Month | | | | | | |
| Number Met | 3/1 | 2/0 | 4/0 | 10/7 | 3/2 | 22/10 |
| Number Partially Met | 6/4 | 6/6 | 4/7 | 1/4 | 7/4 | 24/25 |
| Number Not met | 4/8 | 4/7 | 4/5 | 2/2 | 2/6 | 16/28 |
| Not applicable | 0/0 | 1/0 | 1/1 | 0/0 | 1/1 | 3/2 |

## Summary of Performance

1. The organisation's compliance positon against the NHS Premises Assurance Model (Section 4 of the Report) has further reduced over the past 4 weeks, the effects of not ensuring that appropriate action plans are in place and a lack of physical supporting evidence to demonstrate compliance have significantly contributed to this positon and it is recommended that Estates & Facilities Managers give this some attention as a priority as the position indicates an absence of key documents including policies and procedures, training records, risk assessments and business continuity plans exists. Compliance associated with safety domain including ventilation asset management pressure systems and contractor management needs review and action.

2. The Estates & Facilities management team should look to the work that Paul Johnson has undertaken to demonstrate NHS PAM compliance with Lifts and Lifting equipment which is exemplar.

3. The Trust Assessment of Patient Environment (TAPE) process (Section 3 of the report) which is undertaken quarterly identified in Quarter 2, a number of issues associated with Accessibility, wayfinding and general condition and appearance at the majority of sites, this is further borne out by the 2018 PLACE Assessment results.

4. A follow up of the non-conformances reported at the Bridlington Hospital site on 15 July 2018 TAPE visit shows that of the 20 non-conformances identified 4 are easily resolved through operational measures and 3 of these relating to cleanliness had been resolved. The remaining 16 require a longer term plan to correct and include issues such as poor signage and accessibility issues and it is recommended that those corrective actions required are noted and some planning for resolution is undertaken by EFM teams.

5. The Trust's 2018 PLACE Assessment results have led to a deterioration in the Directorate's overall compliance positon as 50% of the Key Performance Indicators (PLACE National average scores) were not met.

6. Section 6 of the Report- Medical Equipment Surveillance is again a quarterly activity which aims to identify the condition, serviceability and accessibility of medical equipment across our sites. 250 items of medical equipment are sampled over 5 sites and it can be seen from the results that devices that are overdue service and in use was the most significant non-conformance identified during the period.

7. Section 7 -Cleanliness Monitoring. As part of the Trust's requirements to meet the Health & Social Care Act (2008), Regulated Activities Regulations 2014, part 3, the Trust has mandated through its environmental cleanliness policy that both technical and managerial environmental cleaning audits will be undertaken.

   Since last month's report there is a reduction in compliance against average environmental cleaning scores however it should be noted that the York site is not achieving Key Performance Indicator scores associated with Very High risk environments and it is recommended that Domestic services teams work closely with Cleanliness Monitoring teams in identifying any gaps.

   It should also be noted that audit criteria have been relaxed in relation to both Internal surfaces of paper towel dispensers and clear staining on floors that cannot be cleaned, these type of issues are being reported via TAPE assessment process.

8. The Directorate is currently achieving 10 out of its 63 live key performance indicators.

| Last Month Overall Compliance Rating | This Month Overall Compliance Rating |
| --- | --- |
| 33.3% | 15.8% |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Workforce & Organisational Development Committee minutes - 17July 2018

**Attendance:**

Libby Raper, Non-Executive Director (Chair) (LR)
Jenny McAleese, Non-Executive Director (JM)
Dianne Willcocks, Non-Executive Director (DW)
Melanie Liley, Deputy Chief Operating Officer (ML)
Lorraine Boyd, Associate Non-Executive Director (LB)
Lynda Provins, Foundation Trust Secretary (LP)
Polly McMeekin, Acting Director of Workforce and OD (PMc)
Siân Longhorne, Senior HR Lead (minutes)

Lisa Smith, Freedom to Speak Up/Guardian of Safer Working (LS) – For item 3

Neil Wilson, (NW) Head of Partnerships and Alliances; Bhavesh Patel, (BP) Consultant in Obstetrics and Gynaecology; Andrew Grace, (AG) Consultant in Head and Neck – To deliver a presentation on Global Health and Philanthropy

**1 Apologies for Absence:** None received

**2 Minutes of the meeting held on the 19th June 2018**

The minutes of the last meeting held on 19th June 2018 were accepted as a true record and ratified with the following amendments.

ML asked that her job title be corrected to Deputy Chief Operating Officer.

Page 2: DW clarified the suggestion relating to the Monthly Information Pack was hers. The initials DH were a typo.

Under the heading Research Strategy, DW said that the minutes should read, “DW asked if support is received from York St. John University and reported that Rob Aitken has now left”.

It was noted that the action list was not attached with the minutes. DW said that she had asked for the trial of the LocumTap app to be included as mitigation on the HR risk register in response to the risks around medical workforce.

Reference was also made to the previous discussions around Line Management Competency Training. LS said that she was part of the working group and the plan was to deliver the training as bite sized chunks and work would be undertaken to identify areas where it is most needed. It is expected to launch in October. JM requested an update on the pilot and it was agreed that an update would be provided to the Board via the HRD report after three months.

### 3 Freedom to Speak Up Guidance

LS spoke about guidance for Boards on Freedom to Speak Up issued by NHS Improvement and the National Guardian's office, this guidance includes a self review tool to help identify areas to develop and improve. LS explained the importance of the Board engaging with the completion of the self review tool.

LS confirmed that the self review tool was to be completed by the beginning of September and whilst DW agreed that she would be the non-executive link for the work, JM agreed to provide cover for DW and work with PMc due to DW's unavailability during August.

There was a discussion around some of the challenges in operationalising the learning from concerns raised via LS and ML asked how the six monthly Board report that LS produces is fed back across the whole organisation. LS said that the Board report is currently shared with Deputy Directors, JNCC and JLNC. ML said that it would be good to be added to the Operations Steering Group and she would brief to Wendy Scott that was a recommendation.

LS commented that she was concerned about the self review being completed within the timescales. The committee was keen that the self review highlighted the work that is being done.

LR asked that this was brought to the attention of Board to trigger a discussion around priorities.

The committee agreed to LS attending another meeting to bring a paper on Junior Doctor working hours.

### 4 Risk registers

Corporate Learning Risk Register:

It was agreed to add utilisation of the apprenticeship levy to the risk register.

HR Risk Register:

DW commented that the quality of the comments on the risk register were very helpful.

HR1b:

DW suggested adding new clinical leadership as a mitigation to this risk.

PMc stated that she had added the work on our employer brand with Jupiter as a mitigation to this risk. LR said that Mike Keaney is involved in engaging with the community in Scarborough about the employer brand and PMc confirmed that Georgina

Michulitis is meeting with him linked to the work she has been released to undertake around medical workforce vacancies on the East Coast.

Research Risk Register

DW commented that the research risk register includes some low rated risks which should be removed from the register that is presented to the committee.
The committee agreed that the current status and to be completed by columns shouldn't be completed with 'ongoing issue', rather it should be something more specific.

## 5 Monthly Information Pack

The committee's discussion around the monthly information pack focused on how pleased they were to see such a reduction in the sickness absence rate in the May to 3.95%.

DW also commented that the quality of data within the report was good.

## 6 Medical Workforce Report

PMc presented the report and highlighted the trust vacancy rate at the end of June was 11.6%. The report generated a discussion by the committee relating to time to hire and whilst the Trust's metrics compare favourably, the committee asked what scope there was to improve this process.

PMc said that the current vacancy control (VC) process adds 12.5 days to the time to hire and so there was a review of this process underway to improve this whilst also maintaining appropriate grip and control.

The committee discussed the unintended consequences of long time to hire periods including increased temporary staffing spend to fill gaps or shifts being left unfilled and the impact on performance. PMc said that under the current VC process where posts are ultimately approved by the Corporate Directors, only five posts in the last 12 months have not been approved. JM stated that the committee gave their support to develop a swifter process.

PMs also said that often the speed at which references are received can have a big impact on time to hire. JM asked if during the recruitment process candidates could be reminded that they needed to let their referees know to expect a request. PMc said this could perhaps be added to the invite to interview letter.

PMc updated about recruitment initiatives including working with recruitment communications experts, Jupiter and a proposal to partner with Global Medical Careers to extend our reach to potential candidates.

PMc confirmed that of 21 shortlisted candidates for the new Physician Associate roles, 15 had been made offers. Priory Medical Group are keen to jointly employ with the trust four Physician Associates, however these need financial approval.

PMc reported concerns around registered nurse recruitment with concern arising particularly from the University of York retaining their entry requirements of 2 x A grades and 1 x B grade. A number of nurses who had been offered posts have given backword and consideration is now being given as to what incentives could be offered, including

being paid at band 4 until newly qualified nurses receive their PIN (rather than at band 2 as is currently the case), cash incentives for introduce a friend, golden hellos.

The committee agreed that there is a need to increase our engagement with Coventry University.

DW asked whether the it was anticipated that the trust would lose nursing staff when TEWV open the new mental health facility in Spring 2020. The committee agreed that it was worth considering and anticipating some losses particularly in community and amongst the unregistered workforce.

PMc briefed the committee on the work being undertaken by Georgina Michulitis (Medical Workforce Manager), initially for a six month period to specifically look at innovative ways of addressing the medical vacancy position on the East Coast.

PMc also briefed that medical staffing are processing a significant number of doctors to join the trust at changeover on 1st August. PMc reported that fill rates in the region are slightly better than in recent year, with the exception of Scarborough. However, with parallel recruitment activity, the fill rate at York is currently 94.6% and at Scarborough is 82.4% which is much better than in 2017.

The committee asked that the work being undertaken by Georgina Michulitis is brought to the attention of the Board.

## 7 Apprenticeship Update

PMc highlighted to the committee her concerns that as an organisation we are behind on the apprenticeship agenda. A training needs analysis has been undertaken through which it has been identified that we need to provide a minimum of 122 apprenticeships.

HEE have circulated a financial modelling tool for organisations to use.

It was agreed to add apprenticeships and utilisation of the apprenticeship levy to the risk register.

PMc confirmed that an update on apprenticeships would be provided monthly to the Board.

ML advised that within the AHP workforce, although a specific number of apprenticeship opportunities had not yet been identified, this was partly due to the fact there are no AHP national profiles available yet. There is also a workforce review underway within the AHP workforce which will allow the team to identify apprenticeship roles and opportunities.

## 8 Workforce Metrics Report

PMc highlighted some of the key points from the report. The committee had already commented on the improvement in the sickness absence rate and PMc attributed this to the interventions and targeted actions particularly linked to mental health and MSK absence. It appears from the reductions in absence that these interventions are having an impact.

PMc also highlighted the relaxation of tier two visa rules which is positive for us as an organisation.

PMc stated that her team have received positive feedback from the staff benefits fair.

Statutory and mandatory compliance rates were included in the report and PMc explained that core training are those elements that all staff must undertake whilst essential training is role specific.

PMc highlighted the trust's intention to sign the armed forces covenant and it was agreed to bring this to the attention of the Board.

PMc said that the changes to the NHS terms and conditions for staff have now been formally ratified. It was agreed to bring this to the attention of the Board. One key issue in the changes is the closure of band 1 and PMs explained that we need to develop a mechanism to upskill staff currently in those roles. LR asked about the impact of this on the estates and facilities ADM. PMc confirmed that this has been factored in.
PMc stated that there may be an impact on sickness absence as a result of the changes due to the removal of enhancements for sickness.

## Global Health and Philanthropy

NW, BP and AG attended the committee to give a presentation on Global Health and Philanthropy.

The committee thanked the group for their presentation. LR asked how assured they were that the work was linked into HR and more traditional workstreams. NW confirmed that he has met jointly with stakeholders and is linked in with directorates. ML suggested that going forward PMc's workforce reports could cover some of this work.

DW said that she found the work very impressive though was concerned that the committee hadn't already been aware of it and felt it important to ensure that it was brought into the mainstream to improve engagement.

## 9 Arts Report

Provided to the committee for information only

## 10 Out of Hospital Care Board Sub Committee Report

Provided to the committee for information only

## 11 Young Persons Programme

PMc said that this was brought to the meeting as it was worth raising to the committee that the programme was in place.

## 12 BAF Action Plan

LP updated the committee that the Board agreed the organisation's strategic risks in June and there was a plan to produce a position statement in July and score the BAF in August.

## 13 Any other Business

WRES – PMc said that the completed WRES action plan is to be submitted by 10th August. Within the plan there are lots of actions linked to management training and unconscious bias.

DW commented that the WRES is starting to tell a slightly improved story but was concerned that an opportunity has been missed to improve self reporting of diversity information and asked if ways to encourage staff around this could be found.

LR reported that nursing appraisal targets had been discussed at the Quality and Safety committee with a request to reduce nursing targets to 85% from the current trust target of 95%. PMc said that she has had discussions regarding this and disagrees with this approach and feels that appraisals are vitally important in demonstrating our appreciation to staff and how we value their work and contribution. The committee agreed and gave their support to maintaining a target of 95%.

LR suggested that the committee did not have a meeting in August and this was agreed.

LR also thanked the committee as this was to be her last meeting and commented that she had enjoyed having the opportunity to sit on and Chair the committee. The other members also thanked LR for her contributions to the committee.

DW commented that it was important under the new arrangements for Board meetings that the three sub committees get sufficient air time. JM said that more work was needed to the Board reports to ensure that only true exceptions were being reported.

## 14. Attention to the Board

Freedom to Speak Up guidance and self review tool

Role of Medical Workforce Manager and work programme to improve vacancy position on the East Coast

Intention to sign the armed forces covenant

Formal ratification of the revised NHS terms and conditions for staff

**Action Log: Workforce & Organisational Development**

| Month | Action | Responsible Officer | Due date | Completed |
|---|---|---|---|---|
| March | Discuss action plan and measures of success in Developing people strategy post-Board approval. | All | TBA | |
| July | Additions to the risk registers;<br>Corporate Learning Risk Register – add utilisation of the apprenticeship levy<br>HR Risk Register HR1b – add new clinical leadership as mitigation<br>HR Risk Register HR1a and HR1b – add LocumTap pilot as mitigation | PM | August | |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Workforce Report – September 2018

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

## Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

## Purpose of the Report

To update the Board with an overview of work being undertaken to address workforce challenges and key workforce metrics (data up to August 2018).

## Executive Summary – Key Points

- The monthly sickness absence rate in July was 4.00%, increasing from 3.74% from the previous month but lower than the monthly absence rate in the same month of the previous year.
- Demand for temporary nurse staffing in August increased to the equivalent of 460.46 FTE the second highest level of demand in the last 12 months. Demand for temporary medical staffing equated to 101.48 FTE.
- In line with the Apprenticeship reform there are 75 apprentices currently employed by the Trust which plans to increase this to 227 apprenticeships by February 2019.

## Recommendation

The Board is asked to note and discuss the content and findings within the report.

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Director Sponsor: Polly McMeekin, Acting Director of Workforce and Organisational Development

Date: September 2018

## 1. Introduction and Background

September's Workforce Report details a number of key workforce metrics, with commentary around the Trust's current sickness absence levels and the current levels of temporary medical and nurse staffing utilisation within the Trust. The report provides an update on the East Coast medical recruitment campaign and also an update on the eRostering projects including the revised roster policy. The report also provides a summary of the Trust's apprenticeship levy position in line with the government's apprenticeship reform.

## 2. Detail of Report and Assurance

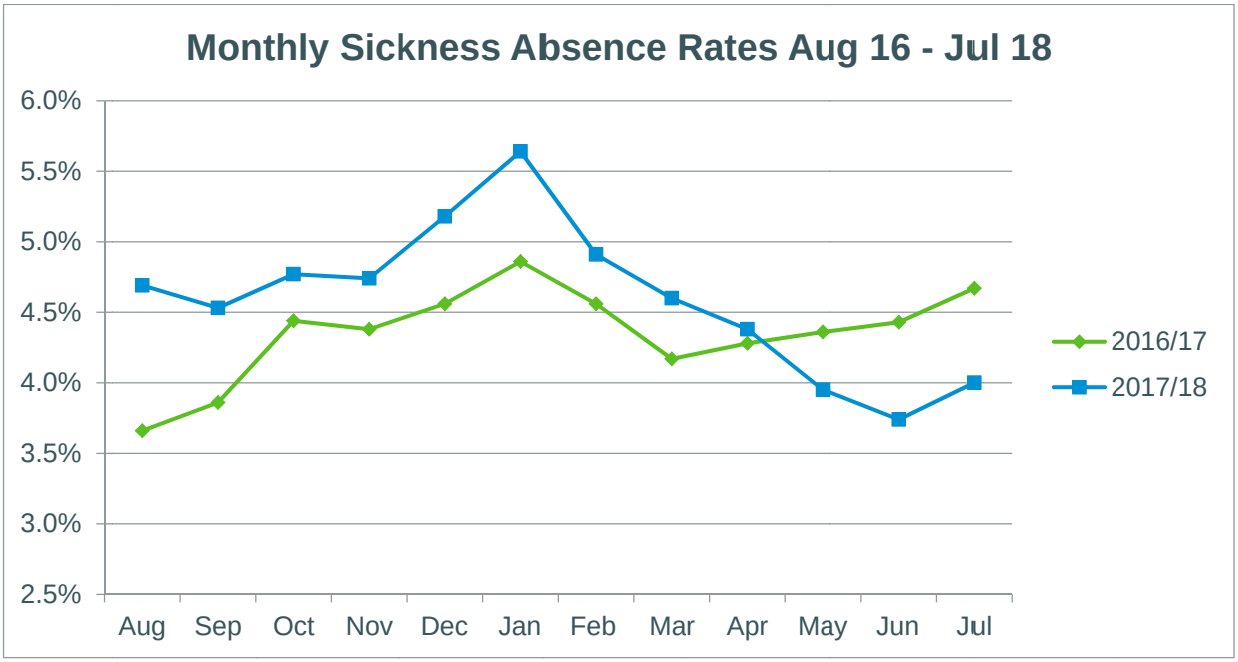
The work referred to in the report forms part of regular discussions around workforce, including at Staff Side and Workforce and Organisational Development Committees. It is informed by a number of key performance indicators which underpin directorate-level workforce plans, and link to the Trust's overall Workforce Strategy.

### 2.1 Sickness Absence

Graph 1 shows the monthly sickness absence rates for the period from August 2016 to July 2018. The monthly absence rate in July 2018 was 4.00% an increase from the previous month's sickness absence rate of 3.74% but lower than the sickness absence rate in the same month of the previous year (the absence rate in July 2017 was 4.67%).

Despite the increase in July 2018, prior to this the monthly sickness absence rate had been decreasing month on month since January 2018 and this has consequently resulted in a decrease in the cumulative annual sickness absence rate over the same period (the annual sickness rate decreased from 4.65% in June to 4.59% in July).

**Graph 1 – Monthly Sickness Absence Rates**




**Source: Electronic Staff Record**

## Sickness Absence Reasons

The top three reasons for sickness absence in the year ending July 2018 based on both days lost (as FTE) and numbers of episodes are shown in table 1 below:

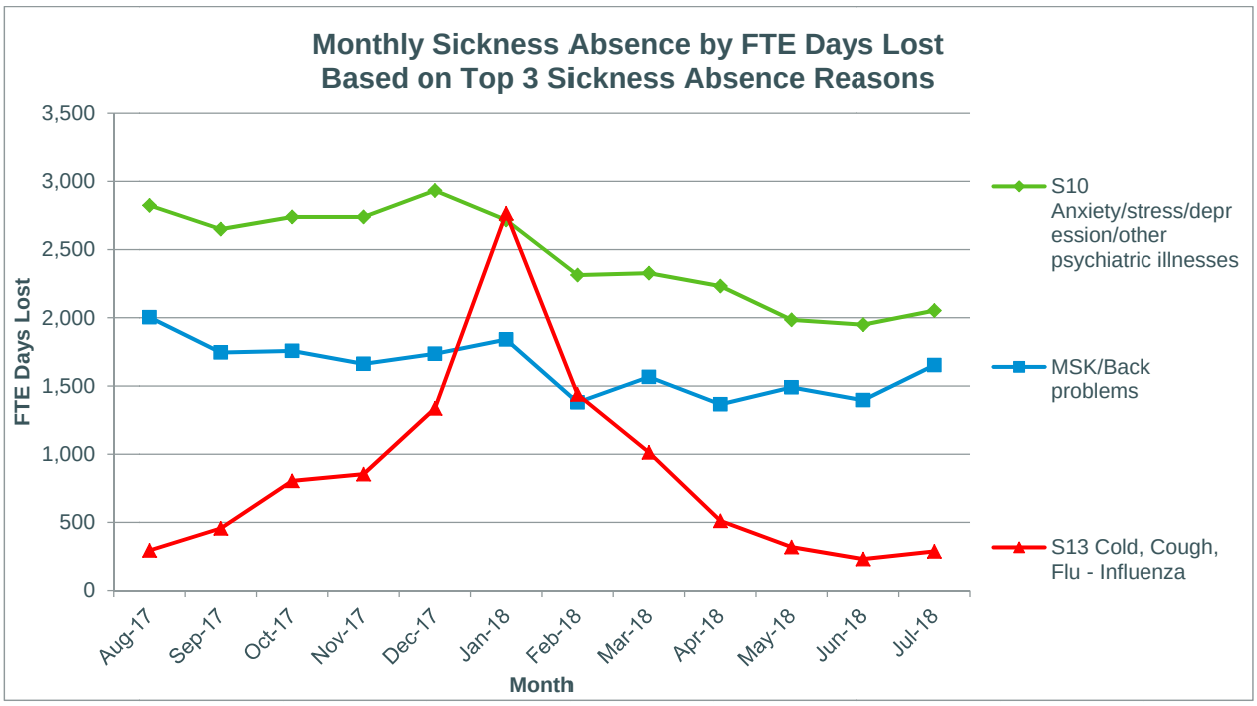
Table 1 – Sickness Absence Reasons - Year to July 2018

| Top three reasons (days/FTE lost) | Top three reasons (episodes of absence) |
|---|---|
| Anxiety/stress/depression – 23.94% of all absence days lost | Cold, cough, flu – 18.35% of all absence episodes |
| MSK problems, inc. Back problems – 15.92% of all absence days lost | Gastrointestinal – 17.77% of all absence episodes |
| Cold, cough, flu – 8.38% of all absence days lost | Anxiety/stress/depression – 10.88% of all absence episodes |

The sickness reason of Anxiety / Stress / Depression remains the most prevalent sickness reason for the year to July based on FTE days lost followed by MSK problems whilst sickness due to Colds, Coughs and Influenza accounted for the highest number of episodes of absence.

Graph 2 below shows the number of FTE days lost due to the top sickness reasons by month over the last year:

### Graph 2 – Monthly Sickness Absence by Reason by FTE Days Lost

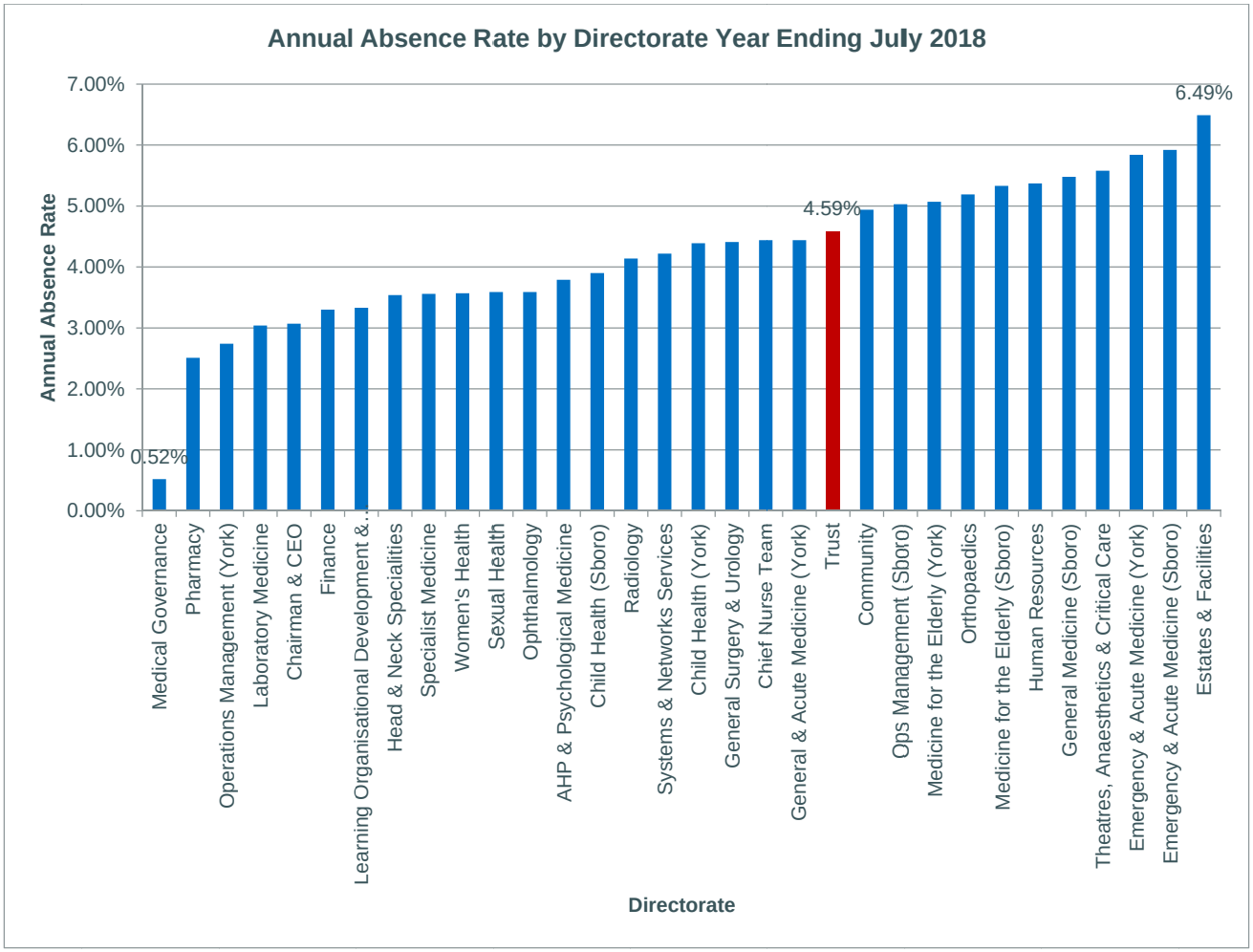



**Source: Electronic Staff Record**

There was an increase in July in the number of FTE days lost for all of the top sickness absence reasons compared with the previous month. The biggest increase was for sickness absence due to MSK problems (there were 256.79 more FTE days lost in July 2018 due to this reason than in June 2018). This suggests that MSK problems, and

particularly long term cases, was a big contributory factor in the increase in the overall monthly sickness absence rate in July.

By directorate, Estates and Facilities has the highest annual sickness absence rate in the year to July 2018 (Graph 3). The Estates and Facilities directorate also accounted for the highest amount of all sickness absence due to the reason of MSK problems (they accounted for 17.5% of all sickness absence due to MSK problems in the Trust).




**Source: Electronic Staff Record**

## 2.2 Temporary Staffing

### Temporary Medical Staffing

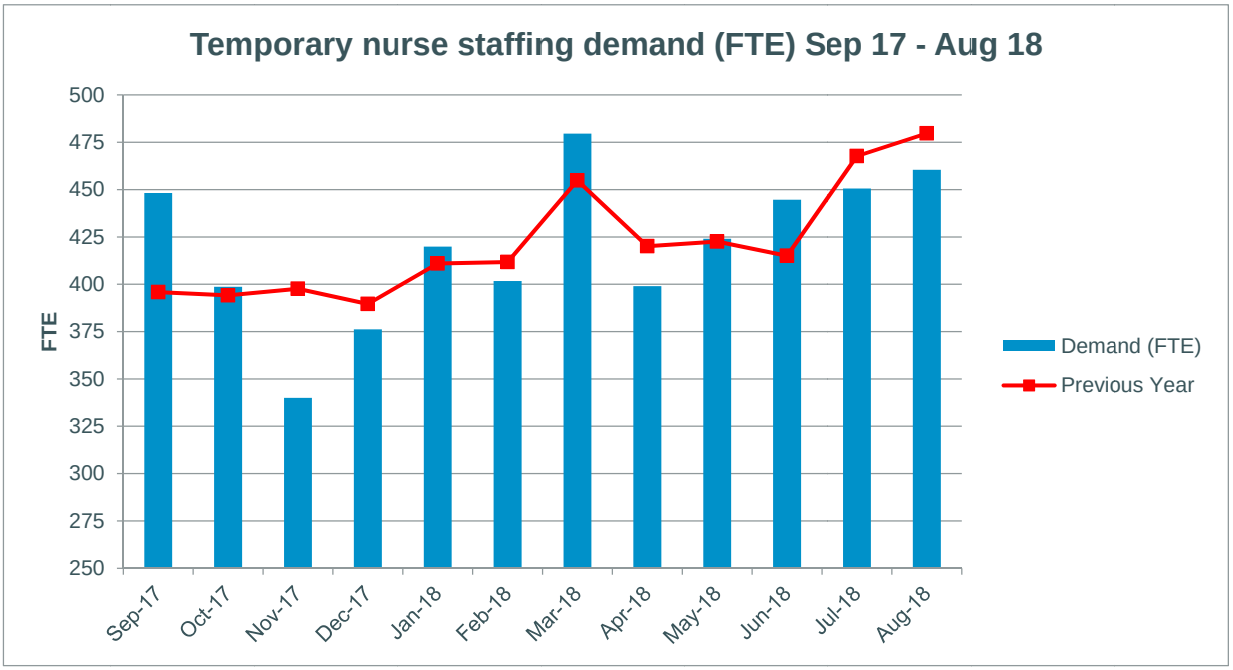
Demand for medical locums over the last 6 months has equated to an average of 102 FTE staff per month. In August, 101.48 Full Time Equivalent (FTE) medical locums were requested at the Trust across both York and Scarborough Hospital. This was a decrease from the peak in medical locum demand in July 2018 (demand in July equated to 112.03 FTE, a seasonal high level of demand due to the increase in the number of trainee leavers prior to the end of their training rotation programs).

In total, 98.87% of the shifts were filled (100.29 FTE). 38% (42.32 FTE) were filled via Bank whilst 61% were filled via Agency (57.98 FTE).

## Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of 420 FTE staff per month. Demand in August 2018 equated to 460.46 FTE, the second highest level of demand within the last 12 months. Graph 4 shows that the increase in demand in August mirrors the trend in previous years and this increase is very likely linked to a seasonal increase in the amount of annual leave taken (the other peak in demand being in March, the end of the annual leave year within the organisation). Analysis of the rosters for nurse staffing shows that the equivalent of 384.58 FTE of nursing staff and HCAs took annual leave in August, compared with 307.14 FTE in July and 364.39 FTE in June.

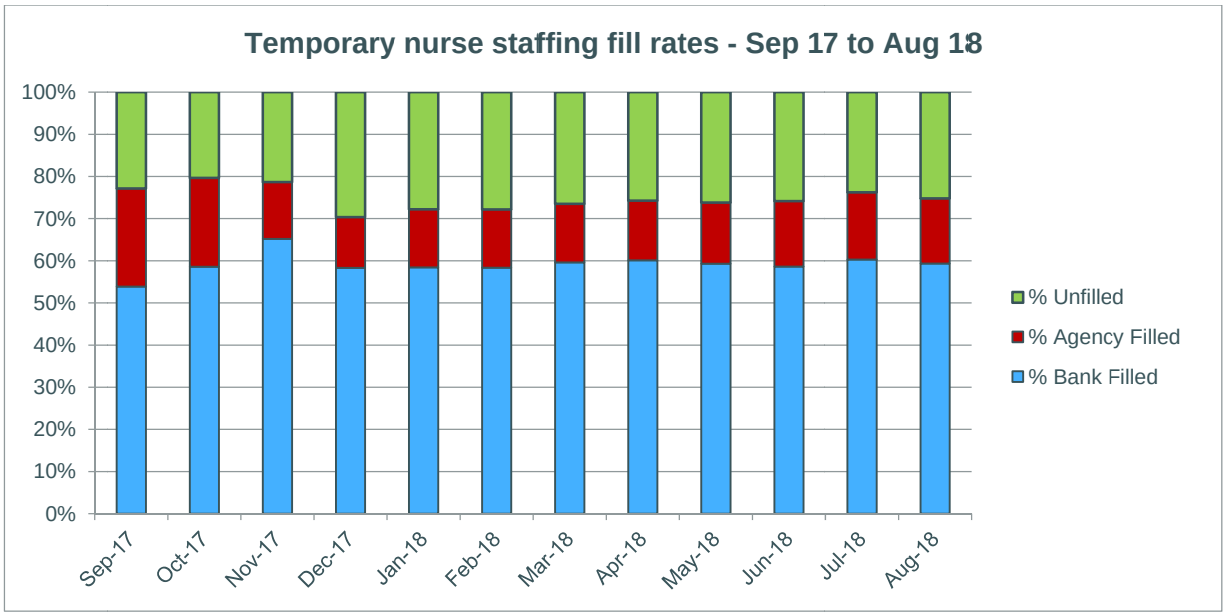
### Graph 4 – Temporary Nurse Staffing Demand




**Source: BankStaff**

Graph 5 shows the proportion of all shifts requested that were either filled by Bank, Agency or were unfilled. Overall, Bank fill-rates made up 59.34% of all requests in August 2018 whilst the Agency fill-rate was 15.46%, both marginally lower than the previous month (60.28% and 15.96% respectively). The proportion of shifts that consequently remained unfilled increased from 23.76% in July to 25.20% in August.

**Graph 5 – Temporary Nurse Staffing Fill Rates**




**Source: BankStaff**

## 2.3 Apprenticeships

The Government introduced Apprenticeship Reforms for England on 1st April 2017. As part of the reforms all employers with an annual pay bill above £3 million need to spend 0.5% of their total pay bill on the Apprenticeship Levy. This equates to a contribution of approximately £1.3m each year for the Trust and can only be used for apprenticeship training provision. The target for Trust Levy expenditure per month is therefore required to be £115,258 to enable a projection spend of £1.3 million and currently the Trust is achieving £27,572 per month expenditure against the Levy. However, by February 2019 the expenditure per month will increase to £85,240 and by September 2019 the Trust will be regularly achieving expenditure in excess of £100,000.

Additionally, public sector bodies with more than 250 employees based in England are to employ an average of at least 2.3% of their staff as apprentices from 2017/2021. This headcount includes anyone on an employer's payroll, including temporary staff. For the Trust, this equates to approximately 201 apprenticeships (these can be new starters or existing staff).

The Trust will have a legal duty, as established in the 2015 Enterprise Act, to 'have regard' for the public sector target, in other words to demonstrate that apprenticeships have been factored into workforce planning, for reasons of recruitment and training/development. To achieve this, each directorate has a nominated 'target' to achieve and the Trust has integrated this directive into all vacancy control applications. Currently, there are 75 apprentices and the Trust is on target to achieve 227 apprenticeships by February 2019.

To continue the momentum to achieve the targets, the Trust must ensure that Apprenticeships are considered high profile and engagement at all levels is essential. The Trust will deliver regular promotional events throughout the year and directorates will be responsible for identifying apprenticeship training opportunities through annual Training Needs Analysis and workforce planning.

## 2.4 Recruitment

### Medical Recruitment on the East Coast

As part of the East Coast medical recruitment campaign to actively target potential candidates and aid the challenging medical vacancy position on the east coast, there have been a number of developments:

- Collaboration with Humber Coast and Vale STP has commenced in relation to their three-year project to recruit 65 international GPs from the EU in partnership with Templars Medical. This project has already established good links with doctors from Spain and some of these doctors require further experience in a hospital setting to satisfy the requirements for GP registration. They also have links with other doctors who are seeking permanent roles in an acute setting;

- Further to Mike Keaney's attendance at a Scarborough Business Ambassadors meeting; links have been established with the High Commissioner for Barbados to the UK. The High Commissioner has advised that Barbados is producing an excess of medical graduates;

- A joint Primary & Secondary Care Recruitment event for doctors is planned for Saturday, 20 October 2018 in the Post Graduate Medical Centre at Scarborough Hospital;

- In addition to the above an inaugural Scarborough Leadership and Management Course for doctors in training is taking place on Friday, 19 October 2018. This course is free of charge and is intended to assist senior specialty registrars in completing non clinical competencies around awareness of NHS structures, regulatory frameworks and finance and in addition will provide support and discussion in relation to planning and preparing for the consultant appointment process. We are hoping to attract some delegates to stay and attend the recruitment event on the following day;

- Currently working in partnership with eight medical agencies which specialise in the introduction of candidates for the purposes of permanent recruitment. We have received 50+ expressions of interest so far (predominantly from doctors with no UK experience) and we are liaising with departments to arrange interviews where appropriate;

- The development of a promotional recruitment video for the East Coast is underway;

- A Capital Project Initiation Request is pending to provide an improved rest & study environment for junior doctors at Scarborough by relocating their mess facilities from its current site and to also provide a suitable location for a consultant common room. The provision of improved mess facilities and the re-establishment of a consultant common room will support this project plan to attract and retain junior doctors & consultants to work on the Scarborough site. The relocation of the doctors' mess will also provide a secondary benefit as

the redundant area could be refurbished to accommodate clinical services and therefore improve the clinical footprint at Scarborough Hospital.

## 2.5 eRostering

The Roster policy was revised and ratified in July 2018. One of the main changes included an increase to the scope of the policy to include all non-medical workforce supporting the five year Healthroster implementation project that began in 2017. The management of staff shift swaps and shift requests has also been made less prescriptive, to allow managers more discretion in approving changes on a case by case basis. This change has been seen to allow more flexibility for staff.

The implementation of the SafeCare software was completed in July with all designated inpatients areas having had the software rolled out and the required training. This project was completed within 6 months as planned with the team delivering training to nominated staff on all inpatient units across the Trust. The SafeCare tool is used by wards, senior nursing and operational teams to manage staffing levels in real time and to use the system effectively wards must input their patient acuity data on a regular basis into the Safe Care tool three times per day. The eRostering team continues to monitor compliancy with this process and there has been a slight decrease in compliance since the project ended – with the average compliance rate falling from 52.50% in June to 48.96 % in August.

The team continues to implement the Healthroster software on a rolling basis with 25 departments having gone live on the roster system since September 2017. This number includes Main Theatres at York as well as non-nursing departments e.g. Radiology in Scarborough. The next phase will include at least 5 AHP teams including Physio MSK teams & Community Response Teams. Preliminary discussion has also commenced with Laboratory Medicine and Radiology York.

The team is also working on a project with Holly Ward trialling 'self-rostering'. The trial began in August and will continue for six months, at which point there will be a review of the roster data (such as temporary workforce spend / sickness levels) and feedback from the staff to ascertain if the method is viable. The initial feedback has been very positive but it is still too early to review any of the roster data.

## 2.6 360 Leadership Behaviours Feedback

The Trust has been working on a local 360 leadership behaviours tool which is nearing completion. The aim of the tool is to enable leaders at all levels in the organisation to gather valuable feedback on their leadership behaviours, in order to identify their strengths and required areas of development to facilitate their growth as a leader.

The 360 tool asks respondents to provide behavioural feedback on both the organisational values and a range of recognised leadership behaviours based on the NHS Leadership Academy's Leadership Qualities Framework. Once gathered it is expected that the leader will self-reflect and use feedback in personal development planning with their line manager.

Leaders will also be able to have a development conversation with a member of the O.D.I.L. team who will support the leader in the interpretation of their results, and in their

action planning and support them to manage the impact of any feedback that the leader may perceives as "negative".

The 360 tool will be tested out in a selection of cohorts on the internal leadership programmes and revised following any feedback before being made more widely available in the spring of 2019.

This work dovetails with the revised appraisal process which is yet to be ratified by our trade union colleagues. The new simpler process moves away from the sixteen matrix scores which anecdotally staff did not find helpful. Reporting of appraisals also moved from the payroll system to the Learning Hub earlier this year and allows for staff and line managers to receive reminders which should increase compliance.

### 2.7 Staff Engagement

The Trust has recently appointed Clever Together to run both the Staff Survey and the Staff Friends and Family Tests. The 2018 Staff Survey will be the start of a change in the way we both run the surveys and the way we use the information received from them. Clever Together will be working closely with the Trust to push forward staff engagement through online forums, asking questions based on the outcome of the Staff Survey directly to our staff, getting their point of view on both the survey results but also on how those results are interpreted for them personally and for the Trust

## 3. Next Steps

This report has detailed key workforce metrics highlighting any issues or trends. In those areas where there are issues, actions which have already been identified have been detailed. The impact of actions will become apparent in subsequent reports.

## 4. Detailed Recommendation

The Board is asked to note and discuss the content and findings within the report.

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# Annual Equality, Diversity and Human Rights Report

# 2017-2018

**August 2018**

**Contents** Page

# Introduction

York Teaching Hospital NHS Foundation Trust is committed to delivering safe, effective, sustainable healthcare within our communities. Continuing to integrate equality, diversity and human rights into our day to day practice will enable inclusive delivery of services and the employment of a workforce that is representative of the communities we serve.

We will achieve this through our Trust Values:

- Caring about what we do
- Listening in order to improve
- Respecting and valuing each other
- Always doing what we can to be helpful

*http://www.yorkhospitals.nhs.uk/about_us/our_values/*

For information about our hospital please visit;

https://www.yorkhospitals.nhs.uk/about-us/

This report is designed to demonstrate our compliance with the equality duty to publish information. Its aim is to be reader friendly with a clear structure and information to establish the current situation including progress, achievements since last year's report and identify where further work is required.

# 1. Our Services

## 1.1 Patient Activity

There are both national and local access and performance targets that the Trust is measured against. This section of the report relates to patient activity which has been extracted from our patient records database. It should be noted that there are local issues which impact on activity figures such as the large number of visitors especially during the summer months, our student population and York Races which attract people from a wide catchment area.

The comparative equalities data used in this section is gathered from our three primary CCG catchments:

- NHS Vale of York CCG
- NHS Scarborough and Ryedale CCG
- NHS East Riding CCG

This is not directly comparable to the total cohort of patients at the Trust and is used to highlight overall themes. Demographics for the local population can be seen at **Appendix A.**

**Report preparation**

In preparing this section of the report we have chosen to look at:

- ✓ Inpatient Admissions (Day Case, Elective, Non Elective)
- ✓ Outpatient Attendance
- ✓ Emergency Department (ED) 4 hour wait to treatment/admission/transfer (Breach/ Non breach)

We have assessed these key national indicators against the following protected characteristics:

- ✓ Gender
- ✓ Age
- ✓ Ethnicity

A graphical and tabular breakdown of Trust Activity Statistics can be seen at **Appendix B**

**Summary**

**Protected Characteristic – Gender**

- There has been very little change from 2016/17 to 2017/18 in terms of gender breakdown of activity, however there was an increase of

2% in outpatient attendances for females (increasing from 55.9% to 57.9%).

- The gender split of Emergency Department attendances and elective inpatient admission overall were much less pronounced than non-elective inpatient and outpatient activity. Emergency Department attendances were 51.6% female and 48.4% male whilst the gender split for elective inpatient admissions was 52.4% female and 47.6% male. Both non-elective inpatients and outpatient attendances are more likely to be female (comprising respectively 60.2% and 57.9% of activity in 2017-18).

**Protected Characteristic – Age**

- During 2017/18 there was a rise in the proportion of outpatients treated aged over 65 compared to 2016/17 whilst the proportion of all outpatients aged under 65 reduced.

- Likewise the Trust's Emergency Departments saw an increase in the proportion of patients attending aged over 65 compared to 2016/17.

- There were no significant changes witnessed in the age differential for all inpatient activity compared to 2016/17.

- Over 65s comprised 32% of all ED attendances in 2017-18; 21.2% were over 75.

- The 18-49 age group had the highest proportion of ED attendances making up 37.2% of all attendances.

- Children (0-17) accounted for 15.5% of attendances at ED.

- The proportion of patients taking longer than 4 hours for treatment or admission to hospital is highest for patients over 75 (making up 38.1% of all breaches). This is followed by the 18-49 age group (with 26% of all breaches). However, proportionately, this age group also had the most number of attendances overall (37.2% of all ED attendances are aged between 18 and 49)

- The 18-49 and over 75 age groups proportionately have the highest non-elective inpatient and outpatient activity. Elective inpatient activity however appears to increase with age.

**Protected Characteristic - Ethnicity**

- For 25.5% of patients' attending ED their ethnicity was unknown and a further 5.3% did not state their ethnicity, making analysis less reliable against BME characteristics. 61.4% of attendances were

recorded as identifying as ‘White British’ and 6.5% as ‘Any other White Background’. Whilst it is not possible to draw conclusions from the data due to the limited data, patients identifying as Asian and those as Chinese in the recorded data are proportionally lower than the overall local population.

- For elective inpatient activity, 8.8% of our inpatients’ ethnicity was unknown, with a further 4.3% not stated. White British people comprise 78.7% of patients with a recorded ethnicity with the next largest group were patients identifying as ‘Any Other White Background’. Patients identifying as Asian and those as Chinese are proportionally lower than the overall local population. Non-elective patients were less likely to have their ethnicity recorded than elective patients.

- 21% patients attending outpatient appointments either did not state their ethnicity or their ethnicity is unknown, making analysis less reliable against BME characteristics. Of those who have a recorded ethnicity ‘White British’ comprised 69% of patients and ‘Any other White Background’ was the next largest at 8.1%.

## 1.2 Patient Information

As a Trust we are committed to providing patient information in accessible formats and production of patient information for treatments and procedures is guided by Trust policy and a range of standards that applies to all patient information leaflets.

- ✓ A standard access statement is included on the back cover or as close to the cover as possible (for sponsored leaflets) which has a central point of contact for patients and relatives to request information in a different language or format. The languages relate to our top interpretation requests. We continue to introduce via the review and reprint process and can be seen in section 8 of this report.

- ✓ An A4 version has for information sent via letter format has been developed and introduced

- ➢ **Looking forward**

- ✓ The Trust has a rolling program of adding patient leaflets to the Trust website. The plan is to have the majority of leaflets on the website by the end of the summer 18.

**On-going work**

The Trust's Implementation of the Accessible Information Standard continues; this standard that applies to all NHS and adult social care organisations to make sure that people who have a disability, impairment or sensory loss are given information they can easily read or understand.

The standard requires us to;

- Ask people if they have any information or communication needs and how to meet these
- Record those needs clearly and in a set way
- Highlight or flag the information gathered on the persons notes/files so it is clear.
- Share information collated with other providers of NHS and adult social care when they have permission to do so;
- Take steps to make sure people receive information which they can access, understand and receive communication support if they need it.

- ✓ The standard does not include interpretation and translation; in implementing the standard the Trust has taken the opportunity to include this it is an important part of communicating with our patients.

✓ We continue to research innovate ways to communicate with our patients.

## The Trust Website

The Trust's website can be viewed at www.york.nhs.uk and complies with WCAG/WAI web standards and guidelines, as required by the NHS and all other UK public sector organisations. The site includes "BrowseAloud" (a free screen reader service) text resizing, access keys and a translation tool for languages other than English. It is also compatible for people using mobile phones, tablets, and other devices to browse the internet.

✓ Patient leaflets are published on the website in PDF format.

## 1.3 Patient Experience

This section of the report is largely unchanged from our previous annual report as it aligns to the progress with delivering the five commitments of the Patient Experience Strategy 2015-18 which remains current.


**Listening** to our patients, welcoming feedback and sharing the results from ward to board helps us improve the quality of the services that we provide.

**Learning** from what patients tell us, identifying actions for improvement and monitoring their delivery

**Responding** to feedback in an open and timely manner and reporting on themes and trends so people can see what matters most to patients, celebrate success and identify what needs improving

**Involving** patients in decisions about their care and delivering a service that is responsive to their individual needs

Nurturing a **culture** of openness, respect and responsibility.

**Key achievements**

- ✓ Text messaging as a method of communications with our patients is continues to be explored across the organisation.
- ✓ The Trust has a dementia strategy which is overseen by the Dementia Steering group
- ✓ There are new patient and visitor information boards across the ward
- ✓ The Mobile chemotherapy unit, which is recognised as a big step forward in improving the experience of patients undergoing chemotherapy.
- ✓ We have received outstanding patient experience feedback received for the new Malton Urology Diagnostic One Stop Clinic

Key points, which supported a successful outcome were:

- Clinical engagement in all elements of the project from day 1
- A focus on detail (there are 9 toilets in the clinic – important for a urology department; the arts team and Trust Charity supported an artist to develop a bespoke interior design for the clinic)
- Staff engagement – throughout the project and ongoing (staff consistently say how much they enjoy working there).

The patient feedback highlighted that, as well as being satisfied with the clinical care, little things make a big difference to people's experiences.

- One of the most frequent comments is people's appreciation of free car parking
- The only negative theme was that, in the first month of operation, the coffee machine in the waiting area was not working and some comments about having to travel to Malton.

✓ Complaints resolution - Improvements have been made through supporting early resolution and/or de-escalation. There is robust administration and governance underpinning the new way of working.

✓ Volunteering - a new training package is being delivered for dining companion volunteers

✓ Welfare of armed forces - A regional meeting of the armed forces family support group took place in June. The vulnerability and isolation of families on bases is recognised and the aim is to provide continuity of care to patients.

**Key Challenges**

**General Data Protection Regulations**

In February the Trust received a letter from the Care Quality Commission regarding the new data protection legislation which took effect from 25 May 2018. This communication highlighted the importance of providing patients with GDPR compliant information, such as privacy notices, that tell patients how their contact details may be used for surveys. All survey posters display opt out information and Patient Advice Liaison Service contact details for registering preference.

**Access to drinking water**

A decision was taken by the Trusts Water Safety Committee to remove water fountains due to the risk of contamination. Patient Advice Liaison Service received two concerns since the water fountains had been removed and patients felt their only option was to buy bottled water. In

addition, three Friends and Family Test comments were received in February regarding access to water in the Emergency Department (ED).

Water is now available in the ED and no further concerns have been raised. It was agreed that feedback would be monitored to ensure there is not an emerging patient experience theme.

**Report on national inpatient survey results**

With 591 surveys returned completed, the Trust had a response rate of 49.8% which was down from 53% in 2016.

The Trust scored an average score of 76% which is higher than in 2016 and was in the top 20% of Trusts on five questions and the bottom 20% of Trusts on four questions.

Compared with the 2016 survey, the Trust showed a 5% or greater improvement on five question scores and a 5% or greater reduction in score on one question.

From the survey the following strengths were identified for the Trust:

- ✓ Keeping to planned admission dates
- ✓ Providing practical help from staff to eat meals
- ✓ Information provision - before operations/procedures, information to family to help support care, knowing who to contact if worried after leaving hospital

The following areas identified for improvement:

- Noise at night from other patients remains an issue for patients despite the good work that has been undertaken to date and the fact that the Trust did score significantly better in this area this year.
- Nurse staffing levels
- Communicating named nurse to patient
- Privacy when discussing condition or treatment

It has been recognised that the Trust in addition to some targeted work at specific sites such as sharing the improvements in medicines management at York with staff at Scarborough as well as rolling out the pharmacy inserts used in packs at York, we are looking at our communication of the results to staff which will likely include listening exercises across sites

**Report on national maternity survey results**

This national survey takes place annually (this was previously undertaken every three years). It was last undertaken in February 2018.

358 surveys were posted and there was a 45% response rate. The average mean rating score, across all questions, was 82% which is higher than in 2015 and the overall impression is positive.

The Trust scored in the top 20% of Trusts on 26 questions and the bottom 20% of Trusts on only 2 questions, both on choice of place to give birth.

Work is ongoing both locally and nationally to ensure choice is more widely known. 17 questions showed at least 5% improvement on the 2015 score, and 1 question showed a 5% or more worsening of score. The remaining questions showed less than 5% in change in score since 2015.

The results and overall scoring is positive, a poster has be designed to provide feedback of the results to staff on the wards.

- Looking forward

  - ✓ Maternity COMFE rounds (patient welfare / care checks) to be relaunched. Peer supporters of the directorate are to be utilised for the COMFE rounds.

  - ✓ Staff communication around infant feeding and supporting patients to make a choice is to be reviewed to ensure consistency to the advice given.

  - ✓ Continuity of Care: A pilot is underway for multiple births with a view for it to be rolled out from patients with diabetes if the pilot return is positive.

**Results of Visiting Time Survey**

It had been agreed that patient feedback would be reviewed at Patient Experience Steering Group to evaluate the impact of the changes on patients, visitors and staff. Feedback gained has been positive in relation to extended visiting times.

Feedback from the Friends and Family Test responses highlighted a mixed picture.  Comments included positive for the new times compared to others who expressed dissatisfaction with being disturbed by other people's visitors, not liking visitors being present during meal times.

The results of the dementia carers survey showed a marked change since the introduction of the new visiting times and John's Campaign, with the majority of carers of people with dementia now stating that they did not feel there were restrictions on their visiting.

Issues relating to visiting times have been highlighted on 'Safety Walk Abouts'. There continues to be feedback from staff about the balance of being open to visitors on the ward, needing to complete ward rounds and attending to patients' personal care in a safe and dignified manner.

Scarborough has previously had a more established culture of open visiting, and the majority of debate about the new visiting times related to the York site.

- Looking forward

Further patient and staff feedback is to be gathered to cover a greater number of wards. This would be reported at the next Patient Experience Steering Group.

# 2 Our Workforce

This year's report focuses on permanent and fixed term employees (i.e. excluding those on bank contracts). There is also a dedicated section which focuses on the key findings for our temporary workforce.

In line with the General Data Protection Regulations, we have combined some categories so that there are at least 10 people in each category. This helps to protect the anonymity of staff. Below is an overview of the Trust's workforce, followed by a profile of those joining and leaving the organisation and findings within pay bands.

**Report Preparation**

The overall number of Trust staff increased from 8,630 on 31 March 2017 to 8,787 on 31 March 2018. This increase is primarily due to some services and their staff transferring into the organisation within the year as well as a more stabilised turnover of staff over the year.

The staff profile is based on a snapshot of all members of staff working for the York Teaching Hospital as at 31 March 2018. Data is also shown from 31 March 2017 to compare how the profile has changed.

The headline statistics below include the overall staff profile, joiners and leavers for the period 1st April 2017 to 31st March 2018.

Also included within this section is a breakdown of the profile by pay grade. The pay grade analysis includes Junior Doctors. Within this work we combined many of the categories together to protect the anonymity of individuals. The analysis is not an equal pay audit; it is not looking at equal pay for equal work but at distribution of staff across pay bands by gender.

1,158 individuals joined the Trust between 1 April 2017 and 31 March 2018, and 941 staff left the Trust during this same time period. The figures for 2017-2018 do not include Junior Doctors as including this group would adversely reflect on the data and on the findings and conclusions which are then drawn.

The highest numbers of staff are in pay bands 2 and 5. This is because band 2 includes most of the administrators and healthcare assistants whilst band 5 is the entry grade for all nursing staff which is the largest staff group in the Trust.

## 2.1 Staff profile

## On-going work

### Protected Characteristic – Gender

- The gender breakdown remains relatively unchanged with women making up 79.3% of the Trust's workforce. The largest proportion of female staff is seen in Nursing and Midwifery roles (93.2% of this group are women, reflecting this being a sector which traditionally employs more women than men).

- Males made up 21.5% of new starters which is slightly higher than the 20.7% of all staff employed in the trust who are male.

- Proportionately the number of men leaving the organisation has increased compared to women. Men now account for 22.8% of leavers, an increase from the 18.6% of male leavers the previous year. 77.2% of all leavers are women which was a decrease from 81.4% the previous year.

- The overall number of female staff is higher in each pay band apart from Medical and Dental grades where there were more men (470 males to 307 females) and this group also accounts for just over a quarter (25.8%) of all male staff. In contrast 4.4% of female staff are in Medical and Dental grades.

- In volume terms a higher number of women are in grades 8a+ than men (215 female staff compared to 83 male staff). This banding includes a variety of different roles including senior nursing roles (Matrons) which tends to attract a higher number of women. However, proportionately, men are more likely to be in band 8a+ roles (i.e. accounting for 4.6% of the male workforce) than women (representing 3.1% of the female workforce).

  (See appendix C Tables/Figures 1-4)

## Protected Characteristic - Ethnicity

- The proportion of staff who identify their ethnicity as being White is 89.4% compared with 89.8% the previous year. Of this, 81.5% declared as White UK.

- The overall percentage of BME staff is 7.2%. The largest BME group was Asian and Asian British, accounting for 4.0% of all staff.

- The percentage of new staff whose ethnicity was unknown decreased to 6.0% (down from 7.8% in the previous year). The percentage of new starters who said they were from BME groups was 7.2% (mirroring the 7.2% of all staff in post who identify their ethnicity as BME).

- The percentage of staff leaving the Trust from a BME group decreased from 6.8% last year to 6.5%. This is slightly lower than the overall Trust percentage of 7.2% that BME staff account for.

- The highest percentage of BME staff is seen for Medical and Dental pay scales (35.3%), equating to 225 people. Compared to this, only 6.5% of all White staff are in Medical and Dental pay scales, although this does equate to 507 people.

- BME staff make up a significant proportion of Medical and Dental staff, which has a major impact on the data and findings which can then be drawn from any analysis of staff within different pay scales. It can however be said that BME staff are less likely to be in band 8a+ roles (0.9% are in band 8a+ roles, with these pay bands accounting for 3.4% of all staff).

(See appendix C Tables/Figures 5-8)

## Protected Characteristic - Sexual Orientation

- The percentage of staff where we do not know or the person does not want to disclose their sexual orientation continues to reduce (from 52.3% in 2017 to 46.9% in 2018). Although this figure still remains high there has been continued improvement in the capturing of this data and this figure has reduced fairly significantly from the 74.7% recorded five years ago.

