York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

Wednesday 28 November 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 28 November 2018

In: Discussion/Dining Room, Postgraduate Centre, Scarborough Hospital

TIME	MEETING	LOCATION	ATTENDEES
12.00 to 1.30	Patient Safety Walkrounds	Scarborough Hospital	Board of Directors
14.00 – 17.00	**Board of Directors meeting held in public**	**Discussion/Dining Room, Postgraduate Centre, Scarborough Hospital**	**Board of Directors & Members of the public**

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public) Agenda

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Apologies for absence and quorum** To receive any apologies for absence	Chair	Verbal	-	14.00 – 14.10
2.	**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	7	
3.	**Minutes of the meeting held on 26 September 2018** To receive and approve the minutes from the meeting held on 26 September 2018.	Chair	B	13	
4.	**Matters arising from the minutes and any outstanding actions** To discuss any matters or actions arising from the minutes	Chair	Verbal	-	
5.	**Patient Story** To receive the details of a patient experience.	Chief Executive	Short Video	-	14.10 – 14.20
6.	**Chief Executives Update** To receive an update from the Chief Executive	Chief Executive	C	33	14.20 – 14.35

	SUBJECT	LEAD	PAPER	PAGE	TIME
Strategic Goal: To deliver safe and high quality patient care					
7.	**Chief Nurse Report** To receive the Chief Nurse Report. Including: • Nurse and Care Staffing Report • Safeguarding Children Annual Report	Chief Nurse	D	37	14.35 – 14.50
8.	**Medical Director Report** To receive the Medical Director Report.	Medical Director	E	89	14.50 – 15.05
9.	**Performance Report** To receive the Performance Report.	Chief Operating Officer	F	119	15.05 – 15.20
	Short Break				15.20 – 15.30
10.	**Director of Estates & Facilities Report** To receive the Director of Estates and Facilities Report.	Director of Estates & Facilities	G	135	15.30 – 15.45
Strategic Goal: To support an engaged, healthy and resilient workforce					
11.	**Director of Workforce Report** To receive the Workforce Report.	Acting Director of Workforce & OD	H	199	15.45 – 16.00

	SUBJECT	LEAD	PAPER	PAGE	TIME
Strategic Goal: To ensure financial sustainability					
12.	**Finance Report** To receive the Finance Report.	Finance Director	I	211	16.00 – 16.15
13.	**Efficiency Report** To receive the Efficiency Report.	Finance Director	J	229	16.15 – 16.30
Governance					
14.	**Reflections on the meeting** • BAF 'at a glance'	Chair	K	235	16.30 – 16.35
15.	**Any other business**	Chair	-	-	16.35

16. Time and Date of next meeting

The next meeting will be held on Wednesday 30 January 2019 in the Boardroom, Foundation Trust Headquarters, York Hospital.

Items for decision in the private meeting: Pathology Service Collaboration

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
November 2018

York Teaching Hospital
NHS Foundation Trust

Additions:

A

Changes:

Prof. Willcocks has completed her term as a Trustee of London Metropolitan University
Dr Boyd is no longer providing leadership support to the North Locality
Mr Golding is now the Managing Director of YTHFM LLP
Mr Keaney is now the Chair of YTHFM LLP
Mr Bertram is now a Director of YTHFM LLP

Deletions:

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 **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 **Director**—Clifton Estates Ltd (linked to JRF)	Nil	Nil	**Chair—Charitable Trustee** **Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust **Member—**Executive Committee YOPA **Patron—**OCAY **Director**— York Media Arts Festival Community Interest Company	**Board Member**—York Museums Trust **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	**Chair**—YTHFM LLP	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 **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 **Trustee**—Graham Burrough Charitable Trust **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	Nil	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)

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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	**Director**—YTHFM LLP	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)	Nil	**Managing Director**—YTHFM LLP	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					
	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 consultan-cies 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 com-missioning 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
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
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Board of Directors – 28 November 2018
Public Board Minutes – 26 September 2018

Present: **Non-executive Directors**

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

Executive Directors

Mr M Proctor	Chief Executive
Mr A Bertram	Deputy Chief Executive/Director of Finance
Mrs B Geary	Chief Nurse
Mrs W Scott	Chief Operating Officer
Mr J Taylor	Medical Director

Corporate Directors

Mrs L Brown	Acting Director of Communications
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:

Ann Bolland – Public Governor – Selby
Sheila Miller - Public Governor – Ryedale and East Yorkshire
Michael Reakes – Public Governor – York
Gerry Richardson – Stakeholder Governor – University of York
Jill Sykes – Staff Governor
Lesley Pratt – Healthwatch York
Quentin Summerfield – Insight Programme
Lisa Smith – Insight Programme
Tracy Astley – Staff Member
Xizi Wan – University of York
QiaoRu Wu – University of York

Ms Symington welcomed everyone to the meeting and explained about the new 3 month pilot approach to the Committee/Board structure.

18/49 Apologies for absence

No apologies were received.

18/50 Declarations of interest

The following declarations were received:

Prof. Willcocks stated that as of the 31 August 2018 she had completed her term as a Trustee of London Metropolitan University.

Dr Boyd is no longer providing leadership support to the North Locality.

No further declarations of interest were raised.

18/51 Minutes of the meeting held on the 25 July 2018

The minutes of the meeting held on the 25 July 2018 were approved as a correct record subject to the following amendments:

Minute No. 18/38 HYMS Academic Year – 3rd paragraph it's should be its.

Minute No. 18/38 HYMS Academic Year – 7th paragraph should read state schools not public schools.

18/52 Matters arising from the minutes

Minute 18/42 Quality & Safety Committee - Mrs McAleese wished to highlight and celebrate that Wi-Fi was now available in the hospital.

Minute 18/40 Out of Hospital Care – Mrs Adams asked if there was any further information available about the delayed transfers of care work Sheffield was doing. Mrs Scott stated that she would find out.

Action: Mrs Scott to provide an update on the DToC work being carried out by Sheffield

No further items were discussed.

18/53 Patient Story

Mr Proctor stated that the story illustrates that the Trust provides good end of life care, despite acute trusts being compared unfavourably at times with the Hospice Movement who are able to provide a fantastic standard of end of life care through charity donations. The story was about a patient who was unable to get into a Hospice and was the relative of a member of staff. He stated that it was also pleasing to share this positive story: if the Trust gets it wrong for a patient at end of life, there is no opportunity to put it right.

Ms Symington stated that this story related to the staff survey question about whether staff would recommend family members or friends to be treated by the Trust.

It was resolved that the Board were moved by the patient story which reminded the Board of its overall purpose.

18/54 Chief Executive Update

CEO Recruitment – Mr Proctor noted the Trust's decision not to make an appointment in September. He confirmed that he was willing to carry on as Chief Executive in the interim period. The trust had been unable to make an appointment which was satisfactory to the trust itself and to the wider health economy.

YTHFM LLP – the new company officially starts trading on the 1 October 2018 and everything possible was being done to reassure staff transferring, especially with regard to the Agenda for Change three year pay deal and pension arrangements which are available to staff. Mr Proctor noted that other Trusts who have not taken this step are now looking for possible job losses as a consequence. Mr Proctor stated that industrial action will commence at 6am tomorrow for 48 hours, but it was likely that the transition would ultimately be a big anti-climactic as nothing would feel any different after the transfer next week. He stated that the Trust was prepared for the strike which would involve up to 200 people, with a greater impact at York than Scarborough and Bridlington. It would be about maintaining business as usual and dealing with any issues as they arose.

Mr Proctor reminded the Board that the business case had been considered at the beginning of 2018 and this had considered options to outsource, but he stressed that creating the LLP was about preventing outsourcing.

Mr Keaney asked whether there were any areas particularly at risk and Mr Proctor responded that it is unknown as the Trust is not absolutely sure who or how many are taking part in the strike action. However, elements like catering will be pared down for staff to ensure that patients are provided for and the Trust would ensure the high-risk areas around domestic services were monitored.

Mr Golding stated that the Unions were taking a national position and were not worried about what Trusts were doing locally. He stated that it may have helped the Trust if the decision to retain the pension arrangements for existing staff had been received before the ballot had been taken. He assured the Board that business continuity arrangements were in place.

Ms Mellor stated that it was really positive that NHSI had said that the Trust was not affected by the pause in the ongoing developments of ADM's. Mr Proctor stated that the pause initiated by NHSI was to do with the approval process.

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

18/55 Quality & Safety Committee Minutes

Mrs Adams stated that nurse staffing had been at the forefront of the Committee's discussions in August as there was concern around how to mitigate the number of new registrants, which was lower than usual. The Committee had also received a presentation from Peter Wanklyn who is the Lead for mortality. He had noted that there had been variable uptake of the training related to investigations and there needed to be an increase in the number of deaths reviewed as the Trust needed to get up to 100% review of all deaths. The other point of note was that the Medical Examiner role would be introduced in the near future.

Mrs Adams stated that there had been a general update in relation to the achievement of the quality priorities for 2018-19 which was a varied picture with pockets of excellence and places where improvements were required. Mrs Adams noted that good progress had been made in respect of the maternity priorities and the noise at night priority.

The position regarding the stroke service at Harrogate had also been discussed.

Mr Taylor stated that national support was needed in respect of achieving the delivery of 7 day services which was reliant on job planning. This work had stalled with the introduction of the junior doctor contract and was likely to stall again when work started on the consultant pay award. Unfortunately, there seemed to be no new money available to help deliver 7-day services.

Mrs McAleese asked how documents usually received by the Q&S Committee were going to be given the same level of scrutiny and assurance received on outstanding items during the pilot period of the Committee/ Board restructure. Mrs Adams stated that she would meet with Dr Boyd, Mr Taylor and Mrs Geary on the morning of each Board to catch up on any relevant items. Mrs Geary stated that she had discussed with Mr Proctor the level of information in her report and embedded some reports for further information. Mrs Adams was concerned about areas such as clinical effectiveness which was being monitored by both the Quality and Safety Committee and the Audit Committee. Mrs Provins stated that she is monitoring both Committee work programmes and action logs when she is constructing the Board agendas to ensure items are not missed.

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

18/56 Chief Nurse Report

Mrs Geary stated that she wished to raise 4 items although she highlighted that the position around nurse staffing was the greatest concern. The number of new registrants taken on is less than usual at about 70 when in previous years it has been over 100. Mrs Geary stated that she had recently attended a meeting in the northern region with both NHSI and NHSE when safe staffing levels were discussed as the way it was reported would be changing. The new system, Safe Care, provided real time acuity and all matrons and Heads of Nursing had access to the system. The system helps to move staff into areas with the greatest need. Mrs Geary noted that although there had been an increase in the use of agency staff, there had not been any off framework agency usage.

Mrs Geary highlighted the positive news that Maternity had achieved CNST and this would mean the Trust would retain the £500k which was linked to this. She noted that there may also be some unallocated funds shared out from those Trusts that did not achieve the standards. Prof. Willcocks commended the team for their achievement. Mrs Geary also stated that Maternity had noted that the standards may change to make them harder to achieve to ensure incremental progression.

Mrs Geary highlighted the CQC joint unannounced targeted inspection taking place around child sexual abuse in the home; however, she noted that the looked after children action plan from a previous inspection was also being reviewed and the team were in ED yesterday.

Mrs Geary stated that a root and branch review was being carried out on the processes for falls and pressures ulcers and that the quarterly reports would be circulated following the meeting.

Mr Keaney asked if there was anything that could be done locally to help the medium-term position with regard to nurse recruitment. Mrs Geary stated that nursing associates were part of the solution and a cohort would qualify in March. Mrs Geary explained the issues with the different programmes being offered and especially the lack of bursary funding which may have an impact on some of the pre-registration programmes. She noted that there were also conversations about a big STP cohort which would provide a wider area to access placements.

Mr Proctor stated that there are conversations taking place and apprenticeships are part of the answer, but there are also unintended consequences. The Local Workforce Action Board is also working on this.

Ms McMeekin stated that the Trust's strength is making joining and on-boarding easy. It was also noted that the STP need to start asking the universities to provide online programmes.

Mrs Geary highlighted that the Trust is also paying newly qualified staff at Band 4 instead of the usual Band 2 whilst they are waiting for their PIN numbers as well as offering a relocation package.

Mr Proctor stated that there is a constant conversation about whether there is anything else that can be done, but it is difficult to compete against those organisations that offer family friendly jobs which have less physical demands and do not require nurses to work weekends (for example Practice Nurse roles in GP surgeries) Acute hospital work is very demanding and the hours can make it difficult to attract and retain staff.

Mrs Adams highlighted the patient experience data and that a lot of work had been done on handling complaints, but that it was a tough nut to crack. She was concerned that complaints needed to be handled in a timely way and wondered how this was being addressed. Mrs Geary stated that work is being done with individual directorates and these numbers fluctuate. This is discussed with directorates at the performance management meetings and they can tell you in detail what is happening and often there are different issues with each case. Mrs Geary also stated that there are a number of new matrons in position.

Mrs McAleese asked how big an issue the MCA is and Mrs Geary responded that an audit has been done and the nursing element is improving. Bite sized education elements are being provided and work is also being done with the Safeguarding Board and the City of York Council. Mr Taylor stated that he is due to meet with the Safeguarding Adults Lead who is also meeting up with one of the Deputy Medical Directors to discuss medical input. Mrs Geary stated that it may be that further education is required. Further assurance will be provided once the meetings have taken place.

Ms Mellor stated that Maternity's CNST achievement is a positive message and should be used when recruiting as stories need to be regularly refreshed to make them compelling. Ms McMeekin stated that LIVEX is also being used to enhance the brand as well as the work with Jupiter.

Mrs Geary stated that international recruitment is being explored, but this may incur a significant cost so will be brought back to Board. Ms Mellor noted links mentioned previously with Barbados and it was confirmed that they were still being worked on.

Mr Keaney stated that the film being made about Scarborough was great and the Trust needed to constantly refresh what makes it different.

Mrs Brown stated that the NHS 70 staff stories put out on social media will continue but may move from still photos to video and Mrs McAleese stated that the work had been brilliant.

Ms Symington stated that the Trust needed to continually change and update is recruitment methods to keep up with recruitment needs in a very competitive market place.

It was resolved that the Board noted the report and in particular the challenges facing the Trust around nurse recruitment and the need to continually update and improve recruitment practice.

18/57 DIPC Annual Report

Mrs Geary stated that a summary of the hospital acquired infections was provided on page 51 with 45 cases of C. Diff (24 with no lapses in care); the Trust was over the MSSA trajectory and had 4 cases of MRSA despite a 0 tolerance (these related to 2 complex patients). Flu management in 2017/18 had been successful despite York being a flu hotspot.

Mrs Geary noted that flu jabs would be provided for those Board members who wanted them at the Board in October.

Mrs Geary stated that there had been a reduction in the number of surgical site infections over the past 12 months and the learning from the external review was being shared. The Infection Control Team had been restructured which had increased engagement with staff as each directorate had a named IP nurse and the lengths of outbreaks had reduced significantly.

Mrs Geary stated that this year there were still challenges with MSSA which remained high, but it was hoped that improvements would be made on the back of the Staph Aureus, AMT and central line work being done. However, she stressed the significant risks around the aging infrastructure, delays to back log maintenance together with no active decant facilities to allow proactive HPV fogging.

Mrs Adams stated it was a really excellent report which evidenced loads of good work, but she expressed concern about sterilisation facilities for surgical equipment and wondered if this was a high priority on the capital programme. Mr Golding stated that he chaired the Decontamination Group and equipment life expectancy was funded as part of the programme.

Mrs Geary stated that she hoped flu this year was not as challenging as last year and that a 4-strain vaccine was being purchased. However, Mr Taylor stated that one of the key risks in relation to flu was its ability to change and adapt.

Mr Proctor also highlighted that Norovirus has an effect every year.

It was resolved that the Board accepted and approved the report.

18/58 Medical Director's Report

National Safety Standards for Invasive Procedures (NatSSIPs) - Mr Taylor highlighted the key points of his report including NatSSIPs which was about a preventative patient safety strategy and based around the WHO safety guidance. This was currently being rolled out to other parts of the hospital like radiology. Good progress was being made with the roll out, however, there was still quite a bit of work to do.

EPMA - Mr Taylor stated EPMA had been talked about for a number of years and was now nearly finished in York Hospital apart from one or two small areas to manage like Paediatrics. The rollout to Scarborough would begin on the 9 October and would hopefully not take as long, as lessons had been learnt from the York roll out.

Ms Symington asked what the benefits were to patients and it was explained that the use of EPMA would reduce the number of drug errors and allergy errors. The system would also mean fewer missed doses and provide a permanent record of drug administration as drug cards could be lost and there was a risk to having multiple cards. Dr Boyd also noted that safety alerts would be aligned to drugs and flagged if entered and drug interactions would be embedded.

Mrs McAleese asked about IV antibiotics treatment within one hour of the sepsis being indicated as this was critically important. Mr Taylor stated that patients were being identified quickly as per the guidance, but delivery of the antibiotics within an hour was not as good. However, he did note that multiple studies had failed to validate the need to give IV antibiotics within an hour, but it is said that if treated promptly 25% of patients who currently die from sepsis could be saved. He stressed that this was a priority for the Trust and there is more work to be done in this area.

Antimicrobial Stewardship - Mr Taylor highlighted the antimicrobial stewardship work being done which was also covered in the DIPC Report, however, he stated that there are

a number of ever-increasing exotic infections developing linked to the over use of antibiotics especially in countries where antibiotics are freely available over the counter. One such infection where there had been 1 or 2 infections seen last year was now being reported at prevalent in 67% of the population of Egypt. These infections highlight the importance of antimicrobial stewardship and the continued work on EPMA also contributes to that.

Ms Symington stated that it sounded like a significant challenge; however, Mr Taylor indicated that there were a couple of more promising antibiotics becoming available. Mr Proctor stated that it was difficult to get the Pharma companies to research antibiotics that would be held in reserve as this was not profitable.

Ms Mellor raised concerns about having separate databases running and wondered if the invasive procedures database mentioned linked into everything else. Mr Taylor stated that ultimately it would link into the Trust's own patient safety dashboards, but would not link to the patient record.

Mrs McAleese noted that nurse staffing was covered in the Chief Nurse Report and wondered why medical staffing was not covered by the Medical Director's Report.
It was noted that HR led on medical staffing so this is why it appeared in the Workforce Report.

Mrs Adams asked if there could be more specific information around the area of anatomy involved in relation to never events to make it easier to learn lessons.

Mr Taylor was asked to comment on performance numbers from a medical perspective especially in relation to cancer and diagnostics. Mr Taylor noted that there is a backlog of reporting in radiology which is a local, STP and national issue as there were not enough expert radiologists so this was a known risk in the system. He highlighted that a year ago one third of reports were classed as urgent and now it was two thirds, but this was due to backlog. Mrs Scott stated that there had been an increase in demand and the Trust was an outlier. Discussions were taking place at the System Planned Care Group about how to manage demand in a different way and understand why the Trust is an outlier. She noted that Morecambe Bay had done a piece of work to restrict access which was working well. She also noted that timely access to diagnostics was some of the issue with cancer times and that a fourth STP group work stream had been created to look at how the system responded to the issues around diagnostics.

Dr Boyd stated that ordering tests was also de-skilling clinicians and it should be more about managing risk around using professional judgement. Mrs Scott stated that tests often led to OPD appointments so the work was about supporting primary care colleagues to reduce demand.

It was resolved that the Board noted the report.

18/59 Performance Report

Mrs Scott stated that this was the first iteration of the new report which would evolve following feedback. She highlighted the ECS trajectory which was at 89% in August with York achieving 96% due to its lower bed occupancy rate of 85%. Scarborough's bed

occupancy was at 89.5% due to the higher population during summer. It was noted that Type 1 attendances continued to rise.

Mrs Scott noted that YAS were developing different pathways, such as 'fit to sit' which was about those patients who did not need to be taken in on a trolley and were fit enough to sit in the waiting room which freed up valuable space in cubicles.

Mrs Scott stated that cancer 14-day fast track in July had only achieved 86.6% against a target of 93% due to large surges in activity in dermatology, urology and colorectal which was mainly down to national TV campaigns. However, she noted that most of the extra referrals in York had converted to cancers which meant a positive early detection rate, which had not been the case in Hull and NLAG. This increase had put significant pressure on OPD and diagnostic capacity. Mrs Scott stated that the Trust had only achieved 72% against a target of 85% and were working with the national support team.

Long waiters were being targeted and performance should bounce back after the anticipated dip. Mrs Scott noted that performance had dipped nationally with only 78.2% being achieved.

Mrs Scott noted that many Trusts had been unable to achieve their RTT with the Trust deteriorating by 6%. She stated that without significant investment it was unlikely the Trust would recover the position. The Trust was expected to maintain the position of 26,303 which it had achieved at the end of March 2018 and the Trust was currently 1707 patients above plan. Any plans to outsource work would require AIC approval and it was unlikely that the Trust could recover the position through outsourcing.

Winter Plan – The winter plan which has been agreed with the system will come to the October Board. A communication plan is also in place and the plan has been discussed at the Executive Board and JNCC. The plan builds on what worked well last year and seeks to increase staffing levels and bed capacity, but the Trust will not be able to have any extra wards open due to staffing constraints on either site. The plan will cost £1m of additional funding and the Trust is now discussing with the CCGs how it might be funded.

Mr Keaney stated that the winter plan would normally be discussed at the Finance and Performance Committee so that there could be discussions about how waiting list numbers affected patient experience and safety. Mrs Scott stated it was not necessarily total waiting list numbers that was the cause for concern. It was more about the number of long waiters in areas such as ophthalmology and the risks involved in the wait. Mrs Scott stated that there are no financial penalties attached to the increase and NHSI are aware of the current position. She also noted that demand has increased, but that this could be said for the majority of Trusts who were in the same position.

Mr Proctor stated that with no additional money for winter the Trust could not move forward and it would be very challenging.

It was highlighted that it was very difficult to reduce the total waiting list numbers without treating more patients. The team were doing everything possible to clean up the waiting list which addressed small numbers. Mr Keaney stated that this was worrying and asked where the Trust could escalate it to. Mr Bertram explained that both regulators were aware of the position as they were involved in the debates. Mr Keaney asked for the

Board to be kept informed of the position as he was aware that even if the Trust had the capacity to treat the patients, according to the AIC without agreement to treat, the Trust would not be paid.

Mr Bertram reminded the Board that this was what had been agreed to when the AIC was approved and the Trust were fully engaged in modelling work so that if money was released by the regulators it would be clear what could be done. Mr Proctor stated that it was useful to have all parties round the table at the AIC discussions.

Mrs Adams stated that there was a lot of attention on long waiters, but stated that there must also be concern about 195 patients waiting over 40 weeks. Mrs Scott stated that weekly meetings are held to go through all long wait patients so that plans can be monitored and tightly managed. However, Mr Proctor stated that some patients do choose not to be available.

Mrs McAleese asked what was being done about patients who do not attend as this was about 6%. Mrs Scott stated that they get text reminders and that a single point of access had also been created, as previously if left ringing telephones had cut off. This single point of access was creating capacity issues. The Trust was also looking at other options. Mr Proctor stressed that 6% DNAs was less than the national figure of 8 to 10%.

Mrs Adams asked about delayed transfers of care (DToC) stating it was really key that the Trust could free up beds to handle demand. Mrs Scott stated that DToC rose in August to 300 bed days with 42 patients waiting for packages or placements. This has been flagged with system leaders and needs to be made slicker. The overall issue is the need for capacity which is a national and local issue. Mrs Scott highlighted that the CQC are coming back into to look at DToC in November to do a follow up on the inspection last year. She recognised that elderly patient lengths of stay have reduced significantly, but the challenge is the complex patients who require packages of care. Mr Proctor stated that bed occupancy had gone from 92% to 97% and that it was vicious circle.

Mrs McAleese asked about the possibility of the Trust opening its own step-down facility and Mrs Scott stated that some Trusts have done this. Mr Golding stated that this may be an option for Bootham Park Hospital site as part of the City of York plans.

It was resolved that the Board noted the report and asked to be kept informed of the RTT issues.

18/60 Emergency Planning Report and Annual Self-Assessment against Core Standards

Mrs Scott stated that the annual self-assessment had taken place and the Trust had moved from partially compliant to substantially compliant.

Mr Hindmarsh stated that the report was in the pack and that the year had been a busy one as LIVEX had been carried out which had involved mass casualties as well as working with a number of partners. LIVEX had involved a range of different scenarios and ensured that there were 70 fully trained staff ready to respond to a notable incident. The Trust had also initiated the heatwave policy during the summer and experienced a cyber-attack in

May 2017. The Trust had completed all the actions which came out of the cyber attack, but the risk remained high and the Trust needed to continually be prepared.

Mr Hindmarsh stated that an internal audit report in spring 2017 had provided limited assurances, but the one carried out in spring 2018 had provided significant assurance. He stated that next year a black start exercise would be carried out one weekday in York, which involved turning off the main power source to make sure the power back up worked.

Mrs Adams commended the team stating that they had really grabbed the agenda and made significant improvements.

Ms Symington stated that resilience was the main focus of the Building Society Board on which she sat as a NED and that in her view the NHS at large were comparatively slow to engage with this agenda.

Ms Mellor was really pleased to see that the Trust was working through the issues although it was obvious that there were still risks.

Mr Hindmarsh stated that in relation to the cyber-attack the Trust was frequently making sure that fire walls were updated but sometimes these did not always match up to those required by external suppliers so the Trust was improving the work done with suppliers to ensure the network was as secure as possible.

Mrs McAleese thanked Mrs Scott and Mr Hindmarsh for the report which was clear, concise and encouraging.

It was resolved that the Board accepted the report and approved the annual self-assessment.

18/61 LIVEX

Mr Hindmarsh stated that LIVEX had been all about partnership and team working. He introduced Lt. Col. Richard Chadwick the Chief Instructor from 2nd Medical Brigade, Sarah Tomlinson, Head of EPRR at NHSE and Dr Phil Dickson who is one of the Trust's Consultant Anaesthetists and who is also the Clinical Lead for the North Yorks & Humber Major Trauma Network.

Ms Tomlinson stated that every organisation had to carry out a major incident exercise every 3 years which was a challenge due to the time and capacity required for planning. She stated that the Trust's commitment had been exemplary and the Trust had gone beyond what had previously been seen both nationally and locally. She stated that partnering with the Army Medical Centre had given the Trust the ability to do the exercise twice, for both Scarborough and York. The exercise received national focus and demonstrated progress, partnership working and commitment over the last 12 months

Dr Dickinson stated the exercise was about testing the distribution framework of the network with pre-agreed numbers of casualties.

Lt. Col Chadwick stated that he had been working with the Trust for 12 months to provide an immersive simulation exercise and he saw a comparable level of clinical care to that provided in military hospitals.

An overview of the Trust wide recommendations on page 137 was given, looking at the elements which needed further work over the coming months.

Mr Proctor stated that he had been part of the command and control element and it had been a really interesting exercise.

Ms Mellor stated that it was a fantastic report detailing a brilliant exercise with superb collaboration. She asked if there had been tests in respect of a flood from voice data and how that would be handled. Mr Hindmarsh stated that elements of this were looked at including mock media enquiries and actors playing concerned relatives, but networking how many calls would be received was not part of the exercise. However, one element that did come up was that there needed to be a different way of calling in staff.

Mrs Scott stated that another element that needed to be looked at was if gold command was in York how would they communicate with Scarborough if this is where the incident was.

Mrs Adams stated that there would also have been intangible benefits such as staff from either site working together and with partners.

Mr Hindmarsh stated that it had been a fantastic few days and had benefits for both the confidence and morale of staff. He noted that twitter comments had been very positive and 97% of feedback questionnaires had been returned. He stated that there had been a huge amount of learning and some other tangibles were about showing how attractive the place was to work which may encourage ex-army medics to join the Trust. Mr Hindmarsh stated that the size and scale of the exercise did not happen elsewhere and was a hugely distinctive and positive achievement for our trust.
Mrs Scott stated that the team had been shortlisted for a Celebration of Achievement Aware and also a Guardian public service award.

It was resolved that the Board recognised the size and scale of the event which had taken place and wished to thank and commend all those involved.

18/62 Director of Estates & Facilities Report

Mr Golding stated that this was the first report since the pause of the Committee structure and ensuing pilot. A summary was provided on page 155 of the sections he wished to highlight. The full Environment and Estates Committee had met for the last time in June, with the August meeting being used to discuss the new report for the Board as no NEDs were present. The minutes of the last meeting and the Committee work programme were attached.

Included in the pack was the Health & Safety and Fire Annual Report, which used to go to the Committee and then come onto the Board. Mr Golding highlighted the HSE interventions during the year 2 regarding pathology, 1 sharps and 1 about dermatitis, all of which have action plans in place. An annual self-assessment audit had been carried out

producing a result of 94% which was used to target areas with poor scores, but also checked those with very high scores as well. Mr Golding noted RIDDOR report numbers had come down with significant reductions in slips, trips and falls and manual handling.

Mr Golding stated that the Annual Fire Report could be found at page 195 together with the Annual Certificate on fire safety for 2017-18. The report did not highlight any concerns, but showed that there was a programme of work in place to reduce fire safety risks including the £3m prioritised for replacing the fire alarms at York and Scarborough. Risk assessments and training were up to date and there had been no enforcement action by the Fire Brigade.

Mr Golding recommended that he and Mr Proctor signed off the report.

Mr Golding stated that at his recent training at the Institute of Directors, it was noted that many Boards include corporate and social responsibility around sustainability. He provided an overview of sustainability including the plans and the actions which were managed by the Sustainability Management Group. The terms of reference for the Sustainability Management Group were contained in the pack and Mr Golding asked the Board to endorse these.

Mr Golding highlighted the compliance element of work in his area which came from the NHS Premises Assurance Model. The compliance team would stay in the Trust and continue to produce the monthly report. Mr Golding referenced the PLACE results which had been received in August and that the comparison in 2017-18 did not make easy reading. He stated that he would bring back a detailed report into the key issues and that the TAPE process which had been running for a couple of quarters had been introduced to try to provide some consistency in approach. Work was also being done with Infection Control around a daily monitoring system for cleaning which included plans to improve.

Mr Golding stated that when the move to the LLP was made performance would be closely monitored as part of the business plan and contract. Key performance indicators were being developed with a trajectory for improvement; however, some of this work may require investment.

Mr Golding asked if there was any feedback on the report which would now be a routine feature in which he would feature items such as Health and Safety and compliance monthly, sustainability quarterly with periodical reports on capital and carter metrics.

Ms Symington stated the compliance rate was worrying and Mr Golding stated that this was currently due to staff doing other work setting up the LLP and that it was about forms not being completed and returned. The area around policies and procedures, he noted that he was aware of a number of these policies and procedures were in draft and he hoped to see a rapid improvement.

Mr Proctor stated that the relationship would be changing to a more professional customer service relationship as the LLP was up and running and he stressed that this work had been done in order to stop an alternative provider having to be brought in from the private sector.

Mrs Adams though the report struck a good balance and she like the statistics, but did think that the PLACE scores were disappointing. Her concern was if the LLP did not improve against the KPIs and she wondered how any concerns would be raised. Mr Golding stated that the compliance team were remaining with the Trust and that some of the issues may require capital investment which would be part of the future discussions.

Mrs Adams asked how long the contract was for and Mr Golding stated that it was for a term of 25 years.

Ms Symington stated that the Board would like to keep this under close review so would like a further report next month.

Action: Further compliance report to be received in October.

It was resolved that the Board accepted the report and approved the Annual Health & Safety & Fire Report for sign off.

Ms Symington stated that the agenda for the meeting had been designed around the 3 new strategic goals and she noted that to this point in the meeting the time had been spent on patient safety which was roughly 70% of the meeting.

18/63 Workforce and Organisational Development Committee

Prof. Willcocks stated that the last Committee meeting had been about closing down items and ensuring there was oversight of others especially the Freedom to Speak Up Guardian/Safer Working Guardian work which was heading in the right direction. Medical workforce issues especially on the East Coast had been discussed in light of the work to use the wider community and highlighting the East Coast as an attractive place to work. Prof. Willcocks stated that apprenticeships was an area of concern which needed a step change and that there was learning for the Trust in the wider STP. She also noted that the WRES is starting to become more proactive.

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

18/64 Director of Workforce Report

Apprenticeships Levy - Ms McMeekin stated that the Trust paid £1.3m per year which equated to £115k a month and was drawing down approximately £27k a month. She stated that rapid improvement was required to maximise opportunities. Part of the problem across the network had been the lack of infrastructure in place across higher education for the first 12 months.

Ms McMeekin stated that a training needs analysis had identified 189 opportunities across directorates which had been detailed and committed to a plan. The Levy equated to around 201 apprentices so the Trust needed to aim closer to 300. Plans were in place to have another 85 apprentices in place by February, but as of September the Trust was approximately £100k short of where it needed to be. A check process had also been embedded in the vacancy control process and work was in progress to look at the LLP's needs from 1 April 2019 as it will have its own levy.

Ms Symington stated that the Board were very supportive of this work and it must be central to the Trust's plans and therefore the Board should receive updates. Mr Keaney also stated that he was massive believer in this approach.

Ms McMeekin stated that she was working with the University of York who had been more reticent in their approach than Hull or Coventry Universities. Mr Keaney noted that Coventry University now have some fantastic facilities in Scarborough and were very keen to continue working with the Trust. Ms McMeekin stated that the NMC rewriting their standards had been a hindrance and that Hull University had anticipated the new standards whilst the University of York had waited to see what the standards were going to be.

Medical Staffing - Ms McMeekin stated that the Medical Recruitment Project on the East Coast was a standing item and it was about actively working in a recruitment agency style. The Trust had close links with 8 agencies and has received 50 CVs which covered multiple specialties, however, most were not trained in the UK so some work to look at this was being done with Ed Smith and Mark Andrews as previously the Trust had been reticent to employ staff not trained in the UK. The Trust has also put on a Management Leadership Course at Scarborough and all 23 places have been filled. This will be a loss leader, but it is about getting clinicians on site especially as the next day will include a recruitment element. Collaborative work is also being undertaken with the STP and there is an NHSE project involving 65 doctors, however, many of these will lack acute experience, but work could be offered as an opportunity to get experience. There are also moves to improve the doctor's mess and re-establish a consultant common room at Scarborough.

Mr Taylor stated that this was a positive multi-stranded approach at Scarborough and Ms Symington stated that it was good to have a list of all the elements being taken forward.

E-Rostering - Ms McMeekin stated that in relation to e-rostering, it had become evident from feedback that there was some staff frustration with the system which was very rigid and did not allow staff to pick and choose shifts. Therefore, the policy had been revamped to empower roster management and promote personal responsibility. Ms McMeekin was confident that this together with the implementation of Safe Care would start to change the tide. A pilot was being undertaken with Holly Ward at Scarborough.

Mrs McAleese stated that she had experienced a system like this and they work brilliantly as staff were much better at holding each other to account. Mrs Geary stated that it was a transparent system so people tend to conform. The rollout would take place in spring supported by ODIL and be linked into work on 360 degree feedback.

Equality, Diversity and Human Rights Annual Report - Ms McMeekin highlighted some of the key achievements detail in the Equality, Diversity and Human Rights Annual Report such as the stakeholders event, aspirations to be a disability confident employer leader, the appointment of 45 Fairness Champions together with work streams around mental health improvements. The report also covered progress, future developments and challenges such as the need to reprocure the interpretation service.

Prof. Willcocks highlighted one amendment on page 275 which should state that York was already signed up as a City of Human Rights.

It was noted that one of the biggest challenges was around data capture and getting staff to disclose personal characteristics, but this was noted as a culture issue especially as there seemed to be a discrepancy with the proportion of staff who would describe themselves as disabled. There was also concern from a retention point of view about the proportion of leavers between the 35 to 59 age group which was higher than the 60 to 65 age group.

Ms Symington stated that the report was illuminating and therefore helpful to the board in its understanding of the workforce.

It was resolved that the Board noted the report and that the Trust needs to accelerate the work around apprenticeships as a matter of urgency.

18/65 Freedom to Speak Up Toolkit Gap Analysis

Ms McMeekin stated that the gap analysis had been completed by the Freedom to Speak Up Guardian, Lisa Smith, Prof. Willcocks and herself and was due in at the end of September. There were 69 standards (43 fully met, 2 not met and 24 partially met). She noted a couple of amendments in relation to the patient story taking place at the start of a public Board and the Annual Report should state 2018/19 not 2019/20.

Mrs McAleese stated that the Trust performed strongly due to giving the role sufficient time, but the issue around learning was across the whole Trust.

Ms McMeekin stated that there were detailed actions and one of the points was about getting staff to ensure that they take issues through their line management route in the first instance as FTSU should be used only as an escalation route.

Prof. Willcocks noted that learning does take place at the Champions Group.

Ms Mellor stated that using 360-degree development would also help with the culture of learning.

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

18/66 Finance and Performance Committee Minutes

Mr Keaney and Mr Bertram stated that they had nothing further to add.

It was resolved that the Board noted the minutes.

18/67 Finance Report

Mr Bertram provided an overview of the Finance Report stating that if you strip out the PSF element then the Trust achieved £9.5m deficit against a target of £9.6m deficit and the Trust is currently on track to hit the target of £14.6m deficit at the end of the financial year. The Trust is on track to achieve the quarter 2 PSF, so will have gained £2.9m of the available £3.5m for quarters 1 and 2. The remaining £600k was lost due to ECS performance in quarter 1. Pulling the elements together, this makes the Trust's position a planned deficit of £6.4m against a planned deficit of £5.9m.

Mr Bertram stated that the key message is that the Trust is where it should be although he stressed that the position is incredibly fragile as the Trust moves into winter and the second half of the year. Mr Bertram highlighted the difficulties with winter funding and the delivery of the planned care waiting lists which may place additional pressure on the financial position if various courses of action are not supported by the Commissioners.

Mr Bertram noted that assumptions around income had been included in the position and that no material QIPP delivery was happening so trading was above the £331m AIC position which would invoke the risk share. The Trust was currently charging 20% of tariff and 50% in respect of high cost drugs which would place real pressure on the Commissioners to the extent that the Commissioners may miss the control totals and their sustainability funding. He stressed that the Trust was working to the terms of the AIC. . Mr Bertram stated that July and August data has not yet been signed off although he is accounting for the position.

Mrs McAleese asked whether the 20% of tariff was a marginal cost and Mr Bertram stated that he was doing a piece work to look at costs and there was a debate still to be had about the 20%.

Ms Symington stated that this issue had been encountered earlier than expected. Mr Bertram noted that the regulators are aware of the position. He stated that he had been really clear on what had been agreed in relation to the risk share and without invoking the risk share the Trust would not be in a position to cover the costs associated with care and it would result in the Trust needing to borrow money. He stated that it feels tense at the moment especially with the difficulties around planned care.

Dr Boyd asked whether the QIPP position was likely to change and Mr Bertram stated no, not materially. He noted that schemes were being progressed, but these would not have benefits until the medium term. Mrs Scott stated that there was no low hanging fruit that would rescue the position.

Mr Bertram stated that the income levels assumed were modest.

The Board had a discussion about organisations failing to meet their control totals and the impact on other organisations and the system. Mrs Scott stated that it was an uncomfortable position as the Trust was not in a position to do what it needed to do to get through work.

Ms Symington highlighted the collective responsibility of a unitary Board.

Mr Bertram highlighted the chart on page 64 which showed the position pre-PSF and actual performance which is following the planned position. He stated that he expected September to be challenging and that the position would deteriorate, but that this was not part of a trend, but as the Trust moved into the second part of the year the CIP position would start to bite. The run rate analysis was starting to show a deviation appearing, but reconciliation had been done and the variation could be explained.

Mr Keaney stated that there was a positive CIP rate and if you took this out the run rate would go up. Mr Bertram stated that he needed to review the proxy 20% variable costs.

Mrs McAleese was concerned that the CIP could be masking an underlying problem. Mr Bertram stated that there was no reason to suggest that the CIP position would slow down as it was running well ahead of last year's trajectory.

Ms Symington asked if there was any further support the Board could provide Mr Bertram and he stated that he would pick further actions up with Corporate Directors and then bring them here if required.

Agency – Mr Bertram stated that the Trust were currently within £100k of the cap of £6.3m (£6.4m spend), but this is in essence due to being unable to fill vacancies. He noted that the split between medical and nursing used to be 50:50, but medical is now the major share. Mrs Geary highlighted that the agency position is scrutinised every week.

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

18/68 Efficiency Report

Mr Bertram gave an overview of the report stating that the Trust had delivered 49% of its CIP for 2018-19 which was better than at this point last year. The level of recurrent delivery was also higher. The report covered both transformational (£6.2m) and transactional (£15.5m) plan delivery. Currently, he wanted to highlight two risks in relation to the failure of the CCGs to deliver the QIPP programme and that the performance element of the PSF was risky as the ECS delivery is at 90.05% with 5 days to go to the end of the second quarter.

Mrs Adams wondered what was behind the over performance of the CIP and Mr Bertram stated that this was due to the transactional side of the programme in which £9m out of £15.5m had been achieved. Mr Bertram stated that £500k of the LLP benefits had been put through to CIPs as a decision had been made not to put all the savings through on the 1 October. The transactional programme is made up of about 400 low value schemes and although some directorates are in a good position, there are some which are struggling.

Ms Symington stated that the Board would be keeping a close eye on this in the months ahead in recognition of the fragility of the situation.

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

18/69 Risk Management Framework

This item was deferred until the Committee/Board structure was finalised.

It was resolved that the Board accepted the withdrawal of the framework.

18/70 Reflections on the Meeting

Ms Symington stated that the new BAF contained the risks to achievement of the Trust's strategic goals and had been scored by the executive team before being approved by the Board in August. The meeting had covered some of the risks and some would be covered in the private meeting the following day. The Board discussed partnership working in light of the AIC and managing demand and whether the score needed to be revisited.

However, Mr Taylor stated that the Trust was working to the agreed contract. Mr Bertram felt there was no lack of engagement on the Trust's part. Ms McMeekin stated that due to sickness levels going up then the Board needed to keep an eye on the healthy engaged resilient workforce risk.

It was noted that the Staff Survey would be released on the 8 October.

Ms Mellor stated that she liked the new format board report and that the summary was a useful guide to the report.

Mrs McAleese stated that she had enjoyed the Board, especially the pace; however, the amount of papers was a challenge. She noted it would be helpful if the papers came out earlier to enable more comprehensive reading and that the minutes of the Committees would not be part of future meetings.

Ms Symington stated that the business had been covered and she did not feel that it had been compromised by not having the Committees.

Observers were asked to comment:

- Mrs Miller thought there was too much information which was very technical and tiring.
- Mr Reakes felt it gave a much better overview.
- Mr Summerfield stated he was impressed by quality of the papers, but the highlight for him had been the LIVEX film.

18/71 Any other Business

No further business was discussed.

18/72 Date and Time of next meeting

The next public meeting of the Board will be held on Wednesday 28 November 2018 in Room S33 Postgraduate Centre, Scarborough 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 – **email circulated 28.08.18**	Mrs Provins	completed
18/52	To provide an update on the DToC work being carried out by Sheffield **– email circulated**	Mrs Scott	completed

18/59	The Board to be kept informed of RTT issues **– this is done via the monthly performance report.**	Mrs Scott	completed
18/62	Further compliance report to be received in October.	Mr Golding	completed
18/69	Risk Management Framework to be reviewed following the revision of the committee structure	Ms Jamieson/ Mrs Geary	Jan 19

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 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

Text here

Recommendation

For the Board to note the report.

Author: Mike Proctor, Chief Executive

Director Sponsor: Mike Proctor, Chief Executive

Date: November 2018

1. CQC system visit

As briefed previously, the CQC is revisiting our health and social care system in the City of York to examine our progress in improving care for elderly patients. This follows their initial visit last year. I have been involved in presentations to the CQC and have been interviewed, along with many others in our senior team and on those of the CCG, the Local Authority, and the Voluntary and Independent provider sectors. I will provide an update regarding the feedback once the visit is complete.

2. Scarborough Acute Services Review

This piece of work, which is to consider how we can deliver sustainable acute services for our east coast patients, is continuing, with the fourth and final clinical reference group having taken place last week.

The clinical reference group comprises consultants from both Scarborough and York, as well as local GPs and representatives from all of the partners involved in the review. To date the clinical reference group has reviewed the Case for Change and described and discussed possible clinical model scenarios and their interdependencies.

The most recent clinical reference group session focused on the evaluation criteria which were used to support a discussion about the 'trade offs' between access, quality, workforce, finances and deliverability for the possible scenarios.

These discussions form part of a broad analysis and evaluation that is being considered further with Clinical Commissioning Group and Humber Coast and Vale Health and Care Partnership colleagues.

A discussion amongst the partner organisations is taking place to review the work done to date, and next steps and likely timeframes will be agreed. We are not at the stage where we are recommending or making decisions on a preferred scenario.

3. New roles and new ways of working

In order to meet the challenges we face we have to work in different ways, sometimes this can be testing for individuals and teams but if we embrace change in the right way and with the right motivations (thinking about what is right for our patients) then change is exciting and creates opportunities for our staff.

Earlier this month I had the pleasure of shadowing Dr Kim Chandler for a morning. Kim is piloting a new role within acute medicine, the acute physician in charge or APIC.

Essentially, I see the APIC role as an incredibly simple concept; to move from the default position of admitting a patient to get a physician's view to a more rapid provision of an expert medical opinion which can be delivered inside the Emergency Department, on the phone to a referring GP or 'hands on' on ward 24.

This provides a direct link between the medical team on the second floor and the Emergency Department and will help to admit only those patients for whom an admission and perhaps extended stay in hospital stay is essential. I look forward to this role being established as a permanent part of our processes.

We also welcomed 12 Physician Associates to the Trust on 22 October, with a further four due to take up rotations with the Trust over the course of a two-year rotational programme.

Over the course of their preceptorship, our physician associates will work in a range of specialties, including Acute Medicine, Gastroenterology, Cardiology, Respiratory Medicine, Endocrinology, Renal Medicine, Elderly Medicine, Rheumatology, Haematology, Oncology, Dermatology, Neurology, Emergency Medicine and Paediatrics.

Still a relatively new role to the NHS, the introduction of the physician associate role is great news for the Trust as it complements the numbers of the medical workforce, and increases access to quality care for patients.

Physician associates are unique in that they are trained in a medical model unlike other professionals - so they develop skill sets to deliver healthcare to patients in multiple settings, very much like a doctor.

4. Business Continuity

We ran a Black Start power exercise at York Hospital at the start of November, where the external power supply is turned off for 15 minutes to test the process of restoring power to without relying on the external transmission network.

I am pleased to report that there was no significant disruption, and that the plans we had in place proved effective.

A more unplanned test followed a few days later as CPD, our core patient database, was not available. I am grateful to the SNS team for getting things back up and running as quickly as possible, to the operations team for invoking our major incident structure to centrally understand and manage the problems caused and to ensure our business continuity plans were enacted to enable minimal impact for patients. I am grateful for everyone's patience and professionalism throughout.

5. Humber, Coast and Vale Health and Care Partnership

The leader of the STP Simon Pleydell, the current lead for our STP (and former Chief Executive of York Trust) is stepping down at the end of November this month. A search for his successor has started, and as soon as this is confirmed I will update the Board.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 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.

The following appendices are attached this month:

Appendix 1 – Nurse and Care Staffing Report
Appendix 2 – Safeguarding Children Annual Report

Executive Summary

Nurse staffing
In October 2018, the Trust Board accepted the revised version of the Nurse and Care Staffing report and the recommendation that quarterly detailed reports would follow. The attached appendix 1 report provides key nurse staffing information and exceptions. The next detailed quarterly report will be January 2019.

Planned versus actual staffing and CHPPD

As required the Trust has submitted the required planned versus actual staffing return to NHSE. The overall planned versus actual staffing figures have been calculated to account for long day efficiency.

October 2018 planned versus actual nurse staffing return

Registered Nurses		Care Staff	
Day shift fill rate	Night shift fill rate	Day shift fill rate	Night shift fill rate
91.3%	90.3%	120.7%	118.2%

Due to the number of RN vacancies Nurse and care staff remains challenging and is included on the Chief Nurse risk register.

Safeguarding children

The Safeguarding Children Team continue to work with our multi agency partners and the Safeguarding Children Boards in City of York, North Yorkshire and East Riding and is continuing to develop and embed robust safeguarding principles and processes throughout the Trust.

Internal activity is as follows:

Activity	Scarborough	York
Statements	12	32
Chronologies	5	5
Advice calls	Across both sites 450 per month	
Referrals	62	73
CP Medicals	17	78
CSAAC Medicals	N/A	92
Rapid response meetings	3	1
CP supervision (group)	10	38
CP supervision (1:1) Unborn	7	7
CP supervision 1:1	1	5
Level 3 training (April to Sept 18)	11	11

Risks include our uptake of statutory and mandatory training; level 3 – specialist practitioner in ED and Maternity services. However this represents a very small number of staff and the team are working proactively with Directorates to address this.

The Risk Register also has high risks in relation to access of electronic safeguarding information. Ongoing collaborative work with SNS is addressing this and the team are working with local areas in raising awareness of safeguarding issues to staff out of hours.

Both these areas are monitored closely and by both Strategic and Operational Governance groups

The action plans developed to address recommendations from CQC Children Looked After and Safeguarding (CLAS) have largely been completed.

Actions have been taken to address findings from internal audit reports and any slippage is being carefully monitored.

The detailed Safeguarding Children Annual Report is attached at appendix 2.

Falls
Q2 2018/19 has shown a decrease in the total number of overall falls with a 17.6% increase in the number of falls which have resulted in moderate harm or above when compared with Q2 2017/18.

The Trust has seen 8 investigations presented at Falls Panel during Q2 for patients who have fallen and come to severe harm.

There are several recurrent themes where patient falls have resulted in moderate harm or above. Whilst there are areas of good practice, themes of identified learning are often repeated during RCAs. Safety briefings are cited as being consistently used as a form of sharing the learning identified; the Patient Safety Team has begun to assess the efficacy of this route of learning.

A full root and branch review of falls prevention is currently being undertaken the findings and recommendations will be reported to board in the near future.

Pressure Ulcers
The total number of pressure ulcers reported during Quarter 2 was 275. The total number of pressure ulcers has increased in comparison to Quarter 2, 2017/18 this equates to an increase of 66 ulcers, incidence remains within the upper and lower control limits

Category	Number
2	42
3	4
4	5
unstageable	15

The Tissue Viability Team suggests that one contributing factor is the very hot summer and the impact on patients' skin integrity. During July and August there was an unusual increase in pressure ulcers. This was reflected nationally with an increase in moisture related issues. Ordinarily there would be an expected reduction in figures during the summer months.

There was an increase in wards reporting five or more ulcers during Quarter 2, these include 23, 25, 26, 28, 35, AMB and AMU on the York site, and Ann Wright, Chestnut, Holly and Oak on the Scarborough site. In order to focus on improvement, four of these wards have been involved in the national pressure ulcer collaborative programme. This has included provision of ward based training and education with a plan to continue to provide face to face ward based training and education for those areas showing an increase in Pressure ulcers. Plans to scale up and spread the learning from the collaborative are underway.

Future reports will report pressure ulcer incidence per 1000 occupied bed days to provide a more accurate ward to ward comparison.

Following the review of falls; a full root and branch review of pressure ulcer prevention and management which will be undertaken early in 2019. The findings and recommendations will be reported to Board.

Recommendation

The Board of Directors are asked to accept the reports and the recommendations within each individual submission.

Author: Beverley Geary, Chief Nurse

Executive Sponsor: Beverley Geary, Chief Nurse

Date: November 2018

Appendix 1

Nurse and Care Staffing Report

In October 2018, the Trust Board accepted the revised version of the Nurse and Care Staffing report and the recommendation that monthly reports would be high level and by exception, with quarterly detailed returns focussing on areas of high risk, developments and updates on initiatives.

This report provides the key information and exceptions on nurse staffing, the next detailed quarterly report will be presented to Board of Directors in January 2019.

Nurse and care staffing remains challenging and is included on the Chief Nurse risk register.

Planned versus actual staffing and CHPPD

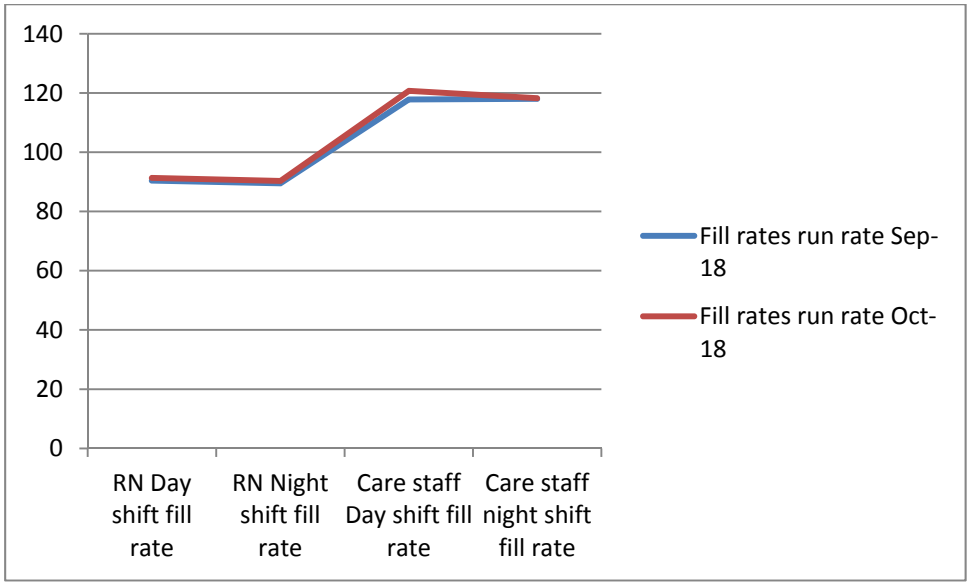
The Trust has submitted the required planned versus actual staffing returned. The detail of the submission is included in Appendix 1.1.

The overall planned versus actual staffing figures have been calculated to account for long day efficiency.

Table 1 October 2018 overall planned versus actual

Registered Nurses		Care Staff	
Day shift fill rate	Night shift fill rate	Day shift fill rate	Night shift fill rate
91.3%	90.3%	120.7%	118.2%

Graph 1 Overall planned versus actual % run rate



From the data presented in Appendix 1.1, 15 wards are identified as challenged from a Registered Nurse (RN) perspective. These include wards where actual staff has only been provided to meet levels of activity. Of specific note is Lloyd Ward at Bridlington, that as reported, only achieved 15.8% of planned staffing levels at night,

however, that ward was only required to be opened 3 nights in October. The Chief Nurse Team have asked colleagues in Operational Management to review the future requirement to plan staffing for this area more effectively.

The Matrons for wards with challenging fill rates report to their Head of Nursing specific concerns for escalation / action.

Nurse Recruitment

The Chief Nurse Team works closely with colleagues in recruitment to deliver the optimum recruitment strategies. Of note in November 2018:

- The new process for internal transfers described in the October 2018 report has been launched
- An agreement for an advert and a process for nurses who qualify in autumn 2019 and been agreed. This will be live during December 2018 and January 2019.
- An agreement for an advert and a process for national recruitment of nursing associates has been agreed. This will be live during December 2018 and January 2019.
- The planned provider event for internal recruitment has stalled due to a regional review of procurement processes. As this process has stalled 3 times, the recruitment team have an interim measure to recruit on a small scale (No 15) RNs from 3 different providers to test the market. Colleagues in Human Resources will challenge the procurement process if further delays arise.
- Deputy Chief Nurse held extraordinary meeting with Matrons to describe some of the new process. New process for bespoke recruitment / local engagement of new staff has been welcomed.

Trust wide and site nurse and care staffing data

Table 2 Trust wide, York acute site and Scarborough and Bridlington site vacancy data

Trust wide

Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
												WTE			%		
B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3
1,657.39	58.11	897.25	1,350.59	97.56	816.78	23.24	1.00	10.40	17.80	0.00	24.00	312.24	-38.45	66.87	18.84%	-66.17%	7.45%

York Acute Hospital

Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
												WTE			%		
B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3
851.95	43.35	469.32	676.47	68.48	428.79	13.24	1	7	7.2	0	1.6	181.52	-24.13	45.93	21.31%	-55.66%	9.79%

Scarborough and Bridlington Acute Hospitals

Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
												WTE			%		
B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3
498.69	14.76	307.71	384.27	25.68	271.47	10	0	3.4	4	0	21.4	120.42	-10.92	18.24	24.15%	-73.98%	5.93%

The data presented in Table 2 shows trust wide data that encompasses the less challenged areas of community and midwifery. The York acute site and Scarborough and Bridlington sites remain the most challenged areas.

The data shows an overall decline in the net vacancy rates trust wide and on each acute hospital site. In future reports, when the new style of data collection has been undertaken for 3 months, run rate graphs for % net vacancy rates will be provided. The data continues to demonstrate the challenges that are being addressed in introducing the Band 4 roles. However, until there is a critical mass of individuals in Associate Practitioner or Nursing Associate positions who can provide appropriate backfill and until every ward and unit has had an appropriate workforce review this discrepancy will remain. The Chief Nursing Team have an agreed schedule to review ward establishments with colleagues in Organisational Development, areas of greatest risk and challenge are being prioritised. The Emergency Department on the Scarborough site is currently ongoing.

SafeCare CHPPD data has been provided to all Heads of Nursing in order to report and escalate to the Chief Nurse. The Heads of Nursing will provide a report in the detailed quarterly report in January 2019. The Chief Nurse Team are pleased to report significant progress with compliance with SafeCare data collection. This data will show trends overtime which will give valuable information regarding skill mix and staffing numbers.

Senior nursing oversight on nursing and care staff continues on a shift by shift basis. Matrons have already begun working 7 days on Scarborough site, this will extend to the York site in early December. This will support the decision making around staffing based upon real time acuity and dependency data.

Helen Hey
Deputy Chief Nurse
November 2018

Appendix 1.1 – Safe Staffing return

Only complete sites your organisation is accountable for			Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Specialty 1	Specialty 2	Total monthly planned staff	Total monthly actual staff	Total monthly planned staff	Total monthly actual staff	Total monthly planned staff	Total monthly actual staff	Total monthly planned staff	Total monthly actual staff								
Ann Wright	430 - GERIATRIC MEDICINE		1,303.00	911.25	816.5	1,350.00	682	680.5	677	834.5	69.9%	165.3%	99.8%	123.3%	483	3.3	4.5	7.8
Ash	100 - GENERAL SURGERY		874.25	896.83	806.5	821.5	651	666.17	0	317	102.6%	101.9%	102.3%	-	399	3.9	2.9	6.8
Beech	300 - GENERAL MEDICINE		1,283.50	1,141.42	1,673.00	1,516.00	1,023.00	957.5	1,023.00	1,065.75	88.9%	90.6%	93.6%	104.2%	842	2.5	3.1	5.6
Cherry	326 - ACUTE INTERNAL MEDICINE	300 - GENERAL MEDICINE	2,072.75	1,279.33	1,683.50	1,664.75	1,655.50	1,175.75	1,333.00	1,330.50	61.7%	98.9%	71.0%	99.8%	529	4.6	5.7	10.3
Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,267.67	1,198.92	1,431.00	1,481.75	682	692	1,023.00	1,076.50	94.6%	103.5%	101.5%	105.2%	740	2.6	3.5	6.0
Coronary Care Unit	320 - CARDIOLOGY		2,430.75	1,744.75	835	853.5	1,364.00	1,084.83	341	705	71.8%	102.2%	79.5%	206.7%	512	5.5	3.0	8.6
Duke of Kent	420 - PAEDIATRICS		1,446.50	1,292.50	411	372.5	682	683.5	341	341	89.4%	90.6%	100.2%	100.0%	188	10.5	3.8	14.3
Graham	430 - GERIATRIC MEDICINE		1,004.00	804.58	1,052.00	1,238.80	682	671.75	682	768.5	80.1%	117.8%	98.5%	112.7%	478	3.1	4.2	7.3
Hawthorn	501 - OBSTETRICS		2,592.50	2,469.00	887.25	883.75	2,139.00	2,056.00	713	713	95.2%	99.6%	96.1%	100.0%	164	27.6	9.7	37.3
Holly	110 - TRAUMA & ORTHOPAEDICS		1,251.25	911.25	1,006.50	1,412.75	651	653	651	809.5	72.8%	140.4%	100.3%	124.3%	520	3.0	4.3	7.3
Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2,783.25	1,938.67	850.5	320.5	2,139.00	1,880.50	356.5	0	69.7%	37.7%	87.9%	0.0%	120	31.8	2.7	34.5
Lilac	101 - UROLOGY		1,689.08	1,399.08	1,580.25	1,706.25	651	968.83	651	1,001.00	82.8%	108.0%	148.8%	153.8%	559	4.2	4.8	9.1
Maple	100 - GENERAL SURGERY		2,124.58	1,524.17	1,055.00	1,147.25	1,297.50	1,137.00	651	734.25	71.7%	108.7%	87.6%	112.8%	532	5.0	3.5	8.5
Oak	430 - GERIATRIC MEDICINE		1,645.00	1,289.25	2,205.50	2,099.17	1,024.00	906.67	1,023.00	1,087.50	78.4%	95.2%	88.5%	106.3%	885	2.5	3.6	6.1
Stroke	328 - STROKE MEDICINE		1,583.92	1,166.92	806	1,115.00	976.5	938	325.5	611	73.7%	138.3%	96.1%	187.7%	426	4.9	4.1	9.0
Johnson	430 - GERIATRIC MEDICINE		1,028.00	934.5	1,422.25	1,513.00	640.5	630	325.5	399	90.9%	106.4%	98.4%	122.6%	735	2.1	2.6	4.7
Kent	110 - TRAUMA & ORTHOPAEDICS		1,136.00	953	875	701.75	619.5	483	0	73.5	83.9%	80.2%	78.0%	-	109	13.2	7.1	20.3
Lloyd	100 - GENERAL SURGERY		1,017.00	432.75	690	400.25	199.5	31.5	199.5	31.5	42.6%	58.0%	15.8%	15.8%	8	58.0	54.0	112.0
11	100 - GENERAL SURGERY		1,689.50	1,367.75	963	1,283.00	682.5	669	682	836	81.0%	133.2%	98.0%	122.6%	811	2.5	2.6	5.1
14	100 - GENERAL SURGERY		2,259.50	2,009.42	1,456.23	1,394.98	1,063.00	1,032.00	712.5	753.25	88.9%	95.8%	97.1%	105.7%	691	4.4	3.1	7.5
16	100 - GENERAL SURGERY		2,124.75	1,716.25	1,007.50	1,131.50	1,364.00	1,209.50	682	747.5	80.8%	112.3%	88.7%	109.6%	733	4.0	2.6	6.6
17	420 - PAEDIATRICS		725.50	587.50	227.5	208	0	0	0	0	81.0%	91.4%	-	-	394	1.5	0.5	2.0
23	430 - GERIATRIC MEDICINE		1,430.00	936.3	1,190.00	1,259.00	651	651	976.5	987.00	65.5%	105.8%	100.0%	101.1%	781	2.0	2.9	4.9
25	430 - GERIATRIC MEDICINE		1,448.33	1,060.50	1,190.50	1,527.33	651	653.25	976.5	1,184.50	73.2%	128.3%	100.3%	121.3%	631	2.7	4.3	7.0
26	430 - GERIATRIC MEDICINE		1,448.83	1,184.00	1,225.50	1,459.25	640.5	635.5	976.5	1,110.75	81.7%	119.1%	99.2%	113.7%	783	2.3	3.3	5.6
28	110 - TRAUMA & ORTHOPAEDICS		1,576.50	1,233.25	1,188.00	1,183.00	651	642	976.5	1,009.50	78.2%	99.6%	98.6%	103.4%	756	2.5	2.9	5.4
29	110 - TRAUMA & ORTHOPAEDICS	103 - BREAST SURGERY	1,618.50	1,047.75	773.5	808.5	651	630	325.5	315	64.7%	104.5%	96.8%	96.8%	439	3.8	2.6	6.4
31	370 - MEDICAL ONCOLOGY		1,832.00	1,568.50	745	749.5	976.5	661.5	325.5	423.92	85.6%	100.6%	67.7%	130.2%	442	5.0	2.7	7.7
32	320 - CARDIOLOGY	400 - NEUROLOGY	1,781.50	1,614.00	1,209.75	1,468.75	682	692.17	1,023.00	1,347.50	90.6%	121.4%	101.5%	131.7%	739	3.1	3.8	6.9
33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1,527.50	1,387.50	1,156.00	1,280.00	651	662.75	976.5	1,209.75	90.8%	110.7%	101.8%	123.9%	766	2.7	3.3	5.9
34	340 - RESPIRATORY MEDICINE		1,610.25	1,475.75	1,176.50	1,146.17	682	719.75	1,023.00	1,124.00	91.6%	97.4%	105.5%	109.9%	776	2.8	2.9	5.8
35	430 - GERIATRIC MEDICINE		1,437.87	1,066.63	1,203.00	1,570.00	651	676.25	976.5	989.5	74.2%	130.5%	103.9%	101.3%	767	2.3	3.3	5.6
37	430 - GERIATRIC MEDICINE		1,015.00	897	1,587.50	1,975.42	651	652	651	981.50	88.4%	124.4%	100.2%	150.8%	543	2.9	5.4	8.3
39	328 - STROKE MEDICINE		1,507.25	907.08	1,167.50	1,811.00	651	642.25	651	945	60.2%	155.1%	98.7%	145.2%	604	2.6	4.6	7.1
36 - Acute Stroke Unit	328 - STROKE MEDICINE		1,685.33	1,449.58	1,364.17	1,432.92	962	923	976.5	1,018.00	86.0%	105.0%	95.9%	104.2%	544	4.4	4.5	8.9
Acute Medical Unit	326 - ACUTE INTERNAL MEDICINE		2,296.50	1,538.25	1,559.45	1,464.45	1,358.00	1,203.00	1,023.00	1,032.50	67.0%	93.9%	88.6%	100.9%	702	3.9	3.6	7.5
Frailty Unit	430 - GERIATRIC MEDICINE	326 - ACUTE INTERNAL MEDICINE	1,992.42	1,286.92	1,520.00	1,562.25	1,364.00	1,169.25	1,023.00	1,161.00	64.6%	102.8%	85.7%	113.5%	687	3.6	4.0	7.5
Coronary Care Unit	320 - CARDIOLOGY		1,777.50	1,360.08	319.25	332	1,364.00	1,078.00	0	0	76.5%	104.0%	79.0%	-	160	15.2	2.1	17.3
Extended Stay Area	100 - GENERAL SURGERY		2,796.42	2,366.67	2,156.50	1,422.50	399	475.17	0	86.5	84.6%	66.0%	119.1%	-	320	8.9	4.7	13.6
G1	120 - ENT	502 - GYNAECOLOGY	1,705.98	1,438.73	822.98	993.23	1,018.00	678.25	341	787.75	84.3%	120.7%	66.6%	231.0%	526	4.0	3.4	7.4
G2	501 - OBSTETRICS		1267.5	1237.5	697.5	601.5	839.5	807.5	337.25	337	97.6%	86.2%	96.2%	99.9%	336	6.1	2.8	8.9
G3	501 - OBSTETRICS		930	885	460.5	395.5	682	649	0	0	95.2%	85.9%	95.2%	-	166	9.2	2.4	11.6
Intensive Care Unit	192 - CRITICAL CARE		5,256.00	4,142.25	392.25	368.25	4,433.00	3,594.75	341	297	78.8%	93.9%	81.1%	87.1%	249	31.1	2.7	33.7
Inpatient Unit	925 - COMMUNITY CARE SERVICES		1,202.50	1,037.92	1,125.00	1,247.17	683	513.5	341	539	86.3%	110.9%	75.2%	158.1%	536	2.9	3.3	6.2
St Helens	925 - COMMUNITY CARE		872.25	839.25	999.75	1,005.25	651	504.5	325.5	469.95	96.2%	100.6%	77.5%	144.4%	517	2.6	2.9	5.5
St Monicas	925 - COMMUNITY CARE SERVICES		599	556.75	626.5	538.5	372	372	372	372	92.9%	86.0%	100.0%	100.0%	143	6.5	6.4	12.9
Whitecross Court	925 - COMMUNITY CARE		939.5	950	1,074.00	1,225.75	651	490.5	325.5	711.5	101.1%	114.1%	75.3%	218.6%	597	2.4	3.2	5.7

APPENDIX 2

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 2018
Safeguarding Children 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	☒		

Executive Summary – Key Points

The Safeguarding Children Team continues to work with our multi agency partners and the Safeguarding Children Boards in City of York, North Yorkshire and East Riding to develop and embed robust safeguarding principles and processes throughout the region and within the Trust in order to improve the care of all children within our services.

Action plans that were developed to address recommendations from CQC Children Looked After and Safeguarding (CLAS) have largely been completed.
Plans to address findings from internal audit reports are ongoing and are being monitored to ensure timely delivery

Risks include our uptake of statutory and mandatory training; level 3 – specialist practitioner, in ED and Maternity services, however this represents a very small number of staff and the team are working proactively with Directorates to address this.

The Risk Register has high risks in relation to access of electronic safeguarding information. Ongoing collaborative work with SNS is addressing this and the team are working with local areas in raising awareness of safeguarding issues to staff out of hours. Both these areas are monitored closely and by both Strategic and Operational Governance groups.

Recommendation

This paper outlines to the board the rising profile of Safeguarding Children and its role within the Trust. It asks the Board to:

- Note Progress and development
- Have an awareness of key challenges, national drivers and priorities for the future.

- Be assured of ongoing work and management of risk
- Give approval to share progress externally to specific bodies and the public (There is also an expectation that the Trust will publish the Safeguarding Children annual reports)

Author: Fiona Mockford, Head of Safeguarding Children and Beverley Geary, Chief Nurse

Director Sponsor: Beverley Geary, Chief Nurse

Date: November 2018

1.0 Introduction

As a provider of health care, York Teaching Hospital NHS Foundation Trust (referred to as the Trust) is committed to safeguarding all children receiving our services, and contributing to the safeguarding of children in general within our communities.
The Trust offers assurance to, and participates with, external agencies and three Local Safeguarding Children Boards (City of York, North Yorkshire & East Riding) to ensure a multi-agency approach to the safeguarding of children in both community and acute settings.

The Trust Safeguarding Children Team provides safeguarding children advice, support, reflective supervision and training for staff working with children & young people (or their parents or carers) where there is known or suspected risk of, significant harm to a child.
The Team Structure can be found at Appendix 1.

2.0 National Context and Local developments

Safeguarding Children continues to be a high priority nationally and locally.
The publication of the Wood Review (2016), Social Care Act (2017) and Working Together to Safeguard Children (2018) have resulted in fundamental changes to the way safeguarding children is organised at a strategic level. Local Safeguarding Children Boards will cease to exist and will be replaced by formal partnerships with three equal partners of Social Care, Police and Health. The executive lead for health will be the Chief Nurse for the CCG. The Trust as a significant provider of healthcare in both City of York and North Yorkshire will continue to be represented at either Chief Nurse or Head of Safeguarding Children level. These partnerships will take effect from April 2019.

Locally, the Trust has had representation at the City of York, North Yorkshire and East Riding of Yorkshire Safeguarding Children Boards for a number of years. All three safeguarding Children Boards continue to provide strong leadership and objective scrutiny of the remit and responsibilities of their partner agencies. All Boards are working with multi-agency involvement to tackle on-going & emerging issues relevant to the safeguarding of children: Child Sexual Abuse and Sexual Exploitation, Neglect, Domestic Abuse, Abuse via the Internet & Social Media etc.

2.1 CQC Children Looked After & Safeguarding Inspections

The Care Quality Commission (CQC) carried out multi-agency Children Looked After & Safeguarding (CLAS) Inspections in December 2016 for City of York and February 2017 for North Yorkshire. Recommendations from these inspections form part of the Safeguarding Children work plan (appendix 2) and we are in a strong position to be able to provide evidence of significant progress.

3.0 Governance and Assurance

3.1 Safeguarding Children Governance

Safeguarding Governance internally has been revisited. The outcome was to develop both an Operational and Strategic Group. The operational group currently meets bi-monthly. This reflects the pace and breadth of service developments within the Safeguarding Children Team.

The strategic group, which meets quarterly, provides strategic overview and challenge. The membership includes representatives of our multi agency partners which facilitates scrutiny and transparency. The title has been changed to Safeguarding Children and Looked After Children. The change in title reflects the role played by the Trust in providing Initial Health Assessments to this vulnerable cohort of children.

3.2 External Governance

As part of multi-agency working the Trust has an obligation to give external assurance to the three Safeguarding Children Boards and to the Clinical Commissioning Groups. This is done by way of self-declaration, with follow-up "challenge" days to provide evidence of the Trust's compliance with Section 11 of the Children Act 2004.

3.3 Assurance

The following routes are used to provide both internal & external assurance:

- Quarterly updates/reports to the Trust Safeguarding Children Governance Group;
- Section 11 Audit submission & related 'Challenge' events, annually to the three Local Safeguarding Children Boards;
- As required as part of contracting assurances to Clinical Commissioning Groups;
- Chief Nurse Reports to the Trust Board;
- Annual Report to Board of Directors.

Internal and external governance structures are shown at appendix 3.

4.0 Internal Activity 2017 – 18

Activity	Scarborough	York
Statements	12	32
Chronologies	5	5
Advice calls	Across both sites 450 per month	
Referrals	62	73
CP Medicals	17	78
CSAAC Medicals	N/A	92
Rapid response meetings	3	1
CP supervision (group)	10	38
CP supervision (1:1) Unborn	7	7
CP supervision 1:1	1	5
Level 3 training (April to Sept 18)	11	11

In 2017/18 the Safeguarding Children Team experienced a significant period of change. The former Head of Safeguarding retired in September 2017 and interim management arrangements were put in place to ensure stability whilst work

continued to address actions arising from two CQC CLAS inspections and to inform local developments.

The have team engaged in collaborative work with SNS to reduce risk and develop increasingly robust systems for safeguarding children. This included daily worklists of children who attend at ED and for whom there are safeguarding concerns. Collaborative work with ED staff led to the introduction of Child Protection-Information Sharing (CP-IS), this is a national system rolled out by NHSI, which allows ED staff to access information about whether a child (or unborn) is subject to a Child Protection plan or is Looked After by the local authority.

ED staff have also been central to the development of a Safeguarding Liaison Nurse role. This has been seen as positive development and has received financial support from the CCG. The role has contributed to the completion of actions developed from the internal audit and aims to increase awareness and compliance within the high risk areas.

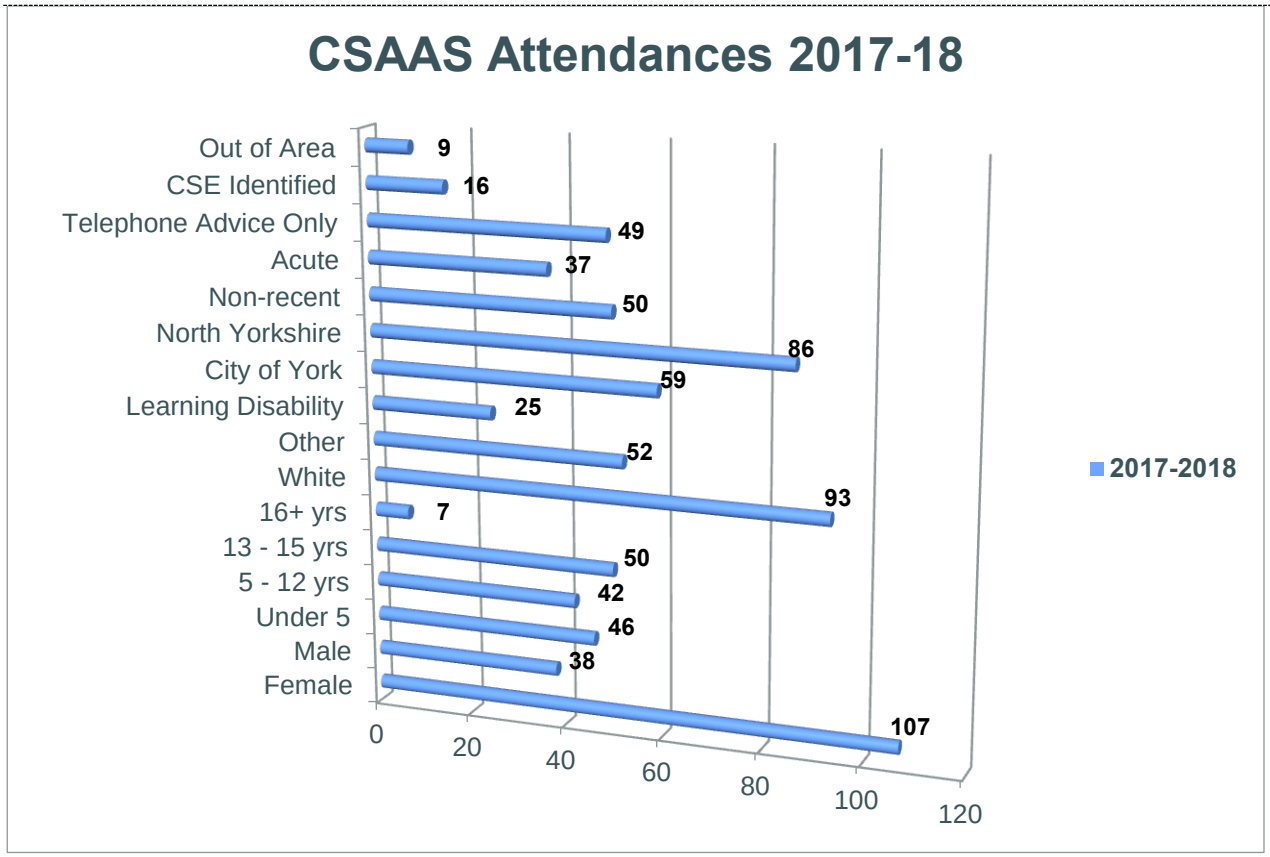
4.1 Child Sexual Assault Assessment Centre

The North Yorkshire and York Child Sexual Assault Assessment Centre (CSAAS) provided by the Trust opened formally in November 2015.

The service provides a facility for an overarching comprehensive medical assessment whenever sexual abuse is alleged, disclosed or suspected. All examinations include a clinical history and physical examination. It may include the taking of forensic samples. The service is not only for the acute cases but for non-recent offences where there may still be signs of trauma, injury or infection.

In all cases by seeing a consultant Paediatrician a holistic approach is taken throughout. The Paediatrician and Lead nurse for the SCAAC contribute to strategy meetings, case conferences and provide expert advice on plans of care, follow up and support.

CSAAC Activity is as follows:



4.2 Safeguarding Children Operational Achievements 2017-2018

In order to create a more accessible Safeguarding Children Systems there has been significant development of recording prompts and support for staff as follows:

Development	Origins	Position	Evaluation
CONSIDER PROMPT – risk and vulnerability assessment (Emergency Department)	Serious Incident (March 2017)	Pilot on York site Launch on Scarborough site Autumn 2018	April 2019
Midwifery Shared Access to Child safeguarding records	CDOP 2017	Active	April 2019
Domestic Abuse Policy	Policy review	Active	April 2021
Intranet Resource	Feedback from staff	Active	Ongoing as necessary

5.0 Risk and Mitigation 2017 – 2018

5.1 Training

Training is now fully embedded in Trust induction and statutory and mandatory training. Average compliance for 2017/18 is shown below.

Level	Compliance
Safeguarding Children Level 1	97%
Safeguarding Children Level 2	93%
Safeguarding Children Level 3 Core Modules	76%
Safeguarding Children Level 3 Specialist Modules	74%

The nationally required training level for all Trust staff continues to be reviewed to ensure that it is in line with the intercollegiate document "Safeguarding Children: Roles & Competencies for Health Care Staff" (RCPCH: 2014).
In addition compliance is monitored by monthly reporting from the Corporate Learning and Development team and there is escalation process where compliance is of concern.

The introduction of Emergency Department Liaison (see below) has also led to a more flexible approach to training delivery where patient demand is high and unpredictable.

5.3 Emergency Department (ED) Development

The process of introducing a robust safeguarding risk assessment, used consistently, into ED has proved problematic for a number of reasons. In 2017/18 there was a collaborative approach involving ED, System Network Services and the SGC team. The resulting risk assessment will require staff to think about hidden children, i.e. those children not present when an adult carer attends and the presentation may impact on their ability to care for children, as well as those brought to the department. The electronic recording is being reinforced by "shop floor" training. Regular dip samples will be introduced ahead of a more formal audit.

5.3.1 Safeguarding Liaison post in Emergency department (ED)

This is a new nationally recognised role that aims to capture safeguarding concerns from the onset of a patient journey and is key to robust protection.

The introduction of this post was seen as evidence of good practice by the CCG who agreed to provide the funding for the post in Scarborough. This post on York site has been funded by ED for an initial 12 month period. The post has key performance indicators and these are reviewed frequently to monitor activity and progress.

The post in Scarborough began in Q2 and therefore comparable data is not available.

5.3.2 Emergency Care Data Set (ECDS) compliance

The Emergency Care Data Set (ECDS) has been designed by NHS Digital. This new process replaced previous coding systems and commenced from October 2017. Its aim is to provide an improved level of detail about emergency care.

The ECDS means specifically that referred services and discharge information (onward referral for treatment, treatment complete, streaming, follow-up treatment and safeguarding concerns) is coded.

In order to facilitate analysis of identified safeguarding risks for children and adults who have attended at ED, a daily Safeguarding worklist has been developed.

When clinicians note the concerns on clinical coding, it is filtered onto a worklist by Systems and Networks (SNS) and sent to both safeguarding teams.

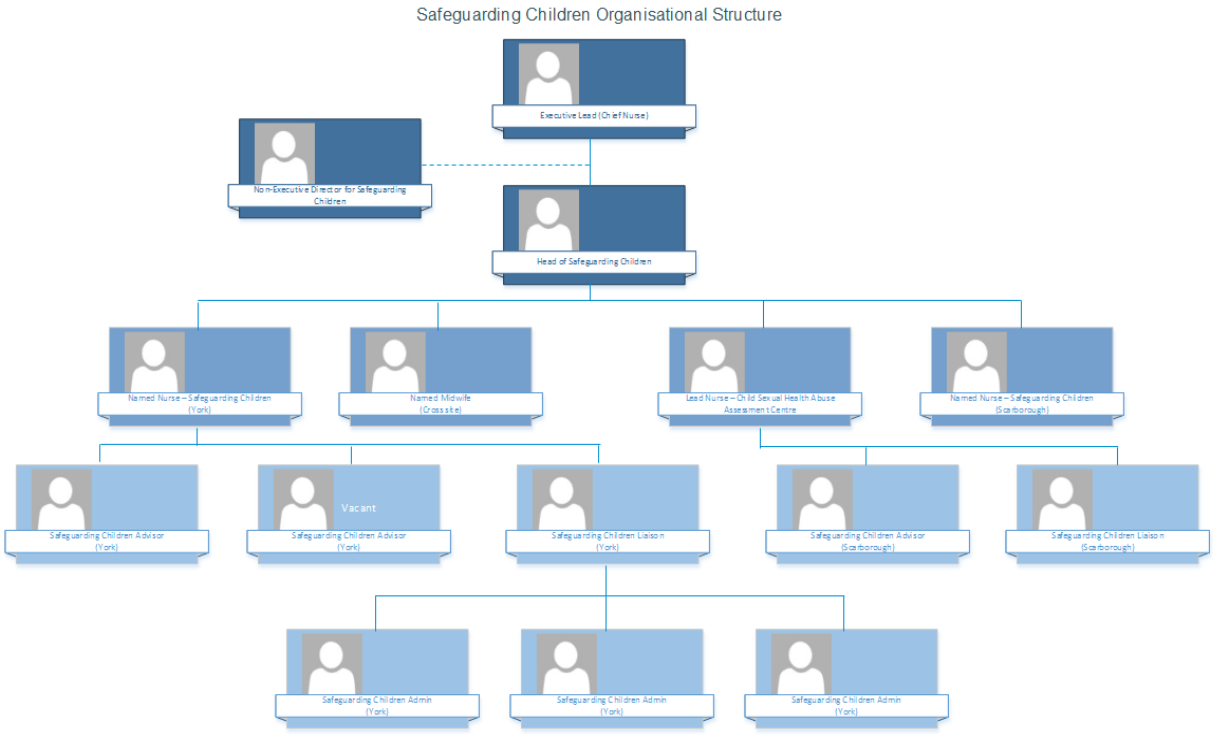
The Safeguarding Children team (SCT) have responsibility to analyse the data for ongoing risk management where necessary which leads to timely intervention.

6.0 Conclusion

There have been key developments during 2017/2018 providing assurance at both a strategic and operational level. Strategic commitment has meant that Safeguarding Children is becoming integral to the culture of the Trust.

Operationally policies and processes are continuously being improved and reviewed to enable staff to have a clear understanding of their roles and responsibilities.

Appendix 1 – Safeguarding Children Organisational Structure



Appendix 2 – Work Plan

Learning Lessons & Serious Case Reviews (Recommendations)

KEY:

OVERDUE **UNDERWAY** **COMPLETE**

Assigned Month	SGT Owner	Recommendation (Reference to which SCR/LLR/SI. I.e. Child's Initial)	Aim / Intended Outcome for Children & Families	Process/Actions	Timescale	Lead Professional	Progress	System of Audit
October 2016	FM	SI 2016/15834	Families can be assured that referrals which include personal details are sent securely	All permanent nursing and medical staff who work in ED or Paediatrics to have individual NHS.net email accounts to enable them to access the group NHS.net email account for their department.	End Oct 2016	Directorate Manager of ED and Paediatrics	Completed.	
October 2016	JS	SI 2016/15834	Families can be assured that referrals pertaining to themselves are completed accordingly.	Referral forms completed by agency staff are to be countersigned by a permanent member of staff prior to sending to CSC. Process for referrals to be updated in Child Protection & Safeguarding Policy.	End Oct 2016	Directorate Manager of ED and Paediatrics	Completed	Dip sampling
Nov 2017	JG	SI 2016/15834	Families can be assured that referrals which include personal details are sent securely	A short film to be produced and up-loaded to You-Tube/York Trust Intranet Site of how to complete a referral form. Video to be viewed by all staff at Level 2 training.	End Nov 2016	Named Nurse for Safeguarding Children	COMPLETE - SUPERCEDED BY THE SAFEGUARDING LIAISON NURSE WHO DOES 1:1 ED TO RAISE AWARENESS OF QUALITY REFERRALS > Ascertained need to apply for funding Application submitted Application granted Narrator identified. > Having become aware that LA's update their referral forms, we now feel that this is not an appropriate use of resources. We will, however, develop an e-resource pack "How to Complete a Referral Form" with examplars.	Audit number of views

Audit Oct 2017	JG	SI for WS	Families can be assured that handover information is given when child being transferred to wards	Handover form to be created & utilised by all ED staff when transferring a child to the paediatric wards. 100% of records of those children admitted to the Paediatric Ward via ED will contain the written Handover Sheet.	End Oct 2016	Directorate Manager of Ed & Paediatrics		Dip sample audit of presence of handover sheet in child's records COMPLETED **REPEAT AUDIT REQUIRED by EO October 2017**
August 2017	FM	SI for WS	Families can be assured that the NICE guidelines are being met	Ensure that the Learning Hub at Level 2 is suitable to meet the needs of medical staff whose prime role is with adults, but also assess children as per NICE Guidance p89 "when to suspect child maltreatment"		Named Dr's for Child Protection & Named Nurse for Safeguarding.	Ongoing. Nhs England are currently in final stages of finalising updated package. Plan to review new package with a view to adopting within the trust. August 2017 FMM	
August 2017	FM	SI for WS	Families can be assured that all staff are aware of safeguarding procedures and escalation thereof.	1. Procedural flow charts to be developed to aid staff with safeguarding procedures. This will include the process for escalating concerns that may arise due to differing opinions of medical/nursing staff. 2. Email to team - which areas are in place/required		Named Dr's for Child Protection & Named Nurse for Safeguarding.	COMPLETE - WE HAVE PROCEDURAL FLOWCHARTS AT THE BEGINNING OF THE CHILD PROTECTION POLICY INSTRUCTING STAFF HOW TO COMPLETE REFERRALS AND STAFF RESOLUTIONS POLICY Timescale to be agreed within wider team. Ascertain availability on Staff room August 2017 FMM 2. FM to email	3 months post implementation COMPLETED
August 2017	JY	LLR for Child A	Children who fail to present for appointments will receive appropriate follow up enabling potential abuse and / or neglect to be recognised and addressed at earliest opportunity.	YTHFT and Primary Care will develop a pathway for managing missed appointments which supports early identification of abuse or neglect. Primary care will develop a standard policy for managing children who fail to present to appointments at Primary Care and Secondary Care settings. YTHFT will incorporate the pathway into the existing "Did not Attend" policy.		Head of Safeguarding, Vale of York CCG	COMPLETE - FOLLOWING AN AUDIT THAT SHOWED POOR UPTAKE THE POLICY AND PROCESS HAS BEEN RE-LAUNCHED AND WILL GO TRUST WIDE ON 1ST JANUARY 2019. WNB/DNA Policy ratified and disseminated. Audit required to evidence adherence to policy August 2017 FMM **Audit will be complete by mid October 2017**	Audit completed. Relaunch of policy

		SI MT	YTHFT to ensure that children presenting with deliberate self-harm or suicidal ideation to have an initial assessment completed without the presence of parent/carer unles child expresses otherwise.	Task & Finish group to develop guidelines for children who attend with deliberate self-harm or suicidal ideation. Documented evidence that child was seen alone or requested adult presence.	April 2018	Matrons for ED and Child Health	A pathway has been developed in North Yorkshire. YTHFT will now develop processes which dovetail with this. End of Dec 2019	
		SI MT	YTHFT to issue guidance to support criteria for referral to Social Care/Prevention services for children attending with deliberate sel-harm.	Work in partnership with local authority colleagues to develop criteria for referral to Socal Care/Prevention Services for children attending with deliberate self-harm. Documented evidence that appropriate referrals are submitted.	June 2018	Named Nurse for SGC, ED Matron and identified colleagues from Social Care/Prevention Services.	A pathway has been developed in North Yorkshire. YTHFT will now develop processes which dovetail with this. End of Dec 2019 August 2018 YTHFT is working collaboratively with multi agency partners to address issues re safe management of children attending ED who have self harmed.	
		Child F						

Development Work

KEY:

OVERDUE	UNDERWAY	COMPLETE

Assigned Month	SGT Owner	Details	Aim/Intended Outcome for Children & Families	Process / Actions	Timescale	Lead Professional	Outcome / Progress of Actions
		1.7 - CQC					
	FM	Ensure practitioners in the ED obtain and record parental consent to refer to children's social care unless this could increase the risk of harm to the child. This is in order to support engagement with subsequent interventions.	Recommendation	**1.** Continue to deliver training as part of statutory and mandatory training. **2.** Create poster informing staff re the need for consent – to be displayed in ED.		Named Nurse / JS / ED Matron	COMPLETE - RATIFIED AND SHARED WITH MULTI-AGENCY PARTNERS. Sept 2017 - Poster mock up done. FM to review and Gov Board to agree.
		1.8 - CQC					
	JM	Ensure that professionals are aware of the policy and national learning that supports the use and reasons for using electronic tags on babies on the maternity ward.	Recommendation	**1.** Develop & distribute a One Minute Guide to inform staff re guidelines. **2.** Amend midwifery training packs to include guidelines.	**1.** August 2017	Named Midwife/Nurse (JM)	COMPLETE - A 1 MINUTE GUIDE WAS DEVELOPED AND IS AVAILABLE ON THE INTRANET FOR STAFF. With Liz Ross for Mat'y Governance sign off. Distribute via Spring Newsletter to wider organisation.
		1.9 - CQC					
	JG	Ensure that regular audit captures staff training need to identify whether practitioners are consistently assessing, recording and appropriately communicating risks to children and young people.	Recommendation	Explore development of mandatory electronic fields in CPD to aid staff in the consistent reporting of risks to children.		Head of Systems & Networks (SR) / Named Nurse	COMPLETE - FURTHER ENHANCED SAFEGUARDING ASSESSMENT GOING LIVE ON 26TH NOVEMBER 2018. October 2017 - Clinical coding introduced into CPD to better capture safeguarding information. Safeguarding risk assesment tool to be embedded into CPD by December 2017.
		1.12 - CQC					

	JM	Ensure that safeguarding discussions and plans are recorded and added to maternal records contemporaneously so that all maternity staff are aware of the most up to date information to safeguard a child.	Recommendation	**1.** Develop a single point of contact maternity mailbox so that records can be updated & filed during current/next working day. **2.** Develop a safeguarding section on CPD to capture discussions in real time. **3.** Explore the use of mobile devices for community midwifery staff.	**1.** September 2017 **2.** April 2018 **3.** September 2017	Head of Midwifery / Head of SNS / Named Midwife (JM)	COMPLETE - MIDWIVES HAVE RECORDED SAFEGUARDING INFORMATION ON AN ELECTRONIC DRIVE SINCE 20TH AUGUST 2018. 2. Meetings held with S&N to develop Safeguarding section on clinical desktop for the storage of all safeguarding information including contemporaneous discussions.
		1.13 - CQC					
	JM	Implement a standard in maternity services so that practitioners are immediately aware of which records contain the context of the risk to the child/young person. To ensure it is clear which record contains the information pertaining to the most recent management of risk for the child/young person.	Recommendation	Standard operating procedure to be developed for storage of maternity safeguarding information.	September 2017	Named Midwife (JM)	COMPLETE - DIVIDERS WERE INTRODUCED BUT THIS HAS ALSO NOW BEEN SUPERCEDED BY ELECTRONIC SAFEGUARDING FILES AS ABOVE. DIVIDERS INDICATE IN PAPER RECORDS THAT THERE IS ELECTRONIC SAFEGUARDING INFORMATION. Dividers being printed.
		1.16 - CQC					
	FM	Ensure that midwives have 1:1 supervision to allow opportunity for case scrutiny and challenge.	Recommendation	**1.** Develop current Safeguarding Children Supervision Policy to include the requirement for all caseload holders to have 1:1 face to face supervision with a member of the Safeguarding Children's Team following an unborn/child becoming subject to a CPP. **2.** Develop a process for sharing the updated policy with staff.	**1.** July 2017 **2.** July 2017	Head of Midwifery / Named Nurse / Named Midwife	COMPLETE - RATIFIED AND DISSEMINATED. 1. To be updated. 2. Staff informed of process by Email
		1.17 - CQC					
	FM	Ensure progress to link the organisation with the CP-IS project in accordance with national NHS contract, including accessing support from designated nurses to ensure the project moves forward.	Recommendation	Agree a clear timetable for implementation of CP-IS between the Trust and NHS CP-IS Project Lead.	August 2017	Head of SNS / Named Nurse	COMPLETE - FURTHER DEVELOPMENTS HAVE BEEN MADE SO THAT EVIDENCE CAN BE GATHERED OF COMPLIANCE WITH CP-IS. Go live date of Jan 2018
	JG	Staff accurately record safeguarding concerns and processes.		Develop a record keeping Bitesize training package	Dec 2018	Named Nurse for Safeguarding Childrer	
	FM / JG	Appropriate new starters to YTHFT will receive safeguarding perceptorship pack		Completion of preceptorship pack	Nov 2018	Head of Safeguarding Children / Named Nurse for Safeguarding Children	

	JG	Safeguarding Children Team have recognised standard operating procedure (SOP) for completion of safeguarding maternity assessment		Development of SOP	Dec 2018	Named Nurse for Safeguarding Children	
	JG	Staff have recognised SOP for safeguarding information chronology on CPD		Development of SOP	May 2019	Named Nurse for Safeguarding Children	We are awaiting completion of Safeguarding chronology area on CPD by SNS
	SCT	All Safeguarding Children Team to receive updated training as facilitators of reflective supervision		Staff to attend training	March 2019	SCT	
	FM	Evidence of record audit for CSAAC service		Record audit to be undertaken	Dec 2018	Head of Safeguarding Children	
	JG	Evidence of Trust wide safeguarding survey		Staff survey to be undertaken	Jan 2019	Named Nurse for Safeguarding Childrer	
	JG	YTHFT will provide information about children not brought to appointments to relevent 0-19 teams		Information Sharing Agreement to be developed and implemented.	Jan 2019	Named Nurse for Safeguarding Children	There are ongoing discussions between YTHFT and COY Healthy Child Service re sharing of information re children not being brought to appointments
	FM	YTHFT will have a robust process for the storage of pre-adoptive records which will allow for recall up to the age of 75		Task and finish group to develop SOP	June 2020	Head of Safeguarding Children	YTHFT are unable to introduce an electronic record keeping system for pre-adoptive records at this time.
	FM / JG	The future of the Safeguarding Liaison role to be decided upon		The impact of the trial Safeguarding Liaison Nurse role will be evaluated using KPI's	Dec 2018	Head of Safeguarding Children / Named Nurse for Safeguarding Children	Chief Nurse has requeted a breakdown of funding required to consider this as a substantive role.
	FM	YTHFT will have a system to identify safeguarding for 16-18 year olds admitted to adult wards		Task and Finish group to develop SOP	Jan 2019	Head of Safeguarding Children	Appropriate task and finish group to be convened.

Audit & Assurance

KEY:

OVERDUE | **UNDERWAY** | **COMPLETE**

Month	SGT Owner	Details	Aim / Intended Outcome for Children & Families	Process / Actions	Timescale	Lead Professional	Outcome / Progress
		1.6 - CQC					
	FM	Undertake regular audit and monitoring of safeguarding practice in the ED to inform frontline practice and assure leaders of quality standards. For example, audit of safeguarding aide memoirs and referrals to Children's Social Care.	Recommendation	**1.** Further develop SGC audit programme with Ed to include: • Quality of Referrals • Completion of ACHILD/ABCD • Identification and appropriate recording of safeguarding concerns. • Recording of consent. **2.** Outcomes of audits to be shared with the trust Safeguarding Children Governance Group.	**1.** August 2017 **2.** October 2017	ED Directorate Mgr / Named Nurse (JG/SC)	COMPLETE - AUDIT COMPLETED AND ACTION PLAN HAS BEEN DEVELOPED. 1. Oct 2017 - Quality of referrals still to be looked at. Ongoing dip samples for completion of ACHILD. ABCD not yet introduced - due December 2017. FM to speak with Jill Willford re ED audit to cover consent, NHS Net, counter signature.
		1.7 - CQC					
	JG	Presence of parental consent to be present on referrals. To audit.	Recommendation	Monthly audit of 10 records across site.	Monthly	Named Nurse (JG/SC)	COMPLETE - REGULAR AUDITS/DIP SAMPLES ARE COMPLETED BY THE SAFEGUARDING LIAISON NURSE TO MONITOR COMPLIANCE. As above
		1.9 - CQC					
	JG	Ensure that regular audit captures staff training need to identify whether practitioners are consistently assessing, recording and appropriately communicating risks to children and young people.	Recommendation	**1.** Schedule trust wide audit as part of audit calendar. **2.** Identify training needs through audit.	May 2018	Named Nurse / Audit Team	COMPLETE - INTRODUCTION OF SAFEGUARDING LIAISON NURSE ROLE HAS ENABLED STAFF TO RECEIVE REGULAR TRAINING RE ASSESSING, RECORDING AND APPROPRIATELY COMMUNICATING RISKS. Training programme to be developed for completion of ABCD and CSE Questions in ED. **Monthly between Jan & April 2018 and audit in April 2018.**
		1.11 - CQC					
	JM	Ensure safeguarding information is highly visible in maternity records. This will aid practitioner's timely understanding of client specific risk and key safeguarding contacts.	Recommendation	Audit to assess if process has become embedded.	September 2017	Head of Midwifery / Named Midwife (JM)	COMPLETE - PROCESS FOR RECORDING AND STORAGE OF SAFEGUARING ON AN ELECTRONIC DRIVE WAS ROLED OUT TO MIDWIFERY STAFF AND WENT LIVE 20TH AUGUST 2018. October 2017 - ? Wether red dividers are at present in the safeguarding records. Audit will be completed 3 months after introduction.
		1.13 - CQC					

	JM	Implement a standard in maternity services so that practitioners are immediately aware of which records contain the context of the risk to the child/young person. To ensure it is clear which record contains the information pertaining to the most recent management of risk for the child/young person.	Recommendation	Audit to be completed to ensure process embedded in practice.	March 2018	Head of Midwifery / Named Midwife (JM)	COMPLETE - AS ABOVE As above. Safeguarding safety plan is currently in place. T**o be audited Nov 2017.**
		1.16 - CQC					
	JM	Ensure that midwives have 1:1 supervision to allow opportunity for case scrutiny and challenge.	Recommendation	Audit compliance of post conference supervision.		Midwifery / Named Nurse / Named Midwife	COMPLETE - 1:1 SUPERVISION WAS INTRODUCED IN JUNE 2017. COMPLIANCE IS MONITORED BY SCT. In place. **Audit to be completed Oct 2017 (completed)and again Dec 2017/Jan 2018.**
	JG	Recommendations from the safeguarding maternity audit will be actioned		Develop action plan following recommendations from safeguarding maternity audit	Feb 2019	Named Nurse for Safeguarding Children	Formal report is yet to be received.
	FM	Lists of children subject to Child Protection plan will be received via a monthly list generated by City of York.		ISA to be completed	Dec 2018	Head of Safeguarding Children	FM has had further contact with counterpart in CoY, this is being considered by CoY w/c 19th November 2018. Draft ISA has been forwarded to COY Council for consultation

Response to Key National Drivers

KEY:

OVERDUE	UNDERWAY	COMPLETE

Month	SGT Owner	Details	Aim / Intended Outcome for Children & Families	Process / Actions	Timescale	Lead Professional	Outcome / Progress

Policies for Review

KEY:

OVERDUE | UNDERWAY | COMPLETE

Month	SGT Owner	Details	Aim / Intended Outcome for Children & Families	Process / Actions	Timescale	Lead Professional	Outcome / Progress
		Safeguarding Children Policy		Review of Safeguarding Children Policy due to be ratified on 28th November 2018.		Head of Safeguarding Children	
		FGM Policy		Review of FGM Policy due for ratification on 28th November 2018.		Named Nurse for Safeguarding Children	
		Supervision Policy		Review of Supervision Policy for ratification February 2019.	Feb 2019	Named Nurse for Safeguarding Children.	