- 93 staff disclosed as lesbian, gay or bisexual (1.1% of all staff, an increase from 0.9% last year). The percentage of heterosexual staff has increased from 46.8% to 52.0%; this increase will most likely be due to the improved means of capturing protected characteristic information via the ESR Self Service functionality.

- 23 new starters (2.0% of all starters) identified themselves as lesbian, gay or bisexual (higher than the figure of 1.1% seen for lesbian, gay and bisexual people in the overall trust's workforce). This percentage is an increase from last year (1.4% of all starters).

**Please note:** In respect of those leaving the Trust and our analysis by pay grade, due to following good practice in data protection and to ensure personal privacy we are unable to make any meaningful conclusions here. Lesbian, gay or bisexual staff account for a small proportion of staff, but also for 46.9% of staff their sexual orientation is still not known, or that staff prefer not to disclose this.

(See appendix C Tables/Figures 9-12)

## Protected Characteristic – Religion and Belief

- The number of staff disclosing their religion and/or belief continues to improve with now 22.7% of our staff not wishing to disclose their religion/belief. Christians make up 35.7% of staff, up from 33.2% the previous year.

- The number of staff where their religion and/or belief is undefined reduced from 29.0% to 25.1%.

- 48.5% of the new staff joining the organisation stated that they were Christian. Initially it appears that this is notably higher than the equivalent percentage of Christians in the trust's overall workforce (35.7%). However if the 'unknowns' are excluded (which account for a high proportion of the trust's overall workforce), 47.6% were Christians[1].

- The proportion of new starters who practice other religions also saw a higher percentage than the equivalent in the trust's overall workforce (12.4% of new starters compared with 7.1% of the overall workforce).

- 36.3% of staff who left the Trust were from Christian religions / beliefs.

- A high proportion of staff from Non-Christian religions is seen in Medical and Dental roles (accounting for 20.7% of such staff – in contrast with 7.1% of the overall workforce). This links to why those from Non-Christian religions are less likely to be in either the below band 6 category or band 6 and above roles.

(See appendix C Tables/Figures 13-16)

[1] More specifically this involves excluding the 2,205 staff where their religion and beliefs are unknown and then re-calculating the percentage who were Christians

## Protected Characteristic - Age

- The workforce age profile has remained relatively stable compared with the previous year with the most notable change being in the percentage of staff in the over 61 age group (although this age group only increased from 5.4% in 2017 to 6.1%).

- Similar to last year, new starters tend to be younger than that seen for the Trust's overall workforce. Individuals aged 25 and under made up 25.1% of all starters but only 7.6% of all staff.

- The leavers rate is unsurprisingly highest for individuals aged under 30. This is likely to be due to younger people generally moving around more to find a job that suits them.

- It is normally expected that the 61 and over age group will have the highest leavers rate (primarily due to retirement), but in the latest year, the 56-60 age group leavers rate has been higher (17.6% of leavers were aged between 56 and 60 compared with 13.3% of staff aged over 61). Overall, staff aged over 56 made up 18.0% of the Trust's overall workforce but 30.9% of leavers.

- Staff aged under 30 made up 19.4% of the workforce, yet this age group made up 26.4% of staff leaving the Trust.

- Younger workers tend to be concentrated in the lower pay bands. This includes 37.7% of those aged under 25 being in the lowest two pay bands of staff. Whilst a further 46.1% of those under 25 were in bands 3 to 5 roles, only 7.7% were band 6 or higher.

(See appendix C Tables/Figures 17-20)

## Protected Characteristic - Disability

- Overall, 2.1% of staff across the organisation identified themselves as disabled, which shows a low overall representation. However, the number of staff who indicated that they have a disability has been increasing (from 110 in 2016 to 132 in 2017 to 181 in 2018).

- The percentage of staff whose disability status is 'not known' has fallen from 43.8% to 37.6%, reflecting the trust's efforts to better capture and improve the quality of such information.

- This low percentage is not reflected in the annual staff survey (2016) where 19% of staff identified themselves as having a long-standing illness, health problem or disability.

- Of the 1,158 new starters, 50 people identified themselves as disabled. This equates to 4.3% of all starters, which is higher than the 2.1% of all trust staff.

- 2.9% of those leaving the Trust were disabled. The percentage of leavers whose disability status was unknown decreased from 36.7% to 29.1%.

**Pay Band - Please note:** Due to confidentiality issues we are unable to make any meaningful conclusions here. A key factor here is the very small numbers of staff in each pay band and we still don't have an accurate figure of how many disabled staff we employ.

(See appendix C Tables/Figures 21-24)

## On-going work

The capture of protected characteristics information at all points of the employment cycle continues to be a key priority.

- ✓ The emphasis is on accuracy and encouraging staff to report information which is reflected in a continued reduction in the proportion of 'do not knows'.
- ✓ Continue to encourage staff to self-report personal data to improve the Trust Equality and Diversity Data and provide a safe environment for individuals to disclose.

➢ **Looking forward**

- ✓ The Trust is going to undertake a review of all HR related forms to ensure appropriate capture of Equality and Diversity data.

- ✓ As a Trust we recognise that we are committed to continually raising staff awareness and confidence in the use of such data in order to identify inequalities between different staff groups, monitor incidents of discrimination, facilitate change and proactively tackle identified issues.

## Our Temporary Workforce Staff profile – A summary

The staff groups included in this section includes; Locum doctors, as well as those in a number of bank roles, e.g. Nurses; Midwives; Healthcare Assistants and those working in areas such as Radiology and Physiotherapy.

As of March 2018 there was a total of 1,169 temporary staff on which the analysis is based. This figure has continued to increase over the last couple of years due to the Trust continuing to expand the internal nurse and medical bank, reflecting the important role played by our temporary workforce.

**Please note:** Due to confidentiality issues it is only possible to report any meaningful information on gender, age and religion/beliefs. This data is also being compared to the overall workforce for the Trust. Key findings on our temporary staff are summarised below:

- The gender split of our temporary workforce is proportionately in line with the trust's overall gender split.

- More likely to see a higher percentage (compared to the Trust's overall workforce) who are 30 years old or younger. (33.9% of our temporary workforce are aged 30 or under compared to 19.4% of the Trust's overall workforce).

- Compared to the Trust's overall workforce, the Trust's temporary workforce is less likely to be aged between 36 and 50, but more likely to be aged between either 51 and 55 or 61 or older.
- More likely to be from Non-Christian religions and beliefs (5.6% compared to 2.6% of all staff). Equally, more likely to be Christian (47.1% compared to 35.7% of all staff).

(See Figures 25 - 27 in Appendix C)

## 2.2 Staff Learning and Development

### The Learning Hub

Learning Hub is the learning management system for York Teaching Hospitals Foundation Trust. All staff can access to it from their workplace or via the internet and use it to undertake online learning, book onto courses and record appraisals. During 2017/2018 clinical skills competencies also started to be added.

Up to the minute reports are available for all staff about their own learning & appraisals, extra reports are also available for managers and heads of departments/directorates to enable them to monitor their own areas.

Whilst Learning Hub was initially focused on statutory and mandatory training, during 2017/2018 many departments switched their own training courses over to Learning Hub and now use this as their main platform for delivery and recording completions. Whilst courses still have to be added centrally they can be managed at ward/department level and training is available for those areas wanting to do so.

### Appraisals and Development Policy

- ✓ Line managers continue to report appraisal activity directly on to the Learning Hub, which is our learning and development portal. There is the functionality within Learning Hub for real-time reporting of appraisals which has gives line managers a full picture of their appraisal activity. This supports the proactive work carried out with directorates and or individual managers who are regularly or periodically not reporting undertaking appraisals with members of staff.

- ✓ The Appraisal policy is being reviewed.

- ✓ The Trust's Pay Progression policy continues to provide accountability from members of staff to ensure their awareness of when their appraisal is due and sharing the accountability for ensuring that it takes place timely and has meaningful outcomes.

- ✓ The NHS Pay Deal introduced in April 2018 will result in most staff being able to reach the top of the band quicker, subject to the new pay progression system.

### Looking Forward

- ➢ There will be new NHS National Guidelines for pay progression which the Trust will be adopting.

We have previously reported about introducing a development policy to incorporate the appraisal policy. The decision was made to keep a separate appraisal policy with a continued focus on a values based approach to managing and developing our staff. The appraisal policy is currently being reviewed and a separate development / talent management policy is being developed. Discussions and consultations have and will continue to take place with our staff side representatives on any proposed changes.

**Staff induction**

- ✓ The Trust has undertaken a full review and update of the Equality, Diversity and inclusion elements of our corporate induction program and the induction program for Health Care Assistants

**Apprenticeships**

- ✓ The Trust continues to adopt an 'access to all' approach to apprenticeships.

The Trust has maintained our historical stance of recruiting young people into 'starter' apprenticeship roles. We are also starting to see a cultural shift with apprenticeships being viewed as a true equivalent to academic learning

Many of the apprenticeship standards that are required for those working in the NHS are not available yet. However, we expect these will be released in 2018/19 at which point we will start to see the formation of progression routes from starter roles to those that are more specialist in nature.

- ✓ The opportunity to complete an apprenticeship is also being offered to existing staff to aid their future progression.

**Project Choice**

**A Health Education England Supported Internship Programme – an update from Karen Porter Project Choice Area Manager**

Project Choice positive change

Project Choice is a supported internship programme for young people aged 16 - 24 with learning disabilities, difficulties or autism (LDDA). NHS Health Education England

support York Teaching Hospitals NHS Trust to deliver the programme in Scarborough and York. The focus is ‘work readiness’ and matching interns skills to potential employment.

The project team ensures there are placements across the Trust looking specifically at entry-level jobs to make sure the right learner is allocated to the right role. They also work closely with department managers to ensure that tasks are clearly understood. In addition, the programme offers training to staff to become work-based mentors, working alongside and supporting interns. Over 40 staff in the Trust have been trained this year to support learners with LDDA, developing unique teaching techniques and skills, which can be transferred across the organisation.

The interns spend a minimum of 12 weeks in their placement and are integrated into the team and into the hospital environment. The Project Choice team uses this time to look at any barriers and potential areas of development. Throughout, interns are gradually assessed on how ready for employment they are.

This year 23 interns have been supported across York and Scarborough hospital sites, giving learners the opportunity to develop their employability skills ready for apprenticeships or employment within or outside of the Trust.

**Looking forward**

- ✓ In September 2018 the programme will start to develop a work experience element for students still at local schools for half a day per week for 6 weeks. This gives students an opportunity to develop skills for the workplace, make choices about career directions and ensures young people understand the importance of matching their skill sets to work while still in education.

## 2.3 Recruitment

The Trust continues to emphasise the importance of a values-based (VBR) approach through its recruitment strategy. All recruitment campaigns which are centrally supported by the HR team utilise VBR methodology.

- ✓ The VBR approach relies on the attraction and selection of new staff according to their motivations and drivers, and ensures that experience and qualifications are not given a disproportionate level of attention in the selection process.

- ✓ Research has shown that values-based recruitment increases workforce diversity as it takes a much broader view, not only of applicants, but of the attributes which make someone suitable to undertake a particular role.

The Trust's Recruitment & Selection training, which is available to all staff, promotes a values based approach. The content of this training course is continually under review to ensure that it reflects current legislation and best practice.

**Careers Events**

- ✓ The Trust continues to attend careers and recruitment-related events hosted in schools, colleges and universities in our community. We continue to support City of York Council with their recruitment events in the city.

**Trust-Wide recruitment**

The Trust Recruitment Team works closely with the Chief Nurse Team to recruit experienced and pre-registered nurses, arranging recruitment events including 'interview on the day' opportunities in York and Scarborough.

The Trust remains active in their work with the University of York and Coventry University to attract nursing students to our Trust, offering application and interview skills seminars to student nurses and Post Graduate Nurses.

- ✓ Following the update in the 2016/17 annual report; the Trust is building on its successes and continues to proactively recruit Nursing Associates, Associate Practitioners and Health Care Assistants to the Trust.

**Physician Associates**

The Trust has been working with its Directorates to support the introduction of a new role of Physician Associate into the Trust.

- Looking forward

  - ✓ We will be interviewing during July 2018 and hope to recruit a cohort of Physician Associates to start work in October 2018.

**Estates & Facilities**

- Looking forward

To assist with an identified shortage of domestics and porters available over the summer period; the Trust are running a campaign to attract individuals from across our communities who are interested in having a bank contract for these roles.

  - ✓ The recruitment and selection process is designed to be completed in one day and accessible to all.

**Social Media**
In addition to more traditional methods, the Trust continues to utilise Facebook and Twitter to promote vacancies to a wide audience.

- Looking forward

There is a plan to increase our use of social media as a strategy to continue to broaden our level of reach, appeal and engagement in our future recruitment campaigns.

**Protected Characteristic – Gender**

- Males made up 31% of the total applicants. 38.1% of these applicants were shortlisted.
- Females make up 68.8% of the total applicants, and 61.4% of those were shortlisted.

**Protected Characteristic – Disability**

- The Trust is a Disability Confident Employer which has two key themes; getting the right people and then keeping and developing them. 5.6% of all applicants stated they have a disability and 4.6% of all applicants shortlisted stated they have a disability.

**Protected Characteristic – Ethnicity**

- The data shows that of a total of 19,730 applications made, 15,052 were white (76.4%) and 4,029 were BME (20.2%) 3.3% were unknown ethnic origin.

- The data shows the number of applicants who are white were the most successful group in getting shortlisted from their job applications when compared to all the other ethnic groups.

**Protected Characteristic – Age**

- Applicants under the age of 20 accounted for 2.7% of all applications. Applicants in their 20s made the highest number of applications with over a third (collectively 36.4%) of the total number of applications.

**Protected Characteristic - Religion and Belief**

- 47.4% of all applications were received from applicants who declared they were Christian and consequently over half (37.4%) of the shortlisted applicants were also Christian. 11.6% of applicants did not disclose their religion and belief. 20% were other religions and 18.9% declared themselves to be atheists

**Protected Characteristic - Sexual Orientation**

- 87.7% of applicants declared themselves to be heterosexual. This is reflected in the shortlisting data, which shows that 91.3% of all applicants shortlisted had declared themselves to be heterosexual.

Please see appendix D for full data set

**Staff Survey Responses**

The annual staff survey which runs in the Autumn each year asks staff whether they believe that Trust provides the opportunity for flexible working patterns and the 2017 results reflected that men and women were equally satisfied with the opportunities for flexible working patterns.

The survey asks if staff have experienced discrimination at work within the last 12 months. 32% of BME staff reported as having experienced discrimination at work, in comparison with the Trust average of 10%.

70% of employees who disclosed as having a disability in the staff survey reported feeling pressure to attend work despite feeling unwell. This was in comparison to the Trust average of 51%. It should be noted that the number of individuals reporting a disability in the staff survey does not correlate with the numbers reporting in the Trust employee records system. The number in the staff survey is considerably higher.

The Trust continues to take remedial action wherever possible through its annual action plan to address the different experiences highlighted

across the protected groups. The action plan is disseminated and worked on at a Directorate level.

As the staff survey is anonymous actions taken through the action plan are generalised. Targeting specific work with those who report through our employee records may prove counterproductive in our aims to increase disclosure of protected characteristics.

## 2.4 Grievance, Disciplinary and Bullying and Harassment

### Bullying and Harassment

The percentage of staff in our 2017 Staff Survey who said they had experienced harassment, bullying or abuse from patients, relatives or the public within the past 12 months was 26% mirroring our 2016 figures.

The number of staff who had experienced harassment, bullying or abuse from staff in the past 12 months increased slightly from 24% in 2016 to 25%.

With reference to specific protected characteristics, of the staff who declared themselves disabled in the staff survey, 33% said they had experienced bullying, harassment or abuse from patients/service users or their relatives and 36% said they had experienced bullying, harassment or absence from staff in the last 12 months.

Likewise, of the staff who declared themselves from black and minority ethnic backgrounds, 26% said they had experienced bullying, harassment or abuse from patients/service users or their relatives and 28% said they had experienced bullying, harassment or absence from staff in the last 12 months. Whilst the number who experienced bullying, harassment or abuse from patients/service users mirrors the number for those staff who declared themselves from a white background (which was also 26%), the number of BME staff who experienced bullying, harassment or absence from staff in the last 12 months was higher than for white staff (28% of BME staff compared with 24% of white staff).

Finally, men who responded generally appeared to have overall, slightly more positive experiences at work than women. Women reported higher scores than men in both the % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months and % experiencing harassment, bullying or abuse from staff (28% and 25% respectively for women compared to 19% and 23% for men).

The number of live bullying and harassment complaints between 1 April 2017 and 31 March 2018 was 3. However, due to the small numbers, it is not possible to give quality monitoring data.

The Trust is committed to a zero tolerance approach to bullying and harassment and has a specific ‘live’ action plan to tackle and raise awareness of Bullying & Harassment issues to improve their resolution.

These include:

- ✓ Developing people management training for managers to include promoting culture change

- ✓ Re-introducing a revised and updated Trust personal responsibility framework to all staff.

- ✓ A full review of the Bullying and Harassment Policy

- ✓ Signposting for all staff from induction onward in respect of raising a complaint to the Freedom to speak up/ safer working guardian

- ✓ Training and developing the network of Fairness Champions how they might respond bullying & harassment issues are raised with them including the support available in the Trust; providing them with a strong link to the freedom to speak up / guardian of safer working

- ✓ Information on the role of the Fairness Champions is given to all new starters to the Trust at corporate induction

- ✓ Restorative practice approach

To ensure compliance with the General Data Protection Regulations we are unable to report on all characteristics due to the small number of disciplinary, grievance and bullying and harassment cases recorded.

**Employment Tribunals**

During this year one Employment Tribunal claim was received and was on the grounds of discrimination. This claim has been successfully defended.

**Grievances**

Continuing the trend from the previous year, the majority of Grievance cases were raised by White British staff. The main reason behind this is most likely due to White British staff accounting for the largest percentage of staff within the Trust.

**Investigations and Disciplinary Action**

The data provided in the report reflects the methodology for the Workforce Race Equality Standard (WRES) indicator and is measured on staff entering into a formal disciplinary investigation during the reporting period from 1 April 2017 and 31 March 2018. (The WRES indicator will then use the current year's data and previous year's data to calculate a two year rolling average on which to base the relative

likelihood of BME staff entering the formal disciplinary process compared to non BME staff)

The vast majority of cases (approximately 96%) involved staff within the groups of White UK and White other groups.

Ongoing work

- ✓ We continue the review of both the Trust Discipline and Grievance Policies and associated Procedures; the purpose of the review is to ensure the documents both support managers to respond promptly and proactively via and informal discussion where appropriate to do so, whilst ensuring the processes feel appropriately person centred. This review will include the development of an updated training package for investigating officers.

## 2.5 Staff Support Groups / partnership working

The Trust staff support groups were established in 2014; a staff Lesbian, Gay, Bi-sexual and Trans (LGBT) Network and the Fairness Champions. Both groups are comprised of staff who have volunteered with the common aims to:

- Provide a safe environment to raise issues
- Give information, guidance and support to staff
- Contribute to staff development activities and awareness events
- Assist colleagues to assess impact of policy etc. to ensure inclusivity
- Signpost and support people to live the Trust values
- Support the role of the Freedom to Speak Up / Safer working Guardian.

**Staff LGBT network 2017/2018** highlights include:

In June 2017 the Trust illuminated the roof of the hospital with rainbow lighting for visible support of York Pride and to the LGBT community; the network also had a presence at York Pride.

In October 2017 we supported a play called 'Vincent River' for the York LGBT Forum Directed by the network's Chair Steven Clark. It concentrated on LGBT issues within society and young people, mental health and social issues as well as hate crime. We gave information to the actors and leaflets to public on sexual health.

Also in October, the Trust joined the York LGBT Forum for a Hate Crime walk through York to raise awareness of LGBT issues in aid of The Matthew Shepherd Foundation.

The Trust continues to be a corporate member of the York LGBT Forum and in November 2017 hosted their Annual General Meeting which included a promotion of our staff network and was hosted by 'HIV Activist' Jonathan Blake whose life was portrayed in the film 'Pride'.

February was LGBT history month and in 2018 the Trust had a display in the entrance of York hospital displaying facts about LGBT staff within the NHS, LGBT issues within communities and it also mapped out the journey LGBT people have come within the NHS and services that are on offer for LGBT staff and patients.

- Looking Forward

  - ✓ Coming up we have supported Chair Steven Clark with his musical production Bring On Tomorrow which will be presented at the York Barbican on 8th July this is an event to promote equality, inclusion

and social diversity within York. The Forum have dedicated some time with the Communications team to tweet and support it via social media.

- ✓ In October 2018 we will be supporting the hate crime walk again.

- ✓ The LGBT forum will be undertaking a review of Transgender issues with society and the community and how as a trust we can encourage more Transgender people to apply to work for us and how we can be an inclusive and safe workplace.

- ✓ The Trust aim is to be recognised as a LGBT Employer on the Stonewall listing of LGBT Friendly employers.

**The Trust Fairness Champions**
**An update from Lisa Smith, Freedom to Speak up / Safer Working Guardian**.

Throughout summer 2017 the Guardian of Safe Working led a Trust-wide recruitment campaign to develop a network of volunteer 'Fairness Champions'.

The role of a Champion is to support the freedom to speak up agenda, help us to promote fairness, raise concerns and challenge behaviour which is inconsistent with the Trust values.

During 2017 34 new Fairness Champions were recruited. It is hoped these roles will play a key part in tackling some of the issues broached in the 2017 staff survey.

The front page of the Trust's 'Staff Matters' publication helped to raise the profile of Champions and dedicated pages were set up on the Trust intranet so that staff could learn a little more about each individual Fairness Champion before making contact.


Fairness Champions were invited to attend the Fairness Champion Steering Group which feeds in to the Fairness Forum (which in turn

reports to the Workforce & Organisational Development Committee). This gives Champions the opportunity to comment directly on policy reviews such as the most recent version of the bullying and harassment policy.

In order to develop and support Fairness Champions, the network has linked with the Organisational Development and Improvement Learning team to secure role-specific 'foundations in conversations', 'introduction to coaching skills' training and sessions on 'mental health and wellbeing' from the Trust's Centre for Occupational Health and Wellbeing. Sessions have taken place on 'unconscious bias'.

- ✓ Champions had a face-to-face presence at each of the Staff Benefits and Wellbeing Fairs to raise awareness of the support available. At the York Hospital fair over 400 leaflets describing "who we are and what we do" were taken and the conversations had with staff were overwhelmingly positive.

➢ Looking forward

- ✓ As well as assisting staff with their individual concerns, throughout July 2018 Fairness Champions will be supporting several departmental "listening exercises" across the Trust.

- ✓ The 2018 recruitment campaign began in June to further enhance the diversity of the network.

- ✓ Further updates on equality and diversity plus peer mentoring sessions are scheduled for the Fairness Champions throughout the coming year.

**Trade Unions / Staff Representatives**

We continue to work in partnership with our trade unions and staff representatives in the on-going development of policies and procedures to ensure fairness and equality in our people management processes. We are also grateful for the practical support of resources for our staff support groups to promote awareness of issues such as bullying and harassment

Working in partnership with other health and social care organisations and third sector organisations (including non-profit making organisations or associations, charities, community groups etc.) enables the Trust to

understand how to affect change effectively making best use of resources available.

Healthwatch York values the opportunity to continue passing on issues raised by the public to the Trust Fairness Forum.

With the help of the Forum Healthwatch York was able to contribute into the production of ‘Getting Things Changed’ a report based on Reasonably Adjusting Hospital Services published by the University of Bristol.

Healthwatch York looks forward to continuing working with the Forum in the future.

Healthwatch York 2018

# 3. Our Achievements

This year, many of our achievements are covered throughout the report; further achievements include;

- ✓ In November 2017, The Trust held a EDS2 stakeholder event and were graded overall as amber against the EDS2 goal, 'better health outcomes', this was determined by stakeholders as an improving picture with positive steps made by the Trust since the previous stakeholder event.

- ✓ The Trust are working with stakeholders to refine the EDS2 action plan and will communicate progress on a regular basis, with a view to holding the next face to face event in 2019.

In early March 2018, the Trust published its Gender Pay Gap reporting in line with the legislative requirements ahead of the 31st March deadline which can be found at https://www.yorkhospitals.nhs.uk/about-us/equality-and-diversity/gender-pay-gap/

- ✓ During the last quarter of 2017, the Trust developed and ratified through the Fairness Forum and the Trust negotiating bodies a new Equality Impact Assessment toolkit to support managers who are implementing a new policy or service.

**Mental Health Awareness**

The Trust has a well-established Mental Health Working Group which supports the overall Health and Wellbeing of our workforce. The Mental Health Working Group is chaired by a Clinical Psychologist (Lead for Psychological Wellbeing) and has a clear strategy and annual action plan. Achievements in 2017/18 include:

- ✓ The development and implementation of a number of new training courses and wellbeing workshops including Managing Mental Health in the Workplace; Sleep and Relaxation workshops; Resilience workshops

- ✓ Undertaking a tender process to procure a new Employee Assistance Provider, Health Assured

- ✓ Establishing Schwartz Rounds which have had very positive feedback and are scheduled throughout the forthcoming year

- ✓ Developing online resources for managers including an Individual Stress Risk Assessment video on the intranet

- ✓ Developing self-help toolkits and booklets for staff who are experiencing mental ill health

- ✓ Ongoing work with the Trust's newly established network of Fairness Champions to enhance mental health knowledge and signposting

- ✓ Sustained Occupational Health-based services for staff who experience mental ill health including cognitive behavioural therapy and Wellbeing Resilience Action Plans (WRAPs)

- ✓ The Trust continues to be a signatory to the Mindful Employer Charter.

- ➢ **Looking forward**

- ✓ Interventions planned for the near future include the roll out of a Trauma Risk Management based training model to support staff who may have experienced trauma at work (such as a never event, Serious Incident, traumatic emergency case or such like) and further roll out of Stress Audits to be offered to teams/Directorates with high mental health absences.

**Disability Confident**

- ✓ As a Trust we successfully attained the disability confident employer status in October 2017. Through the Trust Fairness Forum a review is being undertaken of the actions which should be focused on in both the short and long term to ensure that The Trust maintains this important status.

**Arts Team**

- ✓ The Arts Team show exhibitions from all people across our communities including staff at all levels in the organisation, amateur artists, community groups, patients and professionals.

- ✓ The theme of the exhibitions have included 'what does the human genome mean to you?' The Trust has showcased 6 of York's heroes, from those commended for their commitment to fundraising and kindness to those doing excellent work with care and dementia awareness. Previously we have exhibited work with links to autism and Down syndrome.

- ✓ The Arts team participation programme has supported people affected by Cancer (including family and carers); patients in York

and Easingwold Renal units; patients in an elderly ward in Bridlington.

- ✓ The music programme supports everyone, from the volunteers musicians (students, amateurs, professionals) to the patients, visitors and staff who engage with performances on corridors and wards – in York, Scarborough and Malton hospitals.

- ✓ The environment projects focus on improving the environment through artistic enhancement, where accessible artwork and input from all levels is considered.

**Policy developments**

- ✓ We have developed a suite of documents in respect of assistance and therapy dogs; this aims to provide information regarding Pets as Therapy dogs coming in to the hospital and to give guidance and support for staff with for example hearing or guide dogs. This is currently going through our usual consultation channels.

- ✓ The Trust launched a revised Sickness Absence Policy in October 2017 applicable to all A4C staff. The new policy was developed in partnership with our Trade Union Partners. One of the key changes was a greater emphasis on early support mechanisms for employees.

- ✓ To reflect these changes a renewed management training package was developed and rolled out from April 2018.

- ✓ Trust absence rates have continually improved since January 2018.

➢ Looking forward

- ✓ HR will continue to work with our Trade Union Partners to review and amend as appropriate elements of the policy guidance where appropriate rather than wait until the formal review date.

**York Human Rights City**

- ✓ In March 2017 the Trust Board signalled intent to sign up to the York City of Human Rights. A project founded by the Joseph Rowntree Charitable Trust, the Joseph Rowntree Foundation and the Economic and Social Research Council which aims to make York the UK's first Human Rights City.

# 4. Our Progress against the Equality Objectives

In 2016 as a Trust we determined as we could identify that there was still work to do against our published objectives that these should remain largely unchanged for the 5 year forward. Equality and Diversity is firmly embedded within the Workforce Strategy and led by the acting director of workforce. There is recognition of the intrinsic link between staff experience and patient experience.

The chart below represents the work on our objectives current at the time of writing this report.

| Objective | | Progress |
|---|---|---|
| 1 | Improve data collection, analysis and monitoring of protected characteristics | • Continued awareness raising of the importance of recording protected characteristics<br>• Continued move towards a self-service model of electronic staff records (ESR) making it easier and more discreet for staff to update their own records |
| 2 | Further develop engagement and involvement of patients, carers, governors and staff to reflect local demographics | • Patient stories of experiences with the Trust included at Board Meetings and other staff forums.<br>• Continued promotion of Friends and Family Test.<br>• Revised policy and procedure on concerns and complaints taking into account feedback from patients and staff enabling a more patient-centred focus<br>• Sign up to John's campaign involved engagement with patients and their carers which is responsive to their individual needs. |
| 3 | Develop strong partnerships with social care and GP's to ensure patient pathways are free from barriers between providers for everyone | • Continued development of partnership work with local councils and Health and Well Being Boards<br>• Representative member of the three Healthwatch in our area attends the Fairness Forum<br>• Continued work with local provider /commissioner NHS organisations to assess equality progress against the NHS Equality Delivery Framework.<br>• Member of York Fairness and Equalities Board (FEB), York Equalities Network, York Human Rights City steering Group |
| 4 | Continue the Board of Directors and senior management development programme ensuring equality and diversity is embedded into all decision making processes leading to active promotion of good relations | • Development of an Equality Impact Assessment toolkit which has been ratified by the Fairness Forum and Trust negotiating bodies. |

# 5. Our Challenges and Future Developments

We recognise that a number of the future challenges some of which are outlined below have significant external influences these will be reflected in our forward planning and detailed action plans for 2017/18 and beyond.

- ✓ As a Trust, we will continue the development of our staff and services to meet the requirements under the accessible information standard, this will include looking at a wide range of methods to deliver interpretation and translation services.

- ✓ Following feedback from the EDS2 stakeholder group, the Trust will be assessing its E&D training provision to see how it aligns with local issues and review their recommendation for the training to become mandatory for all staff.

- ✓ The Trust has committed to rolling out training to support the updated Equality Impact Assessment Toolkit to managers across the Trust in the coming months.

- ✓ Since the migration to the disability confident scheme from ‘two ticks’ in 2016; the Trust successfully undertook its first self-assessment in the last quarter of 2017 and will hold the disability confident employer status for a 2 year period; during this time it is our aspiration to become a disability confident leader which is the highest level which can be attained under the revised scheme.

- ✓ During 2018, the Trust will continue to build on the success of the Fairness Champion recruitment during 2017 by undertaking a rolling program of recruitment and development of Fairness Champions across the Trust area

- ✓ The Trust will begin preparation for the introduction of the Workforce Disability Equality Standard (WDES) which is scheduled for the autumn 2018.

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# 6: Appendices

## Appendix A Demographics for the local population by Protected Characteristic

This has been taken from the Office of National Statistics website https://www.nomisweb.co.uk/ 2011 Census data based on the seven constituencies and specific constituency wards as per the Trust constitution. Data for disability, gender reassignment, pregnancy and maternity and sexual orientation is not available from this source.

## Demographics for the Local Population - Age

| Age | Bridlington | | Hambleton | | Ryedale and East Yorkshire | | Scarborough | | Selby | | Whitby | | York | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | number | % | number | % | Number | % | number | % | number | % | number | % | number | % | number | % |
| Age 0 to 4 | 3,185 | 4.7 | 867 | 5.0 | 7,393 | 4.8 | 4,274 | 5.1 | 4,875 | 5.8 | 1,043 | 4.2 | 10,960 | 5.4 | 32,597 | 5.1 |
| Age 5 to 7 | 1,917 | 2.8 | 562 | 3.3 | 4,557 | 2.9 | 2,405 | 2.9 | 2,741 | 3.3 | 687 | 2.7 | 5,971 | 2.9 | 18,840 | 3.0 |
| Age 8 to 9 | 1,228 | 1.8 | 398 | 2.3 | 2,873 | 1.8 | 1,553 | 1.9 | 1,818 | 2.2 | 426 | 1.7 | 3,770 | 1.8 | 12,066 | 1.9 |
| Age 10 to 14 | 3,588 | 5.3 | 1,081 | 6.3 | 8,647 | 5.6 | 4,429 | 5.3 | 4,852 | 5.8 | 1,289 | 5.1 | 10,261 | 5.0 | 34,147 | 5.4 |
| Age 15 | 825 | 1.2 | 224 | 1.3 | 1,954 | 1.3 | 981 | 1.2 | 1,028 | 1.2 | 304 | 1.2 | 2,202 | 1.1 | 7,518 | 1.2 |
| Age 16 to 17 | 1,571 | 2.3 | 442 | 2.6 | 3,904 | 2.5 | 1,971 | 2.4 | 2,167 | 2.6 | 568 | 2.3 | 4,528 | 2.2 | 15,151 | 2.4 |
| Age 18 to 19 | 1,465 | 2.1 | 366 | 2.1 | 3,241 | 2.1 | 2,211 | 2.6 | 1,812 | 2.2 | 505 | 2.0 | 8,095 | 4.0 | 17,695 | 2.8 |
| Age 20 to 24 | 3,040 | 4.4 | 708 | 4.1 | 6,690 | 4.3 | 5,098 | 6.1 | 4,453 | 5.3 | 1,170 | 4.7 | 19,992 | 9.8 | 41,151 | 6.5 |
| Age 25 to 29 | 2,973 | 4.4 | 651 | 3.8 | 6,597 | 4.2 | 4,262 | 5.1 | 4,346 | 5.2 | 1,105 | 4.4 | 14,355 | 7.0 | 34,289 | 5.4 |
| Age 30 to 44 | 11,098 | 16.2 | 2,936 | 17.0 | 26,366 | 17.0 | 13,594 | 16.2 | 16,589 | 19.9 | 3,697 | 14.7 | 39,866 | 19.5 | 114,146 | 17.9 |
| Age 45 to 59 | 14,158 | 20.7 | 4,092 | 23.7 | 33,591 | 21.6 | 17,242 | 20.6 | 18,761 | 22.5 | 5,939 | 23.7 | 37,948 | 18.5 | 131,731 | 20.7 |
| Age 60 to 64 | 5,962 | 8.7 | 1,300 | 7.5 | 13,281 | 8.6 | 6,378 | 7.6 | 6,001 | 7.2 | 2,342 | 9.3 | 12,209 | 6.0 | 47,473 | 7.4 |
| Age 65 to 74 | 9,567 | 14.0 | 2,003 | 11.6 | 19,818 | 12.8 | 10,111 | 12.1 | 7,702 | 9.2 | 3,200 | 12.8 | 17,572 | 8.6 | 69,973 | 11.0 |
| Age 75 to 84 | 5,506 | 8.1 | 1,170 | 6.8 | 11,761 | 7.6 | 6,509 | 7.8 | 4,554 | 5.5 | 2,025 | 8.1 | 11,909 | 5.8 | 43,434 | 6.8 |
| Age 85 to 89 | 1,491 | 2.2 | 300 | 1.7 | 3,066 | 2.0 | 1,741 | 2.1 | 1,147 | 1.4 | 518 | 2.1 | 3,282 | 1.6 | 11,545 | 1.8 |
| Age 90 and over | 758 | 1.1 | 148 | 0.9 | 1,561 | 1.0 | 940 | 1.1 | 603 | 0.7 | 276 | 1.1 | 1,694 | 0.8 | 5,980 | 0.9 |

## Demographics for the Local Population - Gender

| | Bridlington | | Hambleton | | Ryedale and East Yorkshire | | Scarborough | | Selby | | Whitby | | York | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Gender** | **Number** | % | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| All persons | 68,332 | 100.0 | 17,248 | 100.0 | 86,968 | 100.0 | 83,699 | 100.0 | 83,449 | 100.0 | 25,094 | 100.0 | 204,614 | 100.0 | 569,404 | 100.0 |
| Males | 33,051 | 48.4 | 8,403 | 48.7 | 42,880 | 49.3 | 40,343 | 48.2 | 40,947 | 49.1 | 12,227 | 48.7 | 99,555 | 48.7 | 277,406 | 48.7 |
| Females | 35,281 | 51.6 | 8,845 | 51.3 | 44,088 | 50.7 | 43,356 | 51.8 | 42,502 | 50.9 | 12,867 | 51.3 | 105,059 | 51.3 | 291,998 | 51.3 |

## Demographics for the Local Population - Ethnic Group

| **Ethnic Group** | **Bridlington** | | **Hambleton** | | **Ryedale and East Yorkshire** | | **Scarborough** | | **Selby** | | **Whitby** | | **York** | | **Total** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **number** | **%** | **number** | **%** | **number** | **%** | **number** | **%** | **number** | **%** | **number** | **%** | **number** | **%** | **number** | **%** |
| All usual residents | 68,332 | 100.0 | 17,248 | 100.0 | 86,968 | 100.0 | 83,699 | 100.0 | 83,449 | 100 | 25,094 | 100.0 | 204,614 | 100.0 | 569,404 | 100.0 |
| White: English/Welsh/Scottish/Northern Irish/British | 66,513 | 97.3 | 16,741 | 97.1 | 83,682 | 96.2 | 79,232 | 94.7 | 79,686 | 95.5 | 24,393 | 97.2 | 184,635 | 90.2 | 534,882 | 93.9 |
| White: Irish | 194 | 0.3 | 60 | 0.3 | 382 | 0.4 | 232 | 0.3 | 326 | 0.4 | 69 | 0.3 | 1,131 | 0.6 | 2,394 | 0.4 |
| White: Gypsy or Irish Traveller | 49 | 0.1 | 11 | 0.1 | 95 | 0.1 | 30 | 0.0 | 158 | 0.2 | 7 | 0.0 | 300 | 0.1 | 650 | 0.1 |
| White: Other White | 736 | 1.1 | 234 | 1.4 | 1,468 | 1.7 | 1,851 | 2.2 | 1,907 | 2.3 | 290 | 1.2 | 6,922 | 3.4 | 13,408 | 2.4 |
| Mixed/multiple ethnic groups: White and Black Caribbean | 152 | 0.2 | 16 | 0.1 | 149 | 0.2 | 198 | 0.2 | 190 | 0.2 | 30 | 0.1 | 544 | 0.3 | 1,279 | 0.2 |
| Mixed/multiple ethnic groups: White and Black African | 44 | 0.1 | 22 | 0.1 | 83 | 0.1 | 95 | 0.1 | 50 | 0.1 | 14 | 0.1 | 312 | 0.2 | 620 | 0.1 |
| Mixed/multiple ethnic groups: White and Asian | 119 | 0.2 | 29 | 0.2 | 189 | 0.2 | 260 | 0.3 | 271 | 0.3 | 64 | 0.3 | 889 | 0.4 | 1,821 | 0.3 |
| Mixed/multiple ethnic groups: Other Mixed | 81 | 0.1 | 24 | 0.1 | 128 | 0.1 | 171 | 0.2 | 115 | 0.1 | 37 | 0.1 | 719 | 0.4 | 1,275 | 0.2 |
| Asian/Asian British: Indian | 96 | 0.1 | 21 | 0.1 | 94 | 0.1 | 370 | 0.4 | 175 | 0.2 | 13 | 0.1 | 1,540 | 0.8 | 2,309 | 0.4 |
| Asian/Asian British: Pakistani | 9 | 0.0 | 5 | 0.0 | 42 | 0.0 | 114 | 0.1 | 17 | 0 | 55 | 0.2 | 419 | 0.2 | 661 | 0.1 |
| Asian/Asian British: Bangladeshi | 4 | 0.0 | 2 | 0.0 | 29 | 0.0 | 96 | 0.1 | 2 | 0 | 13 | 0.1 | 370 | 0.2 | 516 | 0.1 |
| Asian/Asian British: Chinese | 97 | 0.1 | 18 | 0.1 | 158 | 0.2 | 247 | 0.3 | 170 | 0.2 | 40 | 0.2 | 2,623 | 1.3 | 3,353 | 0.6 |
| Asian/Asian British: Other Asian | 117 | 0.2 | 30 | 0.2 | 198 | 0.2 | 386 | 0.5 | 129 | 0.2 | 30 | 0.1 | 2,001 | 1.0 | 2,891 | 0.5 |
| Black/African/Caribbean/Black British: African | 42 | 0.1 | 19 | 0.1 | 112 | 0.1 | 165 | 0.2 | 170 | 0.2 | 11 | 0.0 | 912 | 0.4 | 1,431 | 0.3 |
| Black/African/Caribbean/Black British: Caribbean | 25 | 0.0 | 3 | 0.0 | 59 | 0.1 | 47 | 0.1 | 33 | 0 | 4 | 0.0 | 209 | 0.1 | 380 | 0.1 |
| Black/African/Caribbean/Black British: Other Black | 7 | 0.0 | 0 | 0.0 | 22 | 0.0 | 11 | 0.0 | 9 | 0 | 2 | 0.0 | 92 | 0.0 | 143 | 0.0 |
| Other ethnic group: Arab | 27 | 0.0 | 8 | 0.0 | 30 | 0.0 | 109 | 0.1 | 9 | 0 | 14 | 0.1 | 500 | 0.2 | 697 | 0.1 |
| Other ethnic group: Any other ethnic group | 20 | 0.0 | 5 | 0.0 | 48 | 0.1 | 85 | 0.1 | 32 | 0 | 8 | 0.0 | 496 | 0.2 | 694 | 0.1 |

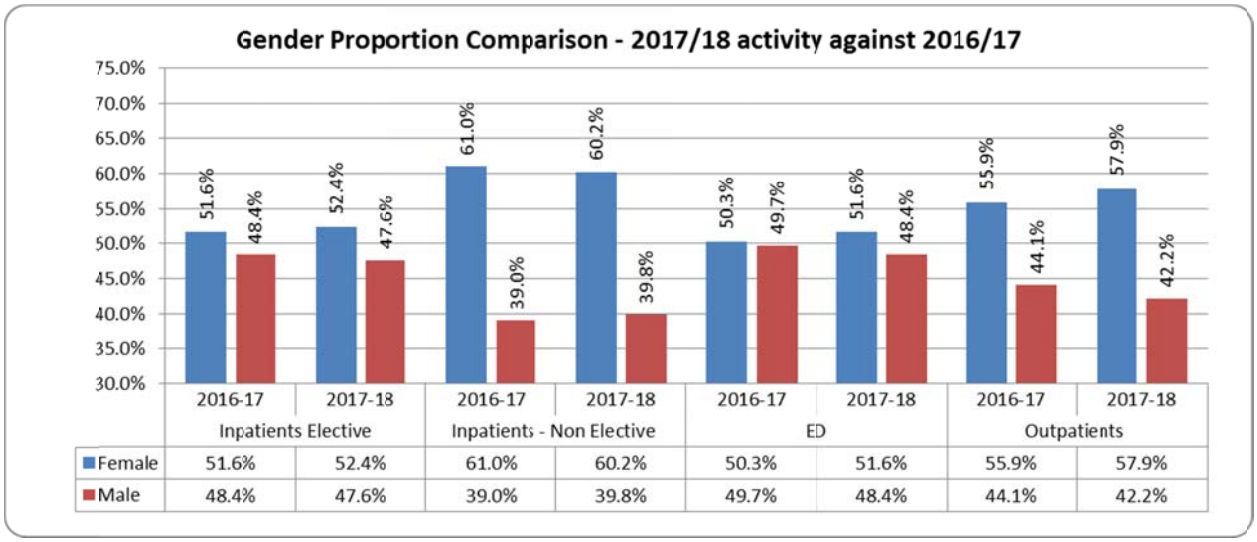
# Demographics for the Local Population - Marital Status

| Marital Status | Bridlington | | Hambleton | | Ryedale and East Yorkshire | | Scarborough | | Selby | | Whitby | | York | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | number | % | number | % | number | % | number | % | number | % | number | % | number | % | number | % |
| All usual residents aged 16+ | 57,589 | 100.0 | 14,116 | 100.0 | 72,287 | 100.0 | 70,057 | 100.0 | 68,135 | 100 | 21,345 | 100 | 171,450 | 100.0 | 474,979 | 100.0 |
| Single (never married or never registered a same-sex civil partnership) | 14,766 | 25.6 | 3,269 | 23.2 | 18,082 | 25.0 | 20,558 | 29.3 | 18,088 | 26.5 | 5,569 | 26.1 | 65,584 | 38.3 | 145,916 | 30.7 |
| Married | 29,952 | 52.0 | 8,239 | 58.4 | 40,306 | 55.8 | 33,417 | 47.7 | 37,705 | 55.3 | 11,075 | 51.9 | 76,206 | 44.4 | 236,900 | 49.9 |
| In a registered same-sex civil partnership | 125 | 0.2 | 26 | 0.2 | 126 | 0.2 | 161 | 0.2 | 125 | 0.2 | 56 | 0.3 | 446 | 0.3 | 1,065 | 0.2 |
| Separated (but still legally married or still legally in a same-sex civil partnership) | 1,334 | 2.3 | 301 | 2.1 | 1,549 | 2.1 | 1,846 | 2.6 | 1,618 | 2.4 | 478 | 2.2 | 3,359 | 2.0 | 10,485 | 2.2 |
| Divorced or formerly in a same-sex civil partnership which is now legally dissolved | 5,883 | 10.2 | 1,216 | 8.6 | 6,406 | 8.9 | 7,696 | 11.0 | 6,059 | 8.9 | 2,142 | 10 | 14,487 | 8.4 | 43,889 | 9.2 |
| Widowed or surviving partner from a same-sex civil partnership | 5,529 | 9.6 | 1,065 | 7.5 | 5,818 | 8.0 | 6,379 | 9.1 | 4,540 | 6.7 | 2,025 | 9.5 | 11,368 | 6.6 | 36,724 | 7.7 |

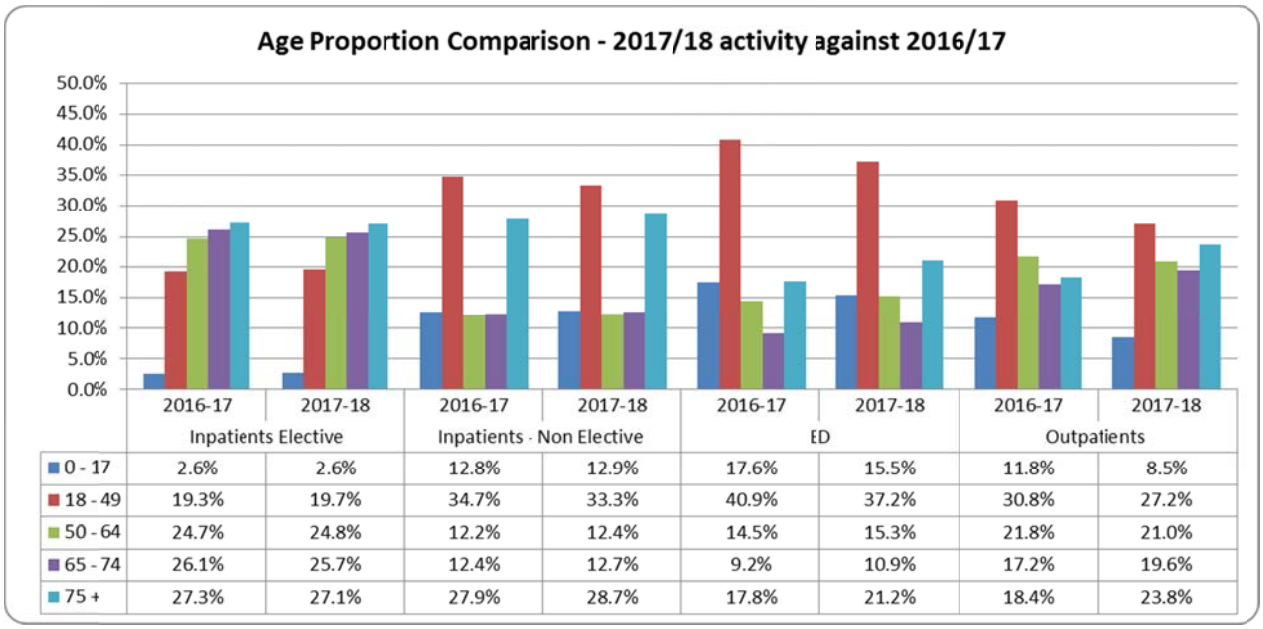
# Demographics for the Local Population - Religion / Belief

| | Bridlington | | Hambleton | | Ryedale and East Yorkshire | | Scarborough | | Selby | | Whitby | | York | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | number | % | number | % | number | % | number | % | number | % | number | % | number | % | number | % |
| All categories: Religion | 68,332 | 100.0 | 17,248 | 100.0 | 86,968 | 100.0 | 83,699 | 100.0 | 83,449 | 100.0 | 25,094 | 100.0 | 204,614 | 100.0 | 569,404 | 100.0 |
| Christian | 46,646 | 68.3 | 12,527 | 72.6 | 61,679 | 70.9 | 54,731 | 65.4 | 59,182 | 70.9 | 17,813 | 71.0 | 122,461 | 59.8 | 375,039 | 65.9 |
| Buddhist | 129 | 0.2 | 27 | 0.2 | 241 | 0.3 | 243 | 0.3 | 133 | 0.2 | 52 | 0.2 | 1,057 | 0.5 | 1,882 | 0.3 |
| Hindu | 37 | 0.1 | 10 | 0.1 | 58 | 0.1 | 156 | 0.2 | 87 | 0.1 | 11 | 0.0 | 988 | 0.5 | 1,347 | 0.2 |
| Jewish | 30 | 0.0 | 10 | 0.1 | 38 | 0.0 | 54 | 0.1 | 60 | 0.1 | 13 | 0.1 | 213 | 0.1 | 418 | 0.1 |
| Muslim | 94 | 0.1 | 23 | 0.1 | 216 | 0.2 | 476 | 0.6 | 95 | 0.1 | 75 | 0.3 | 2,100 | 1.0 | 3,079 | 0.5 |
| Sikh | 22 | 0.0 | 0 | 0.0 | 12 | 0.0 | 7 | 0.0 | 51 | 0.1 | 1 | 0.0 | 134 | 0.1 | 227 | 0.0 |
| Other religion | 219 | 0.3 | 50 | 0.3 | 294 | 0.3 | 292 | 0.3 | 206 | 0.2 | 110 | 0.4 | 755 | 0.4 | 1,926 | 0.3 |
| No religion | 16,047 | 23.5 | 3,360 | 19.5 | 18,098 | 20.8 | 21,519 | 25.7 | 18,070 | 21.7 | 5,146 | 20.5 | 61,070 | 29.8 | 143,310 | 25.2 |
| Religion not stated | 5,108 | 7.5 | 1,241 | 7.2 | 6,332 | 7.3 | 6,221 | 7.4 | 5,565 | 6.7 | 1,873 | 7.5 | 15,836 | 7.7 | 42,176 | 7.4 |

# Appendix B: Trust Activity Statistics




| | Inpatients Elective | | Inpatients - Non Elective | | ED | | Outpatients | |
|---|---|---|---|---|---|---|---|---|
| | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 |
| Female | 51.6% | 52.4% | 61.0% | 60.2% | 50.3% | 51.6% | 55.9% | 57.9% |
| Male | 48.4% | 47.6% | 39.0% | 39.8% | 49.7% | 48.4% | 44.1% | 42.2% |




| | Inpatients Elective | | Inpatients - Non Elective | | ED | | Outpatients | |
|---|---|---|---|---|---|---|---|---|
| | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 |
| 0 - 17 | 2.6% | 2.6% | 12.8% | 12.9% | 17.6% | 15.5% | 11.8% | 8.5% |
| 18 - 49 | 19.3% | 19.7% | 34.7% | 33.3% | 40.9% | 37.2% | 30.8% | 27.2% |
| 50 - 64 | 24.7% | 24.8% | 12.2% | 12.4% | 14.5% | 15.3% | 21.8% | 21.0% |
| 65 - 74 | 26.1% | 25.7% | 12.4% | 12.7% | 9.2% | 10.9% | 17.2% | 19.6% |
| 75 + | 27.3% | 27.1% | 27.9% | 28.7% | 17.8% | 21.2% | 18.4% | 23.8% |

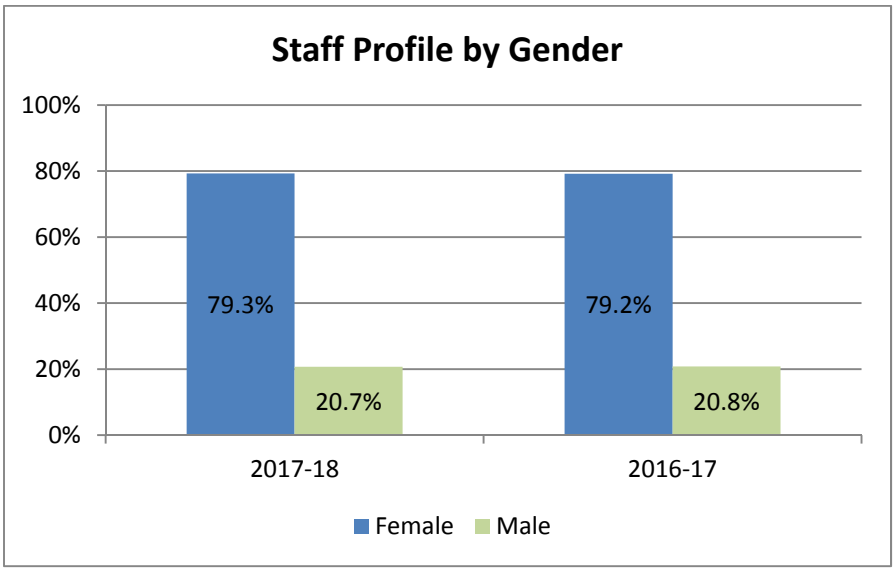
# Activity and Proportion Breakdown by Patient Ethnicity

| Ethnicity | Inpatients Elective | | Inpatients - Non Elective | | ED | | Outpatients | |
|---|---|---|---|---|---|---|---|---|
| | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 |
| African | 63 | 45 | 73 | 91 | 64 | 86 | 241 | 597 |
| Any other Asian background | 89 | 60 | 153 | 149 | 113 | 128 | 458 | 1280 |
| Any other Black background | 12 | 35 | 13 | 17 | 14 | 15 | 75 | 189 |
| Any other White background | 5226 | 5429 | 4503 | 4607 | 7772 | 8140 | 774 | 69329 |
| Any other ethnic group | 130 | 148 | 144 | 151 | 175 | 271 | 398 | 1779 |
| Any other mixed background | 49 | 63 | 102 | 80 | 140 | 135 | 21671 | 791 |
| Bangladeshi | 47 | 51 | 55 | 107 | 70 | 97 | 274 | 877 |
| British | 64558 | 62098 | 55145 | 54135 | 68083 | 77137 | 245058 | 594788 |
| Caribbean | 15 | 17 | 9 | 28 | 23 | 32 | 85 | 269 |
| Chinese | 114 | 119 | 124 | 139 | 98 | 117 | 479 | 1256 |
| Indian | 100 | 120 | 170 | 171 | 148 | 173 | 648 | 1639 |
| Irish | 244 | 246 | 196 | 193 | 234 | 258 | 784 | 2185 |
| Not stated | 3608 | 3429 | 2577 | 2968 | 5071 | 6642 | 95639 | 51937 |
| Pakistani | 41 | 35 | 65 | 59 | 93 | 61 | 221 | 401 |
| Unknown | 5996 | 6914 | 8271 | 10078 | 26931 | 31980 | 0 | 131836 |
| White and Asian | 81 | 67 | 103 | 104 | 124 | 125 | 422 | 992 |
| White and Black African | 44 | 14 | 49 | 43 | 73 | 64 | 222 | 394 |
| White and Black Caribbean | 55 | 63 | 74 | 69 | 98 | 97 | 272 | 550 |
| **Grand Total** | **80472** | **78953** | **71826** | **73189** | **109324** | **125558** | **367721** | **861089** |

| Ethnicity | Inpatients Elective | | Inpatients - Non Elective | | ED | | Outpatients | |
|---|---|---|---|---|---|---|---|---|
| | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 |
| African | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% |
| Any other Asian background | 0.1% | 0.1% | 0.2% | 0.2% | 0.1% | 0.1% | 0.1% | 0.1% |
| Any other Black background | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Any other ethnic group | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | 0.1% | 0.2% |
| Any other mixed background | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 5.9% | 0.1% |
| Any other White background | 6.5% | 6.9% | 6.3% | 6.3% | 7.1% | 6.5% | 0.2% | 8.1% |
| Bangladeshi | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% |
| British | 80.2% | 78.7% | 76.8% | 74.0% | 62.3% | 61.4% | 66.6% | 69.1% |
| Caribbean | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Chinese | 0.1% | 0.2% | 0.2% | 0.2% | 0.1% | 0.1% | 0.1% | 0.1% |
| Indian | 0.1% | 0.2% | 0.2% | 0.2% | 0.1% | 0.1% | 0.2% | 0.2% |
| Irish | 0.3% | 0.3% | 0.3% | 0.3% | 0.2% | 0.2% | 0.2% | 0.3% |
| Not stated | 4.5% | 4.3% | 3.6% | 4.1% | 4.6% | 5.3% | 26.0% | 6.0% |
| Pakistani | 0.1% | 0.0% | 0.1% | 0.1% | 0.1% | 0.0% | 0.1% | 0.0% |
| Unknown | 7.5% | 8.8% | 11.5% | 13.8% | 24.6% | 25.5% | 0.0% | 15.3% |
| White and Asian | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% |
| White and Black African | 0.1% | 0.0% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.0% |
| White and Black Caribbean | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% |