Other Areas

KEY:

OVERDUE	UNDERWAY	COMPLETE

Month	SGT Owner	Details	Aim / Intended Outcome for Children & Families	Process / Actions	Timescale	Lead Professional	Outcome / Progress

YORK Inspection Date December 2016

Recommendation (reference number from final report)	Organisation	Agreed Action	Organisational Lead (Job Title)	Expected Date of Completion	Progress/Update	Progress/Update	Progress/Update	Progress/Update August 2018
1.1								
Work with the City of York Local Authority to develop effective communication pathways to universal health services to better support identification of needs, risks and follow up actions required for children and young people who attend the ED. When developed frontline practitioners across all agencies should be made aware of this new identified process.	YTHFT	**1.** Meet to explore issues and plan timetable for protocol to be devised and ratified. **2.** Implement protocol. **3.** Complete audit 3 months after introduction to ascertain effectiveness.	Head of Information Governance/ Head of Systems and Networks(SNS)/ ED Directorate Manager/ Head of Safeguarding/Representatives from City of York Council.	July 2017 October 2017 January 2018	**1.** Initial meeting planned for 28th June 2017 **2**. Multi-agency agreement finalised. Go live date 01 12 17 **3.** Systems and Networks developed template and were ready to commence on 01 12 17. Due to technical issues within COY, this was unable to proceed to time scale.	2.Information Sharing Agreement finalised with City of York Council. Information shared from 1/2/2018. 3. Audit to be completed May 2018.	**May 2018** COMPLETE	ACTION COMPLETE Information Sharing agreement in place. Daily ED Notifications are shared with City of York Healthy Child Service. City of York will inform us when they are in a position to receive Was Not Brought notifications.
1.2								
Ensure the building, facilities and assessment and treatment arrangements at the emergency department at York hospital meet the needs of children as well as the Royal College of Paediatrics and Child Health (RCPCH) standards for children and young people in emergency settings.	YTHFT	Meeting to discuss feasibility and requirements. (This will be considered in the task and finish group)	Director of Estates and Facilities	December 2017		Capital planning in progress with provisional start date of March 2018. Improvements to facilites for children and young people are included in the plans.	**May 2018** Building work to begin imminently	ACTION COMPLETE Building work is planned for ED waiting areas. A business plan has also been passed to enable children to be seen between 8am and midnight on the Child Assessment
1.3								
Develop prompts within the adult casualty cards to support practitioners in consistently identifying and safeguarding the hidden child.	YTHFT	**1.** ABCD (Adult Behaviour Child Distress) assessment to be introduced to ED. **2.** Explore the development of mandatory fields to capture information. **3.** Ensure Staff are trained in the use of ABCD.	ED Directorate Manager / Head of SNS / Head of Safeguarding	December 2017 To be determined and agreed at the first meeting of the Safeguarding Children Task & Finish Group, July 10th 2017 April 2018	Risk assessment to be embedded in Emergency Department CPD screen December 2017	1. SNS have implemented new clinical coding which better reflects safeguarding concerns. This has resulted in a daily, cross site worklist, which highlights children who have attended ED for whom staff have identified safeguaridng concerns. SNS are now working to embed ACHILD and ABCD on CPD to add to the assessment above. It is anticipated this will be completed by the end of May 2018. 2. Mandatory fields have been discounted due to technicla difficulties working through screens. 3. Once ABCD embedded into CPD training and support will be in place for staff.	**May 2018** Training will begin to be rolled out to assist staff identify hidden children this month. **June 2018** - There has been a delay due to capacity within Systems & Networks, however, following the introduction of the Safeguarding Liaison Nurse role it has become apparent that this may not be the most effective way of recording ACHILD & ABCD. Safeguarding Children Team will work with the Safeguarding Liaison Nurse to develop a safeguarding proforma which will be attached to the CAS Card.	ACTION COMPLETE An electronic safeguarding assessment has been developed and is being introduced to ED. It will encompass ABCD and ACHILD and require actions from the assessment to be recorded. Where deemed appropriate the details of the adult/child will be added to an daily electronic Safeguarding Work List which will be monitored daily by both the safeguarding adult and children teams.
1.4								

Ensure the casualty cards for children and adults are specific enough to support practitioners to consistently consider child safeguarding risks during a presentation to the ED.	YTHFT	**1.** Introduce distinct Casualty cards for Children and Adults with appropriate embedded tools. i.e. ACHILD or ABCD.	ED Directorate Manager / Head of SNS / Head of Safeguarding	To be determined and agreed at the first meeting of the Safeguarding Children Task & Finish Group, July 10th 2017 April 2018	Risk assessment to be embedded in Emergency Department CPD screen December 2017	1. SNS are currently working to embed ABCD into CPD. This will form part of the assessment of safeguarding for adults attending the department where children may be at risk. Enhanced clinical coding also enables staff to identify safeguarding concerns.	**MAY 2018** This remains a work in progress for Systems and Networks June 2018 - There has been a delay due to capacity within Systems & Networks, however, following the introduction of the Safeguarding Liaison Nurse role it has become apparent that this may not be the most effective way of recording ACHILD & ABCD. Safeguarding Children Team will work with the Safeguarding Liaison Nurse to develop a safeguarding proforma which will be attached to the CAS Card.	ACTION COMPLETE An electronic safeguarding assessment has been developed and is being introduced to ED. It will encompass ABCD and ACHILD and require actions from the assessment to be recorded. Where deemed appropriate the details of the adult/child will be added to an daily electronic Safeguarding Work List which will be monitored daily by both the safeguarding adult and children teams.

1.5								
1. Ensure all ED practitioners are aware of the ACHILD form and expectations for its use. **2.** Regular audit of its use will provide assurance that children and young people attending the ED have robust safeguarding assessments.	YTHFT	**1.** Ensure aide memoirs continue to be visible in the ED to remind staff of the use of ACHILD. **2.** Completion of ACHILD to be included in a mandatory field. **3.** Rationale for tools to aid risk assessments to be included in training packages. **4.** Monthly audits will be completed to evidence awareness and embedding of ACHILD.	ED Directorate Manager / Head of SNS	Audit presence of Aide Memoirs September 2017 April 2018 July 2017 September 2017	**4.** Monthly audits of ACHILD have been completed since December 2016. Compliance in March and April was 80%.	1. Aide memoirs visible within ED departments. 2. The use of mandatory fields is not considered appropriate. 4. Local service evaluations of ACHILD have demonstrated increased compliance. A further evaluation will be completed in May 2018. Children named on the daily worklist have their records checked for the presence of ACHILD and any ommisions actioned.	**May 2018** Service evaluation to measure compliance for ACHILD is underway. A Safeguarding Hub is being developed that will display aide memoirs and guides for staff.	ACTION COMPLETE A Safeguarding Liaison Nurse role has been developed and is currently a one year secondment in ED. Part of the role is to monitor and audit quality of safeguarding assessments, referrals and compliance with ACHILD. To date audits have been as follows: Quality of referrals; A CHILD compliance; access to CP IS; ED documentation.
1.6								
Undertake regular audit and monitoring of safeguarding practice in the ED to inform frontline practice and assure leaders of quality standards. For example, audit of safeguarding aide memoirs and referrals to children's Social Care	YTHFT	**1.** Further develop an agreed Safeguarding Children Audit Programme within ED to include: > Quality of Referrals > Completion of ACHILD / ABCD > Identification and appropriate recording of safeguarding concerns > Recording of consent > Outcomes of audits will be shared via the trust Safeguarding Children Governance Group.	Manager / Head of Safeguarding	July & October 2017	Audit team are currently completing safeguarding audit of Emergency Department records	1. The draft report for the audit completed by the Internal Audit team has been shared with the Named Nurse and is being finalised. This will then be shared with the Chief Nurse and be presented to the Safeguarding Operational group in April 2018.	**May 2018** Internal audit report has been shared with governance group and Designated Nurse. An action plan has been developed to address recommendations.COMPLETED	ACTION COMPLETE A Safeguarding Liaison Nurse role has been developed and is currently a one year secondment in ED. Part of the role is to monitor and audit quality of safeguarding assessments, referrals and compliance with ACHILD. All referrals are reviewed and feedback given to practitioners.The Safeguarding Liaison Nurse
1.7								
Ensure practitioners in the ED obtain and record parental consent to refer to children's social care unless this could increase the risk of harm to the child. This is in order to support engagement with subsequent interventions	YTHFT	**1.** SCT to continue to deliver the "Referral and Assessment" package as part of statutory and mandatory training. **2.** Posters informing staff re need for consent to be displayed in Emergency Department. **3.** Presence of consent to be included in referral audit.	ED Directorate Manager / Head of Safeguarding	**1.** Immediately **2.** October 2017 **3.** October 2017	Consent poster went to Safeguarding Children Governance Board 17 October 2017. Agreed to make further changes and share with Social Care.	2. The 'Consent' poster has been shared with COY Children's Social Care and the Multi-Agency Screening team for North Yorkshire Children's Social Care and will be shared with the Safeguardiong Operational Group IN April 2018.	1. Completed. 2. Completed. 3. Completed.	ACTION COMPLETE A Consent poster was developed and shared with multi agency partners for comment. The poster is displayed in ED. The Safeguarding Liaison Nurse monitors all referrals and delivers feedback and where appropriate training to individual practitioners.
1.8								
Ensure that professionals are aware of the policy and national learning that supports the use and reasons for using electronic tags on babies on the maternity ward.	YTHFT	**1.** Organisational guidelines to be reviewed and updated. **2.** SCT to develop & distribute a One Minute Guide to inform staff re guidelines. **3.** Guidelines and rationale to be included in training for new starters to the trust.	Head of Risk / Head of Midwifery / Head of Safeguarding / Named Midwife	**1.** End July 2017 **2.** August 2017 **3.** End July 2017	1,2,& 3 completed	3. The training package for new starters is currently in its second draft. It is envisaged it will be launched in June 2018.		ACTION COMPLETE One Minute Guide distributed. Training package shared with City of York colleagues. First session of new starter training cancelled due to only 7
1.9								

Ensure that regular audit captures staff training need to identify whether practitioners are consistently assessing, recording and appropriately communicating risks to children and young people.	YTHFT	**1.** SCT to schedule trust wide records audit as part of audit calendar. Training needs identified through audit to be addressed through a) Training and b) Written feedback. **3.** Explore the development of mandatory electronic fields in CPD to aid staff in the consistent reporting of risks to children.	**2.** ED Directorate Manager / Child Health Directorate Manager / Head of Midwifery / Head of Systems & Networks / Head of Safeguarding / Named Nurse	**1.** July 2017 **2.** October 2017 **3.** April 2018	1.Trust wide audit has yet to be commenced. Training needs identified through audit will be incorporated into training packages for 2018/19.CPD fields go live December 17. Inpatient audit completed December 2017	1. The audit has been completed by the Internal audit team and the darft report shared with the Named Nurse. The report is being finalised before being shared with the Chief Nurse and Safeguarding Operational group in April 2018.	Completed.	ACTION COMPLETE Audit was completed by Audit team for ED. An action plan was developed following this. Ongoing, the Safeguarding Liaison Nurse is dip sampling on a frequent basis.

1.10								
Complete an audit of communication from ED to universal health services to provide assurance as to when these services are being notified of children and young people's attendances at the ED.	YTHFT	Complete an audit of communication between ED and Primary Care to include time delay between attendance at ED and date information is shared with Primary Care.	ED Directorate Manager / Head of Systems & Networks	December 2017	1.Following implementation of Multi - Agency Information Sharing Arrangement in December 2017. YTHFT will audit April2018	1. Audit to be completed May 2018 following introduction of information sharing with City of York Healthy Child Service on 1/2/2018.	Completed.	ACTION OUTSTANDING
1.11								
Ensure safeguarding information is highly visible in maternity records. This will aid practitioner's timely understanding of client specific risk and key safeguarding contacts.	YTHFT	An audit will be completed to assess whether this process has become embedded	Head of Midwifery / Named Midwife	September 2017	A Safeguarding Safety Plan was introduced that demonstrates a succinct plan with all relevant contact numbers, details of any Child Protection plans and court orders.	There is robust compliance with the Safeguarding safety plans. The safeguarding Children team have also introduced a new system to monitor that appropriate actions have been completed for all unborn babies where there are safeguaridng concerns to ensure that midwives have the relevant infomration needed to protect the unborn baby.		ACTION COMPLETE The use of a Safeguarding Safety Plan has become established. A divider was introduced to contain all maternity safeguarding information with a printed SOP.Since this time we have developed an electronic record keeping system that ensures that safeguarding information is readily available for both hospital and community midwifery staff.
1.12								
Ensure that safeguarding discussions and plans are recorded and added to maternal records contemporaneously so that all maternity staff are aware of the most up to date information to safeguard a child.	YTHFT	**1.** Develop a single point of contact mailbox so that records can be updated and filed during current/next working day. **2.** Explore the development of a Safeguarding section on CPD which can have safeguarding discussions captured in real time. **3.** Explore the use of mobile devices for community midwifery staff who are unable to access records.	Head of Midwifery / Named Midwife / Head of Systems & Networks	**1.** September 2017 **2.** April 2018 **3.** September 2017	All Community Teams have a securee generic mailbox 2.Safeguarding section available on CPD from January 2018	1. A working group is being established to develop a standard operating procedure for storing and sharing of maternity safeguarding documentation. Provisional completion date of July 2018. 2. This remains under development. 3. There are currently no plans to use mobile devices. We are exploring the use of a shared drive for maternity and the safeguarding children team.	June 2018 - 1 & 3. work continues to develop on a shared drive. 2. Due to delays in Systems and Networks being able to complete this work, no timescale is currently available for completion of this work. Aug 2018 An electronic drive has been developed to facilitate the storageof and access to Cause for Concern, Maternal Wellbeing and safeguarding information. This will go live on 20 August 2018	ACTION COMPLETE An electronic record keeping drive has been developed for use by all midwifery staff. Safeguarding staff will also have access so that safeguarding information can be clearly visible in a timely manner. This will go live on 20 August 2018
1.13								
Implement a standard in maternity services so that practitioners are immediately aware of which records contain the context of the risk to the child or young person. This is so that it is clear which record contains the information pertaining to the most recent management of risk for the child or young person.	YTHFT	**1.** Standard operating procedure to be developed for storage of maternity safeguarding information. **2.** Process to be shared with new and existing relevant staff. **3.** Audit to be completed to ensure process embedded in practice.	Head of Midwifery / Named Midwife / Head of Safeguarding	**1.** September 2017 **2.** September 2017 **3.** March 2018	**1 Filing cards with printed SOP purchased & distributed to all areas.2Staff informed by email 3. Yet to be actioned**	3. Audit to be completed ias part of wider matenrity audit in 2018.	Completed.	ACTION COMPLETE The use of a Safeguarding Safety Plan has become established. A divider was introduced to contain all maternity safeguarding information with a printed SOP.Since this time we
1.14								
Ensure that in the absence of being able to recruit permanent paediatric nurses, adult trained nurses have access to paediatric specific courses so that they can confidently contribute to work with children and young people.	YTHFT	**1.** A task and finish group will identify which chouses should be completed in order of priority. **2.** The trust will explore the development of a Paediatric and Safeguarding Liaison Nurse.	ED Directorate Manager / Child Health Directorate Manager	**1.** September 2017 **2.** September 2017	1 Paediatric and Critical Care Nurse Educator facilitates study days in which adult trained nurses are equipped to assist with stabilising the critically ill child, including recognition of sick child.	2. A Safeguarding liasion nurse has been appointed for York Emergency Department. KPI's to be developed for this role.	FM to complete	ACTION COMPLETE Paediatric Educator role has provided training for ED nursing staff. Ongoing there will be a 12 month focus on child mental health training
1.15								

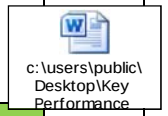
Ensure agency staff receive an appropriate introduction to safeguarding systems at York hospital.	YTHFT	**1.** Develop clearly visible key safeguarding information for agency staff. **2.** Develop process which identifies named member of staff to be first point of contact re safeguarding issues for agency staff. **3.** Audit process to ensure compliance.	ED Directorate Manager / Head of Workforce Development	**1.** October 2017 **2.** October 2017 **3.** April 2018	Standard Operating Procedure is in draft form October 2017	1 and 2). A profroma has been developed and amended and will be reviewed at the safeguarding Operational group in April 2018 prior to sign off. 3. Audit to be completed three months post implementation.	June 2018 - 1 & 2. Devised proforma not deemed to be practical for staff. Following discussion at Operational Governance Group, this will be addressed further.	OUTSTANDING ACTION We are planning to develop a One Minute safeguarding guide to aid agency and bank staff who may be unfamiliar with the trust processes. We are also planning to introduce "Safeguarding Champions" It is planned that eventually there will be at least one Safeguarding Champion
1.16								
Ensure that midwives have 1-1 supervision to allow opportunity for case scrutiny and challenge.	YTHFT	**1.** Develop the current Child Protection Supervision Policy to include the requirement for all caseload holders to have 1:1 face to face supervision with a member of the Safeguarding Children Team following an unborn/child becoming subject to a Child Protection Plan. **2.** Develop a process for the sharing updated policy with staff. **3.** Audit compliance of post conference supervision.	Head of Safeguarding / Head of Midwifery / Named Midwife / Named Nurse	**1.** July 2017 **2.** July 2017 **3.** October 2017	1.Policy Insert drafted for Policy update.2 Staff informed by email & follwed up when 1:1 supervison required. .3.Completed	Completed		ACTION COMPLETE 1:1 supervision was established for all caseload holders following a child or unborn becoming subject to a child protection plan. The Supervison policy has been updated to reflect changes
1.17								
Ensure progress to link the organisation with the CP-IS project in accordance with national NHS contract, including accessing support from designated nurses to ensure the project moves forward.	YTHFT	Agree a clear timetable for implementation of CP-IS between the Trust and NHS CP-IS Project Lead.	Head of Systems & Networks / Head of Safeguarding	August 2017	Meeting planned for 20th June 2017 YTHFT have a go-live date of 01 January 2018 and continue to work closely with NHS-e		**COMPLETE**	ACTION COMPLETE We are live with CP-IS. We are now developing a process for audit and documentation that enables staff to record outcome consistently

NORTH YORKSHIRE Inspection Date February 2017

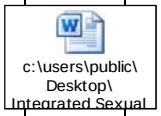
Recommendation (reference number from final report)	Expected Date of Completion	Progress/Update	Progress/Update	Progress/Update	Progress/Update August 2018	Supporting Evidence
3.1						
Develop the approach and documentation for assessing risk in the Scarborough maternity service to ensure any additional needs of the woman and the unborn child are more clearly understood, including making and recording the routine enquiry into the risks of domestic abuse throughout a woman's episode of care.	**1.** October 2017 **2.** March 2018 **3.** September 2017 **4.** March 2018	**January 2018 - 1. Completed 2. Not yet actioned 3. Completed** - See breifcase. September 2017 and Midwives reminded of their responsibility by email 02/10/207 by CMW Mananger (email filed as evidence)4. Not yet actioned	**April 2018** - work has been commenced to develop a trustwide maternity holistic assessment.		ACTION COMPLETE Holistic Assessment has been developed and shared with multi agency partners. Training has been given to community midwives. An electronic record keeping system goes live on 20 August. This will allow midwives to store cause for concerns, maternal well- being forms and will enable the safeguarding team to record any analysis of risk.	c:\users\public\ Desktop\Maternity Holistic Assessment
3.2						
Ensure that details of the reason for a child's attendance at Scarborough ED and the identity of the person who attends with them are recorded at the point of booking in	**1.** January 2018 **2.** April 2018	Lead Nurse for Safeguarding Children has met with SNS to begin CPD development.	**April 2018** - The new coding system is now in place. A daily report is prepared and currently compliance is 100%.		ACTION COMPLETE A Safeguarding Liaison Nurse has been appointed. As part role regular audits and dip samples are completed to monitor information captured and provide training where	c:\users\public\ Desktop\Key Performance
3.3						

Strengthen the arrangements in the ED to enable all children and young people to wait in a welcoming and child friendly environment that is also observable by staff.	**1.** April 2018 **2.** September 2017	**2. Completed**	**April 2018** - There is a plan for major refurbishment to ED in 2018/19. Building plans are being reviewed at the end of this month.		ACTION COMPLETE Although building work remains part of the longer term plan, in the interim the waiting area has been enhanced to provide a sensory area to better meet the needs of children with learning	
3.4						
Procure paediatric scales for use in the ED in Scarborough hospital.	September 2017	**Completed**			ACTION COMPLETE Scales were purchased.	
3.5						
Ensure that maternity services for Scarborough are adequately resourced to provide specialist support where required to women with additional needs such as those with mental health needs, substance misuse issues or teenaged mothers.	**1.** April 2018 **2.** April 2018 **3.** April 2018	**January 2018** - **1.** We are awaiting an outcome of a bid to fund a Perinatal Mental Health Midwife. **2.** The training package is being developed. **3.** The bid process is ongoing.	**April 2018** - no new update.		ACTION OUTSTANDING The bid was successful for a Perinatal Mental Health Midwife. Tees ESK andWear Valley will develop a specialist perinatal team for the Community Mental Health Team. Midwifery staff working closely with the substance misuse team. The current pathway is being reviewed and	

3.6						
Implement processes for assessing risk and identifying additional needs during the transfer of young people aged 16 and over who self-harm to adult wards in the same way as is the case for young people under that age who transfer to the paediatric ward.	**1.** September 2017 **2.** December 2017	**1. Completed**	**April 2018** - 3. Audit has been completed. Has yet to be written up.	**June 2018** - A review of current admission proforma for 16-18 year olds admitted to an adult ward is underway.	ACTION COMPLETE All children aged 16-18 are now admitted to paediatric ward and therefore additional needs are routinely identified. If for any reason admission to an adult ward is deemed necessary, a Safeguarding Safety plan is	
3.7						
Ensure Scarborough maternity records contain the notes of all child protection processes, including core group meeting records, to help inform birth planning.	**1.** September 2017 **2.** September 2017 **3.** March 2018	**1. Completed** -Following discussion regarding practical implications of sensitive information being available on CPD, decision made that when Core Groups Minutes received they will be filed into maternity record. **2.Completed**	**April 2018** - **3.** Audit has been postponed to May 2018 due to staff capacity.	**June 2018** - **3.** Audit will form part of wider maternity records audit.	ACTION COMPLETE An electronic x drive has been set up so that midwifery and safeguarding can access this. All safeguarding information/records and assessments will be stored here. This is live from 20 August 2018.	
3.8		2				
Provide adequate cover for the absence of the safeguarding nurse to ensure that referrals to Children's Social Care made by Scarborough Hospital staff are reviewed for the duration of the pilot programme set up for this purpose	March 2017	**Completed**			ACTION COMPLETE Trial ended April 2017. A Safeguarding Liaison Nurse is now in post at SGH.	
3.9						



Implement processes to enable the integrated sexual health team to effectively contribute to child protection conferences and the work derived from resulting plans.	**1.** December 2017 **2.** January 2018 **3.** September 2017 **4.** April 2018	**January 2018 -** **1.** A pathway has been developed and will be considered by the Safeguarding Governanc eGroup in February 2018. **2.** This has yet to be completed due to staffing capacity. It is anticipated it will now be completed by April 2018. **3.** Work has begun with Safeguarding Children Team and Sexual Health Team.The team are receiving team supervision. A member of the team has attended an ICPC and received 1:1 supervision	**April 2018 -** **2.** Training package yet to be commenced. **4.** Compliance currently 100%.	**Complete**	ACTION COMPLETE The Sexual Health Team recive supervision 3 x per year.A process has been put in place that ensures that safeguarding information is checked for new children/young people as appropriate.	
3.10						
Review the levels of knowledge and understanding of staff in the Sexual Clinical Outreach Team in relation to identification of safeguarding risks and the extent of front line oversight of safeguarding practice.	**1.** October 2017 **2.** December 2017	All staff are compliant with level 3 training	**Completed**		ACTION COMPLETE All staff in the team are compliant with level 3 training and were 100% compliant with reflective supervision at end of 2018/19	



3.11						
Ensure the trust's safeguarding roles have adequate capacity to effectively guide and monitor the work of staff.	January 2018	**January 2018 -** Staffing resource has increased since inspection. - Due to a resignation we are in a position to advertise a post as a Named Midwife/Nurse. This is currently going through Agenda for Change band matching ahead of advertising. - We are awaiting confirmation that we have secured funding to appoint on 0.5 Safeguarding Liaison Nurse for the ED to be managed by the Safeguarding Children Team (SCT). - We have an advert out for an expression of interest in a brief secondment for a band 5 midwife into the SCT. - We are also in consultation with the Child Health Directorate Manager re the development of a rotational post for 2 x band 6 paediatric nurses into the SCT.	**April 2018 -** - It is anticipated that the secondment for the Safeguarding Liaison Nurse for York ED will commence week beginning 09/10/2018. - The 0.5 vacancy in Scarborough has been passed by vacancy control. - The secondment into the SCT from Midwifery is going well. - The vacant position of Named Midwife will be advertised imminently.		ACTION COMPLETE A Named Nurse has been appointed for Scarborough and a vacancy for a Named Midwife will be advertised imminently.	

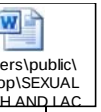
3.12						
Ensure the ED is resourced at all times with sufficient paediatric trained nursing staff in accordance with the relevant guidance on children and young people in urgent care settings.	September 2017	Completed	**April 2018 -** - YTHFT does not feel that we have sufficiently robust evidence to regard this as complete. We will ensure that arrangements are transparent and report at next review. August 2018. - Adult nurses have received training from our paediatric Clinical Educator.		ACTION COMPLETE YTHFT have recruited a paediatric trained nurse as a Safeguarding Liaison Nurse. The Paediatric Nurse Educator works closely with their ED counterpart to monitor compliance with basic and advanced life support techniques.	
3.13						
Develop the new electronic patient records system in the ED at Scarborough so that it both enables audits of key safeguarding activity and supports staff to effectively identify risks to children.	**1.** January 2018 **2.** January 2018 **3.** April 2018	**1.** Lead Nurse for Safeguarding Children has met with SNS begin CPD development **2.** A prototype of the risk assessment has been sent to SNS	**April 2018 -** It is anticipated that the risk assessments for ACHILD and ABCD will become electronic from May 2018. The audit will be completed 3 months after introduction.	**June 2018** - There has been a delay due to capacity within Systems & Networks, however, following the introduction of the Safeguarding Liaison Nurse role it has become apparent that this may not be the most effective way of recording ACHILD & ABCD. Safeguarding Children Team will work with the Safeguarding Liaison Nurse to develop a safeguarding proforma which will be attached to the CAS Card.	ACTION COMPLETE An electronic safeguarding assessment has been developed and is being introduced to ED. It will encompass ABCD and ACHILD and require actions from the assessment to be recorded. Where deemed appropriate the details of the adult/child will be added to an daily electronic Safeguarding Work List which will be monitored daily by both the safeguarding adult and children teams.	
3.14						

Develop the electronic client records system in the sexual health service so that it enables staff to record the child's journey and the activity of partner agencies and so that audits can be effectively carried out.	April 2018	Meetings are scheduled to discuss importing Sexual Health information on CPD	**April 2018** - Discussions continue to take place as to how this should best be progressed. This remains on Systems and Networks work list.		ACTION COMPLETE A Safeguarding area is to be added to the clinical desktop of CPD. This will enable a chronology to be seen by authorised staff of multi agency safeguarding events.	
3.15						
Introduce safeguarding competencies to the midwifery preceptorship programme in order to consolidate knowledge obtained from training and improve practice.	January 2018	The training package is in its 2nd draft and will be introduced to all new staff at level 3 in December 2017. **January 2018** - This package is being developed but the roll out has been postponed until April 2018 due to staff capacity.	**April 2018** - This package remains in developmental stages.		ACTION COMPLETE A new training package has been developed that focuses on both theory and practical skills. A bitesize training package has been developed to support skills in child protection report writing. A One Minute guide has also been developed to raise awareness re:Routine Enquiries	
3.16						
Ensure there is sufficient staff coverage in the ED at Scarborough to enable the abstraction of staff who require level three training.	**1.** September 2017 **2.** April 2018	The Safeguarding Children Team deliver SI training in the department. A series of bitesize training packages has been developed to facilitate easier access	**April 2018** - This has now been passed by vacancy control and will go out to advert imminately.	**June 2018** - Part of the role of the Safeguarding Liaison Nurse will be to deliver bespoke training to increase training compliance.	ACTION COMPLETE The Safeguarding Liaison Nurse role is undertaking training with staff on both sites. This will increase knowledge in a timely manner but also decrease the amount of time staff are off site for training.	
3.17						
Review the training needs analysis in respect of allied health professionals working in the ED at Scarborough to ensure their training requirement matches their role and the degree of contact with children.	September 2017	Completed			ACTION COMPLETE Training was matched with Intercollegiate document. This exercise will be repeated on publication of the new document.	

5.1						
Implement procedures and documentation that support staff to identify 'hidden children' associated with adults who attend for urgent care at Scarborough hospital.	**1.** January 2018 **2.** January 2018 **3.** April 2018	**1.** Lead Nurse for Safeguarding Children has met with SNS begin CPD development **2.** A prototype of the risk assessment has been sent to SNS	**April 2018** - Systems and Networks envisage embedding assessment electronically in May 2018.	**June 2018** - There has been a delay due to capacity within Systems & Networks, however, following the introduction of the Safeguarding Liaison Nurse role it has become apparent that this may not be the most effective way of recording ACHILD & ABCD. Safeguarding Children Team will work with the Safeguarding Liaison Nurse to develop a safeguarding proforma which will be attached to the CAS Card.	ACTION COMPLETE An electronic safeguarding assessment has been developed and is being introduced to ED. It will encompass ABCD and ACHILD and require actions from the assessment to be recorded. Where deemed appropriate the details of the adult/child will be added to an daily electronic Safeguarding Work List which will be monitored daily by both the safeguarding adult and children teams.	
5.2						
Work together to ensure that very young children under one year old with head injuries are streamed into the hospital ED to be seen by a senior clinician in line with LSCB guidance.	**1.** January 2018 **2.** March 2018 **3.** November 2017	**1.** Safeguarding Leads within Vocaire and YTHFT are meeting regularly to progress work-streams	**April 2018** - SCT continue to work closely with VOCARE. We are not aware of outcome of audit. Child Safeguarding Policy is currently being updated and will include management of head injuries in children under one.	**June 2018** - 1. Complete 2. ? 3. ?	ACTION COMPLETE We continue to have a close working relationship with VOCAIRE. If individual anomoly's occur they are addressed directly with clinician concerned. Safeguarding Liaison Nurses have a process of regularly dip	
7.1						

Work together to strengthen the peri-natal mental health offer across North Yorkshire and to develop a clear peri-natal mental health pathway for all women who are mentally unwell during and after pregnancy that accords with the relevant clinical guidance and with clearly defined outcomes.	April 2018	Work-stream begun	**April 2018** - In line with government guidance re "Better Births", Trusts are being aligned into Local Maternity Systems. For YTHFT this will be both North Yorkshire as well as Hull and Goole. Pathways are required to be universal. Our pathway, which has been developed with TEWV, cannot be used.		ACTION COMPLETE Tees Esk and Weir Valley have secured funding to provide a Pernatal Mental Health Service which will also serve women in our Trust.	
8.1						
Work together to ensure that the emergency departments and paediatric wards at Scarborough hospital and Harrogate hospital are adequately resourced with staff who are trained to assess and manage children and young people's emotional health needs and to provide adequate CAMHS guidance and support out-of-hours and at weekends.	**1.** December 2017 **2.** April 2018	Work-stream begun	**April 2018** - Joint work with CAMHS team going well.		ACTION COMPLETE Staff have access to CAMHS Crisis Team. Child Health have a one year secondment for a dual trained mental health/paediatric nurse. The remit will be to deliver training and ensure parity in mental health processes for children across sites.	

11.1						
Work together to strengthen the process that ensures young people who are new to care have their health needs assessed by a medical practitioner within the statutory timescales.		Work ongoing to more accurately capture data re timeliness of IHA's within YTHFT. Data capture to be extended to Scarborough General Hospital	April 2018 - Work is ongoing to embed a robust recording system across the Trust. Where recording has been developed it has proved to be invaluable in increasing the number of Initial Health Assessments completed within timescales and highlighting rationale for those that fall outside.	**Completed.**	ACTION COMPLETE YTHFT have embedded a robust recording system to evidence timeliness in completion of IHA's and further highlight areas that may require strengthening	c:\users\public\ Desktop\Q1 IHA data for
11.2						
Work together to ensure that paediatricians carrying out initial health assessments adopt a consistent approach to involving the child or young person in the assessment and take account of their views.	**1.** November 2017 **2.** June 2018	Training sessions have been delivered by Designated Doctor	**April 2018** - Paediatricians are trained to ensure that the child or young person's views are sought and recorded.	June 2018 - 1. Complete. 2. ?	ACTION COMPLETE Paediatricians have received training toraise awareness regarding capturing the voice of the child. IHA's are audited for quality.We are also exploring the use of tablets to complete IHA's in real time and let	
13.1						
Work together to formally introduce an information sharing protocol to ensure pregnant women are properly notified to the health visiting service by 28 weeks pregnancy.	**1.** September 2017 **2.** October 2017 **3.** March 2018	1& 2. Agreement for notification to be sent at 26 weeks between HDFT & YTHFT Leads 3. yet to be actioned		**June 2018** - 1. Complete. 2. Complete. 3. Will form part of the maternity records audit.	ACTION COMPLETE A Pathway has been agreed. This occurs following the 28 week midwifery appt.	c:\users\public\ Desktop\ante-natal integrated
13.2						
Ensure that paediatricians, health visitors, school nurses and looked after children nurses are able to identify those situations when a looked after child should be subject of a CSE risk assessment.	**1.** November 2018 **2.** November 2017 **3.** September 2017	**3.** Completed		June 2018 - 1. ? 2. Complete	ACTION COMPLETE CONSIDER prompt developed to assist staff in decision making. Spotting the Signs assessment routinely used.	c:\users\public\ Desktop\ CONSIDER Prompt
14.1						

Work together to develop the contribution of the Specialist Clinical Outreach Team (SCOT) of the sexual health service to health assessments for looked after children where they are involved.	**1.** December 2017 **2.** November 2017	Work-stream begun. Meeting planned to develop link to CPD	**April 2018** - Staff from the LAC team met with the SCOT team in march 2018 and a pathway was developed. This will require ratification. It is planned that health assessment training will be delivered by end May 2018.		ACTION COMPLETE Training delivered re Looked After Children assessments. Pathway developed between LAC and Sexual Health team	 c:\users\public\ Desktop\SEXUAL HEALTH AND LAC

Learning Lessons & Serious Cases Recommendations - Completed Actions								
Assigned Month	**SGT Owner**	**Recommendation** (Reference to which SCR/LLR/SI. I.e. Child's Initial)	**Aim / Intended Outcome for Children & Families**	**Process/Actions**	**Timescale**	**Lead Professional**	**Progress**	**System of Audit**

Other Areas - Completed Actions							
Assigned Month	SGT Owner	Details	Aim/Intended Outcome for Children & Families	Process / Actions	Timescale	Lead Professional	Outcome / Progress of Actions

Appendix 3 – Terms of Reference

Strategic Safeguarding and Looked After Children Governance Group

Terms of Reference

e to the

Introduction and Governance Structure

York Teaching Hospital Foundation Trust is committed to ensuring the highest standards of safeguarding and looked after children practice throughout the organisation. The Safeguarding Children Governance structures provide assurance to the Trust Board and multiagency partners that the trust is meeting its statutory obligations with regards to safeguarding and looked after children.

Terms of Reference

1. Status, Roles & Functions

Title: Strategic Safeguarding and Looked After Children Governance Group

Purpose: To oversee operational safeguarding within the Trust in relation to safeguarding children and looked after children.

Reports to: Quality and Safety Group

Receives Reports from: Operational Safeguarding and Looked After Children Governance Group

Chair: Chief Nurse

Vice Chair: Assistant Director of Nursing

Aims, Objectives and Duties:

- Receive feedback on issues affecting the trust from Local Safeguarding Boards including relevant performance management framework exceptions.
- Agree trust reviews carried out as part of SCR's (Serious Case Reviews), safeguarding adult reviews, domestic homicide reviews, MAPPA (Multi Agency Public Protection Arrangements) reviews or other learning reviews relevant to safeguarding.
- Review information in regards to commissioner's local quality reviews.
- Sign off any actions plans resulting from these reviews as completed.
- Preparation for and monitoring of action plans arising from CQC inspection or other inspectorates.
- Ratify trust policies in relation to safeguarding children.

- Review national guidance with relevance to the Trust in relation to safeguarding or looked after children, developing and monitoring action plans where necessary.

- Receive reports on safeguarding training compliance.
- Receive and review quarterly Local Quality Requirements (KPI's).
- Receive annual report in relation to Allegations Against Staff process (LADO).
- Receive exception reports from the Operational Safeguarding and Looked After Children Governance Group.

2. Authority

The Strategic Safeguarding and Looked After Children Governance Group have delegated authority to lead on all Child Safeguarding issues for and on behalf of the Trust.

3. Legal Requirements of the Committee

There are no specific legal requirements attached to the functioning of the Forum; however there will be an obligation to ensure that Codes and Standards of Conduct that apply to Nursing and Midwifery are maintained in accordance with the legal framework of The Nursing and Midwifery Council.

4. Membership

The membership of the Group will comprise:

- Chair: Chief Nurse
- Vice Chair: Assistant Director of Nursing
- Head of Safeguarding Children
- Named Nurse for Safeguarding Children
- Named Midwife for Safeguarding Children
- Named Doctors for Safeguarding Children – York & Scarborough
- Designated Doctor for Safeguarding & Looked After Children
- Assistant Director of Nursing for Emergency Medicine
- Head of Midwifery
- Directorate Manager Child Health
- Allied Health Professionals Senior Manager
- York Sexual Health Clinical Services Manager
- Designated Nurse for Safeguarding & Looked After Children (Vale of York CCG)

The Group will invite co-opted members as appropriate for the discussion

5. Quorum

The Group will be considered quorate with the Chair or Vice Chair, two safeguarding and two representatives from other disciplines.

6. Meeting Arrangements

The Group will meet 4 times per year.

The Head of Safeguarding/Lead Nurse will supply the secretariat service to the meeting.

The secretary/administrator will distribute an agenda and supporting papers in advance of all meeting.

The secretary will distribute notes and actions following all meetings.

The secretary will archive all agendas and supplementary papers in accordance with the Trust's requirements for the retention of documents.

When members of the forum are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary and provide a deputy (if required), the deputy does not form part of the quorate unless agreed with the Chair.

7. Reviewing and Monitoring

The secretary will maintain a register of attendance at meetings. The attendance record will be reported as part of the annual report of the Group.

The Terms of Reference will be reviewed every year or to reflect any change in statute

Author	Named Nurse/Lead for Safeguarding Children
Owner	Chief Nurse
Date of Issue	Oct 2017
Version	1
Approved by	
Review Date:	Jan 2019

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 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

Sepsis
The Quarter 2, 2018/19 CQUIN report in relation to sepsis element 2a is available in Appendix A1 and sepsis 2b element is available in Appendix A2.

Of note, improvement has been seen in screening from 88.66% in Q1 to 96% in Q2.

Treatment within one hour, in the areas audited as part of the CQUIN has also improved from 35.55% in Q1 to 41.11% in Q2.

NCEPOD
NCEPOD have recently published information on themes and recommendations common to all hospital specialties. The report will be discussed at the Clinical Effectiveness group meeting. The report can be found at: https://www.ncepod.org.uk/CommonThemes.pdf

Please note, in future reports a more detailed position on Clinical Effectiveness issues will be presented bi-monthly

Antimicrobial prescribing
Almost all areas have achieved a reduction in antimicrobial consumption. The way in which further reductions can be achieved is by paying close attention to course lengths, ensuring that patients do not receive any extra doses than they absolutely need, and that antibiotics are stopped at the 48 - 72 hour review if there is no sign of infection.

Trust wide performance against the CQUIN target of access choice of greater than 55% of the Access antibiotics.

Recommendation

Board of Directors members are asked to note the Medical Directors Report for November 2018.

Author: Mrs. Rebecca Hoskins, Deputy Director of Patient Safety

Director Sponsor: Mr. James Taylor, Medical Director

Date: November 2018

1. Introduction and Background

Patient Safety
- Sepsis
- Clinical harm reviews

Clinical Effectiveness
- New consultants to the Trust
- Update on treatment for wet age-related macular degeneration
- Clinical effectiveness group

Patient Experience
- Antibiotic prescribing audit

2. Patient Safety

2.1 Sepsis

The Quarter 2, 2018/19 CQUIN report in relation to sepsis element 2a is available in Appendix A1 and sepsis 2b element is available in Appendix A2.

Of note, improvement has been seen in screening from 88.66% in Q1 to 96% in Q2.

Treatment within one hour, in the areas audited as part of the CQUIN has also improved from 35.55% in Q1 to 41.11% in Q2.

2.2 Summary of Cancer Clinical Harm Reviews during 2017-18

Key themes identified by the Directorate Teams for 2017/18 related to; Complex patient pathways, patients choice to delay diagnostic tests or treatment, lack of diagnostic capacity and reporting within and outside the Trust, poor planning of pathways and some administrative delays particularly around typing and completion of consultant letters. There were long delays for clinical teams to complete the CHR's themselves therefore actions taken at the time were difficult to record.

In response, Directorates reported the lessons learned to include the need for; earlier surgical assessment, increase in local EBUS service to cover all hospital patients not just a single site service, increase in pathology and radiology , where to refer for specific diagnostic tests due to external delays, robust surgical cover for periods of annual leave . A number of teams reported the need to work closer with the tracking team to monitor potential breaches and review documentation to ensure the right information is recorded at the right time to avoid requests being returned as incomplete. Through a refresh of the weekly PTL meeting this has improved in 2018/19.

Focus needs to be given to those CHR's that were recorded as avoidable and action plans need to be presented to Cancer Board to monitor improvement. During 2018 a review of the process has been undertaken with the support of NHS England's Intensive Support Team, teams have improved the timeliness of completion of the CHR's a great deal in recent months. With additional focus through Cancer Board the Trust should see improvements in its understanding of the reasons for these delays, the impacts on patient care and the actions that will lead to CHR avoidance in the future.

Flowchart of the CHR process can be found in Appendix B

3. Clinical Effectiveness

3.1 Consultants new to the Trust

The following consultants joined the Trust in October:

Amaran Krishnan
Consultant Upper GI
York

Jesper Roos
Consultant Colorectal & General Laparoscopic
York

Michael Lim
Consultant Colorectal & General Laparoscopic
York

Jeanny Varghese
Consultant Diabetes & Endocrine
Scarborough

Hssein Al-Chalabi
Consultant Radiology
York

Tom Jaconelli
Consultant ED
York

3.2 Update on treatment for wet age-related macular degeneration

Novartis previously announced its intention to appeal the recent judicial review judgment on a CCG policy related to the routine use of an unlicensed medicine for the treatment of wet age-related macular degeneration on the NHS. The first step in launching an appeal of a High Court decision is to seek permission from the High Court itself. In this instance, as in most cases, the High Court has not granted permission to challenge its decision so Novartis is now seeking permission from the Court of Appeal.

The High Court judgement challenges the statutory role of the MHRA (Medicines and Healthcare products Regulatory Agency) and EMA (European Medicines Agency) in protecting public health and assuring the quality of medicines. Novartis suggest it put the financial burden faced by the NHS bodies above a patient's right to medicines which have met the MHRA and EMA regulatory requirements for efficacy safety and quality, as well as NICE cost-effectiveness hurdles.

The Trust does not routinely prescribe Avastin based upon cost at present.

The Ophthalmology Clinical Director is scheduled to discuss this further with the Chief Pharmacist regarding future prescribing.

3.3 Clinical Effectiveness Group

NCEPOD have recently published information on themes and recommendations common to all hospital specialties. The report will be discussed at the Clinical Effectiveness group meeting. The report can be found at: https://www.ncepod.org.uk/CommonThemes.pdf

Please note, in future reports a more detailed position on Clinical Effectiveness issues will be presented bi-monthly.

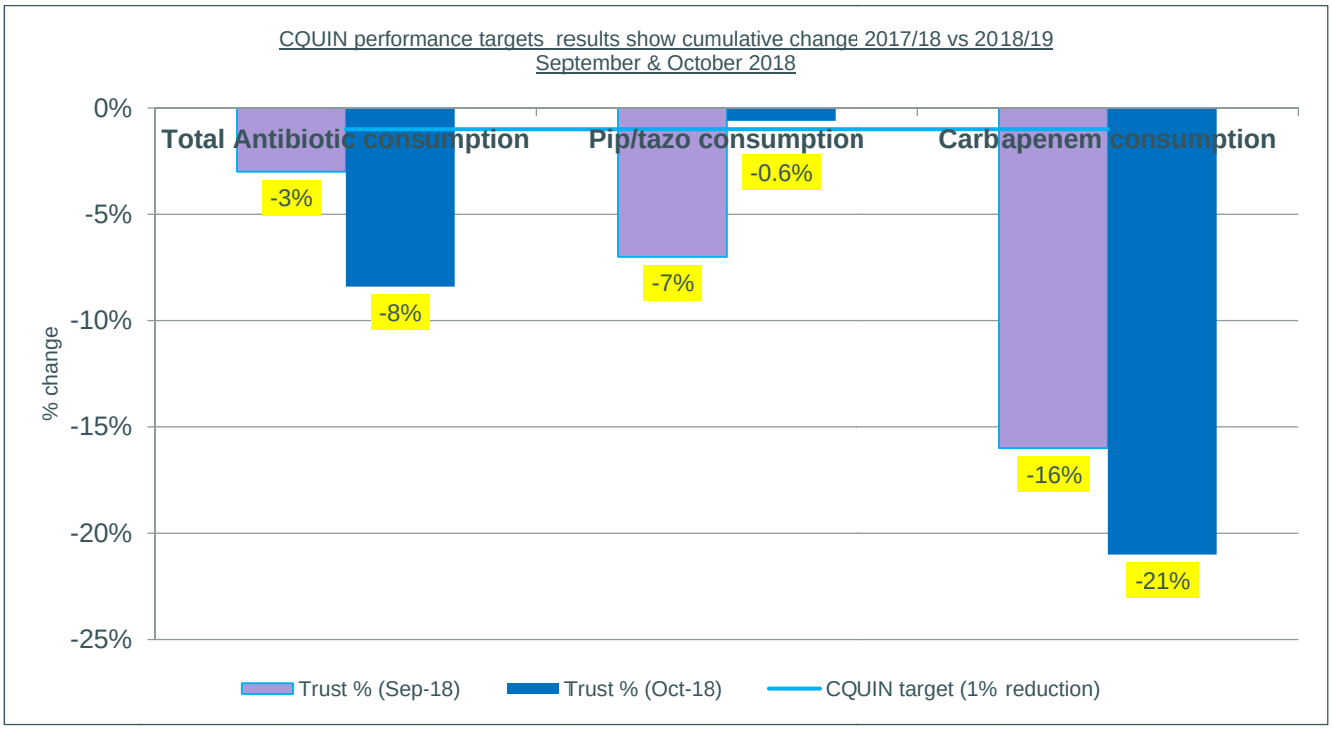
The minutes of the last Clinical Effectiveness Group meeting are available in Appendix C.

4. Patient Experience

4.1Antibiotic prescription audit results

This report details a summary of the antibiotic prescription audit that was carried out in October 2018 in addition to antibiotic consumption data for the Trust that was extracted from the Rx Info website at the beginning of November and reports on antimicrobial usage up to October 2018.
Consumption data % change of cumulative totals 2017/18 vs 2018/19 as detailing results for October 2018

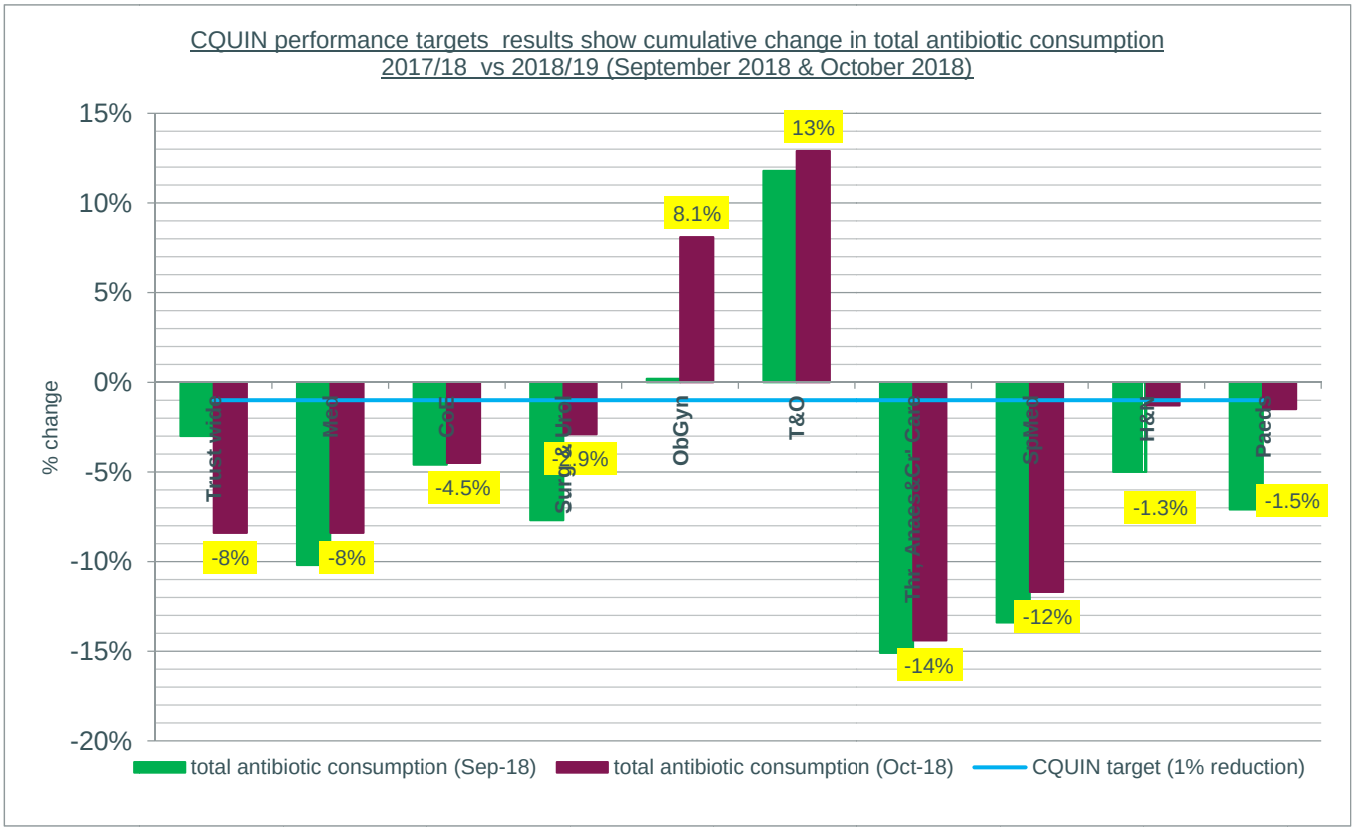
CQUIN Targets – Trust wide



Comments: The Trust pharmacy antimicrobial team continues to work closely with Clinicians and “Team Micro” to actively promote the review of all patients prescribed antibiotics to ensure that no one receives any unnecessary doses. The ARK study is also being implemented in Medicine in York and this demonstrated an increase in the numbers

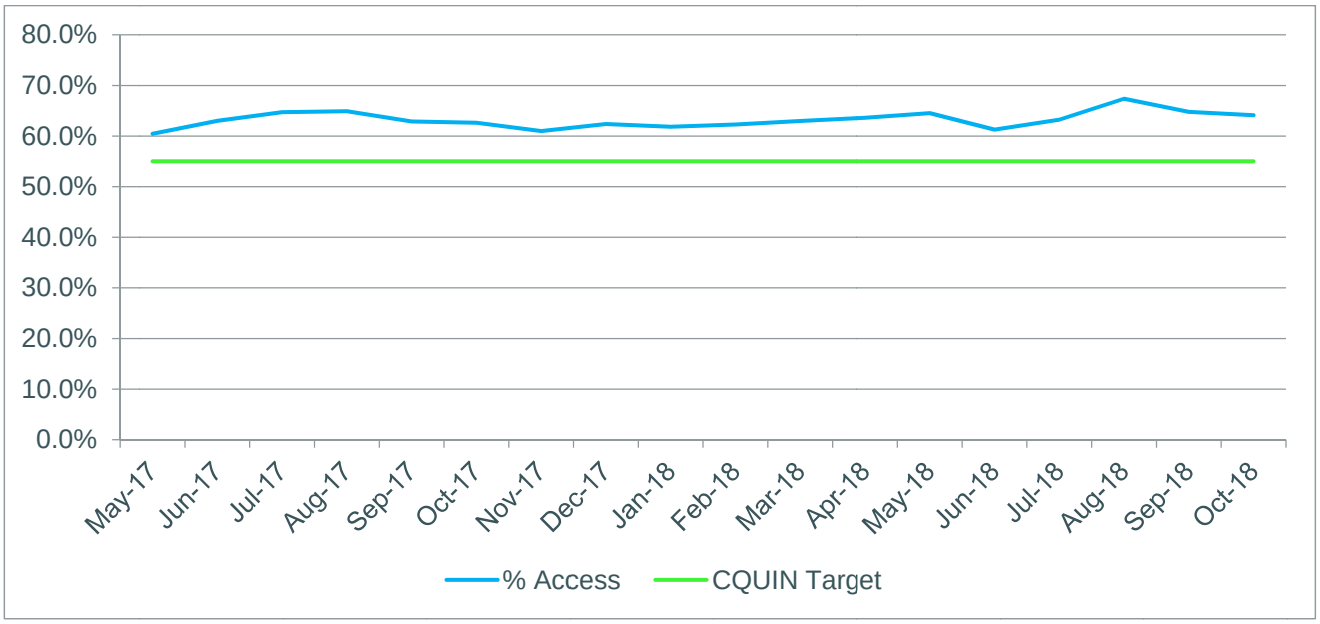
of courses of antibiotics which have been stopped. The new adult formulary has also been introduced which was designed to help reduce the volume of both Pip / taz and the total consumption of antibiotics. Both Pip taz and the carbapenem use is relatively small so that small changes result in a large percentage change. Although piperacillin/tazobactam (pip/taz) is no longer a CQUIN target, we continue to monitor its prescribing along with all other broad spectrum antibiotics because of the threat posed by antibiotic resistance.