## Appendix C - Our Workforce

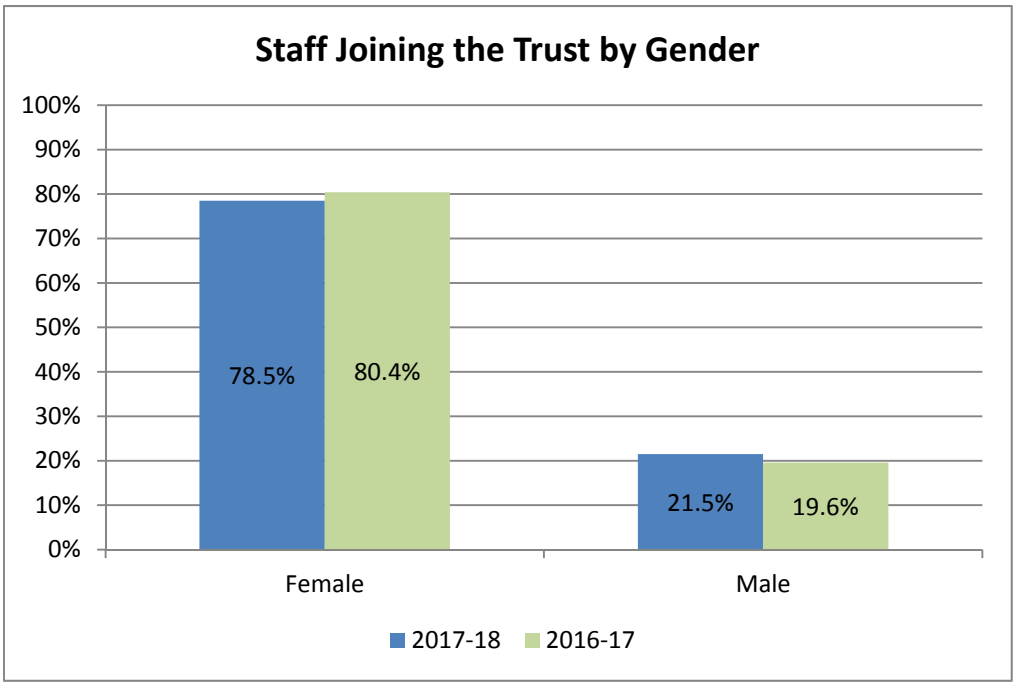
## Figure 1: Staff Profile by gender, 2017-2018 and 2016-2017




## Table 1: York Teaching Hospitals Foundation Trust staff profile by gender, 2017-2018 and 2016-2017

| *Gender* | *Number of staff March 2018* | *% total staff March 2018* | *Number of staff part time 2018* | *Number of staff full time 2018* | *Number of staff March 2017* | *% total staff March 2017* | *Number of staff part time 2017* | *Number of staff full time 2017* |
|---|---|---|---|---|---|---|---|---|
| Female | 6,966 | 79.3 | 3,669 | 3,297 | 6,834 | 79.2 | 3,565 | 3,269 |
| Male | 1,821 | 20.7 | 362 | 1,459 | 1,796 | 20.8 | 340 | 1,456 |
| Total | 8,787 | | 4,031 | 4,756 | 8,630 | | 3,905 | 4,725 |

## Figure 2: Staff joining the Trust by Gender, 2017-2018 and 2016-2017

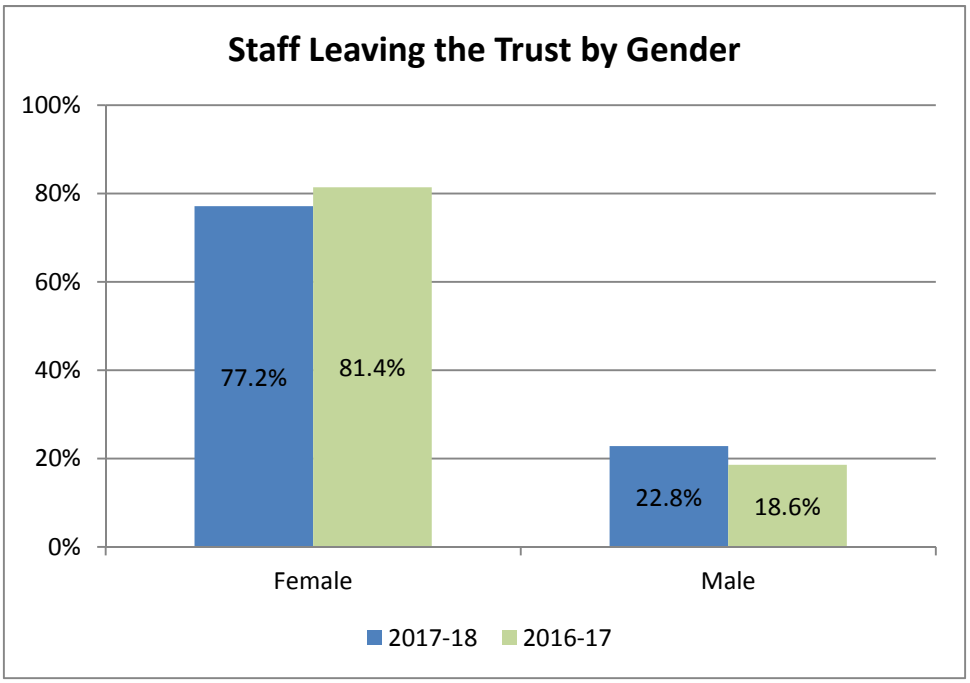



## Table 2 - Staff joining York Teaching Hospitals Foundation Trust from 1 April 2017 to 31 March 2018 by gender

| | Total new staff during the year | % of new staff during the year | % total staff at 31 March 2018 | % new staff previous year |
|---|---|---|---|---|
| Gender | | | | |
| Female | 909 | 78.5 | 79.3 | 80.4 |
| Male | 249 | 21.5 | 20.7 | 19.6 |
| Total | 1,158 | | | |

Note – all data here excludes Rotational Doctors

## Figure 3: Staff Leaving the Trust by Gender, 2017-2018 and 2016-2017



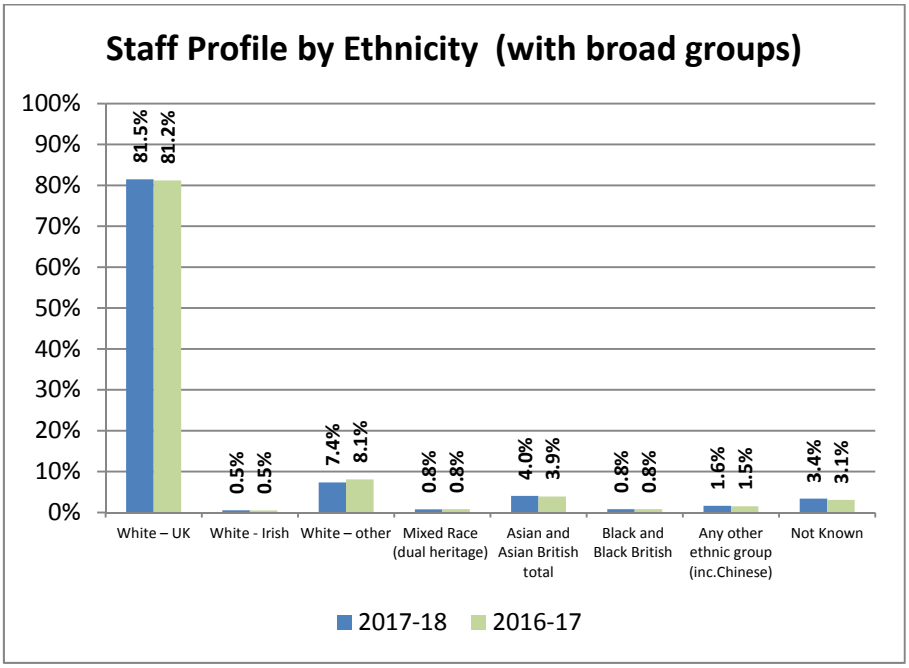

## Table 3 - Staff leaving York Teaching Hospitals Foundation Trust 1 April 2017 to 31 March 2018 by gender

| Publishable data – no category <10 | Total number of staff leaving Trust | % staff leaving | % total staff | % staff leaving in previous year |
|---|---|---|---|---|
| Gender | | | | |
| Female | 726 | 77.2 | 79.3 | 81.4 |
| Male | 215 | 22.8 | 20.7 | 18.6 |
| Total | 941 | | | |

## Table 4: Pay grade by gender, 2018

| | Description of band | Pay Range (A4C Pay bands - 1 April 2017 to 31 Mar 2018) | Female | % Female staff in this pay band | Male | % male staff in this pay band | Total | % total staff in this pay band |
|---|---|---|---|---|---|---|---|---|
| Band 1 | Cooks, Domestics Assistants | £15,404 - £15,671 | 473 | 6.8% | 167 | 9.2% | 640 | 7.3% |
| Band 2 | Administrators, Healthcare Assistants | £15,404 - £18,157 | 1,572 | 22.6% | 302 | 16.6% | 1874 | 21.3% |
| Band 3 | Senior Admin posts, Community Healthcare Assistants | £16,968 - £19,852 | 793 | 11.4% | 177 | 9.7% | 970 | 11.0% |
| Band 4 | Officers, Craftsperson, Medical Secretary | £19,409 - £22,683 | 487 | 7.0% | 94 | 5.2% | 581 | 6.6% |
| Band 5 | Nurses, Advisors Physiotherapists, | £22,128 - £28,746 | 1,415 | 20.3% | 215 | 11.8% | 1630 | 18.6% |
| Band 6 | Managers, Sisters, Senior Roles | £26,565 - £35,577 | 1,185 | 17.0% | 183 | 10.0% | 1368 | 15.6% |
| Band 7 | Senior managers, Area Leads | £31,696 - £41,787 | 512 | 7.3% | 122 | 6.7% | 634 | 7.2% |
| Band 8a, b, c, d and 9 | Directorate Managers, Area Leads | £40,428 - £100,431 | 215 | 3.1% | 83 | 4.6% | 298 | 3.4% |
| Medical and Dental | Consultants, Specialty Doctors, Clinical Assistants | | 307 | 4.4% | 470 | 25.8% | 777 | 8.8% |
| Personal Pay scale | Apprentices, Non Exec Directors | | 7 | 0.1% | 8 | 0.4% | 15 | 0.2% |
| Total Staff | | | 6,966 | 100.0% | 1821 | 100.0% | 8787 | 100.0% |

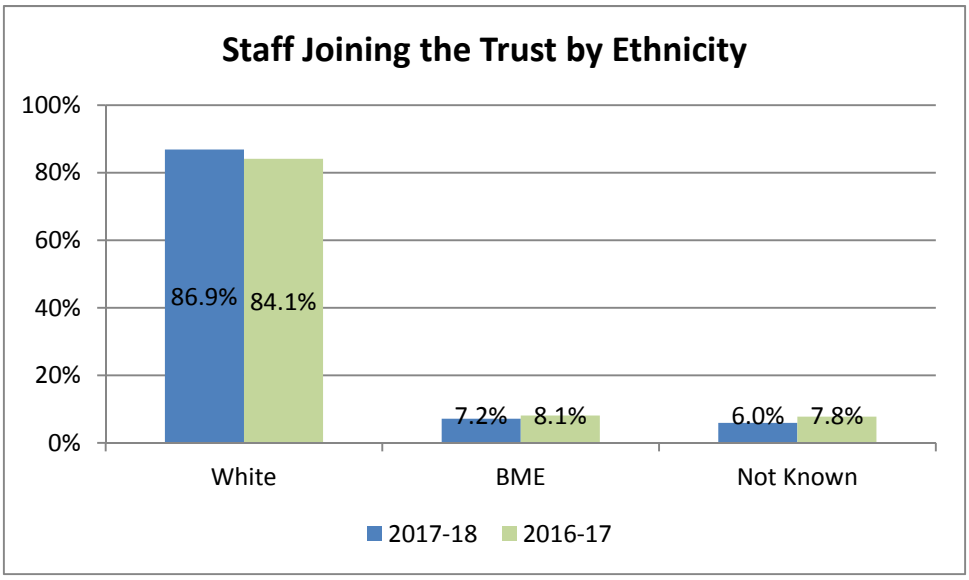
## Figure 5: Staff Profile by ethnicity, 2017-2018 and 2016-2016




## Table 5: York Teaching Hospitals Foundation Trust staff profile by ethnicity, 2017-2018 and 2016-2017

| Ethnicity | Number of staff March 2018 | % total staff March 2018 | Number of staff part time 2018 | Number of staff full time 2018 | Number of staff March 2017 | % total staff March 2017 | Number of staff part time 2017 | Number of staff full time 2017 |
|---|---|---|---|---|---|---|---|---|
| White – UK | 7,159 | 81.5 | 3,448 | 3,711 | 7,011 | 81.2 | 3,324 | 3,687 |
| White – Irish | 48 | 0.5 | 12 | 36 | 39 | 0.5 | 10 | 29 |
| White – other | 646 | 7.4 | 308 | 338 | 697 | 8.1 | 332 | 365 |
| White total | 7,853 | 89.4 | 3,768 | 4,085 | 7,747 | 89.8 | 3,666 | 4,081 |
| Mixed Race (dual heritage) total | 68 | 0.8 | 18 | 50 | 72 | 0.8 | 20 | 52 |
| Asian and Asian British total | 355 | 4.0 | 62 | 293 | 339 | 3.9 | 56 | 283 |
| Black and Black British total | 71 | 0.8 | 18 | 53 | 73 | 0.8 | 16 | 57 |
| Any other ethnic group (Inc. Chinese) | 143 | 1.6 | 24 | 119 | 129 | 1.5 | 26 | 103 |
| BME total | 637 | 7.2 | 122 | 515 | 613 | 7.1 | 118 | 495 |
| Not Known | 297 | 3.4 | 141 | 156 | 270 | 3.1 | 121 | 149 |
| Total | 8,787 | 100.0 | 4,031 | 4,756 | 8,630 | 100.0 | 3,905 | 4,725 |

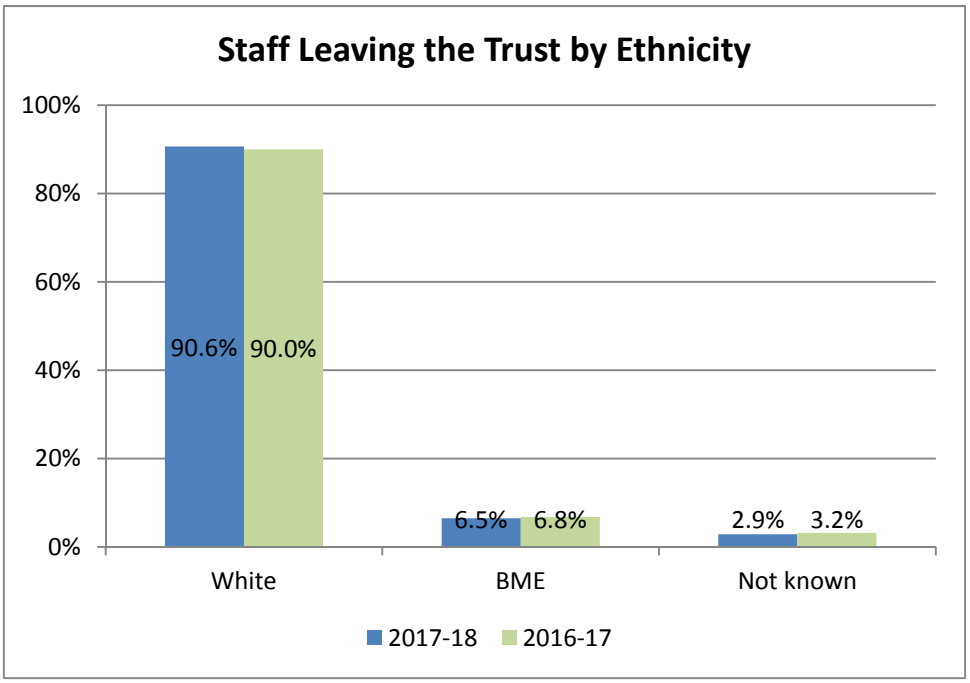
## Figure 6: Staff joining the Trust by Ethnicity, 2017-2018 and 2016-2017




## Table 6 - Staff joining the Trust from 1 April 2017 to 31 March 2018 by ethnicity

| | Total new staff during the year | % of new staff during the year | % total staff at 31 March 2018 | % new staff previous year |
|---|---|---|---|---|
| Ethnicity | | | | |
| White (including White Irish and White other) | 1,006 | 86.9 | 89.4 | 84.1 |
| Black and minority ethnic people (Black, Asian, Mixed race and any other group) | 83 | 7.2 | 7.2 | 8.1 |
| Not Known | 69 | 6.0 | 3.4 | 7.8 |
| Total | 1,158 | | | |

## Figure 7: Staff Leaving the Trust by Ethnicity, 2017-2018 and 2016-2017




## Table 7 - Staff leaving the Trust 1 April 2017 to 31 March 2018 by ethnicity

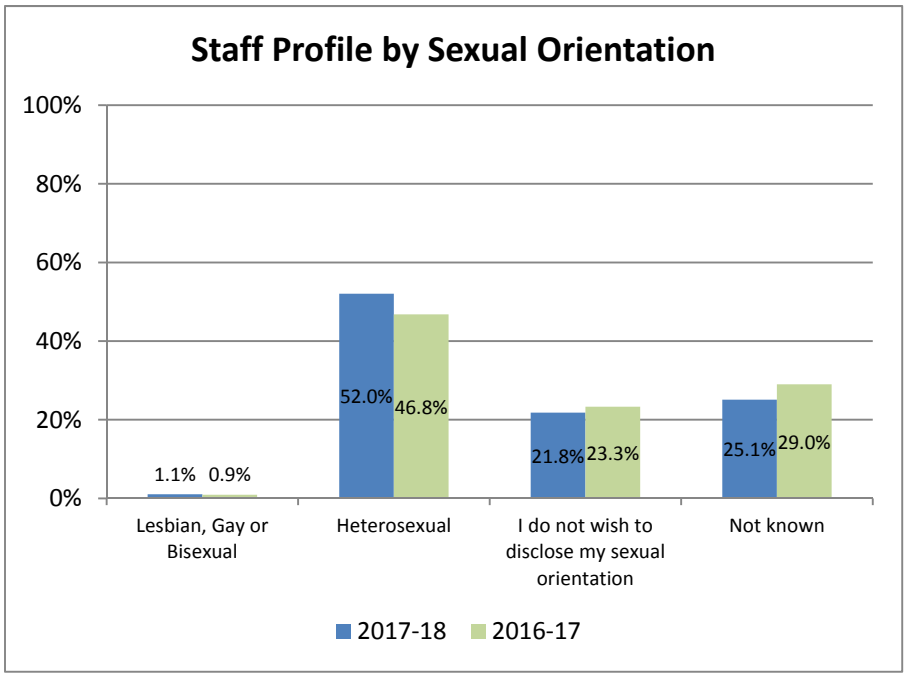
| Publishable data – no category <10 | Total number of staff leaving Trust | % staff leaving | % total staff | % staff leaving in previous year |
|---|---|---|---|---|
| Ethnicity | | | | |
| White | 853 | 90.6 | 89.4 | 90.0 |
| Black and Minority ethnic people (Black, Asian, Mixed Race and any other group) | 61 | 6.5 | 7.2 | 6.8 |
| Not known | 27 | 2.9 | 3.4 | 3.2 |
| | 941 | | | |

## Table 8: Pay band by ethnicity, 2018

| Pay band | White staff | % White staff | BME staff (e.g. mixed race, Asian and Black/Black British/Chinese) | % BME staff | Ethnicity not known | % ethnicity not known | Total staff | % total staff in this pay band |
|---|---|---|---|---|---|---|---|---|
| Band 1 | 604 | 7.7% | 21 | 3.3% | 15 | 5.1% | 640 | 7.3% |
| Band 2 | 1,721 | 21.9% | 78 | 12.2% | 75 | 25.3% | 1,874 | 21.3% |
| Band 3 | 929 | 11.8% | 14 | 2.2% | 27 | 9.1% | 970 | 11.0% |
| Band 4 | 538 | 6.9% | 29 | 4.6% | 14 | 4.7% | 581 | 6.6% |
| Band 5 | 1,376 | 17.5% | 188 | 29.5% | 66 | 22.2% | 1,630 | 18.6% |
| Band 6 | 1,278 | 16.3% | 55 | 8.6% | 35 | 11.8% | 1,368 | 15.6% |
| Band 7 | 598 | 7.6% | 19 | 3.0% | 17 | 5.7% | 634 | 7.2% |
| Band 8a, b, c, d and 9 | 289 | 3.7% | <10 | * | <10 | * | 298 | 3.4% |
| Medical and Dental | 507 | 6.5% | 225 | 35.3% | 45 | 15.2% | 777 | 8.8% |
| Personal Pay scale | 13 | 0.2% | <10 | * | <10 | * | 15 | 0.2% |
| Total Staff | 7,853 | 100.0% | 637 | 100.0% | 297 | 100.0% | 8,787 | 100.0% |

Note - * signifies percentages cannot be shown due to confidentiality issues

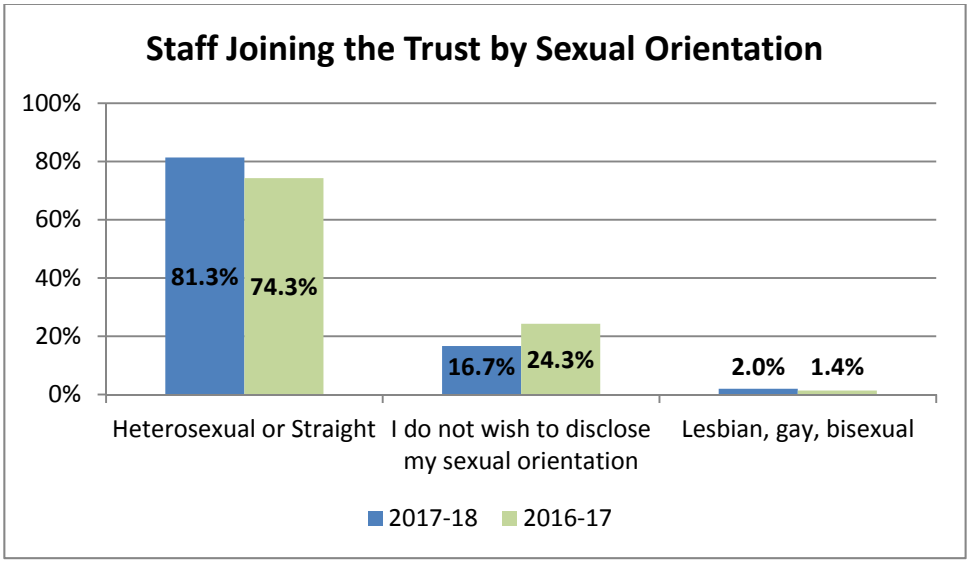
## Figure 9: Staff Profile by Sexual Orientation, 2017-2018 and 2016-2017




## Table 9: York Teaching Hospitals Foundation Trust staff profile by sexual orientation, 2017-2018 and 2016-2017

| Sexual Orientation | Number of staff March 2018 | % total staff March 2018 | Number of staff part time 2018 | Number of staff full time 2018 | Number of staff March 2017 | % total staff March 2017 | Number of staff part time 2017 | Number of staff full time 2017 |
|---|---|---|---|---|---|---|---|---|
| Lesbian, gay or Bisexual | 93 | 1.1% | To protect anonymity of staff the part / full time analysis cannot be shown here | | 78 | 0.9% | To protect anonymity of staff the part / full time analysis cannot be shown here | |
| Heterosexual | 4,573 | 52.0% | | | 4,042 | 46.8% | | |
| I do not wish to disclose my sexual orientation | 1,915 | 21.8% | | | 2,009 | 23.3% | | |
| Not known | 2,206 | 25.1% | | | 2,501 | 29.0% | | |
| Total | 8,787 | | | | 8,630 | | | |

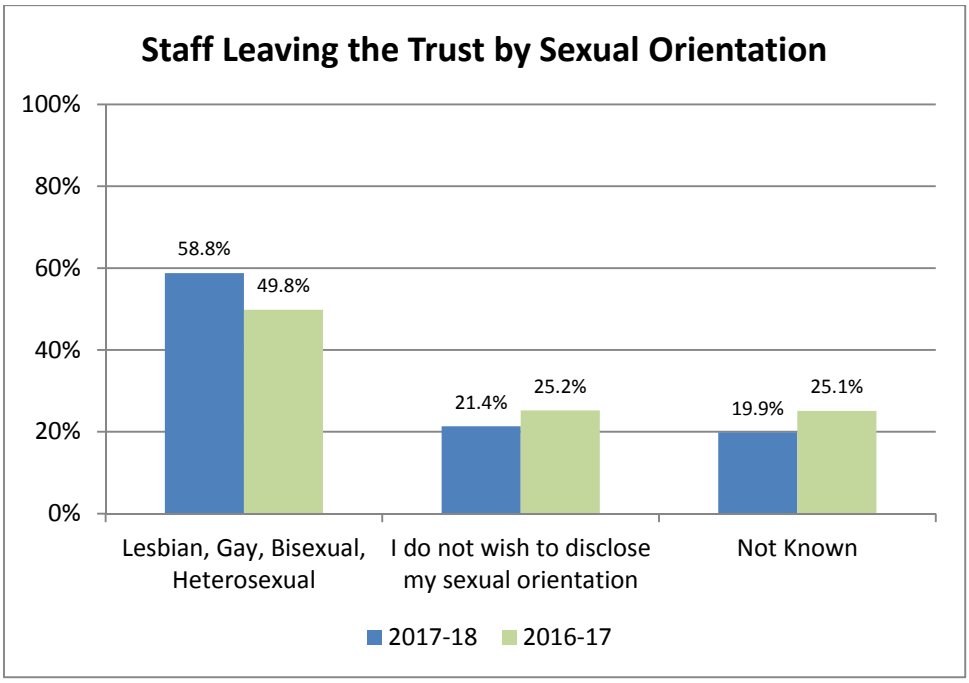
## Figure 10: Staff joining the Trust by Sexual Orientation, 2017-2018 and 2016-2017




## Table 10 - Staff joining the Trust from 1 April 2017 to 31 March 2018 by Sexual Orientation

| | Total new staff during the year | % of new staff during the year | % total staff at 31 March 2018 | % new staff previous year |
|---|---|---|---|---|
| Sexual orientation | | | | |
| Lesbian, gay, bisexual | 23 | 2.0 | 1.1 | 1.4 |
| Heterosexual | 942 | 81.3 | 52.0 | 74.3 |
| I do not wish to disclose my sexual orientation | 193 | 16.7 | 21.8 | 24.3 |
| Not known | 0 | 0 | 25.1 | 0 |
| Total | 1,158 | | | |

## Figure 11 - Staff leaving the Trust 1 April 2017 to 31 March 2018 by Sexual Orientation




## Table 11 - Staff leaving the Trust 1 April 2017 to 31 March 2018 by Sexual Orientation

| Publishable data – no category <10 | Total number of staff leaving Trust | % staff leaving | % total staff | % staff leaving in previous year |
|---|---|---|---|---|
| Sexual Orientation | | | | |
| Lesbian, Gay, Bisexual, Heterosexual | 553 | 58.8 | 53.1 | 49.8 |
| I do not wish to disclose my sexual orientation | 201 | 21.4 | 21.8 | 25.2 |
| Not Known | 187 | 19.9 | 25.1 | 25.1 |
| Total | 941 | | | |

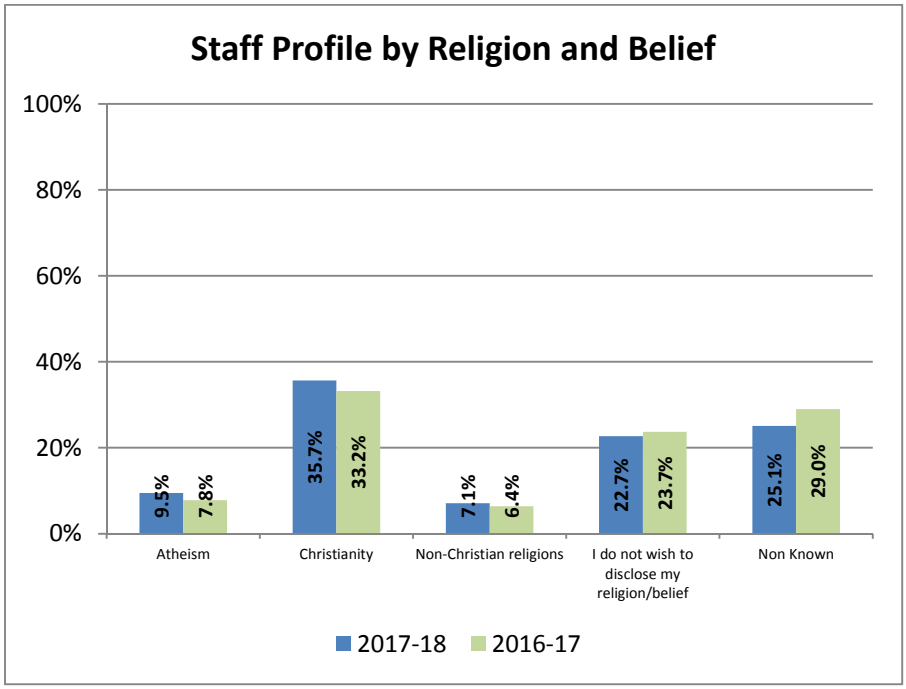
Note - due to confidentiality issues we are unable to report findings for Lesbian, Gay, Bisexual staff as a specific group

## Table 12: Pay band by sexual orientation, 2018

| | Number of staff below band 6 | % staff below band 6 | Number of staff band 6 and above, personal pay scale and Medical & Dental | % of staff band 6 and above | Total | Total % |
|---|---|---|---|---|---|---|
| Lesbian, Gay or Bisexual | 64 | 1.1% | 29 | 0.9% | 93 | 1.1% |
| Heterosexual | 3,037 | 53.3% | 1,536 | 49.7% | 4,573 | 52.0% |
| Not known/do not wish to disclose | 2,594 | 45.5% | 1,527 | 49.4% | 4,121 | 46.9% |
| Total staff | 5,695 | 100.0% | 3,092 | 100.0% | 8,787 | 100.0% |

Note – due to confidentiality issues it is only possible to report data based on very broad paybands

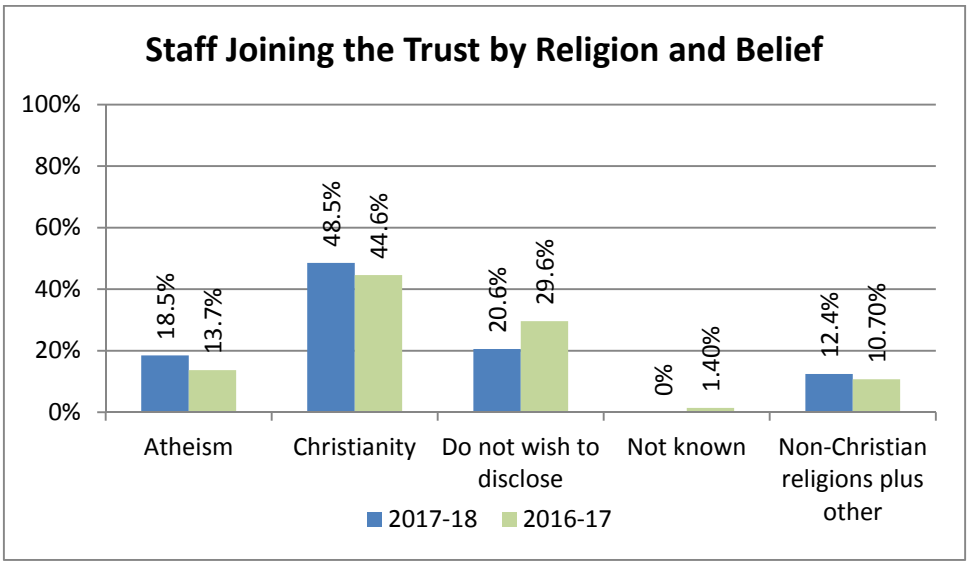
## Figure 13: Staff Profile by Religion and Belief, 2017-2018 and 2016-2017




## Table 13: York Teaching Hospitals Foundation Trust staff profile by Religion and Belief, 2017-2018 and 2016-2017

| Religion and Belief | Number of staff March 2018 | % total staff March 2018 | Number of staff part time 2018 | Number of staff full time 2018 | Number of staff March 2017 | % total staff March 2017 | Number of staff part time 2017 | Number of staff full time 2017 |
|---|---|---|---|---|---|---|---|---|
| Atheism | 833 | 9.5 | 270 | 563 | 675 | 7.8 | 199 | 476 |
| Christianity | 3,134 | 35.7 | 1,432 | 1,702 | 2,862 | 33.2 | 1,297 | 1,565 |
| Non – Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism) plus other | 622 | 7.1 | 199 | 423 | 553 | 6.4 | 172 | 381 |
| I do not wish to disclose my religion/belief | 1,993 | 22.7 | 1,019 | 974 | 2,041 | 23.7 | 1,017 | 1,024 |
| Not Known | 2,205 | 25.1 | 1,111 | 1,094 | 2,499 | 29.0 | 1,220 | 1,279 |
| Total | 8,787 | | 4,031 | 4,756 | 8,630 | | 3,905 | 4,725 |

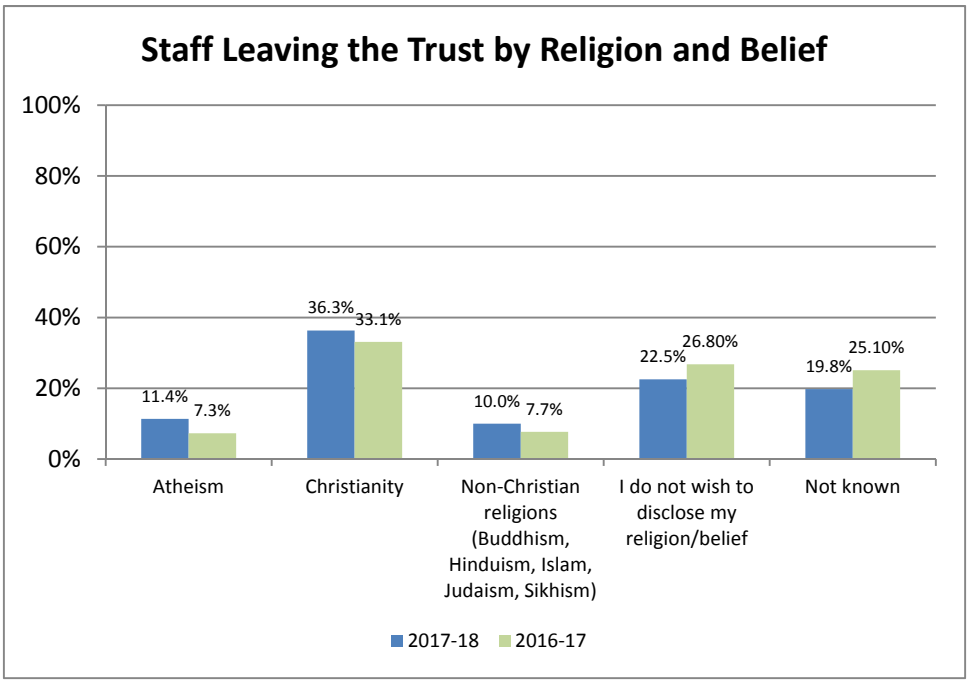
## Figure 14: Staff joining the Trust by Religion and Belief, 2017-2018 and 2016-2017




## Table 14 - Staff joining the Trust from 1 April 2017 to 31 March 2018 by Religion and Belief

| | Total new staff during the year | % new staff during the year | % total staff at 31 March 2018 | % new staff in previous year |
|---|---|---|---|---|
| Religion and belief | | | | |
| Atheism | 214 | 18.5 | 9.5 | 13.7 |
| Christianity | 562 | 48.5 | 35.7 | 44.6 |
| Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism) plus other | 144 | 12.4 | 7.1 | 10.7 |
| Do not wish to disclose | 238 | 20.6 | 22.7 | 29.6 |
| Not known | 0 | 0.0 | 25.1 | 1.4 |
| Total | 1,158 | | | |

## Figure 15: Staff Leaving the Trust by Religion and Belief, 2017-2018 and 2016-2017



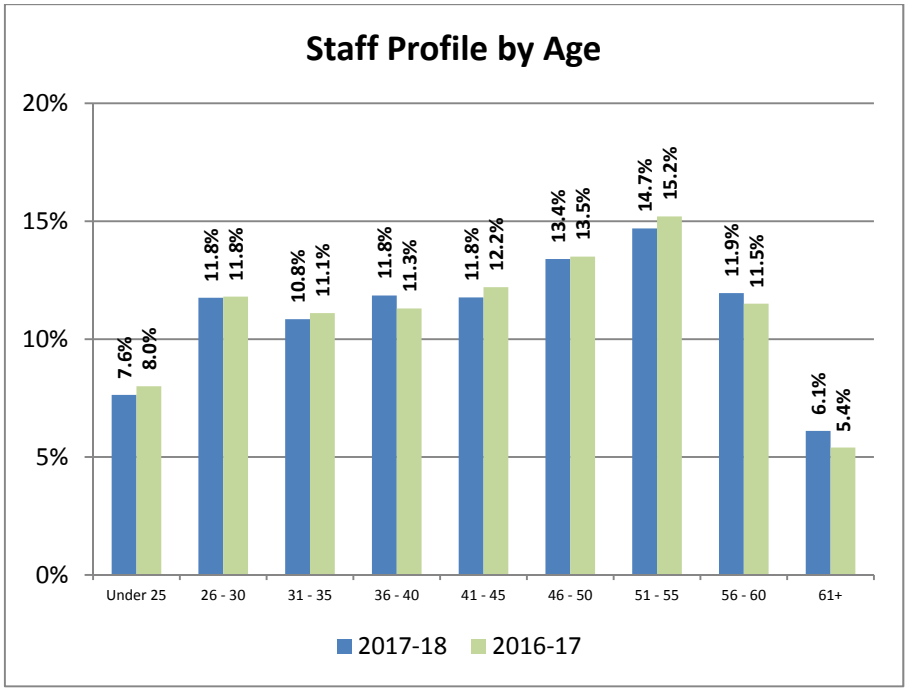

## Table 15 - Staff leaving the Trust 1 April 2017 to 31 March 2018 by Religion and Belief

| | Total number of staff leaving Trust | % staff leaving | % total staff | % staff leaving in previous year |
|---|---|---|---|---|
| Religion and belief | | | | |
| Atheism | 107 | 11.4 | 9.5 | 7.3 |
| Christianity | 342 | 36.3 | 35.7 | 33.1 |
| Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism) plus other | 94 | 10.0 | 7.1 | 7.7 |
| Do not wish to disclose | 212 | 22.5 | 22.7 | 26.8 |
| Not known | 186 | 19.8 | 25.1 | 25.1 |
| Total | 941 | | | |

## Table 16: Pay band by religion and belief, 2018

| Religion | Number of staff below band 6 | % staff below band 6 | Number of staff band 6 and above and personal pay scale | % of staff band 6 and above and personal pay scale | Number of staff in Medical & Dental Grade | % of Staff in Medical & Dental grade |
|---|---|---|---|---|---|---|
| Atheism | 547 | 9.6% | 200 | 8.6% | 86 | 11.1% |
| Christianity | 2116 | 37.2% | 811 | 35.0% | 207 | 26.6% |
| Buddhism, Hinduism, Islam, Judaism, Sikhism | 58 | 1.0% | 26 | 1.1% | 144 | 18.5% |
| Other | 283 | 5.0% | 94 | 4.1% | 17 | 2.2% |
| Not known | 1334 | 23.4% | 701 | 30.3% | 170 | 21.9% |
| I do not wish to disclose my religion/belief | 1357 | 23.8% | 483 | 20.9% | 153 | 19.7% |
| Total staff | 5695 | 100.0 % | 2315 | 100.0% | 777 | 100.0% |

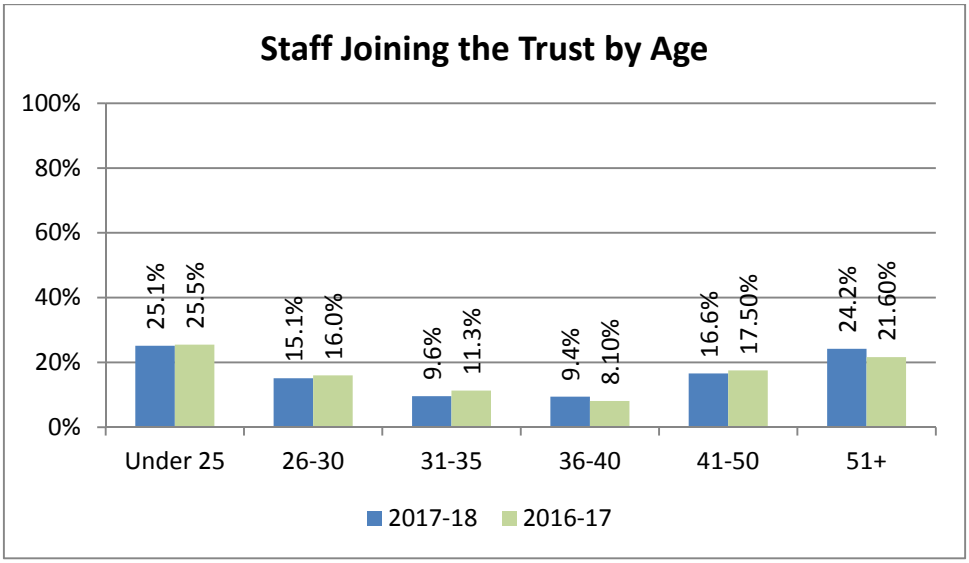
## Figure 17: Staff Profile by Age, 2017-2018 and 2016-2017




## Table 17: York Teaching Hospitals Foundation Trust staff profile by age, 2017-2018 and 2016-2017

| Age | Number of staff March 2018 | % total staff March 2018 | Number of staff part time 2018 | Number of staff full time 2018 | Number of staff March 2017 | % total staff March 2017 | Number of staff part time 2017 | Number of staff full time 2017 |
|---|---|---|---|---|---|---|---|---|
| Under 25 | 671 | 7.6 | 131 | 540 | 688 | 8.0 | 120 | 568 |
| 26-30 | 1,033 | 11.8 | 280 | 753 | 1,018 | 11.8 | 275 | 743 |
| 31-35 | 953 | 10.8 | 423 | 530 | 955 | 11.1 | 432 | 523 |
| 36-40 | 1,041 | 11.8 | 512 | 529 | 979 | 11.3 | 493 | 486 |
| 41-45 | 1,034 | 11.8 | 518 | 516 | 1,051 | 12.2 | 505 | 546 |
| 46-50 | 1,177 | 13.4 | 538 | 639 | 1,169 | 13.5 | 539 | 630 |
| 51-55 | 1,291 | 14.7 | 607 | 684 | 1,308 | 15.2 | 640 | 668 |
| 56-60 | 1,050 | 11.9 | 612 | 438 | 994 | 11.5 | 547 | 447 |
| 61+ | 537 | 6.1 | 410 | 127 | 468 | 5.4 | 354 | 114 |
| Total | 8,787 | | 4,031 | 4,756 | 8,630 | | 3,905 | 4,725 |

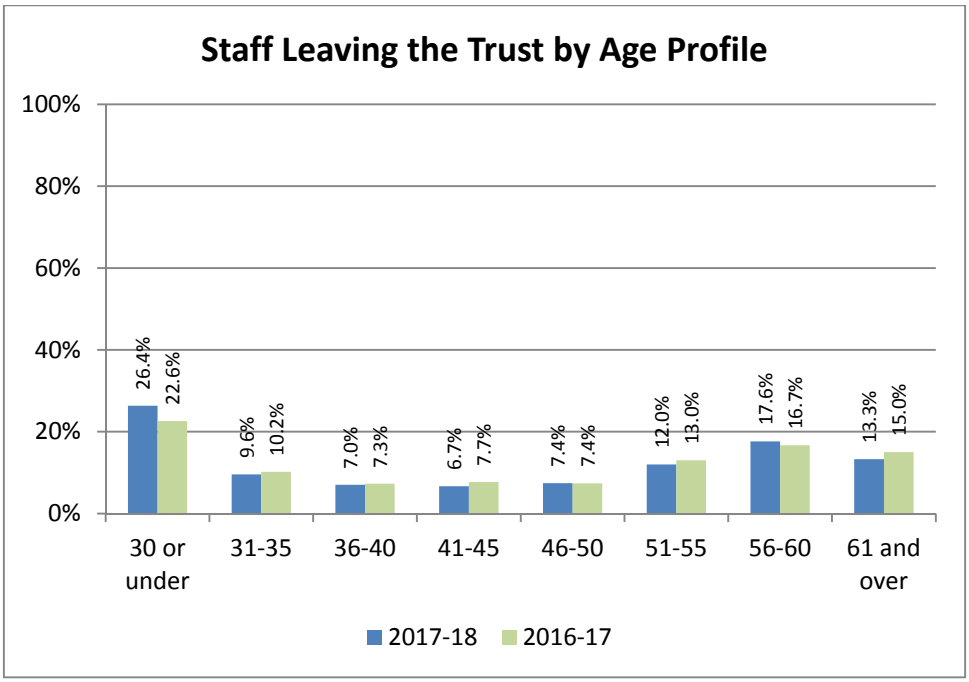
## Figure 18: Staff joining the Trust by Age, 2017-2018 and 2016-2017




## Table 18 - Staff joining the Trust from 1 April 2017 to 31 March 2018 by age

| | Total new staff during the year | % new staff during the year | % total staff at 31 March 2018 | % new staff in previous year |
|---|---|---|---|---|
| Age Profile | | | | |
| Under 25 | 291 | 25.1 | 7.6 | 25.5 |
| 26-30 | 175 | 15.1 | 11.8 | 16.0 |
| 31-35 | 111 | 9.6 | 10.8 | 11.3 |
| 36-40 | 109 | 9.4 | 11.8 | 8.1 |
| 41-50 | 192 | 16.6 | 25.2 | 17.5 |
| 51+ | 280 | 24.2 | 32.8 | 21.6 |
| Total | 1,158 | | | |

## Figure 19: Staff Leaving the Trust by Age, 2017-2018 and 2016-2017



## Table 19 - Staff leaving the Trust 1 April 2017 to 31 March 2018 by age

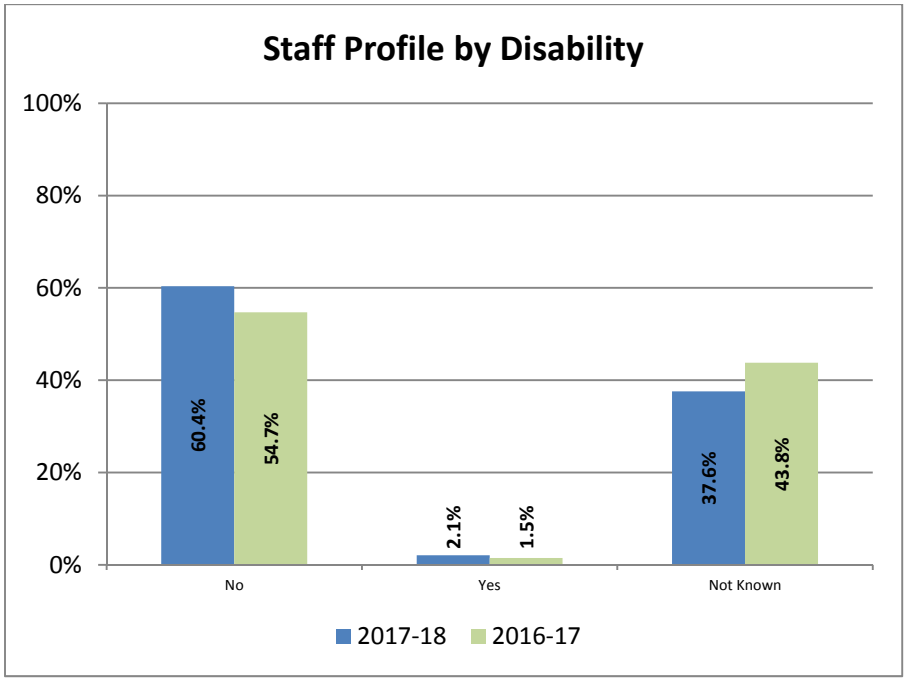
| Publishable data – no category <10 | Total number of staff leaving Trust | % staff leaving | % total staff | % staff leaving in Previous year |
|---|---|---|---|---|
| Age | | | | |
| Under 30 | 248 | 26.4 | 19.4 | 22.6 |
| 31-35 | 90 | 9.6 | 10.8 | 10.2 |
| 36-40 | 66 | 7.0 | 11.8 | 7.3 |
| 41-45 | 63 | 6.7 | 11.8 | 7.7 |
| 46-50 | 70 | 7.4 | 13.4 | 7.4 |
| 51-55 | 113 | 12.0 | 14.7 | 13.0 |
| 56-60 | 166 | 17.6 | 11.9 | 16.7 |
| 61 and over | 125 | 13.3 | 6.1 | 15.0 |
| Total | 941 | | | |

## Table 20: Pay band by age, 2018

| | Under 25 Years | % staff under 25 years | 26 – 50 years | % staff 26-50 years | Over 50 years | % over 50 years | Total staff | % total staff in this pay band |
|---|---|---|---|---|---|---|---|---|
| Personal Salary | <10 | * | <10 | * | <10 | * | 15 | 0.2% |
| Medical and Dental | 52 | 7.7% | 555 | 10.6% | 170 | 5.9% | 777 | 8.8% |
| Band 1 | 31 | 4.6% | 327 | 6.2% | 282 | 9.8% | 640 | 7.3% |
| Band 2 | 222 | 33.1% | 977 | 18.7% | 675 | 23.5% | 1,874 | 21.3% |
| Band 3 | 82 | 12.2% | 541 | 10.3% | 347 | 12.1% | 970 | 11.0% |
| Band 4 | 30 | 4.5% | 322 | 6.1% | 229 | 8.0% | 581 | 6.6% |
| Band 5 | 197 | 29.4% | 995 | 19.0% | 438 | 15.2% | 1,630 | 18.6% |
| Band 6 | 52 | 7.7% | 934 | 17.8% | 389 | 13.5% | 1,368 | 15.6% |
| Band 7 | | | 411 | 7.8% | 216 | 7.5% | 634 | 7.2% |
| Band 8a+ | | | 171 | 3.3% | 127 | 4.4% | 298 | 3.4% |
| Total | 671 | | 5,238 | | 2878 | | 8,787 | |

Note - due to confidentiality only totals for band 6 and above and under 25 years can be shown

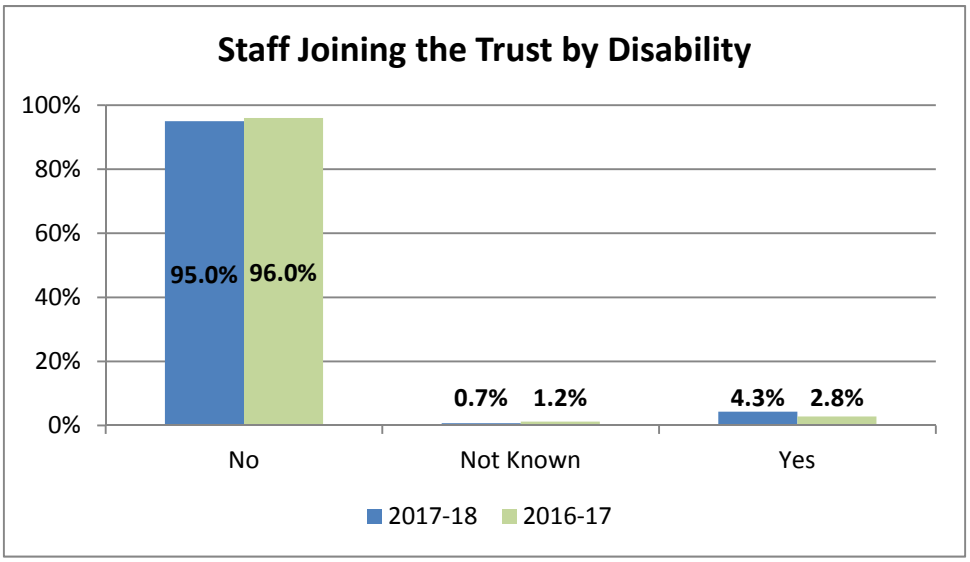
## Figure 21: Staff Profile - Disability, 2017-2018 and 2016-2017




## Table 21: York Teaching Hospitals Foundation Trust staff profile - disability status, 2017-2018 and 2016-2017

| Disabled Person | Number of staff March 2018 | % of staff March 2018 | Number of staff part time 2018 | Number of staff full time 2018 | Number of staff March 2017 | % of staff March 2017 | Number of staff part time 2017 | Number of staff full time 2017 |
|---|---|---|---|---|---|---|---|---|
| No | 5,304 | 60.4 | 2,274 | 3,030 | 4,720 | 54.7 | 1,977 | 2,743 |
| Yes | 181 | 2.1 | 76 | 105 | 132 | 1.5 | 54 | 78 |
| Not Known | 3,302 | 37.6 | 1,681 | 1,621 | 3,778 | 43.8 | 1,874 | 1,904 |
| Total | 8,787 | | 4,031 | 4,756 | 8,630 | | 3,905 | 4,725 |

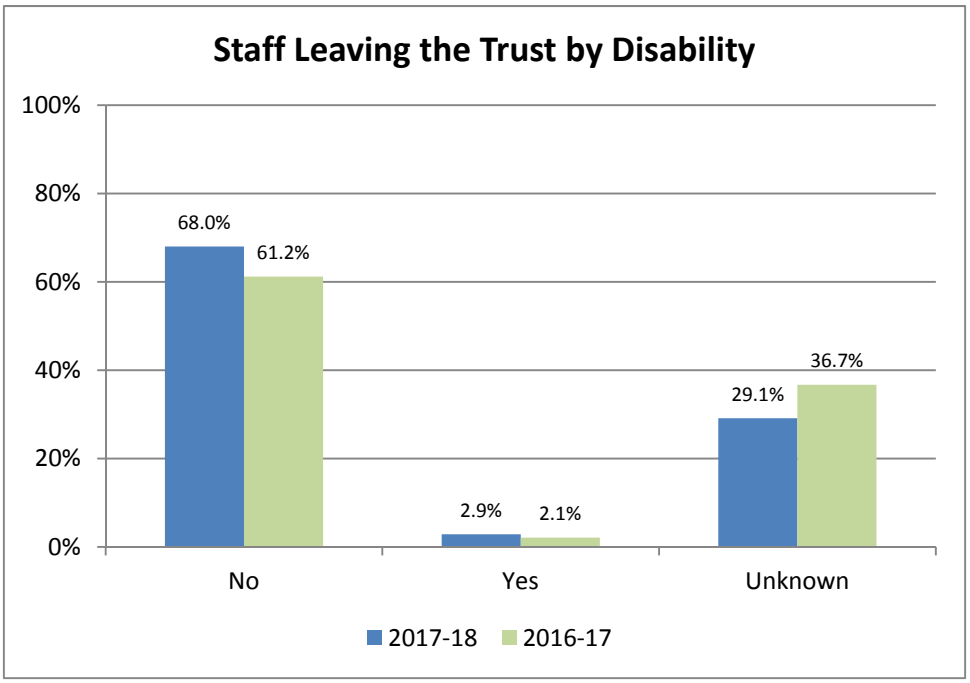
## Figure 22: Staff joining the Trust - Disability, 2017-2018 and 2016-2017




## Table 22 - Staff joining the Trust from 1 April 2017 to 31 March 2018 - disability status

| | Total new staff during the year | % of new staff during the year | % total staff at 31 March 2018 | % new staff previous year |
|---|---|---|---|---|
| Disabled Person | | | | |
| No | 1,100 | 95.0 | 60.4 | 96.0 |
| Yes | 50 | 4.3 | 2.1 | 2.8 |
| Not known | 8 | 0.7 | 37.6 | 1.2 |
| Total | 1,158 | | | |

## Figure 23: Staff Leaving the Trust - Disability, 2017-2018 and 2016-2017




## Table 23 - Staff leaving York Teaching Hospitals Foundation Trust (disability) 1 April 2017 to 31 March 2018

| Publishable data – no category <10 | Total number of staff leaving Trust | % staff leaving | % total staff | % staff leaving in previous year |
|---|---|---|---|---|
| Disabled person | | | | |
| No | 640 | 68.0 | 60.4 | 61.2 |
| Yes | 27 | 2.9 | 2.1 | 2.1 |
| Not Known | 274 | 29.1 | 37.6 | 36.7 |
| Total | 941 | | | |

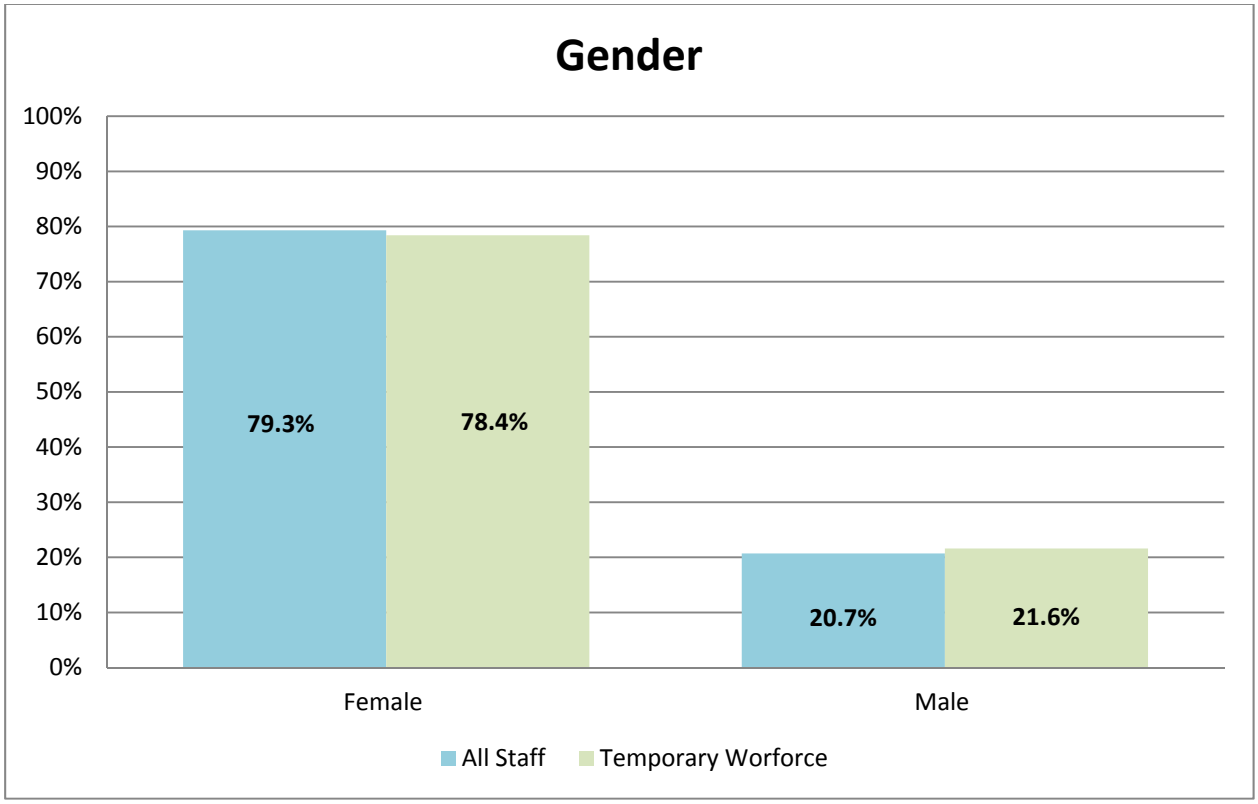
## Table 24: Pay band by disability, 2018

| Disabled | Number of staff below band 6 | % staff below band 6 | Number of staff band 6 and above, personal pay scale and Medical & Dental | % of staff band 6 and above | Total | Total % |
|---|---|---|---|---|---|---|
| Non - Disabled Staff | 3,561 | 62.5% | 1,743 | 56.4% | 5,304 | 60.4% |
| Disabled staff | 133 | 2.3% | 48 | 1.6% | 181 | 2.1% |
| Not known | 2,001 | 35.1% | 1,301 | 42.1% | 3,302 | 37.6% |
| Total staff | 5,695 | | 3,092 | | 8,787 | |

Note – due to confidentiality issues it is only possible to report data based on very broad paybands

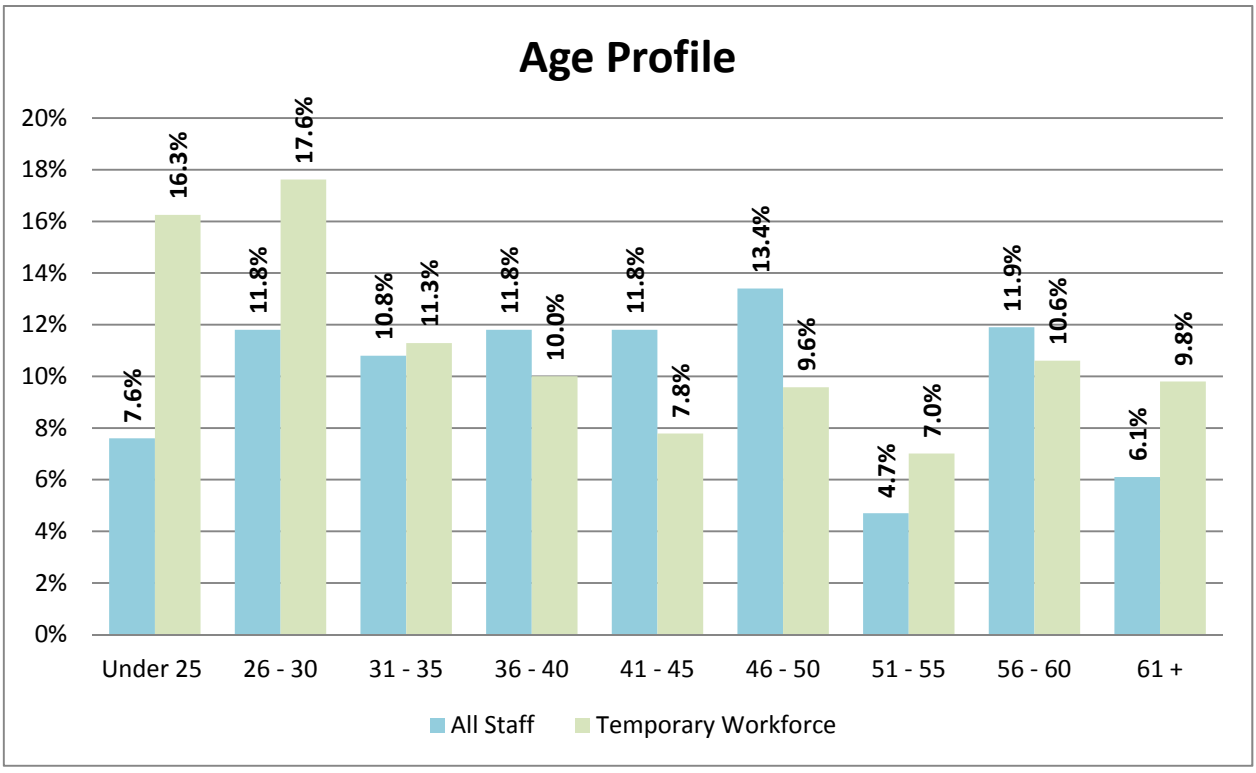
## Our Temporary Workforce Staff

### Figure 25: Temporary Workforce Staff Profile by Gender, 2018

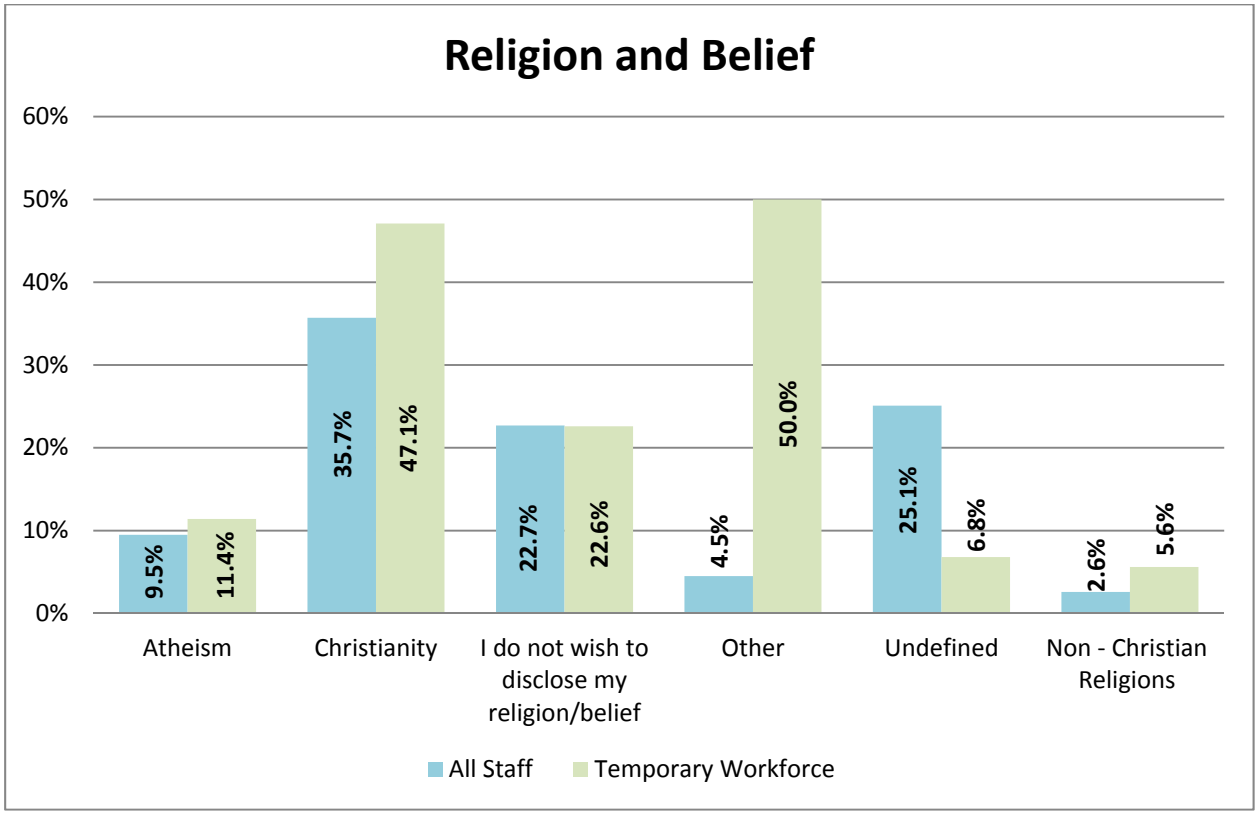



Note – all the analysis is solely based on those where their 'main role in the organisation was recorded as bank or locum.

### Figure 26: Temporary Workforce Staff Profile by Age, 2018



## Figure 27: Temporary Workforce Staff Profile by Religion and Belief, 2018




Note – this data is influenced by the fact the levels of staff not wishing to disclose this and also 'Unknowns' are better for temporary workforce staff

## Appendix D Recruitment

Following a transitional year for the Trust in 2016-2017 where we migrated from using NHS jobs to system called TRAC. The tables below are extracted from TRAC from 1st April 2017 to 31st March 2018. Narrative given in the Protected Characteristics given in section 2.3 is using amalgamated data.

### Table 1 Recruitment by gender 2017-2018

| Category | Applied April 2017 to March 2018 | Shortlisted April 2017 to March 2018 | % applications shortlisted | % applications |
|---|---|---|---|---|
| Gender | | | | |
| Male | 6109 | 31 | 263 | 38.1 |
| Female | 13572 | 68.8 | 424 | 61.4 |
| I do not wish to disclose | 49 | 0.2 | 3 | 0.4 |
| Not stated | 0 | 0 | 0 | 0 |
| Total | 19730 | 100 | 690 | 100 |

### Table 2: Recruitment by disability, 2017-2018

| Category | Applied April 2017 to March 2018 | Shortlisted April 2017 to March 2018 | % applications shortlisted | % applications |
|---|---|---|---|---|
| None / Not Applicable | 18095 | 91.7 | 659 | 95.5 |
| Physical impairment | 135 | 0.7 | 5 | 0.7 |
| Sensory impairment | 154 | 0.8 | 4 | 0.6 |
| Mental health condition | 186 | 0.9 | 3 | 0.4 |
| Learning disability/difficulty | 276 | 1.4 | 4 | 0.6 |
| Long-standing illness | 277 | 1.4 | 7 | 1 |
| Other | 160 | 0.8 | 6 | 0.9 |
| Not stated | 447 | 2.3 | 2 | 0.3 |
| Total | 19730 | 100 | 690 | 100 |

## Table 3: Recruitment by ethnicity, 2017-2018

| Category | Applied April 2017 to March 2018 | Shortlisted April 2017 to March 2018 | % applications shortlisted | % applications |
|---|---|---|---|---|
| WHITE - British | 13535 | 68.6 | 363 | 52.6 |
| WHITE - Irish | 99 | 0.5 | 3 | 0.4 |
| White Northern Irish | 15 | 0.1 | 0 | 0 |
| White English | 130 | 0.7 | 2 | 0.3 |
| White Scottish | 22 | 0.1 | 0 | 0 |
| White Welsh | 7 | 0 | 0 | 0 |
| White Cornish | 0 | 0 | 0 | 0 |
| White Cypriot | 3 | 0 | 1 | 0.1 |
| White Greek | 16 | 0.1 | 0 | 0 |
| White Greek Cypriot | 1 | 0 | 0 | 0 |
| White Turkish | 1 | 0 | 0 | 0 |
| White Turkish Cypriot | 0 | 0 | 0 | 0 |
| White Italian | 23 | 0.1 | 0 | 0 |
| White Irish Traveller | 0 | 0 | 0 | 0 |
| White Traveller | 1 | 0 | 0 | 0 |
| White Gypsy/Romany | 0 | 0 | 0 | 0 |
| White Polish | 132 | 0.7 | 8 | 1.2 |
| White ex-USSR | 10 | 0.1 | 0 | 0 |
| White Kosovan | 0 | 0 | 0 | 0 |
| White Albanian | 0 | 0 | 0 | 0 |
| White Bosnian | 0 | 0 | 0 | 0 |
| White Croatian | 1 | 0 | 0 | 0 |
| White Serbian | 0 | 0 | 0 | 0 |
| White other ex-Yugoslav | 0 | 0 | 0 | 0 |
| White Other European | 112 | 0.6 | 1 | 0.1 |
| White mixed | 23 | 0.1 | 0 | 0 |
| WHITE - Any other white background | 921 | 4.7 | 36 | 5.2 |
| MIXED - White & Black Caribbean | 54 | 0.3 | 1 | 0.1 |
| MIXED - White & Black African | 74 | 0.4 | 3 | 0.4 |
| MIXED - White & Asian | 102 | 0.5 | 3 | 0.4 |
| Mixed - Black & Asian | 0 | 0 | 0 | 0 |
| Mixed - Black & Chinese | 0 | 0 | 0 | 0 |
| Mixed - Black & White | 2 | 0 | 0 | 0 |
| Mixed - Chinese & White | 0 | 0 | 0 | 0 |
| Mixed - Asian & Chinese | 1 | 0 | 0 | 0 |
| MIXED - any other mixed background | 107 | 0.5 | 6 | 0.9 |
| ASIAN or ASIAN BRITISH - Indian | 835 | 4.2 | 50 | 7.2 |
| ASIAN or ASIAN BRITISH - Pakistani | 593 | 3 | 71 | 10.3 |
| ASIAN or ASIAN BRITISH - | 110 | 0.6 | 11 | 1.6 |

| | | | | |
|---|---|---|---|---|
| Bangladeshi | | | | |
| Asian Mixed | 7 | 0 | 1 | 0.1 |
| Asian Punjabi | 6 | 0 | 1 | 0.1 |
| Asian Kashmiri | 1 | 0 | 0 | 0 |
| Asian East African | 0 | 0 | 0 | 0 |
| Asian Sri Lankan | 6 | 0 | 0 | 0 |
| Asian Tamil | 7 | 0 | 0 | 0 |
| Asian Sinhalese | 0 | 0 | 0 | 0 |
| Asian British | 26 | 0.1 | 0 | 0 |
| Asian Caribbean | 0 | 0 | 0 | 0 |
| ASIAN or ASIAN BRITISH - Any other Asian background | 426 | 2.2 | 27 | 3.9 |
| BLACK or BLACK BRITISH - Caribbean | 95 | 0.5 | 1 | 0.1 |
| Black Somali | 1 | 0 | 0 | 0 |
| Black Mixed | 1 | 0 | 0 | 0 |
| Black Nigerian | 47 | 0.2 | 4 | 0.6 |
| Black British | 19 | 0.1 | 0 | 0 |
| BLACK or BLACK BRITISH - African | 892 | 4.5 | 41 | 5.9 |
| BLACK or BLACK BRITISH - Any other black background | 48 | 0.2 | 0 | 0 |
| OTHER ETHNIC GROUP - Chinese | 115 | 0.6 | 4 | 0.6 |
| Vietnamese | 1 | 0 | 0 | 0 |
| Japanese | 0 | 0 | 0 | 0 |
| Filipino | 58 | 0.3 | 1 | 0.1 |
| Malaysian | 3 | 0 | 0 | 0 |
| OTHER ETHNIC GROUP - Any other ethnic group | 392 | 2 | 37 | 5.4 |
| Not stated | 649 | 3.3 | 14 | 2 |
| Total | 19730 | 100 | 690 | 100 |

## Table 4: Recruitment by age, 2017-2018

| Category | Applied April 2017 to March 2018 | Shortlisted April 2017 to March 2018 | % applications shortlisted | % applications |
|---|---|---|---|---|
| Under 20 | 534 | 2.7 | 9 | 1.3 |
| 20 - 24 | 3234 | 16.4 | 69 | 10 |
| 25 - 29 | 3955 | 20 | 178 | 25.8 |
| 30 - 34 | 2976 | 15.1 | 121 | 17.5 |
| 35 - 39 | 1916 | 9.7 | 74 | 10.7 |
| 40 - 44 | 1761 | 8.9 | 60 | 8.7 |
| 45 - 49 | 1802 | 9.1 | 50 | 7.2 |
| 50 - 54 | 1681 | 8.5 | 52 | 7.5 |
| 55 - 59 | 1148 | 5.8 | 48 | 7 |
| 60 - 64 | 603 | 3.1 | 21 | 3 |
| 65+ | 118 | 0.6 | 8 | 1.2 |
| Not stated | 2 | 0 | 0 | 0 |
| Total | 19730 | 100 | 690 | 100 |

## Table 5: Recruitment by religion / belief, 2017-2018

| Category | Applied April 2017 to March 2018 | Shortlisted April 2017 to March 2018 | % applications shortlisted | % applications |
|---|---|---|---|---|
| Atheism | 3724 | 18.9 | 98 | 14.2 |
| Buddhism | 190 | 1 | 22 | 3.2 |
| Christianity | 9348 | 47.4 | 258 | 37.4 |
| Hinduism | 516 | 2.6 | 34 | 4.9 |
| Islam | 1302 | 6.6 | 137 | 19.9 |
| Jainism | 6 | 0 | 3 | 0.4 |
| Judaism | 13 | 0.1 | 1 | 0.1 |
| Sikhism | 38 | 0.2 | 4 | 0.6 |
| Other | 1871 | 9.5 | 71 | 10.3 |
| I do not wish to disclose my religion/belief | 2290 | 11.6 | 60 | 8.7 |
| Not stated | 432 | 2.2 | 2 | 0.3 |
| Total | 19730 | 100 | 690 | 100 |

## Table 6: Recruitment by sexual orientation, 2017-2018

| Category | Applied April 2017 March 2018 | Shortlisted April 2017 March 2018 | % applications shortlisted | % applications |
|---|---|---|---|---|
| Heterosexual or Straight | 17300 | 87.7 | 630 | 91.3 |
| Gay | 268 | 1.4 | 7 | 1 |
| Lesbian | 107 | 0.5 | 2 | 0.3 |
| Bisexual | 363 | 1.8 | 6 | 0.9 |
| I do not wish to describe my sexual orientation. | 1206 | 6.1 | 34 | 4.9 |
| Gay or Lesbian | 45 | 0.2 | 9 | 1.3 |
| Other sexual orientation not listed | 5 | 0 | 0 | 0 |
| Undecided | 6 | 0 | 0 | 0 |
| Not stated | 430 | 2.2 | 2 | 0.3 |
| Total | 19730 | 100 | 690 | 100 |

## Appendix E – Grievance, Disciplinary and Bullying & Harassment

## Table 1: number of grievances by ethnic origin, 2017-2018 and 2016-2017

| | Number of Grievances year ending 31 March 2018 | Number of Grievances year ending 31 March 2017 |
|---|---|---|
| White – UK | 26 | 29 |
| White – Irish | 0 | 0 |
| White (not UK or Irish – Includes White unspecified) | <10 | <10 |
| Mixed Race (dual heritage) total | 0 | 0 |
| Asian and Asian British total | <10 | 0 |
| Black and Black British total | 0 | 0 |
| Any other ethnic group (including Chinese) | 0 | 0 |
| Not Known | 0 | <10 |
| **Total** | **28** | **38** |

Note - * signifies that this figure cannot be shown due to confidentiality issues

## Table 2: Disciplinary investigations by Ethnicity, 2017-2018 and 2016-2017

| Ethnicity | Disciplinary Investigations Year ending 31 March 2018 | Disciplinary Investigations Year ending 31 March 2017 |
|---|---|---|
| White – UK | 56 | 60 |
| White – Irish | <10 | 0 |
| White (not UK or Irish – Includes White unspecified) | <10 | <10 |
| **White total** | **63** | ***** |
| Mixed Race (dual heritage) total | 0 | <10 |
| Asian and Asian British total | <10 | <10 |
| Any other ethnic group (including Chinese) | <10 | <10 |
| **BME total (e.g. mixed race, Asian and Asian British, Black and Black British, Chinese)** | **<10** | **<10** |
| Not Known | <10 | 0 |
| **Total** | **66** | **70** |

Note - * signifies figures cannot be shown due to confidentiality issues

## Table 3: Disciplinary investigations by Gender, 2017-2018 and 2016-2017

| Gender | Disciplinary Investigations Year ending 31 March 2018 | Disciplinary Investigations Year ending 31 March 2017 |
|---|---|---|
| Female | 41 | 47 |
| Male | 25 | 23 |
| **Total** | **66** | **70** |

## Table 4: Disciplinary investigations by Disability, 2017-2018 and 2016-2017

| Disabled | Disciplinary Investigations Year ending 31 March 2018 | Disciplinary Investigations Year ending 31 March 2017 |
|---|---|---|
| Yes | <10 | <10 |
| No | 46 | 43 |
| Not Declared | * | * |
| Undefined | | |
| Total | 66 | 70 |

Note - * signifies figures cannot be shown due to confidentiality issues

## Table 5: Disciplinary investigations, sanctions and suspensions by Sexual Orientation, 2017-2018 and 2016-2017

| Sexual Orientation | Disciplinary Investigations Year ending 31 March 2018 | Disciplinary Investigations Year ending 31 March 2017 |
|---|---|---|
| Heterosexual | 38 | 33 |
| I do not wish to disclose my sexual orientation | 11 | 17 |
| Undefined | 17 | 20 |
| Total | 66 | 70 |

## Table 6: Disciplinary investigations, sanctions and suspensions by Religion / Belief, 2017-2018 and 2016-2017

| Religion and Belief | Disciplinary Investigations Year ending 31 March 2018 | Disciplinary Investigations Year ending 31 March 2017 |
|---|---|---|
| Atheism | <10 | <10 |
| Christianity | 30 | 21 |
| I do not wish to disclose my religion/belief | 13 | 23 |
| Undefined | 16 | 18 |
| Other | <10 | <10 |
| Total | 66 | 70 |

## 7. How are we doing?

We are accountable to our staff, service users and members of the public.

Should you have any feedback or concerns about equality of access to services or in the workplace, please contact:

Margaret Milburn – Equality, Diversity and Inclusion Officer
Telephone: 01904 726633
Email: margaret.milburn@york.nhs.uk

# NHS Vale of York CCG and York Teaching Hospital NHS Foundation Trust

## Equality Delivery System 2: Performance Assessment and Grading Report 2017

### NHS Equality Delivery System 2 (EDS2)

The NHS Vale of York CCG and York Teaching Hospital Foundation Trust (YTHFT) has been working together using the national NHS Equality Delivery System 2 (ED2). This is a tool designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS2 aims to assist organisations to achieve compliance with the Public Sector Equality Duties by encouraging them – in engagement with stakeholders – to review and improve their equality performance and to identify future priorities and actions.

At the heart of the EDS2 is a set of 18 outcomes grouped into four objectives. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined.

**The four EDS objectives are**:

| |
|---|
| 1. Better health outcomes |
| 2. Improved patient access and experience |
| 3. A representative and supported workforce |
| 4. Inclusive leadership |

For each EDS outcome, there are four grades to choose from:

- Excelling (all protected groups) – **Purple**
- Achieving (for most (6-8) protected groups) – **Green**
- Developing (for some (3-5 protected groups) – **Amber**
- Undeveloped (no evidence at all, few or no protected groups) – **Red**

You can find out more about EDS2 at https://www.england.nhs.uk/wp-content/uploads/2013/11/edsnov131.pdf.

## Local Approach

In November 2017, the CCG and YTHFT held a workshop that brought together key stakeholders including the voluntary and community sector to review progress against their EDS2 priorities. The workshop looked at progress against existing shared priorities and also focused on progress and gaps against EDS2 Goal 1 'Better health Outcomes' the table below provides an update of key achievements against the shared priorities for 2016-17 and agreed joint actions for 2018/19

## Update on 2015/16 joint priorities

The table below gives an update on the 2015/16 priority actions and a summary of the assessment panel's comments.

| Action / Priority | Update on progress | Comments from assessment workshop |
|---|---|---|
| 1. To develop and implement a joint approach to equality and diversity training. The current national e-learning programme does not take into consideration more local inequalities this will also enable consistency across the area.<br>• To develop a regional equality and diversity e-learning programme for NHS staff, to be peer reviewed by knowledge experts from our local interest groups | In a joint approach with input from the Regional Equality and Diversity Network, we have contributed to a Health, Education England (HEE) National e-learning package. This was released summer 2017. | The panel were unsure if the national e-learning package met the action identified as it had not been tailored specifically to the region. |
| 2. To improve the collection and analysis of patient/service user data for people with protected characteristics.<br>• To identify two protected characteristics per year to measure the level of current recording and set improvement targets - areas suggested 2015/2016 sexual orientation | There is a National emphasis on LGBT data by NHS digital. The Sexual Orientation Monitoring (SOM) Information Standard, which was introduced in 2017 and provides the mechanism for recording the sexual orientation of all patients/service users aged 16 years and over across the whole of health and social care. | The panel felt that this action had not really been addressed. It was suggested that the hospital start small with one service area with a focus on improving the collection of data for sexual orientation and ethnicity and then gradually extend, sharing learning and good practice. |

| Action / Priority | Update on progress | Comments from assessment workshop |
|---|---|---|
| and age<br>• To implement both qualitative and quantitative data capture processes and to triangulate findings with local and national research findings | The standardisation of monitoring sexual orientation will help to ensure that all health and social care organisations are able to compare data and demonstrate the provision of equitable access and services for LGB individuals.<br><br>The CCG has carried out some audit work to help identify equality data being collected. The data collection systems at the Trust now allow for the recording of transgender. | |
| 3. Explore how we can make better use of technology to enable improved access to our services.<br>• Review current processes to raise concerns, make a complaint or to access PALS support<br>• To review first point of contact processes and to develop and promote alternative contact | There has been work done on the PALS reporting system, allowing reports to be produced and analysed around equality related complaints. The following supports the use of technology:<br>• Patients can now register to book phone<br>• Patients can sign up for text reminders for appointments. | The panel felt that this action was completed. |

| Action / Priority | Update on progress | Comments from assessment workshop |
|---|---|---|
| processes where appropriate, for example by text message | • Sexual Health have an 'app' for young people<br>• Dermatascopes enable local skin test at GP rather than attending hospital.GP appointments online.<br>• Antenatal follow-up is on the phone. | |
| 4. To create positive and inclusive healthcare settings /environments for everyone.<br>• Use of inclusive images and language in our literature and buildings<br>• Staff training so feel comfortable to ask questions related to protected characteristics | At the Trust there was an Image gathering Initiative during LGBT History Month 2016 to develop a library and children's services ensured gender balance in words and pictures for a coming into hospital information leaflet. There is a process in place to check the appropriateness of imagery and wording for Trust leaflets. | The panel felt that there was more work that could be done here and that this may include the implementation of the Accessible Information Standard. |
| 5. Directory of services<br>• How to access NHS Services | A review of options acknowledged the need to link what was readily available from other organisations. Working in partnership; a directory for older people has been developed by Healthwatch York. | The panel felt that this action was completed. However, due to the success of the directory they wondered if it could be updated and re-printed. It was also felt that a similar directory would be |

| Action / Priority | Update on progress | Comments from assessment workshop |
|---|---|---|
| | | useful, for example for young people transitioning from children services to adult services. |
| 6. Information sharing<br>• Generate and share information and knowledge across a wider area | The CCG and Trust share performance information and there have been two clinical summits (GP's and hospital staff) from different parts of the medical sector working together to discuss shared areas of interest. | The panel felt that there was more work to be done here to increase awareness of EDS2 and progress being made, particularly with the community and voluntary sector. |
| 7. Develop options for improved representation.<br>• Better sharing of purpose of EDS and how people can be more widely involved | During 2016 there was thought given to how to increase involvement and representation from protected groups including the need for training/workshops. There were also efforts made to look at identifying meetings attended to share key equality information across organisations. There has been a presentation of an EDS2 report to the Council Governors to help raise awareness. | The panel felt there had not been enough progress made for this action and there was more work to be done here and that there could be greater representation at the assessment panels and increased awareness of EDS2. |

The assessment panel was also asked to review evidence provide by YTHFT and the CCG for progress against the outcomes of EDS2 Goal 1: Better Health Outcomes. The table below shows grades awarded against the outcomes and a summary of comments / feedback.

| Goal 1: 'Better Health Outcomes' | Panel Grade | Comments |
|---|---|---|
| 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities | Developing | Should acknowledge the work of the provider alliance board.<br>Ambulance service had improved.<br>Mental health crisis team – mixed comments.<br>Anomalies in services – pharmacy contract does not provide GP prescriptions only hospitals.<br>Evidence – no mention of visually impaired access to services (sensory impairment). Also lack of reference / evidence presented relating to Black and ethnic minoritised groups (BME); Lesbian, gay, bisexual and transgender (LGBT); and religion and belief. |
| 1.2 Individual people's health needs are assessed and met in appropriate and effective ways | Developing | Electronic prescribing would be of benefit to hospital.<br>Some good work around: frailty service – dementia flag; 'This is me' booklet; cancer care – chemo mobile bus; discharge liaison officer; passport system; healthcare navigator assigned to individual complex conditions; less missed appointments.<br>Lack of reference / evidence presented relating to sensory impairment; transgender; BME; and religion and belief. |

| Goal 1: 'Better Health Outcomes' | Panel Grade | Comments |
|---|---|---|
| 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed | Developing | Improvements need to be made in transition of child to adult services; learning disabilities; and cystic fibrosis.<br>Hospital community services are patchy.<br>Access issues for rural communities – services in rural communities are no accessible enough at present.<br>Group transition may not work for young adults, BME and LGBT. |
| 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse | Developing | Introduction and encouraging of 'fairness champions' – no evidence given on 'Freedom to speak up guardian'.<br>Electronic prescribing protects patients.<br>7 day end of life care has improved.<br>For elderly people, buzzers are being put out of reach or hidden, and physical contact by nurses not explained.<br>Problems with agency nurses on ward 28 – increase of agency nurse's increases risk. There should training for nurses / NHS staff on visual impairments – links into Accessible Information Standard.<br>Practice under attack – use of outliers on wards due to free beds – affects outcomes of 1.4 and 1.3.<br>Some issues around use of datex.<br>Some issues being advised to go through Healthwatch rather than PALS.<br>Groups at risk: Absence of communication support / counselling on children's ward. Other groups – BME, people whose primary language is not English, sensory loss and disability. |
| 1.5 Screening, vaccination and | | Flu campaign good.<br>Varied notifications – email/text/post/locations/various times for |

| Goal 1: 'Better Health Outcomes' | Panel Grade | Comments |
|---|---|---|
| other health promotion services reach and benefit all local communities | Developing | surgeries and pharmacies.<br>Have we evidence of uptake by different groups? E.g. travellers / / learning disabilities / BME.<br>Dementia screening at hospital is reaching targets.<br>Antenatal classes online<br>Concerns around access / promotion of prostate cancer screening. |

Based on the information provided in the above two tables the following shared priorities and joint action plan were identified and agreed for 2018/19.

| Goal / Priority | Action | Impact / Success measure | Progress | Lead and timescales |
|---|---|---|---|---|
| 1. To develop and implement a joint approach to equality and diversity training.<br><br>(carried over from 2015/16 priorities) | Working with the CCG to review the current national training program to consider if it fulfils local requirements | | | Joint Dec 2018 |
| | To increase number of staff completing E&D training (e-learning - and / or face to face)<br><br>To work towards E&D | Number of staff who have accessed E&D training (increase to be measured year on year); baseline to be established in 2018/19 | | YTHFT March 2019 |

| Goal / Priority | Action | Impact / Success measure | Progress | Lead and timescales |
|---|---|---|---|---|
| | training becoming mandatory. | Number of staff attending corporate induction program | | |
| 2. To improve the collection and analysis of patient/service user data for people with protected characteristics. (carried over from 2015/16 priorities) | Identify a service to audit and monitor the collection of LBGT, disability and ethnicity data.<br>Establish system for analysing data to inform service improvement.<br><br>Roll out learning from audit to other services | Service identified and equality monitoring collected for identified protected groups, baseline to be established 2018.<br><br>System established for analysing equality monitoring data and feeding into service improvement action plans.<br><br>Improved equality monitoring collection adopted by identified services<br><br>Equality monitoring included in CCG contract monitoring | | YTHFT 2019<br><br>2019<br><br>2020<br><br>CCG 2019 |
| | Collect baseline data on | Improved disclosure | | YTHFT and |

| Goal / Priority | Action | Impact / Success measure | Progress | Lead and timescales |
|---|---|---|---|---|
| | disability in preparation for WDES including updating personal data via self-service ESR | rates of disability by disabled staff.<br><br>Data collected in preparation for publication with action plan in August 2019 | | CCG 2018<br><br>YTHFT August 2019 |
| 3. Explore how we can make better use of technology to enable improved access to our services. | Completed 2016/17. Services will continue to adopt new technology to improve patient access and care. | | | |
| 4. To create positive and inclusive healthcare settings /environments for everyone. | Carry out audit of service implementation of AIS<br><br>Identify any barriers including IT systems<br><br>Promote access to 'Browse Aloud' by GP practices | Audit complete, any barriers identified and actions to address agreed | | YTHFT 2019<br><br>CCG 2018/19 |
| | Work with Healthwatch to monitor and respond to complaints relating to access | Improved access, attendance and experience for patients with communication | | CCG and YTHFT 2018/19 |

| Goal / Priority | Action | Impact / Success measure | Progress | Lead and timescales |
|---|---|---|---|---|
| | | needs. Measured through PALS complaint process | | |
| 5. Improve patient experience and access to services including the development of Directory of services<br><br>Directory for older people was developed by Healthwatch York | Develop Information guide/ booklet on accessing health services when transitioning from young people's services to adult services | Development, promotion and dissemination of Directory<br><br>Improved patient experience for young people transitioning from children to adult services, measured through PALs, patient surveys | | CCG 2019<br><br>YTHFT 2018/2019 |
| | Improve transition pathway between children's and adults' services for young people with cystic fibrosis.<br>• Review pathway and identify barriers<br>• Adapt pathway and include in directory | Improved patient experience for young people transitioning from children to adult services with cystic fibrosis, measured through PALs, patient surveys | | CCG and YTHFT March 2019 |
| | Develop Information guide/ booklet on accessing health services for people with LD. | Guide / booklet produced and disseminated<br><br>Improved access and patient experience of | | CCG March 2019 |

| Goal / Priority | Action | Impact / Success measure | Progress | Lead and timescales |
|---|---|---|---|---|
| | | people with learning disabilities, measured through PALs, patient surveys | | |
| | Review access issues relating to rurality<br><br>• Ensure review of patient transport includes engagement with rural communities.<br>• Consider including rurality as a group on equality impact analysis<br>• Look at how technology can be used to improve access for people in rural communities | Engagement plan for patient transport review includes rural communities – any issues / barriers / inequalities fed into to EIA and any mitigating actions agreed<br><br>Better understanding of access issues relating to access and rurality<br><br>Improved access / patient experience for people living in rural communities, measured through PALS, patient surveys<br><br>Develop suitable measures to track impact on patients in rural areas | | CCG |

| Goal / Priority | Action | Impact / Success measure | Progress | Lead and timescales |
|---|---|---|---|---|
| 6. Information sharing<br><br>Generate and share information and knowledge across a wider area | Improve sharing and understanding of patient experience data e.g. surveys and patient engagement between hospital and CCG<br>Analysis of PALS and patient experience data by protected groups. | • Improved insight into patient experience that can be fed into service improvements and commissioning decisions. | | Joint 2018<br><br>YTHFT 2018 |
| | Identify and agree key messages to be shared with stakeholders e.g. 6 monthly updates on EDS progress<br>Identify and agree mechanisms for dissemination particularly through existing VCS networks | Improved communication and engagement with stakeholders particularly VCS organisations working with / representing protected groups and rural communities. | | Joint 2018 |
| 7. Develop options for improved representation and involvement of | • Review current invitee list and identify any gaps, particularly around specific protected groups and rural areas | • Increased engagement from a wider range of protected groups in assessing progress and identifying joint | | Joint 2019 |

| Goal / Priority | Action | Impact / Success measure | Progress | Lead and timescales |
|---|---|---|---|---|
| EDS2 - Increase reach of consultation invitees for input into EDS2 process, i.e. more groups represented/ involved.<br>8. | • Identify additional groups e.g. faith groups<br>• Review methods and approaches for EDS2 engagement<br>• Agree engagement plan and hold panel / engagement event in Spring 2019<br>• Agree EDS2 Goals / outcomes to be assessed in 2019 | priorities relating to EDS2<br>• Increased insight into patient experience and barriers for protected groups | | |

The CCG and YTHFT plan to hold a further EDS2 engagement event in spring 2019, where we will review progress against these priorities and actions.

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Freedom to Speak Up Self Review Tool

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☐ **to ensure financial sustainability**

Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☒ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☒ | | |

Purpose of the Report

This self-review tool aims to help boards carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

Executive Summary – Key Points

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Recommendation

To read, discuss and ratify the gap analysis.

Author: Lisa Smith, Freedom to Speak Up Guardian
Dianne Willcocks, Senior Independent Director
Polly McMeekin, Acting Director of Workforce and Organisational Development

Director Sponsor: Polly McMeekin, Acting Director of Workforce and Organisational Development

Date: September 2018

National Guardian
Freedom to Speak Up

NHS
Improvement

# Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

# How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

| Self review indicator<br><br>(Aligned to well-led KLOEs) | To what extent is this expectation being met? | What are the principal actions required for development? | How is the board assured it is meeting the expectation?<br><br>Evidence |
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| **Our expectations** | | | |
| **Leaders are knowledgeable about FTSU** | | | |
| Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. | Fully met | | Included in FTSU 6/12 board reports |
| Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. | Partially met | Appreciation of FTSU role yet to be fully understood by all senior leaders. All can appreciate vision. | Feedback from FTSU Guardian.<br><br>Staff Survey feedback |
| They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. | Fully met | | Developing People Strategy includes this as does full range of leadership programmes run internally and externally. |
| Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy. | Fully met | Developing People Strategy ratified by Board Committee | Developing People Strategy ratified by Board Committee |

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| **Leaders have a structured approach to FTSU** | | | |
| There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. | Fully met | | As above :We don't have a stand alone FTSU strategy – but the vision is incorporated in Developing People and Raising Concerns Policies |
| There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. | Fully met | | Up to date policy signed off by staff side. |
| The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian. | Fully met | | Staff side, ODIL, HR involved in drafting the Developing People ( DP) Strategy |
| Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures. | Fully met | | Bi-annually reports to the Board as well as Staff survey feedback |
| **Leaders actively shape the speaking up culture** | | | |

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| All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. | Partially met | Developing People, Improving Care framework to be rolled out. | Language of 'living our values' regularly appears in leader communications and at Board |
| They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. | Partially met | New patient safety lead to give fresh impetus to learning from incidents and feedback.<br><br>Staff Survey action plan. | Review using Board Assurance Framework (BAF) as well as reflections from Board meetings. Patient Story launches each board meeting. |
| Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. | Partially met | Work with the Communications Team to create a more visible and approachable culture | Most are visible undertaking patient safety workarounds and staff surgeries |
| Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. | Fully met | | FTSU Guardian has regular 1;1 meetings with senior leaders |
| Senior leaders model speaking up by acknowledging mistakes and making improvements. | Partially met | New patient safety lead to give fresh impetus to learning from incidents and feedback. | Review using Board Assurance Framework (BAF) as well as reflections from Board meetings. Patient Story |

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| | | Staff Survey action plan<br><br>Constructive dialog with JNCC and LNC | launches each board meeting.<br><br>Staff Survey |
| The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly. | Fully met | | Via promotion of the multiple channels that staff can speak up, through the FTSU Guardian's reporting |
| **Leaders are clear about their role and responsibilities** | | | |
| The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. | Fully met | | Mike Proctor Executive lead<br><br>Dianne Willcocks Non Executive Director lead |
| They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. | Fully met | | Regular scheduled meetings in diary with FTSU Guardian |
| Other senior leaders support the FTSU Guardian as required. | Fully met | | FTSU able to readily access any senior leader |
| **Leaders are confident that wider concerns are identified and managed** | | | |

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| Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. | Partially met | Need to allow collaboration between complaints, incident reporting and patient safety to triangulate feedback and learning. | FTSU Guardian accesses Staff Survey / Staff Survey action plan and attends JNCC and LNC meetings. They also Chair the Junior Doctor Forum (dual role) and attends Board meetings to present their findings |
| The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate. | Fully met | | Patient safety issues included in board report |
| **Leaders receive assurance in a variety of forms** | | | |
| Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process. | Partially met | Improved Communications to some areas | FTSU Guardian undertakes agile working across all sites to spread the word. Living our values is communicated widely.<br><br>Guardian also attends corporate inductions to capture new starters. |

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| Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers | Partially met | Implementation of the WRES action plan. | Recruitment of fairness champions representative of diverse staff groups. |
| Speak up issues that raise immediate patient safety concerns are quickly escalated | Fully met | | Case reviews and FTSU data |
| Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority | Fully met | | Where there is evidence – the disciplinary policy is followed |
| Lessons learnt are shared widely both within relevant service areas and across the trust | Partially met | Further work required to share learning from Datix and providing feedback to staff | New role of Challenging B&H Lead in HR has pan Trust oversight in this remit.<br><br>New Patient Safety Lead to share learning across Trust |
| The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented | Fully met | | Annual audit undertaken by FTSU Guardian |
| FTSU policies and procedures are reviewed and improved using feedback from workers | Fully met | | Annual review with staff side |

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| The board receives a report, at least every six months, from the FTSU Guardian. | Fully met | | 6 monthly report and attendance at board by FTSU Guardian |
| **Leaders engage with all relevant stakeholders** | | | |
| A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan. | Partially met | Trust is procuring external support to deliver real-time engagement tool as well as delivering both the Staff Survey and Staff FFT. | Staff Survey results<br>Debate at JNCC and JLNC meetings |
| Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. | Partially met | To share FTSU bi-annual reports with these stakeholders. | Staff Survey results and action plans are shared with CQC and Commissioners. |
| Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). | Fully met | | FTSU report and attendance at public board meeting bi-annually |
| The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. | Not met | To be included in annual report 19/20. | Annual Report includes detail of the appointment of the FTSU role only |

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| Reviews and audits are shared externally to support improvement elsewhere. | Fully met | | FTSU Guardian shares amongst networks and via the NGO |
| Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture | Partially met | To link directly with the NGO | Dialog via the FTSU Guardian only |
| Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians | Partially met | FTSU Guardian to establish relationship with regulator | Full engagement with other FTSU guardians and CQC |
| Senior leaders request external improvement support when required. | Fully met | | Trust funded external reviews when required (Lab Med). |
| **Leaders are focused on learning and continual improvement** | | | |
| Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. | Partially met | Implementation of staff engagement facility. | Delivery of staff survey action plan.<br><br>Honest discussion /challenge at Board regarding culture and WRES |
| Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. | Fully met | | FTSU Guardian attends regional network and |

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| | | | shares best practice |
| Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. | Fully met | | FTSU shares case reviews with board and advices on actions from recommendations as appropriate. |
| Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation. | Partially met | Learning from incidents remains on the staff survey action plan | FTSU and Staff Survey reports receive discussion at Board and Board Committees |
| The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success. | Not met | On anniversary of policy will review jointly with staff side | |
| The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. | Fully met | | Policy is reviewed annually |
| A sample of cases is quality assured to ensure:<br>• the investigation process is of high quality; that | Fully met | | Via annual audit |

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| outcomes and recommendations are reasonable and that the impact of change is being measured<br><br>• workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome<br><br>• Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored | | | |
| Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. | Partially met | Within the realms of confidentiality | Positive experiences and feedback from staff who have spoken up are shared at various training events etc. |
| **Individual responsibilities** | | | |
| **Chief executive and chair** | | | |
| The chief executive is responsible for appointing the FTSU Guardian. | Fully met | | FTSU Guardian appointed by (previous) CEO |

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| The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. | Partially met | To secure more confidential meeting venues. | FTSU Guardian undertakes agile working to ensure presence on each site. Guardian speaks at Corporate Induction and attends Board of Directors bi-annually to deliver report personally |
| The chief executive and chair are responsible for ensuring the annual report contains information about FTSU. | Partially met | Data to be included in 19/20 annual report | Annual report 16/17 detailed arrangements for FTSU Guardian appointment. Investment in role etc. |
| The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office. | Fully met | | Via the FTSU Guardian |
| Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly. | Fully met | | Regular meetings with both |
| **Executive lead for FTSU** | | | |

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| Ensuring they are aware of latest guidance from National Guardian's Office. | Fully met | | FTSU Guardian shares guidance as appropriate |
| Overseeing the creation of the FTSU vision and strategy. | Fully met | | Support of the Board to drive cultural change for open and transparent environment. Feedback received by FTSU Guardian from CEO and Chair informed policy |
| Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian. | Fully met | | Recruitment process followed and staff involved in both assessment centre and interview. |
| Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence. | Fully met | | Fairness Champions cover absence and escalation policy adhered to |

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| Ensuring that a sample of speaking up cases have been quality assured. | Fully met | | Via audit internally. |
| Conducting an annual review of the strategy, policy and process. | Fully met | | Reviewing data via audit and bi-annual reports |
| Operationalising the learning derived from speaking up issues. | Partially met | Learning from feedback via datix is yet to be fully exploited. | HR Team overseeing learning and implement with support from staff side. |
| Ensuring allegations of detriment are promptly and fairly investigated and acted on. | Fully met | | Policy followed. |
| Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process. | Fully met | | Bi-annual reports provide assurance as well as patterns and areas of development. |
| **Non-executive lead for FTSU** | | | |
| Ensuring they are aware of latest guidance from National Guardian's Office. | Fully met | | Via FTSU Guardian and Fairness Forum and Fairness Champion Steering Group |
| Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up | Fully met | | SID meets with CEO / Chair and triangulates |

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| strategy. | | | information with the FTSU Guardian and HR reports |
| Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement. | Partially met | Could inform more discussions | Robust discussion at Board and Board sub-committee. |
| Role-modelling high standards of conduct around FTSU. | Fully met | | Visibility od SID in trust and hi-level of engagement in diverse settings ie Fairness Champions/Fairness Forum /Schwartz rounds |
| Acting as an alternative source of advice and support for the FTSU Guardian. | Fully met | | Readily available to FTSU Guardian |
| Overseeing speaking up concerns regarding board members. | Fully met | | Recently addressed concerns relating to an Executive. |
| **Human resource and organisational development directors** | | | |
| Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues | Fully met | | FTSU Guardian attends senior HR meeting and shares case reviews/ |

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| with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up. | | | intelligence |
| Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust. | Partially met | Continue to share learning and provide Guardian with ready access to information to support FTSU culture. | HR Senior Team share learning with wider team. Work in progress |
| Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively. | Partially met | New management standards training in development to address this | FTSU Guardian speaks at Corporate Inductions; Chairs the Junior Dr Forum and attends JNCC and JLNC meetings |
| **Medical director and director of nursing** | | | |
| Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues. | Partially met | FTSU Guardian to work with Deputy Director for Patient Safety and Heads of Safeguarding to build relationships and share intelligence | FTSU Guardian meets with Medical Director and Chief Nurse. |

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| Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up. | Fully met | | FTSU Guardian has access as appropriate |
| Ensuring learning is operationalised within the teams and departments that they oversee. | Partially met | Strategy and vision understood but operational learning yet to be embedded across all areas. | HR Policies and Procedures altered to reflect feedback. Development of Line management competency training following feedback. |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Finance and Performance Committee Minutes – 21 August 2018

**Attendance:** Mike Keaney (MK) Chairman, Andrew Bertram (AB), Wendy Scott (WS), Lynette Smith (LS) Graham Lamb (GL), Steve Kitching (SK), Lynda Provins (LP), Joanne Best.

**Apologies for Absence:** Melanie Liley (ML)

**Minutes of the meeting held on the 17th July 2018**

The minutes of the last meeting held on 17th July 2018 were agreed subject to the following amendments:-

**Page 6, paragraph 7 –** 'this may be due to reduced take ***up*** of shifts by Bank Staff'

**Page 8, paragraph 1 –** 'It was ***noted*** that no clinical harm has been identified to date'

MK noted that with the forthcoming changes to Board this could be the last Finance and Performance Committee. MK stated that the F&P Committee had been a very successful Committee and thanked everyone for their support.

**Matters Arising** - WS told the Committee that the Deputy Chief Operating Officer at Scarborough is retiring but will be returning to a different role. Stated that an external recruitment process had occurred but that no appointment had been made therefore will now be advertised internal with a view to appointing to a Scarborough based role.

**September Board Agenda –** LP explained to the Committee the plans for the new Board structure, noting that there will be an expectation that Board papers will be read prior to Board meetings which will allow discussions to be succinct and focussing on areas of concern. A discussion continued with regards to work programmes, SLR reports, Tender reports and it was agreed that these will all be submitted to the Board.

MK stated that although the F&P Committee will no longer take place he would be happy to be approached if required.

**Emergency Care Standard –** LS told the Committee that ECS performance for August look positive despite July seeing a high demand in emergency care attendances. LS reported that the ECS performance for July had achieved 88.0% which is in line with the ECS trajectory and compares to 87.0% achieved in July 2017, noting that there had been lower bed occupancy on both York and Scarborough sites. There has been a 7% increase in the planned number of attendees for July 18. Staffing is still a concern as there is a dependency on agency staff.

The Committee discussed the on-going challenges to the service that occur on both York and Scarborough sites with regard to tourism and the increased number of attenders noting that the service levels will not be sustainable over the winter months. The CCG are aware of the increase of attenders noting that this is a trend. This is under review with the possibility that the closure of Driffield Minor Injuries Unit has contributed to the rise in attenders.
It was noted that the Emergency Care Standard must achieve 90% by September to receive the Provider Sustainability Funding ECS elements, based on the original guidance. It was noted that the guidance was released at the end of Q1 for Q1and as such LS could not full assurance that the Guidance for Q2 would not change.

The committee discussed the need to ensure that work is underway to prioritise demand management initiatives; benchmarking suggests that the York and Scarborough and Ryedale localities have suffered from persistent low investment in out of hospital care and external reviews have showed that this system is 'hospital centric'.. This is a contributing factor.

GL noted that the A & E Board discussed initiatives but that there is no funding to support these.

LS – Ambulance handovers continue to be a concern across the Trust with 198 taking more than 60 minutes, 150 of these were at Scarborough Hospital.

It was noted that although Delayed Transfers of Care have increased from June they still remain below the peak of April and May, however the number of super stranded has improved from July 2017. LS stated that the Complex discharge working group is leading work on the self-assessment of action planning for the Super Stranded national target reduction of 25%. The main focus of the operational weekly meetings with directorates is now on winter planning.

**Cancer –** LS stated that the Trust did not achieve the 62 day to 1st Treatment from GP referral in June, achieving 82% against a planned target of 85%, the June performance has been challenging however the dip in performance was expected. The Trust has been working with NHSI Intensive Support Team (IST) around the Trusts longest waiting patients. As a consequence of this targeted focus on long waiters, it is likely that performance will continue to deteriorate in July and August, NHSI are aware of this.

Urology tumours comprise of one third of the breaches for June, there continues to be delays in TRUS biopsies and significant delays in prostatectomies with Hull informing the Trust that the prostatectomies delays will continue with the next available treatment slot not been available until the end of September 2018.

The colorectal pathway has seen a 17% rise in referrals with a 20% rise in diagnosed cancers which has contributed to 6 breaches in June 18. The Directorate is working with NHSI IST to map the pathways, confirming delays in diagnostic stage due to capacity constraints to meet the increasing demands.

Following these pressures the enhanced Cancer Strategic Leadership for the Trust has been implemented, collaboration with NHSI and the Cancer Alliance are underway to develop a 62 day recovery plan across the Alliance. The Cancer Alliance undertook a prioritisation workshop in August to identify the proposed cost reductions to HCV Schemes as a result of the loss of funding for Q2.

The Committee discussed the loss of HCV STP Cancer Alliance funding as result of not achieving the 62 day cancer target. A meeting of Alliance members has taken place to reprioritise schemes as a result of a reduction in the funding available. One of the schemes that has been postponed is the 'lung bus' due to mobilise initially in Hull.

**Planned Care – LS** - The RTT position for July is 84.5% which is above the planned trajectory of 84% this compares to 84.1% in June 17 and 88.2% in July 17. The number of patients on the waiting lists has increased representing a 6.8% increase on the Trust activity plan for July and 5.7% increase from March 18. It was noted that this increase is primarily driven by increased demand.

There were no 52 week breaches declared in July following the implementation of the 52 week action plan and weekly meetings targeting long wait patients, however the risk still remains high.

The Committee discussed how active management is having a positive impact but noted that this was not sustainable long term. The Trust has been more productive in relation to planned care in 2017 but that the April 18 bed pressures have had a big impact on the service. Development of the Outpatients transformation Programme with a PID in development will be submitted to the Planned Care Board in September for approval.

The group discussed the issue of the AIC and the need for CCG permission to undertake additional planned work before funding would be released. This matter would be referred through to the Board meeting given the current waiting list performance and challenge with system finance.

AB reminded the committee that under the aligned incentive contract discussions can take place to recuperate additional costs for non-planned care

**Diagnostic-**
The diagnostic concerns for July remain similar to last month, achieving 95.6% compared with 96.3% in June. The challenges include capacity issues in endoscopy and radiology services. There has been an increase in cancer and urgent referrals to radiology and endoscopy which in is reducing the available capacity for routine requests.

As noted in the July 2018 minutes the Trust engaged with NHS Elect to complete a demand and capacity review in radiology, this will inform the development of detailed service level standards for turnaround and reporting. The diagnostic recovery plan is being refreshed to target demand reduction, maximizing capacity, and looking at enablers and ways of working. The System Transformation Board has agreed that the external PWC resources will be targeted at reviewing options to reduce endoscopy demand to target a reduction in WLI.

MK suggested that this should be discussed at Board tomorrow.

**CQUINS –** LS noted that there were no issues to the CQUINS and that although they continue to be monitored. Q1 has been approved by the CCGs.

**Finance – GL** – The income and expenditure position for month 4 is a deficit of £5.2m against the planned deficit of £4.8m giving an adverse variance against plan of £0.4m.

It was noted that excluding the Provider Sustainability Funding (PSF) the month 4 control total was £7.5m deficit and that this had been exceeded with an actual reported deficit of £7.4m. Although Sustainability funding eligibility is assessed at the end of the quarter, the month 4 position assumes receipt of month 4 sustainability funding because of positive performance against the financial control total, ECS delivery has also been assumed in the report position for month 4.

The Trust received confirmation that its appeal against the loss of Q1 ECS sustainability funding of £0.6m has been unsuccessful; this has been removed from the reported position.

An additional analysis sheet was circulated round the Committee that showed additional analysis of the run rate income and expenditure categories as per the NHSI Investigation Report recommendations. The Run Rate shows that average spend has increased to £41.8m in the period April to July, compared to £41.0m on average for quarters 3 and 4 last year. It was noted that this increase has fallen in non-pay expenditure areas and analysis is underway with Directorates to understand the reasons for the increase, particularly to review if any trend increases are likely to be sustained. Notwithstanding this pressure on expenditure the Trust has matched the in-month overall income expenditure plan.

Agency total cap is £14.9m as per NHSI's direction for the Trust, month 4 suggests a spend cap of £5.0m but actual reported agency expenditure was slightly above cap at £5.1m. Noting a reduction in agency expenditure for July 2018.

It was noted that the report now identifies excluded drugs and devices from the main category of drug expenditure. Under the AIC reimbursement for the CCG component of this additional spend is only at 50% and an adjustment to the overall reported income level has been made to reflect this arrangement. Noting that the share of excluded drug and device expenditure commissioned by NHSE is not subject to any AIC adjustment.

GL reported that income levels reflect higher than planned non-elective demand and ED attendances.

AB offered assurance that income compensation will support this additional work.

GL - Adjustment has been made to reduce the income level in accordance with the requirements of AIC to reflect the most likely outturn following reconciliation under the AIC arrangements. The Systems Transformation Board are overseeing the development of reporting system.

The CIP target for 2018-19 is £21.7m and the profile for delivery has been set using intelligence around previous year's delivery trajectories. To date £9.1m in full year terms has been delivered, notably £6.1m recurrently.

The Committee continued to discuss the Trusts Run Rate Analysis report p76 of the Board pack, it was noted that there were no issues with agency spend for July and that drug spend was on plan.
AB told the Committee that the £2m cash draw down that was highlighted in the Finance paper is no longer required therefore the application has been withdrawn. Specifically agreement had been reached with commissioners to pay at the start of the month from September onwards (as oppose to the usual 15th of the month) in line with the latest helpful guidance from NHSI&E.

**Efficiency - SK** – the Trusts Efficiency programme target for 2018-19 is £21.7m and that as at the end of July 2018 delivery is £9.1m which equates to 42% of the annual target. This compares to a delivery position of £6.4% in July 2017, noting that this is £1.8m up from last month.

It was noted that for month 4 the Trust continues to be in a strong position showing improvement in the risk profile of plans. Focus is now on the high to medium risk plans to convert them to low risk deliverable schemes.

SK stated that transactional schemes represent £16m which is 64% of the overall Efficiency Target of which £7.4m has been delivered of this £4.4m is recurrent.

Transformational Schemes represent 26% (£5.7m) of the overall Efficiency Target of which £1.7m has been delivered recurrently. It was noted that plans are continuing to be developed.

The Committee discussed who the Efficiency data will be reported to if the Finance and Performance Committee does not occur; AB stated that this information will be reported to the Board.

WS discussed the work that is underway to create a portfolio of reports relating to Trust transformation schemes. These will be shared at the monthly efficiency group and will be used to support discussions at Executive Board and in other forums. .

It was noted that if the F&P Committee commences in the New Year then data will be delivered to the Committee in the new format.