CQUIN Targets – By Directorate



Almost all areas have achieved a reduction in antimicrobial consumption. The way in which further reductions can be achieved is by paying close attention to course lengths, ensuring that patients do not receive any extra doses than they absolutely need, and that antibiotics are stopped at the 48 - 72 hour review if there is no sign of infection.

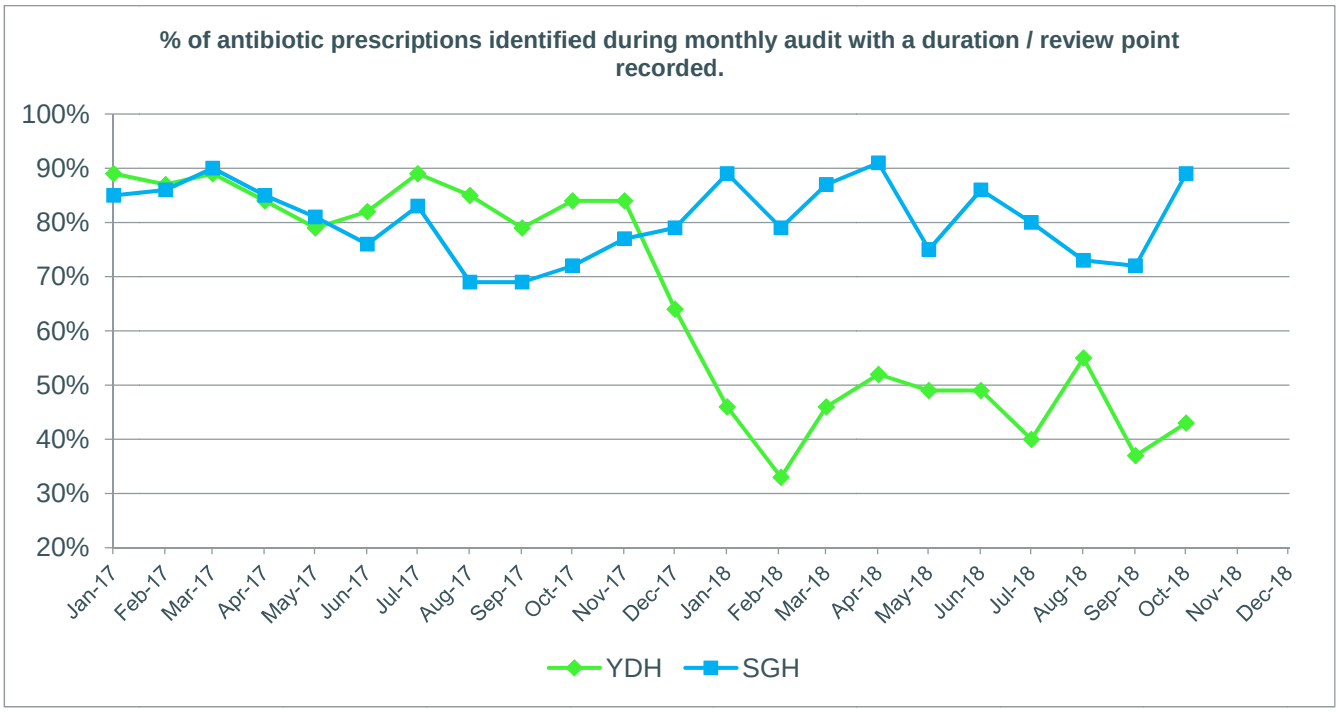
Trust wide performance against the CQUIN target of access choice of greater than 55% of the Access antibiotics.



Comments: AWaRe Essential Medicines List WHO 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 is trying to encourage the balance of antibiotics used by an organisation to be in favour of the Access list, and encourage a decreased use of Watch and Reserve antibiotics. Currently, the Trust is achieving this indicator comfortably at 64%; however there is no complacency and the antibiotic formulary is continually reviewed to ensure the appropriate recommendations are included.

Monthly Antibiotic prescription audit.

On one day each month the pharmacy team carry out a point prevalence audit of antibiotic prescribing across the Trust. This provides a snap shot of Trust prescribing against the standards of antimicrobial prescribing.
The first measure is the percentage of patients whose prescriptions include either a review date or duration of treatment. This is important as it helps to prevent patients from receiving any unnecessary doses of antibiotics. The second measure is the percentage of prescriptions which includes an indication. This is important at it focuses on the infection which the antibiotic is being used to treat. This helps to support review of the antibiotic as the patient's condition improves. The recording of indication is a mandatory field in the electronic prescribing and administration system (ePMA). This allows York to achieve 100% for this indication.



Key Indicator results for October 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	31%	42%	22%	31%	14%	33%	75%	36%
Indication recorded **YH**	99.5%	100%	98%	100%	100%	100%	100%	100%
indication recorded **SH**	100%	100%	100%	100%	NA	100%	NA	NA
duration recorded **YH**	43%	46%	47%	24%	67%	86%	56%	40%
duration recorded **SH**	89%	94%	84%	100%	NA	70%	NA	NA

Trust wide the % of patients' prescribed antimicrobials on any one day remains consistently close to the regional and national average of 30%.

ePMA was been rolled out on the Scarborough wards during October 2018 and it needs to be noted that the audit was carried out close to implementation so many of the prescriptions identified were recorded within 72 hours of prescribing (i.e. inside the automatic review point that ePMA generates). It will be interesting to see whether next

month a similar dip in the % of prescriptions with a meaningful duration recorded is seen at SH as has occurred at YH.
There was a very much appreciated level of support from YH colleagues during implementation and because of this all antimicrobial prescriptions that were transcribed from paper chart to ePMA had a meaningful duration recorded.

5. Recommendation

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

York Teaching Hospital NHS Foundation Trust

CQUIN Report – Q2 2018-19

2a: Timely identification of patients with sepsis in emergency departments and acute inpatient settings.

1. Introduction

The percentage of patients who met the criteria for sepsis screening and were screened for sepsis

The indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards.

This applies in 17/18 and 18/19.

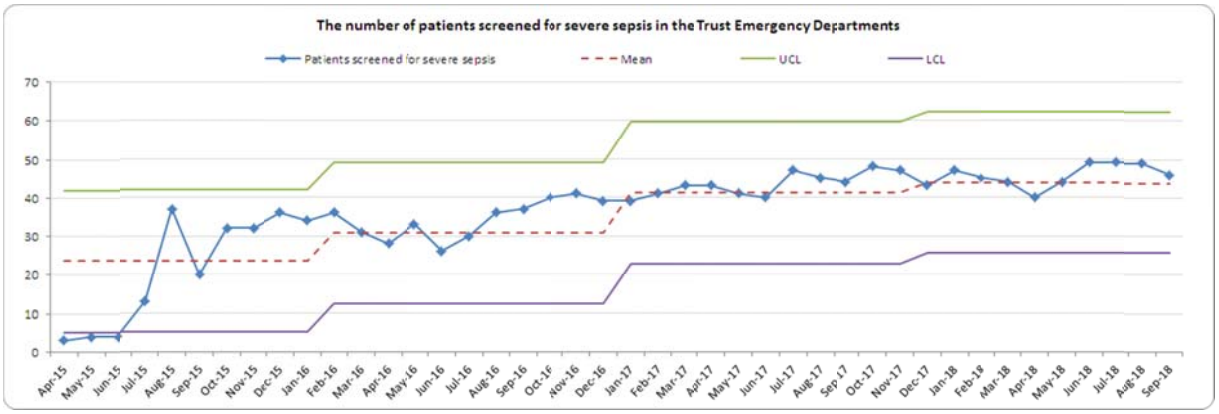
2. Q2 Milestone

Payment based on % of eligible patients (based on local protocol) screened:	
Less than 50.0%:	No payment
50.0%-89.9%:	5.0%
90.0% or above:	12.5%

3. Evidence

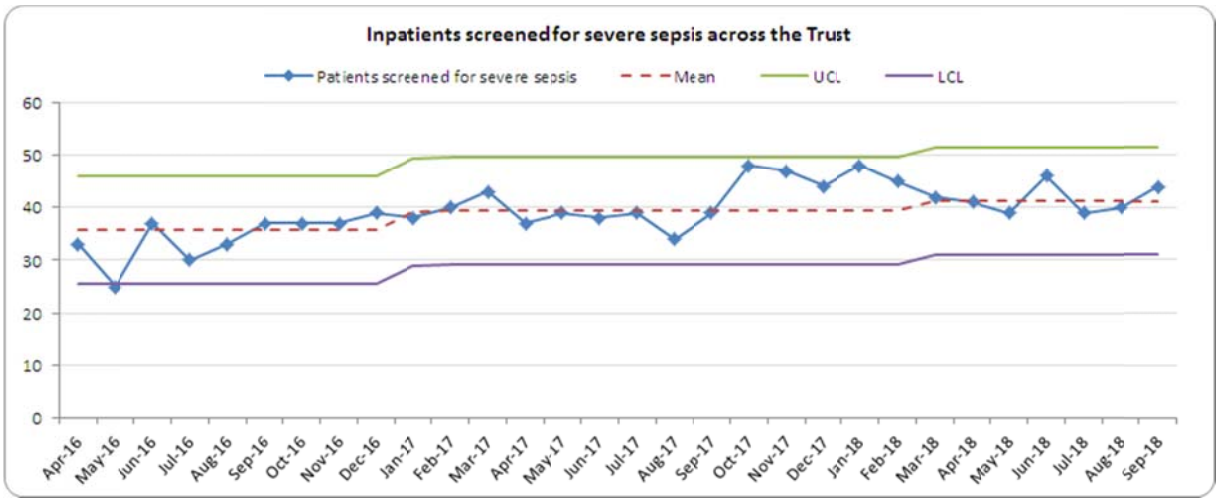
ED Screening

Quarter	Month	Number included	Number Screened	Percentage	Overall Quarter Compliance
Q1 2018/19	April 2018	50	40	80%	**88.66%**
	May 2018	50	44	88%	
	June 2018	50	49	98%	
Q2 2018/19	July 2018	50	49	98%	**96%**
	August 2018	50	49	98%	
	September 2018	50	46	92%	



Inpatient Screening

Quarter	Month	Number included	Number Screened	Percentage	Overall Quarter Compliance
Q1 2018/19	April 2018	50	41	82%	**84%**
	May 2018	50	39	78%	
	June 2018	50	46	92%	
Q2 2018/19	July 2018	50	39	78%	**82%**
	August 2018	50	40	80%	
	September 2018	50	44	88%	



4. Direct feedback to be provided to Consultants where target not met quarter on quarter and continuing to promote the use of the electronic screening tool.

York Teaching Hospital NHS Foundation Trust

CQUIN Report – Q2 2018-19

2b: Timely treatment of sepsis in emergency departments and acute inpatient settings &
2c: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

1. Introduction

2b: The percentage of patients who were found to have sepsis in sample 2a and who received IV antibiotics within 1 hour.

The indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards.

2c: Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours.

Appropriate clinical review by either:

- Infection (infectious diseases/ clinical microbiologist) senior doctor
- Infection pharmacist
- Senior member of clinical team

2. Q2 Milestone

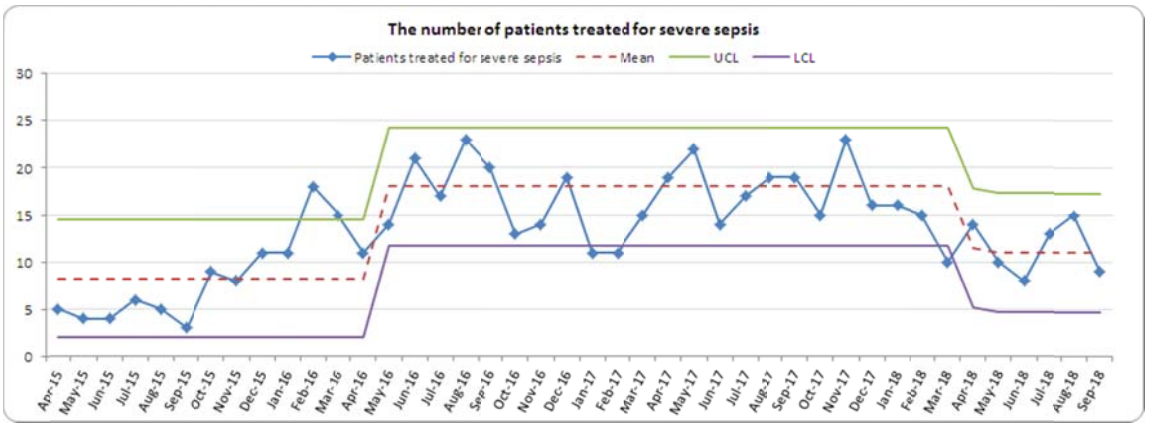
2b:
ED Achieve 90% of ED Treatment within 60 mins

Inpatients –
2c: Perform an empiric review for at least 50% of cases in the sample

3. Evidence

2b: Treatment in Q2

Quarter	Month	Number included	Number Screened	Percentage	Overall Quarter Compliance
Q1 2018/19	April 2018	30	14	46.66%	**35.55%**
	May 2018	30	10	33.33%	
	June 2018	30	8	26.66%	
Q2 2018/19	July 2018	30	13	43%	**41.11%**
	August 2018	30	15	50%	
	September 2018	30	9	30%	



2b: Inpatient: Q2 Quality Improvement

Timely Treatment in ED

- Monthly data is being shared with both Emergency Departments (time to antibiotics, blood culture contamination rates) for display for front line staff in poster form. These posters have been placed in both staffrooms and will be updated on a quarterly basis.
- Process mapping has been done in both Emergency Departments through Q2. Scarborough Hospital requires further mapping to follow patients through the main department in Q3.
- We will continue to perform a retrospective audit collecting data on the potential barriers to patients receiving antibiotics in order to identify potential themes through Q3 and 4. The data from Q2 will be discussed in local Sepsis Steering Groups and presented in the Q3 report.

York ED

- Since September 2018, staff have been encouraged, where appropriate, to take a blood gas for a lactate on arrival. These should all be taken to the Consultant in charge or requesting doctor for reviewing and acknowledgement. This aims to identify those individuals with raised lactates earlier, which may be a marker for severe sepsis.
    - The Emergency Department are to attach a poster with normal ranges of values to the blood gas machine, encouraging non-medical staff to seek urgent review of their blood gas should the values fall outside of this range.
- In October 2018, we began using A4 laminates containing the SIRS criteria to attach to the CAS cards in order to improve communication between triage and the clinical decision maker. These cards aim to highlight patients who may have sepsis and encourage timely medical review.
- A specific sepsis trolley is being introduced in November 2018 to York ED. This is a Bristol Maid Trolley, which tethers to the wall in the First Assessment triage area. The trolley will contain all that is needed for a sepsis screen as well as containing relevant antibiotics. This should lead to improved efficiency in diagnosing and managing sepsis.

CQUIN Indicator 2b: Timely treatment of sepsis in emergency departments and acute inpatient settings & 2c: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

Scarborough ED

- Time zero flags continue to be used and placed on drip stands for all patients identified as potential sepsis on admission.
- Time zero posters placed around the department to highlight to staff the importance of early antibiotics.
- In October 2018, a feedback process to staff has been instigated for cases where it is known that patients have had a significant wait for their antibiotics. This allows the team to look for common themes where improvements can be made and ensure that staff know what "good" looks like.
- There has been ongoing local education through Q2 on ensuring techniques for venepuncture and blood culture sample collection are good. OSCEs are held to ensure training has been adequate.
- The local department has ensured during Q2 that there are well organised antibiotic stock with appropriate drug monographs and compatibility charts situated in a folder in the drug room.

Prescribing

- Both Emergency Departments have an up-to-date local antibiotic formulary poster in prominent places. Additional posters are in situ in York Emergency Department as previously there were only two in the department.

Move to NEWS2

- A project lead has been established and there is a plan to move the Trust towards NEWS2 by the end of March 2019.

Blood Culture Contamination Rates (Appendix 2: July and August Data)

- Clinical nurse educators in the Emergency Departments and Acute Medical Units to ensure that staff who take blood cultures have had their practice reassessed via an OSCE.
- Rates of contamination will continue to be shared with the Emergency Departments on a regular basis.
- From Q3 we will be reporting blood culture contamination rates from all the Acute Medical Units in Scarborough and York.

Further Focussed Work

- World Sepsis Day was held on 13th September 2018 with events across the Trust
    - Micro-teaching sessions were held in both Emergency Departments, Acute Medical Units and on some of the inpatient wards across the Trust
        - It is planned to set up a working group to implement multi-disciplinary team sepsis simulations on inpatient wards
    - The Patient Safety Team visited the majority of inpatient wards in York and Scarborough hospitals promoting World Sepsis Day and

the need to identify sepsis early to achieve improved outcomes. This was done through the use of a quiz and information videos.
    - There were information stands in prominent places in York and Scarborough Hospitals, with information leaflets for staff and the public about the importance of early identification of sepsis. This was combined with an article in the “Staff Matters” magazine in September 2018.
    - One thousand laminated cards with the Trust sepsis guideline for adults were distributed across the Trust for staff to attach to their ID badges. They contain a reminder of the Sepsis 6 to aid with timely identification and treatment of sepsis.
- District Nurses Screening Tool
    - A screening tool is being piloted with a District Nurse team based in York. Feedback is awaited by the end of Q 4.
    - An electronic learning package is being written to help with the roll out of this across the District Nursing teams once the tool has been evaluated. This should be implemented by the end of Q 4.
- The Emergency Department sepsis groups continue to function and have had good staff engagement. Both meet on a roughly bimonthly basis with minutes taken at each. These meetings allow clinical staff to be involved in improvement projects in order to take “ownership” of the Sepsis targets.
- Sepsis Link Nurse Study days are being planned for March 2019, with the ultimate aim of having a Sepsis Champions Network across the Trust.

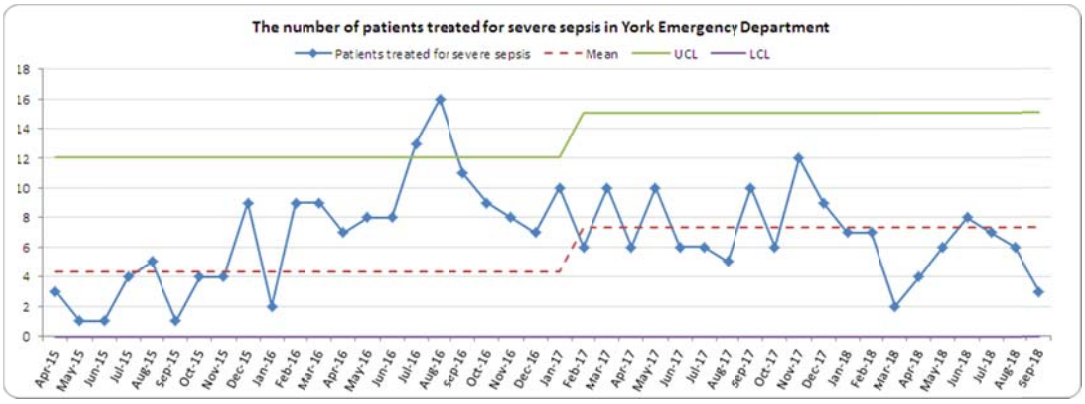
Appendix 1

Q2 Compliance rates for those patients receiving antibiotic treatment within one hour

York

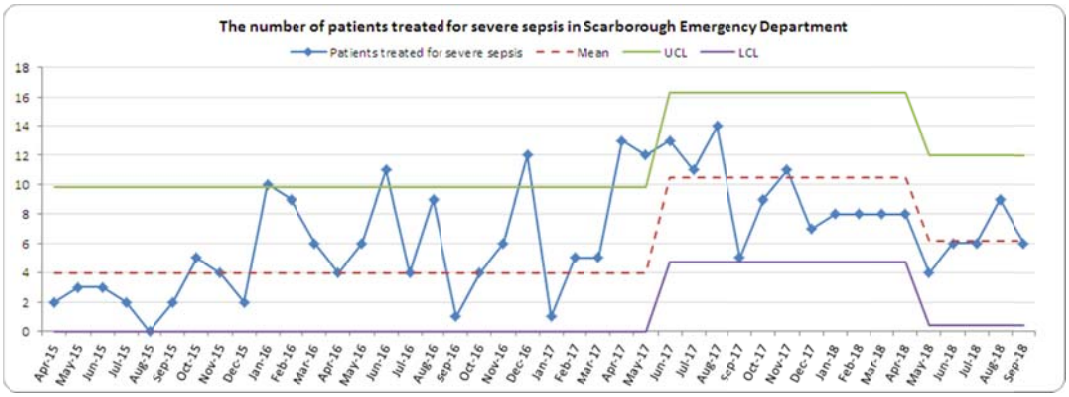
CQUIN Indicator 2b: Timely treatment of sepsis in emergency departments and acute inpatient settings & 2c: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

Quarter	Month	Number included	Number Screened	Percentage	Overall Quarter Compliance
Q1 2018/19	April 2018	12	4	33%	**39%**
	May 2018	17	6	35%	
	June 2018	17	8	47%	
Q2 2018/19	July 2018	16	7	44%	**40%**
	August 2018	13	6	46%	
	September 2018	11	3	27%	



Scarborough

Quarter	Month	Number included	Number Screened	Percentage	Overall Quarter Compliance
Q1 2018/19	April 2018	18	8	44%	**53%**
	May 2018	13	4	31%	
	June 2018	13	6	46%	
Q2 2018/19	July 2018	14	6	43%	**42%**
	August 2018	17	9	53%	
	September 2018	19	6	32%	

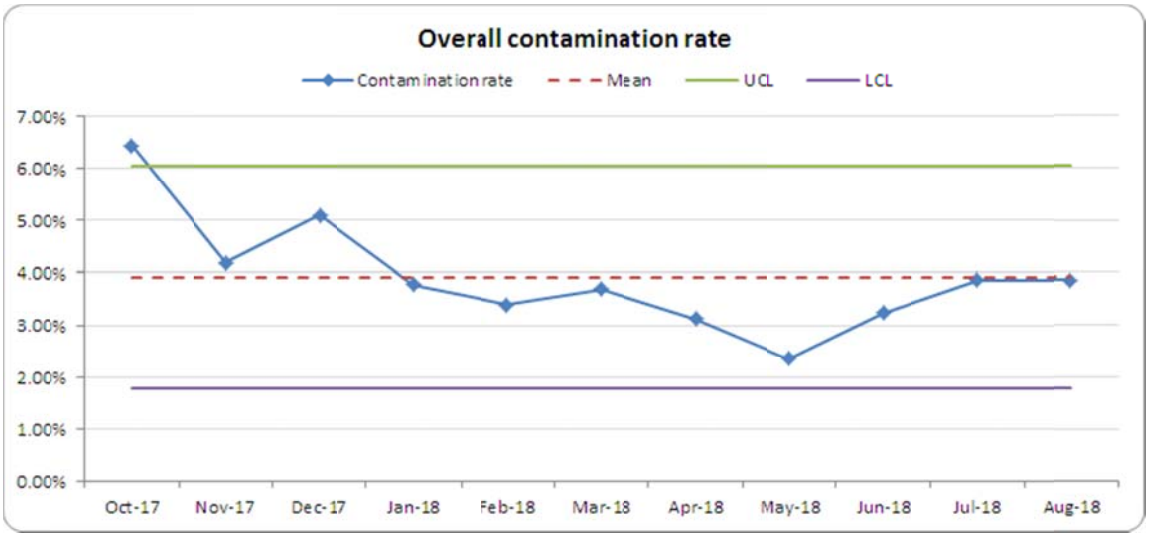


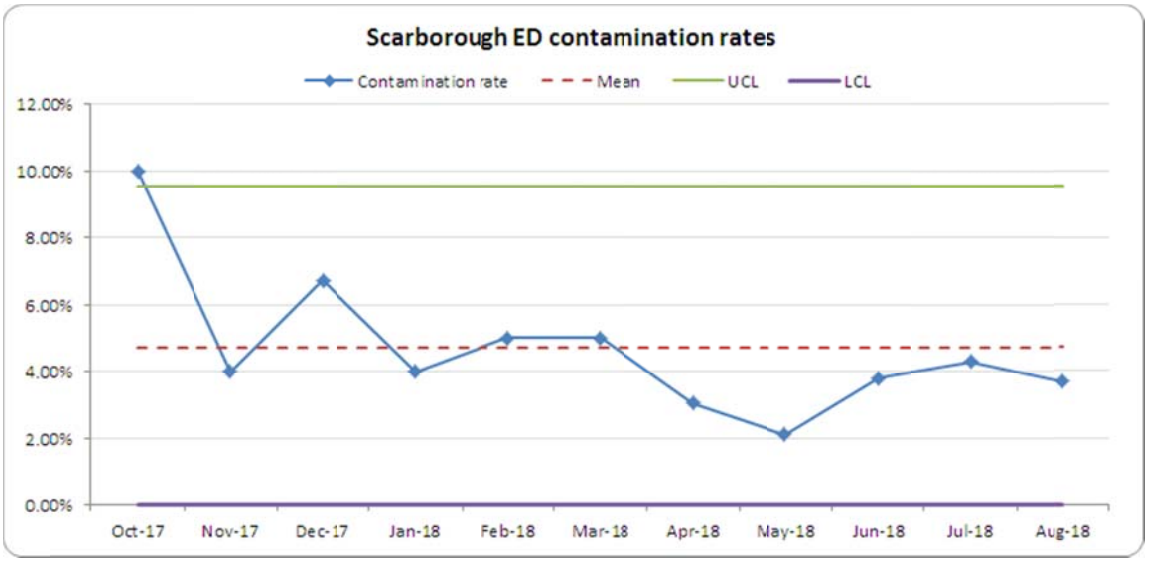
Appendix 2

Blood culture contamination rates for Q2.
Please note that due to unavailability of laboratory staff, the contamination rates for September are not available. September's contamination rates will be reported in Q3.

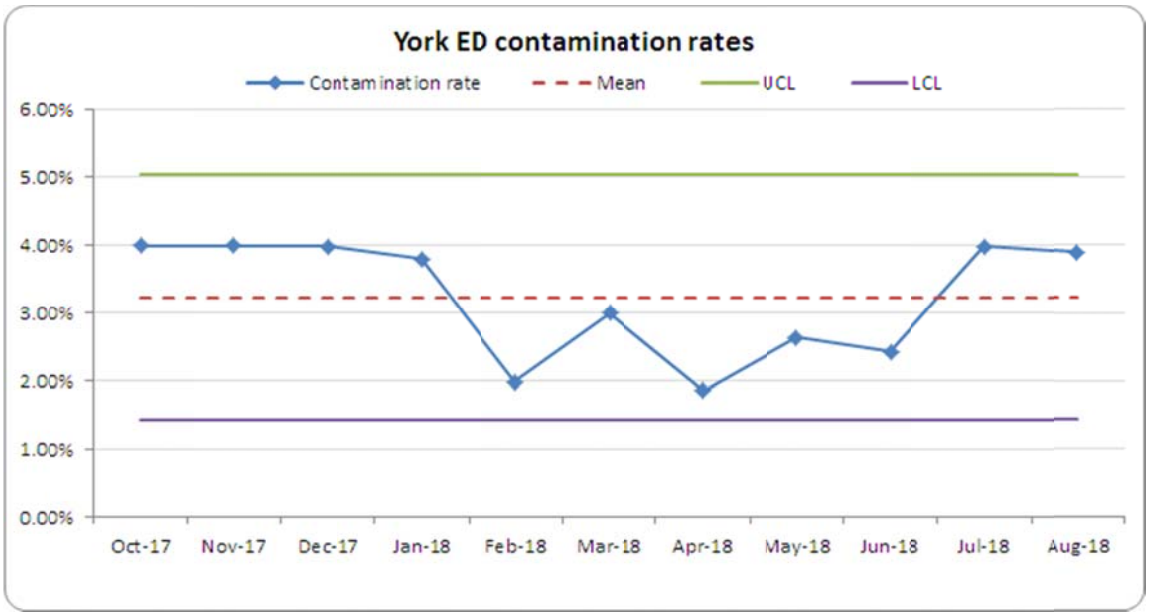
CQUIN Indicator 2b: Timely treatment of sepsis in emergency departments and acute inpatient settings & 2c: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

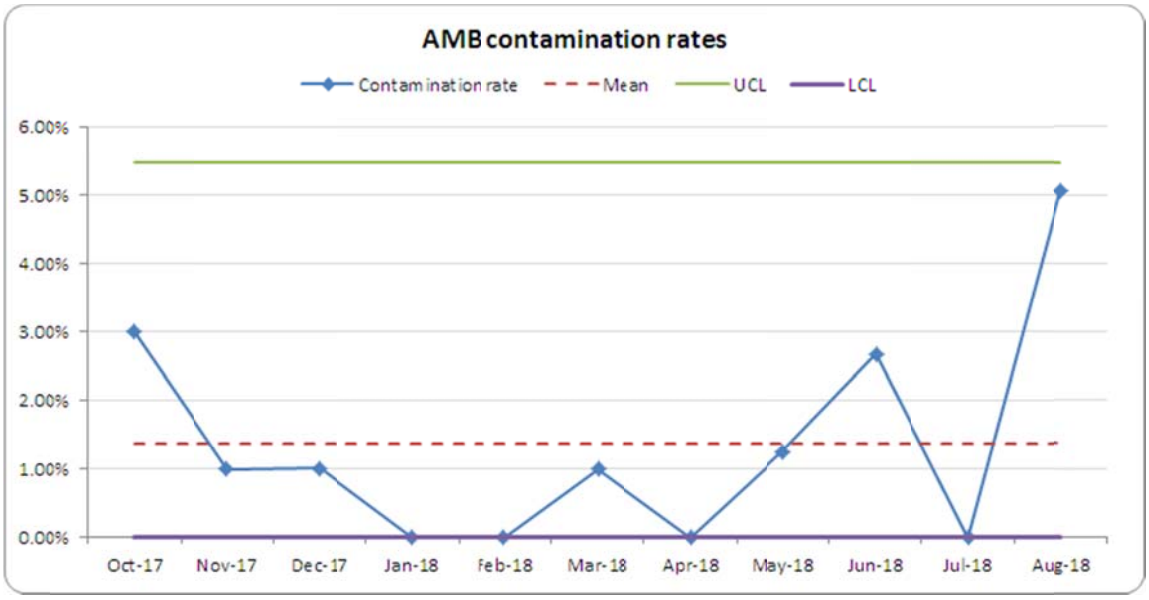
Month	Ward	Total blood cultures	Total positive blood cultures	Percentage of contaminated positive blood cultures	Overall contamination rate
July	SH - ED	626	78	(27) = 35%	4.31%
	YH - ED	402	74	(16) = 22%	3.98%
	YH - AMB	82	6	(0) = 0%	0.00%
August	SH - ED	676	93	(25) = 27%	3.70%
	YH - ED	386	56	(15) = 27%	3.89%
	YH - AMB	79	11	(4) = 36%	5.06%





CQUIN Indicator 2b: Timely treatment of sepsis in emergency departments and acute inpatient settings & 2c: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.





CQUIN Indicator 2b: Timely treatment of sepsis in emergency departments and acute inpatient settings & 2c: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

APPENDIX B

PROCESS FLOW FOR CLINICAL HARM REVIEWS (CHR) V1.7 (November 2018)

Reference : Gateway reference 04237 – Managing long waiting cancer patients – Policy on "backstop" measures. (January 2016)

The above document explained the process for managing "long waiting" cancer patients on 62 day pathways and described the 'backstop' waiting time beyond which patients should be specifically reviewed for potential harm. It advised that any cancer patient waiting 104 days or more from referral to the first definitive treatment should be reviewed in accordance with the process outlined in the document. The selection of 104 days is to align with the reporting capabilities of the Open Exeter data collection system.

The policy refers specifically to the number of days between urgent GP referral and first definitive treatment for cancer patients.

The Going Further on Cancer Waiting Times operational standards have been designed to take into account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons. For these reasons, some patients may have a recorded waiting time in excess of 62 days, which is both accurately reported and is clinically directed in the best interests of the patient concerned.

It is also recognised that a small proportion of patients will have a recorded waiting time of more than 104 days for this reason i.e. 6 weeks beyond a breach of the 62 day standard. The exact approaches to managing patients with a long waiting time, both proactively and retrospectively, require clarification so that avoidable non-clinical factors can be identified and separated from clinically appropriate management, and patient choice. Equally, providers should have effective processes in place to review such patient pathways and escalation approaches for delays which may have direct clinical significance and/or have resulted in a harm event for the delayed patient concerned.

The policy states that the process for potential clinical harm reviews is;

- Where an individual patient with a confirmed cancer diagnosis has waited over 104 days, there should be a clear, transparent process in place to identify if the extended delay has caused harm to the patient.
- Where there was a medical reason for the patient to wait for cancer treatment then there should be clear evidence that the patient pathway has been reviewed at regular intervals.
- If either a single delay or a sequence of delays can be shown to have resulted in a serious harm event for the patient concerned, or the available evidence suggests that this may have been the case, then the Trust/s where such delays occurred should follow their policy for investigating and reporting the case as a SI. It would be good practice to undertake SI-type reviews for cases of harm not considered to be 'serious' under SI definitions.
- A serious communication breakdown or administrative error in a patient pathway may also be considered as a SI. This would depend on the overall circumstances and the actual/potential consequences of the error/s concerned.
- The RCA will shape the terms of reference for the SI investigation process.
- Where an SI investigation commences the Trust must follow its escalation process through to the senior clinical lead at the relevant CCG (or other process as locally agreed).

The number of patients treated on and beyond day 104 is reported to the Trust Board through the Cancer Board report available on a monthly basis on SIGNAL.

Shared Pathways

As a number of patients care is shared across providers, a 'Principals' document has been agreed and is being tested with Hull and East Yorkshire NHS Trust. The principal is to share CHR's where patients have been treated at Hull through the Cancer Managers to enable shared learning. This is work in progress currently.

Roles and responsibilities

There are a number of key players in reviewing CHR's and RCA's, namely the Cancer Tracking team, Clinical team and Directorate Management team. All have responsibility for breach avoidance but where Cancer Breaches cannot be avoided they are the key partners in reviewing the issues that caused the delay and actions that need to be taken to avoid the same issues in the future. These roles and actions have been identified in colour on the flowchart on the following page.

Holding to account

The ultimate responsibility for delays to patients care and the resultant potential for harm rests with the Chief Executive. He devolves that responsibility through the Executive Board to the Directorate Performance and Assurance meetings and to Cancer Board for summaries and overall reporting.

Directorates have direct responsibility for the services they provide and must work with support service Directorates to ensure the best possible care for every patient.

The NHS Elective Care Intensive Support Team have supported the Trust to enhance the RCA and CHR review processes and the following process flowchart has been produced as a result.

This document has been agreed at Trust Cancer Board in April 2016 and following further review in October 2016 and October 2017 a number of elements have updated.

PROCESS FLOW DIAGRAM V 1.6 (October 2018)

Key :
CTT – Cancer Tracking Team
DMT – Directorate Management Team

Patient pathway monitored and progress reported through PTL meetings and cancer escalation processes.

First definitive treatment started on or **before day 62** of pathway.

No action required. However it is good practice for DMT to review non-breach cases to identify areas of good practice to support service improvement.

First definitive treatment started **after day 62** of pathway.

First definitive treatment started **between day 63 and 103** of pathway.

ACTION - CTT prepare **Root Cause Analysis (RCA)** timeline. Completed document saved to Q:\Cancer monitoring\Breach

First definitive treatment started on or **after day 104** of pathway.

ACTION - CTT prepare RCA timeline and ensure **Clinical Harm Review** (CHR) section available. Completed document saved to Q:\Cancer monitoring\ Breach monitoring.

TIMELINE

Within 7 days of treatment

ACTION - DMT review pathway and identify lessons learned internally and with other providers where breach is 'shared'. **DMT** record avoidable/ unavoidable reasons on RCA document and re-save to Q drive. It is good practice to involve clinical teams in this process.

ACTION - DMT review RCA\CHR with senior MDT treating clinician or Clinical Lead as agreed with team. RCA\CHR document updated and saved as above.

ACTION – DMT email the completed RCA\CHR to Cancer Board email group. **DMT** to agree and implement remedial actions, monitor key themes and report findings to PAM meetings and Cancer Board each month via report template.

Within 21 days of treatment

DELAY due to medical reason- The RCA\CHR should show clear evidence that the pathway was reviewed at regular intervals.

DELAY due to single or a sequence of delays that can be shown to have resulted or may have resulted in a serious harm event.

ACTION – follow investigation and reporting of the case as a Serious Incident (SI). Where harm not considered 'serious' it is still good practice to undertake SI type reviews.

DELAY due to serious communication breakdown or administrative error may also be considered as an SI – taking into account the overall circumstances and the actual/potential consequences of the error concerned.

ACTION – Directorate and/or Cancer Board to consider if SI appropriate in each case.

ACTION – **DMT** to review delays, issues and lessons learned and create Directorate Action Plan for issue avoidance. **DMT** to review "Duty of Candour" for patients and their families.

ACTION – **DMT** & Clinical Lead to send a report of key themes and actions taken to Cancer Board to share lessons learned. Cancer Board will be held to account by Exec Board through monthly reporting.

Within 21 to 90 days of treatment (90 days for SI's only)

ACTION – An overview of numbers and themes is shared at monthly Cancer Boards, which is attended by the GP Cancer Leads of the local CCG's, and a summary is added to the Medical Directors Report for Executive Board.

Within 90 days of treatment

York Teaching Hospital NHS Foundation Trust

Clinical Effectiveness Group Meeting Minutes

Tuesday, 02 October 2018, 16.00
Neurosciences Seminar Room, York
VC from Orchard Room, Scarborough

Attendance: Glenn Miller (GM), Claire Scotter (CS), Emma George (EG), Jane Crewe (JC), Anne Hallam (AH), Greg Quinn (GQ), Christine Foster (CF), Ang Tashi Lama (AL), Peter Standring (PS), Simon Hearn (SH) and Sheila Vass (SV)

Apologies: Fiona Jamieson and Lorraine Clennett

Minutes of meeting held on 23 July 2018

The minutes from the meeting held on 23 July 2018 were reviewed and agreed by the Group.

GM asked when the new proposed format of the meeting will start from. CS confirmed the new format was agreed to start from September 2018..

NICE Drug Report

JC presented the NICE Drug Technology Appraisal (TA) Report which was accepted by the Group.

Three TAs are currently pending (within 90 days of publication):

- TA536 Alectinib an option for untreated ALK-positive advanced non-small-cell lung cancer
- TA537 Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs
- TA540 Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma

TA537 was discussed at the York & Scarborough Medicines Commissioning Committee meeting in September 2018 and will need ratification by the CCG Board.

Action Log

The action log was reviewed and the following updates were discussed:

Action 4 *(Jan-18) Clinical Audit C3140 BriefCASE to review together with the Patient Safety Team audit results – GM and Becky Hoskins to discuss*
GM confirmed he had met with Becky and further discussion is required to re-design the methodology for this audit.
Further Action: GM and Becky Hoskins to discuss further the re-design of these audits and the evidence required

Action 10 *(Apr-18) NCEPOD NIV 'Inspiring Change' – forward details to FJ to review* an update was received from FJ and EG confirmed the NIV service is now in place on Ward 34 and appropriate staff training had been provided.
Further Action: EG to confirm availability of NIV cover out of hours

Action 13 *(May-18) NG70 Air Pollution guidance – FJ requested further assurance that this will be taken on by the independent company* the new company came into effect on 01October 2018 and the guidance has been sent onto them for review as required.
Action agreed as complete

Action 26 *(May-18) National Prostate Audit update – the Directorate need to write up the Trust's compliance with the audit standards from the published national report giving comparison between Trust performance and national performance against the standards. Once written up this needs to be returned to the Clinical Effectiveness Team (CET)* response not received from Ben Blake-James despite requests for the report to be sent to the Clinical Effectiveness Team.
Further Action: GM to discuss with Ben Blake-James the completion and submission of the Trust report, with the information available from the published National Report

Action 27 *(May-18) Testicular Torsion Audit – to provide Clinical Effectiveness Team with copy of audit report* CS advised that Ben Blake-James has confirmed that this audit is completed, however despite various and continued requests for the audit report, this has not been forthcoming.
Further Action: GM to discuss returning the report to CET with Ben Blake-James

Action 44 *(Jul-18) IV Fluid Therapy in Hospitals (CG174/QS66) – CF/FJ to review clinical audits to ascertain if they evidence the Trust's compliance*
SH informed the Group he will be meeting with Colin Jones to review and complete NICE baselines.

Further Action: SH to meet with Colin Jones in order to discuss audits required to provide evidence for the Baseline Assessment of this NICE guidance

Action 52 *(Jul-18) NCEPOD Chronic Neurodisability: Each and Every Need (2018) – to meet with clinical leads to assist with completion of Trust Self-assessment Checklist* This ongoing, meeting re-arranged 12 October 2018.
Further Action: SV to meet with Dr Highet to provide information on the requirements to complete the self-assessment checklist and where information can be obtained from if required

Action 53 *(Jul-18) Mental Health in General Hospitals: Treat as One (2017) – to request update from the Trust's Consultant Liaison Psychiatrist and feedback to CEG* SV to review response received from Dr Martin.
Further Action: SV to include the feedback received from Dr Martin on Action Log for next CEG meeting

NICE Report

SH presented the NICE Report and the following were discussed:

Partial with Action Plan

NG14 Melanoma
Recommendations 1.1.1 & 1.1.4:
Action: SH to forward to Emily Shephard and Donna Jack to comment on these recommendations and any evidence they may be able to provide.

NG42 Motor Neurone Disease
Recommendation 1.7.3:
Action: **To forward to Charlotte Oliver, Macmillan End of Life Care Co-ordinator, for opinion on advanced care planning**.

Recommendation 1.10.8: It was discussed that an audit could be undertaken to identify if there are any delays from referral to gastroscopy being performed.
Action: To discuss with the Baseline Assessment Lead, the undertaking of a clinical audit in order to provide supporting evidence.

Recommendation 1.10.9:
Action: To ask Berenice Carter if she can clarify the status for PEG referrals and dietetic review

Recommendation 1.14.3: Discussion held regarding fact that the actions identified appear to be the individual development actions.

Action: Forward to Jayne Pateraki for the Trust view on compliance

NG65 Spondyloarthritis
Recommendations 1.4.22 & 1.4.27: It discussed that the action plan needs to reflect the associated audit action plan. It was also queried whether the completion date of 2021 was appropriate.
Action: to discuss action plans from Baseline Assessment and associated audits with Esme Ferguson
Action: To confirm that action completion date of 2021 is an appropriate timescale

NG80 Asthma
Recommendation 1.3.3: Discussed that Child Health should include on their Directorate Risk Register - the use of FeNO and spirometery in Asthma Clinic until routine use has been achieved.
Action: To advise Gemma Barnes and Peter Standring of the request for this recommendation to be included on Directorate Risk Register until use of FeNO and spirometry is used as routine in Asthma clinics

QS86 Falls in Older People
Discussed that Jill Wilford will have been replaced by Tom Jacques as lead for this Baseline Assessment.
Action: EG to discuss the Baseline with Tom Jacques to ensure he is aware of the status and any actions

QS153 Multimorbidity
Recommendation 2: There is no timescale or end date specified to complete actions.
Action: To establish end date by which action should be achieved with the Baseline Assessment Lead

Partial No Actions Required

NG35 Myeloma
Recommendations 78 & 79: Whole body MRI is not available as an option in the Trust. It was discussed that Radiology should review regarding whether any actions are planned by Radiology.
Action: To discuss with Lorraine Clennett to establish whether Radiology agree with this status.

NG38 Fractures (non-complex)
Recommendation 18: Discussed that surgery is not always possible within the specified timeframe given the amount of Trauma pending. It was suggested adding to ED/ T&O Risk Registers.

Action: To advise Ed Smith and James Stanley of the request for this recommendation to be included on Directorate Risk Register, with mitigation to reduce/prevent risk as a result

QS149 Osteoporosis
Recommendation1: Fracture risk assessment not performed for all patients.
Action: The Group agreed this response was sufficient and appropriate

NG77 Cataracts in adults
Recommendation 1.6.3: Bilateral simultaneous cataract surgery only considered for patients requiring general anaesthetic.
Action: The Group agreed this response was sufficient and appropriate

PH53 Weight management: lifestyle services for overweight or obese adults
Recommendation 4: Awareness of weight management services for staff has been raised by Occupational Health but unable to raise awareness of options for patients as these are not commissioned locally.
Action: The Group agreed this response was sufficient and appropriate

As GM was not present at this point of the meeting, those present felt that in the absence of both GM and FJ, final approval for each of the above NICE Baseline status that are either Partial with Action Plan or Partial No Action Required would be requested from GM.

NCEPOD Report
SV presented the NCEPOD Report.

NCEPOD Progress Updates

Chronic Neurodisability Cerebral Palsy (CNCP): Each and Every Need (2015)
Date of meeting has been arranged with Dr Highet to assist with drawing-up an appropriate action plan to implement the recommendations from the report.
Action: SV to meet with the lead to assist with completion of Trust Self-assessment Checklist

Mental Health in General Hospitals: Treat as One (2017)
An updated Self-assessment Checklist was received from the Trust's Consultant Liaison Psychiatrist.
Action: SV to review information received and provide an update at next CEG meeting

Acute Non-Invasive Ventilation: Inspiring Change (NIV) 2017
Catherine Balcombe (Lead Sister - Critical Care Outreach Team) is working with Steph Williams (Sister - Ward 34) in producing an agreed combined

documentation that will further complete the Trust Self-assessment Checklist - completion date is to be confirmed.
Action: SV to establish completion date of above action for NCEPOD self-assessment

NCEPOD Action Plans

Emergency & Elective Surgery in the Elderly (EESE) 2010
Recommendation 8: An agreed means of assessing frailty in the peri-operative period should be developed and included in risk assessment.
Feedback from Action Lead: This action sits between Elderly Care and Surgery. Helen Hey does not believe they have an agreed process yet.
Action: SV to follow-up with Elderly Medicine and General Surgery nurse leads for progress update for this action

Alcoholic Liver Disease (ALD) (2012)
There are 14 outstanding recommendations with due date of January 2017. To date we have not received any responses to our follow-up attempts.
Action: SV to contact GM and ask if Charlie Milson is still the appropriate lead for the actions arising from this study.

Clinical Audit Report

CS presented the Clinical Audit Report:

Annual Audit Programme 2018-19

A total of 250 audit topics were originally approved for inclusion on the Annual Programme 2018-19.

At the time of this report an additional **46** audits have been added, following identification by either Directorate Governance Leads or Clinical Directors as arising priorities for audit; therefore, there are now **296** audits on the 2018-19 Annual Audit Programme of which **128** (43%) have been registered to date.

12 audits have been registered and completed from this year's Annual Audit Programme to date.

Registrations

A total of **44** new clinical audits were registered with the Clinical Effectiveness Team during 01 July - 18 September 2018 which included **23** local audits, **6** re-audits and **15** national audits.

BriefCASEs for Discussion

A total of **6** BriefCASEs relating to NICE guidance were presented to the Group for discussion:

2018-0027 Cystic Fibrosis Weekend Audit

This audit was undertaken to review respiratory weekend working for people with Cystic Fibrosis (CF), across the York site over 2017.

Conclusion

As an overall service, these results reflected that twice daily treatments at weekends are offered 96.5% of the time and actual contacts are made 83% of the time due to patients not being available for treatment/off the ward. There are no clear documented inclusion criteria for weekend lists at present to audit against.

A7024-1 IV Prescription Standards

This re-audit was undertaken in York following the release of a new IV prescription chart, which was designed to make adhering to NICE standards a simpler task. The drive for this came from the fact the initial study showed 100% compliance with basic prescription standards, but major deficits in other areas of IV fluid use.

Conclusion

Compared to the previous audit, the overall performance of the trust has improved.