MK addressed the Committee thanking them for their contributions to the Committee and noting that the Finance and Performance Committee had been an excellent group.

**BAF –** No update was given to the Committee

**AOB – RISK** – AB advised that the finance CRR had been reviewed by the senior finance team with a number of changes made. He discussed the Trusts financial position overall in relation to the AIC.

The Committee had a brief discussion about the Risks that had been raised throughout the meeting including the 62 day to 1st Treatment from GP referral, long waits in the Emergency Department, Bed Occupancy levels, Radiology backlog issues and transfer of care. WS told the Committee that City of York Council are very supportive of the transfer of care and have invested £200,000. It was noted that CYC recognise that this is a priority.

**Action Log:**

| Month | Action | Responsible Officer | Due date | Completed |
|---|---|---|---|---|
| Jun 18 | To consider adding waiting list data to the Data Quality Group work programme | Andy Bertram | 21.08.18 | Completed – on Nov DQ Group Agenda |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Finance Report

**Trust Strategic Goals:**

☐ **to deliver safe and high quality patient care**
☐ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

## Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☒ | | |

## Purpose of the Report

To report on the financial position of the Trust.

## Executive Summary – Key Points

This report details the 2018/19 month 5 financial position for York Teaching Hospital NHS Foundation Trust.

The Trust is reporting an Income and Expenditure deficit of £6.4m against a planned deficit of £5.9m after including all PSF adjustments. The Trust is currently reporting a £0.5m adverse variance to plan, almost all of which relates to the loss of quarter 1 sustainability funding due to the Trust missing the ECS target requirements.

## Recommendation

The Board is asked to note the report.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: September 2018

## 1. Month 5 Summary Financial Position

Including all sustainability funding adjustments the month 5 income and expenditure position is a deficit of £6.4m against a planned deficit of £5.9m. The Trust is therefore reporting a £0.5m adverse variance against plan, almost all of which relates to the loss of quarter 1 sustainability funding due to the Trust missing the ECS target requirements.

Excluding Provider Sustainability Funding (PSF) the month 5 control total was a £9.6m deficit. This position has been achieved with an actual reported deficit of £9.5m. Whilst sustainability funding eligibility is assessed at the end of the quarter, the month 5 position assumes receipt of month 4 and month 5 full sustainability funding because of positive performance against the financial control total and positive delivery against the Emergency Care Standard (ECS). This position is subject to the formal quarter two reconciliation process.

To date the reported financial position therefore assumes all sustainability funding with the exception of quarter 1 ECS. This has a value of £0.6m. Following confirmation that the Trust's appeal against the loss of Q1 ECS sustainability funding has been unsuccessful this has now been permanently removed from the reported position and from the Trust's forecast outturn.

## 2. Summary Financial Commentary

The detailed Finance Report in the Board's Performance Pack includes the additional analysis reviewing run rate income and expenditure categories as per the NHSI Investigation Report recommendations. The overall expenditure run rate analysis shows spend has increased to £42.8m in August which is significantly higher than the first four months of the financial year and the last six months of 2017/18 under the financial recovery plan actions.

A full reconciliation has been undertaken and the variance in run rate is understood. Of note is the material pressure increase from the, externally funded, pay award arrears paid in August.

Agency expenditure has been reset at a total cap of £14.9m as per NHSI's direction for the Trust. For the period to month 5 this suggests a spend cap of £6.3m. The actual reported agency expenditure was slightly above cap at £6.4m but reductions in agency expenditure are evident from the 2017/18 outturn position.

The reports now separately identify excluded drugs and devices from the main category of drug expenditure. The report confirms excluded drug and device expenditure ahead of plan by £0.8m. Under the AIC, reimbursement for the CCG component of this additional spend is only at 50%, and an adjustment to the overall reported income level has been made to reflect this arrangement. The share of excluded drug and device expenditure commissioned by NHSE is not subject to any AIC adjustment.

Work has been progressing through the AIC Management Group on the detailed understanding of the trading position under the AIC agreement. The Trust's plan assumes £10m of QIPP delivered in the contract agreements with our three AIC commissioners.

The activity position currently confirms QIPP is not delivering and therefore the Trust is overtrading on the agreed contract. The Trust's reported income position reflects the risk share agreement. In addition to non-delivery of the QIPP the Trust is delivering higher levels of activity than the Trust's initial activity projections. These are notable in non-elective activity particularly. A further adjustment has been made to Trust income levels to reflect the marginal cost of delivery chargeable under the AIC for this additional work. Work to reconcile this position with the CCGs is underway but this is proving extremely challenging for CCG affordability.

This trading position manifests itself in adverse variances on all Trust expenditure lines. These are compensated by the income adjustments.

The CIP target for 2018/19 has been profiled this year using intelligence around previous years' delivery trajectories. The total target for 2018/19 is £21.7m with £10.7m (49%) delivered in full year terms to date; notably £6.6m delivered recurrently. Plans for delivery now sit under either transformational or transactional scheme programmes. Transformational scheme plans total £6.2m with £1.7m delivered year to date and transactional scheme plans total £15.5m with £9.0m delivered year to date.

There are no new cash issues to bring to the Board's attention this month. We have been able to sustain a positive position, particularly influenced by the changes to the payment profiles agreed with the CCGs under the AIC arrangement. This position is being closely monitored and scrutinised by the Finance Team.

Significant Finance Risks

- The Board should be aware that QIPP is not delivering and significant additional activity is presenting at the Trust. Whilst under the risk share arrangements this compensates the Trust for the cost this is proving extremely challenging in terms of affordability for our local CCGs
- Control over our expenditure position remains a key risk. As we move to the second half of the financial year our internal CIP requirements will accelerate and it is important that we see the monthly expenditure run rate reduce. Expenditure discipline will require enhancement, recognising key patient safety considerations.

## 3. Supplementary Action

At this stage there are no supplementary actions required by the Board of Directors. Key actions in place continue to be:

- AIC risk share application
- Evaluation and application of the financial implications of additional to plan activity with the CCGs
- Expenditure discipline and control
- Efficiency programme delivery
- QIPP delivery through the STB
- Cash flow management
- Medium-term financial planning underway with commissioners. The Board of Directors will receive the first cut medium-term financial plan at the November

Board meeting. The operating framework (describing the 2019/20 business rules such as control totals, PSF, tariff, etc.) is not expected until January.

## 4. Recommendation

The Board of Directors is asked to note the current financial position and to continue to support the expenditure control approach and the work with CCGs under the AIC.

# Finance Report

## August 2018

Produced September 2018

### The Board Assurance Framework is structured around the four ambitions of the Trust:

**Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.

**Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.

**People and Capability** - The quality of our services is wholly dependent on our teams of staff.

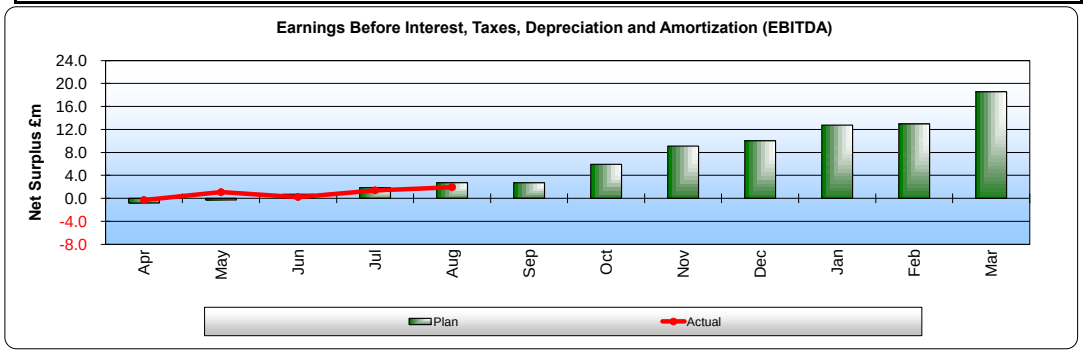
**Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

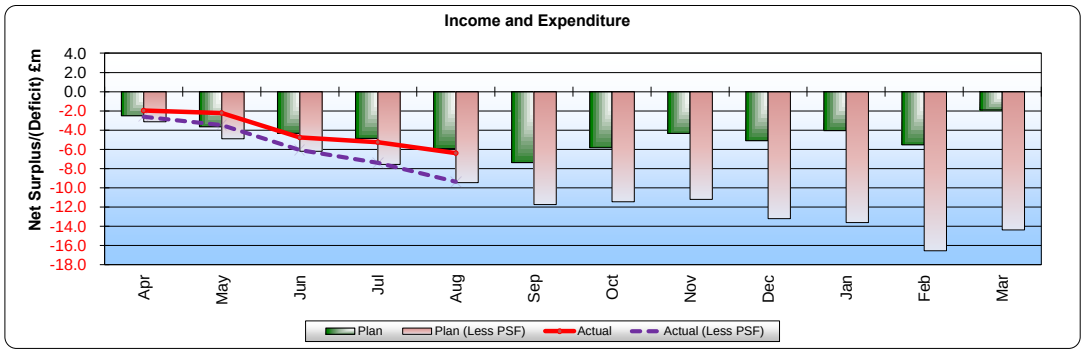
# Summary Income and Expenditure Position
## Month 5 - The Period 1st April 2018 to 31st August 2018

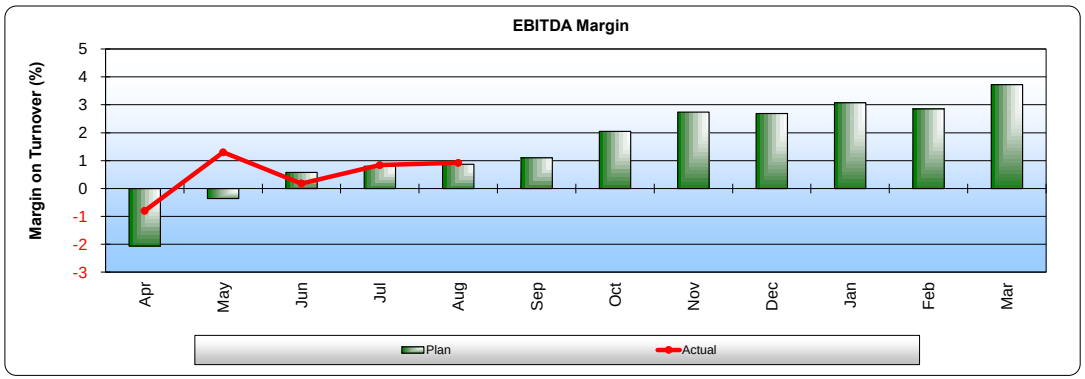
York Teaching Hospital NHS Foundation Trust

**Summary Position:**

* The Trust is reporting an I&E deficit of £6.4m, placing it £0.5m behind of the operational plan.
* Income is £2.8m ahead of plan, with clinical income being £3.0m ahead of plan and non-clinical income being £0.2m behind plan.
* Operational expenditure is ahead of plan by £2.7m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £1.9m (0.92%) compared to plan of £1.8m (0.9%), and is reflective of the reported net I&E performance.




| | Annual Plan | Plan for Year to Date | Actual for Year to Date | Variance for Year to Date | Forecast Outturn | Annual Plan Variance |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **NHS Clinical Income** | | | | | | |
| Elective Income | 22,967 | 10,634 | 10,556 | -78 | 22,967 | 0 |
| Planned same day (Day cases) | 35,496 | 16,311 | 16,802 | 491 | 35,496 | 0 |
| Non-Elective Income | 115,387 | 48,513 | 50,327 | 1,814 | 115,387 | 0 |
| Outpatients | 58,848 | 24,732 | 25,101 | 369 | 58,848 | 0 |
| A&E | 15,390 | 6,823 | 7,057 | 234 | 15,390 | 0 |
| Community | 20,181 | 8,877 | 8,877 | 0 | 20,181 | 0 |
| Other | 114,719 | 47,104 | 46,930 | -174 | 114,719 | 0 |
| Pass-through excluded drugs expenditure | 44,215 | 18,576 | 18,945 | 369 | 44,215 | 0 |
| | **427,203** | **181,570** | **184,595** | **3,025** | **427,203** | **0** |
| **Non-NHS Clinical Income** | | | | | | |
| Private Patient Income | 1,042 | 434 | 320 | -115 | 1,042 | 0 |
| Other Non-protected Clinical Income | 1,560 | 650 | 788 | 138 | 1,560 | 0 |
| | **2,602** | **1,084** | **1,108** | **24** | **2,602** | **0** |
| **Other Income** | | | | | | |
| Education & Training | 13,736 | 5,723 | 6,165 | 442 | 13,736 | 0 |
| Research & Development | 3,182 | 1,326 | 1,208 | -118 | 3,182 | 0 |
| Donations & Grants received (Assets) | 0 | 0 | 0 | 0 | 0 | 0 |
| Donations & Grants received (cash to buy Assets) | 623 | 260 | 260 | 0 | 623 | 0 |
| Other Income | 32,002 | 12,003 | 12,028 | 25 | 32,002 | 0 |
| Sparsity Funding | 2,600 | 1,083 | 1,083 | 0 | 2,600 | 0 |
| PSF | 12,479 | 3,536 | 2,974 | -562 | 11,917 | -562 |
| | **64,622** | **23,931** | **23,719** | **-212** | **64,060** | **-562** |
| **Total Income** | **494,427** | **206,585** | **209,422** | **2,837** | **493,865** | **-562** |
| **Expenditure** | | | | | | |
| Pay costs | -337,282 | -137,905 | -140,514 | -2,609 | -337,282 | 0 |
| Pass-through excluded drugs expenditure | -44,215 | -18,576 | -19,424 | -848 | -44,215 | 0 |
| PbR Drugs | -6,726 | -3,049 | -3,469 | -420 | -6,726 | 0 |
| Clinical Supplies & Services | -48,221 | -20,779 | -22,128 | -1,350 | -48,221 | 0 |
| Other costs (excluding Depreciation) | -51,920 | -21,742 | -21,950 | -208 | -51,920 | 0 |
| Restructuring Costs | 0 | 0 | 0 | 0 | 0 | 0 |
| CIP | 10,948 | -2,742 | 0 | 2,742 | 10,948 | 0 |
| **Total Expenditure** | **-477,415** | **-204,793** | **-207,485** | **-2,692** | **-477,415** | **0** |
| **Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)** | **17,012** | **1,792** | **1,937** | **145** | **16,450** | **-562** |
| Profit/ Loss on Asset Disposals | 0 | 0 | 41 | 41 | 0 | 0 |
| Fixed Asset Impairments | -300 | 0 | 0 | 0 | -300 | 0 |
| Depreciation - purchased/constructed assets | -10,717 | -4,465 | -4,880 | -415 | -10,717 | 0 |
| Depreciation - donated/granted assets | -395 | -165 | -165 | 0 | -395 | 0 |
| Interest Receivable/ Payable | 130 | 54 | 41 | -13 | 130 | 0 |
| Interest Expense on Overdrafts and WCF | 0 | 0 | 0 | 0 | 0 | 0 |
| Interest Expense on Bridging loans | 0 | 0 | 0 | 0 | 0 | 0 |
| Interest Expense on Non-commercial borrowings | 0 | 0 | 0 | 0 | 0 | 0 |
| Interest Expense on Commercial borrowings | -967 | -364 | -372 | -7 | -967 | 0 |
| Interest Expense on Finance leases (non-PFI) | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Finance costs | 0 | 0 | 0 | 0 | 0 | 0 |
| PDC Dividend | -6,670 | -2,779 | -3,007 | -228 | -6,670 | 0 |
| Taxation Payable | 0 | 0 | 0 | 0 | 0 | 0 |
| **NET SURPLUS/ DEFICIT** | **-1,906** | **-5,927** | **-6,404** | **-477** | **-2,468** | **-562** |

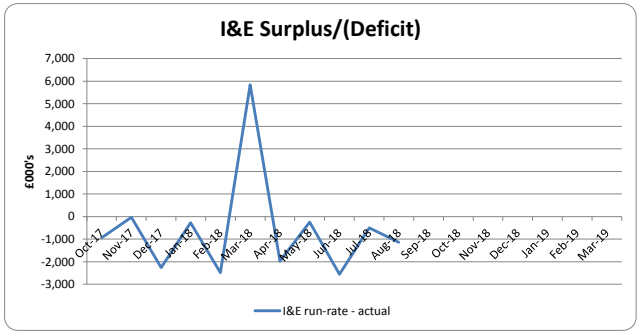
# Summary Trust Run Rate Analysis
## Month 5 - The Period 1st April 2018 to 31st August 2018

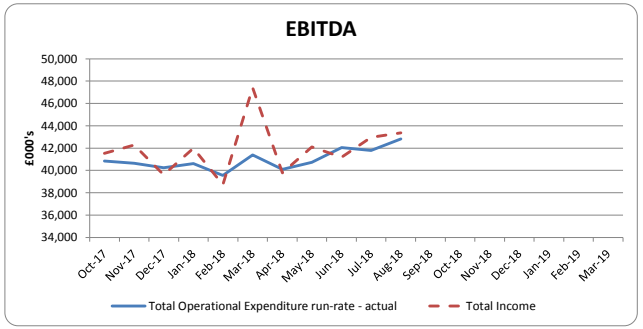
York Teaching Hospital NHS Foundation Trust

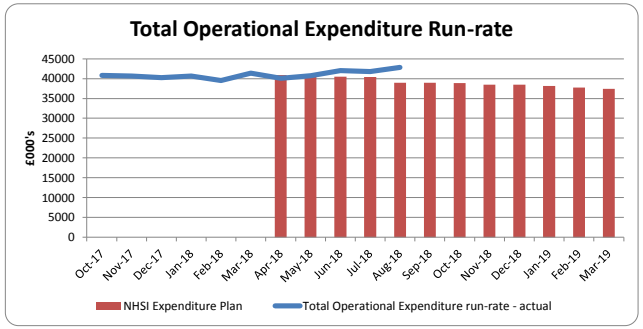
**Key Messages:**

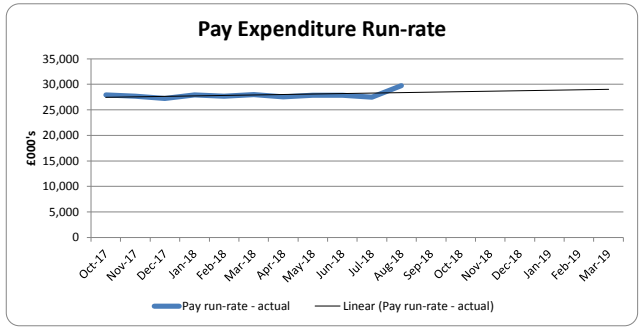
* The total operational expenditure in August was £42.8m. The average total operational expenditure in the previous ten months was £40.8m. Resulting in an adverse variance of £2m. This was largely attirbutable to the pay award arrears being paid in August.

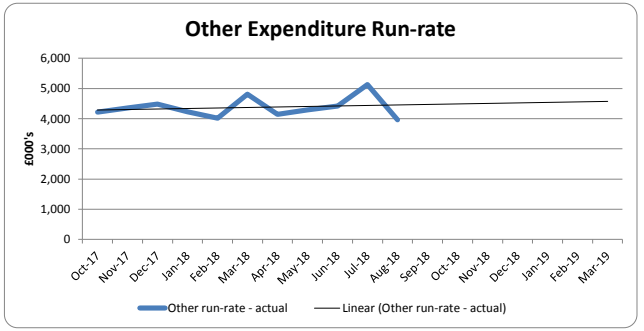
* In month operational income exceeded expenditure by £0.5m, resulting in a positive EBITDA for the month.

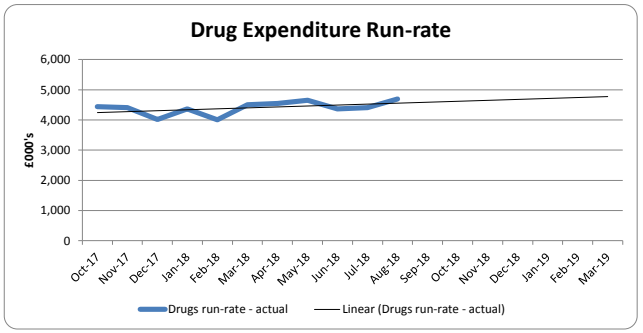


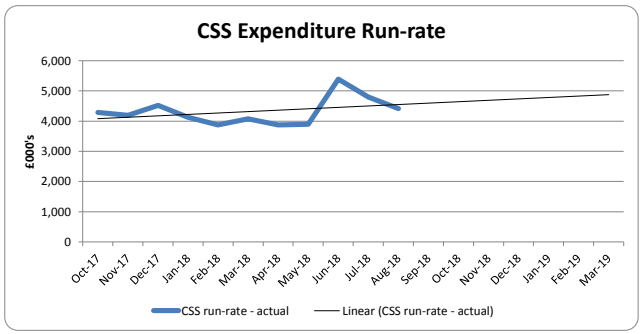




| | Monthly Spend | | | | | | | | | | | | | | | | | Monthly Ave | Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | | |
| Total Income | 41,538 | 42,272 | 39,613 | 42,003 | 38,738 | 47,400 | 39,791 | 42,110 | 41,183 | 42,970 | 43,367 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 41,762 | 1,605 |
| Pay Expenditure | -27,901 | -27,678 | -27,214 | -27,902 | -27,651 | -28,002 | -27,550 | -27,881 | -27,852 | -27,465 | -29,766 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -27,710 | -2,056 |
| Drug Expenditure | -4,438 | -4,411 | -4,013 | -4,369 | -4,008 | -4,507 | -4,549 | -4,651 | -4,368 | -4,402 | -4,691 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -4,372 | -319 |
| CSS Expenditure | -4,285 | -4,196 | -4,522 | -4,132 | -3,877 | -4,070 | -3,871 | -3,895 | -5,392 | -4,790 | -4,413 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -4,303 | -110 |
| Other Expenditure | -4,217 | -4,358 | -4,484 | -4,225 | -4,017 | -4,807 | -4,140 | -4,296 | -4,424 | -5,131 | -3,959 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -4,410 | 451 |
| EBITDA | 697 | 1,629 | -620 | 1,375 | -815 | 6,014 | -319 | 1,387 | -853 | 1,182 | 538 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 968 | -430 |

# Contract Performance

## Month 5 - The Period 1st April 2018 to 31st August 2018

York Teaching Hospital NHS Foundation Trust

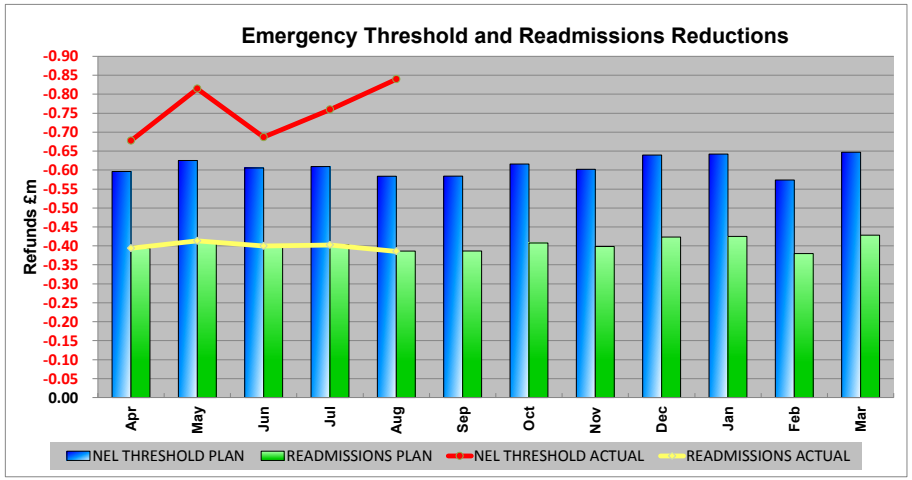
| Contract | Annual Contract Value | Contract Year to Date | Actual Year to Date | Variance |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Vale of York CCG | 219,316 | 92,097 | 95,200 | 3,103 |
| Scarborough & Ryedale CCG | 77,783 | 33,127 | 34,286 | 1,159 |
| East Riding CCG | 42,696 | 17,790 | 18,177 | 387 |
| Other Contracted CCGs | 17,372 | 7,268 | 7,419 | 151 |
| NHSE - Specialised Commissioning | 43,499 | 18,030 | 18,369 | 339 |
| NHSE - Direct Commissioning | 15,340 | 6,370 | 5,963 | -407 |
| Local Authorities | 4,456 | 1,857 | 1,851 | -6 |
| **Total NHS Contract Clinical Income** | **420,462** | **176,539** | **181,265** | **4,726** |

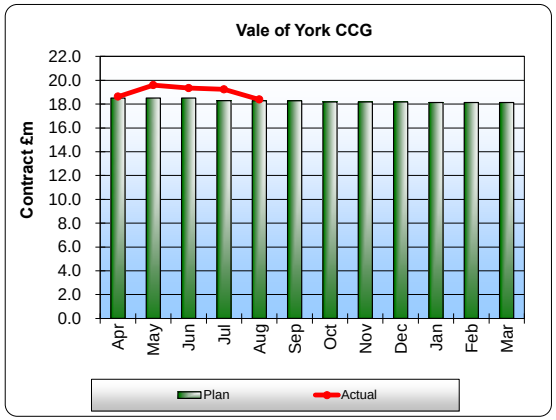
| Plan | Annual Plan | Plan Year to Date | Actual Year to Date | Variance Year to Date |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Non-Contract Activity | 12,088 | 5,025 | 4,413 | -612 |
| Risk Income | -5,347 | 6 | 0 | -6 |
| **Total Other NHS Clinical Income** | **6,741** | **5,031** | **4,413** | **-618** |

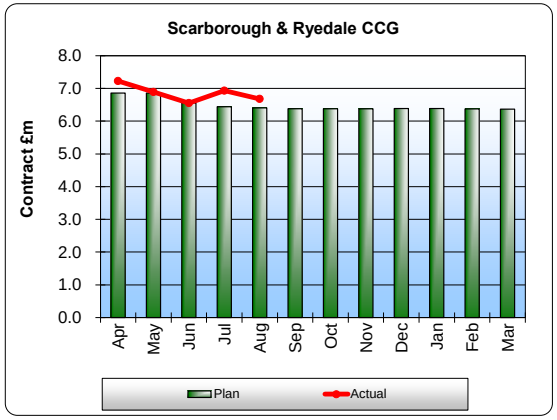
| | |
|---|---|
| Sparsity funding income moved to other income non clinical | -1,083 |
| Winter resilience monies in addition to contract | 0 |

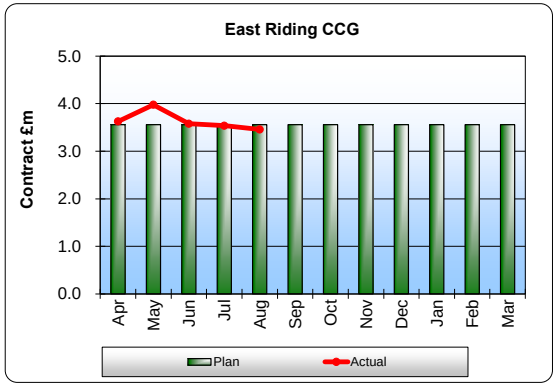
| | | | | |
|---|---|---|---|---|
| **Total NHS Clinical Income** | **427,203** | **181,570** | **184,595** | **3,025** |

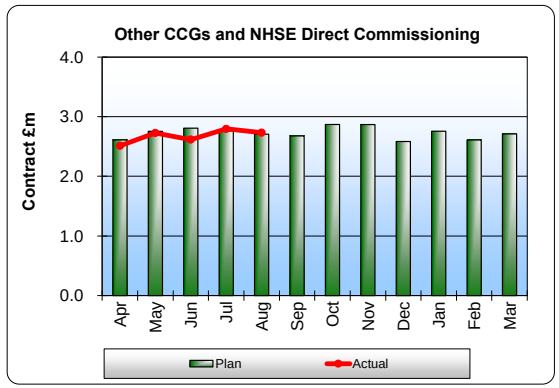
**Activity data for August is partially coded (70%) and July data is 93% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.**

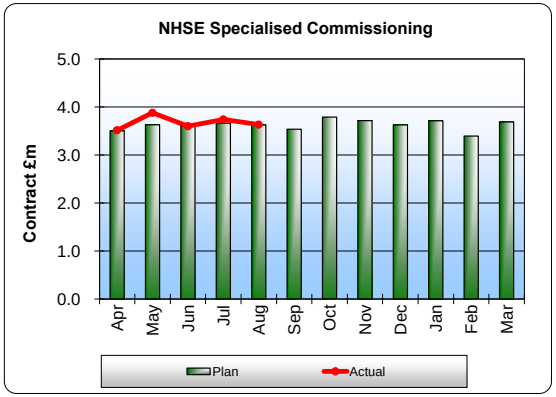


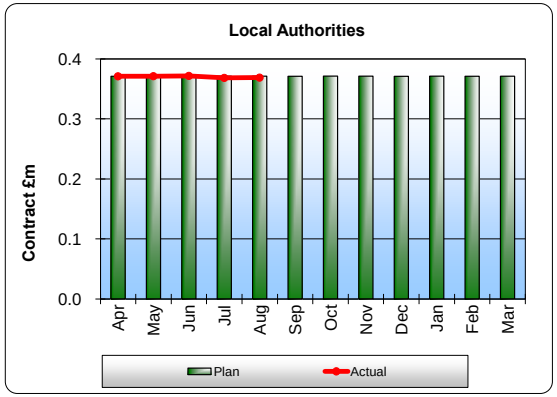



# Agency Expenditure Analysis

## Month 5 - The Period 1st April 2018 to 31st August 2018

York Teaching Hospital NHS Foundation Trust

**Key Messages:**

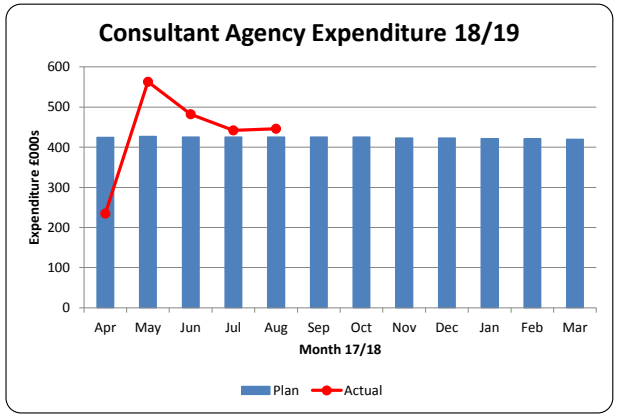
* Total agency spend year to date of £6.4m, compared to the NHSI agency ceiling of £6.3m.

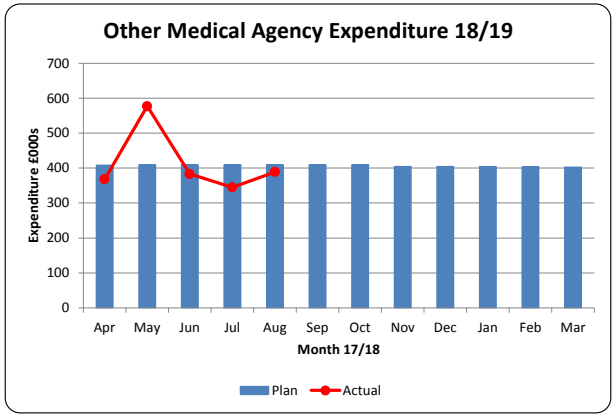
* Consultant Agency spend is broadly on plan.

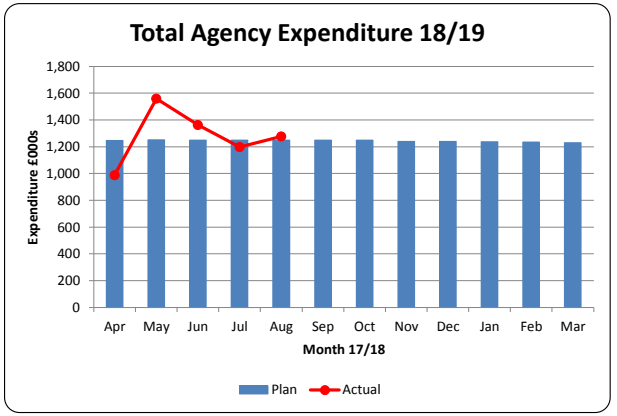
* Nursing Agency is broadly on plan.

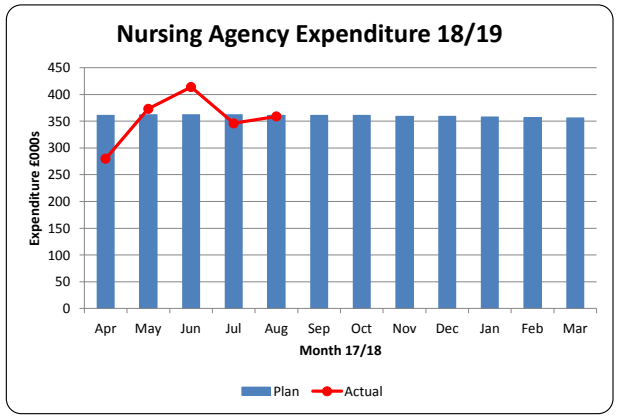
* Other Medical Agency spend is broadly on plan.

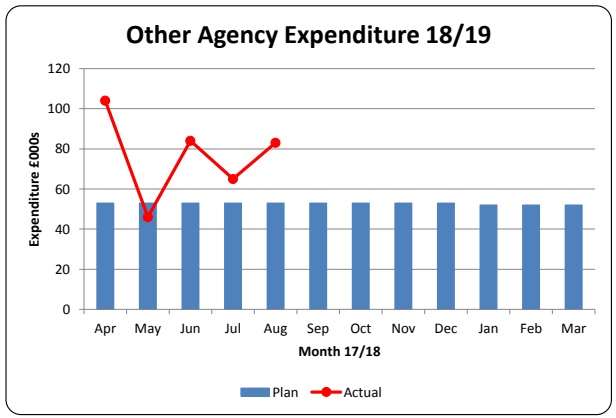
* Other Agency spend is ahead of plan £0.1m.

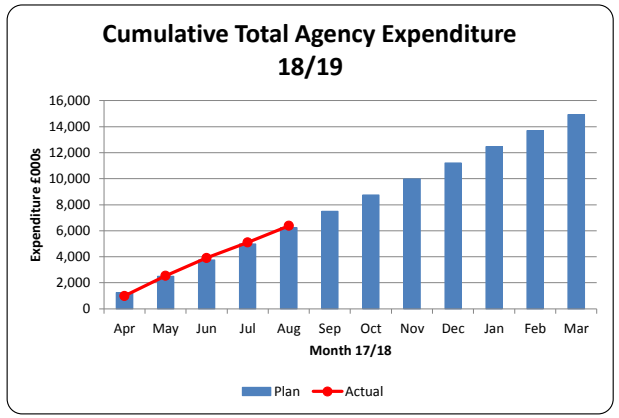


# Expenditure Analysis
## Month 5 - The Period 1st April 2018 to 31st August 2018

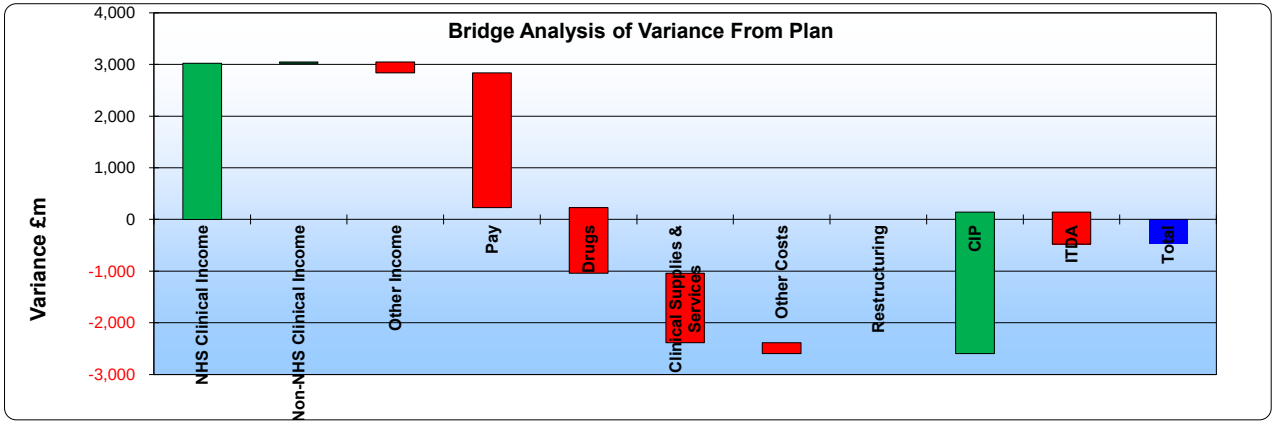
York Teaching Hospital NHS Foundation Trust

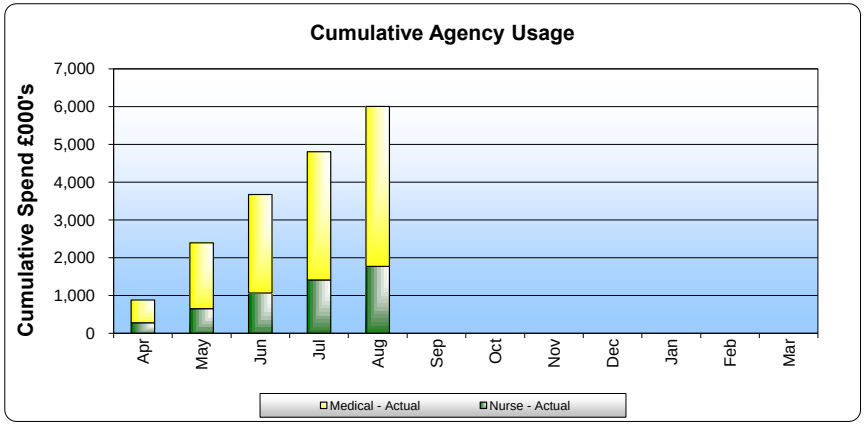
**Key Messages:**

There is an adverse expenditure variance of £2.7m at the end of August 2018. This comprises:

* Pay expenditure is £2.6m ahead of plan.
* Drugs expenditure is £1.3m ahead of plan.
* CIP achievement is £2.7m ahead of plan.
* Other expenditure is £1.5m ahead of plan.

| Staff Group | Annual | Year to Date | | | | | | | | Previous | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Plan | Contract | Overtime | WLI | Bank | Agency | Total | Variance | Variance | |
| Consultants | 59,894 | 24,827 | 22,037 | - | 653 | - | 2,168 | 24,858 | -31 | 0 | |
| Medical and Dental | 30,160 | 12,326 | 13,340 | - | 85 | - | 2,067 | 15,492 | -3,166 | 0 | |
| Nursing | 93,062 | 38,660 | 32,581 | 167 | 55 | 4,285 | 1,773 | 38,861 | -201 | 0 | |
| Healthcare Scientists | 13,682 | 4,149 | 4,471 | 3 | 5 | 3 | 84 | 4,567 | -418 | 0 | |
| Scientific, Therapeutic and technical | 16,468 | 6,833 | 6,227 | 37 | 0 | 15 | 81 | 6,361 | 473 | 0 | |
| Allied Health Professionals | 27,113 | 11,195 | 9,753 | 45 | 79 | 3 | 90 | 9,969 | 1,225 | 0 | |
| HCAs and Support Staff | 48,822 | 20,321 | 18,079 | 294 | 33 | 20 | 61 | 18,487 | 1,835 | 0 | |
| Chairman and Non Executives | 186 | 77 | 70 | - | - | - | - | 70 | 7 | 0 | |
| Exec Board and Senior managers | 15,790 | 6,470 | 5,778 | 1 | - | - | - | 5,779 | 691 | 0 | |
| Admin & Clerical | 39,393 | 16,213 | 15,346 | 65 | 25 | 42 | 67 | 15,545 | 668 | 0 | |
| Agency Premium Provision | 4,241 | 1,767 | 0 | 0 | 0 | 0 | 0 | 0 | 1,767 | 0 | |
| Vacancy Factor | -12,721 | -5,430 | 0 | - | - | - | - | 0 | -5,430 | 0 | |
| Apprenticeship Levy | 1,192 | 497 | 525 | 0 | 0 | 0 | 0 | 525 | -28 | 0 | |
| **TOTAL** | **337,282** | **137,905** | **128,207** | **612** | **936** | **4,369** | **6,390** | **140,514** | **-2,609** | **0** | |



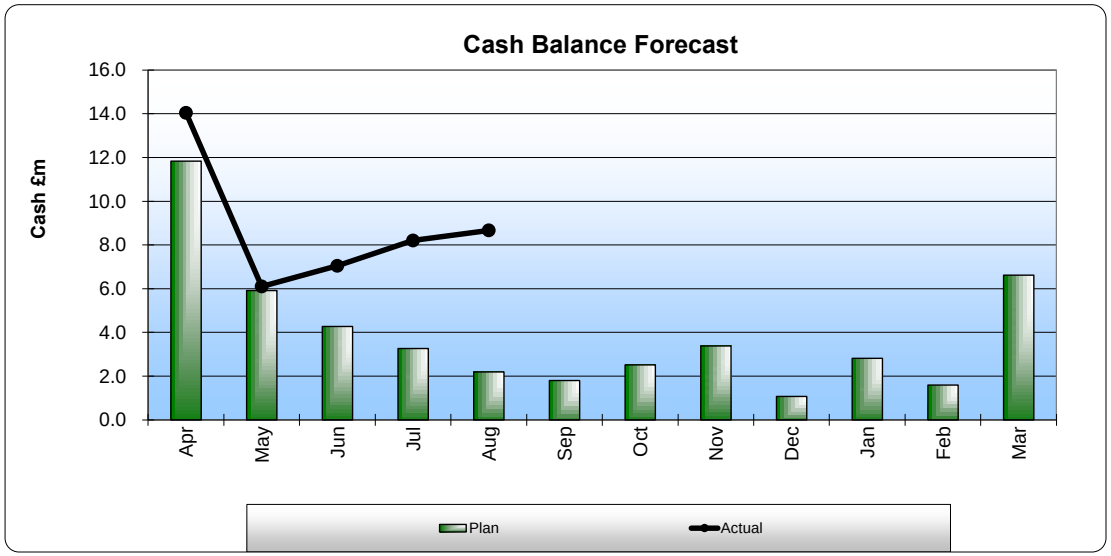
# Cash Flow Management

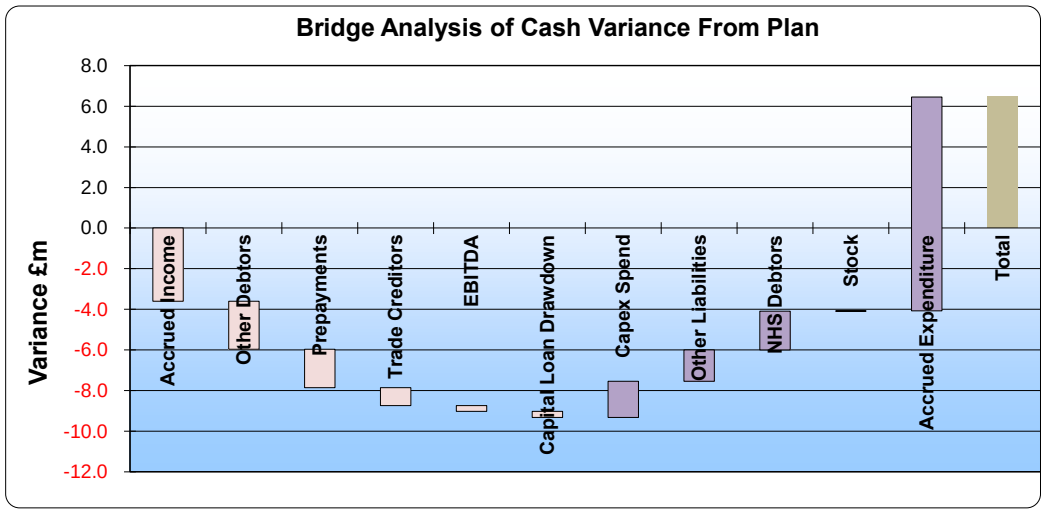
## Month 5 - The Period 1st April 2018 to 31st August 2018

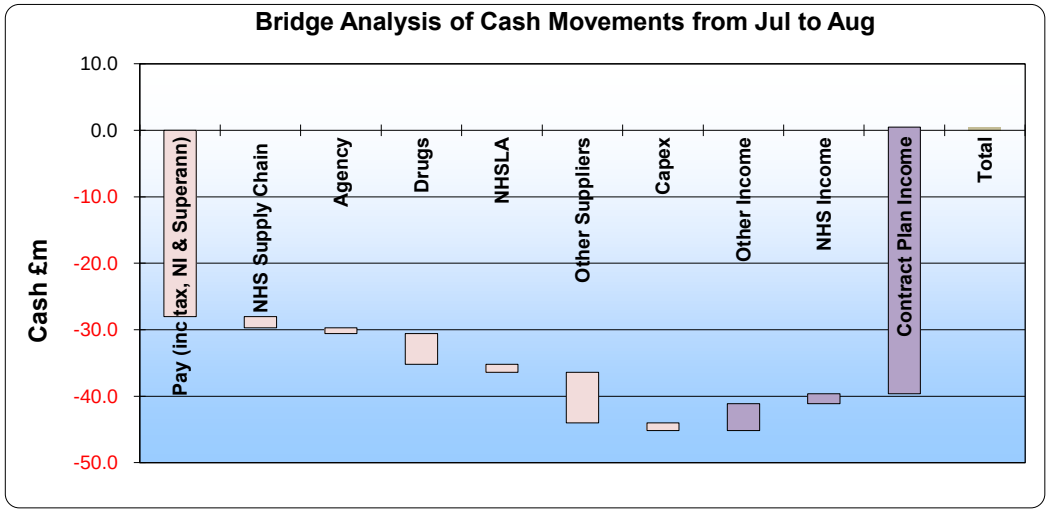
York Teaching Hospital NHS Foundation Trust

### Key Messages:

* The cash position at the end of August was £8.7m, which is £6.5m above plan.
* This is significantly influenced by increased accrued expenditure, which is linked to Oracle Cloud issues creating delays in processing invoices for payment.
* Slippage of the Capital Programme has also influenced the cash position.



# Cash Flow Management

## Month 5 - The Period 1st April 2018 to 31st August 2018

York Teaching Hospital NHS Foundation Trust

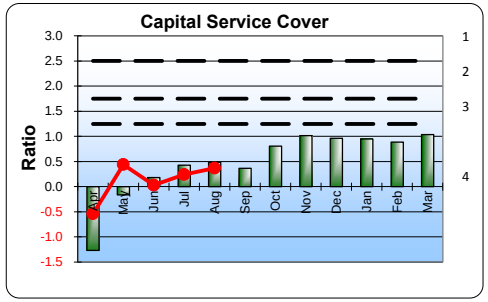
### Key Messages:

* The receivables balance at the end of August was £10m, which is slightly below plan.
* The payables balance at the end of August was £13.2m which is above plan. This is attributable to new system invoice validation backlogs.
* The Use of Resources Rating is assessed is a score of 3 in August, and is reflective of the I&E position.

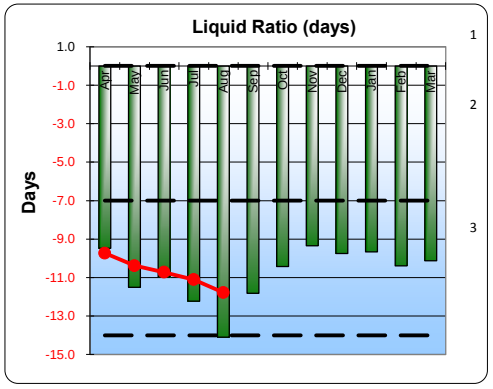
**Significant Aged Debtors (Invoices Over 90 Days)**

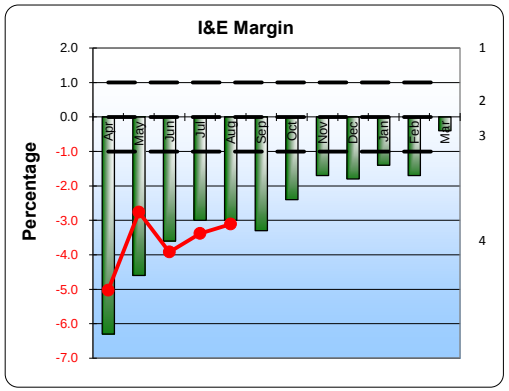
| | |
|---|---|
| **Hull & East Yorkshire NHS Trust** | **£366K** |
| **NHS Property Services** | **£255K** |
| **Northern Doctors Urgent Care** | **£216K** |
| **Depuy Ireland** | **£180K** |

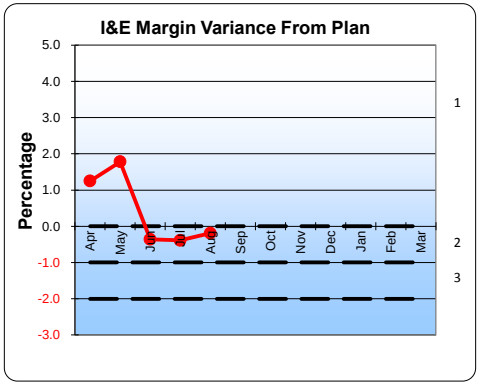
| | Current | 1-30 days | 31-60 days | Over 60 days | Total |
|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m |
| Payables | 5.04 | 2.84 | 2.46 | 2.82 | 13.16 |
| Receivables | 4.33 | 1.79 | 0.72 | 3.12 | 9.95 |

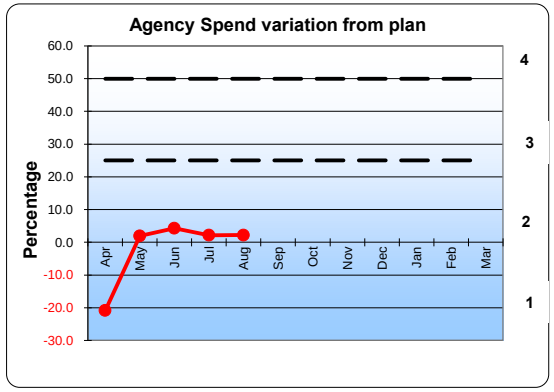



| | Plan for Year | Plan for Year-to-date | Actual Year-to-date | Forecast for Year |
|---|---|---|---|---|
| Liquidity (20%) | 3 | 4 | 3 | 3 |
| Capital Service Cover (20%) | 4 | 4 | 4 | 4 |
| I&E Margin (20%) | 3 | 4 | 4 | 3 |
| I&E Margin Variance From Plan (20%) | 1 | 1 | 2 | 2 |
| Agency variation from Plan (20%) | 1 | 2 | 2 | 1 |
| Overall Use of Resources Rating | **3** | **3** | **3** | **3** |



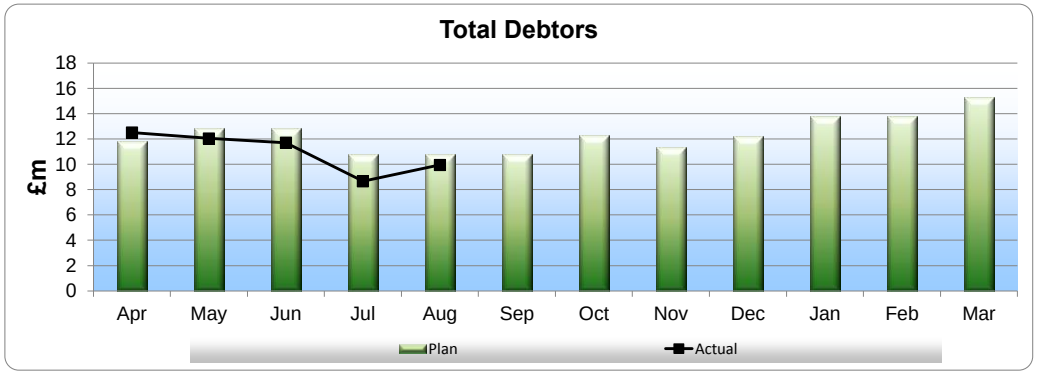
# Debtor Analysis

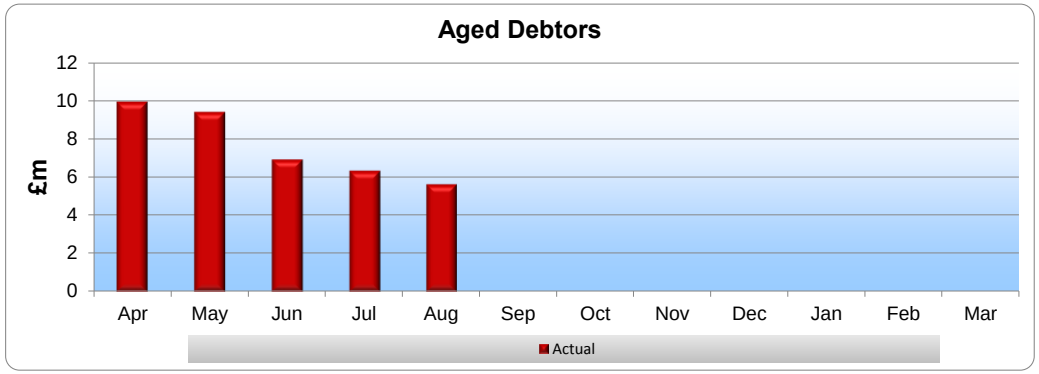
## Month 5 - The Period 1st April 2018 to 31st August 2018

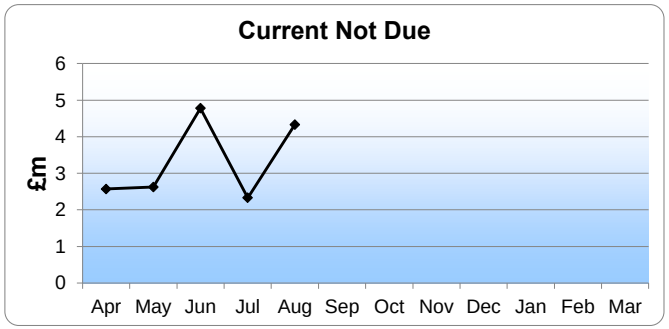
York Teaching Hospital NHS Foundation Trust

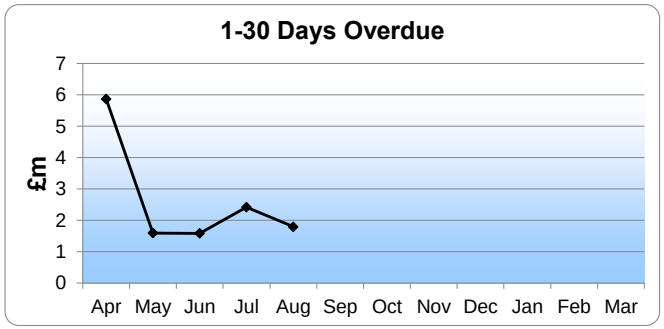
### Key Messages:

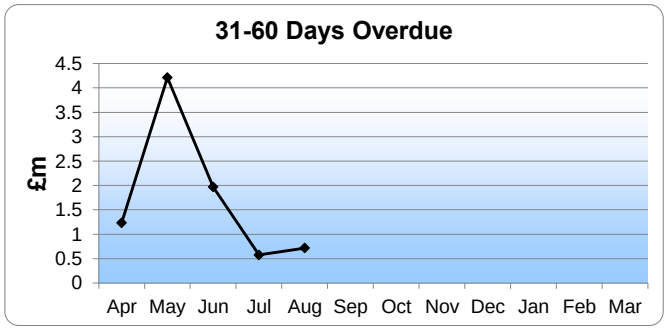
* At the end of August, the total debtor balance was £10m, which is slightly below plan. £4.3m of this relates to 'current' invoices not due.
* Aged debt totalled £5.6m. This has reduced by £700k on the previous months position reflecting the positive work around debtor management.
* Long term debtors (Over 90 Days) have reduced by £500k from the July position. This area will remain a focus over the coming months.
* Accrued income has reduced slightly on the previous month, however it remains at higher than planned levels. Focus is required to turn accruals in to invoices to secure cash payments.

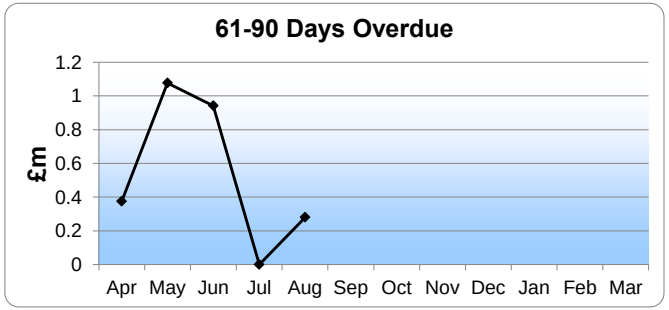


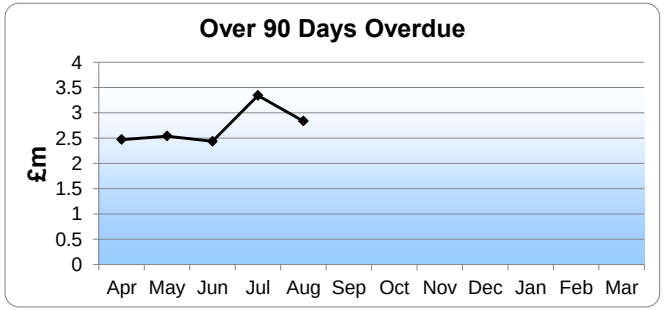



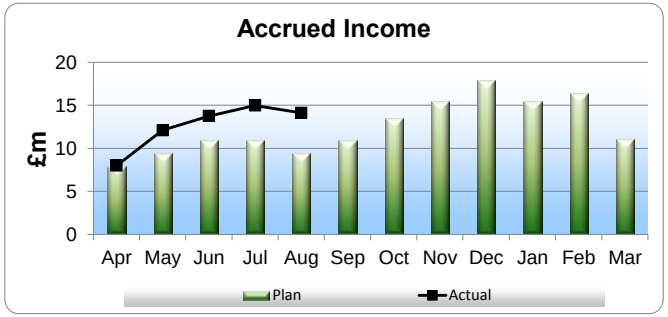



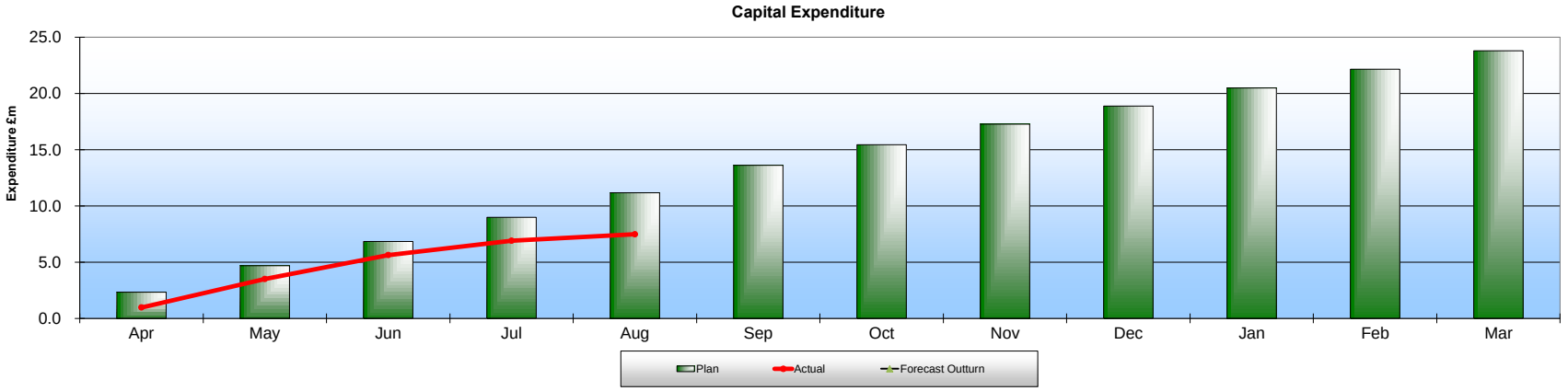



# Capital Programme
## Month 5 - The Period 1st April 2018 to 31st August 2018

York Teaching Hospital NHS Foundation Trust

**Key Messages:**

* The Capital plan for 2018-19 is £23.803m
* This is mainly funded by the loan supported schems for both the Endoscopy Extension and the VIU Development at York Hosital with a combined total of £11m
* The main schemes on the Scarborough site include the replacement of the Fire Alarm system, the lifts in Radiology and the MRI and Xray rooms
* The main schemes on the York site are the Fire alarm replacment, the Cardiac/VIU lab replacements and the completion of the MRI replacement.
* This is alongside the Trustwide backlog maintenance plan and the systems and network plan with a combined total of £3.465m




| Scheme | Approved in-year Expenditure | Year-to-date Expenditure | Forecast Outturn Expenditure | Variance | Comments |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | |
| SGH /York MRI Replacement | 1,999 | 871 | 1,999 | 0 | |
| SGH X ray Rooms | 660 | 14 | 660 | 0 | |
| York VIU/Cardiac Equipment | 1,379 | 98 | 1,379 | 0 | |
| Radiology Lift Replacement SGH | 860 | 547 | 860 | 0 | |
| Fire Alarm System SGH | 1,529 | 645 | 1,529 | 0 | |
| Other Capital Schemes | 650 | 731 | 650 | 0 | |
| SGH Estates Backlog Maintenance | 1,000 | 191 | 1,000 | 0 | |
| York Estates Backlog Maintenance - York | 1,265 | 358 | 1,265 | 0 | |
| Cardiac/VIU Extention | 3,000 | 338 | 3,000 | 0 | |
| Medical Equipment | 450 | 110 | 450 | 0 | |
| SNS Capital Programme | 1,200 | 384 | 1,200 | 0 | |
| Capital Programme Management | 1,455 | 677 | 1,455 | 0 | |
| Endoscopy Development | 8,000 | 1,647 | 8,000 | 0 | |
| Charitable funded schemes | 623 | 267 | 623 | 0 | |
| Fire Alarm System York | 1,120 | 607 | 1,120 | 0 | |
| Slippage to be managed in year | -1,387 | 0 | -1,387 | 0 | |
| Estimated In year work in progress | 0 | 0 | 0 | 0 | |
| **TOTAL CAPITAL PROGRAMME** | **23,803** | **7,485** | **23,803** | **0** | |

| This Years Capital Programme Funding is made up of:- | Approved in-year Funding | Year-to-date Funding | Forecast Outturn | Variance | Comments |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | |
| Depreciation | 5,538 | 3,058 | 5,538 | 0 | |
| Loan Funding b/fwd | 2,401 | 773 | 2,401 | 0 | |
| Loan Funding | 11,000 | 2,181 | 11,000 | 0 | |
| Charitable Funding | 623 | 267 | 623 | 0 | |
| Strategic Capital Funding | 4,026 | 1,206 | 4,026 | 0 | |
| Sale of Assets | 215 | 0 | 215 | 0 | |
| **TOTAL FUNDING** | **23,803** | **7,485** | **23,803** | **0** | |

## Efficiency Programme

**Month 5 - The Period 1st April 2018 to 31st August 2018**

**Key Messages:**

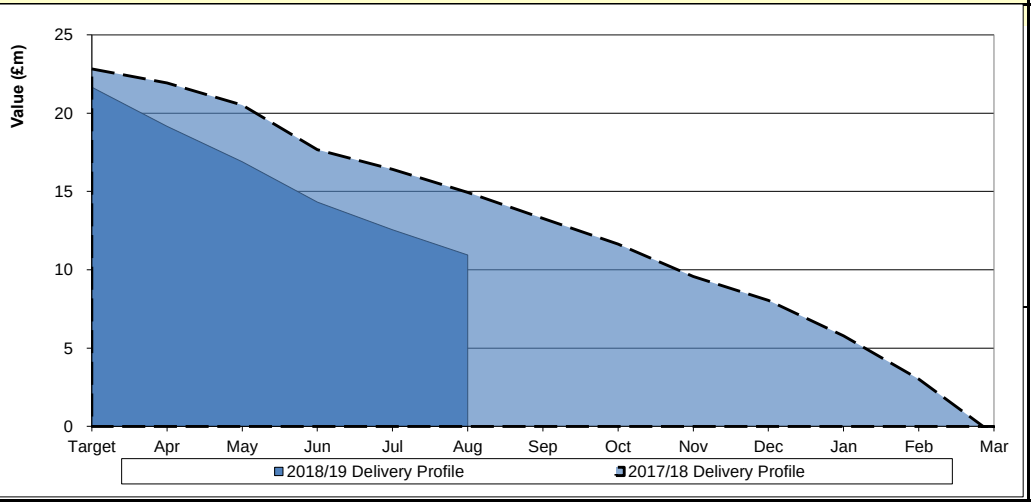
* Delivery - £10.7m has been delivered against the Trust annual target of £21.7m, giving a shortfall of (£10.9m).
* Part year NHSI variance - The part year NHSI variance is £2.8m.
* In year planning - The 2018/19 planning surplus is currently £0.0m.
* Four year planning - The four year planning surplus is £3.8m.
* Recurrent delivery - Recurrent delivery is £6.6m in-year, which is 30% of the 2018/19 CIP target.

# Efficiency - Total CIP

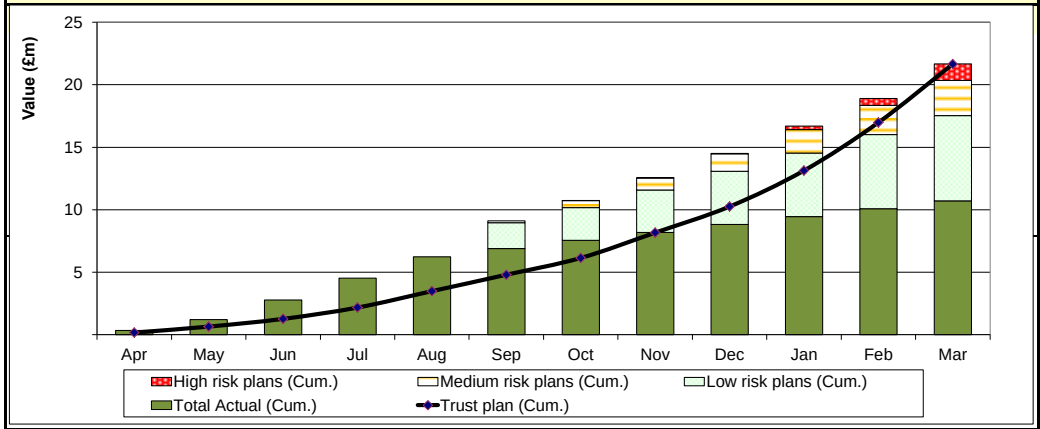
## Executive Summary

| | £m |
|---|---|
| **2018/19 CIP Target** | **£21.7** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £3.5 |
| Actual Delivery at Month 5 | £6.2 |
| **NHSI Variance Month 5** | **£2.8** |
| Recurrent Delivery | £6.6 |
| Non Recurrent Delivery | £4.1 |
| **Total Delivery** | **£10.7** |
| **In Year Gap to Delivery** | **-£10.9** |
| **In Year Planning** | |
| Forecasted Delivery | £21.7 |
| **Forecasted Planning (Gap)/Surplus** | **£0.0** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£50.5** |
| 4 Year Plans | £54.3 |
| **4 Year Planning (Gap)/Surplus** | **£3.8** |

## Gap to delivery 2018/19 - Progress profile compared to 2017/18




## In Year CIP Delivery and Future Plans by Risk




## Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 798 |
| Total Number of Assessed Schemes - Directorate | 584 |
| Total Number of Assessed Schemes - Signed Off | 196 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 2 | 0 | 0 | 0 | 0 |
| | 2 | 1 | 0 | 0 | 0 |
| | 3 | 7 | 4 | 1 | 0 |
| | 6 | 17 | 3 | 2 | 0 |
| Rare | 524 | 9 | 1 | 2 | 0 |
| | Consequence/Severity | | | | |

**High Risk Plans: 8 : ED (2) - Clinical Model York and Scarborough; Child Health (1) - capacity; Elderly (1) high level of nursing vacancies; Gen Med York (1) CF Service lack of capacity; Lab Med (2) Specimen Reception impact on turnaround times and Consolidation of Services; E&F (1) Linen Changes - Directorate to reassess score. Moderate Risk Plans: 33**

## Efficiency Programme

**Month 5 - The Period 1st April 2018 to 31st August 2018**

**Key Messages:**

* Transactional CIP schemes represent £15.5m of the £21.7m Efficiency Target.
* Delivery at Month 5 is £9.0m of which £4.9m is recurrent.

# Efficiency - Transactional CIP

## Executive Summary

| | £m |
|---|---|
| **2018/19 Transactional CIP Target** | **£15.5** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £2.8 |
| Actual Delivery at Month 5 | £5.5 |
| **NHSI Variance Month 5** | **£2.8** |
| Recurrent Delivery | £4.9 |
| Non Recurrent Delivery | £4.1 |
| **Total Delivery** | **£9.0** |
| **Gap to Delivery** | **-£6.4** |
| **In Year Planning** | |
| Forecasted Delivery | £15.5 |
| **Forecasted Planning (Gap)/Surplus** | **£0.0** |
| **Long Term Planning** | |
| **4 Year Transactional CIP Target (18/19 to 21/22)** | **£42.7** |
| 4 Year Plans | £46.5 |
| **4 Year Planning (Gap)/Surplus** | **£3.8** |

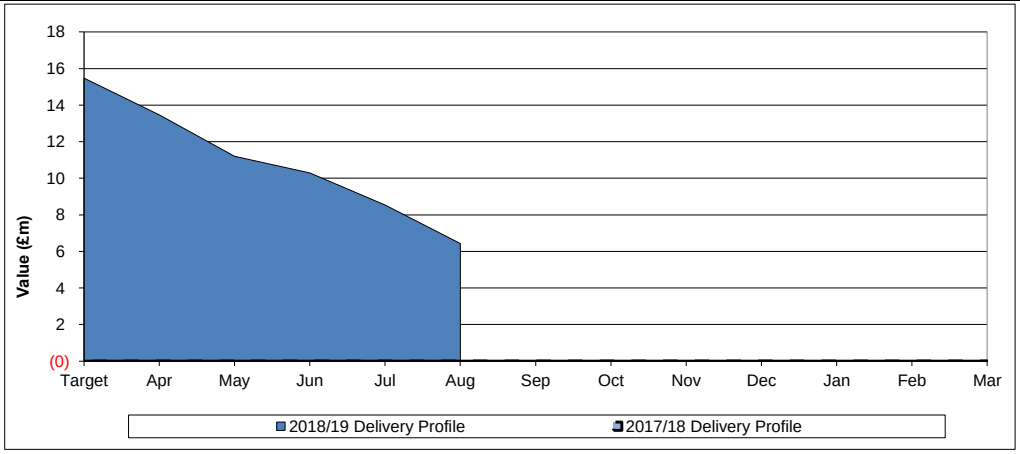
## Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 782 |
| Total Number of Assessed Schemes - Directorate | 575 |
| Total Number of Assessed Schemes - Signed Off | 192 |

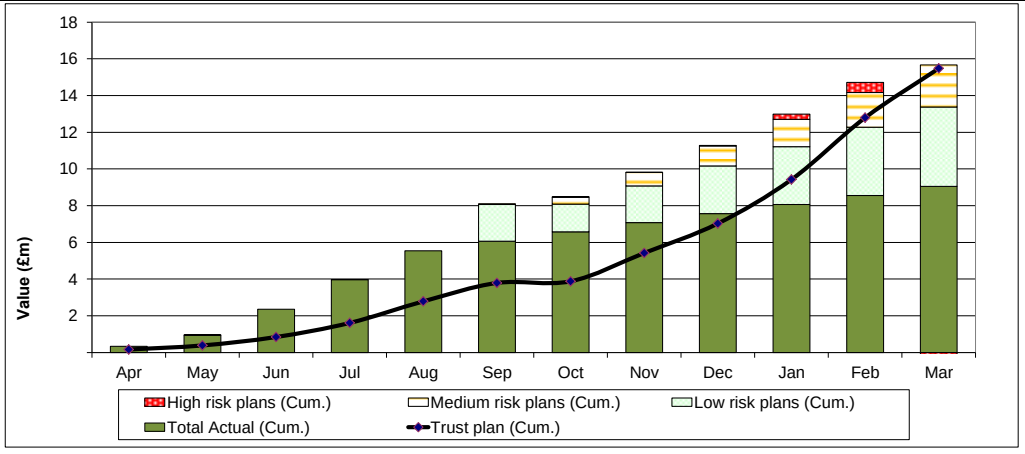
| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 2 | 0 | 0 | 0 | 0 |
| | 2 | 1 | 0 | 0 | 0 |
| | 3 | 7 | 4 | 1 | 0 |
| | 6 | 16 | 3 | 2 | 0 |
| Rare | 516 | 9 | 1 | 2 | 0 |

**High Risk Plans: 8 : ED (2) - Clinical Model and Staffing; Child Health (1) - capacity; Elderly (1) high level of nursing vacancies; Gen Med York (1) CF Service lack of capacity; Lab Med (2) Specimen Reception impact on turnaround times and Consolidation of Services; E&F (1) Linen Changes - Directorate to reassess score.** **Moderate Risk Plans: 32**

## Gap to delivery - 2018/19




## In Year CIP Delivery and Future Plans by Risk



## Efficiency Programme

**Month 5 - The Period 1st April 2018 to 31st August 2018**

**Key Messages:**

* 16 Transformational schemes represent £6.2m of the £21.7m Efficiency Target.
* Delivery at Month 5 is £1.7m, of which £1.7m is recurrent.
* Project Plans are being developed for Transformational Schemes; the main themes are Outpatient Productivity, Theatre Productivity, Pharmacy Biosimilars, SNS Paperlite and Printer Strategy, E&F ADM.
* An Executive Summary of each Transformational Scheme forms part of the reporting pack.

# Efficiency - Transformation Programme

## Executive Summary

| | £m |
|---|---|
| **2018/19 Transformation CIP Target** | **£6.2** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £0.7 |
| Actual Delivery at Month 5 | £0.7 |
| **NHSI Variance Month 5** | **£0.0** |
| Recurrent Delivery | £1.7 |
| Non Recurrent Delivery | £0.0 |
| **Total Delivery** | **£1.7** |
| **Gap to Delivery** | **-£4.5** |
| **In Year Planning** | |
| Forecasted Delivery | £6.2 |
| **Forecasted Planning (Gap)/Surplus** | **£0.0** |
| **Long Term Planning** | |
| **4 Year Transformation CIP Target** | **£7.8** |
| 4 Year Plans | £7.8 |
| **4 Year Planning (Gap)/Surplus** | **£0.0** |

## Governance Risk Heat Map

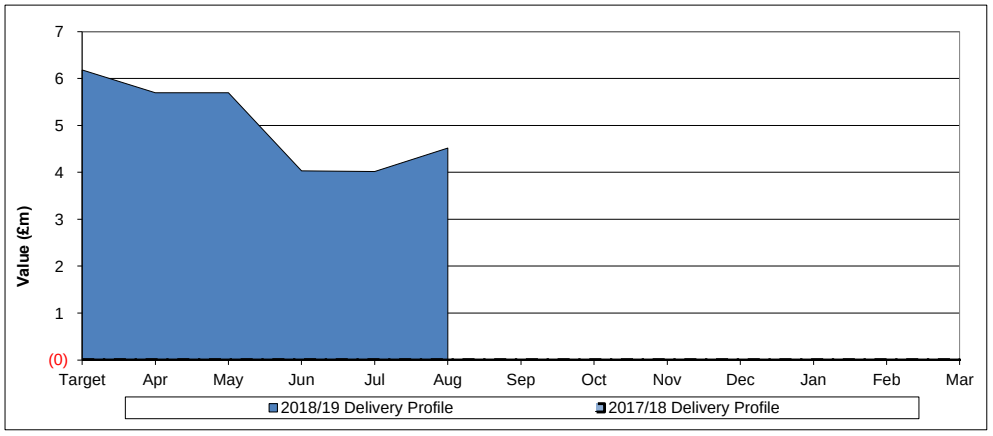
| | |
|---|---|
| Total Number of Schemes | 16 |
| Total Number of Assessed Schemes - Directorate | 9 |
| Total Number of Assessed Schemes - Signed Off | 4 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 1 | 0 | 0 | 0 |
| Rare | 8 | 0 | 0 | 0 | 0 |

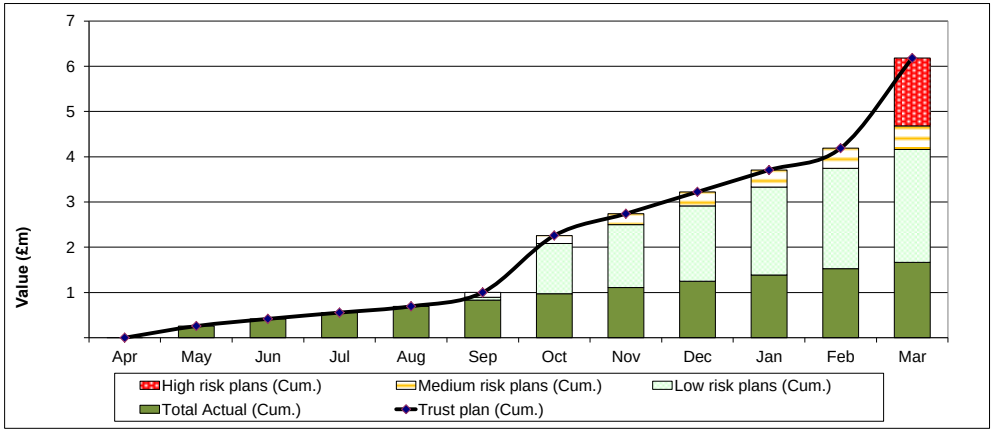
Consequence/Severity

**of the 9 schemes assessed: 1 Moderate Risk - SNS Paperlite: risk being not having access to patient notes; and 8 Low Risk**

## Gap to delivery - 2018/19




## In Year CIP Delivery and Future Plans by Risk

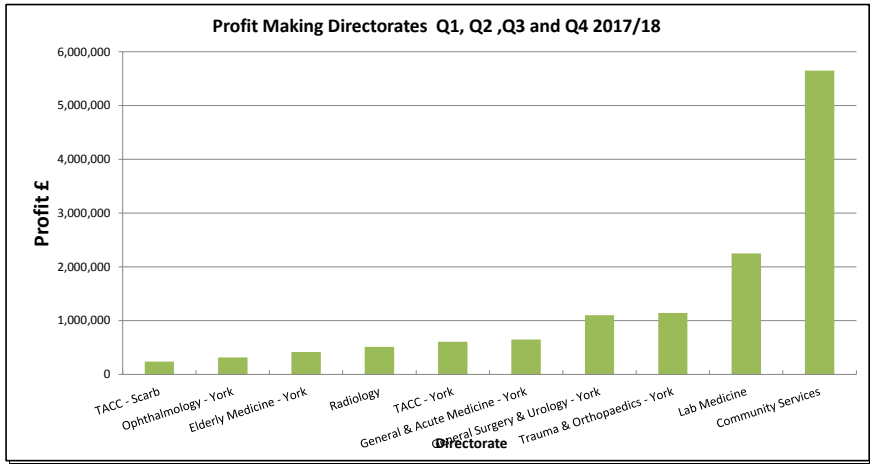


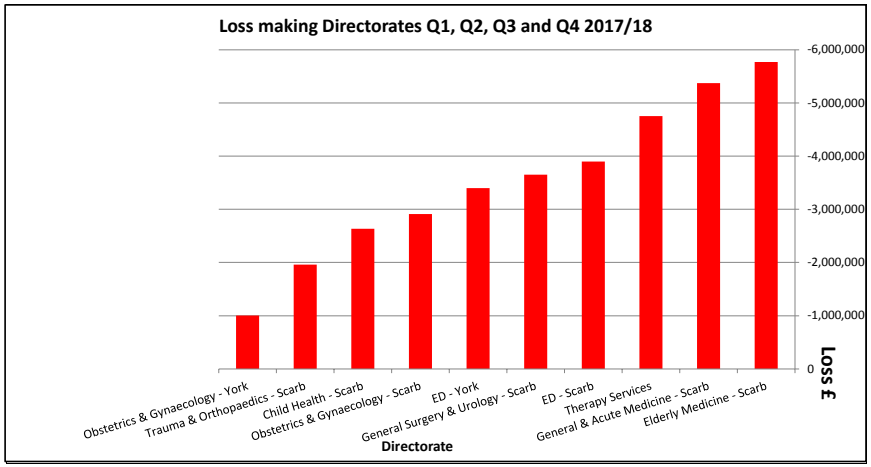
# Service Line Reporting
## Month 4 - The Period 1st April 2018 to 31st July 2018

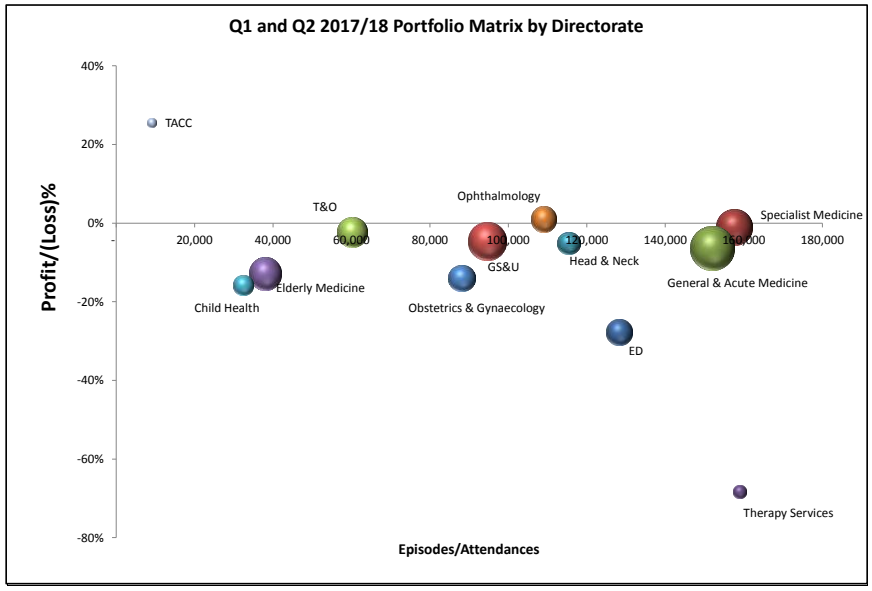
York Teaching Hospital NHS Foundation Trust

**Key Messages:**

* Current data is based on Q1, Q2, Q3 and Q4 2017/18
* The annual mandatory Reference Cost submission is now the key focus for the team
* The SLR Leadership Programme was launched on 25th September 2017 with phase one ending in May 2018
* Phase two of the SLR Leadership Programme will soon be launched for any Finance Managers who have not yet been through the process




| | |
|---|---|
| DATA PERIOD | Q1, Q2 and Q3 2017/18 |
| CURRENT WORK | * Reference Costs are now the key focus for the team<br><br>* The SLR Leadership Programme was launched on 25th September 2017. This is a programme of work to enable the Finance Managers to become confident users of the SLR system and data, and also to provide a structured process for investigating loss making activity and areas for improvement. Phase one of the SLR LP completed in May 2018. Phase two will focus on any new Finance Managers who have not yet been through the programme and those that are continuing to build their confidence in the system.<br><br>*Qlikview user guides have been published to help users log in and navigate round the system. More user guides covering different areas of Qlikview will be released over the coming months |
| FUTURE WORK | * Q1 2018/19 SLR reports and the NHSI Costing Transformation Programme requirements will become the focus once Reference Costs has been submitted<br><br>* Planning for the NHSI Costing Transformation Programme will soon begin to ensure that we are prepared for future mandatory reporting requirements |

| | |
|---|---|
| FINANCIAL BENEFITS TAKEN SINCE SYSTEM INTRODUCTION | **£3.68m** |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 26 September 2018
# Efficiency Programme Update

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

Purpose of the Report

The Board is asked to note the August 2018 position.

Executive Summary – Key Points

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2018/19 target is £21.7m and delivery, as at August 2018 is £10.7m

Recommendation

For information.

Author: Steven Kitching, Head of Corporate Finance & Resource Management

Director Sponsor: Andrew Bertram, Finance Director

Date: September 2018

## Briefing note for the Board of Directors meeting 26 September 2018

## 1. Summary reported position for August 2018

### 1.1 Current position – highlights

***Delivery*** - Delivery is £10.7m to August 2018 which is (49%) of the £21.7m annual target. This position compares to a delivery position of £7.9m in August 2017.

***In year planning -*** At August 2018 CIP is 100% planned in the following risk categories:

| Planning Risk | Prior Month £'m | Current Month £'m | Change |
|---|---|---|---|
| Low | 17.2 | 17.5 | ↑ |
| Medium | 3.5 | 2.9 | ↓ |
| High | 0.8 | 1.3 | ↑ |
| **TOTAL** | **21.7** | **21.7** | ↹ |

***Four year planning*** – The four year planning shows a surplus of £3.8m. The position in August 2017 was a gap of (£8m).

***Recurrent vs. Non recurrent*** – Of the £10.7m delivery, £6.6m (62%) in-year has been delivered recurrently. Recurrent delivery is £2.2m ahead of the same position in August 2017.

### 1.2 Overview

Delivery in month 5 continues to be strong with continued improvement in the risk profile of plans.

There has been a slight increase in high risk plans of £0.5m.

**Transactional schemes**
Transactional schemes of £15.5m represent 71% of the overall Efficiency Target of which £9.0m has been delivered of which £4.9m is recurrent.

**Appendix 1** attached provides a summary of the Transactional CIP – Directorate Performance for 2018/19.

**Transformational schemes**
Transformational schemes of £6.2m represent 29% of the overall Efficiency Target of which £1.7m has been delivered recurrently. Plans continue to be developed.

Current live schemes are Outpatient Productivity, Theatre Productivity/Utilisation, Pharmacy Biosimilars, SNS Paperlight and Printer Strategy, Estates and Facilities ADM.

## High Risk Directorates

There are 9 High Risk directorates in terms of planning and delivery that require support to ensure successful delivery of CIP, **Appendix 2** attached.

Two of the Directorates are being supported through the NHSI Productivity Work and are in the early developmental stages; these are Radiology and General Surgery (Endoscopy).

Two Directorates have Transformational schemes that are being worked up and delivered these are TACC for Theatre Productivity and Outpatients.

The Corporate Efficiency Team are working closely with Directorates and request that over the next few months Child Health, General Medicine, Elderly Medicine Scarborough, Specialist Medicine and Ophthalmology are invited to present to the Efficiency Delivery Group.

## QIA

There are 8 high risk schemes, a reduction of 4 from the previous month due to 1 scheme not being supported and removed (skill mix), 2 schemes being re-assessed by Directorates to Moderate Risk (Infrastructure at Bridlington and skill mix) and 1 scheme re-assessed to Low Risk (Turnaround Times Pathology).

The remaining 8 schemes are grouped into the following themes:
Staffing risk relating to vacancies and skill mix (4), CF service (1), Policy relating to Linen changes (1) and Development of Child Protection Expert team (1), Consolidation of Service with HEY (Histopathology, Microbiology and Virology) (1).

High and Moderate Risk schemes are as attached in Appendix 3.

Full QIA's are to be submitted by 14 September 2018 and will be reviewed at next month's EDG.

## Model Hospital

**Use of Resources –** To provide update next month on the Model Hospital and Use of Resources and areas of opportunity.

## NHSI Operational Productivity Work streams

An update on the performance of Work streams in Wave 1 are attached in Appendix 4.

## 2.0 Risk

Recurrent delivery and long term planning remain the key risks to the programme.

| Risk | Proposed Actions to address Risks |
|---|---|
| Recurrent Delivery | • Executive Leads to be identified for transformational workstreams – ongoing.<br>• Incentivise recurrent delivery.<br>• Review of non-activity related underspends over last 3 years to be taken recurrently.<br>• Performance Management of Delivery is picked up through formal performance meetings. |
| Planning | • Joint working with the Operational Team and Corporate Improvement Team to identify plans and efficiencies through the various transformational work streams of: Emergency Care, Planned Care, Integrated Care and Other – Ongoing.<br>• NHSI Work Programme – to firm up plans with the potential for new plans to be developed – Ongoing 2nd wave implementation stage.<br>• Align Efficiency Plans with QIPP – work has started with our two main commissioners to identify shared savings and system improvements. This will avoid duplication of efficiencies and produce robust plans - Ongoing, £2m CIP identified at risk with QIPP.<br>• Model Hospital – this will help us to identify opportunities and will be used as a signpost to our internal Service Line Reporting (SLR) model.<br>• Resource Management meetings with Directorate teams will continue to evolve and will encompass a multi-disciplinary approach where appropriate.<br>• Efficiency Workshops with Directorates.<br>• Seeking External assistance for review of Acute East Coast Service. |

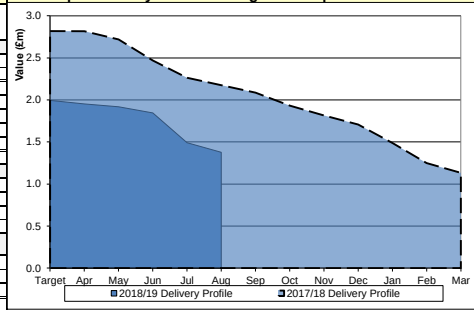
# Transactional CIP - Directorate Performance 2018/19 - August Position - APPENDIX 1

## Specialist Medicine

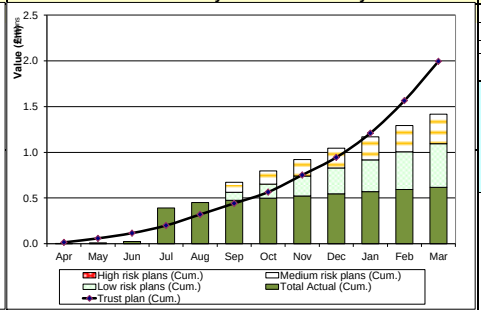
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£1,995** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £321 |
| Actual Delivery at Month 5 | £451 |
| **NHSI Variance Month 5** | **£131** |
| Recurrent Delivery | £358 |
| Non Recurrent Delivery | £259 |
| **Total Delivery** | **£617** |
| **In Year Gap to Delivery** | **-£1,377** |
| **In Year Planning** | |
| Forecasted Delivery | £1,417 |
| **Forecasted Planning (Gap)/Surplus** | **-£578** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£3,774** |
| 4 Year Plans | £3,120 |
| **4 Year Planning (Gap)/Surplus** | **-£654** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 36 |
| Total Number of Assessed Schemes - Directorate | 24 |
| Total Number of Assessed Schemes - Signed Off | 7 |

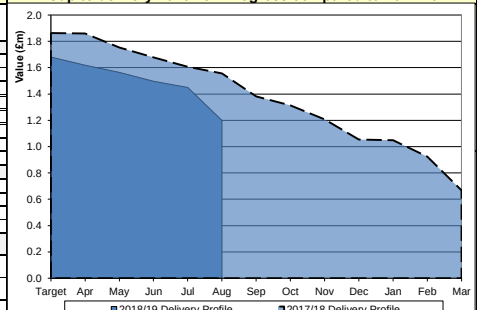
| Probability/ Likelihood | | | | | |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 24 | 0 | 0 | 0 | 0 |
| | Negligible - None | | | | Catastrophic/death |
| | Consequence/Severity | | | | |

## Radiology

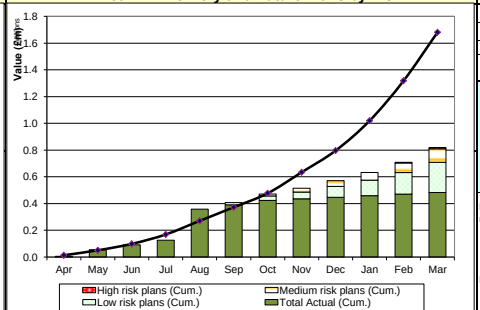
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£1,681** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £270 |
| Actual Delivery at Month 5 | £358 |
| **NHSI Variance Month 5** | **£87** |
| Recurrent Delivery | £126 |
| Non Recurrent Delivery | £356 |
| **Total Delivery** | **£482** |
| **In Year Gap to Delivery** | **-£1,199** |
| **In Year Planning** | |
| Forecasted Delivery | £819 |
| **Forecasted Planning (Gap)/Surplus** | **-£862** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£3,783** |
| 4 Year Plans | £2,708 |
| **4 Year Planning (Gap)/Surplus** | **-£1,074** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 36 |
| Total Number of Assessed Schemes - Directorate | 22 |
| Total Number of Assessed Schemes - Signed Off | 0 |

| Probability/ Likelihood | | | | | |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 1 | 0 | 0 | 0 |
| Rare | 20 | 0 | 1 | 0 | 0 |
| | Negligible - None | | | | Catastrophic/death |
| | Consequence/Severity | | | | |

**Moderate Risk Plans:** **1 - relates to reconfiguration of Breast Screening and potential loss localised mobile service**

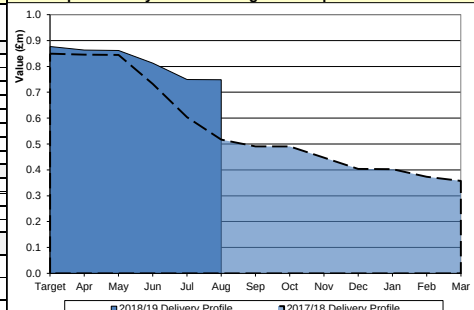
**Plans to be reviewed and signed off following new process Sep 18**

## Child Health

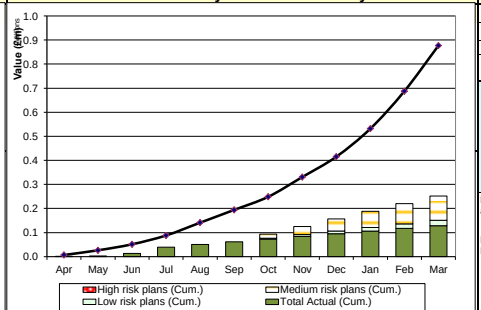
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£877** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £141 |
| Actual Delivery at Month 5 | £50 |
| **NHSI Variance Month 5** | **-£91** |
| Recurrent Delivery | £128 |
| Non Recurrent Delivery | £0 |
| **Total Delivery** | **£128** |
| **In Year Gap to Delivery** | **-£748** |
| **In Year Planning** | |
| Forecasted Delivery | £252 |
| **Forecasted Planning (Gap)/Surplus** | **-£625** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£2,128** |
| 4 Year Plans | £547 |
| **4 Year Planning (Gap)/Surplus** | **-£1,580** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 39 |
| Total Number of Assessed Schemes - Directorate | 32 |
| Total Number of Assessed Schemes - Signed Off | 9 |

| Probability/ Likelihood | | | | | |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 1 | 6 | 0 | 1 | 0 |
| Rare | 23 | 1 | 0 | 0 | 0 |
| | Negligible - None | | | | Catastrophic/death |
| | Consequence/Severity | | | | |

**Moderate Risk Plans:** **6 - increased activity/capacity issue and service development**

**High Risk Plans:** **1 - relates to Child Protection Team - expert opinion capacity issue - awaiting full QIA**

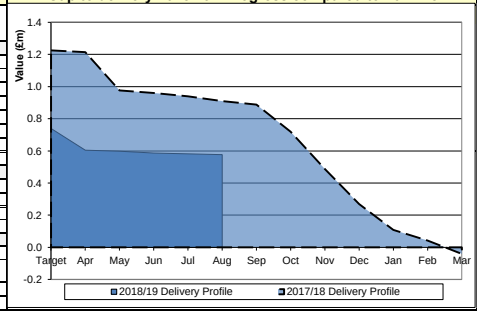
**Plans to be reviewed and signed off following new process Sep 18**

## Medicine for the Elderly Scar

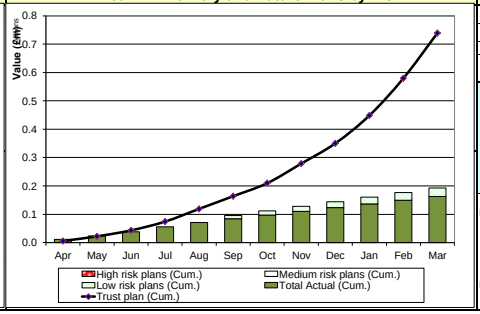
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£739** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £119 |
| Actual Delivery at Month 5 | £71 |
| **NHSI Variance Month 5** | **-£48** |
| Recurrent Delivery | £60 |
| Non Recurrent Delivery | £103 |
| **Total Delivery** | **£163** |
| **In Year Gap to Delivery** | **-£577** |
| **In Year Planning** | |
| Forecasted Delivery | £193 |
| **Forecasted Planning (Gap)/Surplus** | **-£547** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£2,626** |
| 4 Year Plans | £250 |
| **4 Year Planning (Gap)/Surplus** | **-£2,376** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 17 |
| Total Number of Assessed Schemes - Directorate | 12 |
| Total Number of Assessed Schemes - Signed Off | 2 |

| Probability/ Likelihood | | | | | |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 12 | 0 | 0 | 0 | 0 |
| | Negligible - None | | | | Catastrophic/death |
| | Consequence/Severity | | | | |

**High Risk Plans:**

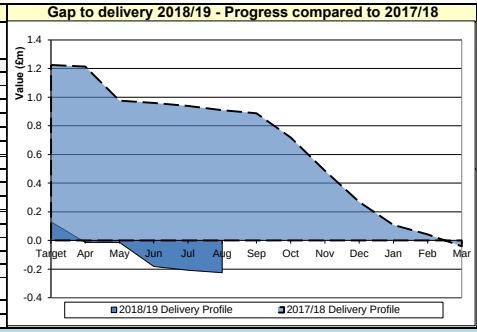
**Plans to be reviewed and signed off following new process Sep 18**

## Medicine for the Elderly York

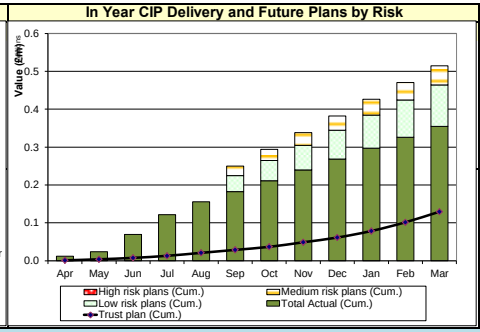
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£129** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £21 |
| Actual Delivery at Month 5 | £156 |
| **NHSI Variance Month 5** | **£135** |
| Recurrent Delivery | £183 |
| Non Recurrent Delivery | £172 |
| **Total Delivery** | **£355** |
| **In Year Gap to Delivery** | **£225** |
| **In Year Planning** | |
| Forecasted Delivery | £515 |
| **Forecasted Planning (Gap)/Surplus** | **£385** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£460** |
| 4 Year Plans | £1,024 |
| **4 Year Planning (Gap)/Surplus** | **£564** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 19 |
| Total Number of Assessed Schemes - Directorate | 13 |
| Total Number of Assessed Schemes - Signed Off | 2 |

| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 1 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 12 | 0 | 0 | 0 | 0 |

**High Risk Plans:** **1 - relates to high level of nursing vacancies - awaiting full QIA**

**Plans to be reviewed and signed off following new process Sep 18**

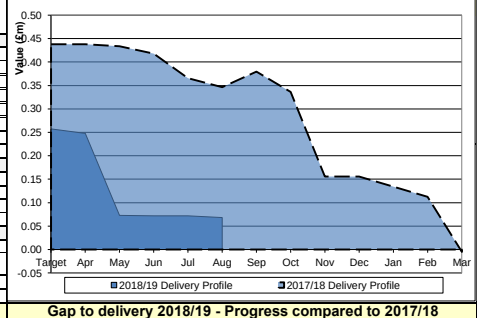
formance 2018/19 - August Position

## Community

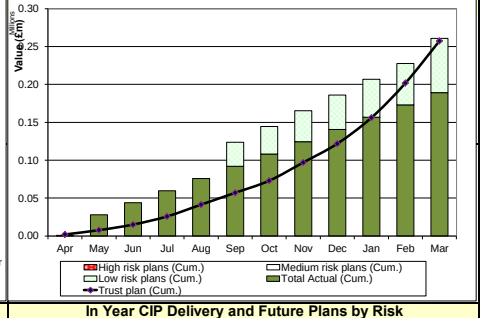
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£257** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £41 |
| Actual Delivery at Month 5 | £76 |
| **NHSI Variance Month 5** | **£34** |
| Recurrent Delivery | £187 |
| Non Recurrent Delivery | £2 |
| **Total Delivery** | **£189** |
| **In Year Gap to Delivery** | **-£68** |
| **In Year Planning** | |
| Forecasted Delivery | £261 |
| **Forecasted Planning (Gap)/Surplus** | **£4** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£599** |
| 4 Year Plans | £806 |
| **4 Year Planning (Gap)/Surplus** | **£207** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 24 |
| Total Number of Assessed Schemes - Directorate | 21 |
| Total Number of Assessed Schemes - Signed Off | 3 |

| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 1 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 20 | 0 | 0 | 0 | 0 |

**Moderate Risk Plans:** **1 - relates to skill mix of nursing staff**

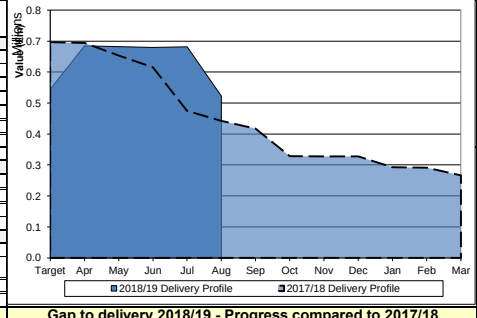
**Plans to be reviewed and signed off following new process Sep 18**

## General Medicine - Scarborough

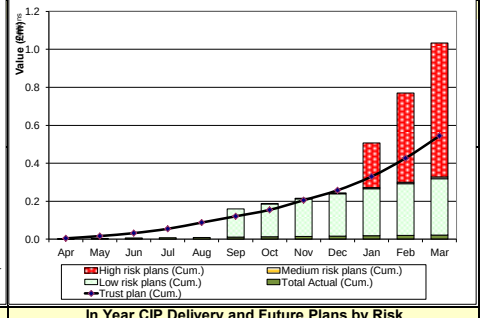
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£544** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £87 |
| Actual Delivery at Month 5 | £9 |
| **NHSI Variance Month 5** | **-£79** |
| Recurrent Delivery | £21 |
| Non Recurrent Delivery | £0 |
| **Total Delivery** | **£21** |
| **In Year Gap to Delivery** | **-£523** |
| **In Year Planning** | |
| Forecasted Delivery | £1,034 |
| **Forecasted Planning (Gap)/Surplus** | **£489** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£1,204** |
| 4 Year Plans | £1,789 |
| **4 Year Planning (Gap)/Surplus** | **£584** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 28 |
| Total Number of Assessed Schemes - Directorate | 20 |
| Total Number of Assessed Schemes - Signed Off | 10 |

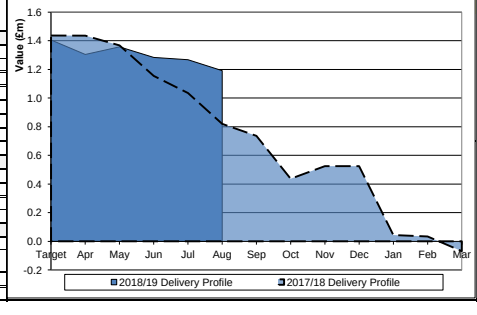
| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 19 | 1 | 0 | 0 | 0 |

## General Medicine - York

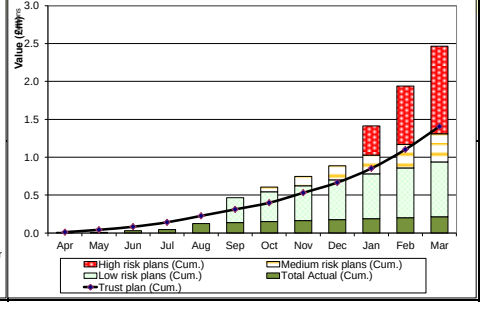
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£1,406** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £226 |
| Actual Delivery at Month 5 | £124 |
| **NHSI Variance Month 5** | **-£102** |
| Recurrent Delivery | £116 |
| Non Recurrent Delivery | £98 |
| **Total Delivery** | **£214** |
| **In Year Gap to Delivery** | **-£1,192** |
| **In Year Planning** | |
| Forecasted Delivery | £2,465 |
| **Forecasted Planning (Gap)/Surplus** | **£1,060** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£4,118** |
| 4 Year Plans | £5,882 |
| **4 Year Planning (Gap)/Surplus** | **£1,764** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 53 |
| Total Number of Assessed Schemes - Directorate | 41 |
| Total Number of Assessed Schemes - Signed Off | 22 |

| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 1 | 0 | 0 |
| | 2 | 0 | 0 | 0 | 0 |
| Rare | 38 | 0 | 0 | 0 | 0 |

**High Risk Plans:** **1 - Development of CF Service lack of capacity - awaiting full QIA**

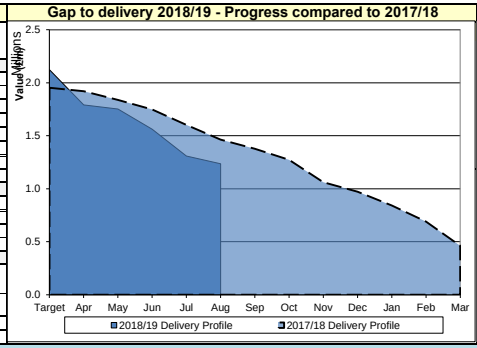
**Plans to be reviewed and signed off following new process Sep 18**

## General Surgery and Urology

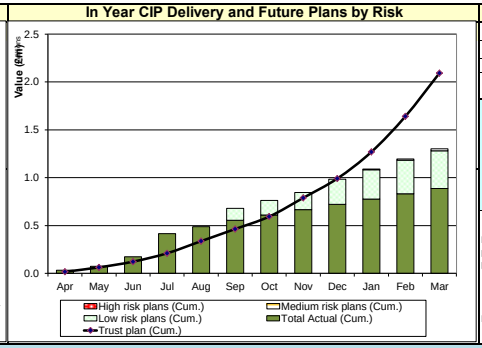
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£2,092** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £336 |
| Actual Delivery at Month 5 | £488 |
| **NHSI Variance Month 5** | **£151** |
| Recurrent Delivery | £521 |
| Non Recurrent Delivery | £366 |
| **Total Delivery** | **£887** |
| **In Year Gap to Delivery** | **-£1,205** |
| **In Year Planning** | |
| Forecasted Delivery | £1,302 |
| **Forecasted Planning (Gap)/Surplus** | **-£791** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£4,939** |
| 4 Year Plans | £4,541 |
| **4 Year Planning (Gap)/Surplus** | **-£398** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 42 |
| Total Number of Assessed Schemes - Directorate | 34 |
| Total Number of Assessed Schemes - Signed Off | 9 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 1 | 1 | 1 | 0 | 0 |
| Rare | 31 | 0 | 0 | 0 | 0 |

Consequence/Severity

**Moderate Risk Plans:** 2 - (1) Plastics self payers risk of not booking in chronological order; (2) income related to Plastics Service - no impact on patients - financial risk - rating to be reivewed

Plans to be reviewed and signed off following new process Sep 18

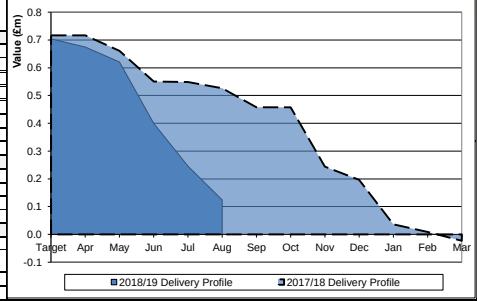
formance 2018/19 - August Position

## Head and Neck

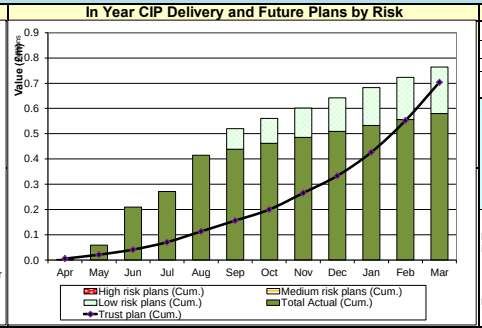
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£704** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £113 |
| Actual Delivery at Month 5 | £415 |
| **NHSI Variance Month 5** | **£302** |
| Recurrent Delivery | £281 |
| Non Recurrent Delivery | £299 |
| **Total Delivery** | **£580** |
| **In Year Gap to Delivery** | **-£124** |
| **In Year Planning** | |
| Forecasted Delivery | £764 |
| **Forecasted Planning (Gap)/Surplus** | **£60** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£1,886** |
| 4 Year Plans | £1,227 |
| **4 Year Planning (Gap)/Surplus** | **-£660** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 18 |
| Total Number of Assessed Schemes - Directorate | 17 |
| Total Number of Assessed Schemes - Signed Off | 10 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 3 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 14 | 0 | 0 | 0 | 0 |

Consequence/Severity

**Moderate Risk Plans:** 1 - Paperless clinics - information not being available

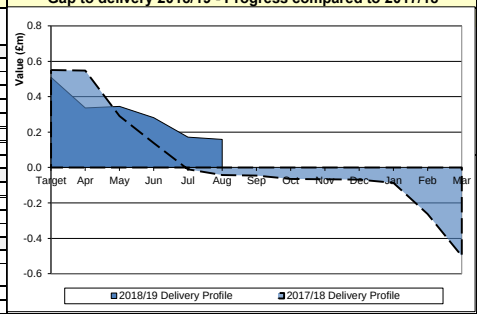
Plans to be reviewed and signed off following new process Sep 18

## Lab Medicine

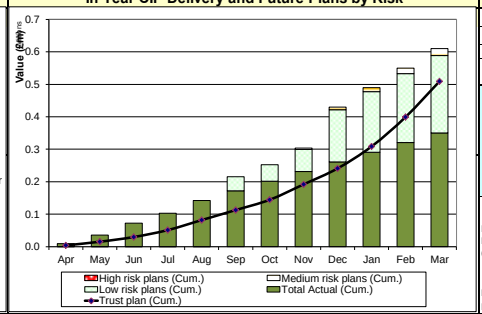
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£509** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £82 |
| Actual Delivery at Month 5 | £142 |
| **NHSI Variance Month 5** | **£60** |
| Recurrent Delivery | £298 |
| Non Recurrent Delivery | £52 |
| **Total Delivery** | **£350** |
| **In Year Gap to Delivery** | **-£159** |
| **In Year Planning** | |
| Forecasted Delivery | £610 |
| **Forecasted Planning (Gap)/Surplus** | **£101** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£2,812** |
| 4 Year Plans | £2,967 |
| **4 Year Planning (Gap)/Surplus** | **£155** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 49 |
| Total Number of Assessed Schemes - Directorate | 47 |
| Total Number of Assessed Schemes - Signed Off | 8 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 1 | 0 | 0 | 1 | 0 |
| | 1 | 1 | 0 | 1 | 0 |
| Rare | 40 | 2 | 0 | 0 | 0 |

Consequence/Severity

**High Risk Plans:** 2 - (1) Skill mix in Microbiology lack of managerial support - reviewed by Directorate downgraded to Moderate (2) Specimen Reception staffing impact on turnaround times - awaiting full QIA

**Moderate Risk Plan** 1 - Microbiology Consolidation of service equipment

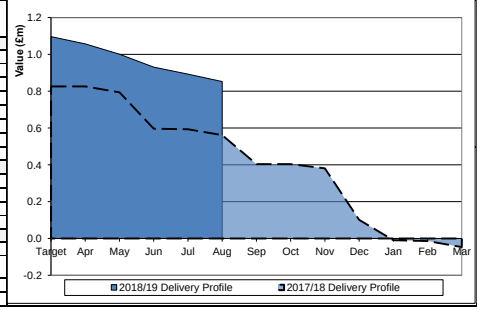
Plans to be reviewed and signed off following new process Sep 18

## Ophthalmology

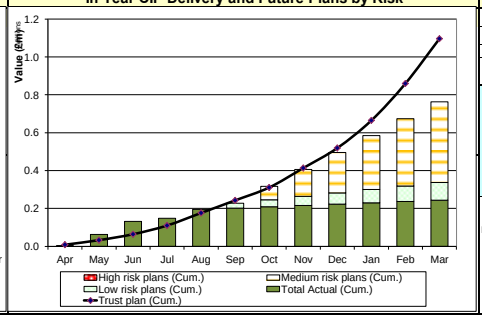
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£1,096** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £176 |
| Actual Delivery at Month 5 | £195 |
| **NHSI Variance Month 5** | **£19** |
| Recurrent Delivery | £84 |
| Non Recurrent Delivery | £160 |
| **Total Delivery** | **£244** |
| **In Year Gap to Delivery** | **-£852** |
| **In Year Planning** | |
| Forecasted Delivery | £763 |
| **Forecasted Planning (Gap)/Surplus** | **-£333** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£3,018** |
| 4 Year Plans | £2,057 |
| **4 Year Planning (Gap)/Surplus** | **-£961** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 28 |
| Total Number of Assessed Schemes - Directorate | 23 |
| Total Number of Assessed Schemes - Signed Off | 15 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 2 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 2 | 0 | 0 | 0 |
| | 0 | 1 | 1 | 0 | 0 |
| Rare | 16 | 0 | 0 | 1 | 0 |

Consequence/Severity

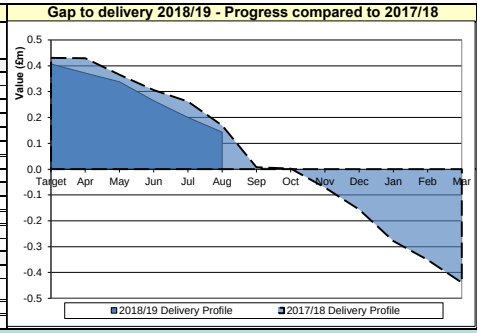
**Moderate Risk Plans:** 7 schemes - to be reassessed by Directorate as Financial Risk Plans

## Pharmacy

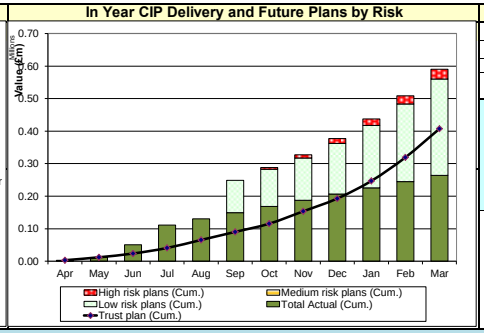
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£407** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £65 |
| Actual Delivery at Month 5 | £130 |
| **NHSI Variance Month 5** | **£65** |
| Recurrent Delivery | £201 |
| Non Recurrent Delivery | £63 |
| **Total Delivery** | **£264** |
| **In Year Gap to Delivery** | **-£143** |
| **In Year Planning** | |
| Forecasted Delivery | £590 |
| **Forecasted Planning (Gap)/Surplus** | **£183** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£1,153** |
| 4 Year Plans | £1,436 |
| **4 Year Planning (Gap)/Surplus** | **£283** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 18 |
| Total Number of Assessed Schemes - Directorate | 7 |
| Total Number of Assessed Schemes - Signed Off | 6 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 7 | 0 | 0 | 0 | 0 |

Consequence/Severity

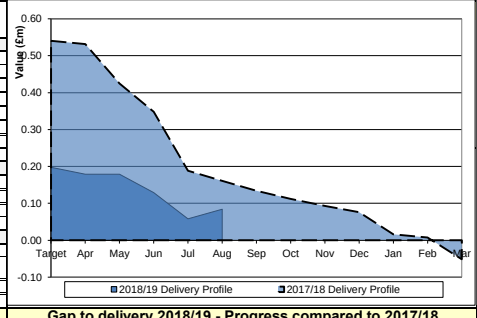
formance 2018/19 - August Position

## Sexual Health

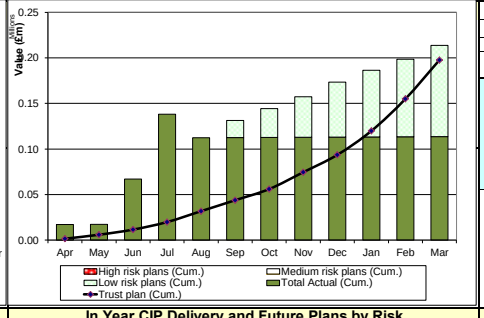
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£198** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £32 |
| Actual Delivery at Month 5 | £112 |
| **NHSI Variance Month 5** | **£81** |
| Recurrent Delivery | £2 |
| Non Recurrent Delivery | £112 |
| **Total Delivery** | **£114** |
| **In Year Gap to Delivery** | **-£84** |
| **In Year Planning** | |
| Forecasted Delivery | £214 |
| **Forecasted Planning (Gap)/Surplus** | **£16** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£588** |
| 4 Year Plans | £664 |
| **4 Year Planning (Gap)/Surplus** | **£75** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 11 |
| Total Number of Assessed Schemes - Directorate | 9 |
| Total Number of Assessed Schemes - Signed Off | 7 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 1 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 8 | 0 | 0 | 0 | 0 |

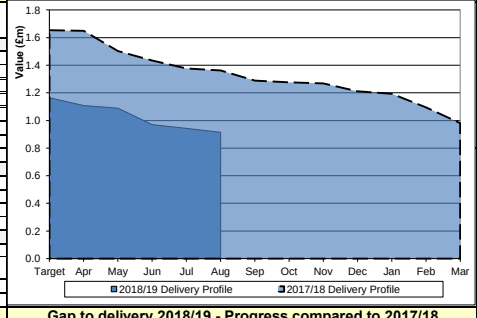
Consequence/Severity

## Womens Health

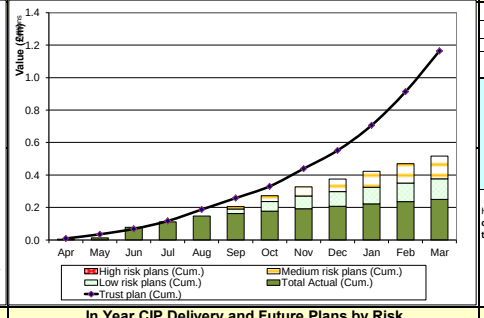
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£1,164** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £187 |
| Actual Delivery at Month 5 | £147 |
| **NHSI Variance Month 5** | **-£40** |
| Recurrent Delivery | £143 |
| Non Recurrent Delivery | £107 |
| **Total Delivery** | **£250** |
| **In Year Gap to Delivery** | **-£915** |
| **In Year Planning** | |
| Forecasted Delivery | £517 |
| **Forecasted Planning (Gap)/Surplus** | **-£648** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£2,825** |
| 4 Year Plans | £960 |
| **4 Year Planning (Gap)/Surplus** | **-£1,865** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 49 |
| Total Number of Assessed Schemes - Directorate | 33 |
| Total Number of Assessed Schemes - Signed Off | 7 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 1 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 27 | 4 | 0 | 1 | 0 |

Consequence/Severity

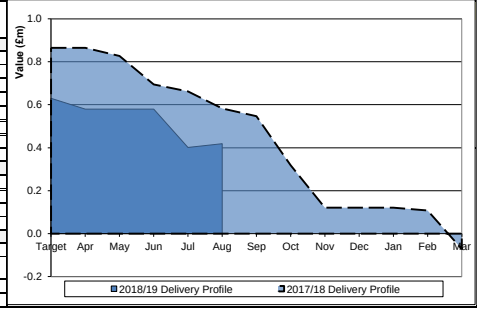
High Risk Plans: 1 - Preassessment Clinic - Bridlington activity without infrastructure **- Directorate re-assessed downgraded to MODERATE Risk - Business Case addresses infrastructure and only DC work being performed to mitigate risk.**

## ED Scar

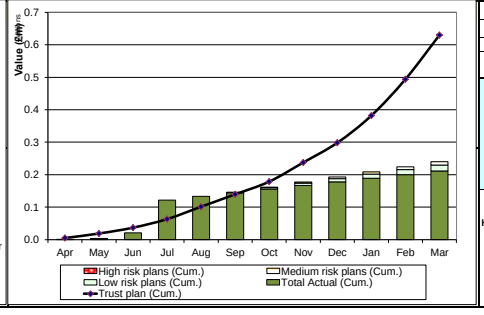
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£630** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £101 |
| Actual Delivery at Month 5 | £133 |
| **NHSI Variance Month 5** | **£32** |
| Recurrent Delivery | £118 |
| Non Recurrent Delivery | £93 |
| **Total Delivery** | **£211** |
| **In Year Gap to Delivery** | **-£419** |
| **In Year Planning** | |
| Forecasted Delivery | £240 |
| **Forecasted Planning (Gap)/Surplus** | **-£390** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£2,070** |
| 4 Year Plans | £420 |
| **4 Year Planning (Gap)/Surplus** | **-£1,649** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 21 |
| Total Number of Assessed Schemes - Directorate | 16 |
| Total Number of Assessed Schemes - Signed Off | 9 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 1 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 15 | 0 | 0 | 0 | 0 |

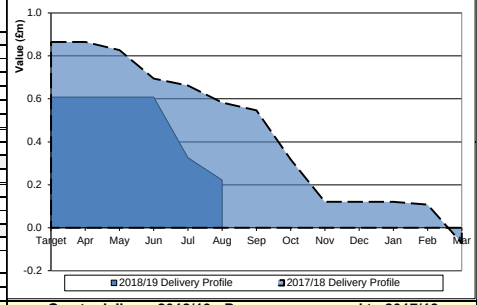
Consequence/Severity

**High Risk Plans - 1 scheme relating to staffing revised clinical model - awaiting full QIA.**

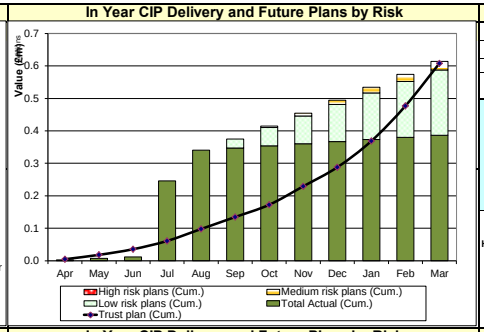
## ED York

| Executive Summary | £000 |
|---|---|
| **2018/19 CIP Target** | **£608** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £98 |
| Actual Delivery at Month 5 | £341 |
| **NHSI Variance Month 5** | **£243** |
| Recurrent Delivery | £70 |
| Non Recurrent Delivery | £316 |
| **Total Delivery** | **£387** |
| **In Year Gap to Delivery** | **-£222** |
| **In Year Planning** | |
| Forecasted Delivery | £614 |
| **Forecasted Planning (Gap)/Surplus** | **£6** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£1,870** |
| 4 Year Plans | £995 |
| **4 Year Planning (Gap)/Surplus** | **-£875** |

Gap to delivery 2018/19 - Progress compared to 2017/18




In Year CIP Delivery and Future Plans by Risk




Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 24 |
| Total Number of Assessed Schemes - Directorate | 17 |
| Total Number of Assessed Schemes - Signed Off | 10 |

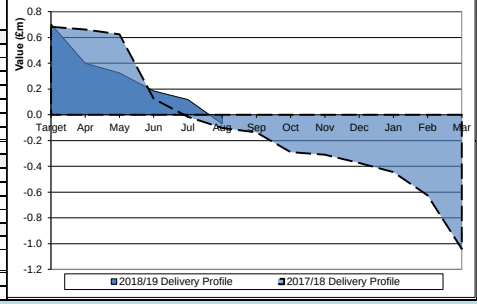
| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 1 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 16 | 0 | 0 | 0 | 0 |

High Risk Plans - 1 schemes relating to revised clinical model.