This is with the exception of 1000ml boluses being used frequently as resus fluid, and ABCDE assessments are not being documented for post-patients receiving larger quantities of resus fluid.

Documentation of fluid plans in medical notes has improved, but still the majority of patients still do not have any mention of IVIs noted down.

Expert help appears to be consistently sought when patients require 2000mls fluid in a resus situation.

Use of ABCDE assessment after initial fluid resus has increased, but remains low.

The vast majority of patients are receiving the correct amount of maintenance fluid, but almost none had a fully correct daily electrolyte prescription.

C3089-1 Neonatal Jaundice

This audit looked at the diagnosis and management of Neonatal Jaundice and the Trust's performance against NICE guidelines to avoid long term complications of jaundice.

Conclusion

- Bilirubin was measured every 6 hrs in patient with jaundice at <24 hrs of age in 90% of patients as compared to 66.6% in the last audit
- Documentation that parents have been explained improved by 18% from last audit
- Percentage decrease from 42.3% to 18.18% about checking bilirubin when baby is not jaundiced

C3232 IV Fluid Therapy – Prescribing (Routine Maintenance)
This was an observational audit which aimed to establish the Trust's level of compliance with NICE QS66 and IV fluid prescribing for routine maintenance. In addition, it also generated qualitative insights around IV fluid prescribing at the Trust.

Conclusions
Compliance with prescribing standards on the fluid charts was good. Recording of information in the notes was poor.
Use of resuscitation fluids was largely good. Use of maintenance fluids and correct assessment of electrolyte and glucose requirements was largely poor. Further improvements, particularly in documentation, prescription of maintenance fluids and senior supervision are required.

C3280 IV Fluid Therapy NICE guideline at Scarborough General Hospital
This audit aimed to establish the Trust compliance with NICE guideline (CG174).

Key Findings:

- Documentation of type of fluid, volume and rate – 100% standard achieved
- Patients with IV fluid management plan the standard achieved was 53%. However the number fluid management plans meeting the entire standard was only 24%

C3298 Assessment of the Use of Spanning External Fixation in Lower Limb Trauma
This audit evaluated the use of temporizing external fixation, investigating the indications and outcome against NICE Guidance (NG39) Major Trauma: assessment and initial management recommendations 1.5.38 - Use damage control surgery in patients with haemodynamic instability who are responding to volume resuscitation and 1.5.39 - Use definitive surgery in patients whose haemodynamic status is normal.

Conclusion
Whilst it is a standard practice in the Trust to use temporising external fixation for damage control, the findings did highlight that the overall complications outweighed the benefits of using temporising external fixation in isolated hind foot trauma.

As GM was not present at this point of the meeting, those present felt that in the absence of both GM and FJ final approval for each of the above Audit Reports would be requested from GM.

Audit for Escalation

The CET have received confirmation that the *National Comparative Audit of Blood Transfusion Programme Use of FFP and Cryoprecipitate in Neonates and Children: Management Of Massive Haemorrhage* (which is a mandatory Quality Account for 2018-19) is not relevant to the Trust as we very rarely use FFP or Cryoprecipitate on children hence there is an insufficient number of patients to participate.

The Group agreed that this National Audit should be removed from the Trusts Annual Audit Programme 2018-19

Escalation to Quality and Safety Committee

No specific items were identified for escalation to the Q&S committee.

Any Other Business

No further items were raised for discussion.

Next Meeting

Tuesday, 06 November 2018, 15:00 – 16:30
Neurosciences Resource Room, York / VC from Orchard Room, Scarborough

NHS
York Teaching Hospital
NHS Foundation Trust

F

Performance and Activity Report

October Performance 2018

Produced November 2018

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Assurance Framework Responsive

Performance Summary by Month – Trust level

Operational Performance: Unplanned Care	Target	Sparkline / Previous Month	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
Emergency Care Attendances		▼	16570	15158	16236	14712	13719	15845	16374	17985	17242	18903	18215	17073	16960
Emergency Care Breaches		▼	2222	1263	2766	2728	2499	2983	2439	1786	1722	2266	1366	1650	1545
Emergency Care Standard Performance	95%	▲	86.6%	91.7%	83.0%	81.5%	81.8%	81.2%	85.1%	90.1%	90.0%	88.0%	92.5%	90.3%	90.9%
ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	38%	39%	41%	41%	40%	39%	39%	38%	38%	37%	38%	38%	38%
ED Total number of patients waiting over 8 hours in the departments		▲	371	152	791	833	668	872	607	195	159	260	110	212	216
ED 12 hour trolley waits	0	◀▶	2	0	5	14	15	40	13	0	0	0	0	0	0
ED: % of attendees assessed within 15 minutes of arrival		▲	67%	69%	57%	63%	61%	57%	64%	67%	63%	62%	70%	61%	65%
ED: % of attendees seen by doctor within 60 minutes of arrival		▲	35%	42%	41%	45%	43%	40%	41%	42%	40%	41%	50%	42%	45%
Ambulance handovers waiting 15-29 minutes	0	▲	745	649	823	702	679	784	702	762	765	785	766	883	891
Ambulance handovers waiting 30-59 minutes	0	▼	368	172	537	424	360	471	325	317	260	355	342	360	345
Ambulance handovers waiting >60 minutes	0	▼	257	55	548	390	367	419	302	152	110	216	104	238	132
Non Elective Admissions (excl Paediatrics & Maternity)		▲	4411	4304	4575	4515	4092	4525	4442	4791	4603	4840	4730	4589	4638
Non Elective Admissions - Paediatrics		▲	790	800	934	736	654	844	703	734	639	668	536	689	861
Delayed Transfers of Care - Acute Hospitals		▲	932	958	865	660	885	1010	1134	1092	1020	1071	1336	1180	1251
Delayed Transfers of Care - Community Hospitals		▼	312	439	506	483	357	266	464	358	262	307	301	381	357
Patients with LOS 0 Days (Elective & Non-Elective)		▲	1342	1388	1311	1398	1173	1324	1394	1518	1448	1573	1479	1421	1436
Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	1057	1045	1130	1153	1034	1108	1002	1055	986	1056	1032	1108	1082
Ward Transfers - Non clinical transfers after 10pm	100	▲	67	57	113	99	106	94	106	58	71	73	38	76	83
Emergency readmissions within 30 days		▼	738	796	877	771	765	807	782	885	819	913	822	-	-
Stranded Patients at End of Month		▲	367	333	402	474	412	430	413	377	366	385	369	379	403
Super Stranded Patients at End of Month		▲	129	99	126	161	139	157	150	123	118	125	118	132	159

Operational Performance: Planned Care	Target	Sparkline / Previous Month	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
Outpatients: All Referral Types		▲	19670	19492	16186	19348	17400	19134	18992	20017	19365	20201	18652	17760	20478
Outpatients: GP Referrals		▲	10441	10381	8247	10280	9220	10223	10066	10436	9926	10548	9726	9197	10705
Outpatients: Consultant to Consultant Referrals		▲	2322	2218	1889	2146	1965	2065	2069	2186	2146	2248	1975	1923	2358
Outpatients: Other Referrals		▲	6907	6893	6050	6922	6215	6846	6857	7395	7293	7405	6951	6640	7415
Outpatients: 1st Attendances		▲	9979	10007	8032	9742	8605	9107	8900	9959	9586	9696	9056	8467	10237
Outpatients: Follow Up Attendances		▲	17147	18399	14703	17573	15388	16544	16134	17565	16738	17103	15635	15553	17784
Outpatients: 1st to FU Ratio		▼	1.72	1.84	1.83	1.80	1.79	1.82	1.81	1.76	1.75	1.76	1.73	1.84	1.74
Outpatients: DNA rates		▼	6.1%	6.1%	6.1%	6.3%	6.2%	6.3%	5.7%	5.8%	5.9%	6.5%	6.4%	6.1%	6.0%
Outpatients: Cancelled Clinics with less than 14 days notice	180	▲	176	167	133	210	213	194	168	149	145	184	173	160	180
Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	862	780	702	949	757	844	849	728	885	945	1070	884	941
Diagnostics: Patients waiting <6 weeks from referral to test	99%	▲	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%	96.1%	96.1%	96.3%	95.6%	93.5%	94.9%	95.9%
Elective Admissions		▲	791	788	596	566	602	529	636	781	759	741	617	578	767
Day Case Admissions		▲	6169	6056	5101	5958	5410	5723	5452	6054	6041	6092	6112	5707	6450
Cancelled Operations within 48 hours - Bed shortages		▲	27	2	74	118	129	168	62	18	7	10	4	34	68
Cancelled Operations within 48 hours - Non clinical reasons		▲	91	65	169	191	189	205	117	103	89	98	96	106	137
Theatres: Utilisation of planned sessions		▼	88%	93%	86%	83%	85%	84%	88%	92%	92%	92%	93%	91%	90%
Theatres: number of sessions held		▲	704	718	542	599	543	520	565	628	636	608	553	555	674
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		▲	57	54	76	74	50	105	76	60	61	74	63	76	79

Assurance Framework Responsive

Performance Summary by Month – Trust level continued

18 Weeks Referral To Treatment	Target	Sparkline / Previous Month	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
Incomplete Pathways	92%	▲	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%	83.8%	84.2%	84.1%	84.5%	83.7%	83.1%	83.4%
Waits over 52 weeks for incomplete pathways	0	◀▶	1	0	0	0	1	2	1	14	9	0	0	1	1
Waits over 36 weeks for incomplete pathways	0	▲	199	202	238	260	297	356	409	450	438	390	369	298	361
Total Admitted and Non Admitted waiters	26303	▲	25174	24894	25006	25185	25334	26303	26967	27480	27425	27796	27756	27525	27616
Number of patients on Admitted Backlog (18+ weeks)		▼	1465	1448	1623	1818	1928	2223	2303	2334	2330	2273	2272	2245	2219
Number of patients on Non Admitted Backlog (18+ weeks)		▼	1699	1761	1816	1880	1921	2179	2070	2002	2041	2023	2245	2401	2369

Cancer (one month behind due to national reporting timetable)	Target	Sparkline / Previous Month	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
Cancer 2 week (all cancers)	93%	▲	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%	93.9%	93.7%	93.5%	86.6%	86.6%	83.8%	-
Cancer 2 week (breast symptoms)	93%	▲	97.0%	94.5%	94.0%	94.6%	99.1%	98.9%	96.2%	96.1%	93.6%	94.7%	97.4%	99.0%	-
Cancer 31 day wait from diagnosis to first treatment	96%	▲	96.8%	98.7%	99.6%	99.2%	98.6%	98.7%	98.2%	99.2%	98.9%	98.4%	99.2%	97.6%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	▲	82.5%	97.4%	96.9%	93.9%	100.0%	97.1%	96.6%	97.4%	100.0%	97.6%	94.3%	92.9%	-
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	▲	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▲	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%	78.0%	78.4%	82.0%	72.0%	81.1%	76.6%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	▲	90.9%	90.6%	89.5%	95.5%	95.1%	93.6%	90.9%	84.3%	96.5%	91.3%	93.0%	87.7%	-

Assurance Framework
Responsive

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

CQUIN Name & Description	Executive Lead	Operational Lead	Quarter 1 Outcome	Quarter 2 Outcome	Quarter 3 RAG & Risks	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	Achieved	No risks identified	Green
1c. Uptake of Flu Vaccinations 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) Timely identification of patients with sepsis in emergency departments and acute inpatient settings	Jim Taylor	Rebecca Hoskins	Partially Achieved	Partially Achieved	Amber	Amber
2b. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Timely treatment of sepsis in emergency departments and acute inpatient settings.	Jim Taylor	Rebecca Hoskins	Partially Achieved	Partially Achieved	Amber	Amber
2c. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) 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	Achieved	No risks identified	Green
2d. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Jim Taylor	Anita Chalmers	Annual Return – no risks identified			
4. Improving services for people with mental health needs who present to A&E 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. 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	Achieved	No risks identified	Green
6. Advice & Guidance 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	Achieved	No risks identified	Green

Assurance Framework Responsive

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

CQUIN Name & Description	Executive Lead	Operational Lead	Quarter 1 Outcome	Quarter 2 Outcome	Quarter 3 RAG & Risks	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 - Achieved	No risks identified	Green
			Acute - Achieved	Acute - Achieved	No risks identified	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 - Achieved	No risks identified	Green
			Acute - Achieved	Acute – Partially Achieved	No risks identified	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 - Achieved	No risks identified	Green
			Acute - Achieved	Acute – Partially Achieved	No risks identified	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 - Achieved	No risks identified	Green
			Acute - Achieved	Acute - Achieved	No risks identified	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 - Achieved	No risks identified	Green
			Acute - Achieved	Acute – Partially Achieved	No risks Identified	Green

Assurance Framework
Responsive

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

CQUIN Name & Description	Executive Lead	Operational Lead	Quarter 1 Outcome	Quarter 2 Outcome	Quarter 3 RAG & Risks	Quarter 4 RAG
10. Improving the assessment of wounds 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	Achieved		Amber	Amber
11. Personalised care and support planning 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) 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	NHSE response awaited	No risks identified	Green
GE2. Activation System for Patients with Long Term Conditions 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	NHSE response awaited	No risks identified	Green
GE3. Medicines Optimisation 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	NHSE response awaited	No risks identified	Green
CSAAS. Child Sexual Assault Assessment Services Implementation of the Sexually Transmitted Infections (STI) Pathway and referral to appropriate care	Wendy Scott	Liz Vincent	Achieved	NHSE response awaited	No risks identified	Green
Enhanced Armed Forces Covenant 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	NHSE response awaited	No risks identified	Green

Assurance Framework Responsive

Emergency Care Standard and Unplanned Care

Operational Context

The Trust achieved the planned trajectory for the Emergency Care Standard (ECS) at 90.9% (90% plan) and is therefore on target to achieve the Q3 Provider Sustainability Funding (PSF) requirement of 90%. This is a notable improvement compared to October 17 at 84.6%. The Trust performance outperformed the national position of 89.1% for the second consecutive month.

Unplanned care continued to be challenging during October, attendances increased for the Trust compared to October 2017; 2%, +390 attendances. The Scarborough Locality experienced a reduction of 3% (-271 attendances). York locality services continues to rise, Type 1 and Type 3 locality attendances were up 8% (+661 attendances) compared to October last year. The rise was exclusively seen at the York ED which saw a rise of 10% compared to the same period last year; a rise of 671 attendances, almost 23 extra attendance a day during the month. Year to Date (YTD) Type 1 and 3 attendances are up 5.5% on last year (up 4.5% on plan). The increase is being reviewed by the Technical and Information Group, with a report due in November. Early indications have identified some pressures in primary care resulting in more patients coming direct to the hospital.

Ambulance arrivals decreased slightly -1% (-27) when comparing October 2018 to October 2017. Despite there only being a slight decrease in ambulance arrivals there was a significant improvement in the number of ambulances delayed for over an hour (238 in September 2018 to 132 in October 2018). This is an area of concern and risk as the winter months approach, NHSI IST team are offering support to Scarborough Hospital, following on from the Action on A&E work to support handover processes. The Trust will be reporting actions Ambulance Handovers weekly to NHSI over winter.

The Trust has seen an increase of bed-base pressures progressing through the month, with both Scarborough and York Hospitals having only 14 days below a bed occupancy of 90% at midnight. Increasing acuity has been reported by the clinical teams, and more recently York Hospital has been significantly affected by closed wards due to infection. The Delayed Transfers of Care (DToC) position worsened in October compared with September and is the highest seen this year. This has been affected by care home capacity and availability of packages of home care. The Trust is actively working through the Complex Discharge multi-agency group to mitigate the pressures from increased demand, and delayed patients through the Winter Plan preparations.

Targeted Actions in October

- Ongoing implementation of the Single Improvement Programme for Scarborough Hospital emergency, elderly and acute medicine and Emergency Care Transformation Plan at York.
- Ongoing development of the £950k capital works to create the assessment area at Scarborough Hospital (to be implemented end of December).
- Winter plan finalised, with quality impact assessment complete and risks escalated on the funding of the plan to Board and Regulators.
- Refresh of Ambulance Handover action plan across the Trust to target delayed Handovers, with identified support from NHSI IST for Scarborough hospital
- Detailed audit of end of life care patients requiring ‘Fast Track’ support completed by the Trust and Commissioners.
- Discharge Hub finalised for Scarborough Hospital, launched on 7th November.

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 Trust September 2018 was 89%.

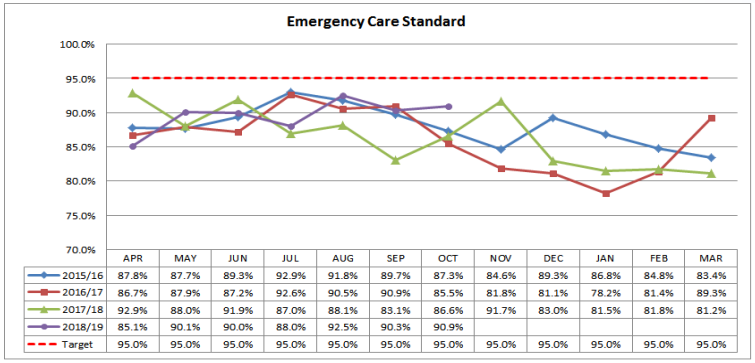
Consequence of under-achievement

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

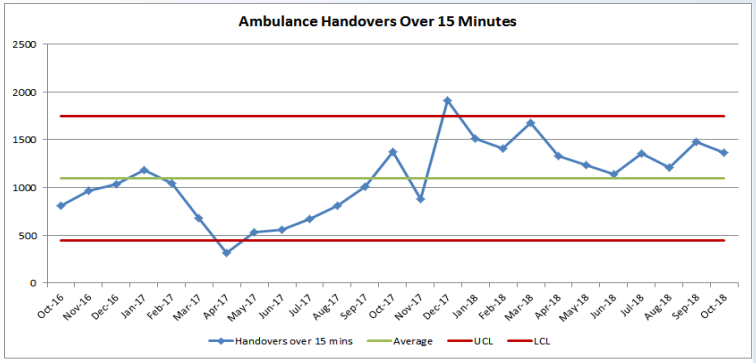
Performance Update:

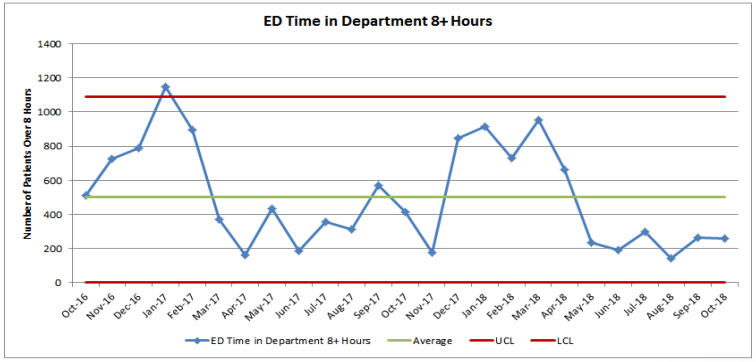
- The Trust achieved 90.9% in October 2018 against the planned trajectory of 90%.
- Attendances increased for the Trust compared to October 2017; 2%, +390 attendances. The Scarborough Locality experienced a reduction of 3% (-271 attendances). York locality services continues to rise, Type 1 and Type 3 locality attendances were up 8% (+661 attendances) compared to October last year.
- The number and percentage of patients waiting over 8 hours has decreased by 42% (-155) compared to October 2017.
- Ambulance Handovers remain a challenge, with 132 handovers over 1 hour.

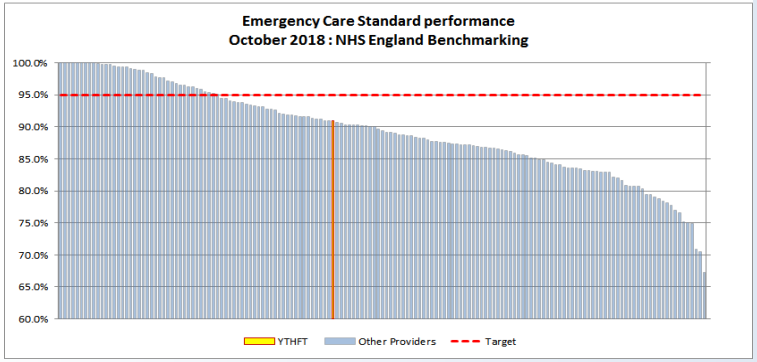
Performance:



	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%	90.3%	90.9%					
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%







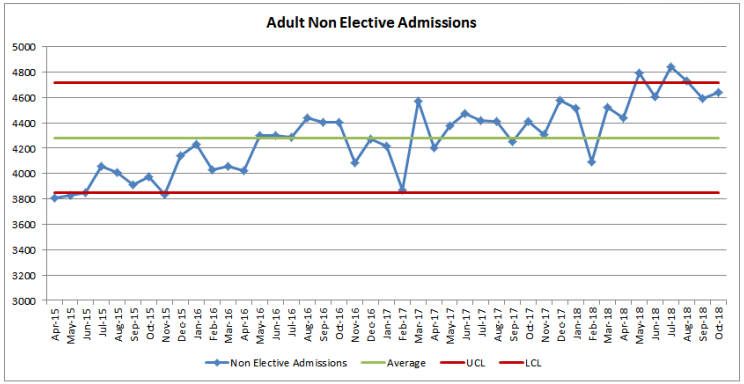
Assurance Framework Responsive

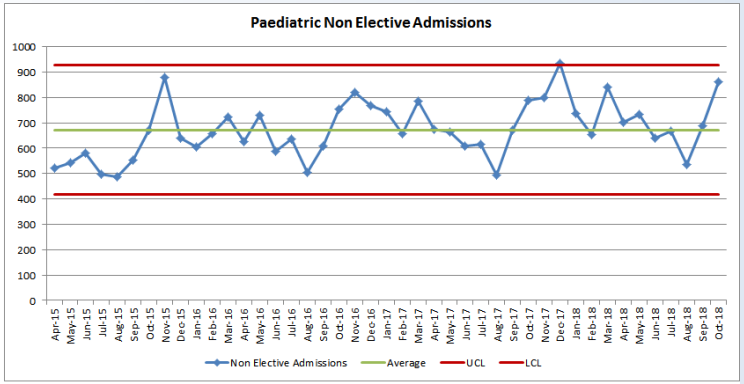
Unplanned Care

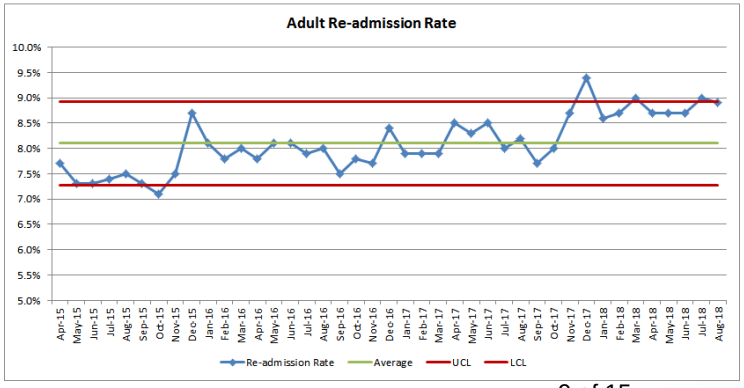
Performance Update:

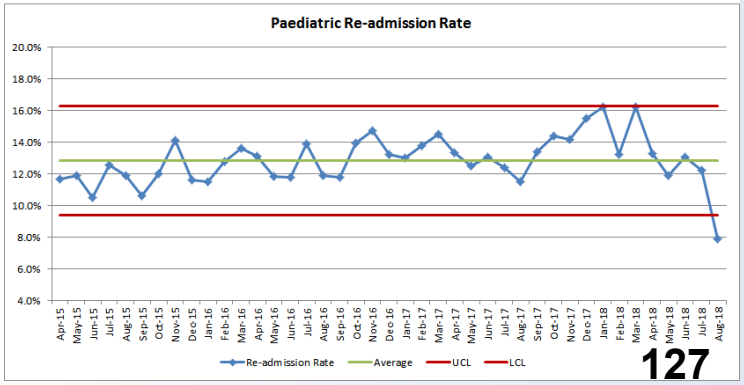
- The number of non-elective admissions in October 2018 has increased by 5% comparing to October 2017 (+227) and remains over plan year to date. The Trust has seen continued increases in non-elective admissions in General Surgery & Urology York hospital.
- The adult readmission rate remained at 9% for August 2018. This is being reviewed to understand the causes of the sustained increase in readmissions.
- Acute DTOCs have increased in October, primarily at York Hospital (which has seen a significant rise in October). This has been affected by care home capacity and availability of packages of home care. The Trust is actively planning to mitigate the pressures from increased demand, and delayed patients through the Winter Plan preparations.
- Despite an increase in the number of stranded and super stranded patients at the end of October, the number of beds occupied by super stranded patients (patients who stay more than 21 days) has seen a Year to Date reduction (up to October) of 21%, against a target of 25% by December 2018.

Performance:









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Assurance Framework Responsive

Cancer Waiting Times

(Reported a month in arrears)

Operational Context

The Trust has not achieved the 14 day Fast track referral from GP target in September at 83.8%, a deterioration against the August position. This is below the national average for Fast Track for September 2018 at 91.2%. The Trust position continues to be affected by the demand and capacity imbalance in the Dermatology Service, with 58.6% of Dermatology Fast Track referrals seen within 14 days. This is despite significant joint work between primary care, clinical commissioners and the directorate team to implement a range of new ways of working and triage. Of the 229 patient breaches, the Dermatology patients compromises 52% (118). Of the Dermatology breaches, 86.6% of patients had no cancer. The Corporate Director team are considering the Directorate's options appraisal to ensure clinical safety within the service. The Colorectal service also experienced delays in the 14 day Fast Track, with 70 patients waiting over 14 days, of these 65.7% had no cancer. The service has been piloting a new approach to fast track to mitigate these pressures. The CCG have reviewed DNA patients, and are now expanding the review of patients who cancel or re-arrange their appointments to target a reduction in patient choice breaches.

The Trust continues to experience high demand for Cancer Fast Tracks, with an 9% (+128) increase in referrals in September compared to September 2017. The Trust is undertaking more Cancer activity as a result with 1,395 Fast Track patients seen in September is an increase of 21% compared to September 2017, and this is impacting on the capacity available for routine outpatient appointments, particularly in Dermatology, Urology and Colorectal services. Improvements at the start of the pathways are being seen with 25% of patients seen by Day 7 of their pathway; the highest proportion since February 2018. Lung and Breast saw over 50% within 7 days.

The 62 day target from referral to treatment declined from August and remains under the national standard at 76.6% for September. This is below the national position for September (78.2%). This equates to 134 patients treated in September, with 35 accountable breaches (41 patients). These were spread across a range of tumour pathways, with the highest number of breaches seen in prostate and colorectal cancers. The prostate and colorectal pathways are priority areas for the Humber, Coast and Vale Cancer Alliance. The Trust has secured £242,000 in additional funding for diagnostics towards improving the 62 day performance. £150,000 has been allocated to fund additional endoscopy activity using an external provider to support the colorectal pathway, £50,000 towards funding MRI activity to support the prostate pathway, again via an external provider. £42,000 has been secured for additional radiographic support to our third CT scanner on the York site; to support a pilot of the lung fast track pathway.

The Trust also failed the 31 Day Surgery and 62 Day screening targets in September. All other Cancer Waiting Time targets were met. The Trust has had a recent post-implementation review of progress from the NHSI Intensive Support Team, which noted improvement in internal processes. However, given the priority for cancer performance, it is proposed that a more focussed discussion of the actions in place and remaining challenges would be beneficial at a future Board.

The Trust met all targets in Quarter 2 with the exception of 14 day Fast Track (Trust 85.7%, National 91.6%) and 62 day 1st Treatment (Trust 76.4%, National 78.6%).

Targeted Actions in October

- Implementation of the Standard Operating Procedure (SOP) for removing patients from the Cancer Patient Tracking List (PTL) commenced, with weekly monitoring
- Revised Cancer Governance implemented to strengthen lessons learned from Clinical Harm Reviews and specific performance review of Tumour Site recovery plans at Cancer Board
- Successful bids through the Cancer Alliance to support cancer diagnostic delays, building on the capacity and demand analysis by tumour site.
- Assessment by directorate on options to increase 7 day Fast Track capacity, to inform the operational plan for 2019-20
- Ongoing weekly monitoring of all patients through the Patient Tracking List review, with escalations and action completed in week

Assurance Framework Responsive

14 Day Fast Track – Cancer Waiting Times

Standard(s):

Fast Track referrals should be seen within 14 days.

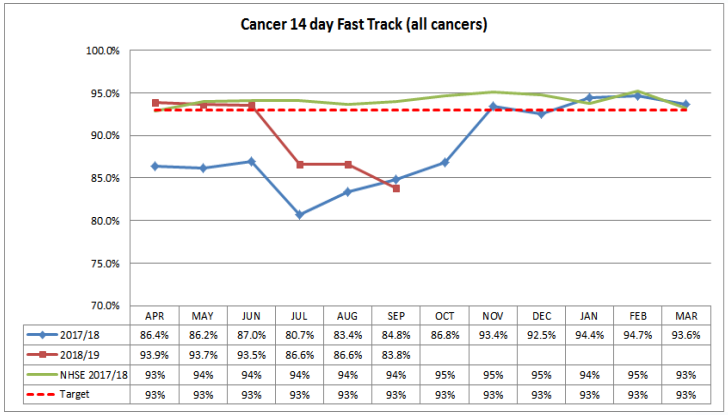
Consequence of under-achievement:

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

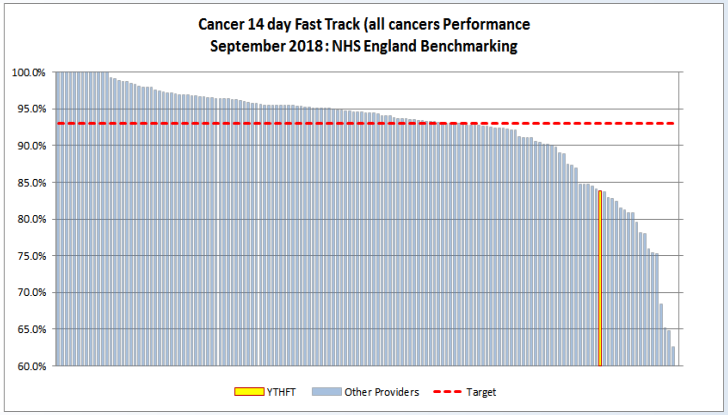
Performance Update:

- The Trust achieved 86.6% against the 93% target in September 2018.
- Of the 229 patient breaches, the Dermatology patients accounted for 52% (118). Of the Dermatology breaches, 86.6% of patients had no cancer.
- 16% of the breaches were due to patient choice (e.g. did not attend or could not attend within target).
- Fast Track referrals were 9% (+128) higher than September 2017.

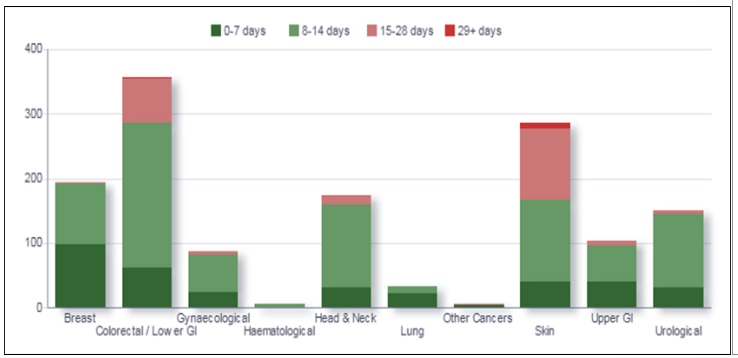
Performance:

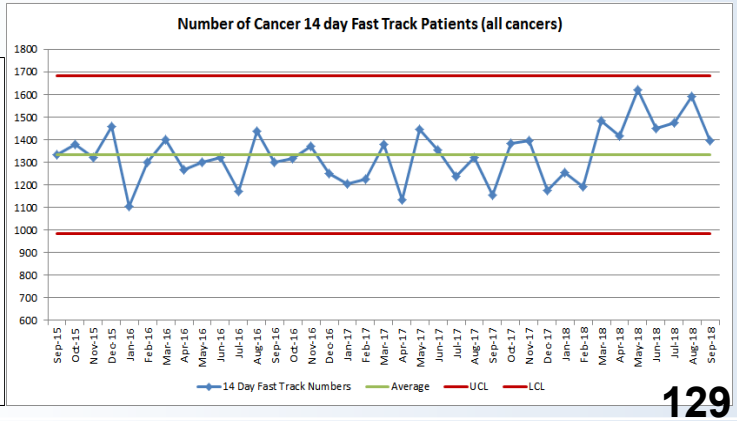


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2017/18	86.4%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%
2018/19	93.9%	93.7%	93.5%	86.6%	86.6%	83.8%						
NHSE 2017/18	93%	94%	94%	94%	94%	94%	95%	95%	95%	94%	95%	93%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%



Trust totals of Fast Track Referrals seen





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.

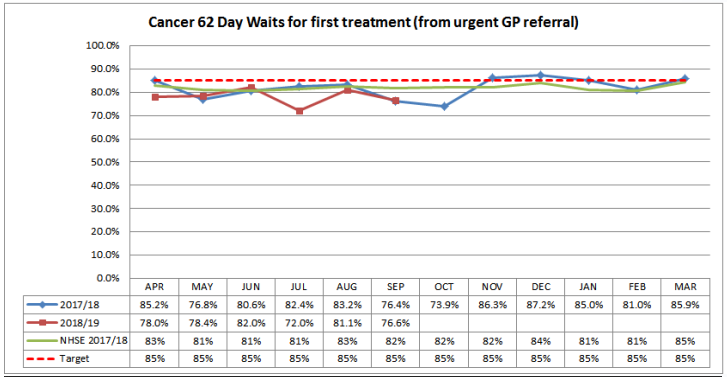
Consequence of under-achievement:

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.

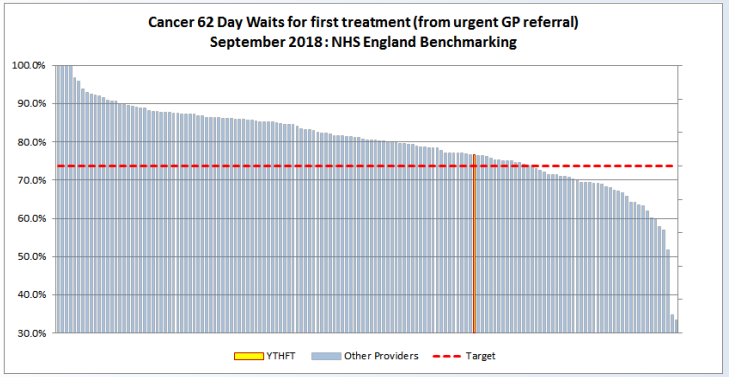
Performance Update:

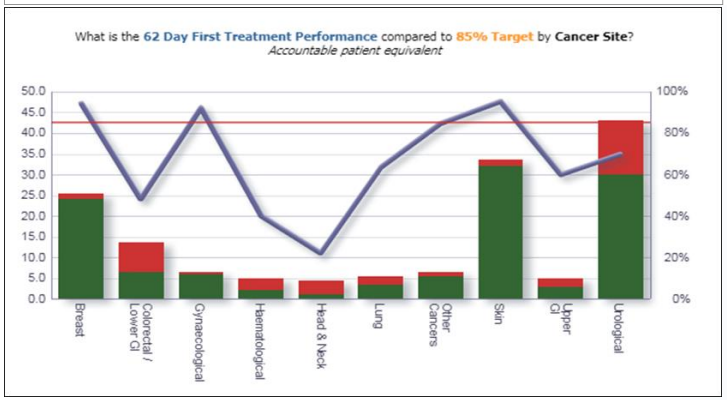
- The Trust achieved 76.6%% against the 85% target for September, equating to 35 accountable breaches (41 patients).
- There were breaches across a range of tumour sites with highest number of breaches in Urology (16 patients) Urology also comprised the highest percentage of long wait patients, with 6 patients treated over 104 days.
- Of the reported patient breaches, 45% relate to delays to diagnostic tests or treatment plans/ lack of capacity, 25% relate to complex or inconclusive diagnostics and 9% were due to patient not attending or unavailability.

Performance:



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2017/18	85.2%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%
2018/19	78.0%	78.4%	82.0%	72.0%	81.1%	76.6%						
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 an 0.3% increase to the total incomplete waiting list in October, rising to 27,616. The primary actions to reduce the waiting list commence in November. The Trust has seen an 11% increase of average daily referrals comparing September to October. GP referrals are moving back towards plan, at 1.8% over plan for the year to date, however, the total referrals remain high, and are impacting on the total waiting list position. October has also seen an increase in cancellations due to bed shortages, reflecting the increase in urgent care pressures. The Trust plan allows for a reduction in elective activity in January, and February and as such the incomplete list remaining above plan is a risk for the end of year target.

The Trust's RTT position has improved from September, at 83.4%. This is 1% lower than the Trust plan for October. The backlog has reduced across both admitted and non-admitted pathways. The Trust has increased the validation resource for the PTT pathway, with the new posts in place in mid-November. Detailed recovery work is underway in Ophthalmology and Dermatology, both with significant backlogs and identified clinical risk. The Maxillo-Facial recovery plan is in place. Further recovery plans have been requested for Cardiology and Respiratory.

The number of long wait patients (those waiting more than 36 weeks) has increased in October. These delays are across multiple specialities, with weekly monitoring in place by the Corporate Operations team. The Trust has also declared one 52 week breach in for Trauma and Orthopaedics in October – this is the same patient as declared in September, as they were unable to attend in October.

The Trust remains on plan for elective work overall, with an increase in day case (YTD) off setting a 5.7% reduction in elective work compared to plan. Elective care was impacted in April by ongoing winter pressures, and in October not achieving the planned increased level of activity.

The Trust has seen an improvement to the national diagnostic target at 95.9%, against the standard of 99%. There are particular pressures in endoscopy, Echo CT and MRI and MRI under General Anaesthetic (MRI GA). Echo-cardiographs have been affected by staff shortages and the service is reviewing actions to mitigate the pressures. The radiology recovery plan is in development for the end of November and includes consideration of a sustainable approach to the MRI GA, which are primarily for children.

Targeted Actions in October

- Ophthalmology Action Plan implemented to address clinical risk in Glaucoma Follow Up patients and to address cataract backlogs through re-deployment of Trust resource.
- Dermatology options appraisal completed and reported to Corporate Directors for consideration. This includes temporary consolidation of the East Coast Fast Track Clinics at Malton
- Implementation of the RTT action plan , with 4 additional validation posts commenced in November
- Ongoing implementation of the programme structure and metrics for the core planned care Transformation Programmes: Theatre Productivity, Outpatients Productivity, Refer for Expert Opinion and Radiology Recovery.
- Ongoing monitoring of all patients over 40 weeks to ensure all actions are taken to ensure patients have a plan to avoid a 52 week breach.

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.

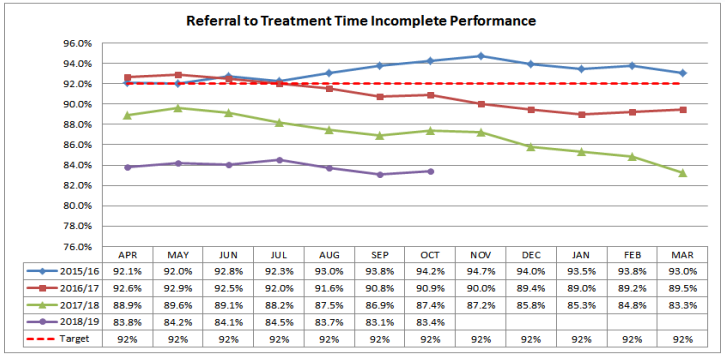
Consequence of under-achievement:

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

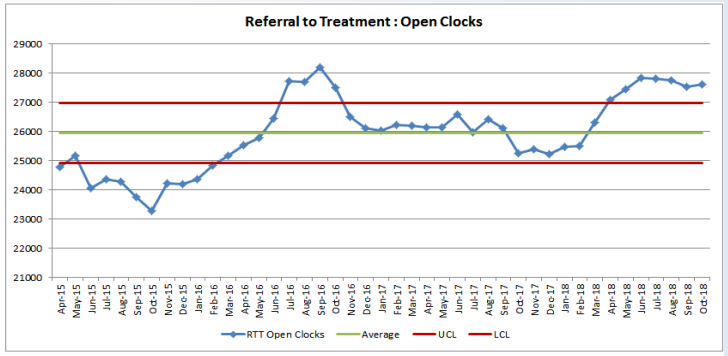
Performance Update:

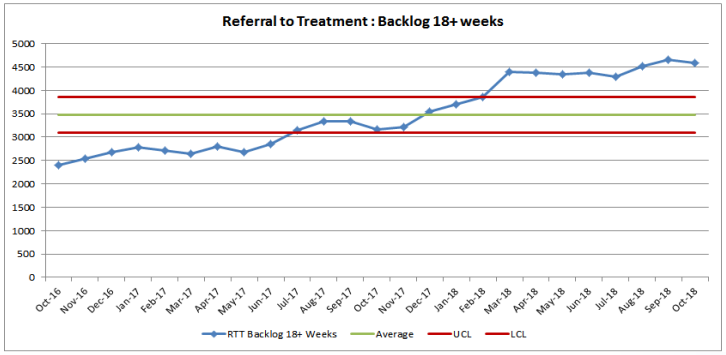
- The Trust achieved 83.4% RTT in October 2018, with 4,588 patients waiting over 18 weeks.
- The total number of patients on the RTT Incomplete pathway was 27,616 in October 2018, a 0.3% (+91) improvement on September's position (27,525). This is 1,819 clocks (7%) above the Trust plan for October.
- There were 20478 referrals received in October 2018, an increase of 5.1% (+808) on October 2017. GP referrals were 2.5% higher (+264) than October 2017
- The Trust 'Did Not Attend/ Was Not Brought' (DNA) rate remains relatively steady at 6%, although Scarborough Hospital DNA rate is higher at 7.3%.

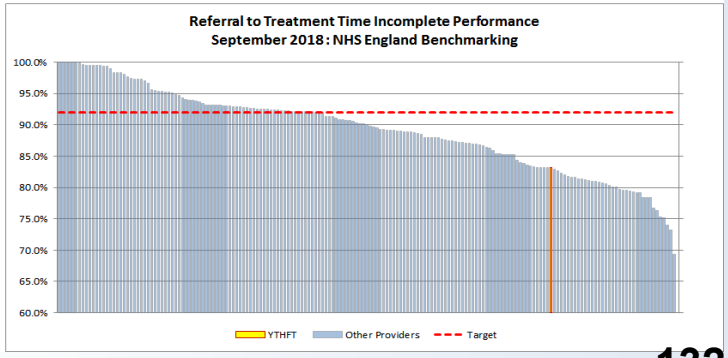
Performance:



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2015/16	92.1%	92.0%	92.8%	92.3%	93.0%	93.8%	94.2%	94.7%	94.0%	93.5%	93.8%	93.0%
2016/17	92.6%	92.9%	92.5%	92.0%	91.6%	90.8%	90.9%	90.0%	89.4%	89.0%	89.2%	89.5%
2017/18	88.9%	89.6%	89.1%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%
2018/19	83.8%	84.2%	84.1%	84.5%	83.7%	83.1%	83.4%					
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%







Assurance Framework Responsive

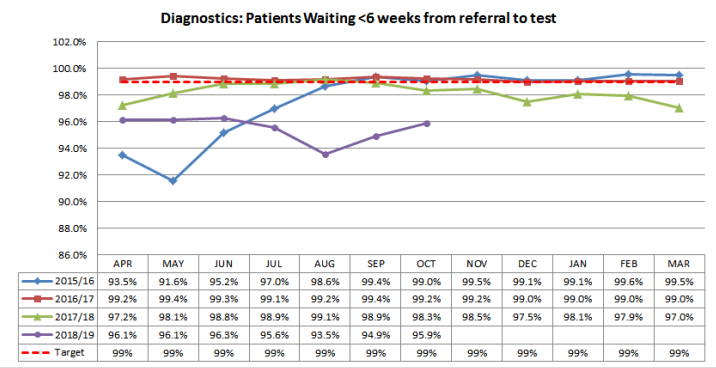
Diagnostic Test Waiting Times

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

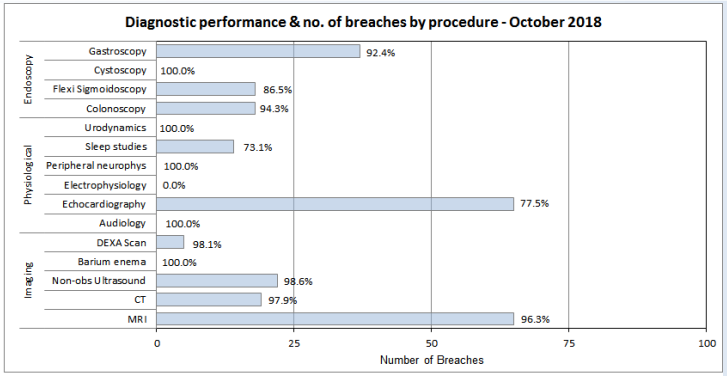
Consequence of under-achievement: Patient experience, clinical outcomes, timely access to treatment and regulatory action.

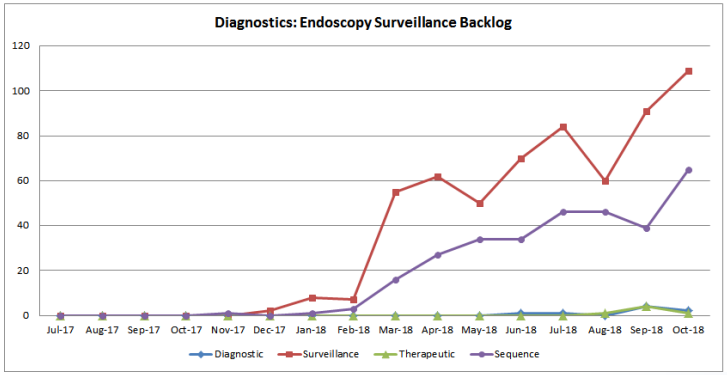
Performance Update: The Trust achieved 95.9% against the 99% target for October 2018, an improvement from the September 2018 position (94.9%). Key areas for recovery include echo-cardiography, endoscopy, sleep studies, CT and MRI. Plain Film reporting is also experiencing significant pressure. The Trust has retained the outsourcing capacity to support the radiology reporting timescales.

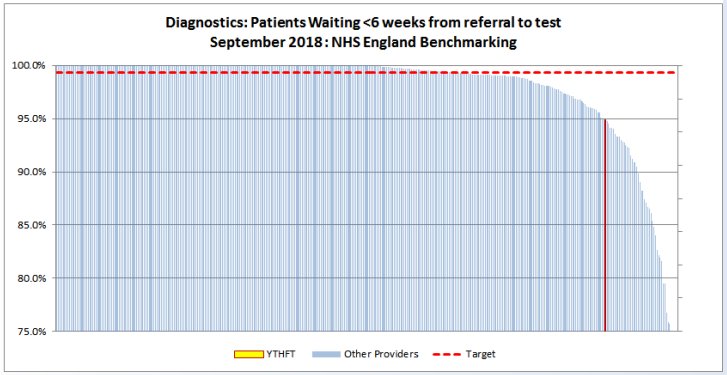
Performance:



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2015/16	93.5%	91.6%	95.2%	97.0%	98.6%	99.4%	99.0%	99.5%	99.1%	99.1%	99.6%	99.5%
2016/17	99.2%	99.4%	99.3%	99.1%	99.2%	99.4%	99.2%	99.2%	99.0%	99.0%	99.0%	99.0%
2017/18	97.2%	98.1%	98.8%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%
2018/19	96.1%	96.1%	96.3%	95.6%	93.5%	94.9%	95.9%					
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%







York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 2018
Director of Estates and Facilities Report – November 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 monthly 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 Report provides the Board of Directors with an overview of the key responsibilities of the Estates and Facilities Directorate and highlights any prevalent themes.

Updates are also provided in the following areas for information and assurance:

- Health, Safety and Security
- Sustainability
- Facilities Management Compliance
- Performance against Lord Carter metrics

Recommendation

The Board of Directors is asked 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: November 2018

1. Director's Overview

The operational Estates and Facilities functions transferred to YTHFM LLP in October 2018, and payroll successfully implemented a new payroll run for the LLP at the end of October.

As Board members are aware, there are ongoing challenges faced as a result of the national clinical waste crisis. Our business continuity plans are working well, and despite the situation carrying on for much longer than anticipated, there has been no impact on clinical services. New arrangements should be in place next month when the situation will return to normal.

Thursday 8th November saw members of Estates and Facilities involved in a Black Start exercise to test the power resilience of the Trust in line with our statutory requirements. All incoming power to the York site was shut down, and replaced automatically by our generators and uninterruptable power supplies. Only minor problems were uncovered, with business continuity plans working successfully across the site. This provides significant assurance around our resilience.

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 offers assurance in relation to the measures being taken by the Trust to ensure compliance with health and safety legislation.

2.1 Health and Safety Monthly Report

A monthly Health and Safety Report has been prepared for October 2018. A copy of this report is attached for information and assurance. (Appendix 1).

Summary Note: Board members are asked to note the contents of this report.

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".*

The Annual Sustainable Development Report has been prepared and is attached for information and assurance (Appendix 2). The Board's attention is drawn in particular to progress against the 10 priorities in the action plan.

Summary Note: Board members are asked to note the contents of this report.

4. Facilities Management Compliance

A copy of October's Monthly Facilities Management Compliance Report is attached for information purposes (Appendix 3).
Key areas for improvement will be agreed with the LLP over the next ten months, meanwhile the LLP is focusing on improving the safety related compliance scores.

This month the Facilities Management Compliance Report contains an overview of the Trust's PLACE scores. A full report on the PLACE inspection is attached as appendix 4.

Summary Note: Board members are asked to note the update regarding ongoing compliance measures.

5. Performance Against Lord Carter Metrics

Revised Lord Carter metrics and new model hospital data have now been issued for 2017/18. Further details regarding these metrics will be provided as part of the November Monthly Facilities Management Compliance Report and the Director of Estates and Facilities will provide an update regarding this at the December meeting of the Board of Directors.

6. Next Steps

A further report will be prepared for the Board of Directors in December 2018.

7. Detailed Recommendation

The Board of Directors is asked to note the updates and assurance provided.

APPENDIX 1

Health and Safety Summary Report – October 2018

1. Introduction

This report relates to October 2018 and is designed to provide assurance on the health and safety activity outlining reported statistics in relation to incidents, reports through the patient advice and liaison service (PALS) and key initiatives or challenges in the Trust. The report provides an update on health and safety management issues relevant to the Trust forming part of the wider Trust management approach of non-clinical risk.

The information presented within the report details the total numbers Trust-wide[1] unless otherwise stated.

2. October Summary

Open Employee and Public Liability Claims

In October there were 6 employee liability claims; these are summarised below:

- Industrial disease asbestos;
- Needle stick injury;
- Slip, soft tissue injury;
- Cage trapping finger resulting in a fracture to finger;
- Drug trolley lid, injuring finger;
- Physiological injury harassment.

There have been no public liability claims during the month.