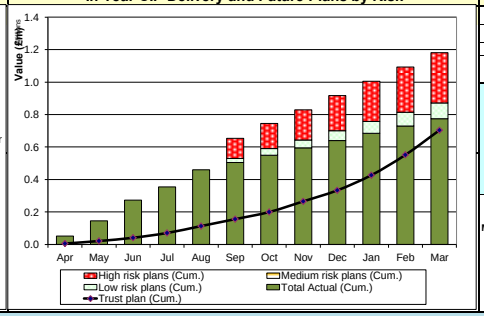
## Orthopaedics

| Executive Summary | £000 |
|---|---|
| **2018/19 CIP Target** | **£704** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £113 |
| Actual Delivery at Month 5 | £460 |
| **NHSI Variance Month 5** | **£347** |
| Recurrent Delivery | £519 |
| Non Recurrent Delivery | £255 |
| **Total Delivery** | **£774** |
| **In Year Gap to Delivery** | **£71** |
| **In Year Planning** | |
| Forecasted Delivery | £1,181 |
| **Forecasted Planning (Gap)/Surplus** | **£478** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£3,001** |
| 4 Year Plans | £3,520 |
| **4 Year Planning (Gap)/Surplus** | **£519** |

Gap to delivery 2018/19 - Progress compared to 2017/18




In Year CIP Delivery and Future Plans by Risk




Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 46 |
| Total Number of Assessed Schemes - Directorate | 31 |
| Total Number of Assessed Schemes - Signed Off | 20 |

| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 1 | 0 | 0 | 0 |
| Rare | 30 | 0 | 0 | 0 | 0 |

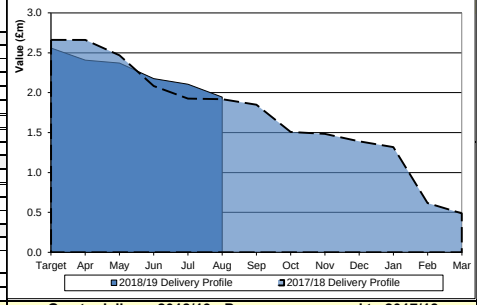
Moderate Risk Plans: 1 - Parallel Lists run by Clinical Fellows

formance 2018/19 - August Position

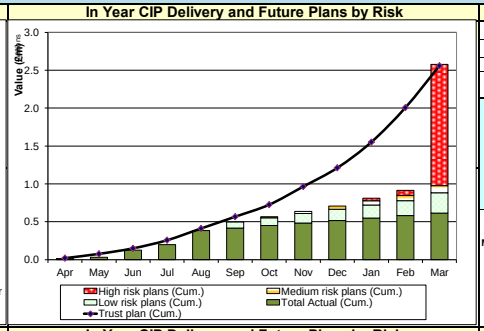
## TACC

| Executive Summary | £000 |
|---|---|
| **2018/19 CIP Target** | **£2,559** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £411 |
| Actual Delivery at Month 5 | £384 |
| **NHSI Variance Month 5** | **-£28** |
| Recurrent Delivery | £334 |
| Non Recurrent Delivery | £280 |
| **Total Delivery** | **£614** |
| **In Year Gap to Delivery** | **-£1,945** |
| **In Year Planning** | |
| Forecasted Delivery | £2,578 |
| **Forecasted Planning (Gap)/Surplus** | **£18** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£6,740** |
| 4 Year Plans | £3,495 |
| **4 Year Planning (Gap)/Surplus** | **-£3,246** |

Gap to delivery 2018/19 - Progress compared to 2017/18




In Year CIP Delivery and Future Plans by Risk




Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 52 |
| Total Number of Assessed Schemes - Directorate | 31 |
| Total Number of Assessed Schemes - Signed Off | 5 |

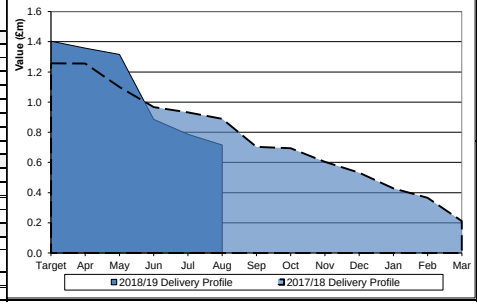
| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 1 | 0 | 0 |
| Rare | 29 | 1 | 0 | 0 | 0 |

Moderate Risk Plans: 1 - Staffing vacancies

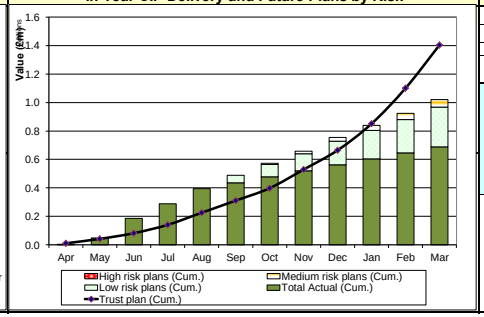
## AHP and Psychological Medicine

| Executive Summary | £000 |
|---|---|
| **2018/19 CIP Target** | **£1,404** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £226 |
| Actual Delivery at Month 5 | £395 |
| **NHSI Variance Month 5** | **£169** |
| Recurrent Delivery | £493 |
| Non Recurrent Delivery | £195 |
| **Total Delivery** | **£688** |
| **In Year Gap to Delivery** | **-£715** |
| **In Year Planning** | |
| Forecasted Delivery | £1,021 |
| **Forecasted Planning (Gap)/Surplus** | **-£383** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£3,282** |
| 4 Year Plans | £1,902 |
| **4 Year Planning (Gap)/Surplus** | **-£1,381** |

Gap to delivery 2018/19 - Progress compared to 2017/18




In Year CIP Delivery and Future Plans by Risk




Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 35 |
| Total Number of Assessed Schemes - Directorate | 35 |
| Total Number of Assessed Schemes - Signed Off | 9 |

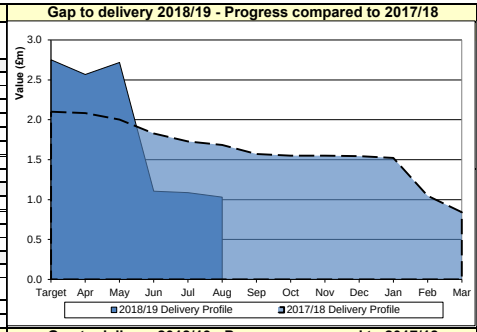
| Probability/ Likelihood | Negligible - None Consequence/Severity | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 35 | 0 | 0 | 0 | 0 |

## Estates and Facilities

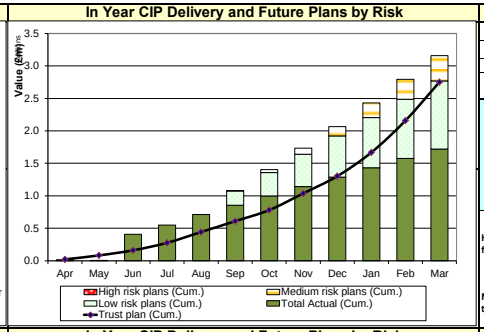
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£2,751** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £442 |
| Actual Delivery at Month 5 | £711 |
| **NHSI Variance Month 5** | **£269** |
| Recurrent Delivery | £1,697 |
| Non Recurrent Delivery | £23 |
| **Total Delivery** | **£1,721** |
| **In Year Gap to Delivery** | **-£1,031** |
| **In Year Planning** | |
| Forecasted Delivery | £3,159 |
| **Forecasted Planning (Gap)/Surplus** | **£408** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£6,843** |
| 4 Year Plans | £5,571 |
| **4 Year Planning (Gap)/Surplus** | **-£1,273** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 47 |
| Total Number of Assessed Schemes - Directorate | 33 |
| Total Number of Assessed Schemes - Signed Off | 12 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 1 | 0 | 0 |
| | 1 | 5 | 0 | 0 | 0 |
| Rare | 26 | 0 | 0 | 0 | 0 |

Consequence/Severity

High Risk Plans: 1 - Frequency of linen changes - Directorate reassessed score to be re-evaluated - awaiting ful QIA

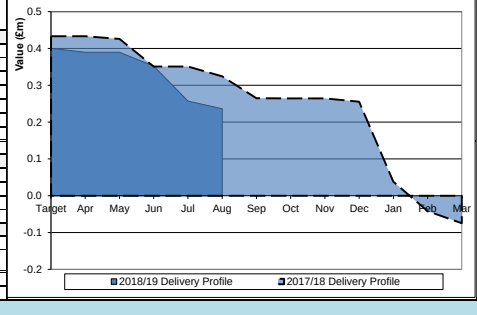
Moderate Risk Plans: 5 - Soft FM schemes cook/chill, waste, electric points, toilet rolls - financial risk more than quality/safety - to be reassessed by Directorate

## SNS

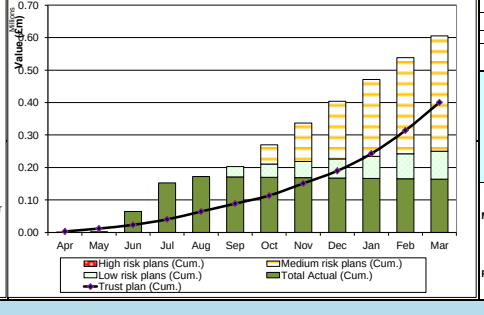
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£400** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £64 |
| Actual Delivery at Month 5 | £172 |
| **NHSI Variance Month 5** | **£108** |
| Recurrent Delivery | -£14 |
| Non Recurrent Delivery | £178 |
| **Total Delivery** | **£164** |
| **In Year Gap to Delivery** | **-£236** |
| **In Year Planning** | |
| Forecasted Delivery | £605 |
| **Forecasted Planning (Gap)/Surplus** | **£205** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£1,403** |
| 4 Year Plans | £1,162 |
| **4 Year Planning (Gap)/Surplus** | **-£241** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 16 |
| Total Number of Assessed Schemes - Directorate | 14 |
| Total Number of Assessed Schemes - Signed Off | 8 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 1 | 0 | 0 | 0 |
| Rare | 13 | 0 | 0 | 0 | 0 |

Consequence/Severity

Moderate Risk Plans - 1 - Paperlite - accessbility of notes

Plans to be reviewed and signed off following new process Sep 18

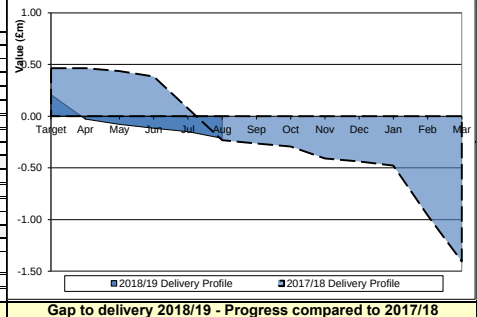
formance 2018/19 - August Position

## Finance

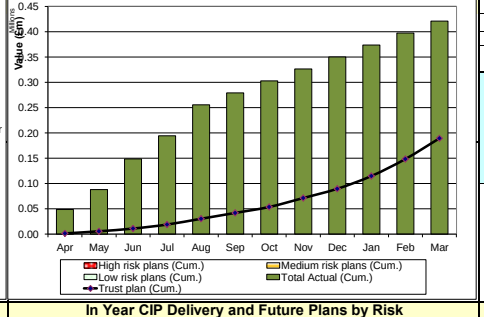
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£189** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £30 |
| Actual Delivery at Month 5 | £256 |
| **NHSI Variance Month 5** | **£225** |
| Recurrent Delivery | £277 |
| Non Recurrent Delivery | £144 |
| **Total Delivery** | **£421** |
| **In Year Gap to Delivery** | **£232** |
| **In Year Planning** | |
| Forecasted Delivery | £421 |
| **Forecasted Planning (Gap)/Surplus** | **£232** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£1,088** |
| 4 Year Plans | £428 |
| **4 Year Planning (Gap)/Surplus** | **-£660** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 21 |
| Total Number of Assessed Schemes - Directorate | 16 |
| Total Number of Assessed Schemes - Signed Off | 0 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 16 | 0 | 0 | 0 | 0 |

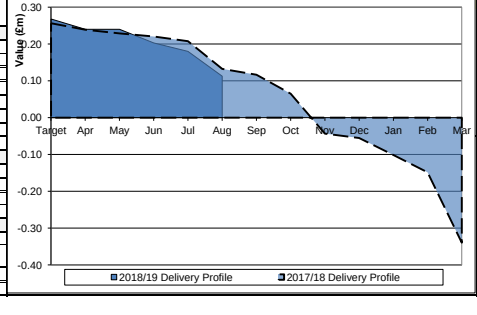
Consequence/Severity

## HR

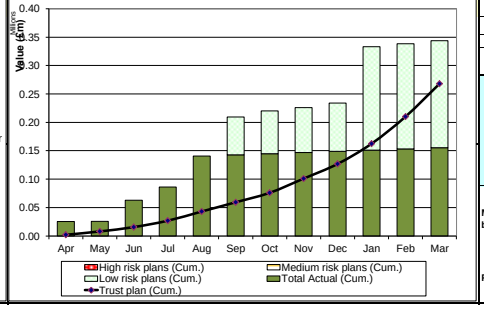
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£268** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £43 |
| Actual Delivery at Month 5 | £141 |
| **NHSI Variance Month 5** | **£98** |
| Recurrent Delivery | £45 |
| Non Recurrent Delivery | £110 |
| **Total Delivery** | **£155** |
| **In Year Gap to Delivery** | **-£113** |
| **In Year Planning** | |
| Forecasted Delivery | £344 |
| **Forecasted Planning (Gap)/Surplus** | **£76** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£918** |
| 4 Year Plans | £1,029 |
| **4 Year Planning (Gap)/Surplus** | **£111** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 17 |
| Total Number of Assessed Schemes - Directorate | 14 |
| Total Number of Assessed Schemes - Signed Off | 3 |

| Probability/ Likelihood | Negligible - None | | | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 2 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 12 | 0 | 0 | 0 | 0 |

Consequence/Severity

Moderate Risk Plans: 2 - relate to financial risk around salary flexibility and medical staff pay progression - to be reassessed by directorate

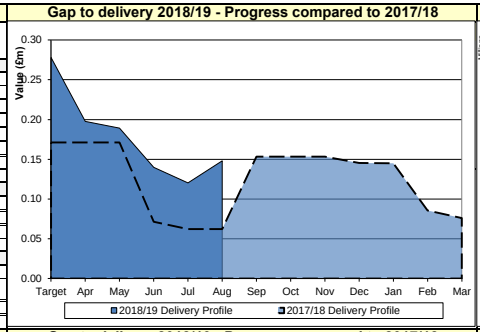
Plans to be reviewed and signed off following new process Sep 18

## Ops Management

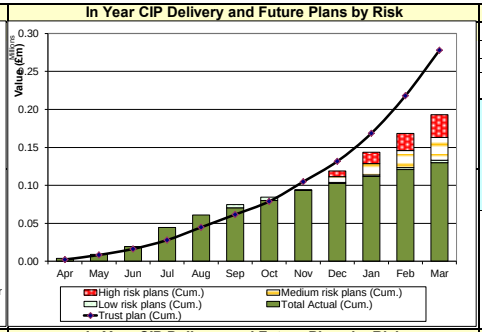
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£278** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £45 |
| Actual Delivery at Month 5 | £61 |
| **NHSI Variance Month 5** | **£16** |
| Recurrent Delivery | £97 |
| Non Recurrent Delivery | £33 |
| **Total Delivery** | **£130** |
| **In Year Gap to Delivery** | **-£148** |
| **In Year Planning** | |
| Forecasted Delivery | £193 |
| **Forecasted Planning (Gap)/Surplus** | **-£85** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£786** |
| 4 Year Plans | £228 |
| **4 Year Planning (Gap)/Surplus** | **-£559** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 13 |
| Total Number of Assessed Schemes - Directorate | 6 |
| Total Number of Assessed Schemes - Signed Off | 1 |

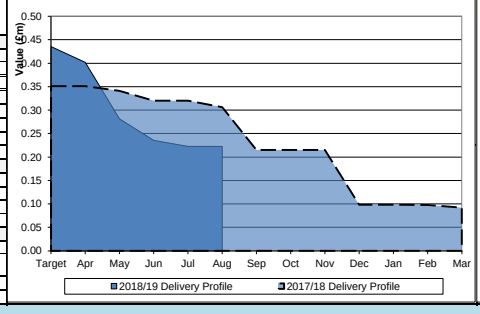
| Probability/ Likelihood | Negligible - None | | Consequence/Severity | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 6 | 0 | 0 | 0 | 0 |

## Chief Nurse Team

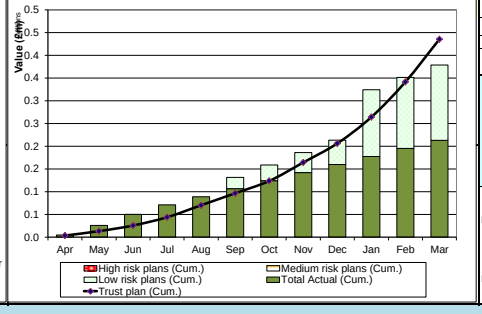
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£435** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £70 |
| Actual Delivery at Month 5 | £89 |
| **NHSI Variance Month 5** | **£19** |
| Recurrent Delivery | £189 |
| Non Recurrent Delivery | £23 |
| **Total Delivery** | **£213** |
| **In Year Gap to Delivery** | **-£223** |
| **In Year Planning** | |
| Forecasted Delivery | £378 |
| **Forecasted Planning (Gap)/Surplus** | **-£57** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£760** |
| 4 Year Plans | £410 |
| **4 Year Planning (Gap)/Surplus** | **-£350** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 8 |
| Total Number of Assessed Schemes - Directorate | 4 |
| Total Number of Assessed Schemes - Signed Off | 2 |

| Probability/ Likelihood | Negligible - None | | Consequence/Severity | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 1 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 3 | 0 | 0 | 0 | 0 |

**Moerate Risk Plans: 1 - reduction in Agency Nursing spend**

**Plans to be reviewed and signed off following new process Sep 18**

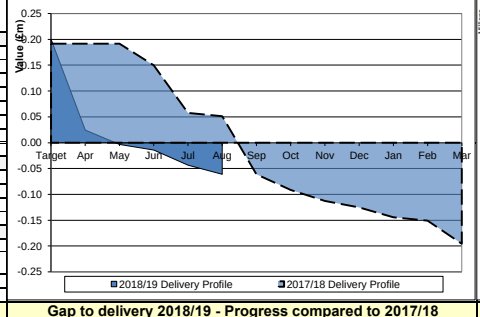
formance 2018/19 - August Position

## Chief Exec

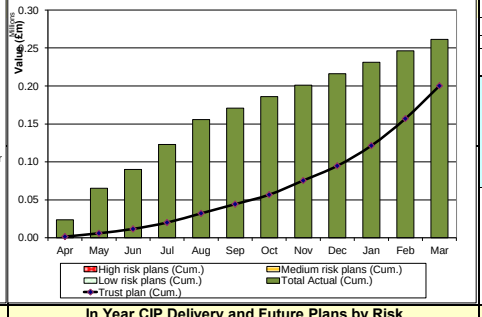
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£200** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £32 |
| Actual Delivery at Month 5 | £156 |
| **NHSI Variance Month 5** | **£124** |
| Recurrent Delivery | £181 |
| Non Recurrent Delivery | £80 |
| **Total Delivery** | **£261** |
| **In Year Gap to Delivery** | **£61** |
| **In Year Planning** | |
| Forecasted Delivery | £261 |
| **Forecasted Planning (Gap)/Surplus** | **£61** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£512** |
| 4 Year Plans | £261 |
| **4 Year Planning (Gap)/Surplus** | **-£251** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 5 |
| Total Number of Assessed Schemes - Directorate | 3 |
| Total Number of Assessed Schemes - Signed Off | 0 |

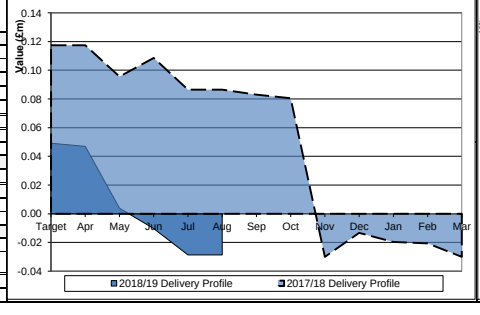
| Probability/ Likelihood | Negligible - None | | Consequence/Severity | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 3 | 0 | 0 | 0 | 0 |

## Medical Governance

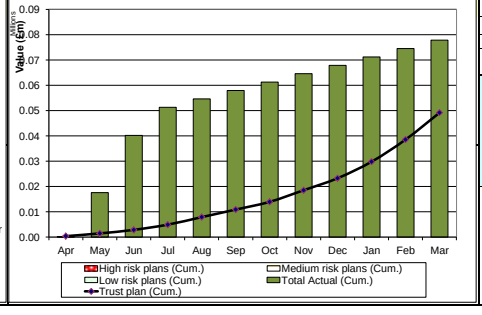
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£49** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £8 |
| Actual Delivery at Month 5 | £55 |
| **NHSI Variance Month 5** | **£47** |
| Recurrent Delivery | £37 |
| Non Recurrent Delivery | £41 |
| **Total Delivery** | **£78** |
| **In Year Gap to Delivery** | **£29** |
| **In Year Planning** | |
| Forecasted Delivery | £78 |
| **Forecasted Planning (Gap)/Surplus** | **£29** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£172** |
| 4 Year Plans | £81 |
| **4 Year Planning (Gap)/Surplus** | **-£91** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 5 |
| Total Number of Assessed Schemes - Directorate | 2 |
| Total Number of Assessed Schemes - Signed Off | 0 |

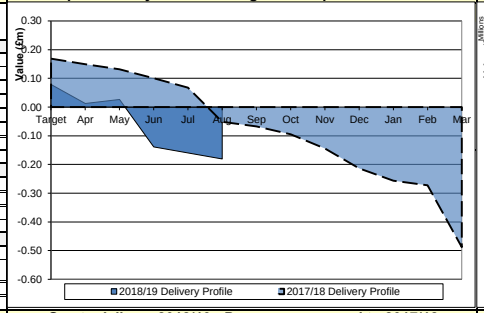
| Probability/ Likelihood | Negligible - None | | Consequence/Severity | | Catastrophic/death |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 2 | 0 | 0 | 0 | 0 |

## Learning Organisational Development & Research

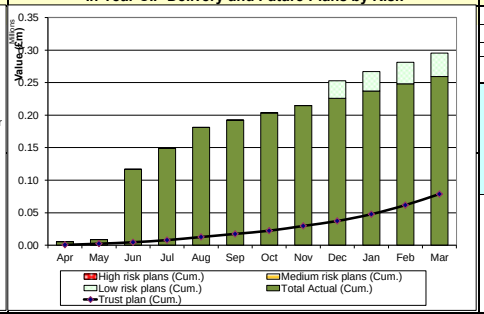
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **£79** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | £13 |
| Actual Delivery at Month 5 | £181 |
| **NHSI Variance Month 5** | **£168** |
| Recurrent Delivery | £134 |
| Non Recurrent Delivery | £125 |
| **Total Delivery** | **£259** |
| **In Year Gap to Delivery** | **£181** |
| **In Year Planning** | |
| Forecasted Delivery | £295 |
| **Forecasted Planning (Gap)/Surplus** | **£217** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **£414** |
| 4 Year Plans | £715 |
| **4 Year Planning (Gap)/Surplus** | **£301** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 14 |
| Total Number of Assessed Schemes - Directorate | 6 |
| Total Number of Assessed Schemes - Signed Off | 0 |

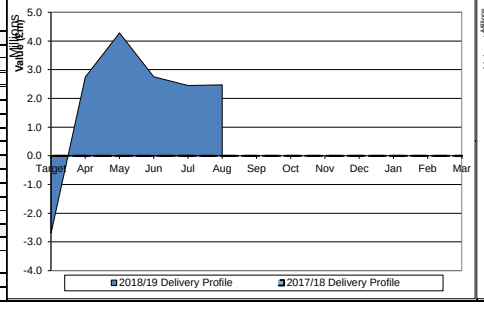
| Probability/ Likelihood | | | | | |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 6 | 0 | 0 | 0 | 0 |
| | Negliable - None | | | | Catastrophic/death |
| | Consequence/Severity | | | | |

## Corporate

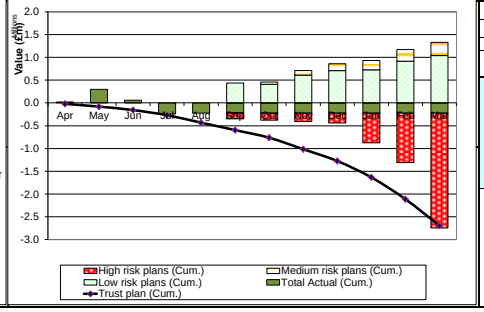
### Executive Summary

| | £000 |
|---|---|
| **2018/19 CIP Target** | **-£2,695** |
| **In Year Delivery** | |
| NHSI YTD Target at Month 5 | -£433 |
| Actual Delivery at Month 5 | -£223 |
| **NHSI Variance Month 5** | **£210** |
| Recurrent Delivery | -£324 |
| Non Recurrent Delivery | £101 |
| **Total Delivery** | **-£223** |
| **In Year Gap to Delivery** | **£2,472** |
| **In Year Planning** | |
| Forecasted Delivery | -£1,416 |
| **Forecasted Planning (Gap)/Surplus** | **£1,279** |
| **Long Term Planning** | |
| **4 Year CIP Target (18/19 to 21/22)** | **-£15,267** |
| 4 Year Plans | £4,140 |
| **4 Year Planning (Gap)/Surplus** | **£19,406** |

### Gap to delivery 2018/19 - Progress compared to 2017/18




### In Year CIP Delivery and Future Plans by Risk




### Governance Risk Heat Map

| | |
|---|---|
| Total Number of Schemes | 7 |
| Total Number of Assessed Schemes - Directorate | 1 |
| Total Number of Assessed Schemes - Signed Off | 0 |

| Probability/ Likelihood | | | | | |
|---|---|---|---|---|---|
| Almost Certain | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 |
| Rare | 1 | 0 | 0 | 0 | 0 |
| | Negliable - None | | | | Catastrophic/death |
| | Consequence/Severity | | | | |

## RISK SCORES - AUGUST 2018 - APPENDIX 2

| DIRECTORATE | Yr1 Target | 4Yr Target | Yr 1 Plan v Target | | Yr 1 Delivery v Target | | Y1 Recurrent Delivery v target | | 4 Yr Plan v Target | | | Overall Financial Risk | Governance Risk |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | (£000) | (£000) | % | Risk | % | Risk | % | Risk | % | Risk | Total Score | | |
| CHILD HEALTH | 877 | 2,128 | 29% | HIGH | 15% | HIGH | 15% | HIGH | 26% | HIGH | 12 | HIGH | LOW |
| WOMENS HEALTH | 1,164 | 2,825 | 44% | HIGH | 21% | HIGH | 12% | HIGH | 34% | HIGH | 12 | HIGH | MEDIUM |
| MEDICINE FOR THE ELDERLY SCAR | 739 | 2,626 | 26% | HIGH | 22% | HIGH | 8% | HIGH | 10% | HIGH | 12 | HIGH | MEDIUM |
| OPHTHALMOLOGY | 1,096 | 3,018 | 70% | HIGH | 22% | HIGH | 8% | HIGH | 68% | HIGH | 12 | HIGH | LOW |
| RADIOLOGY | 1,681 | 3,783 | 49% | HIGH | 29% | HIGH | 8% | HIGH | 72% | HIGH | 12 | HIGH | MEDIUM |
| SPECIALIST MEDICINE | 1,995 | 3,774 | 71% | HIGH | 31% | HIGH | 18% | HIGH | 83% | HIGH | 12 | HIGH | MEDIUM |
| EMERGENCY MEDICINE SCAR | 630 | 2,070 | 38% | HIGH | 34% | HIGH | 19% | HIGH | 20% | HIGH | 12 | HIGH | LOW |
| TACC | 2,559 | 6,740 | 101% | MEDIUM | 24% | HIGH | 13% | HIGH | 52% | HIGH | 11 | HIGH | MEDIUM |
| GS&U | 2,092 | 4,939 | 62% | HIGH | 42% | MEDIUM | 25% | HIGH | 92% | HIGH | 11 | HIGH | LOW |
| EMERGENCY MEDICINE YORK | 608 | 1,870 | 101% | MEDIUM | 64% | LOW | 12% | HIGH | 53% | HIGH | 9 | MEDIUM | MEDIUM |
| GEN MED SCARBOROUGH | 544 | 1,204 | 190% | LOW | 4% | HIGH | 4% | HIGH | 149% | LOW | 8 | MEDIUM | MEDIUM |
| GEN MED YORK | 1,406 | 4,118 | 175% | LOW | 15% | HIGH | 8% | HIGH | 143% | LOW | 8 | MEDIUM | LOW |
| AHP & PSYCHOLOGICAL MEDICINE | 1,404 | 3,282 | 73% | HIGH | 49% | LOW | 35% | LOW | 58% | HIGH | 8 | MEDIUM | LOW |
| SEXUAL HEALTH | 198 | 588 | 108% | MEDIUM | 57% | LOW | 1% | HIGH | 113% | LOW | 7 | MEDIUM | LOW |
| HEAD AND NECK | 704 | 1,886 | 109% | MEDIUM | 82% | LOW | 40% | LOW | 65% | HIGH | 7 | MEDIUM | LOW |
| LAB MED | 509 | 2,812 | 120% | LOW | 69% | LOW | 58% | LOW | 106% | MEDIUM | 5 | LOW | LOW |
| COMMUNITY | 257 | 599 | 101% | MEDIUM | 74% | LOW | 73% | LOW | 134% | LOW | 5 | LOW | LOW |
| PHARMACY | 407 | 1,153 | 145% | LOW | 65% | LOW | 49% | LOW | 125% | LOW | 4 | LOW | HIGH |
| ORTHOPAEDICS | 704 | 3,001 | 168% | LOW | 110% | LOW | 74% | LOW | 117% | LOW | 4 | LOW | MEDIUM |
| MEDICINE FOR THE ELDERLY YORK | 129 | 460 | 398% | LOW | 274% | LOW | 141% | LOW | 223% | LOW | 4 | LOW | MEDIUM |
| | | | | | | | | | | | | | |
| **CORPORATE** | | | | | | | | | | | | | |
| SNS | 400 | 1,403 | 151% | LOW | 41% | MEDIUM | -3% | HIGH | 83% | HIGH | 9 | MEDIUM | LOW |
| OPS MANAGEMENT YORK | 278 | 786 | 69% | HIGH | 47% | LOW | 35% | LOW | 29% | HIGH | 8 | MEDIUM | HIGH |
| CHIEF NURSE TEAM DIRECTORATE | 435 | 760 | 87% | HIGH | 49% | LOW | 44% | LOW | 54% | HIGH | 8 | MEDIUM | MEDIUM |
| HR | 268 | 918 | 128% | LOW | 58% | LOW | 17% | HIGH | 112% | LOW | 6 | LOW | LOW |
| ESTATES AND FACILITIES | 2,751 | 6,843 | 115% | LOW | 63% | LOW | 62% | LOW | 81% | HIGH | 6 | LOW | MEDIUM |
| CHAIRMAN & CHIEF EXECUTIVES OFFICE | 200 | 512 | 131% | LOW | 131% | LOW | 90% | LOW | 51% | HIGH | 6 | LOW | MEDIUM |
| MEDICAL GOVERNANCE | 49 | 172 | 158% | LOW | 158% | LOW | 74% | LOW | 47% | HIGH | 6 | LOW | HIGH |
| FINANCE | 189 | 1,088 | 222% | LOW | 222% | LOW | 146% | LOW | 39% | HIGH | 6 | LOW | LOW |
| LOD&R | 79 | 414 | 375% | LOW | 330% | LOW | 171% | LOW | 173% | LOW | 4 | LOW | HIGH |
| | | | | | | | | | | | | | |
| **TRUST SCORE** | **21,659** | **50,507** | **100%** | **MEDIUM** | **49%** | **LOW** | **30%** | **MEDIUM** | **108%** | **MEDIUM** | **7** | **MEDIUM** | **MEDIUM** |

# Master QIA Assessments and Signoff - HIGH RISK - APPENDIX 3

**Number of Schemes** 8

| | | | This section should be completed by the Directorate for any new schemes. | | | | | | | | | | | This section should be completed by the | | | | | | This section should be completed by CET/Quality Lead and Safety Lead as appropriate. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Initial Risk Assessment - Directorate | | | | | | | | | | | Residual Risk Assessment - After review | | | | | | Risk Assessment - After review (Clinical Lead for Efficiency) | | | | | | |
| Directorate | Scheme Ref | Scheme Name | Q&S Risk Assessed | Description of risk | Potential Clinical Impact | Impact on Service | Date Assessed | Probability/ liklihood | Consequence/Severity | Risk Rating | Risk Acceptability | Directorate QIA assessed | Possible mitigation | Likelihood | Consequence | Risk Rating | Risk Acceptability | Date Assessed | Date assessed by Nursing Lead (Quality) | Date assessed by Clinical Lead for Efficiency (Safety lead) | Review date | Current Assessed Risk | Clinical Lead QIA Assessed | Clinical Lead Comments | Directorate Response to comments | UPDATE |
| ED York | CIPEDY48a | Revised Clinical Model - In reach to ED from Elderly & Medicine (200 Y 125 S) - York | Yes | Staffing shortfalls, not always able to deliver sessions | Increased admissions | Delays in treatment, increased LOS | 04/09/2017 | 3 | 3 | 9 | High Risk | YES | 0 | 0 | 0 | 0 | Not Assesse | 0 | 0 | 0 | 0 | High Risk | NO | 0 | 0 | Awaiting full QIA - deadline 14.09.18 |
| Child Health | CIPCH033 | Child Protection Expertise Team. | yes | expert opinion service | None | Capacity issue | 25/10/2016 | 2 | 4 | 8 | High Risk | YES | 0 | 0 | 0 | 0 | Not Assesse | 0 | 0 | 0 | 0 | High Risk | NO | 0 | 0 | Awaiting full QIA - deadline 0289.18 |
| Medicine for the Elderly Y | CIP-EMS3 | Vacancy factor | Yes | High levels of substantive vacancies (predominantly nursing) | Increase utilisation of temporary / transient workforce which could impact quality and safety | Potential descrease in perceived quality of care and financial duress | 31/05/2017 | 4 | 2 | 8 | High Risk | YES | 0 | 0 | 0 | 0 | Not Assesse | 0 | 0 | 0 | 0 | High Risk | NO | NEED TO PROVIDE EVIDENCE WHY AGENCY STAFF MAY DELIVER LOWER QUALITY WORK. WP TO EMAIL JT - WHAT STEPS HAVE BEEN TAKEN TO ADDRESS RECRUITMENT ISSUES | Transient workforce versus sustantive workforce - potentially not familiar with the organisation, policies, processes and culture, Continuity of care also impacted by consistently high levels of transient workforce. | Awaiting full QIA - deadline 14.09.18 |
| Lab Medicine | CIPPATH37 | Microbiology Skill Mix (BMS Posts) | YES | Reduction in managerial support | Department organisation and workload management | Increased turnaround times | 27/05/2016 | 3 | 3 | 9 | High Risk | YES | Stepwise ch | 2 | 2 | 4 | Moderate R | 27.05.16 | 0 | 31.05.16 | 0 | Moderate Risk | YES | Agree Moderate Risk | 0 | DIRECTORATE RE-ASSESSED - MODERATE RISK |
| Lab Medicine | CIPPATH126 | SPECIMEN RECEPTION MLA - ORDERCOMMS | Yes | Reduction in staff that may not support contigency in the event of a failure | Delay to patient results | Increased turnaround times | 22/12/2016 | 2 | 4 | 8 | High Risk | YES | 0 | 0 | 0 | 0 | Not Assesse | 0 | 0 | 09.03.17 | 0 | High Risk | YES | RK TO WRITE LETTER TO NT & SR RE ORDERCOMMS CONTINGENCY | 0 | Awaiting full QIA - deadline 14.09.18 |
| Lab Medicine | CIP1819EC01 | Length of Stay | Yes | Analyser only on trial 1718 | None | Quicker turnaround times and flexibility in testing. | 30/07/2018 | 5 | 2 | 10 | High Risk | YES | Approval of | 1 | 1 | 1 | Low Risk | 0 | 0 | 0 | 0 | Low Risk | NO | 0 | 0 | DIRECTORATE RE-ASSESSED - LOW RISK |
| Lab Medicine | CIPPATH194 | CONSOLIDATION OF SERVICES WITH HEY - HISTOLOGY, VIROLOGY & IMMUNOLOGY | YES | redundance/ loss of staff | TAT/delayed results | TAT/delayed results | 30.7.18 | 3 | 4 | 12 | High Risk | YES | in progress | 3 | 4 | 12 | High Risk | 0 | 0 | 0 | 0 | High Risk | NO | 0 | 0 | Awaiting full QIA - deadline 14.09.18 |
| Gen Med York | CIPGMY140 | Fulfilling aspirations to become a CF centre | Yes | Risk that patient numbers will continue to grow without infastructure | lack of avaialbility of appropriate specialist accommodation | would have to re-direct patients to appropriate facility | 25/05/2016 | 3 | 3 | 9 | High Risk | YES | 0 | 0 | 0 | 0 | Not Assesse | 0 | 0 | 17.08.16 | 0 | High Risk | YES | Agree High Risk. Aspiration appropriate to pursue providing backing of Trust. Who is Clinical Lead? RK to drop email to Clin Lead on update of services - LETTER 25.10.16 | 0 | Awaiting full QIA - deadline 14.09.18 |
| Womens Health | CIPWH227 | Pre assessment clinic efficiency | Self Assessed | More elective activity being done at Bridlington without infrastructure available | Possible increased risk of poor outcomes as reduced medical cover and no ICU facilities at Bridlington | Increased activity | 19.12.16 | 2 | 4 | 8 | High Risk | YES | Bridlington | 1 | 4 | 4 | Moderate R | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 | DIRECTORATE RE-ASSESSED - MODERATE RISK |
| Estates and Facilities | CIPE&F024 | Frequency of Linen Changes | Yes | Wards don't adhere to frequency of change | None | Increased costs as changed too frequently | 07/06/2016 | 3 | 3 | 9 | High Risk | YES | 0 | 0 | 0 | 0 | Not Assesse | 0 | 0 | 0 | 0 | High Risk | NO | Why is this high risk ...is this purely financial risk? Would Q&S be lower risk providing patient comfortable/clean. | It is a financial risk only and it is felt that neither quality or safety would be affected by the linen change reduction. | Awaiting full QIA - deadline 14.09.18 |
| ED Scar | CIPEDY48b | Revised Clinical Model - In reach to ED from Elderly & Medicine (200 Y 125 S) - Scar | Yes | Staffing shortfalls, not always able to deliver sessions | Increased admissions | Delays in treatment, increased LOS | 04/09/2017 | 3 | 3 | 9 | High Risk | YES | 0 | 0 | 0 | 0 | Not Assesse | 0 | 0 | 0 | 0 | High Risk | NO | 0 | 0 | Awaiting full QIA - deadline 14.09.18 |

## HIGH RISK THEMES

| CATEGORY | NO OF SCHEMES | THEME | MOVEMENT | COMMENT |
|---|---|---|---|---|
| Staffing Risk | 4 | Vacancies, skill mix, | ↓ | 1 Scheme removed not supported (ED), 1 scheme reassessed Moderate Risk, Lab Med. Awaiting Full QIA for 4 schemes, deadline 14.09.18 |
| Infrastructure | 1 | Brid/CF Service | ↓ | 1 Scheme reassessed by Directorate to Moderate, Women's Health. Awaiting Full QIA for 1 scheme, deadline 14.09.18 |
| Policy | 1 | Linen changes (E&F) | ↑↓ | Awaiting Full QIA - deadline 14.09.18 |
| Development | 1 | Child Protection Ex Team | ↑↓ | Awaiting Full QIA - deadline 28.09.18 |
| Consolidation of Services | 1 | Pathology with HEY | ↑↓ | Awaiting Full QIA - deadline 14.09.18 |
| LOS | 0 | Pathology | ↓ | 1 scheme reassessed Low Risk, Lab Medicine |
| TOTAL | 8 | | | |

# Master QIA Assessments and Signoff - MODERATE RISK - APPENDIX 3

| Number of Schemes | 31 |
|---|---|

| | | | This section should be completed by the Directorate for any new schemes. | | | | | | | | | | This section should be completed by the Directorate for schemes which have been reassessed. | | | | | | This section should be completed by CET/Quality Lead and Safety Lead as appropriate. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Initial Risk Assessment - Directorate | | | | | | | | | | Residual Risk Assessment - After review | | | | | | Risk Assessment - After review (Clinical Lead for Efficiency) | | | | | | |
| Directorate | Scheme Ref | Scheme Name | Q&S Risk Assessed | Description of risk | Potential Clinical Impact | Impact on Service | Date Assessed | Probability/ likelihood | Consequence/ Severity | Risk Rating | Risk Acceptability | Directorate QIA assessed | Possible mitigation | Likelihood | Consequence | Risk Rating | Risk Acceptability | Date Assessed | Date assessed by Nursing Lead (Quality) | Date assessed by Clinical Lead for Efficiency (Safety lead) | Review date | Current Assessed Risk | Clinical Lead QIA Assessed | Clinical Lead Comments | Directorate Response to comments |
| Chief Nurse Team | CIPCN027 | reducing agency spend | y | 0 | 0 | 0 | 08/02/2017 | 3 | 2 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Head and Neck | CIPHN98 | Bring Nuffield Activity in house (TACC BCF) | 0 | activity falls, waiting list/ times increase | only effects routine cases, condition worsten | targets not met | 11/07/2018 | 3 | 2 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 09.03.17 | 0 | Moderate Risk | YES | 0 | 0 |
| Head and Neck | CIPHN105 | Paperless outpatient Clinics move to next year trailing this year start with 1250 saving | 0 | information not available | decision making | more FU | 06/01/2017 | 3 | 2 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Head and Neck | CIPHN100 | BRING RAMSEY ACTIVITY IN HOUSE | 0 | activity falls, waiting list/ times increase | only effects routine cases, condition worsten | targets not met | 11/07/2018 | 3 | 2 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Ophthalmology | CIPOPH50 | NR Pay underspends | no Q&S risk | no risk | none | none | 13/072016 | 5 | 1 | 5 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 07.12.17 | 0 | Moderate Risk | YES | Require more v | 0 |
| Ophthalmology | CIPOPH51 | NR Non Pay underspends | no Q&S risk | no risk | none | none | 13/072016 | 5 | 1 | 5 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 07.12.17 | 0 | Moderate Risk | YES | Require more i | 0 |
| Ophthalmology | CIPOPH58 | Cleaning vs disposing of theatre packs | Contaminat ion risk | Items not cleaned thoroughly / dirty used | Patient harm | Patient harm | 17/01/2017 | 1 | 4 | 4 | Moderate Risk | YES | Training / education and follow existi ng Trust protocols for decon | 0 | 0 | 0 | Not Assessed | 0 | 0 | 09.03.17 | 0 | Moderate Risk | YES | 0 | 0 |
| Ophthalmology | CIPOPH63 | reduced use of CESP through Op theatre case | workforce gaps mean service not consistently in place | service delays | patient waiting times increase | RTT missed | 17/01/2017 | 2 | 3 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Ophthalmology | CIPOPH70 | paperlite | Information not available for decision making | Delay finding information | Decsions not made | Increase number of FU | 17/01/2017 | 3 | 2 | 6 | Moderate Risk | YES | Training and education | 0 | 0 | 0 | Not Assessed | 0 | 0 | 09.03.17 | 0 | Moderate Risk | YES | 0 | 0 |
| Ophthalmology | CIPOPH78 | Reducing Locum Costs | Reduce number of qualified staff to do clinical work if no perm staff to replace | Waiting lists increase | conditions worsen and potential harm | 0 | 17/01/2017 | 3 | 2 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Ophthalmology | CIPOPH81 | Virtual Review Clinics | Time planned appropriate ly | time allocation does not fit need - less patients seen overall | delays in clinics - whilst bedding in | delays in clinics - whilst bedding in | 17/01/2017 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 09.03.17 | 0 | Moderate Risk | YES | 0 | 0 |
| SNS | CIPSNS20 | Paperlight - Health Records Staffing | Y | NOT BEING ABLE TO ACCESS NOTES | MAY NOT HAVE ACCESS TO NOTES IF SYSTEM FAILURE | POTENTIAL TO INCREASE APPOINTMENT TIME AND REDUCE THROUGHPUT | 05.07.16 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 17.08.16 | 0 | Moderate Risk | YES | 0 | 0 |
| HR | CIPHR9 | HR element of Salary Flexibility - introduced | Yes | This project doesn't materialise | NIL | Budgets remain as they are | 02/06/2016 | 4 | 1 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| HR | CIPHR28 | HR element of schedule 15 Medical staff incr | Yes | Nominal | NIL | Budgets remain as they are | 05/01/2017 | 4 | 1 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Orthopaedics | CIPO&TYS2a | Parallel Lists - York Q3 17/18 | YES | Clinical Fellow runs into difficulty | Patient has longer in Theatre | Overrun lists in Theatres, Patient experince is not good | 06/06/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | Query: Case se | 0 |
| Child Health | CIPCH042 | Skill Mix Review SCBU York (Unqualified) | Yes | Introduce a revised training programme | skills to be developed through the training period | low during this training period as shift always covered by a qualified nurse | 17/05/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | Details of train | This relates to the introduction of a neonatal practitioner role on the York site (Role in place on the Scarborough site band 3.) In York the staff are nursery nurse and paid band 4 |
| Child Health | CIPCH031 | Endocrine Clinic - Tertiary Visiting - potential | yes | reduced tertiary activity increase trust activity | capacity issues | Capacity Issue | 25/10/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Child Health | CIPCH035 | Epilepsy Development of Service. | yes | in house service | none | loss of tertiart expertise | 25/10/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Child Health | CIPCH037 | Increased activity from neighbouring Trusts | yes | increased activity | none | Capacity Issue | 25/10/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Child Health | CIPCH046 | TEWV - Regional Eating disorder Centres. | Yes | new service | consultant capacity | consultant capacity | 25/10/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Child Health | CIPCH082 | Review of SGH Community Block Contract | yes | SLA under review | increased activity | Capacity Issue | 25/10/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Radiology | CIPRAD4a | Reconfigure Breast Screening Service | YES | Loss of localised services by removing mobile | Patients unwilling to travel to fixed base service | Improve efficiency and remove uncertainty around site costs, alos will allow disabled patients to be screened closer to home | 02/06/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | RK TO EMAIL D | 0 |
| TACC | CIPTACC005 | Non Recurrent vacancies removed YTD | 0 | Delays in recruitment - Managed within service through matrons or department haeds | Risk managed within service | Risk managed within service | 01.06.16 | 2 | 3 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 17.08.16 | 0 | Moderate Risk | YES | Agree Moderat | 0 |
| Community | CIPCOM87 | DISTRICT NURSING SKILL MIX REVIEW | Y | Skill mix based on erroneous activity data. | Capacity not meeting demand and patients receiving reduced care | Potential increased sickness and R&R issues. | 30/11/2017 | 3 | 2 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| General Surgery & Urology | CIPGSU128 | Self-Pay Service (Plastics) | Risk of disadvanta ging NHS patients vs self-pay | Risk of not booking in chronological order | Small clinical risk of delaying patients procedure | Potential negative impact on service | 22/01/2018 | 2 | 3 | 6 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| General Surgery & Urology | CIPGSU138 | IA FORM 36 - INCREASE IN INCOME AS PER APPROVED AMENDMENT LETTER TO APPROVED RC 2016/17-37 - DEVELOPMENT OF PLASTIC SURGERY SERVICE | Small risk - demand may not materialise | No risk to patients | No clinical risk | Risk to service that demand may not be as anticipated | 22/01/2018 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |
| Estates and Facilities | CIPE&F043 | Introduce Cook Chill at Scarborough | Yes | Project on-going to evaluate return on investment | None | None | 07/06/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | Why different s | 0 |
| Estates and Facilities | CIPE&F152 | Reduce patient food cost per day from £9.50 | Yes | Suitably qualified person to deliver project - unable to recruit suitable applicant. | None | None | 07/06/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 17.08.16 | 0 | Moderate Risk | YES | Query: Nutritio | 0 |
| Estates and Facilities | CIPE&F121 | Roll out DMR waste across all Theatres | Yes | Financial savings not achieved | None | None | 07/06/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | What is DMR? | Dry Mixed Recycled waste such as cardboard |
| Estates and Facilities | CIPE&F157 | Installation of Data Points by in-house staff | Yes | Financial savings not achieved | None | None | 07/06/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 17.08.16 | 0 | Moderate Risk | YES | 0 | 0 |
| Estates and Facilities | CIPE&F163 | Re-tender contract for supply of Toilet Paper | Yes | Quality may be compromised if cheaper alternative introduced on all sites. If current higher quality is deemed the most suitable no financial savings will be achieved. | None | None | 07/06/2016 | 2 | 2 | 4 | Moderate Risk | YES | 0 | 0 | 0 | 0 | Not Assessed | 0 | 0 | 0 | 0 | Moderate Risk | NO | 0 | 0 |