Reported Non–Clinical Serious Incidents

There have been no non-clinical serious incidents reported for October.

3. Health and Safety Performance Monitoring - Summary of October

Reactive Monitoring

Review of Datix reported incidents for October in the main remained in line with the Trust monthly[2] averages for each reporting category.

A detailed breakdown of incident types can be seen in table 1 shown below.

[1] As of 01 October 2018 the report encompasses York Teaching Hospital Facilities Management LLP.

[2] Recorded incidents from Oct 2015

Table 1

Incident Type	Oct-18	Ave record month
E&F Contact With	0	0
STF (Pt & Others)	224	249
Staff Incidents	73	83
Security	16	26
E&F Equipment Issues	22	25
E&F Facilities	19	14
E&F Fire	11	6
E&F H&S	5	7
Cumulative Total Month	370	411
Total Datix	1309	1280

Reporting under Reporting of Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

For October, no RIDDOR incidents were reported on DATIX. One incident was reported to RIDDOR; this incident was a late report which related to December 2017, but this was not reported as work related at the time of the initial report on Datix.

The frequency of these incidents is monitored; as of the date of the production of this report (13/11/18), it has been 85 Days since the last RIDDOR reportable incident occurred in the Trust with the total number of RIDDOR incidents for 2018/19 being 7 (year to date), compared to 5 for the same period in 2017/18. If reporting continues at this rate, the estimated year end number of RIDDOR incidents for the 2018/19 will be 11.

Proactive Monitoring

Review of Trust Patient Advice and Liaison Service data (PALS) forms part of the health and safety proactive monitoring processes.

For October, non-clinical and environmental (Estates and Facilities Management) PALS, there have been no reports in all categories except for comments as demonstrated in table 2 shown below.

Table 2

	Oct-18
Complaints	0
Concern	0
Compliment	0
Enquiry	0
Comment	9
Total	9

The general themes from the reported comments are as follows:

- Staff attitude (2)
- Availability of hand gel
- Issue with lift

- Smoking – YDH
- Referral letter and contacting the Trust
- Access to the blue badge car park – YDH
- Noise produced by tugs – YDH
- Temperature levels within the hospital - YDH

4. External Authorities

There has been one communication with the UK Health and Safety Executive (HSE) in regards to a scheduled audit of the class 3 lab at Scarborough Hospital planned for 14 November. There has been ongoing communication with NHSI and NHSE in regards to Trust arrangements as part of the regional NHS waste consortium for disposal of clinical waste.

Both of the above are being managed via the relevant operational teams, with oversight by the Health Safety & Environmental department.

5. Conclusion

This report highlights the performance of health, safety and non-clinical risk in the Trust for October as part of the ongoing wider work of the Trust Health Safety and environmental functions.

6. Recommendation

The Board of Directors are asked to note the contents of this report.

APPENDIX 2

York Teaching Hospital NHS Foundation Trust

Board of Directors – 27 November 2018
Sustainable Development 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

1. To receive, review and endorse the work of the Sustainable Development Group
2. To note the progress on the 10 priority actions and agree the work plan going forwards.

Executive Summary – Key Points

- Sustainable Development Assessment Tool and Sustainable Development Template reports
- Progress on 10 priority actions for 2017 and 2018
- Priorities for 2018/ 2019 and beyond

Recommendation

It is recommended that the Board:

1. Receive, review and endorse the work of the Sustainable Development Group
2. To note the progress on the 10 priority actions and agree the work plan going forwards.

Author: Jane Money, Head of Sustainability

Director Sponsor: Brian Golding, Director of Estates and Facilities

Date: 16 November 2018

1. Introduction and Background

This report provides the Board of Directors with a review of the work of the Sustainable Development Group, an overview of the progress within the year and also a refresh of the action plan which forms part of the process to deliver improvements in line with the Board-approved Sustainable Development Management Plan.

Each of the 10 priority actions has a lead officer who updates their progress against the action plan, on a quarterly basis, for further discussion in the context of the Board-approved Sustainable Development Management Plan at the quarterly Sustainable Development Group meetings. This is part of the Trust's commitment to integrate sustainable development throughout the organisation and deliver progress in line with its mission statement "*The York Teaching Hospital Foundation Trust strives to actively encourage, promote and achieve environmental sustainability in all that it does".*

2. Detail of Report and Assurance

Assurance is provided to the Board of Directors through the work of the Sustainable Development Group and through this Board by providing a quarterly sustainability update report that highlights progress against the priority actions which are identified through the completion of the Sustainable Development Assessment Tool, and an annual report of the Sustainable Development Group as a means of reviewing annual progress.

2.1 Relationship with the Business Assurance Framework

In addressing the BAF, the work of Sustainable Development Group provides assurance relating to the risk "Failure to develop a Trust-wide environmental sustainability agenda" as part of the Trust strategic goal "To ensure financial sustainability".

The Sustainable Development Group has completed the assessments using the new Sustainable Development Assessment Tool (SDAT) and has achieved an overall score of 49%.

The Trust recognises that engagement and behaviour change is a key part of improving its performance both against the SDAT benchmarking tool and in fulfilling its obligations under the Climate Change Act through achieving further carbon reductions. It was agreed with the Environment and Estates Committee that this should be addressed when the Sustainability team become better resourced and supported through the Sustainability Engagement and Carbon Reduction programme with WRM (see below).

2.2 Annual Report of the Sustainable Development Group 2017/18 – Overview of the Year

The Group has had some notable successes in its work but with some areas not well enough resourced within the last year to complete all of the 10 priority actions (see below) and so work is continuing to develop and deliver these aspects of sustainability.

On the whole, the Sustainable Development Group meetings are reasonably well attended, and a table of meeting attendance is attached (Appendix 2a).

Corporate Directors approved the funding arrangements for a carbon reduction project which will integrate sustainable development more widely through a range of training and awareness raising activities. 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 February 2019 following completion of the recruitment process.

This culture/behavioural change programme of work with consultants WRM will reduce carbon emissions 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, within its mission statement and through its strategic goals.

Work of the Group

The focus of the Group in the last year has been to deliver progress against the following:

- 10 priority actions from the Trust's Board-approved Sustainable Development Management Plan with quarterly progress reports to the Environment and Estates committee, plus regularly review and update
- Report the Trust's achievements during the last year within the Trust's Annual Report and Accounts (Appendix 2b). For the second year running, the Trust's sustainability reporting has been within the top three trusts nationally.
- A review and update of the Trust's entry on the national NHS Sustainable Development Assessment Tool (SDAT) which is the replacement for the Good Corporate Citizenship Assessment Tool.
- A review and update the Trust's submission on the NHS Sustainable Development Unit Template which is used to provide information in the Annual report.

Existing Work Programme

During the last few months, the Sustainable Development (SD) Group has continued to progress its priority actions which has enabled the Trust to continue to reduce its carbon emissions, particularly those due to utility/energy use and also those due to waste, procurement and transport, and helped to achieve a SDAT score of 49% (as compared with 44% on last years' Good Corporate Citizenship Assessment).

With reference to the 10 priority actions, the group's attention has focused on:

1. An external stock take/gap analysis on the extent of engagement in sustainability to be used as a basis for developing an action plan. Completed.
2. Delivery of further "invest to save" energy projects based on current outline proposals subject to business case approval. Ongoing.
3. Implementation of Sustainable Design Guidance for all new Capital investment Projects. This is now being considered in the VIU project preparation work. Completed.
4. Implementation of the new mandatory Business Case (BC) consultation on sustainability through communication with BC authors leading to further guidance on standard assessment methods, and sustainability impact assessment statements for Board reports. Ongoing.

5. Implementation of a Trust-wide Travel Plan and set new targets for delivery in 2017/18 and beyond. Ongoing.
6. Review of the Waste Management Plan and set new targets for delivery in 2017/18 and beyond. Ongoing.
7. Business Continuity workshops to establish corporate response to operational risks which may (or may not) be as a result of the changing climate. Completed.
8. Seek to develop actions on the pathway to achieving more sustainable models of clinical care. Ongoing.
9. Seek to raise awareness and incorporate sustainability criteria in more procurement decisions and activities including those relating to social value. Ongoing.
10. Review the Board approved SDMP - The gap analysis work at the top of this list has resulted in an action plan which will lead to a further review of the Board approved Sustainable Development Plan (SDMP). Ongoing.

<u>Proposed Work Programme</u>

The new work programme will build on the above with the introduction of the following actions:

- Tackle the lack of awareness of environmental sustainability issues and recruit and train "champions" to establish a more sustainable culture throughout the Trust
- Behaviour change project to incorporate plans to save energy and improve the control of the Building Energy Management System
- Investigate opportunities to increase the Trust's Electric Vehicle charging capabilities and provide other initiatives to increase the take up of sustainable travel choices with active travel as a key focus, together with reduction in single occupancy car journeys and a reduction in CO2 emissions and pollution
- Improve the recording of adverse weather events and the impacts to identify areas in need of adaptation plan in the context of the changing climate
- Continue with the implementation of Sustainable Design Guidance for all new Capital investment Projects
- Consider inclusion of sustainability impact assessment statements for Board reports.
- Continue to review use of Trust Green Spaces including consideration of introducing bee hives
- Develop an organisational approach and understanding of the wider benefits of developing sustainable care models, and evidence this through the redesign of a targeted model (using the recently approved business case for the Outpatient Parenteral (IV) Antibiotic Therapy (OPAT) service)
- Proposal to develop an electronic staff forum with the opportunity to take part in online discussions on a range of topics relating to staff workforce issues.
- Improve opportunities and reporting of re-use of equipment and materials to reduce procurement costs and carbon footprint
- Reduction of single use plastic and non- recyclable packaging

A full copy of the action plan can be found at Appendix 2c.

Key Drivers and Targets

The Trust has a Board-approved commitment to sustainability and a Sustainable Development Management Plan with carbon reduction targets in line with the Climate Change Act 2008 and those published in the NHS Sustainable Development Unit Guidance.

NHS Standard Contract Service Condition 18 states the following for 17/18 and 18/19:

18.1 In performing its obligations under this Contract the Provider must take all reasonable steps to minimise its adverse impact on the environment.

18.2 The Provider must maintain a sustainable development plan in line with NHS Sustainable Development Guidance. The Provider must demonstrate its progress on climate change adaptation, mitigation and sustainable development, including performance against carbon reduction management plans, and must provide an annual summary of that progress to the Co-ordinating Commissioner.

18.3 The Provider must, in performing its obligations under this Contract, give due regard to the impact of its expenditure on the community, over and above the direct purchase of goods and services, as envisaged by the Public Services (Social Value) Act 2012.

Sustainable Development Group Meetings

Meetings will continue to be held quarterly.

3. Detailed Recommendations

It is recommended that the Board

1. Receive, review and endorse the work of the Sustainable Development Group.
2. To note the progress on the 10 priority actions and agree the work plan going forwards.

Sustainable Development Group

Attendance record from June '17 – October '18

	10.8.17	**30.11.17 cancelled**	**11.1.18 cancelled**	**18.4.18**	**1.8.18**	**17.10.18**	**Total (4)**
Brian Golding, Director of E&F (Chair)	X			√	√	√	3
Jane Money, Head of Sustainable Development	√			√	√	√	4
Ian Willis, Head of Procurement	√			X	X	√	2
Lydia Larcum / Sarah Vignaux, HR Manager	√			X	X		1
Andrew Bennett, Head of Capital Projects	√			√	√	√	4
~~Zara Ridge~~/Dan Braidley, Transport	X			X	X	X	0
Hugh Stelmach, Waste Manager	√			X	X	X	1
Comms Team (ad hoc)							
Steve Bennison, Finance Manager	X			√	√	√	3
~~CoYC rep~~							
Mark Hindmarsh, Head, Operational Strategy	√			X		X	1
Andrew Hurren, Deputy Head, Operational Performance	X			X	√	X	1
Steve Reed, Head of Strategy, Out of Hospital Care	√			X	√	X	2
Andy Betts, Head of E&F				X	X	√ D Morrall	1
Colin Weatherill, Head of Health, Safety & Security				√	√	X	2

Appendix 2b

Sustainability Section of the Annual Report and Accounts 2017/18

Sustainability

Over the last 12 months, the Trust has progressed the objectives set out in its Board approved Sustainable Development Management Plan (SDMP) including its commitments to continue to review its performance against the national bench-marking tool – the Good Corporate Citizenship Assessment model and to review and improve its action plan and carbon baseline information in line with the NHS Sustainable Development Unit (SDU) guidance.

Governance, vision and corporate approach

The Trust's Director of Estates and Facilities continues to chair the Sustainable Development Group as the Trust's Board lead representative, which manages and monitors the Sustainable Management Development Plan. This Group reports to the Environment and Estates Committee who highlight to the Trust Board any matters relating to sustainability which impact on the Board's Assurance Framework.

The Sustainable Development group has agreed with the Environment and Estates Committee an SDMP mission statement as follows: *The York Teaching Hospital Foundation Trust strives to actively encourage, promote and achieve environmental sustainability in all that it does*. It must, however, be pointed out that this Trust appreciates that sustainability is when social, economic and environmental needs are met (and the Trust addresses all of these issues), but this mission statement attempts to ensure that sustainability is not purely focused on the financial and social aspects which is often how sustainability is interpreted, e.g. in the context of the Sustainability and Transformation Plan Guidance.

This Trust has made significant progress in many areas and further actions have been be implemented this year as detailed in the sections below.

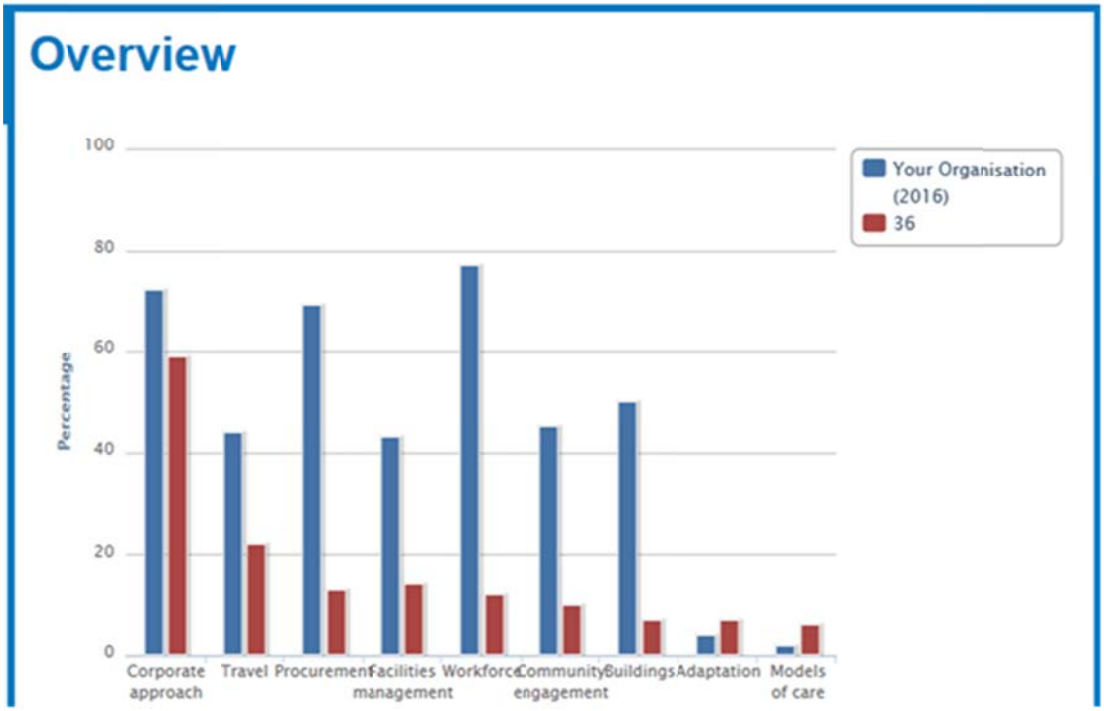
The last assessment against the Good Corporate Citizen (GCC) tool template achieved an overall score of 44% in November 2016 which was an 11% improvement on the previous (33%) score. Since then the Adaptation and Models of Care leads (along with others) have improved their scores to exceed the 25% minimum threshold which was then also achieved for all 9 areas (thus achieving the target for all of the individual areas for 2018) and these additional actions would have further increased the Trust's total score to approx. 50% if the other areas had been updated too.

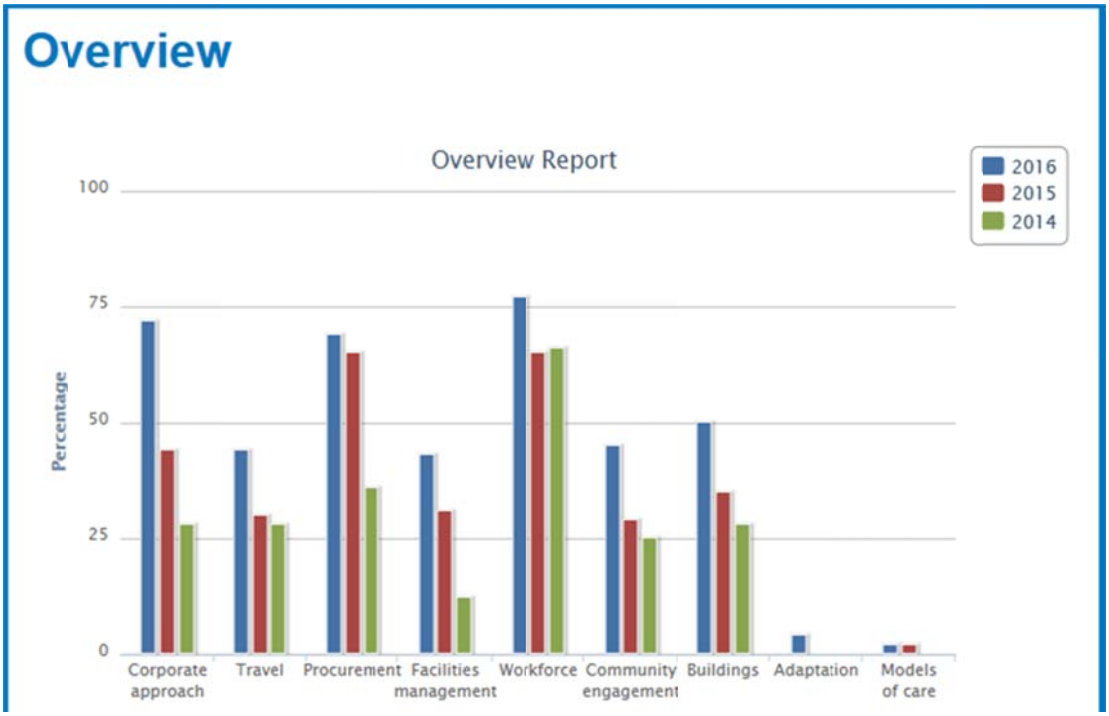
The GCC model was withdrawn nationally before these updates could be entered in favour of a new Sustainable Development Assessment Tool (SDAT), the replacement for the GCC model. The SDAT has updated and stream-lined the old GCC model and set up a new process aligned with the UK's commitment to the United Nations Sustainable Development Goals. Work is now underway to assess the Trust's current score with this replacement national benchmarking SDAT model.

At the last formal assessment, two of the Good Corporate Citizen (GCC) output graphs have been reproduced below to show:

1. This Trust's performance was significantly ahead of others in the majority of GCC areas when compare with other Acute Trust's

2. The Trust has made year on year improvement in the scores over the last three years.





The SD group is continuing to monitor performance indicator information and progress can be seen against a 2013-14 baseline on carbon, energy, waste produced and waste recycled.

Indicator	KPI	Targets	Baseline value 2013-14	2014-15 value	2015-16	2016-17
Total Carbon Footprint	Total tonnes CO2	28% by 2020 from 2013-14 80% by 2050	115,582	118,487	121,202	111,708 (3.35% decrease from 2013/14)
Energy efficiency of estate	KgCO2/m2		160	120 (25% reduction)	114.5 (28.4% reduction on 2013-14	102.9 (35.7% reduction on 2013-14)

Indicator	KPI	Targets	Baseline value 2013-14	2014-15 value	2015-16	2016-17
Total energy carbon	Tonnes CO2	-10% in 2016-17	25,423	23,176 (9% reduction)	22,311 (12% reduction on 2013-14)	19,683 (23% reduction on 2013/14)
Energy Costs	£/units		0.06	0.05 (17% reduction)	0.04 (33% reduction on 2013/14)	0.03 (50% reduction on 2013/14)
Waste recycled	Tonnes recycled	25%	325 (14%)	314 (14%)	496 (24%)	599 (25%)
Total waste	Tonnes waste		2,232	2,166 (3% reduction)	2,058 (8% reduction from 2013-14	2,380 (7% **increase** in waste)

Work is also on-going to develop transport KPIs through the updated Travel Plan and other monitoring information has been recorded in relation to specific projects undertaken this year in the sections below.

Carbon targets and emissions

The 2009 approved targets were to achieve NHS ***carbon emission targets of 10 per cent by 2015*** (from 2007 baseline), and ***80 per cent by 2050***. These targets were re-stated in the 2015 report and other targets were adopted in line with national NHS guidance including **34 per cent by 2020** from a 1990 baseline (which is stated to be equivalent for Health and Social Care England) to **28 per cent from a 2013 baseline.**

The Trust's Sustainable Development Group have looked in more detail at the carbon emissions using the NHS Sustainable Development Unit assessment template in order to monitor progress and highlight the areas where further work is required to reduce emissions.

The total measured Trust emissions will be reviewed at least every year whilst the carbon emissions from utilities is reviewed monthly, waste recycled is reported quarterly and transport mileage is also reviewed quarterly.

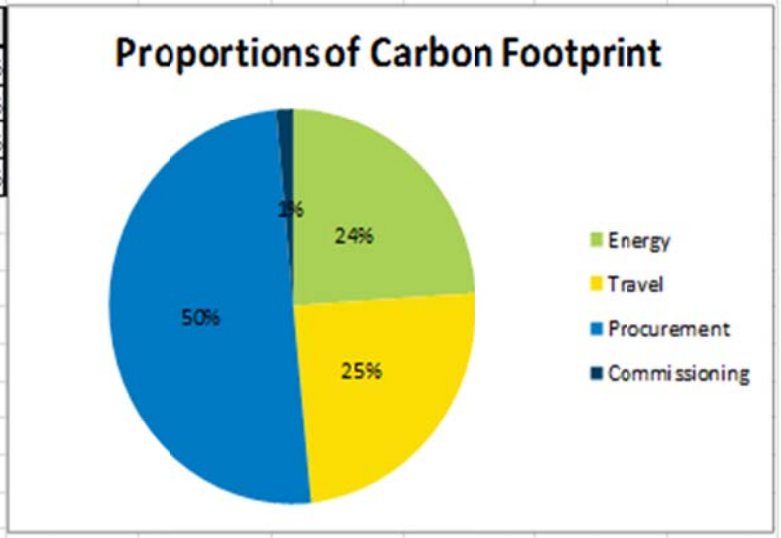
This is the third Annual Carbon Emissions Report providing the Trust with an indication of its environmental and sustainability impact. The content of the data within this year's report is substantially more robust.

This year's report shows an 8% reduction in carbon emissions from 2015/16 levels. This is the first time the Trust has been able to record an overall reduction in annual carbon emissions since adopting the NHS Sustainable Development Unit Annual Report format, and the Trust is also able to report a 3% reduction against the 2013/14 baseline. Although this is a good result, carbon emission levels are still significantly higher than the original adopted baseline year of 2007/08 and our ultimate objective is to reduce total carbon emissions below this baseline number, and also work towards the 28% reduction target from 2013/14 by 2020/21.

The emissions for the base year of 2007-08 is assessed to be 91,493 tonnes CO2e (carbon emissions) and in 2013/14 this is recorded as 115,582 tonnes of CO2e after the merger of the York NHS Trust with the merger with Scarborough and Bridlington Hospital Trusts. Since that time several major projects have been instigated to help the Trust to work towards the 28% target 2020, from the 2013-14 baseline.

The last reported total emissions for the year 2016-2017 were 111,708 tonnes CO2e. This represented an increase of plus 22 per cent since 2007 where the total emissions have had a general trend which increased year on year until 2016-17 when an 8% reduction in emissions was achieved against 2015/16. However it should be noted that the largest increase in actual carbon emissions is due to procurement and some of this is thought to be largely as a result of better recording of information particularly within the last 2 years following the introduction of the compulsory use of purchase orders for all invoices which are paid via the financial (Oracle) payments system. More work is needed to understand the actual trends in specific areas but the approximately half of the reduction in total emissions is due to reduction in procurement spend this year once inflation has been taken into account.

Category	% CO_2e
Energy	24%
Travel	24%
Procurement	50%
Commissioning	1%



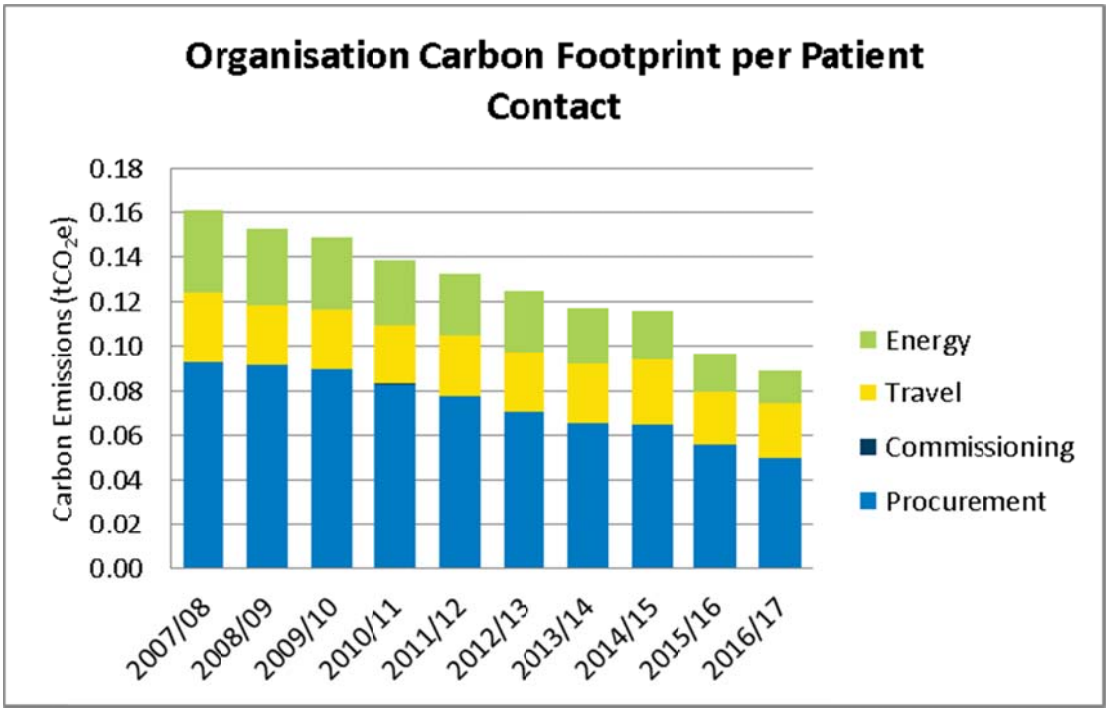
The Trust follows the Treasury methods for reporting emissions which are summarised below

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Total	91,493	94,355	100,158	101,174	108,555	110,863	115,582	118,497	121,177	111,708
Scope 1	12,500	12,029	12,474	12,304	13,343	14,690	14,018	15,504	16,509	16,841
Scope 2	9,024	9,730	10,068	9,962	10,144	10,724	10,811	8,220	6,492	3,947
Scope 3	69,969	72,596	77,617	78,908	85,068	85,450	90,753	94,773	98,176	90,919

Scope1 are carbon emissions from gas use, scope 2 are from grid electricity use and scope 3 are indirect emissions, broken down in the table below:

(tCO_2e)	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Total	69,969	72,596	77,617	78,908	85,068	85,450	90,753	94,773	98,176	90,919
Procurement (eClass)	47,453	51,367	54,902	54,453	58,174	56,748	58,010	59,494	63,502	56,042
Commissioning	166	180	192	191	0	346	21	182	222	196
Travel	18,714	17,323	18,688	20,434	22,891	24,150	27,797	30,928	30,654	31,397
Waste	439	392	420	462	352	330	333	313	275	271
Water	196	198	187	185	210	203	248	252	250	247
Energy Well to Tank and T	3,000	3,137	3,226	3,183	3,441	3,674	4,345	3,604	3,272	2,765

Also, it should be noted that the number of patients have continued to rise since the baseline year and that the **carbon savings per patient contact have improved year on year giving an overall decrease of 48 per cent since 2007/08**.



Decreases were noted in relation to carbon emissions from energy, which achieved a **23** per cent reduction against the 2013-14 levels. It should be noted that some of this reduction could be due to the milder weather experienced in recent years, but the emissions from electricity has decreased since 2013/14 by 64% and much of this will be due to the York, Scarborough and Bridlington Energy Projects which have been implemented since 2013/14. Whilst the Trust has 2007/8 baseline data the accuracy of the data collation at that time cannot be verified but the change in energy emissions suggest a 4% decrease. By comparison, information from the NHS Sustainable Development Unit has noted that there has been a 4.3 per cent decrease in building energy carbon footprint across NHS Providers in England between the 2007-08 baseline and the 2016 reports.

During 2016, delays in the delivery of the Scarborough Energy Project, which was due to achieve further savings of a 15 per cent reduction against 2014-15 Trust carbon energy savings, and a savings of at least 10 per cent on energy emissions from the 2013/14 baseline year, means that this was not achieved in 2016/17.

Whilst the Bridlington Hospital energy saving project completed on 1st April 2016 and has achieved savings of approx. 400 tonnes (25% of site emissions) of CO2e and £160,000 savings, the Scarborough hospital project (which was delayed due to some electrical infrastructure issues with Northern Powergrid) was officially opened on 23 March 2017 (NHS Sustainability Day) and so the first full year of savings are now anticipated in 2017/18 which will be over 2,000 tonnes of CO2e per annum, with some of this already being achieved in the latter part of 2016/17 as, the new Combined Heat and Power system was being trialled from late September 2016.

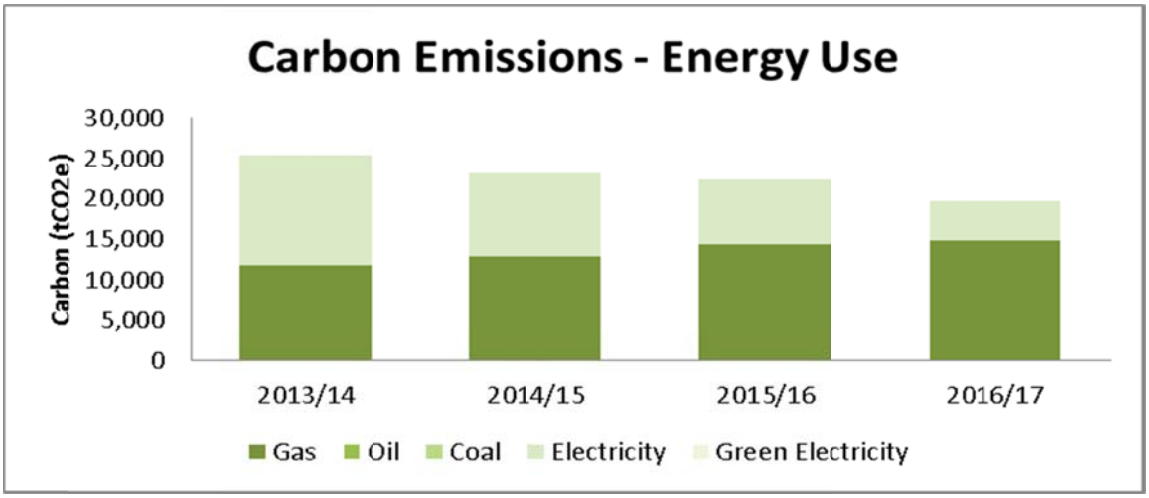
Whilst carbon emissions from energy are now reducing as a result of the Carbon Energy Fund programme at York, Scarborough and Bridlington, work must accelerate in relation to procurement, as the growth in carbon emissions for the category has increased by 18% per cent since the baseline year and is currently approximately 50 per cent of the Trusts current carbon footprint. It is recognised that investment decisions must take account of and mitigate against rising carbon emissions. In April 2017, the Trust introduced a mandated internal consultation with the Head of Sustainability as part of the Business Case development procedure for all proposals over £50,000.

The Trust has used the e Class Procurement data, thanks to the procurement team, but there is still more work to undertake and scope to improve the procurement data reliability further. It is likely that as data reliability improves in this area, previous years reporting data may need to be amended. This is an evolving model and procurement remains our most significant carbon emissions source.

Although the information shows a good level of reduction this year and also a significant reduction in carbon emissions per patient contact, generally carbon emission levels are still significantly higher than the adopted baseline year of 2007/08 and the additional baseline of 2013/14 and our ultimate objective is to reduce total carbon emissions below this baseline number. So, in summary this is an encouraging year but a long way still to go.

Energy

The Trust's energy related carbon emissions have gradually reduced over the last three years as a result of the introduction of the energy saving and carbon reduction plans for the three major acute hospitals which are the biggest energy users and carbon emitters within the Trust. Carbon and Energy Fund Projects have now been completed at York, Scarborough and Bridlington Hospitals and a further plan has been developed in 2017/18 for implementation in the next few weeks.



At York Hospital, the resulting operational savings in the first year of a fifteen year energy performance contract were £902, 500 and 3,000 tonnes of carbon (approx. 25% reduction of the site's emissions) which were higher than the guaranteed savings of £692, 941. However, in the last year, a CHP engine design fault has led to problems with the operation of the plant and so the carbon savings have been significantly reduced, although financially, the Trust has not suffered due to the energy performance guarantee and therefore the shortfall in savings is being refunded to the Trust. The failing CHP engine was replaced in May 2017 bringing the carbon savings for York back on track in 2017/18.

Similar projects were completed at this Trust's Bridlington Hospital in 2016 and at Scarborough Hospital in 2017 and these are anticipated to save another 2,800 tonnes of carbon and approx £300, 000 operating costs per annum**.** Due to the late completion of the Scarborough project the Scarborough and Bridlington CO2 savings were 1,391` tonnes of CO2 although £300,000 energy savings were achieved.

These Carbon and Energy Fund projects have achieved the following awards:

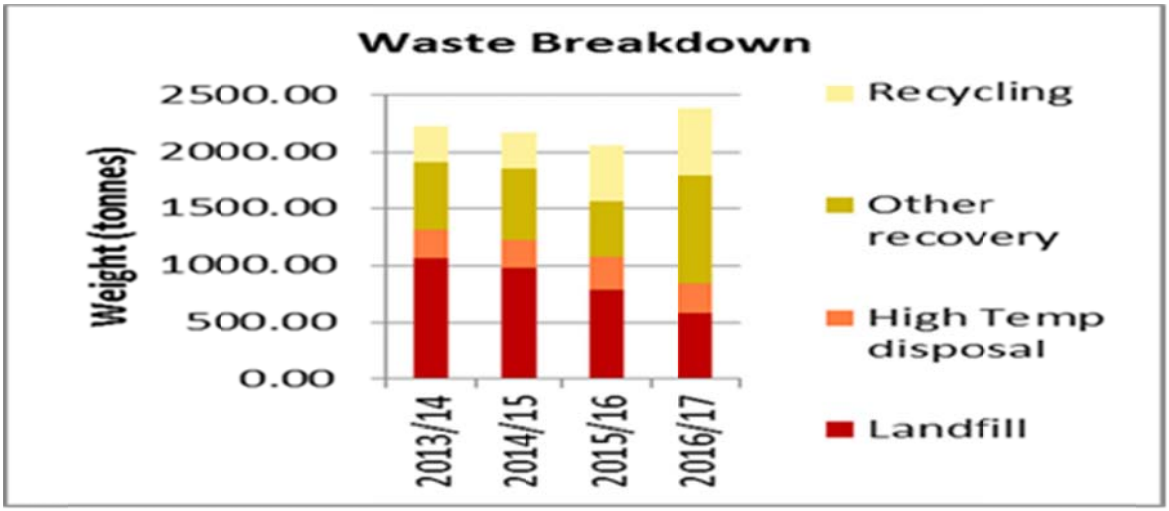
- CHPA Integrated Energy Project Winner (2014)
- H &V News Retrofit Project of the Year Winner (2016)
- NHS SD Unit – Innovation Award
- Highly commended runner up (2016)
- Building Better Health Care - Efficiency Award – Highly commended runner up (2016)

Water

Water consumption is monitored and reported internally at all sites on a monthly basis (along with electricity and gas use). Any significant variation in consumption and cost from the budget projections is reviewed and investigated as necessary.

Waste

The Trust has a Waste Management Plan which aims to prevent, reduce and recycle waste in order to reduce the amount of waste we produce from going to landfill. This important plan is further supported by specific action plans for each of our individual Trust Hospital Sites to help to maximise every opportunity for waste recycling or waste reduction where feasible.



Whilst the total tonnage of waste continues to increase, carbon emissions have decreased as waste segregation across the Trust has been significantly improved. Recycling levels have increased from 15% in 2013/14 to 25% in 2016/17 (equating to 599 tonnes) and in the current year 2017/18 the rate has further been increased to achieve 27%. During 2016/17 clinical waste being sent for incineration was reduced by approximately 24 tonnes, which is expensive and has resulted in costs savings of approximately £8k per annum and this also reduces carbon emissions.

The domestic waste is now being sent to a new Waste Recovery Plant at Allerton Park (between York and Harrogate). In the third quarter of 2017/18, of the 630 tonnes of waste produced;

- 223 tonnes of domestic waste were sent for Waste Recovery = 35%
- 178 tonnes of waste recycled = 28%
- 126 tonnes of clinical waste sent for incineration = 20%

- 103 tonnes of offensive waste sent to landfill = 17%

HTM 07:01 stipulates that the offensive waste MUST be disposed of via deep landfill. Our current waste contractor has submitted a request to the EA to permit the offensive waste to be a recognised as an RDF (refuge devised fuel) for Waste Recovery and is awaiting a response.

The Trust has also approved the roll-out waste paper consoles across the Bridlington Hospital site, in 2018. This will further increase the paper waste being recycled instead of going into the domestic waste stream. In addition work is underway to explore the feasibility of recycling single use metal items from the Trust's Head & Neck department with HES (our clinical waste contractor).

Travel

The Trust works with the City of York Council (CYC) and North Yorkshire County Council to promote sustainable travel options and to implement and deliver activities with patients, visitors and staff. The Trust and CYC share the post of Travel Co-ordinator and this has led to the promotion of joint initiatives such as iTravel promoting heathy travel choices, including cycling and heathier options for commuting.

Travel at work is subject to an expenses travel choices flow chart to reduce the need to travel through arrangement for meetings /teleconferencing etc, use public transport, share travel and use lower carbon options.

Much of the focus of the work in 2017/18 has been around consultation on its draft travel plan and the implementation of activities which raise awareness and tackle carbon emissions and air pollution whilst promoting healthy choices and cost effective solutions. The Trust has also looked at the Sustainable Development Unit's Health Outcomes of Travel Tool and is planning to use this to help to quantify the impacts of Trust related travel and model the targets and plans going forwards.

The 2017 NICE Guidance (NG70) on Air Pollution: Outdoor Air Quality and Health, which covers road-traffic-related air pollution and its links to ill health, served to highlight the need for action based on the links between action to improve air quality and the prevention of a range of health conditions and deaths. The Trust has recorded its current status on NG70 as 'Partially compliant with an action plan'. The action plan includes the completion of the final draft travel plan to achieve a Board approved healthy travel and transport plan, incorporating tasks relating to the expansion of the electric vehicle charging infrastructure and low and zero carbon emission vehicles, reviewing car parking policies, supporting active travel and healthier choices, and reducing emissions through driver training and monitoring to reduce emissions and fuel use.

The following projects continued to report successes in terms of cost and carbon savings within the last year:

Staff Enterprise Pool Car Service for a lower carbon cost effective solution.

The scheme was first launched at York Hospital in 2014 and subsequently re-launched and expanded in 2016 to Scarborough, Tadcaster, Bridlington and Malton hospital sites. The scheme has over 500 staff members who use the pool car system (across 5 locations). The staff pool car system has delivered the following savings:

Carbon Savings

- 40% reduction in CO2 emissions (as compared to staff using their own cars)
- over 1000 journeys per month transferred from costly staff mileage claims to economical, low CO2 cars

Cost Savings

- Financial savings of £70,000 per annum (or more if more people use them instead of their own cars)
- 1.5 million miles removed from 'grey fleet' travel mileage claims

The pool cars all have 1 litre petrol engines which are no more than 2 years old ensuring that they run at 99gm CO2 per km.

York Trust Hospitals Liftshare scheme – to encourage staff to share their journey to work to reduce congestion, carbon and pollution.

The scheme was promoted through various events and staff communications which increases the numbers registered on the scheme year on year. As of March 2018, the scheme has 448 members, with 257 journeys added and 52 registered Liftshare 'teams' using the 32 designated car share spaces. Over the next 12 months, those figures will result in

Carbon Savings

- CO2 reduction of 68 tonnes (plus177.61 kg NOx reductions)
- Mileage savings of 346,225 miles

Cost Savings for Staff

- Collectively staff save £39,937 on fuel with Liftshare

More information at **www.yorkhospitals.liftshare.com**

Sustainable and Active Travel Promotions
Promotional activities have been undertaken at both York and Scarborough Hospitals to raise awareness of sustainable and active travel choices through advice the City Council's iTravel and Winter Challenge (active travel) initiatives. Alongside this there was advice on personal travel planning, public transport and cycling. The Trust took part in National Clean Air Day promoting "no idling" at Trust premises.

Electric Vehicles (EV)
Electric charging points have been installed at York and Scarborough for fleet vehicle use and the Trust now has 9 electric service delivery vans in operation out of the 33 Trust owned fleet (27% electric vehicles). EV charging units have been installed as follows:

3 units at the Transport depot on Amy Johnson Way, Clifton Moor
2 units at the Estates building at York Hospital, Wigginton Road
1 unit at Scarborough hospital
1 unit at Bridlington hospital
1 unit at Selby hospital
1 unit at Malton hospital

Procurement

From April 2017, the Trust introduced a mandated internal consultation with the Head of Sustainability as part of the Business Case development procedure for all proposals over £50,000. The aim is to ensure that the business case author is aware of the environmental impacts and gives consideration to mitigation measures make the proposal more sustainable and more cost effective in the long-term. The Trust recognises that approximately 50% of its carbon emissions come from procurement and, where there is an opportunity, it considers the supply chain for new contracts and buying local supplies or from local suppliers e.g. food, taxi service. Tenders also include questions about the Social Value impacts.

Workforce and Employment

The Trust has a Workforce Strategy and also a Staff Health, Well-being and Engagement Strategy with a 3 year action plan and a Steering Group.

In 2015, the Trust was deemed an Exemplar Organisation in staff health and wellbeing by NHS England. The Trust offers a range of benefits which it continues to update and review through its employment practices (e.g. Flexible Working Policy, Special Leave Policy and Childcare Vouchers which help to accommodate and support the specific needs of parents and carers, Living Wage Employer, apprenticeships schemes, work with Job Centre Plus to recruit staff from 'return to work' schemes). This work has resulted in our Trust piloting further initiatives for NHS England to further improve staff health and wellbeing.

NHS Health Checks are now offered to all staff over 40 years of age, with advice provided which is tailored to the individual. In addition, positive management behaviours training has been introduced particularly in relation to supporting mental wellbeing and staff with mental ill health.

The Trust has introduced or enhanced its services for staff as follows:
Physiotherapy – recruited additional part-time physiotherapist to increase clinic time for staff referrals as well as undertake preventative / education / promotion work
Talking Therapies – recruited additional psychologist to increase capacity, for which the referral is via an occupational health specialist.

In relation to physical activity/sedentary behaviour, the Trust is continuing to widen and improve the offers around physical activity via Staff Benefits. The key challenge for this year is tackling sedentary behaviour in the workplace and at home.

The Trust has a Modern Slavery statement on its website and also promotes fair opportunities through its fairness champions.

In 2018, work will commence to establish green champions and will promote sustainability opportunities more widely with new staff, continuing staff and also introduce Board learning and development.

Partnerships and Engagement

The SD Group has continued to deliver sustainability communication and engagement work through a range of events and activities across several sites e.g. personal travel planning and active travel advice, electric vehicles promotions, NHS Sustainability Day, National Clean Air Day, recycling promotions, energy efficiency advice, energy centre open day and staff messages on a variety of climate change, sustainability and carbon/energy reduction measures. Many of these activities have been undertaken in partnership with others, for example local Councils, Citizens Advice, contractors and are often based on best practice from other Trusts and the Sustainable Development Unit.

During the last 12 months, the Trust has worked closely with a number of partners on a range of initiatives including the One Planet York Pledge and Leadership group which was set up by City of York where knowledge is shared between over 20 commercial, public and community organisations and the organisations assist each other with the delivery of sustainable initiatives. One of these initiatives in 2016-17 was the promotion of free insulation in homes where patients have cold related illnesses, and also for the last 2 years, the Trust has offered energy efficiency advice to staff and visitors to the hospital. Other issues under discussion are the feasibility studies solar panels and potential upgrades or additions to the electric vehicle charging infrastructure. One Planet York now hold an annual event with involvement from the Trust where all organisations can promote their work and consider whether there are other opportunities of mutual interest.

NHS Sustainability Day events were held for visitors and staff to find out more about the work of the Trust's SD Group and also to invite them to offer their ideas about sustainability opportunities.

The Trust's Sustainable Development Management Plan is available on the Trust website and also a "plan on a page" strategy poster was prepared and used at a number of events in the last year.

In terms of promoting healthy food in the community, the Trust signed up to the catering pledge to play our part in improving public health and encouraging people to choose a healthier diet.

An action plan has been established and work is underway to achieve specific targets on the percentages of healthy food choices available in our in-house staff restaurants and vending facilities. Healthy Choices have been rolled out across all sites and, following discussion with dieticians, information relating to healthy food choices will start to be made available to patients and their relatives.

In 2018, further work will be undertaken to better integrate the sustainability principles and practices throughout the Trust and to encourage the public and staff to offer ideas on how to improve our environment and sustainability.

Buildings

A draft sustainable building design guide has been developed and will be introduced in 2018 to incorporate capital project procedures and sustainability checklists together with the objectives to achieve BREEAM 'Excellent'/'Very Good', including the need to gain 'innovation credits' in the field of sustainable performance by incorporating innovative technology where practicably feasible and economically viable to do so, also tackling issues around resilience, biodiversity and the use of green space.

The Trust's Capital Project meetings include input from the Head of Sustainability and the Estates Strategy also includes a section on sustainability and sets out how the Trust buildings can serve the needs of the sustainable healthcare in the local community.

Models of Care

Significant progress has been made in the last year to take this agenda forwards and a few examples are given below:

The Trust's Out of Hospital Care Directorate (16%) of workforce have undertaken a series of strategy roadshows (over twenty held) and produced a video animation to explain about moving care closer to home. The video is available through the Trust staff intranet and has been emailed to all directorate staff.

The Out of Hospital Care Directorate are working with the Corporate Learning team to develop a Health Coaching educational programme to support staff with the skills to enable patients to self-manage and be less reliant on services. The aim of 'health coaching' is to optimise patients to be more involved in their condition and treatment and this shifts the emphasis of care. This also covers 'prevention' and links to the every contacts counts agenda. A cohort of staff are currently being trained (in house) and this is then to be rolled out to all community nurses.

There are now numerous examples of initiatives which use technology to reduce the need to travel to appointments and/or offer more empowering care e.g. Specialist nurses offer telephone support as well as telephone follow up appointments. Telemedicine has been established for prisoners who require and ED consultation, to be rolled out further for OPD in various specialities. Patients who share their care in the community have access to Telehealth systems. The Trust has also implemented an advice and guidance service for GPs reducing the need for patients to be referred for outpatient appointments.

There are also numerous additional examples of how the Trust is "Delivering Care Closer to Home" and "Delivering a systems approach to Care" e.g. The Trust has increased the provision of home based intermediate care so this is available across the whole Trust footprint. This includes the re-provision of a bed based intermediate care facility as a home based service allowing a significant increase in the numbers of people supported at home. The Trust will continue to develop this by integrated intermediate care services with those provided by the local authority and voluntary sector. The Trust is working with the Vale of York CCG and a number of independent care providers on developing a suite of support to care homes to support residents to be cared for without need for admission.

Recent engagement with local Healthwatch colleagues included a co-production in developing integrated intermediate care and reablement services which included a number of focus groups and the setting up of a public reference group.

Adaptation

Formal emergency planning procedures are in place to deal with any adverse circumstances which would include current and future climate change risks.

The Trust's Heat-wave plan was reviewed in March 2018 to link the plan to the Public Health / NHS England national heat-wave plan, continuing to widen out what was orginally an Estates and Facilities focused plan to include clinical as well as non-clinical actions.

Recent evidence of adaptation work followed on from the December 2015 floods when, one of the Trust's buildings Tadcaster Health Centre was flood damaged, and a nearby bridge was washed away. Pool cars were located to Tadcaster to improve accessibility whilst the bridge was repaired. Repairs to the health centre were completed in 2016/17 including additional work to improve the flood defences in the event that the area gets flooded again.

Work is on-going to review and update business continuity plans which require further consideration of the consequences arising from disruptive weather events and to raise awareness of longer term trends.

Workshop sessions have been delivered , in conjunction with Estates, IT and HR that will provide a consistent Trust-wide directorate response to:

- Loss of power
- Denial of building
- Fuel shortages including Gases
- Staffing shortages
- Loss of IT

The Business Continuity (BC) policy is being incorporated into an overarching Emergency Planning & Preparedness Policy, and this policy and discussions at the BC Steering Group will reinforce understanding & plans for "Adaptation to Climate Change".

SDMP Action Plan – 2018/19

York Teaching Hospital NHS Foundation Trust

SDMP Action	Latest Update	Target Dates for Delivery	Lead Officer	KPIs/Metrics to measure performance
Corporate Approach – Workstream Lead – Jane Money				
CA1 - To discuss at Board level what our approach should be with regards to how Sustainability is explicitly stated in the Trust mission	SDMP Mission agreed in April as follows: *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. Further discussions planned during 2018/19 to coincide with Phase 2 WRM Engagement Project	Sept 18	JM/BG/SR	
CA2 - Extend KPIs to consider how we might report within SDMP on Social Value and Procurement and air pollution (- to be discussed and developed via Trust Travel Plan) **IW/ DB**		June 19	JM/IW/DB	
CA3 - Undertake further work with consultants to reduce carbon emissions and improve communication on sustainable choices	Phase 2 of WRM Project on Sustainable Development Engagement approved by Corporate Directors (June 2018). Contract terms now being drafted and new posts with HR for banding	Jan 19	JM	
CA4 - Ensure that business case guidance is followed in relation to sustainable development and social value considerations	Recent increase in business case requesters for advice on Sustainability. Resourcing this support is currently an issue but once new roles in post this should become less of an issue		JM	
CA5 - Arrange dates for proposed talks to members and other local stakeholders and review opportunities to influence	Previous discussion with Lynda Provins about this but was postponed	Feb 19	JM	
CA6 - Review communications of SDMP to staff, patients, visitors and the local community following Sustainability Week 2018	Sustainability week not particularly well attended due to hot weather. Further comms work planned as part of WRM Phase 2 project as mentioned above	Jan 19	JM	
CA7 - Recruit Sustainability Champions to raise awareness across the organisation and provide them with appropriate training and resources	Waiting for WRM Project to commence and new posts to be recruited	Jan 19	JM	
CA8 - Review external, community, patient and user consultation to identify opportunities and gaps for communications		Feb 19	JM	

CA9 - Determine a range of social , economic and environmental objectives for engagement		Sept 19	JM	
CA10 - Contact Kay Gamble Deputy Lead for Patient Experience to discuss recruitment of volunteers through Trust Volunteer Services (plus One Planet York Event, Universities etc.) to help seek views and engage the public on improvements to environmental and sustainability performance		Jan 19	JM	
CA11 - Support Fairness Champions in promotion of SDMP		Jan 19	JM	
CA12 - Jenny Louth and Seraph Mollier to review provision of food banks over next 2 years via Nutrition Steering Group sub-group – to support the running of food banks (e.g. as a food collection site or supporting staff volunteers) to meet the needs of our local community (***Andy Betts to delegate***)			ABetts/JL/ SM	
Asset Management & Utilities – Workstream Leads – Jane Money/Andy Betts				
AM1 - Develop plans to reduce our energy and water demand to improve our water and energy efficiency	Part of WRM project as mentioned above	Jan 19	JM/ABetts	
AM2 - Encompass training to ensure that responsibility for a sustainably built assets and utility performance management is embedded in the roles and responsibilities for Estates and Facilities teams	Andrew Bennett planning an event to launch Sustainable Design Guide	Jan 19	JM/ABetts	
Travel & Logistics – Workstream Lead – Dan Braidley				
TL1 - Complete work on Trust wide travel plan and also update on progress/ compliance against the *NICE NG70 Air pollution: outdoor air quality and health guidance*	Work has begun on providing a summary version of the travel planning document which clarifies the four key aims around which the prioritised action plan will be developed. These are as follows: • Active travel as a key focus • Reducing single occupancy car journeys • Reducing CO2 emissions and pollution wherever possible • Identifying sustainable travel options for clinical / ward staff / shift workers / Jr Doctors / Nurses etc – through positive support and encouragement.		DB	

TL2 - Undertake work to improve the collation of carbon footprint reporting and set carbon emission reduction targets as part of the Trust Travel Plan.	DB will look into once established in new post 6.8.18 – ongoing. Will require alterations to collation and recording of data i.e. mileages, train ticket booking system etc.		DB	
TL3 - Undertake communications regarding sustainable travel choices (including Liftshare scheme and Enterprise promotional work) and review travel hierarchy as part of work regarding upcoming car park permit changes	Designated Liftshare spaces installed at Scarborough 30.7.18 Comms ongoing – 2x sustainable travel events have been held in the last 2 months – 19.9.18 (York) and 3.10.18 (Scarborough). A new staff transport section has also been established on Staffroom, collating all existing information as well as adding more links and guidance.		DB	
TL4 - Consider salary sacrifice options in relation to encouraging low pollution and low carbon travel options			DB	
TL5 - Consult with internal and external partners as part of the Trust Travel Plan and consider monitoring options	Sept / Oct – DB has met with First Buses re. establishing more bus services to the York site. DB met with City of York Council, Portakabin and others with a mind to establish a regional sustainable transport network. DB met reps from North Yorks County Council re. ensuring Scarborough Hospital was prominent in planning for new walking and cycling networks.		DB	
TL6 - Review our sharing of best practice following attendance at the NHS Employers Sustainability event in Leeds 27.2.18	NHS Employers National Case study distributed.		DB	
TL7 - Investigate whether Senior level approval is required for all high carbon business travel and review recording arrangements to improve accessibility	JM and DB discussed with Steve Kitchin, Sarah Hogan and Ed Pearson. Further analysis of data required to determine whether there are cost effective options to improve the current policy		DB	
TL8 - Continue with discussions regarding the installation of accessible electric charging points at York Hospital	Ongoing – including the possibility of renewable energy sources. City of York Council are keen to establish a 'hyperbub' at the hospital site that could be incorporated into the Trust plans.		DB	
TL9 - Work with Pool car provider to incorporate further electric vehicles into the Trust's fleet and ensure our pool vehicles include sustainable options for staff to consider	Discussions ongoing – Enterprise are finalising a proposal re. adding a journey sharing feature into the Enterprise Pool car booking system		DB	
TL10 - Continue with proposed works around the promotion of staff cycling	Scarborough staff cycle storage – a design has been agreed by all relevant stakeholders allowing for drainage access and fire escape access. This will be mostly sheltered and will offer 36 secure cycle parking spaces. CYC will do a free high vis kit giveaway at York on Monday 5th November.		DB	
TL11 - Promote and improve the use of teleconferencing facilities for Board and Committee meetings and through WRM project	Will be incorporated into travel plan.		DB	

TL12 - Create and communicate site Green Travel Plans clearly to staff, patients, users/clients, visitors, suppliers and to local communities	Ongoing.		DB	
TL13 - Continue engagement work with local stakeholders and set up additional meetings with major York organisations such as the University of York	In progress. DB meeting with University of York on Tuesday 16.10.18. See above re. regional travel network proposal.		DB	
TL14 - Undertake a travel survey in 2019 once the car park permit changes have been implemented	Dates TBC		DB	
TL15 - Assess Health Outcomes of Travel through use of NHS SD Unit HOTT and review changes resulting from Travel plan			DB	
TL16 - Undertake work to reduce the environmental impact (GHGs and Air pollution) of the logistics associated with the delivery of goods and services to our organisation.	Links in with Sustainable facilities sub group work – work to follow in 2019 / 2020 post plastic reduction work.		DB	
TL17 - Monitor the environmental impacts (CO2e and air pollution) associated with our suppliers' transport and logistics and are actively working with our suppliers to find ways to minimise their traffic burden (e.g. more efficiently planned deliveries, less polluting vehicles etc.)	Currently Scarborough and York hospitals have air pollution monitoring equipment installed by the local Council who will feed back their findings. More work required in 2019.		DB	
TL18 - At least 10% of our fleet and pool vehicles are fully electric i.e. on the government Go Ultra Low approved vehicles or similar government approved EV list.	Currently our transport fleet has more than 10% electric vehicles. Pool cars to be considered when contract renewed in 2019.		DB	
Adaptation to Climate Change/ Resilience – Workstream Lead – Andrew Hurren				
A1 - Work with Communications team to brief staff regarding roll out of ERP and Business Continuity (BC) plans		October 2018	AH	n/a
A2 - Adaptation to Climate Change and Resilience to be explained in SDMP	380 BC Action Cards now on Intranet – next step is to implement testing with lessons learned and record of cause of incident (if adverse weather – this would be recorded noting risks (including severe weather) reviewed quarterly at Emergency Planning Steering Group (ESPG)	Ongoing	AH	
A3 - Invite Head of Sustainability to join Emergency Planning Steering Group and BC sub-group	This has now been completed.	June 2018	AH	n/a

A4 - Monitor our carbon reduction plans to ensure they contribute to an overall reduction in emissions and risk	Risk register relating to Sustainability and Changing climate reviewed quarterly by SD Group – EPSG has own risk register which is reviewed quarterly	Complete	JM/AH	
A5 - A record of overheating events, action plan, impact and risks to ensure that Trust has suitable adaptation plans in place for the changing climate needs to be developed ***JM/CW*** to check overheating events and risks are reported to HSCRG and EEC	Meeting to be set up by CW to report on lessons learnt from last incidence of a level 3 Heatwave event in July. **CW** reviewing heatwave plan in light of issues identified during 2018 heat wave.	December 2018	JM/CW	
A6 - JM to review adaptation as a whole and develop a plan to ensure staff are aware of the impact upon sustainability	JM to expand on section on Adaptation/ resilience whilst undertaking annual review SDMP		JM	
A7 - *Damian Moon* to check Business Continuity plans are HTM compliant and include contingencies for water/power shortages			ABetts/DM	
Capital Projects – Workstream Lead – Andrew Bennett				
CP1 - Implement the measures in Sustainability Design Guidance	Guidance now in use by Capital team including for new Vascular Imaging Unit . Launch event to be planned for guidance to both Capital and Estates teams	December 2018	AB	
CP2 - Where appropriate develop further opportunities for direct patient and visitor engagement as part of the design process for new building and refurbishment projects and incorporate this into new Capital Projects Procedures			AB	
Green Space & Biodiversity – Workstream Lead – Andy Betts				
GS1 - John Dickinson to review grounds and green spaces in their local areas and consider further actions over next year to ensure negative impacts are minimised	Andy Betts to delegate these actions	Jan 19	ABetts/JD	
GS2 - John Dickinson to review their local areas and work with local greenspace and biodiversity partners such as wildlife trusts, local bee keepers, or the local nature partnership to improve biodiversity on our estate in line with local strategic plans.		Jan 19	ABetts/JD	

GS3 - John Dickinson to develop more quantitative metrics for applying to projects at the post-occupancy evaluation stage. Consider extending sub-metering to individual ward and departmental levels to demonstrate that we are delivering positive impacts on the health and wellbeing of building users and the environment.		Jan 19	ABetts/JD	
GS4 - Seraph Mollier to lead project to have a third party supplier to provide a fruit and veg stall initially on the York site working with a local supplier (locally sourced and locally gown) and consider rolling this out to other main sites in 2019 if the project is successful	Current contract for York Hospital ground floor retail areas does not allow the Trust to arrange for the sale of fruit and vegetables from another supplier. The Director of Estates and facilities has contacted the company Director to request a variation on the contract which would allow the Trust to set up a fruit and vegetable stall. A reply is awaited. (AB)	June 18	ABetts/SM	
GS5 - Seraph Mollier and Jenny Louth to aim to exceed Govt guidelines during future catering and food contracts and processes where possible and advise where this has and has not been achieved		April 19	ABetts/SM/ JL	
GS6 - Seraph Mollier, Jenny Louth, Pierre and Hugh Stelmach to investigate opportunities for on-site composting or using compost from our waste contractor	The green waste from our hospital sites is currently collected and converted by Yorwaste into compost. I have asked Yorwaste if they will donate sufficient quantities of their compost (free of charge) to our gardening staff to use across our main hospital sites. If successful, our green waste would return as compost. HS	Sep 18	ABetts/SM/ JL/PG/HS	
GS7 - Jane Money to investigate potential use of green space at south end of York Hospital and also "*York Men in Sheds*" initiative	Currently limited resources/ time to progress this and may be one to postpone til 2019/20.		JM	
Sustainable Care Models – Workstream Lead – Steve Reed				
SC1 - JM to carry out regular sustainability awareness activities for Board over 2018-19 and consider holistically sustainable care models and associated progress reporting	Work to commence as part of WRM Phase 2 Project. JM	February 2019	JM	
SC2 - Roll out health coaching training to all community nurses	Top line progress so far • 15 Health Coaching Facilitators (2 days plus 4 half days) started their training last September with a follow-up half day planned for September 2018 • ODIL are in the process of talking with all facilitators to identify what take up they have had with staff and any training/ support they might need in September.	July 18	SR	

	Training was completed this month for: • 243 staff in community (2 x half days)			
SC3 - Develop an organisational approach and understanding of the wider benefits of developing sustainable models, and evidence this through the redesign of a targeted model	Proposal to use development of the Outpatient Parenteral (IV) Antibiotic Therapy (OPAT) service as the targeted model	Mar 19	SR	
SC4 - Monitor training for all nursing and medical staff to support brief interview by acute wards in relation to supporting patients to live more healthy and sustainable lives	Will be measured through delivery of the Trust CQUIN	Mar 19	SR	
SC5 - Identify a best practice approach (using national literature or advice from WRM) to test on a single care pathway/service to assess sustainable delivery	National sustainable care pathways guidance obtained, need to understand application for use with the OPAT service (above)	Mar 19	SR	
SC6 - Run an open event for staff involving a number of speakers (including staff)who have links and connections with overseas healthcare organisations with the intention of forming a staff Steering Group to publicise and develop potential staff exchange programmes	Event scheduled for October Clinical Governance Sessions	Oct 18	SR	
SC7 - Continue to develop our approach to engaging local people in the design of services	Report to Board (July 2018) on Home First engagement process and proposals for next steps; engagement to be built into cancer strategy. To be discussed with new engagement lead.	Complete	SR	
Our People/Workforce – Workstream Lead – Sarah Vignaux				
OP1 - To engage a new provider of staff survey /staff friends and family test. The aim is to provide staff with an opportunity to take part in online discussions on a range of topics.	The tendering process is underway with a new contract to be awarded by 1st September. Oct updated; Completed – Tender awarded, work started with new provider.	Dec 18	Sarah Vignaux / Vicki Mallows/ Alison Cockerill	Undertake a review of the contract 6 months post implementation. Comparison of staff friends and Family and Staff survey results pre and post implementation.
OP2 - Further development of our ongoing commitment to stakeholder engagement through a review of attendees at Trust Fairness Forum.	Initial discussions to be held at August Fairness Forum – deferred to Nov Fairness Forum.	Nov 18	Sarah Vignaux	Development of a revised agenda.

				Seeking feedback from group post implementation.
OP3 - Commitment to ongoing review of policy related to smoking on site.	Started – visit to another Trust took place late summer to review their policy.	Apr 19	Sarah Tostevin	
OP4 -Commitment to ongoing review and promotion of staff wellbeing schemes and staff benefit schemes;	Staff benefits are embedded in the Trust - website for staff benefits available externally. Embedded - Available benefits promoted annually via staff benefits fairs. Embedded - Health and wellbeing task and finish group in place	Ongoing	Sarah Tostevin	
OP5 -Corporate action plan to be developed following results of staff survey.	Embedded annual process - staff survey results due December 18	Dec-18	Vicki Mallows / Alison Cockerill	
OP6 - Benchmark of equality and diversity policy / strategy against other Trusts	Started - Information gathering in progress	Apr 19	Sarah Vignaux	
OP7 - Commitment to implement alternative recruitment methods to reduce travel.	Partially completed -Some methods already available – e.g. webex.	Ongoing	Will Thornton	
OP8 -Commitment to rolling review of recruitment activities to enable us to reach different communities (aim to increasing the diversity of our workforce)	Embedded activity - Already attending fairs and recruitment events within the community Use of social media (e.g. Facebook) to promote posts	Ongoing	Will Thornton	
OP9 - Create and implement plan for removal of band 1 posts in line with national terms and conditions update.	Partially completed - Plan released Sept 2018, implementation complete by Dec 18.	Dec 18	Will Thornton	
OP10 -Review and update disability confident action plan in readiness for upcoming self-assessment	Embedded - Successful self-assessment Oct 2017, undertaken biennially; next due Oct 2019	Mar 19	Sarah Vignaux	
OP11 - Create specific sub-groups of executive policy group to enable successful implementation of certain workforce policies	Policy group embedded. Sub groups as needed. For example; group to be put together to review training package and implementation of discipline policy	Dec 18	Jenny Flinton / Sarah Vignaux	
OP12 - Rolling program of engagement with stakeholders through Equality and Delivery system which assesses access to services for protected groups	Embedded process – but ongoing assessment required. Next event due early summer 19.	June 19	Sarah Vignaux	
OP13 - Implement international recruitment programs to meet supply shortages in UK market	Started - engagement with organisations across the globe	Ongoing	Will Thornton	
OP14 - Undertake a rolling review of the Trust recruitment processes with key stakeholders.	Partially completed Listening exercises have started with the Chief Nurse team in reviewing nursing recruitment with a focus on improving applicant experience.	Dec 18	Will Thornton	
OP15 -Continue implementation of the 'Trust brand' through targeted recruitment campaigns	Partially completed - Work with an external provider has been undertaken to develop the brand we are in the early implementation stage. Two successful campaigns have been undertaken so far	Ongoing	Will Thornton	
OP16 - Create and implement a supporting staff procedural document	Partially completed - Initial draft due end of Oct 18	Nov 18	Brian Tomlinson	

Sustainable Use of Resources – Workstream Lead – Andy Betts				
SU1 - Health and Well-Being group working to increase the amount of healthy and sustainable food choices in our community services/organisation (Pierre Gomez is chair)	Vending machines are CQUIN compliant together with all cold food including sandwiches, drinks and confectionary e.g. 80% of drinks has less than 5g of sugar. Work is on-going with dieticians through Health and Well- Being Group to ensure that healthy choices are available in the hot food served at community hospitals cafes at Malton and Selby Hospitals and also at all this Trust Acute hospitals (PG)		ABetts/SR	
SU2 - Hugh Stelmach to review whether all relevant staff are trained in their role in minimising the use of chemicals.		Jan 19	HS	
SU3 - Seraph Mollier and Jenny Louth to consider the tracking the food miles, consumption patterns and disposal of food and drink products for staff and patients and where possible incorporate this into future contracts. Also to consider maximising the use of fresh and seasonal food		Jan 19	SM/JL	
SU4 - Paul Johnson (ideally with Andrew Bennett) to review the reduction of hazardous and toxic chemicals and take a pro-active approach as contractors are engaged		Jan 19	ABetts/PJ	
SU5 - A Betts to speak to Liz Vennart regarding supporting staff on how to reduce food wastage to reduce the environmental impact and to help support staff avoid food poverty.			ABetts	
SU6 - Hugh Stelmach to ensure all waste streams are subject to a formal contract. Each contract will have relevant KPIs and supplier involvement to encourage innovative ways of waste management and waste reduction, where possible.	Work has begun on the specification for the confidential and general paper waste and WEEE waste streams contract tender (for all Trust sites). Negotiations are also currently underway to renew the domestic waste contract.	Dec 18	HS	
SU7 - Hugh Stelmach (with Colin Weatherill) to review the Waste Management Policy. The aim of the review is to ensure the guidance within the policy is relevant and reflects the current waste practices at all Trust sites *including continual reduction of hazardous waste (from a clinical perspective).* Further actions will also be developed to raise awareness with staff of the need to improve waste	27% recycling target set for 2018/19 25% recycling achieved in 2017/18 (a significant improvement from 2013/14 when only 16% was achieved. The proportion of waste being sent to landfill has reduced form 49% (723 tonnes) in 2013/14 to 23% (616 tonnes) in 2017/18	Dec18	HS/CW	

separation to achieve higher rates of recycling and waste recovery.				
SU8 - Develop and promote sustainable catering initiatives which tackle plastics removal and reduction in non-recyclable materials	Sustainable Facilities sub-Group set up and chaired by JM. Board supported top five actions. DB to organize comms and posters relating to top five actions	October 2018	JM/DB/CW	
Procurement – Workstream Lead – Ian Willis				
P1 - Monitor the environmental impacts (CO2e and air pollution) associated with our suppliers' transport and logistics and work with our suppliers to find ways to minimise their traffic burden	We are working in partnership with NHS Supply Chain to consolidate the number of deliveries that are made to site. We currently receive 35% of our goods via this route but over the next year we are seeking to move this to 50%	July 19	IW	Monitored by the Partnership Programme Board
P2 - Improve reporting and take up of material re-use by signing up to a network such as 'Warp It' which enables staff to trade surplus assets with each other through an online marketplace	Part of WRM phase 2 project - Corporate Directors approval granted June 2018 for WRM Phase 2 and new job roles with HR for banding	Jan 2019	IW	
P3 - Recycled unbleached paper	We have rolled out to the Trust the use of 100% recycled and unbleached copier paper	Sept 18	IW	Monitoring uptake through TR Reporting
Carbon/GHGs – Workstream Lead – Jane Money				
C1 - Develop SMART targets and monitoring methods in carbon reporting through Sustainable Engagement project with consultants WRM	Corporate Directors approval granted for WRM Phase 2 and new job roles with HR for banding. Phase 2 WRM contract outline now with Procurement 2017/18 Carbon footprint in preparation to be completed before October EEC		JM	
C2 - Review air pollution via Trust Travel Plan and Health promotion via Health and Wellbeing and Green Teams	Environmental and Sustainability Manager in post from 6th August and will review this area of work		JM/DB	

York Teaching Hospital NHS Foundation Trust

FM Contract (YTHFM)

Monthly FM Compliance Report

Month	**October 2018 (7)**
David Biggins	Head of FM Compliance & Performance
(Quarter) /Year	(3) 2018/2019
Version	1.1

With effect from 1st October 2018 the provision of Estates, Facilities and Capital Development services transferred into a wholly owned subsidiary (York NHS FM).

As part of the contract monitoring arrangements an FM Compliance team led by Head of FM Compliance has been retained by York NHS Teaching Hospital Foundation Trust with the remit to monitor compliance and performance of the FM Contract.

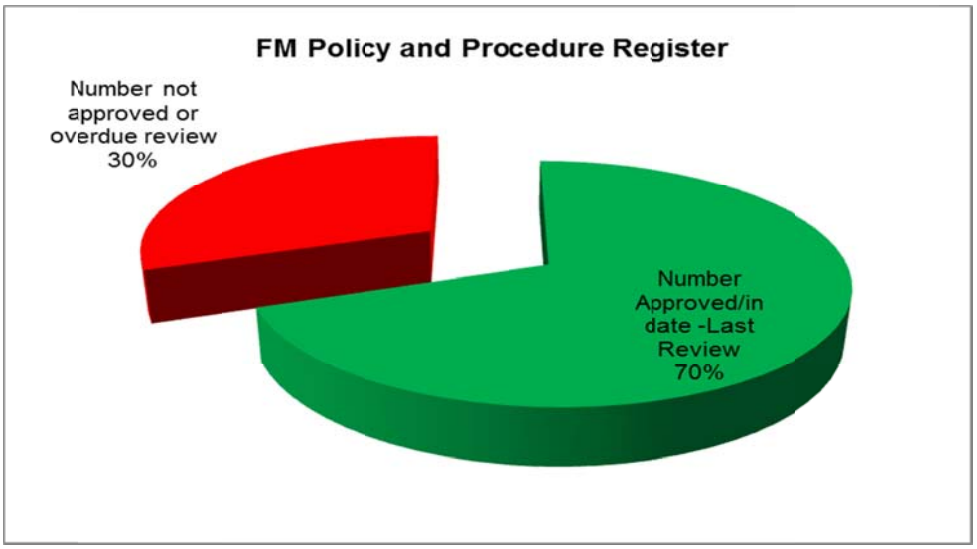
This report supersedes previous Estates & Facilities Directorate Monthly FM Compliance Reports that were issued between February and September 2018.

1. Policy and Procedure Compliance- Directorate

There has been a 9% reduction on compliance with this Key Performance Indicator against the previous month. Portering and Travel and Transport policies & procedures remain overdue review and there are still a number of other policies and procedures which are outstanding including Ventilation and Air Conditioning, and Catering.

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.

The Electrical Safety Plan currently published on the Trust intranet is overdue review.



2. Decontamination of Reusable Medical Devices- Site

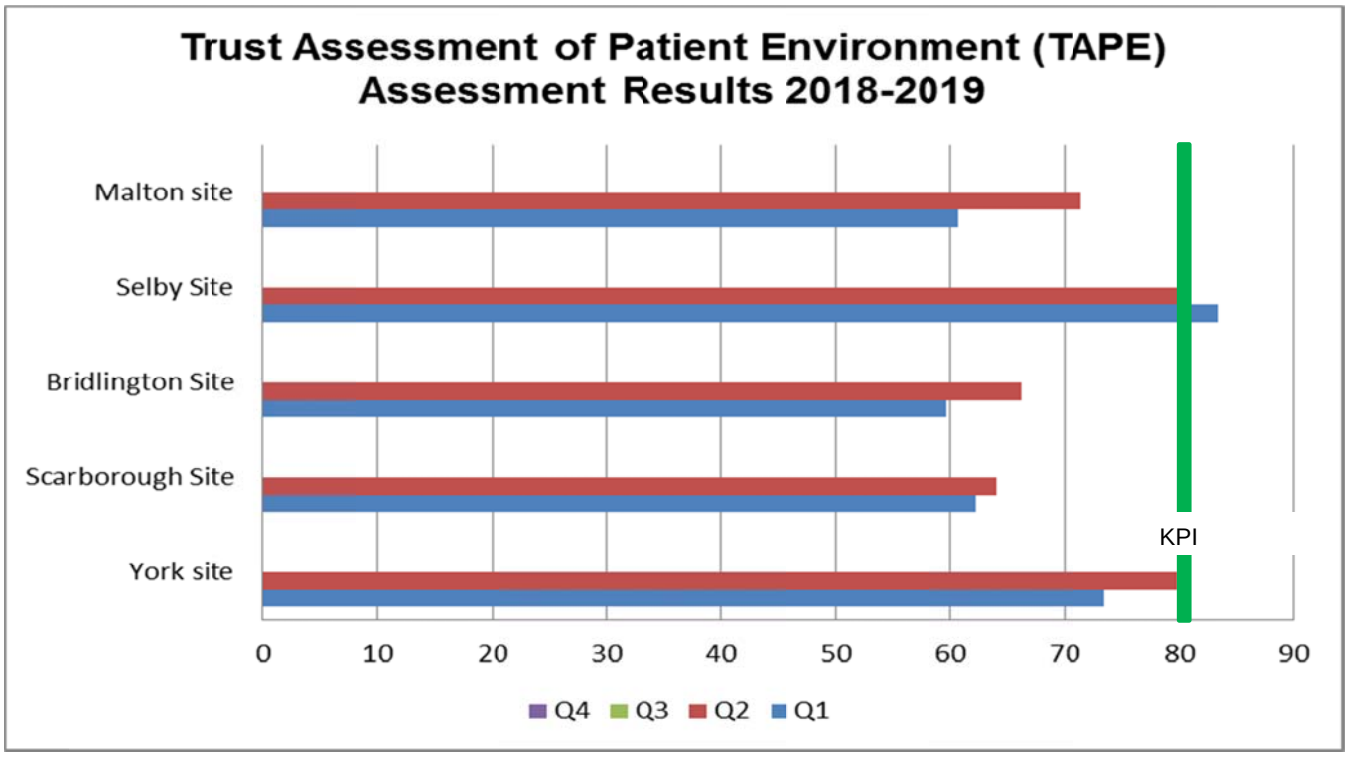
Decontamination of Reusable Medical Devices- Audit Dashboard					Reviewed:	27th September 2018							
Audit Activity	Last Audit	Next Audit			Annual Audits to date	No of Major Corrective Actions at Last audit							
					Overall Compliance	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Endoscopy SGH/BDH	Aug-18	Aug-19			Endoscopy SGH/BDH	4	1	2	3	5	4	0	
Endoscopy -York	Aug-18	Aug-19			Endoscopy -York	0	0	5	5	0	2	0	
Sterile Services- SGH	Aug-18	Aug-19			Sterile Services- SGH	2	2	0	0	2	0	0	
Sterile Services- York	Aug-17	Aug-18			Sterile Services- York	0	2	2	1	0	0	0	
Outpatients- BDH	May-18	May-19			Outpatients- BDH	4	2	0	2	0	1	0	
Outpatients-SGH	Jan-18	Jan-19			Outpatients-SGH	1	1	0	0	0	0	0	
Cardio Unit- SGH	May-18	May-19			Cardio Unit- SGH	2	1	1	0	1	1	2	
Cardio Unit- York	May-18	May-19			Cardio Unit- York	*	*	*	*	*	2	0	
Last audit Scores	R	A	G/NA		Audit Action Plan Submission								
Endoscopy SGH/BDH	0	3	162	165	Endoscopy SGH/BDH								
Endoscopy -York	0	3	162	165	Endoscopy -York								
Sterile Serv- SGH	0	1	35	36	Sterile Serv- SGH								
Sterile Serv- York	0	5	31	36	Sterile Serv- York								
Outpatients- BDH	0	1	14	15	Outpatients- BDH								
Outpatients-SGH	0	1	14	15	Outpatients-SGH								
Cardio Unit -York	0	1	14	15	Cardio Unit -York								
Cardio Unit- SGH	2	1	12	15	Cardio Unit- SGH								
	2	16	444										

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, condition and appearance, accessibility and privacy and dignity associated with our sites.

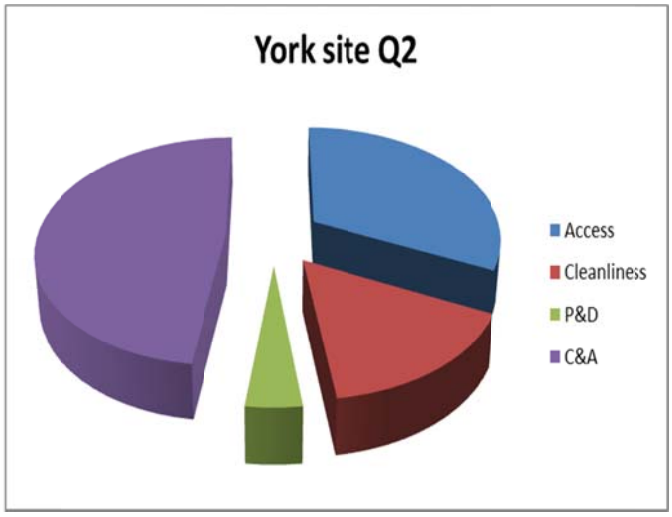
Currently only one site is meeting the 80% Key Performance Indicator set, however over the past 9 months and at the last 2 quarterly assessments site scores are generally improving as issues are identified and then subsequent corrective actions are taken by Estates & Facilities teams.

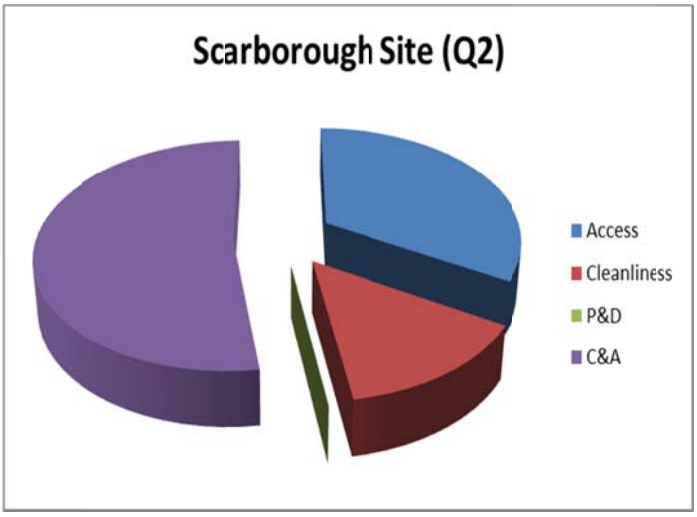
Quarter 3 Assessments are due to be undertaken over the next 4 weeks.

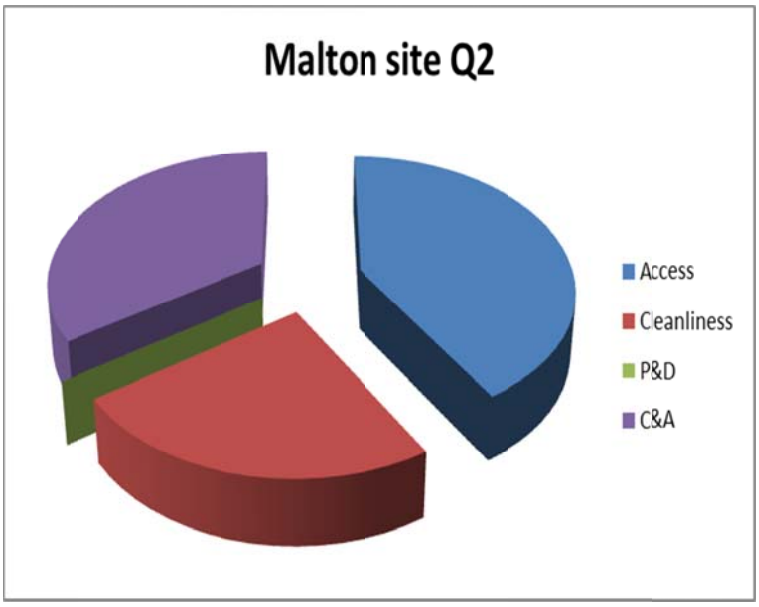


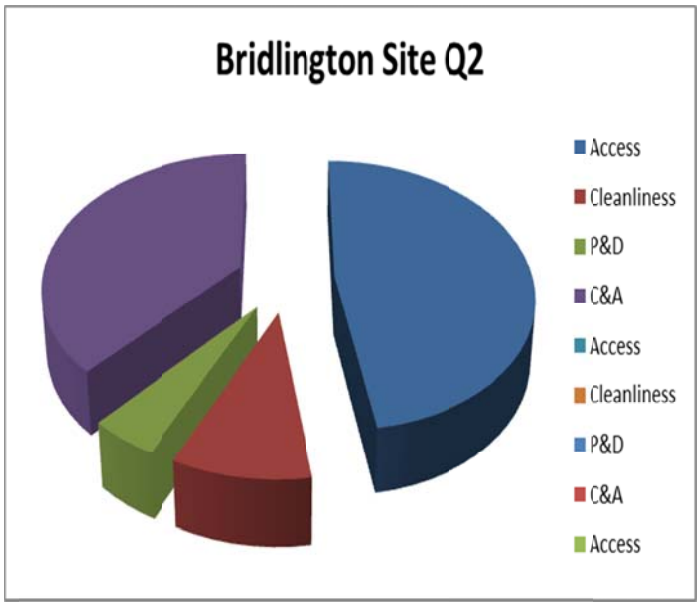
TAPE- Non- Conformances- By site

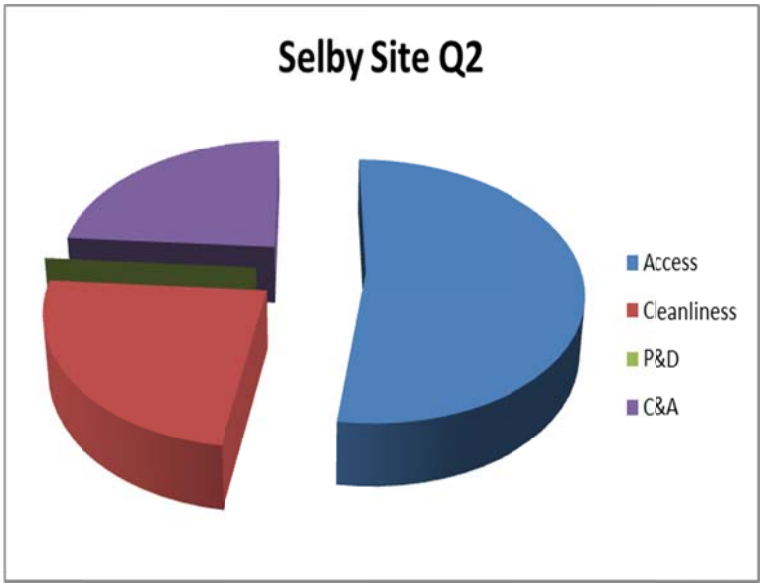
Accessibility, Cleanliness, Privacy & Dignity (P&D) **Condition & Appearance (C&A)**











It can be seen from the non-conformance information above that a number of non-conformances identified are associated with the condition and appearance, cleanliness 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.

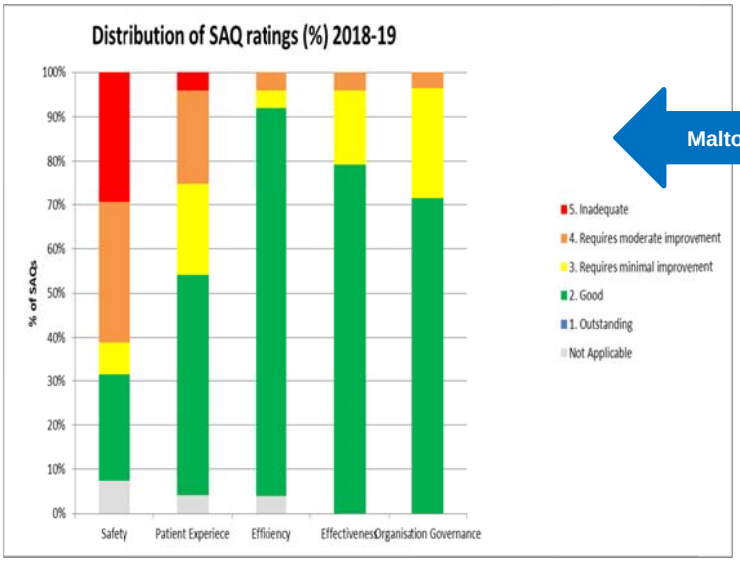
Accessibility is more complex in that the design and specification of the built environment will in primarily determine how accessible the environment is for existing buildings detailed accessibility audits will be undertaken by the FM Compliance team once fully resourced, beginning in in autumn so that a fuller picture of compliance with Building Regulations Approved Document M and NHS Wayfinding guidance can be evaluated.

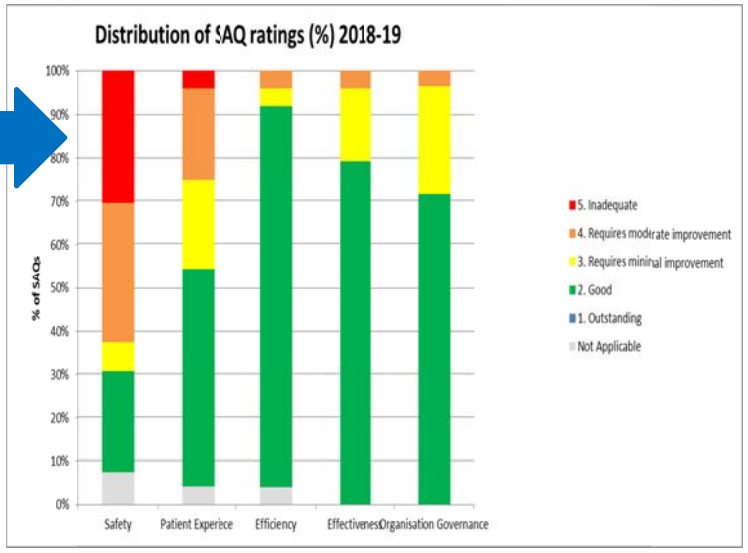
4. NHS Premises Assurance Model Position (By site)

26th August 2018

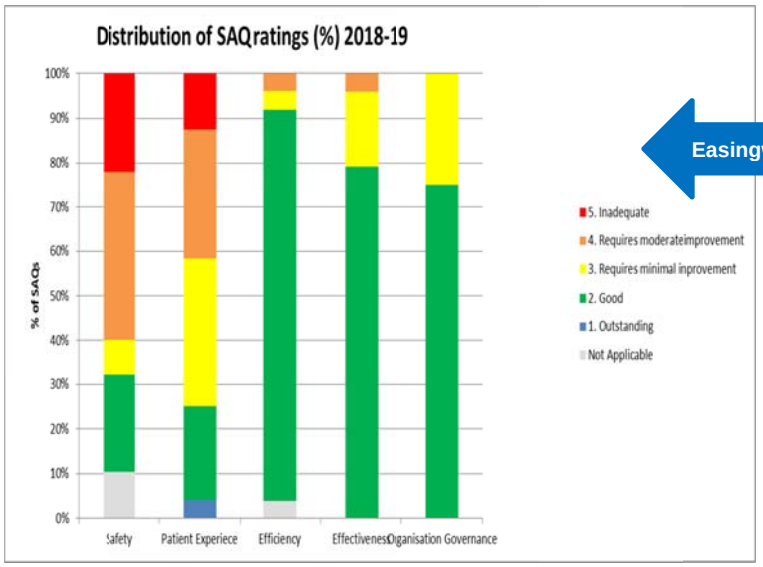
26th October 2018

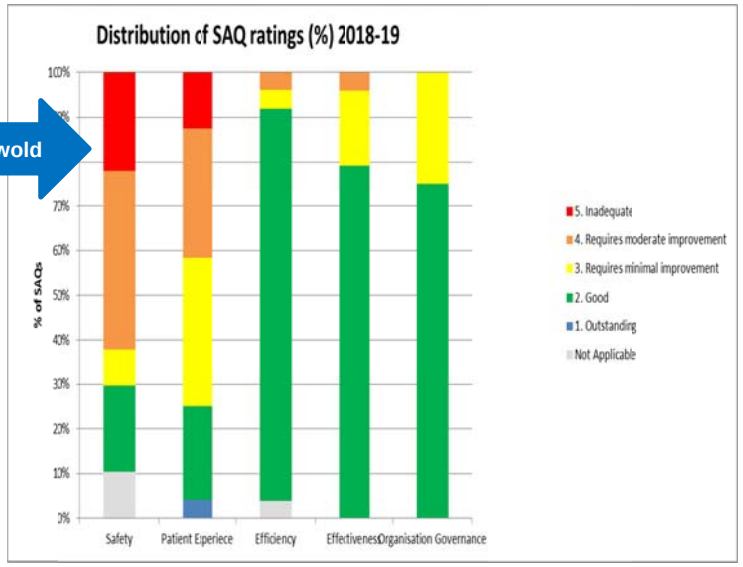
Malton



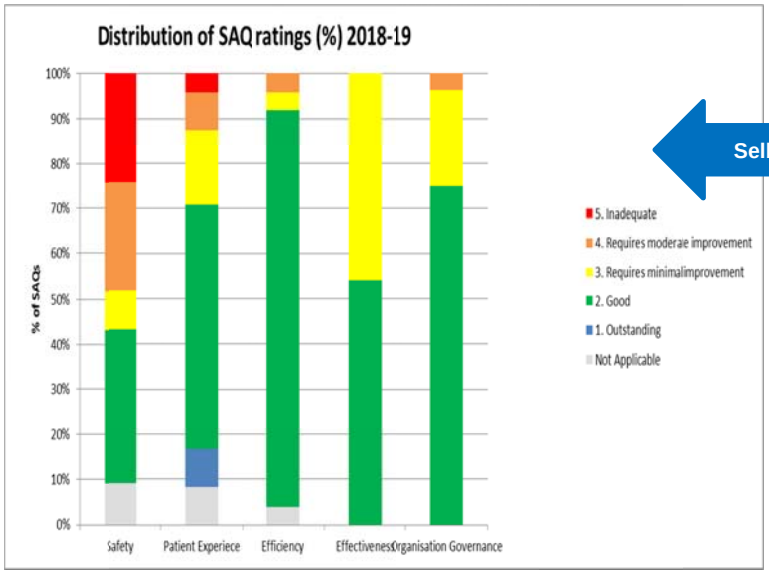


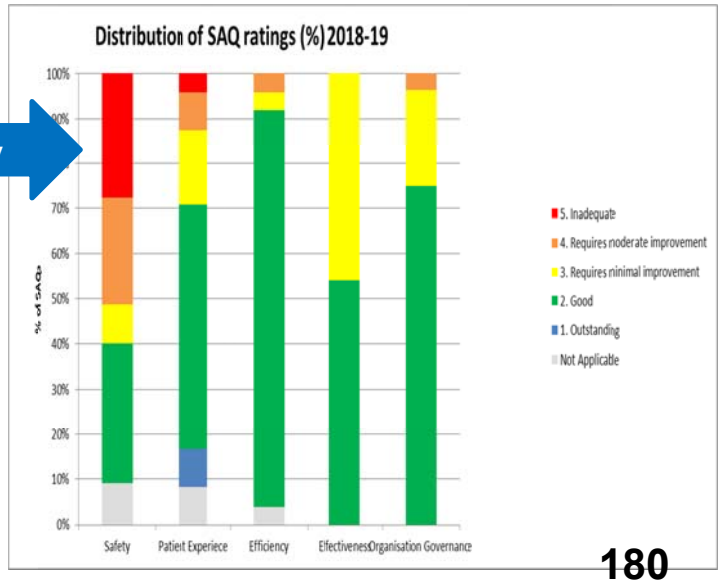
Easingwold



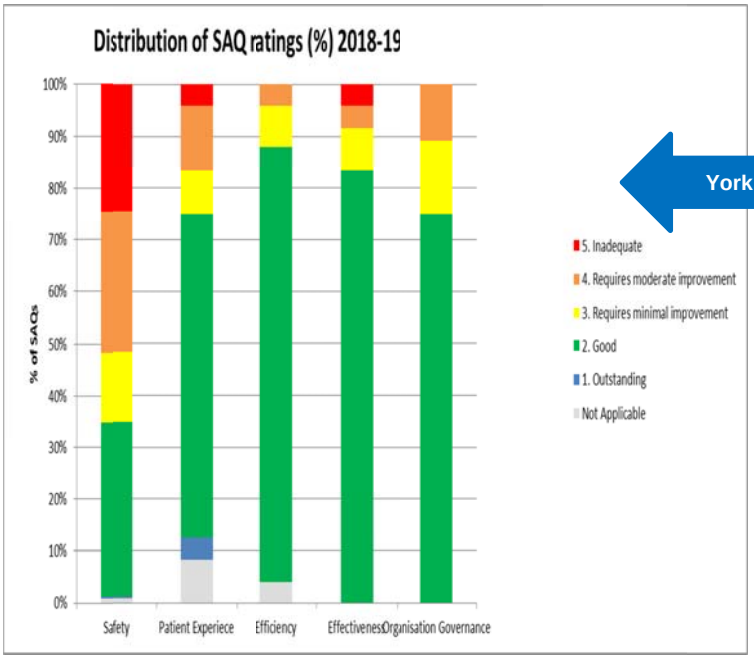


Selby

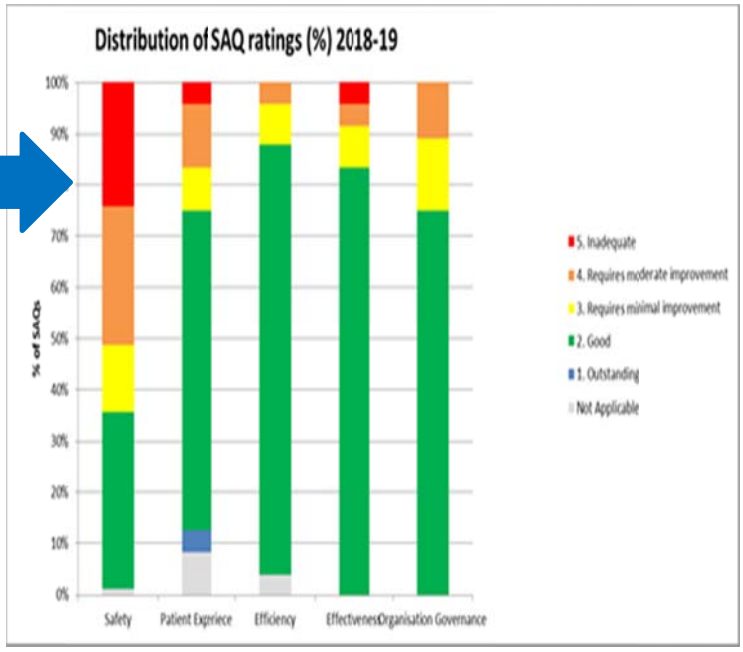




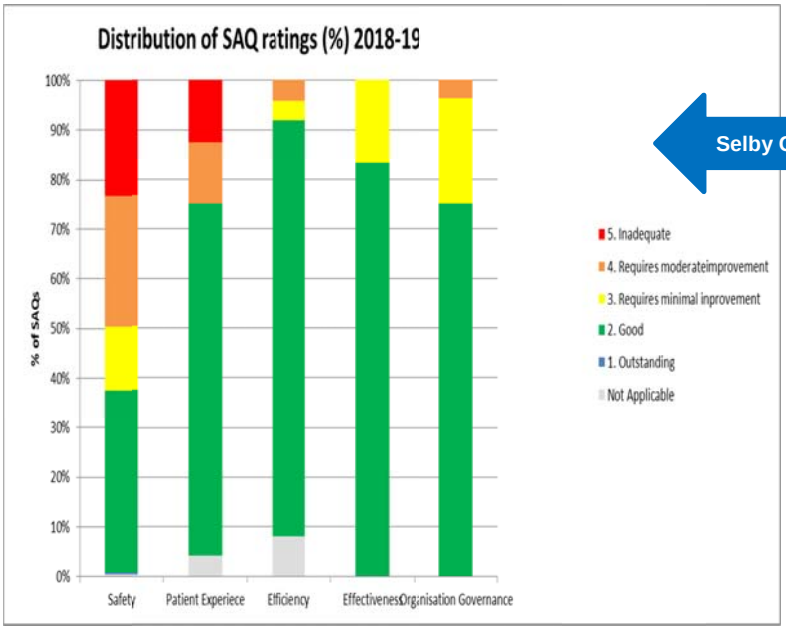
26th August 2018



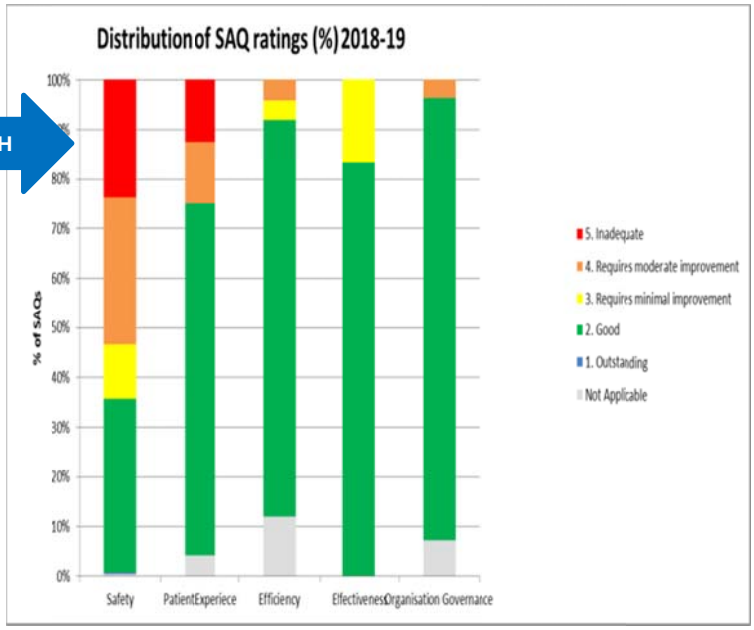
26th October 2018

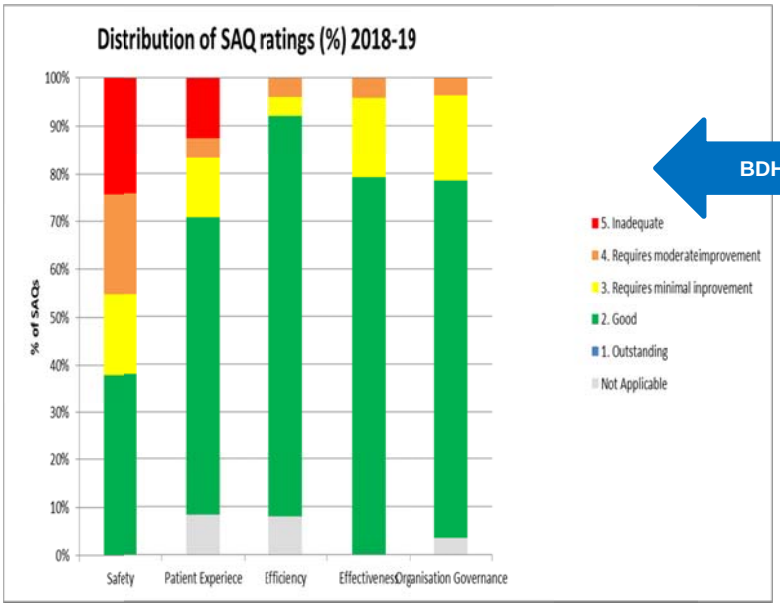


York

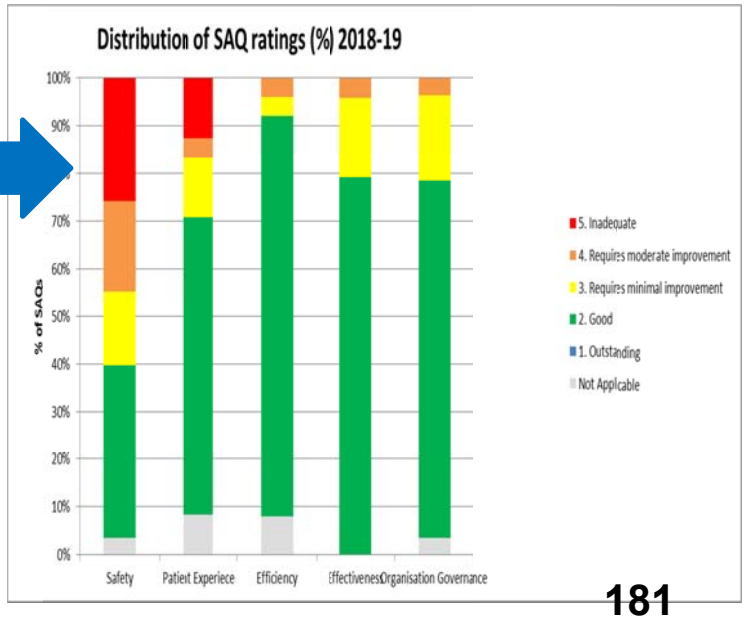


Selby CH





BDH



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,(ie less than 20% "inadequate" or "requiring moderate improvement" ratings. Both safety and patient experience domain assurance is affected.