## NHSI Operational Productivity Workstreams - Wave 1 - August 2018

| | Scheme | Phase | Exp. Delivery | Benefits (Operational KPI's) Metric | Qty Before | Qty After | Productivity | Efficiency 18/19 & 19/20 | RAG RATING | ACTIVITY - FORECAST 2018/19 | | | | ACTIVITY - ACTUAL 2018/19 | | | | FINANCE - FORECAST 2018/19 | | | | FINANCE - ACTUAL 2018/19 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | 2017/18 | 2018/19 | | £M | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| | **TOTAL** | | | | | | | **-£12.15** | | | | | | | | | | | | | | | | | |
| **T&O** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quality & Safety | Reduction in LOS @ YTH - Primary Hip | 2 | | **LOS** | 3.4 | 3.4 | 0 | | **RED** | | | | | | | | | | | | | | | | |
| | Reduction in LOS @ YTH - Primary Knee | 3 | | **LOS** | 7.11 | 4.2 | -2.9 | | **RED** | | | | | | | | | | | | | | | | |
| Access & Flow | Increase in outpatient utilisation | 2 | | **Utilisation rate of clinics** | | | | | **RED** | | | | | | | | | | | | | | | | |
| | Increase in theatre productivity | 2 | | **RTT Incomplete** | 96.31% | 98% | 2% | | **RED** | | | | | | | | | | | | | | | | |
| | Reduction in LOS @ YTH - Primary Hip | 2 | | | 3.4 | 3.4 | 0% | | **RED** | | | | | | | | | | | | | | | | |
| | Reduction in LOS @ YTH - Primary Knee | 2 | | | 7.11 | 4.2 | -2.9 | | **RED** | | | | | | | | | | | | | | | | |
| Finance & Efficiency | Increase in day-case rates | 2 | | **Day-case rate** | 59% | 65% | 6% | | **RED** | | | | | | | | | | | | | | | | |
| | Increase in theatre productivity | 2 | 2018/19-2019/20 | **Profit/Loss (£M)** | £1.30 | £2.80 | | -£2 | **RED** | | | | | | | | | | | | | | | | |
| | Repatriation of private sector activity (York) | 2 | 2019/20 + | **Elective activity Income (£M)** | 0 | £0.25 | | £0 | **RED** | | | | | | | | | | | | | | | | |
| | **TOTAL T&O** | | | | | | | **-£2** | | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** |
| **Procurement Project Brief 1** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Finance & Efficiency | Variance for top 100 products | 2 | 2018/19 | **%** | 7.2 | 5.5 | -1.7 | | | | | | | | | | | | | | | | | | |
| | Non-NHSSC Savings | 2 | 2018/19 | **£M** | £0 | £0.19 | | -£0.19 | | | | | | | | | | | | | | | | | |
| | NHSSC Savings (to achieve best in class) | 2 | 2018/19 | **£M** | £0.60 | £1.00 | | -£0.40 | | | | | | | | | | | | | | | | | |
| | **TOTAL PROCUREMENT** | | | | | | | **-£0.6** | | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** |
| **Cardiology Brief 1 – Capacity & Demand VIU** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quality & Safety | | | | | | | | | | | | | | | | | | | | | | | | | |
| Access & Flow | Maximise Activity through Regents Park | 2 | 2018/19 | **Procedure numbers/ Attendances** | 453 | 696 | 243 | | **RED** | | | | 243 | | | | | | | | | | | | |
| | Maximising activity through 3 sessional working in current VIU | 2 | 2019/20 | **Procedure numbers/ attendances** | 1061 | 1440 | 379 | | **RED** | | | | | | | | | | | | | | | | |
| Finance & Efficiency | Maximising Activity through Regents Park | | 2018/19 | **£M** | £0.43 | **£1.14** | | -£0.71 | **RED** | | | | | | | | | | | | £0.7 | | | | |
| | Maximising activity through 3 sessional working in current VIU | 2 | 2019/20 | **£M** | £2.90 | £4.30 | | -£1.40 | **RED** | | | | | | | | | | | | | | | | |
| | **TOTAL CARDIOLOGY BRIEF 1** | | | | | | | **-£2.1** | **RED** | **0** | **0** | **0** | **243** | **0** | **0** | **0** | **0** | **£0.0** | **£0.0** | **£0.0** | **£0.7** | **£0.0** | **£0.0** | **£0.0** | **£0.0** |
| **Estates & Facilities Brief 1 – ADM** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Finance & Efficiency | Delivering a significant and tangible contribution to the Trust's financial recovery plan, supporting The Trust to continue to deliver sustainable, high quality and safe services. It must be noted that these figures are indicative at this point in time. Revenue Savings | | 2017/18 - revised to 2018/19 | **£M** | £0.0 | £6.2 | | -£6.18 | | | | | | | | | | £1.5 | | £2.3 | £2.3 | £1.5 | | | |
| | Revenue Savings (BV) | | 2019/20 | **£M** | £0.0 | £1.0 | | -£1.0 | | | | | | | | | | | | | | | | | |
| | **TOTAL E&F BRIEF 1 ADM** | | | | | | | **-£7.2** | | | | | | | | | | **£1.5** | **£0.0** | **£2.3** | **£2.3** | **£1.5** | **£0.0** | **£0.0** | **£0.0** |

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| **Estates & Facilities Brief 2 – Soft FM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quality & Safety | Continue to Meet NHS National Cleaning Specification | 2 | 2018/19 | PLACE & TAPE Assessment | Meeting national average (PLACE) 98% | Meeting national average (PLACE) **TBD** | | | | | | | | | | | | | | | | | | | | | | |
| | Continue to Meet NHS National Cleaning Specification | | | PLACE & TAPE Assessment | Partially Meeting Internal KPI (TAPE) 80% | Meeting Internal KPI (TAPE) **80%** | | | | | | | | | | | | | | | | | | | | | | |
| Access & Flow | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Finance & Efficiency | Reduction in sqm cleaning costs relating to pay and non pay elements | 2 | 2017/18 | £ / m2* | £46 | £40 | | -£0.00 | | | | | | | | | | | | | | | | | | | | |
| | Reduction in sqm cleaning costs relating to pay and non pay elements | | 2018/19 | £ / m2* | £46 | £40 | | -£0.17 | | | | | | | | | | | | | | | | | | | | |
| | Increase in Weighted Activity unit (WAU) per wte associated with cleaning productivity | 2 | 2018/19 | £ / m2* | £672 | £585 | | | | | | | | | | | | | | | | | | | | | | |
| | Reduction in patient food costs | | 2018/19 | £ / Pt Meal | £3.42 | £2.71** - | | -£0.18 | | | | | | | | | | | | | | | | | | | | |
| | Reduction costs – toilet tissue | | 2018/19 | £ | | | | -£0.01 | | | | | | | | | | | | | | | | | | | | |
| | **TOTAL E&F BRIEF 2 - SOFT FM** | | | | | | **0** | **-0.355** | | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** |
| **Estates & Facilities Brief 3 - Combined Heat and Power** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quality & Safety | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Access & Flow | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Finance & Efficiency | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Estates & Facilities Brief 4 - Estates Optimisation (Short Term)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quality & Safety | Maintain cleanliness to National Specification | 2 | | **PLACE Assessment 98%** | 98% | 98% | 0% | | | | | | | | | | | | | | | | | | | | | |
| | Improve condition and appearance of site | | | **TAPE Assessment 80%** | 64% | 80% | 16% | | | | | | | | | | | | | | | | | | | | | |
| Finance & Efficiency | Energy saving Costs reduction | 2 | | **Electricity Kwh** | 482,277 kwh* | | | £0.0 | | | | | | | | | | | | | | | | | | | | |
| | Energy saving Costs reduction | | | **Gas Kwh** | 5,569,386 kwh* | | | | | | | | | | | | | | | | | | | | | | | |
| | Utilisation of Space- Reduction in Non clinical space | 2 | | **>35%** | 28% | 20% | -8% | | | | | | | | | | | | | | | | | | | | | |
| | Cleaning costs reduction | 2 | 2018/19 | **Annual cost (£M)** | £0.64 | £0.55 | | -£0.1 | | | | | | | | | | | | | | | | | | | | |
| | Maintenance cost avoidance of 5% | 2 | 2018/19 | Annual cost (£) | £0.28 | £0.27 | | £0.0 | | | | | | | | | | | | | | | | | | | | |
| | **TOTAL E&F BRIEF 4 - Estates Optim (ST)** | | | | | | | -£0.1 | | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** | **£0.0** |
| **Radiology Brief 1 Capacity & Demand** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quality & Safety | | | | | | | | | **RED** | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | **RED** | | | | | | | | | | | | | | | | | | | |
| Access & Flow | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Finance & Efficiency | | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Undertaking increased activity with no increase in resources | | | | | | | | **RED** | | | | | | | | | | | | | | | | | | | |
| | Actual reduction in staff costs | | | | | | | | **RED** | | | | | | | | | | | | | | | | | | | |
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| **Radiology Brief 2 - Rationalisation of Current Service** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Finance & Efficiency | Reduction in costs | 2 | | £ | £0.07M | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Radiology Brief 3 - Financing of Operational Assets** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Finance & Efficiency | Cost reduction through Managed Service Contract | 2 | | £ | | | | | RED | | | | | | | | | | | | | | | | | | | | | |
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**Key**:
Phase 1 – Model Hospital Data Analytics
Phase 2 – Development of Trust Plans
Phase 3 – Delivery of Plans (First Wave)
Phase 4 – Benefit Tracking

| KEY | |
|---|---|
| RAG | |
| Red | Not Implemented |
| Amber | In Progress |
| Green | Completed |

York Teaching Hospital
NHS Foundation Trust

# Meeting of the Board of Directors - 26 September 2018
# Risk Management Framework

**Trust Strategic Goals:**

☒ **to deliver safe and high quality patient care**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

| | | | |
|---|---|---|---|
| For information | ☒ | For approval | ☐ |
| For discussion | ☒ | A regulatory requirement | ☐ |
| For assurance | ☐ | | |

Purpose of the Report

For the Board of Directors to approve the updated Risk Management Framework

Executive Summary – Key Points

The Board are asked to note and approve the revised Risk Management Framework. Key changes have been influenced by the recent findings of an Internal Audit which arrived at a conclusion of 'Significant Assurance'. Changes are

- **Reference is made to the various Committees that have responsibility for the review of the Corporate Risk Register**
- **Enhanced detail has been included on the 'Generic duties and responsibilities section'**
- **An improved explanation of the relationship between the Risk Management and Board Assurance Frameworks**
- **Reference to how risk management aligns with the 'Three Lines of Defence' assurance model**
- **Enhanced Key Performance Indicators**
- **Identification of key risk specialist roles within the organization**
- **The adoption of the Risk Register Module within Datix to bring consistency , improve triangulation and provide better risk identification and reporting. This will commence with the Corporate Risk Register and then be rolled out within the organization with the two Acute and Emergency Care Groups being initial priority.**
- **Clairifies the scores for consideration of escalation to the CRR**
- **Clairifies the period of regular review for risks by score**

Training:

Risk Management Training to be provided to the Board in December 2018.

Training to be provided to key directorate staff

Recommendation

The Board of Directors is asked to note the new inclusions and approve the revised Risk Management Framework.

Author: Fiona Jamieson, Deputy Director of Healthcare Governance

Director Sponsor: Beverley Geary, Chief Nurse

Date: September 2018

**DRAFT**

York Teaching Hospital
NHS Foundation Trust

# Risk Management Framework

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|---|---|
| Author: | Fiona Jamieson, Head of Healthcare Governance |
| Owner: | Chief Executive |
| Publisher: | Healthcare Governance |
| Version: | 11.0 |
| Date of version issue: | |
| Approved by: | Board of Directors |
| Date approved: | |
| Review date: | July 2020 |
| Target audience: | All staff employed by the Trust |
| Relevant Regulations and Standards | Underpins all outcomes - CQC Essential Standards of Quality and Safety |
| Links to Organisational/Service Objectives, business plans or strategies | Organisational Strategy, Financial Plan, Patient Safety Strategy and Directorate Strategies |
| **Executive Summary**<br>This framework describes the processes and system for risk management utilised by the Trust | |
| **This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.** | |

## Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

| Version | Date Approved | Version Author | Status & location | Details of significant changes |
|---|---|---|---|---|
| 5 | March 2007 | | | Various amendments – see previous version history on Q-Pulse |
| 6 | May 2008 | Elaine Miller Head of Risk & Legal Services | | Various amendments – see previous version history on Q-Pulse |
| 7 | July 2009 | Elaine Miller Head of Risk & Legal Services | Bootham Park | Various amendments – see previous version history on Q-Pulse |
| 8 | Dec 2014 | Fiona Jamieson Head of Healthcare Governance | Staffroom | Reviewed and updated into new template |
| 9 | September 2016 | Fiona Jamieson Deputy Director of Healthcare Governance | Staff Room | Added statement on Risk Appetite |
| 10 | July 2018 | Fiona Jamieson Deputy Director of Healthcare Governance | Staff Room | Reviewed and updated to reflect Internal Audit recommendations, improved description of relationship between BAF and CRR, improved description of generic duties, adoption of Datix Risk Management Module, improved key performance indicators |

## Contents

## Introduction

This document provides articulates the commitment of the Board of Directors to the identification and consistent management of risk within York Teaching Hospitals NHS Foundation Trust and the operational framework for its delivery The Board aims to do this by:

Defining risk as

> 'The effect of uncertainty on the delivery of objectives and refers to any variation on the expected or desired objective or outcome'.

For example, we have an objective to keep patients and staff safe at all times, risk is therefore anything that is stopping or could stop us from keeping people safe whilst in our care.

The primary purpose of risk management is to:

- Reduce harm for patients, staff, visitors or contractors;
- Promote the success of York Teaching Hospitals NHS Foundation Trust;
- Protect everything of value to the Trust (such as reputation, market share, exemplary clinical outcomes); and
- Continuously improve patient experience, safety and quality performance.

Identifying risk as:

- Anticipating what could stop us from achieving our objectives or goals. To help identify areas of risk we look at our historical performance and trends, previous events, current challenges, and needs of people who use our services as well as thinking about future scenarios or potential outcomes that could help or hinder the delivery of strategy. We are all required to be open, honest, think ahead and take an active part in identifying risk.

Analysing risk by:

- Estimating the severity (the impact the risk has on the Trust and people in our care) and likelihood (the chance of something happening). The scores are multiplied to give an overall risk rating. The risk rating is used to determine risk management priorities and monitor acceptable amounts of risk.
- Within the Framework colleagues are required to challenge constructively any assumptions made regarding severity and likelihood, and to strive to ensure risk is kept within agreed tolerance.

Treating Risk:

- Risk is treated proactively using a combination of prevention, detection and contingency controls. **Prevention** controls ensure activities are performed in a certain way and typically involve policies, clinical or operational procedures, guidelines, and training or computer systems. **Detection** controls alert management to any deficiencies and allow for corrective action, thereby preventing the risk materialising. These typically involve performance monitoring, audits, alarms or tests. **Contingency** controls are designed to allow the Trust to recover from a failure to manage risk and allow the Trust to continue to function albeit in a modified way. Colleagues are required to understand and implement all controls designed to manage risk at the Trust.

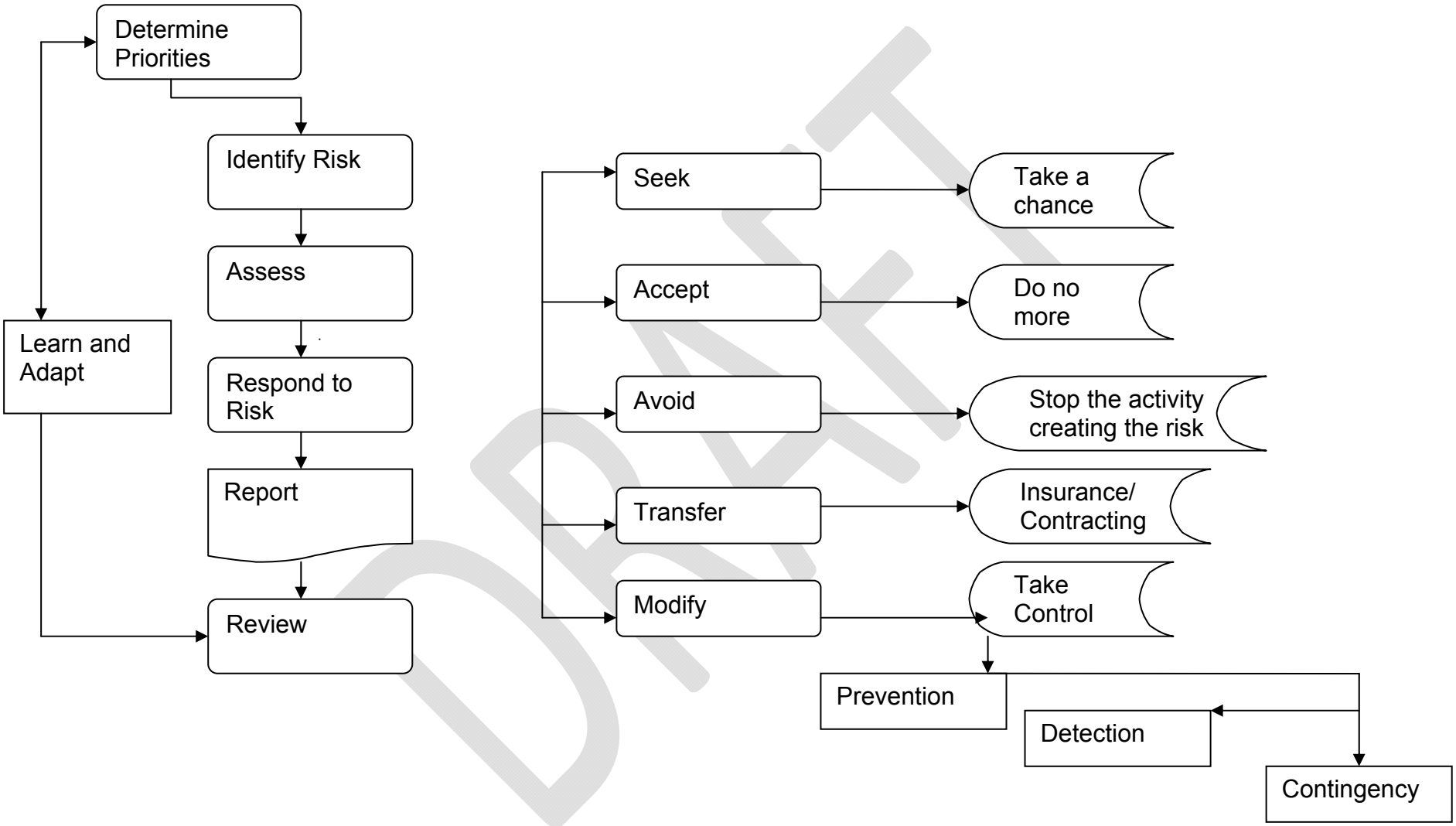
Learning

- Organisational learning is reflected in the Trust's ability to continuously reduce the frequency of the same adverse event (incident, complaint or claim), and continuously improve performance. Controls are monitored and continuously improved as part of an open and learning culture.

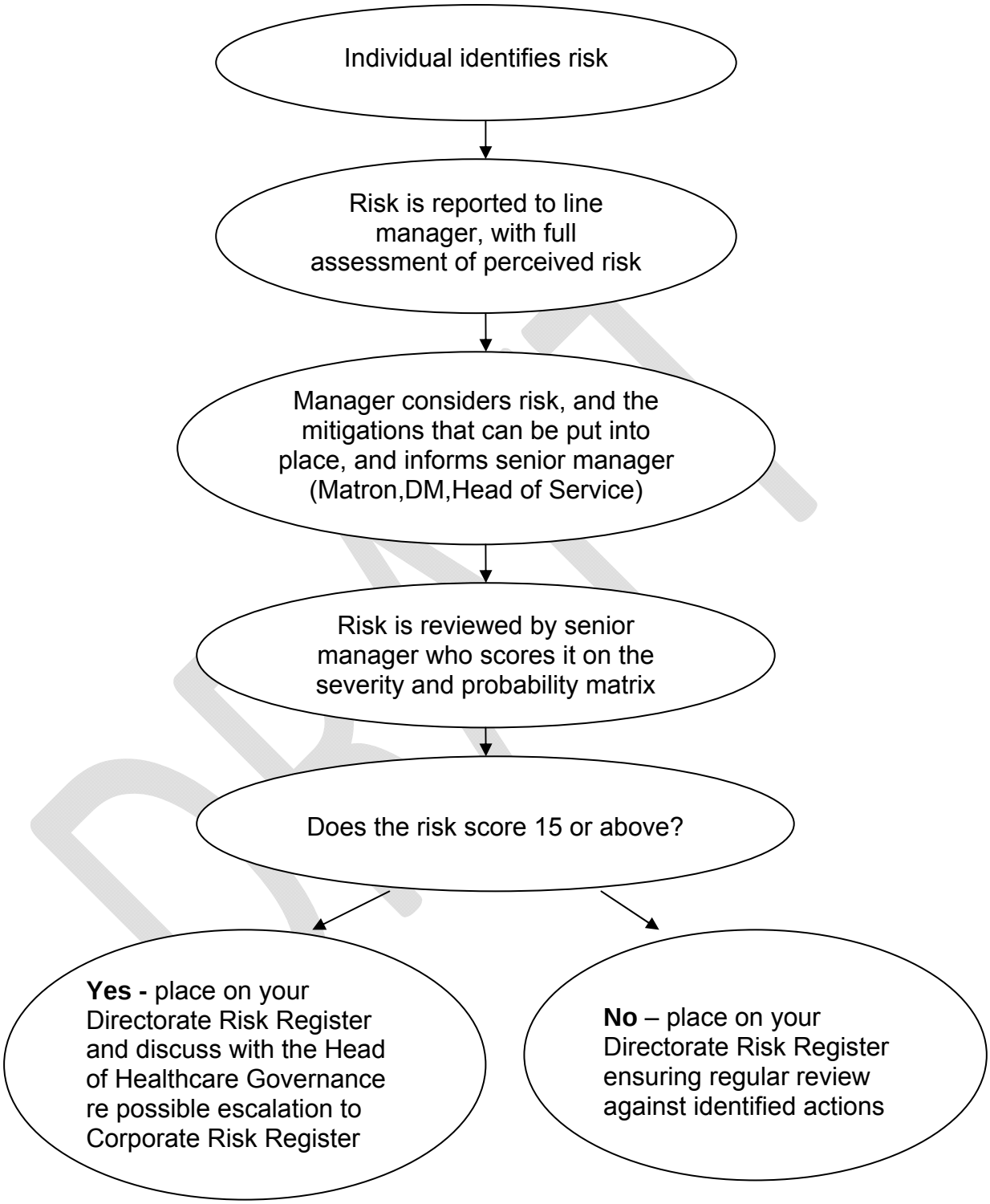
Responsibility

- This Framework identifies that risk management is everyone's responsibility. This policy applies to all Trust employees, contractors or volunteers working at the Trust.

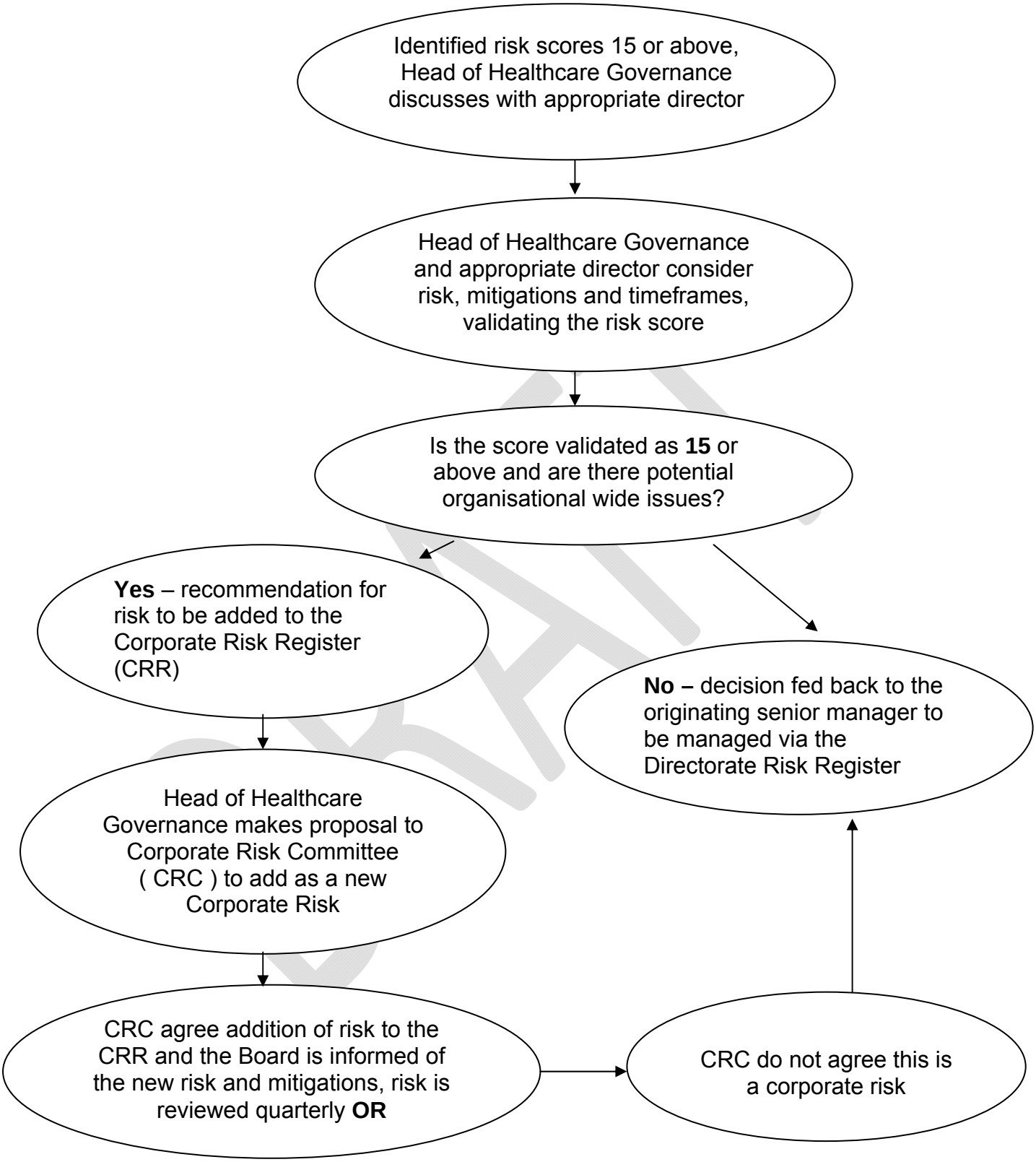
## Risk Management at a Glance



## FLOWCHART: IDENTIFICATION OF LOCAL RISKS



## FLOWCHART: IDENTIFICATION OF CORPORATE RISKS



# 1 The Framework

**1.1** This document is the framework for the management of risk at York Teaching Hospitals NHS Foundation Trust. Risk management is an integral component of the Trust's Quality Governance Framework. By complying with the organisational arrangements described in this document, services will ensure the effective identification, assessment and control of risk thereby promoting and supporting the achievement of objectives.

**1.2** The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Uncertainty of outcome helps to define risk. Risk management includes identifying and assessing risks, and responding to them in an effective and resilient manner.

**1.3** At all times the Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

**1.4** The Trust's governance framework shall be supported by an effective risk management system that delivers continuous improvements in safety and quality, and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

**1.5** The Risk Management Framework compliments, and works alongside the organisations Board Assurance Framework (BAF) in its role in helping manage the immediate strategic level risks, through the reference of risks detailed on the Corporate Risk Register on the face of the Board Assurance Framework report). The Board Assurance Framework (BAF) as the organizations primary risk management document is a key mechanism that the Board uses to reinforce strategic focus and better management of risk. It is a mechanism that is used by a Board to hold itself to account, identifying those risks that are a threat to the delivery of corporate objectives, and therefore seeks to ensure appropriate mitigations are in place.

# 2 Objective

**2.1** The Trust will establish an effective risk management system which ensures that:

- All risks that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust are proactively identified and managed well
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff
- Controls are put in place which are effective in their design and application to manage risks, and risk treatment is understood by those expected to apply control
- All staff have a responsibility to comply with controls, whilst the operation of controls is monitored by management
- Gaps in control are rectified
- Management are held to account for the effective operation of controls
- Assurances are reviewed regularly and acted on
- Staff continuously learn and adapt to improve safety, quality and performance
- Risk management systems and processes are embedded locally across directorate teams and in corporate services including business planning, service development, financial planning, project and programme management and education

## 2.3 The Trust shall achieve this by:

- Developing and driving a clear strategy to meet patient needs
- Actively engaging openly with patients and the public, colleagues and stakeholders
- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process
- Developing and using the Datix Risk Management Module to ensure that all risk registers are consistent and transparent.
- Regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations
- Providing training to keep risk under prudent control
- Investigating thoroughly, learning and acting on defects in care
- Liaising with enforcing authorities, regulators and assessors
- Effective oversight of risk management through team and committee structures
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings
- Effective reporting and arrangements to hold staff to account
    - Being clear on the organisational appetite for risk
    - High areas of risk being incorporated into the Annual Internal Audit Program
    - Ensuring that our strategy incorporates the three lines of defence, that is

**Operational Management**: Operational managers own and manage risks. They also are responsible for implementing corrective actions to address process And control deficiencies. They are responsible for maintaining effective internal Controls and for executing risk and control procedures on a day-to-day basis. Operational management identifies, assesses, controls, and mitigates risks, guiding the development and implementation of internal policies and procedures and ensuring that activities are consistent with goals and objectives. Through a cascading responsibility structure, mid-level managers design and implement detailed procedures that serve as controls and supervise execution

**Risk Management and Compliance Functions:**
A risk management function (and/or committee) that facilitates and monitors the implementation of effective risk management practices by operational management and assists risk owners in defining the target risk exposure and reporting adequate Risk-related information throughout the organization. A compliance function to monitor various specific risks such as noncompliance with applicable laws and regulations. Multiple compliance functions often exist in a single organization, with responsibility for specific types of compliance monitoring, such as health and safety, supply chain, environmental, or quality monitoring. In the Trust, Directors portfolios are contain specific responsibility for areas of risk and these each provide assurance to the appropriate Sub Committee of the Board. For example, The Director of Facilities and Estates holds the risk portfolio for compliance with Health and Safety Regulations within the organisation. They are supported by a Lead Manager and provide assurance of compliance to the Environment and Estates Committee.

**Internal Audit**: Internal Audit provide the governing body and senior management with comprehensive assurance based on the highest level of independence and Objectivity within the organization. This high level of independence is not available in the second line of defence. Internal audit provides assurance on the effectiveness of governance, risk management, and internal controls, including the manner in which the first and second lines of defence achieve risk management and control objectives.

# 3 Scope of the Framework

**3.1 Risk management is everyone's responsibility**. This Framework applies to all employees, contractors and volunteers. All employees are required to co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised under specific and generic responsibilities on pages 19.

**3.2** Effective employee engagement is vital to our success and our ultimate objective to be trusted to deliver safe, effective and sustainable healthcare within our communities. Our values, drivers and motivators set out "*the way we do things around here*" and these guide our work patients, colleagues and stakeholders. Our guiding values, drivers and motivators are:

We care about what we do;

- We respect and value each other;
- We listen in order to improve; and
- We always do what we can to be helpful.

And we enable and support each other by:

- Working in partnership and responding to local needs;
- Respecting differences and building on similarities;
- Empowering people to be involved in decisions about how we provide care; and
- Encouraging others to behave respectfully in line with our values.
- Having a group of specialist risk management advisors within the organisation

**3.3** By wholeheartedly embracing our values, drivers and motivators in all risk management activity, this policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation.

# 4 Risk Appetite

**4.1** Defining Risk Appetite

Risk appetite can be defined as the amount and type of risk that the organisation is willing to take in the pursuit of its strategic objectives. The level of risk (low, medium, high) the organisation is prepared to accept will vary by objective and will depend on the Board's risk attitude (averse, tolerant or seeking).

The Trust Risk Appetite Statement can be found at Appendix 4.

Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

Risk appetite can be described as the amount of (Low, Moderate, High) risk the organisation is prepared to accept. This will vary with each strategic objective and will depend upon the Board's risk attitude being averse, tolerant or seeking.

# 5 Operational Framework for Risk Management

## The Risk Management Process

## Step 1: Determine Priorities

**5.1** Risk is defined as the effect of uncertainty on the objective[1]; or in others words it is anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful (for a summary of key terms used in this document see Appendix 1). The Board of Directors and Senior Management will be clear about objectives for each service and express these in specific, measurable, achievable ways with clear timescales for delivery.

## Step 2: Identify Risk

**5.2** Evaluating what is stopping, or anticipating what could prevent, the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning and strategic planning processes and compliance requirements. Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive. In order to do this the Board of Directors, senior leaders and directorate teams should identify what is uncertain; consider how it may be caused and what impact it may have on the objective and service.

## Step 3: Assess Risk

**5.3** Estimate the magnitude of a risk by multiplying the severity of impact by the likelihood of the risk occurring. Be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating residual risk and risk scoring matrix guidance is provided in appendices 2 and 3.

## Step 4: Respond to the Risk

**5.4** There are a number of different options for responding to a risk[1]. These options are referred to as risk treatment strategies. The main options most likely to be used include:

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*
- **Accept** - this strategy is used when no further mitigating action is planned and the risk exposure is considered acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- **Avoid** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer arrangement*.
- **Modify** - this strategy involves specific controls designed to change the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:

  There are three types of control used to modify risk and comprise of:

  (i) **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks etc.

  (ii) **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits.

  (iii) **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls are designed to maintain resilience Provide resilience and maintain services at an acceptable level.

  A combination of all 3 types of control is usually required to keep risk under prudent control.

[1] Based on BSI (2008) *Risk Management - Code of Practice*. BS 31100:2008. London. British Standard International

## Step 5: Report Risk

**5.5** All risks shall be recorded on the DATIX Risk Register Module. Key outputs from the risk management system shall be reported to relevant staff/committees depending on the residual risk score as follows:

- >15 to be validated and where appropriate escalated to the Corporate Risk Committee for consideration of addition to the Corporate Risk Register
- < 15 [Relevant] Committee of the Board of Directors as part of the Committee's work plan
- <15 – Specialty/Directorate/Departmental Governance meeting at least quarterly
- ≤8 – Ward/Departmental Management at least quarterly

The **Board of Directors** shall receive summary reports at each formal meeting to inform them of all material risks, along with the nature of associated controls and action plans. The risk profile shall be part of the Chief Executive's report and cover as a minimum the risk source, description of the risk, the residual risk (exposure after control), main controls, date of review and risk owner.

Each Director's Corporate Risks will be presented in their report to the appropriate Sub Committee of the Board (Finance and Performance, Quality and Safety, Workforce and Development and Estates and Facilities). Each committee will monitor all Corporate Risks scoring 15 and over that are relevant to the work of that Committee. This will cover risk description, changes to scores and mitigations and any escalation to the Board of Directors

The **Corporate Risk Committee** will receive reports to monitor the quality, completeness and utilisation of risk registers, and also oversee of the distribution of risk across the Trust. Reports will cover the risk description, the residual risk, main controls, date of review and risk owner.

Directorates will have access to Datix and will have the ability to run system generated directorate specific reports in order to review the identification of risks within their wards, departments and specialties, and check that adequate controls are in place and actions are being implemented and monitored

**Corporate Directors** will be informed by Head of Healthcare Governance (or relevant Executive Director) of any new significant risk arising.

**The Audit Committee** will scrutinise assurances on the entire risk management system to ensure it remains fit for purpose and, at the Committee's discretion, will examine assurances on the operation of controls for all significant risk exposures or any other risk of interest to the Committee.

**Urgent Escalation** - in the event of a significant risk arising out with meetings of the above, the risk will be thoroughly assessed, reviewed by the relevant Clinical Director, Chief Nurse, Directorate Manager and Executive Director and reported to the Chief Executive (or their deputy) within 24 hours of becoming aware of the risk. The Chief Executive, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive will assign responsibility to a relevant Executive Director for the management of the risk and the development of mitigation plans. The risk will be formally reviewed by the Executive Team at their next weekly meeting.

## Step 6: Review Risk

**5.6** Review risk at a frequency proportional to the residual risk. Discretion regarding the frequency of review is permitted. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

- ≥15 – at least monthly by relevant, directors for corporate risks
- >15 at least monthly by relevant directors for corporate risks and at least monthly by CDs, Matrons, Directorate Managers when the risk is not corporate but local to the directorate
- <15 – Specialty/Directorate/Departmental Governance meeting at least quarterly
- ≤8 – Ward/Departmental Management at least quarterly
- Executive Directors will review Directorate Risk registers bi monthly at Directorate Performance Management Meetings

### 5.7 The Sub Committees of the Board

The totality of the Trust's risk governance infrastructure includes the oversight provided by Board committees in their risk-related roles. Committees of the Board of Directors comprise of Corporate Risk Committee, Workforce Strategy Committee, Audit Committee, Quality & Safety Committee, Remuneration Committee, Estates and Facilities Committee and Finance & Performance Committee. These committees play a vital role in effective risk management and shall apply the following principles to enable the Board to keep risk under prudent control at all times:

a) oversee and advise the Board on current risk exposures and future risks to the Trust's strategy;
b) oversee risk appetite and tolerance for those areas under the Committees purview;
c) address risk and strategy simultaneously taking into account assurance on the operation of control, the current and prospective macro-economic, public policy and financial environment;
d) challenge the Trust's analysis and assessment of risk;
e) advise the Board on risk treatment and strategy;
f) oversee due diligence appraisal of any proposed strategic transactions involving acquisition, merger or disposal;
g) evaluate risk management capability;
h) examine risks associated with emerging regulatory, corporate governance and industry best practices; and
i) consult experts to optimise risk treatment where necessary.

# 6 Impact upon Individuals with Protected Characteristics

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This Framework can be made available in alternative formats on request including large print, Braille, audio, and different languages. To arrange this please refer to the Trust's "Interpreter Services – guide for staff" on Staffroom.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

## 6.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analyzed and published on an annual basis as part of our Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

# 7 Roles and Responsibilities

The success of this framework is dependent on a range of individuals being involved in the implementation of this document. The responsibilities on individuals in ensuring compliance with this document are detailed below:-

**7.1 Chief Executive**, as Accounting Officer, has overall accountability to the Board of Directors for effective risk management. The Chief Executive is responsible for ensuring priorities are determined and communicated, risk is identified and managed in accordance with the Board's appetite for taking risk. The Chief Executive is the Board lead for risk management processes across the Trust. They shall, on behalf of the Board, implement and maintain an effective system of risk management. They shall also be responsible for: (i) risk management development; (ii) developing and communicating the Board's appetite for taking risk; (iii) establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these; and (iv) monitoring the management of risk across divisions.

**7.2 All Executive, Clinical Directors, Directorate Managers and Heads of Service,** have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They shall intervene robustly to ensure teams within their sphere of control follow the risk management process. In addition, executive directors, clinical and all other directors shall also be responsible, where required, for the provision of specialist advice to the Board of Directors. This acknowledges that all directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in respect of their specific areas of expertise.

**7.3. The Chair and Non-Executive Directors** have a responsibility to seek assurance on the effectiveness of the risk management system and on the Board's appetite for taking risk. They should also seek assurance that material risks are proactively mitigated and monitored

**7.4 Deputy Director of Healthcare Governance** - has day-to-day responsibility for risk management process. They shall report to the Chief Executive for: (i) the development of risk management framework (ii) administration of risk management systems; (iii) oversight of risk exposures facing the business; (iv) provision of risk management training and support to divisions; and (v) the maintenance of the corporate risk/safety management plan. They shall be responsible for the maintenance and reporting of the Corporate Risk Register and carry out sufficient checks within and across divisions to monitor the management of risk alongside the Board's appetite for taking risk. They shall be responsible for the effectiveness of the Datix system, a governance system on which the Board depend, taking whatever action is necessary with colleagues, or the system Vendor, to ensure its effectiveness, validity, data quality and data completeness. The Deputy Director of Healthcare Governance shall take the lead in triangulating lessons for learning ensuring defective arrangements, alerts or changes in practice are conveyed to front line teams promptly and acted upon.

**7.5 Foundation Trust Secretary** – is the lead officer for the production and management of the BAF supported by the Corporate Directors. The Foundation Trust Secretary is responsible for the coordination of the BAF, ensuring that the information is reported appropriately.

**7.6 Risk Management Experts –** The following post holders hold specific responsibility for risk management. The key posts are detailed below:

- Chief Executive
- Deputy Director of Healthcare Governance
- Head of Safety and Security
- Fire Safety Manager
- Deputy Director of Corporate Finance
- Head of Corporate Finance and Resource Management
- Head of Procurement

# 8 Generic duties and responsibilities

| Main Duties | Board of Directors | Chairs of Sub Committees of the Board of Directors | Executive Director | Clinical Director/Directorate Manager/Heads of Service | Other Managers | All Employees |
|---|---|---|---|---|---|---|
| Strategy & Policy | • Determine the Trust's vision, mission and values<br>• Set corporate strategy<br>• Provide leadership | Seek assurance that the vision, mission and values are being embedded<br>seek assurance on the delivery of corporate strategy<br>Seek assurance on executive leadership | • Develop and oversee the implementation of strategic plans<br>• Develop and communicate corporate objectives<br>• Proactively anticipate risk<br>• Provide leadership and guidance to employees, business partners and stakeholders | • Develop and Implement Clinical Strategy<br>• Alignment of divisional objectives to Trust strategy | • Alignment of team/personal objectives to Trust strategy | • Deliver personal objectives<br>• Abide by ***Trust values and behaviours*** |
| Organise | • Establish an effective risk management system<br>• Establish and keep under review the Board's appetite for taking risk<br>• Focus on material risk and proactive anticipation of future risk | • See assurance on the effectiveness of the risk management system<br>• Seek assurance on the Board's appetite for taking risk<br>• Seek assurance that material risks are proactively mitigated and monitored | • Develop & apply Risk Management Process<br>• Accept and allocate ownership for risk<br>• Share ownership for cross-enterprise risk | • Apply Risk Management Process<br>• Accept and allocate ownership for risk<br>• Proactively anticipate risk<br>• Provide leadership and guidance | • Apply Risk Management Process<br>• Accept and allocate ownership for risk<br>• Proactively anticipate risk<br>• Provide leadership and guidance | • Follow Risk Management Process<br>• Accept ownership for risk |
| Plan & Control | • Decide what opportunities, present or future, the Board wants to pursue and what risks it is willing to take in developing the opportunities selected Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks<br>• Decide whether or not a risk can be accepted<br>• Simultaneously drive the business forward whilst making decisions which keep risk under prudent control | • To seek assurance that accepted risks are being mitigated as far as reasonably possible<br>• Be assured that all identified corporate risks are regularly reviewed with progress being made<br>• To escalate and concerns over a lack of progress being made on any corporate risk to the Board | • Design, apply and monitor the operation of controls to ensure the achievement of objectives and promote organisational success<br>• Ensure failure does not disable – contingencies are in place and tested for all reasonably foreseeable situations<br>• Allocate structure and prioritise resources within and across divisions or directorates so that risk is managed in accordance with the Board's risk appetite. | • Design and apply controls to manage risk in line with the Board's appetite for taking risk<br>• Prepare risk management mitigation plans<br>• Ensure adequate emergency preparedness and contingencies for foreseeable disruptive events<br>• Manage resources to optimum effect<br>• Develop policies, guidelines, procedures and standards to govern the management of risk locally | • Design and apply controls to manage risk in line with the Board's appetite for taking risk<br>• Remain alert to risk<br>• Manage resources to optimum effect<br>• Develop and implement risk management plans | • Undertake and keep up to date with mandatory training and other relevant training<br>• Follow policies, clinical standards and relevant procedures<br>• Act on lessons for learning |

| Main Duties | Board of Directors | Chairs of Sub Committees of the Board of Directors | Executive Director | Clinical Director/Directorate Manager/Heads of Service | Other Managers | All Employees |
|---|---|---|---|---|---|---|
| Monitor | • Keep under review material risk exposures that are not accepted by the Board at each formal meeting | • To seek assurance that material risk exposures are reviewed at each meeting of the sub committee | • Challenge, support, supervise and hold colleagues to account for performance and continuous improvement | • Monitor the operation of controls and address identified gaps in control | • Supervise the work of others to ensure controls are applied correctly | • Report concerns, defects, adverse events or failures to contain risk adequately. |
| Audit | • Determine Audit priorities using a risk-based approach<br>• Take account of reports from the Audit Committee | • To seek assurance that determined audit priorities using a risk based approach are kept under regular review | • Determine Audit Priorities using a risk-based approach<br>• Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues<br>• Account for control of risk to the Audit Committee where required | • Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues<br>• Account for control of risk to the Audit Committee where required<br>• Undertake appropriate inspection/checks of controls for safety critical procedures | • Cooperate fully and assist Internal Audit,<br>• Challenge recommendations if they are not agreed<br>• Develop and implement changes in practice within the timescales agreed<br>• Report when concluded. | • Cooperate with Internal Audit and act on their findings<br>• Carry out instructions based on agreed audit recommendations |
| Review | • Effectively hold those responsible for managing risk to account for performance and continuous improvement.<br>• Take decisions | • To seek assurance that those accountable for managing risk to account for performance and continuous improvement, do so | • Report to the Board all material risks and significant gaps in control | • Report to the Board all material risks and significant gaps in control<br>• Escalate risk in accordance with this Policy<br>• Ensure all risks are reviewed correctly | | |

## 9 Key Performance Indicators

| Area | Metric | Target | Status | Date |
|---|---|---|---|---|
| Identification and Management of Risks | Risks are clearly articulated, identifying issue and causation, are scored accurately and have appropriate mitigations | Ongoing | Monthly review | |
| Risk Register | Risk Registers are in a consistent template | By April 2019 | | |
| Risk Register | Corporate and Directorate risk registers reflect ward –board risks throughout the organisation, identifying internal and external influences | Regular Review | | |
| Risk Review | Risks with a rating of >15 are reviewed on a monthly basis | All risks with a score of 15 and above are monitored monthly and where necessary referred to the relevant Governance Facilitator for the Director | | |
| Risk Review | Risks with a rating of <15 are reviewed on a quarterly basis | Quarterly at Governance Meetings | | |
| Sub Committees of the Board | Regularly review all risks on the Corporate Risk Register Scoring >15 | At the monthly sub committees of the Board | | |
| Board of Directors | The Board are Quarterly sighted on all Corporate Risks and seek assurance that risks are being mitigated | Quarterly | | |

## Appendix 1: Glossary of Terms used within Policy

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

| | | | |
|---|---|---|---|
| **Board Assurance Framework** | A document setting out material risk and assurances on the operation of controls to manage those risks | **Risk** | Effect of uncertainty on objectives |
| **Control** | An intervention used to manage risk | **Risk acceptance** | Informed decision to take a particular risk |
| **Exposure** | Extent to which the organisation is subject to an event | **Risk aggregation** | Process to combine individual risks to obtain more complete understanding of risk |
| **Hazard** | Anything that has potential for harm | **Risk analysis** | Process to comprehend the nature of risk and to determine the level of risk |
| **Incident** | Event in which a loss occurred or could have occurred regardless of severity | **Risk appetite** | Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate |
| **Inherent risk** | Exposure arising from a specific risk before any intervention to manage it | **Risk assessment** | Overall process of risk identification, risk analysis and risk evaluation |
| **Level of Risk** | Overall magnitude of a risk. It can be significant, high, moderate, low or very low. | **Risk avoidance** | Decision not to be involved in, or to withdraw from, an activity based on the level of risk |
| **Material Risk** | Most significant risks or those on which the Board or equivalent focuses | **Risk management** | Coordinated activities to direct and control the organisation with regard to risk |
| **Near Miss** | Operational failure that did not result in a loss or give rise to an inadvertent gain | **Risk owner** | Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments |
| **Operational Risk** | The risk of loss or gain, resulting from internal processes, people and systems or from external events | **Risk Register** | A record of information about identified risks. |
| **Programme Risk** | Risk associated with transforming strategy into solutions via a collection of projects | **Target Risk** | A level of risk being planned for |
| **Residual risk** | Current risk. The risk remaining after risk treatment | | |

## Appendix 2: Calculating Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring.

| SEVERITY INDEX | | LIKELIHOOD INDEX* | | |
|---|---|---|---|---|
| 5 | Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence | 5 | Very Likely | No effective control; or ≥1 in 5 chance within 12 months |
| 4 | Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure | 4 | Somewhat Likely | Weak control; or ≥1 in 10 chance within 12 months |
| 3 | Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure | 3 | Possible | Limited effective control; or ≥1 in 100 chance within 12 months |
| 2 | Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction | 2 | Unlikely | Good control; or ≥1 in 1000 chance within 12 months |
| 1 | No harm; 0 - £50K loss; or No disruption – service continues without impact | 1 | Extremely Unlikely | Very good control; or < 1 in 1000 chance (or less) within 12 months |

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

### Severity

Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

### Likelihood

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

### Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the risk score is determined it is the highest l risk score that must be referred to on the risk register**.

# Appendix 3: Risk Grading

| SCORE | Incident / Risk Grade (NPSA Cat.) | Level of Risk | Communicated to and overseen by | Investigation Level |
|---|---|---|---|---|
| **15 - 25** | Catastrophic | **SIGNIFICANT** | Alert Chief Nurse<br>Reported to Board of Directors | SI Procedures<br>RCA – 45 days<br>(Board notification) |
| **10-14** | Major | **HIGH** | Alert Clinical Director<br>Reported to Risk Management Committee | Divisional RCA – 28 days |
| **8 - 9** | Moderate | **MEDIUM** | Inform Divisional Manager<br>Overseen at Divisional Level | Directorate Analysis – 28 days |
| **4-6** | Minor | **LOW** | Inform Ward/Departmental Manager<br>Oversee at Ward/Departmental Level | Ward/Department Analysis – 10 Days |
| **1-3** | None | **VERY LOW** | Ward/Departmental Management | Ward/Department Analysis – 10 Days |

## 5X5 MATRIX

| X | LIKELIHOOD | | | | | |
|---|---|---|---|---|---|---|
| SEVERITY | | 1 | 2 | 3 | 4 | 5 |
| | 1 | 1 | 2 | 3 | 4 | 5 |
| | 2 | 2 | 2 | 6 | 8 | 10 |
| | 3 | 3 | 6 | 9 | 12 | 15 |
| | 4 | 4 | 8 | 12 | 16 | 20 |
| | 5 | 5 | 10 | 15 | 20 | 25 |

## Appendix 4: Risk Appetite Statement

**1: Quality & Safety**
Delivering high quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an on-going commitment to being a learning organisation. The trust has a risk adverse (Low) appetite to risk which compromises the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.

**2 Patient Centred Care**
This Trust has made a commitment to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services. The trust is risk adverse (Low) to enabling care without validating and verifying what outcomes are possible and desirable with all stakeholders.

**3: Partnerships**
This trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the trust's current and future services. The trust has a risk seeking (High) appetite for developing these partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.

**4. Financial Stability**
The Trust is committed to fulfilling its mandated responsibilities in terms of managing public funds for the purpose for which they were intended. This places tight controls around income and expenditure whilst at the same time ensuring public funds are used for evidence based purpose. The Trust is averse (Low risk appetite) to committing non-evidence based expenditure without its agreed control limits.

**5: Recovery**
As a Trust we look beyond clinical recovery through facilitating recovery and promoting social inclusion by measuring the effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the person and their family. The trust is risk adverse (Low) to recovery that does not provide high levels of compliance with service user outcome measures.

**6: Improvement and Innovation**
Innovation is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The trust has a risk tolerant (Moderate) appetite to risk where benefits, improvement and value for money are demonstrated.

**7: Leadership & Talent**
The trust is committed to developing its leadership and talent through its Organisational Development and Workforce strategy. The trust is committed to investment in developing leaders and nurturing talent through programmes of change and transformation. The trust has a tolerant (Moderate) appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.

## 8. Operational Delivery of Services

The Trust is committed through its embedded strategy, governance and performance management frameworks to deliver the activity for which it has been commissioned. The Trust has an adverse (Low) appetite for failing to deliver the requirements outlined and agreed in commissioner contracts.

## Appendix 5: Policy Management

### 1 Consultation Process

This document has been subject to external assessment of the Risk Management Strategy.

### 2 Quality Assurance Process

The author has consulted with the following to ensure that the document is robust and accurate:-

- External experts
- Corporate Risk Committee
- Other Directors
- Sample users

The policy has also been proof read and the review checklist completed by the Policy Manager prior to being submitted for approval.

### 3 Approval Process

The approval process for this policy complies with that detailed in section 3.3 of the Policy Development Guidance.

### 4 Review and Revision Arrangements

The Policy Author will be responsible for review of this policy in line with the timeline detailed on the cover sheet.

Subsequent reviews of this policy will continue to require the approval of the Corporate Risk Committee

### 5 Dissemination and Implementation

The Policy will be disseminated, posted onto the intranet and will be supported by training for the Board, the Risk Team, Risk Reviewers and Managers.

### 6 Register/Library of Policies/Archiving Arrangements/ Retrieval of Archived Policies

Please refer to the Policy Development Guideline for detail

### 7 Standards/Key Performance Indicators

- Care Quality Commission - Essential Standards of Quality and Safety

## 8 Training

Risks may be identified proactively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

**a) Risk Register**

The Risk Register is a part of Datix and provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto Datix.

**b) Risk Management Training**

This document recognises that training will be required to effectively manage risks in line with the process set out above. Details of all trust training programmes are set out in the Training Needs Analysis which can be found in the Mandatory Training Policy and associated documents.

i) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk management process by the Deputy Director of Healthcare Governance. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

ii) All staff shall receive an introduction to the Risk Management Process briefing as part of the Corporate Induction programme.

iii) Additional training will be provided through an e-learning programme.

iv) Directorate, Ward and Departmental managers will have further more detailed risk management process training incorporating how to use the Datix Risk Register database before access to the database is enabled.

v) Staff designated to regularly undertake Root Cause Analysis will have the opportunity to undertake Root Cause Analysis training.

## 9 Trust Associated Documentation


- Moore P., A. (2013) *Countering the Biggest Risk of All: attempting to govern uncertainty in healthcare management*. London. Good Governance Institute
- Chapman R., J. (2012) *Simple tools and techniques for enterprise risk management (2nd Edition)*. London. Wiley Finance
- Audit Commission (2009) *Taking it on Trust: a review of how boards of NHS Trusts get their assurance*. London. Audit Commission
- BSI (2008) *Risk Management - Code of Practice*. BS 31100:2008. London. British Standard International
- NPSA (2004) *Seven Steps to Patient Safety*. London. NPSA
- DH (2003) *Building the Assurance Framework: A Practical Guide for NHS Boards*. London. Department of Health
- DH (2000) *An Organisation with a Memory*. London. HSMO


## 10 External References

- See above

## 11 Process for Monitoring Compliance and Effectiveness

This document does not utilise the standardised table but the following indicators shall form the Key Performance Indicators by which the effectiveness of the Risk Management Process shall be evaluated:-

- All verified significant risks are reported to the Board of Directors at each formal meeting of the Board
- All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of a Committee of the Board
- The risk profiles (for risks ≥10) for all divisions are reviewed by the Corporate Risk Committee as part of a rolling programme of reviews
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and ≥80% of risks are within review date and none are overdue for review by 6 or more months.

Compliance with the above will be monitored by the Deputy Director of Healthcare Governance, reviewed by the Chief Executive and reported within an annual report submitted to the Corporate Risk Committee.

The following mechanisms will be used to monitor compliance with the requirements of this document:

- Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting
- Evidence of review of significant risk exposure by the Corporate Risk Committee at each formal meeting of the committee
- Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and revision)

## Appendix 6: Dissemination and Implementation Plan

| | |
|---|---|
| Title of document: | Risk Management Policy |
| Date finalised: | February 2015 |
| Previous document in use? | Yes |
| Dissemination lead | Policy Author |
| Implementation lead | Policy Author |
| Which Strategy does it relate to? | Patient Safety Strategy, Organisation Strategic Plan, Financial Plan, Health and Safety Strategy |

| **Dissemination Plan** | |
|---|---|
| Method(s) of dissemination | Via Team Brief, Local Intranet, Briefings |
| Who will do this | Policy Author |
| Date of dissemination | On approval |
| Format (i.e. paper or electronic) | Electronic |
| **Implementation Plan** | |
| Name of individual with responsibility for operational implementation, monitoring etc | Policy author and those named in section 5 of this document |
| Brief description of evidence to be collated to demonstrate compliance | Agenda's, Minutes and papers of relevant meetings<br>Risk Registers |

York Teaching Hospital
NHS Foundation Trust

# Board Assurance Framework – ‘at a glance’

## Board Assurance Framework – At a glance

**Strategic Goals**

- **To deliver safe and high quality patient care**
- **To support an engaged, healthy and resilient workforce**
- **To ensure financial stability**

| Goal | Strategic Risks | Original Risk Score | Residual Risk Score | Target Risk Score |
|---|---|---|---|---|
| **Patient Care** | Failure to maintain and improve patient safety and quality of care | **16** | **9 ↔** | **3** |
| **Patient Care** | Failure to maintain and transform services to ensure sustainability | **20** | **12 ↔** | **6** |
| **Patient Care** | Failure to meet national standards | **25** | **12 ↔** | **1** |
| **Patient Care** | Failure to maintain and develop the Trust's estate | **25** | **9 ↔** | **4** |
| **Patient Care** | Failure to develop, maintain/replace and secure IT systems impacting on security, functionality and clinical care | **20** | **9 ↔** | **6** |
| **Workforce** | Failure to ensure the Trust has the required number of staff with the right skills in the right location | **25** | **16 ↔** | **1** |
| **Workforce** | Failure to ensure a healthy, engaged and resilient workforce | **16** | **9 ↔** | **2** |
| **Workforce** | Failure to ensure there is engaged leadership and strong, effective succession planning systems in place | **16** | **4 ↔** | **1** |
| **Finance** | Failure to achieve the Trust's financial plan | **25** | **12 ↔** | **6** |
| **Finance** | Failure to develop and maintain engagement with partners | **16** | **9 ↔** | **4** |
| **Finance** | Failure to develop a trust wide environmental sustainability agenda | **20** | **4 ↔** | **1** |