<20% Red or amber PAM Ratings	20-30%	>30% Red or amber PAM Ratings

Percentage of SAQs (Safety & Patient Experience) rated as inadequate or requiring moderate improvement

York Site	48%
Scarborough Site	52%
Bridlington Site	44%
Selby Site	47.6
Malton Site	57%
Easingwold Site	60%

It should be noted that as Estates & Facilities functions have now moved into the wholly owned subsidiary (WOS) that the WOS model formed is expected to provide to the Trust a quarterly assurance position against the NHS Premises Assurance Model Safety and Patient Experience domains.

It is essential that Estates & Facilities Managers within the WOS fully engage with this process 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.

The NHS PAM Efficiency, Effectiveness and Governance domains will be assessed by the Trust FM Compliance team and this change is reflected on the revised Key Performance Indicator dashboard shown in section 7 of this report.

5. PLACE ASSESSMENT 2017 & 2018 RESULTS

The organisations 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 position 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 Trust's local indicators such as TAPE and Cleanliness monitoring audits also demonstrate limited assurance.

The tables on the next page compare the organisation's positions 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 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

Environmental Cleanliness Monitoring

The FM Compliance team now have a full team of Cleanliness Monitoring Officers in place who monitor environmental cleanliness via Technical audits across the organisation in accordance with the NHS National specification for cleanliness and requirements of Regulation 15 (Premises and Equipment) of the Regulated Activities Regulations 2014, (Part 3).

The average scores by site are shown in Section 7- KPI Dashboard of this report with some more area specific information relating to a sample of areas classified as “Very High Risk” within the NHS National cleaning specification available at Appendix 1

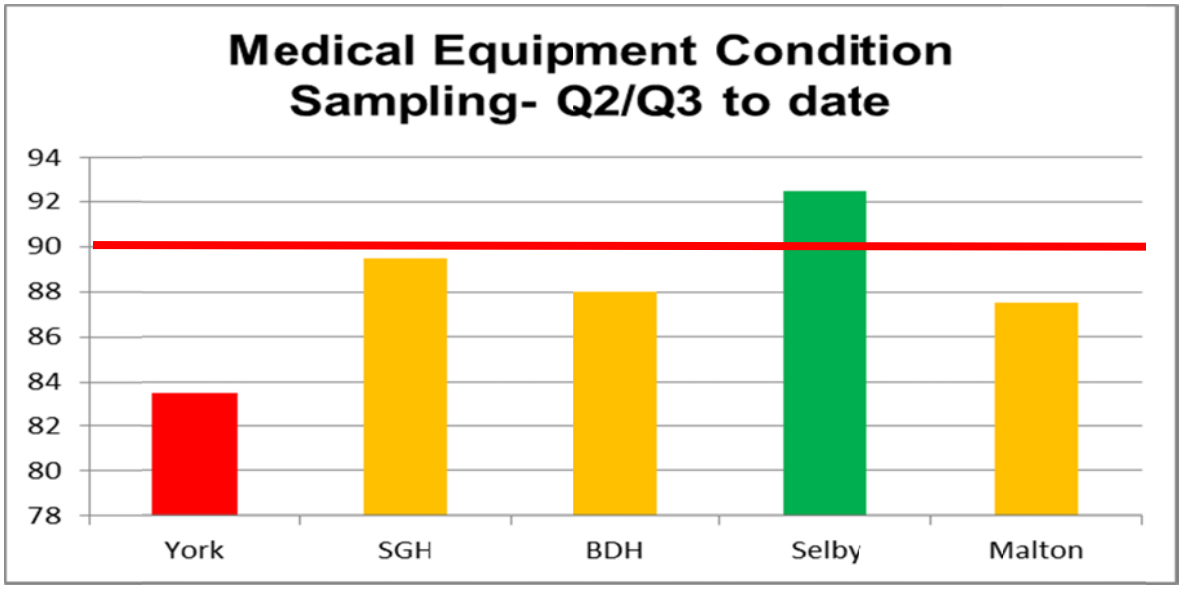
Medical Equipment Surveillance Results

The provision of medical equipment in a manner that is both appropriately maintained is a key requirement of compliance with Regulation 15 of the Health & Social Care Act (Regulated Activities) Regulations 2014, part 3.

Sampling of FM Contract performance in this area is undertaken quarterly at sites shown on the graph below through an audit of 250 devices across the organisation.

The Key Performance Indicator against this activity is 90% compliance which in terms of the audit allows 25 defects against the audit criteria.

The York site data below includes data relating to operating theatre and Post anaesthetic care unit equipment at the York site.



7. Facilities Management Key Performance Indicator Dashboard- Month 7- October 2018

Metric Description	KPI	York Site	SGH Site	Bridlington 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%	70%	70%	70%	70%	70%	↓
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* ***(Trust) Efficiency, Effectiveness & Governance Domains***	<20%	7.7%	2.5%	3.8%	2.5%	3.8%	New Metric
All sites are demonstrating **less than 20%** *moderate improvement or inadequate compliance ratings against the* ***NHS Premises Assurance Model (LLP) Safety & Patient Experience domain.***	<20%	48%	52.1 %	44%	47.6%	57.2%	
PLACE Assessment 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%	95.39	97.34	98.03	95.61	NA	↑
High Risk (av)	>95%	85.29	92.95	95.47	90.86	83.56	↑
Significant Risk (av)	>85%	73.52	76.98	79.46	93.45	84.5	↓
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%	83.5%	89.5*	88.	92.5	87.5	↓
	KPI	York Site	SGH	Bridlington	Selby	Malton	

Total Number of KPIs in place =70	York Site	Scarborough Site	Bridlington Site	Selby Site	Malton Site	Total
Last Month/This Month						
High Assurance	1/1	0/1	0/3	7/8	2/2	10/15
Partial Assurance	5/7	6/8	7/5	4/5	4/6	26/31
Limited Assurance	8/6	4/5	5/6	2/1	6/5	25/23
Not applicable	0/0	0/0	1/0	2/0	1/1	4/1

Summary of Performance

1. The organisation's compliance position against the NHS Premises Assurance Model (Section 4 of the Report) has again slightly 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 position and it is recommended that Estates & Facilities Managers give this some attention as a priority.

2. The current position indicates an absence of key documents including policies and procedures, training records, risk assessments and business continuity plans.
   Compliance associated with safety domain including ventilation asset management, design and layout of environments, pressure systems and contractor management needs some review and action with some pace.

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, cleanliness and general condition and appearance at the majority of sites, this is further borne out by the 2018 PLACE Assessment results.

4. A process for checking progress against any defect rectifications identified during TAPE assessments is in place.

5. The Trusts 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 each quarter.
   Although this surveillance only provides a sample of around 1% of the total medical device inventory in use it is providing some useful data to identify where defect rectification is required with the information shared with FM Contract providers (LLP) within 1 working day of the surveillance.

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.

   The Wholly owned subsidiary is currently providing assurance at a level of 21% against safety Key Performance Indicators

HIGH	**60-70**	**85-100 %**	High number of KPIs are being met indicating operational arrangements are effective and generally being met	
PARTIAL	**30-69**	**42-84 %**	A moderate number of KPIs are being met indicating some elements of good practice but also elements that require improvement	
LIMITED	**<30**	**<42%**	Very Few KPIs are being met indicating week operational controls and significant improvement required	**21%**

APPENDIX 1

Sample of " Live" Cleaning Scores as at 11am on 26th October 2018

BDH	Theatre Suite (Shepherds Daycase)	Theatres	Very High (Biweekly)	97.15
BDH	Main Theatres	Theatres	Very High (Biweekly)	98.74
BDH	New Vanguard Theatre	Theatres	Very High (Biweekly)	97.92
SS	ERU - Renal Unit	Easingwold Renal Unit	Very High	95.1
SS	MAH - Urgent Care Centre	Malton Hospital	High	81.27
SGH	Theatres	Theatres	Very High	99.04
SWM	Minor Surgery	Clinical Department	Very High	94.24
YH	Theatres - Patient Areas	Theatres	Very High	93.95
YH	Day Theatres	Theatres	Very High	97.09
YH	Eye Theatres	Theatres	Very High	96.4

York Teaching Hospital NHS Foundation Trust

Directorate of Estates and Facilities

PLACE Results 2018

Patient Led Assessment of the Care Environment

Contents

1.0 Introduction

The Patient Led Assessment of Care Environments (PLACE) is a process by which NHS Providers can engage with patient groups and undertake assessments of key areas of facilities management provision in healthcare organisations providing a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

PLACE assessments are an annual evaluation of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors) over a 4-5 week period, usually in the spring.

The National PLACE results and accompanying Reports were published on 16th August 2018 by NHS Digital and The Government statistical service and can be accessed at:

https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place/2018---england#summary

2.0 The PLACE Assessment Process

The Patient Led Assessments of the Care Environment (PLACE) for York NHS Teaching Hospital Foundation Trust took place between 28th March and 2nd May 2018 on all of the Trust in-patient sites utilising 20 teams of patient assessors and Trust staff.

All of the assessments were self-assessments with over 30 patient representatives, in 20 teams actively involved in the process and an external validator being used for five sites ,(St Helens, St Monica's, York, Selby and Bridlington). The external validators used were Ross Mitchell from Harrogate District Foundation Trust and Arran Richardson from Leeds Teaching Hospitals NHS Trust.

Members of Trust Board of Governors were eligible to act as `patient assessors` within their Trust since their primary role is to represent the interests of patients/public.

A Joint training venture was delivered by between Health watch York and the Trust in December 2017 to ensure the assessment process was understood by the patient assessors and Trust staff involved in the assessment process. Additional Training was provided at the Scarborough site in January 2018 with both events being attended by around 30 trust staff and patient assessors.

PLACE teams consisted of the mandatory 50% patient assessors and leads from Facilities, Matrons, FM Compliance Managers and Infection prevention & Control teams, importantly for the process Infection prevention Specialist Nurses attended a number of assessments across sites.

The minimum specified 25 per cent of wards, departments and non-ward areas with varying age and condition was met which allowed the PLACE teams to make informed judgements about the areas visited.

At the end of the process, each hospital/ unit which has undertaken an assessment is provided with a score against each of the six assessment domains: Cleanliness; Food and Hydration; Privacy Dignity and Wellbeing, Condition Appearance and Maintenance, Dementia and Disability.

This overall result is calculated by reference to the score (points) achieved expressed as a percentage of the maximum score (points) which could have been achieved had every aspect of the assessment they undertook achieved the maximum score.

The food assessment is split into two components – an Organisational component which addresses the catering services provided by the organisation, and an assessment of ward based practice and the quality (taste, texture and temperature) of the food provided. The questions in the Organisational section are scored according to a weighting algorithm which reflects the relative importance of each question. To allow for the fact that different hospital types answer a slightly different number of questions there are three weighting algorithms. All questions in the Ward-based component have a maximum score of 2 with the exception of Food Taste which from 2015 uses the weighted methodology.

Participating organisations and others who may use these data will be able to benchmark their performance or the performance of particular types of organisations.

For the purposes of comparison, a national average of scores from all participating hospitals/ units has been calculated. This average is weighted to take account of the fact that hospitals vary in size and that in larger hospitals not all areas are assessed. The weighting factor used in this calculation is bed numbers. Bed numbers are used since they are common to all organisations, whereas some premises in which assessments are undertaken do not have wards e.g. certain mental health/learning disabilities units and Treatment Centres.

This national average score is included in national performance data compiled by NHS Digital. NHS Improvement, namely the NHS Model Hospital portal.
PLACE Scores also form part of the Estates & Facilities Directorate Key performance indicator information.

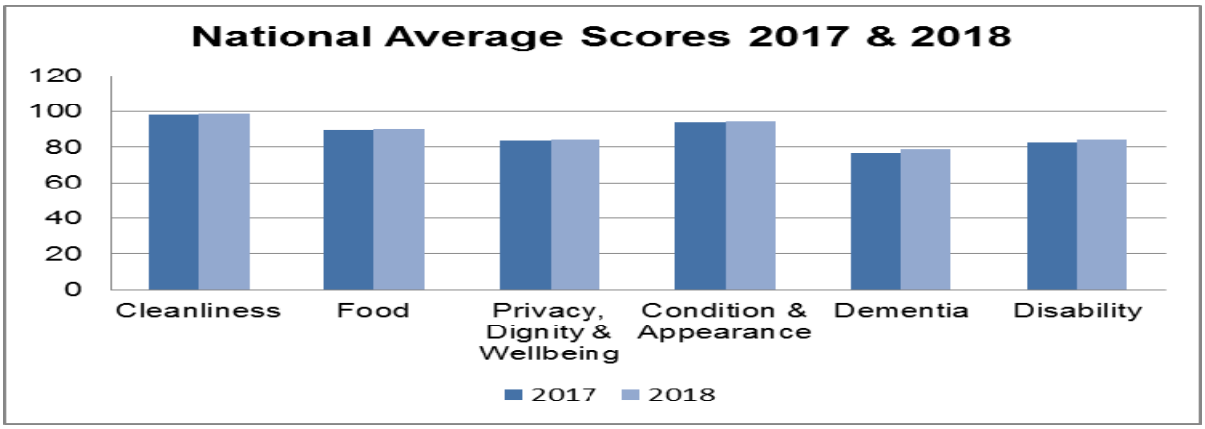
The calculation used to produce the National Average is:

$$\frac{\textit{The sum of [Each site's score (points) multiplied by the number of beds at the site]}}{\textit{The total number of beds at all assessed site}}$$

3.0 National Results 2018

The number of PLACE assessments undertaken nationally was 1,198 compared to 1,230 in 2017.
Overall the National average benchmark was slightly higher for all domains as shown in the graph 1 below with the most significant increases in National average being accessibility/disability and dementia domains.

Graph 1



4.0 York NHS Teaching Hospitals NHS Foundation Trust PLACE Results

The organisations compliance positon against PLACE assessment domains has reduced over the past 12 months across the majority of our sites..
The exception to this is the Selby Community Hospital site which scored well and above the national average on several domains as can be seen on Table 3 on the next page.

The remaining sites compliance position against National average benchmarks has reduced with some significant reductions across all our sites in terms of disability (40 reduction against benchmark), Dementia (38% reduction against benchmark), Condition, appearance & maintenance (30% reduction against benchmark) and a 23% reduction in terms of cleanliness.

PLACE 2018 –ORGANISATION SCORES

The results below are the aggregated site results expressed as an average score, this is the formula used by NHS Digital to calculate the organisations overall score and is the score by which the National average is set. The organisational scores form part of the NHS Model Hospital dataset for York NHS Teaching Hospitals Foundation Trust.

CLN Score %	Food Score %	Org Food Score %	Ward Food Score %	PDW Score %	CAM Score %	DEM Score %	DIS Score %
94.82%	79.21%	82.35%	77.78%	74.62%	86.64%	59.12%	66.74%

[1]

PLACE 2018- SITE SCORES

The following tables 2 and 3 show the organisations PLACE results by site and offer a comparison between 2017 and 2018 results and analysis of how in 2018 the organisation performed against national average results.

Table 2

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

[1] [1] Data source NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place

Table 3

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%

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

5.0 Emerging Themes from our Results

Findings at this year`s PLACE Assessments across all sites identified a number of key themes which have led to the Trusts current positon, a summary of the typical findings is shown below.

Condition, Appearance & Maintenance of our Buildings

Assessment teams found multiple examples where ceiling tiles, doors and walls are in poor condition in some areas at many of the sites. Defects reported included holes in walls, scuffed doors and walls, cracked and flaking paintwork and damp patches (at 2 sites), stained, missing or damaged ceiling tiles and carpets and glazing which was in poor condition in some areas.

Communal and external areas were also identified as requiring improvement at some sites including road markings, paving potholes in roads, litter and cigarette butts particularly at the main sites where footfall is highest

In external areas there were also examples of poorly maintained street furniture, external windows in poor condition and signage and wayfinding improvements needed at some sites including Bridlington.

Across our sites a number of floors were found to be in poor condition in a number of clinical and non-clinical areas, defects included the use of tape to carry out temporary repairs for poorly joined or cracked flooring at multiple locations, PLACE Teams made several notes on the need for replacement of some floors.

Cleanliness Domain

There were multiple examples of environments and equipment not being visibly clean, however there was also some very good examples of cleanliness in our clinical areas particularly at the Selby Hospital site.

Issues such as dusty ventilation grilles in clinical areas and high and low surface dust on fixtures, fittings and equipment in wards and departments were raised with a number of areas also not prominently displaying cleaning schedules in wards and departments.

Fixtures such as hand gel and paper towel dispensers, pull cord switches in bathrooms and internal glazing, shower and bed curtains were found , on some occasions, to be not visibly clean during inspection periods, several wards and departments across our main sites scored poorly at assessment including X Ray department, Ante Natal Department and Wards 26 and 37 at the York site, Anne Wright Ward , Ash Ward and Duke of Kent Ward at the Scarborough site.

Privacy, Dignity & Wellbeing Domain

The PLACE Assessment teams identified a number of patient and visitor privacy, dignity and wellbeing improvements that could be made across sites.

Selby Hospital achieved the national average benchmark in this domain.

Emerging themes from this year`s assessment included the absence of privacy curtains in bathrooms that open onto corridors and other areas (an issue which was identified frequently at all sites) and also ill- fitting cubicle curtains that do not provide patients privacy in some areas.

The lack of treatment rooms on some wards or departments also results in patients having to undergo minor treatments at their bed space which PLACE Teams felt compromised dignity and privacy to an extent.

The assessment teams at some sites also felt that Reception desks were so close in proximity to waiting areas that anyone using reception desks wasn't afforded appropriate privacy.

Food & Hydration

Generally food quality in terms of taste, texture and temperature the findings and results were acceptable or good it is also noted that PLACE assessors felt that effective arrangements for patient hydration were also in place across all sites.

The domain scores were reduced by issues around food service including issues such as patient not getting protected meal times, the bedside table not being adequately prepared for the patient's meal and more than one course being served together.

The issue of patients having to eat meals at the bedside due to a lack of communal dining spaces in some areas was also raised at some sites.

It was also noted that on some wards patients were not given the chance to wash their hands before their meal and that they were not assisted with any food packaging removal where needed.

Dementia

The organisations dementia score has not significantly reduced since last year`s assessment however it has also not improved sufficiently to meet the National average and common themes which have been identified in previous years around the design and layout of environments were apparent again this year, these include colour schemes, signage and environmental layout across our sites.

Disability

The organisations disability score has marginally reduced since last year`s assessment and is below the national average with the Bridlington Hospital score being amongst the lowest nationally at 50.20%.

The main themes associated with the results are the lack of hand rails along stretches of corridors at multiple sites and on approaches to bathrooms at our main sites a theme which is noted annually.

Poor external and internal signage and wayfinding was also a significant contributory factor at the Bridlington site culminating in the low score achieved.
Other general themes noted include the type and design of chairs provided at Reception and waiting areas across our organisation which tend to be of the same height and width in a waiting area and in order to provide improved accessibility there should be a mixture of heights and widths supplied.
Hearing loops and other portable hearing assistive devices were found in many reception areas to be missing at assessment or in some cases present but Reception staff were not aware of how to operate them.

6.0 Trust Assessment of Patient Environment (TAPE) Process

The implementation of the Trusts own internal " mini Place" process (Trust Assessment of Patient Environment) TAPE, in Quarter 3 of 2017/2018 provides a framework by which key stakeholders can measure the cleanliness, condition and appearance, accessibility, and privacy and dignity arrangements at sites and additionally gauge progress against some elements of PLACE Action plans.

The TAPE Process is undertaken on a quarterly basis led by our FM Compliance team with engagement from Infection prevention and facilities management teams and results are reported on via monthly reports to Estates & Facilities Managers and to Trust Environment & Estate Committee on a quarterly basis with the process forming part of the Board Assurance Framework relating to premises and environment.

TAPE Assessment activity carried out to date reinforces many of the findings from springs PLACE Assessment.

The graphs below (graph 2 and 3) show sites performance against the TAPE Assessment and also this year`s Average PLACE Scores of the domains that are measured in both TAPE and PLACE
Graph 2

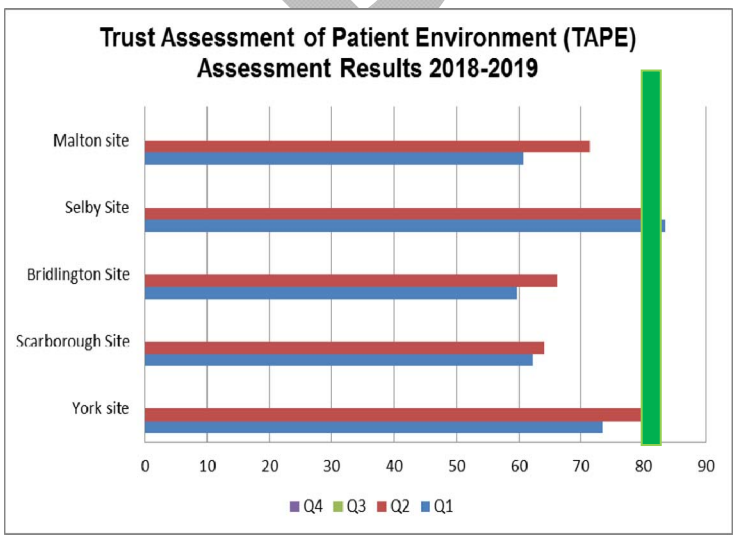
The graphs (2-5) show that the TAPE Assessment process is broadly identifying similar issues and defects at our sites on a quarterly basis as the PLACE Assessment on an annual basis, the exception to this is Privacy, Dignity and wellbeing and this can be explained in that when undertaking TAPE Assessment only around 24 clinical areas are assessed per annum (over 4 quarters) however via the Annual PLACE Assessment around 60 clinical areas are assessed.

Both Quarterly TAPE and annual PLACE Process have identified that the most prevalent opportunities for improvement are associated sites are at Bridlington, Malton and Scarborough sites.

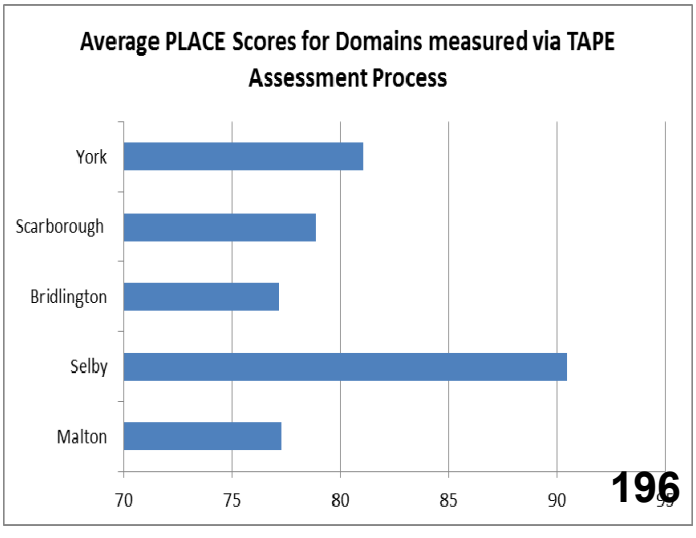
The most prevalent opportunities relating to environmental improvement are shown in (Graphs 4 & 5) and are associated with arrangements for accessibility/disability and the condition, appearance and maintenance elements of our sites, however due to the scale of PLACE assessment it was identified that there are also significant opportunities for improvement around privacy, dignity and wellbeing arrangements.

The data below is taken from PLACE Assessments undertaken between March and May 2018 and TAPE Assessments undertaken in March/April 2018. (Quarter 1 Data)

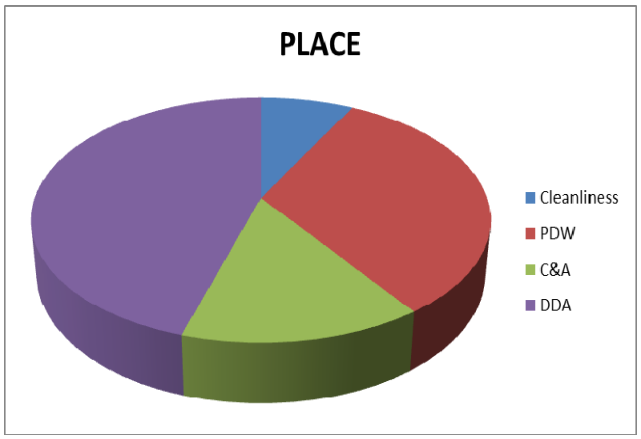
Graph 2



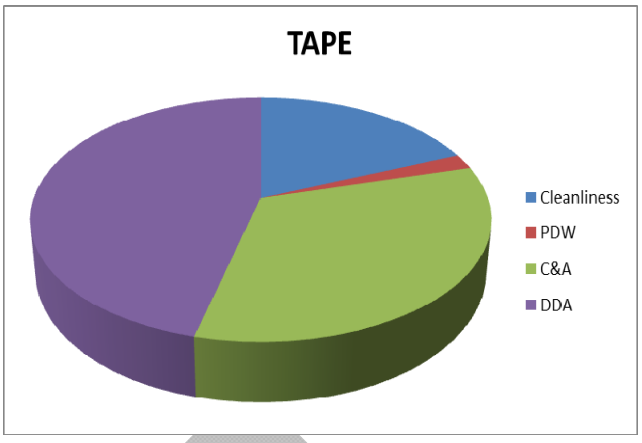
Graph 3



Graph 4



Graph 5



It can be seen then that the TAPE Process is a useful tool in allowing the Trust to gauge performance against some of the Place Domains on a quarterly basis whilst also identifying opportunities for both rapid and long term improvement of our general built environment.

7.0 PLACE Action Plans & Local Improvement Plans

The PLACE process has generated a number of Action Plans which relate to opportunities for improvement identified during the site PLACE assessments, in past years these action plans have not been closely monitored by Estates & Facilities Managers and it is recommended that these plans and the Rectification reports created following TAPE audits are monitored more closely by the Directorate Managers and Supervisory staff in order to drive improvement.

A Monthly compliance report is currently produced by FM Compliance team and provided to all EFM Managers which gives details of performance against all FM Key performance indicators including those associated with PLACE and TAPE processes.

9.0 Feedback for Patient Assessors and Governors

At the end of each PLACE Assessment the patient representatives on teach assessment team are invited to provide written feedback on their experiences of the assessment process under the questions shown in the table below

The PLACE teams patient assessor responses are shown below:

	Yes	No
Were you given sufficient time to undertake the assessments?	**100%**	**0%**
Did Trust staff take notice of your views and comments?	**100%**	**0%**
Where you, at any time put under pressure to agree with something that you didn't agree with?	**0%**	**100%**
Did you fell sufficiently prepared to undertake the assessments?	**95%**	**5%**

The patient assessor responses suggest that the 2018 assessments were a positive experience at which the patient assessors felt fully engaged with the process.

The patient assessors and governors are to be invited to attend training and feedback sessions during Winter 2018 which will be facilitated by the FM Compliance Team and should also be attended by Key stakeholders from Estates & Facilities Management teams. This will allow the 2018 assessment process, scores and action plans to be reviewed and identify how any improvements can be made for the annual 2019

The future numbers of Patient Assessors and Governors will need to be maintained and reviewed. The FM Compliance team will work with Trust Patient experience team to ensure adequate assessors are available and appropriately trained and that arrangements for external validation and peer review at PLACE Assessments are maintained.

David Biggins
Head of FM Compliance
York NHS Teaching Hospital Foundation Trust
September 2018

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 2018
Workforce Report – November 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 October 2018).

Executive Summary – Key Points

- The monthly sickness absence rate in September was 4.49%. This was an increase in sickness absence for the third month in a row.
- A new line manager and supervisor training workshop has been piloted in October and November with 56 staff from different staff groups, roles, levels of seniority and sites attending. A significant waiting list has now built up, just through word of mouth demonstrating the need for this support.
- The East Coast medical recruitment project is starting to deliver some measurable benefits with a number of recent appointments projected to help achieve significant savings on locum costs.

Recommendation

The Board is asked to note and discuss the content and findings within the report.

Author: Polly McMeekin, Acting Director of Workforce and Organisational Development

Director Sponsor: Polly McMeekin, Acting Director of Workforce and Organisational Development

Date: November 2018

1. Introduction and Background

November'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 reports includes updates on a number of activities including the flu vaccination programme, staff survey, medical workforce vacancy rates and the EU settlement scheme.

2. Detail of Report and Assurance

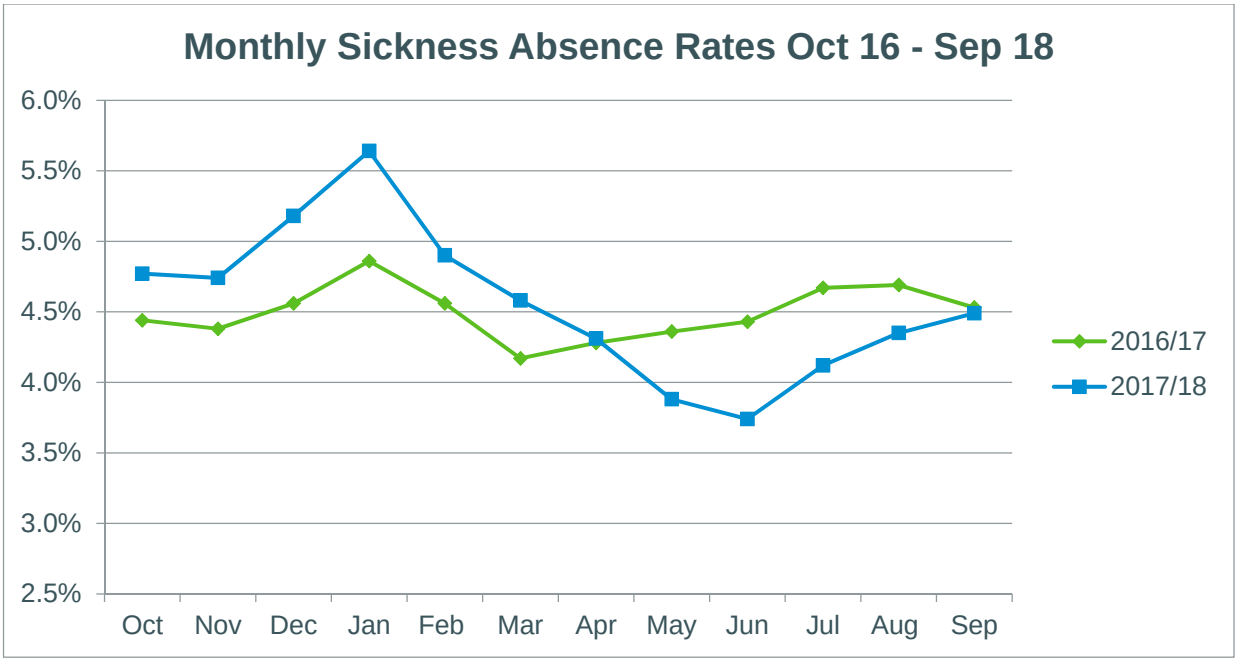
The work referred to in the report forms part of regular discussions around workforce, including at Staff Side Committees. It is informed by a number of key performance indicators which underpin directorate-level workforce plans, and link to the Trust's overall Workforce Strategy.

2.1 Sickness Absence

Graph 1 shows the monthly sickness absence rates for the period from October 2016 to September 2018. The monthly absence rate in September 2018 was 4.49%. This was an increase to the monthly absence rate for the third month in a row. The monthly absence rate in September 2018 was similar to the rate in the same month of the previous year.

The annual absence rate in the year to the end of September 2018 was 4.57%, although this is an improvement from the rate at the start of the current financial year (4.74%), it is higher than the rate in the year to September 2017 (4.49%).

Graph 1 – Monthly Sickness Absence Rates



Source: Electronic Staff Record

Sickness Absence Reasons

The top three reasons for sickness absence in the year ending September 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 September 2018

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 23.08% of all absence days lost	Cold, cough, flu – 18.53% of all absence episodes
MSK problems, inc. Back problems – 15.59% of all absence days lost	Gastrointestinal – 17.85% of all absence episodes
Cold, cough, flu – 8.5% of all absence days lost	Anxiety/stress/depression – 10.66% of all absence episodes

Whilst stress/anxiety/depression and MSK remain the top reasons for sickness absence by time lost, the percentage of all time lost due to both of these reasons has reduced from the start of the current financial year. In the year to April 2018, stress/anxiety/depression accounted for 24.26% of all time lost, whilst MSK problems accounted for 15.88% of all time lost.

Activities to reduce sickness absence

A further tranche of Attendance Challenge meetings have recently taken place in Directorates with high absence levels – General Surgery, TACC, T&O and the newly established Unplanned Care Groups in York and SGH. These sessions are a new approach involving Directorate Managers, matrons and other senior nursing staff, HR and Occupational Health to drill down into local issues and key local causations and agree some joined-up actions and solutions to help address these.

In addition bespoke masterclasses are being run by HR in a number of areas including Child Health, the Unplanned Care Group in York, Finance and Estates and Facilities, focusing on the Directorate specific needs. Similar initiatives are currently being developed and planned in others areas.

To support mental health there are a number of initiatives including the development of the RAFT project which is being piloted until next spring (providing immediate support and signposting to staff involved in traumatic incidents at work), further EAP (Health Assured) promotion, continuance of Schwartz Rounds and mental health training for managers. In addition the network of Fairness Champions across the Trust continues to grow and receives positive feedback in helping and signposting staff who may be struggling.

2.2 Temporary Staffing

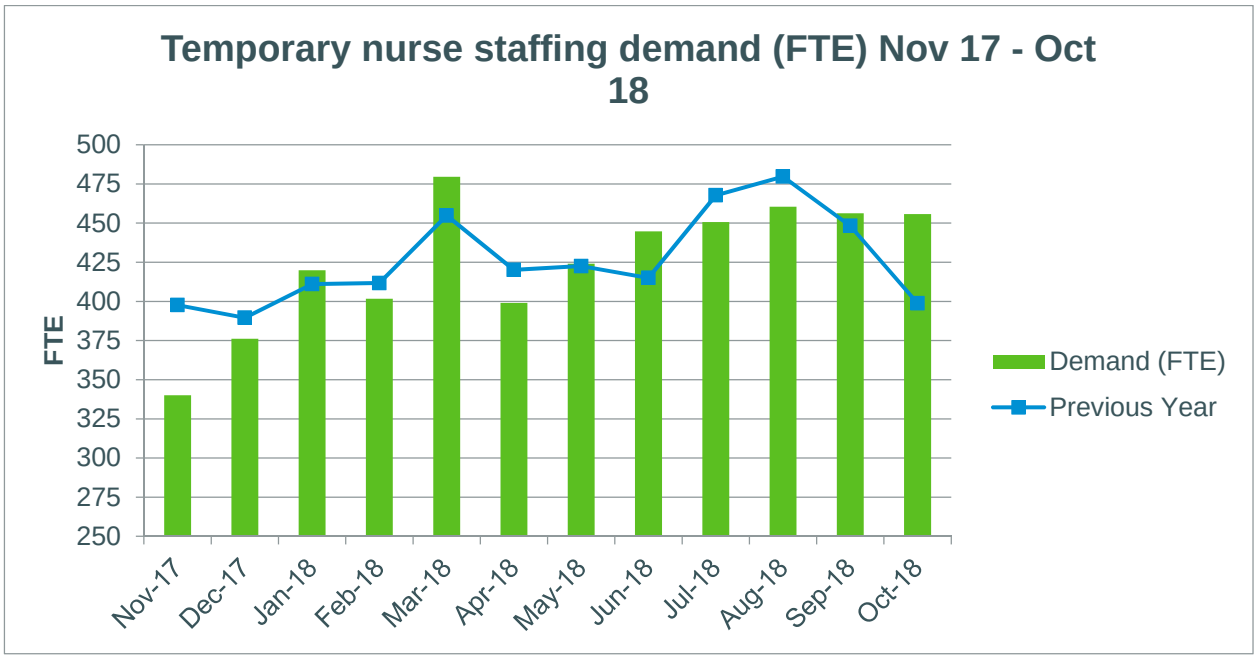
Temporary Medical Staffing

In October 2018 101.55 FTE Medical & Dental roles were covered by a combination of bank (37%) and agency (63%) workers.

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of 425 FTE staff per month. Demand in October 2018 equated to 455.74 FTE. This was not a significant change from demand in the previous month; however was 14% higher than demand in the same month of last year (October 2017). Graph 2 shows the pattern of demand over the last 12 months compared to the previous 12 months.

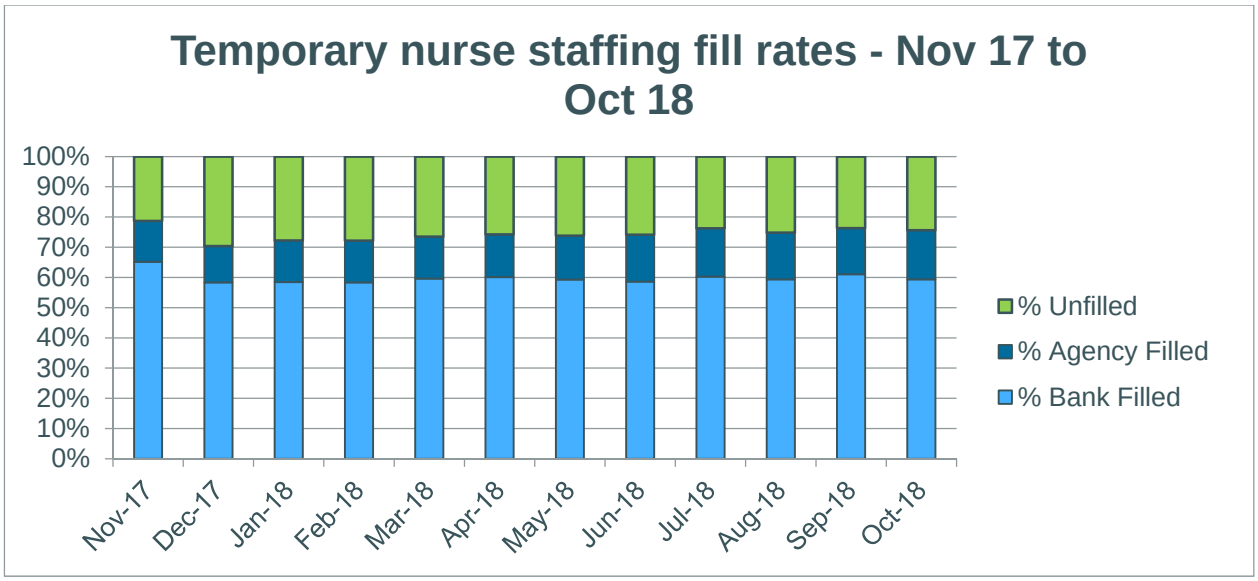
Graph 2 – Temporary Nurse Staffing Demand



Source: BankStaff

Graph 3 shows the proportion of all shifts requested that were either filled by bank, agency or were unfilled. Overall, bank accounted for 59.35% of all filled requests in October 2018 – this is in line with average bank fill rates over the last 12 months. The agency fill-rate was 16.27%. This was the first time in the last 12 months that agency fill for nursing has been in excess of 16%. The proportion of shifts that remained unfilled in October was 24.38% which was an increase from the previous month (23.7%) but slightly lower than the average (25.66%).

Graph 3 – Temporary Nurse Staffing Fill Rates



Source: BankStaff

2.3 Line Management & Supervisor Training

HR has led a multi-disciplinary working group to develop a new workshop for staff who have supervisory or line management responsibilities. The aim is for this to be rolled out to all managers and supervisors, outlining the desired behaviours expected from them as leaders, empowering them to use appropriate discretion, and be more people focused. The workshop includes:

- developing insight and understanding of one's own behaviour and how it may differ from that of others;
- how to effectively manage staff with different personality types;
- roles and responsibilities of managers/supervisors, Staff Side Representatives, HR, Fairness Champions, Freedom to Speak Up Guardian;
- how to manage consistently in line with Trust values, the personal responsibility framework, policies & procedures (and employment law), while understanding the level of discretion available to ensure people are managed in a compassionate way i.e. on a case-by-case basis, and fairness being determined by the context of each case rather than being a one-size-fits-all approach.
- practical, real-life examples of situations supervisors and managers will find themselves in, to convert this knowledge into practice.

We have piloted the workshop during October and November with 56 staff across Bridlington, Scarborough and York; covering a range of staff groups and various levels of seniority. It is being delivered by HR in partnership with Staff Side and the Freedom to Speak Up Guardian, and has received very positive feedback. There is now a waiting list of 83 managers that has built up by word of mouth, demonstrating a real demand for this type of support.

Existing managers will be trained concurrently with new managers. This is to prevent existing local and often cultural practices in some departments undermining the new ethos.

Next steps are:

- To identify managers who can be trained to deliver the workshop to their own staff, in partnership with HR, Staff Side and/or the Freedom to Speak Up Guardian. Role modelling our expectations is paramount to drive this change.
- To run the workshop on a regular open-access basis to keep pace with demand.
- Utilise workforce data to target particular challenging areas where line managers / supervisors need some elevated support.
- Identify alternative methods of delivery (acknowledging that we do not have the facilitation or room capacity to deliver face-to-face training to all supervisors and line managers in a reasonable timescale); e.g. e-learning, webinars, podcasts, videos.

The workshop is being evaluated over three tranches - on the day again at one and three months post-attendance. This is to capture behavioral change. Other measures of impact / effectiveness will be the number of formal grievances, disciplinary cases etc. for those areas with supervisors who have been trained; and the number of informal referrals e.g. to the Freedom to Speak Up Guardian; ODIL or HR.

2.4 Recruitment Key Activities

Medical Recruitment

Earlier this year, the Trust accepted a proposal to try a different approach to medical recruitment on the East Coast. At the point of accepting this proposal, the medical vacancy factor in Scarborough was 21%.

The project launched in July 2018 and a range of activities have delivered a number of measurable benefits:

- Appointment of a Consultant Anaesthetist. The appointment follows three previous unsuccessful attempts to recruit within the last 12-months. This appointment alone will be significantly cheaper than temporary staffing via agency (after commission and with on-costs, the hire will be £91,000 cheaper over a period of 12-months);

- Appointment of a Trust Grade (CT Level) Doctor in Emergency Medicine, to replace a long-term locum. There have been two previous attempts to recruit to the vacancy within the last 12-months. This appointment is projected to save the Trust approximately £55,000 in locum costs over a period of 12-months;

- The recruitment event on 20 October produced eight offers of appointment. Seven are for Trust Grade (CT Level) Doctors in Acute and Emergency Medicine. The eighth is to a Trust Grade (ST Level) Anaesthetist. From these appointments, there is the potential for a £440,000 saving in locum costs over a period of 12-months;

As it stands, the combination of these appointments, together with other recruitment that has taken place over the last two-months has started to have a positive impact on the medical vacancy rates at Scarborough.

To continue this work and strengthen the ‘talent acquisition’ model of recruitment, it is has been agreed to extend the present arrangements (i.e. the release of the Medical

Workforce Manager by back-filling her 'day job' with a Band 6 Medical Staffing Manager) and to recruit a part time band 3 administrator to provide additional support to the project. This has been agreed for a further 12 months to run until January 2020.

Medical vacancy position

The Trust's overall net medical vacancy rate is 11.1%. The net vacancy % is calculated as follows;

(Vacancies + Leavers Pending - Starters Pending) / Establishment

The table below shows the breakdown of medical vacancies by site and grade.

	Consultant	Middle Grades	Training Grades (inc. Trust Grades)	Foundation grades	Total
Scarborough	**20.8%**	**17.9%**	**24.5%**	**2.3%**	**18.7%**
York	**4.5%**	**13.6%**	**13.6%**	**0%**	**7.8%**

A more detailed breakdown of the medical vacancy position by site is provided in appendix 1.

2.5 Fourth Cohort of Trainee Advance Clinical Practitioners

The Trust has secured through the Local Workforce Action Board funding to support a fourth cohort of trainee Advance Clinical Practitioners. The regional funding provides £18,000 per trainee, per annum and as such additional funding is required from the Trust to support these individuals on their band 7 salaries. A business case to train ten in the Emergency Department and Acute Medicine at Scarborough was approved by the Corporate Director Team on 2nd October. The Acute Medical Unit at York also has funding to support three trainees as well as one each in Community and General Surgery and Urology. Over 70 applications were received; 24 shortlisted and 8 offers have been made following the interviews on 19th and 20th November for York and Scarborough respectively. Of the eight offered the majority are Allied Health Professionals. The Trust will revisit the applications received with a view to interview further candidates before Friday 30th November. The majority of the appointees will attend Sheffield Hallam University. Whilst the apprenticeship standard for Advance Clinical Practitioners was approved in August 2018; no local university has matched their curriculum to the standard yet.

2.6 Second Cohort of Trainee Nurse Associates

On 23rd October the Trust advertised for 20 Trainee Nurse Associates to be trained at Coventry University, Scarborough Campus. 26 applications were received and 21 are scheduled to attend interviews in early December. We are partnering with St Catherine's Hospice in Scarborough to provide placements out of an acute setting for this second

cohort. The first cohort are due to qualify in March 2019 and we have successfully retained all 15 and placed them across the Trust.

2.7 Flu Campaign

The 2018/19 'Flu campaign launched on 8 October 2018, with 'super clinics' taking place at York, Scarborough and Bridlington Hospitals. The vaccine uptake for the Trust as a result of the super clinics, up to and including 31st October was 40% for frontline healthcare workers. The target is to have above 75% of frontline workers vaccinated. Data is collated weekly and submitted to Immform on a monthly basis from mid November to mid February.

To support the Trust's commitment to provide a timely and accessible vaccination and to ensure that the organisation meets its obligations outlined in the national plan, a Trust wide survey has been introduced to support access to the vaccine and further improve our understanding of activity against the plan. These opt in/out 'e' questionnaires are now being sent to unvaccinated frontline staff following the completion of the super clinics. Of the responses so far 668 responded that they did not wish to have the vaccine whilst 222 advised they had already received it via their GP / Pharmacist. 958 want to have the vaccine and we will target those areas to make sure it continues to be freely available.

Drop in sessions have now also commenced which are proving to be very busy and running alongside these are also roving vaccinators. Details of all clinics and the roving vaccinator schedule are published on the Trusts intranet pages and staff may now access the consent form from the intranet to bring along to clinics for ease and help reduce queuing times.

2.8 Staff Survey

The 2018 annual Staff Survey campaign was launched on 5th October. This year the Trust appointed CleverTogether as their independent survey contractor and, for the first time, the format is an online only survey of all eligible staff with the majority of staff receiving a link to their questionnaire via their Trust email accounts.

To help promote this year's survey there has been an increased focus on staff communications and engagement particularly in the use of social media and on highlighting actions implemented within the organisation as a result of feedback from previous years' surveys.

By 22nd November 41.8% of staff have completed their survey (inclusive of York Teaching Hospital Facilities Management).

The survey will close on Friday 30th November 2018 and it is anticipated that initial summary findings and headlines will be made available at the beginning of December.

2.9 Corporate Induction

All new starters are required to attend Corporate Induction during their first six weeks of employment.

Corporate Induction is now recognised by the Learning Hub as a one off learning programme for all staff (including Medical and Dental staff), which means compliance can be easily tracked by managers.

Staff who are not considered to be new starters, but have had a break in service, have an option available to self-declare.

The mandatory training team will contact staff and managers where there is more than six weeks service but a Corporate Induction date has not yet been booked.

Corporate Induction attendance compliance as at November 2018 was 95%.

2.10 Workforce Planning

The Trust's internal workforce planning process is receiving a significant overhaul. Given the current workforce environment it is important that there is a route through which directorates can work and be supported to consider what their future workforce might look like whilst optimizing new and innovative roles.

The outcome of these plans can be used to help inform our discussions with external stakeholders, including our STP partners and local education providers, ensuring that we have a valuable and meaningful input into securing the supply of our workforce for the future.

In order that these plans add value, it is important that they are aligned with activity and finance plans and so the workforce team have recently been involved in the 2019/20 planning round meetings.

Draft plans for each clinical directorate are now being developed with involvement from key stakeholders within the directorate and workforce teams with the agreed process describing that the plans would be formally approved at Operational Performance Assurance meetings. It is the aim that all clinical directorates will have a workforce plan by the start of the new financial year.

2.11 EU Settlement Scheme

The EU Settlement Scheme enables EU citizens and their family members to continue living and working in the UK after the UK's withdrawal from the European Union on 29th March 2019. Whilst the scheme will go fully live in March 2019, the government has launched a number of pilot schemes which have run from 1 November, targeting particular groups of staff / sectors to both test and help refine the national system, and to enable early applications and early conformation of settlement status for those affected.

For EU citizens working in the healthcare sector, they can apply for settlement status as part of the pilot which launches on 29 November 2018. This pilot will run initially until 21 December 2018 and is entirely voluntary. For individuals not wishing to use the pilot scheme they will be able to apply for settlement status at any time from March 2019 until June 2021. The benefit for employees applying as part of the pilot is to give early opportunity and early confirmation of status to those citizens. The Trust currently employs

324 EU nationals. To support staff retention the Trust has agreed to fund the cost of the application which is £65 each.

From 19 November we have been cascading information from the Home Office to enable staff who are EU citizens to make early applications as part of the pilot. This will be via a general communications (e.g. Staff room, Staff Bulletin), a more targeted communication based on nationality data held in ESR followed by details of the scheme itself and how staff can make applications during the pilot.

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 of Directors is asked to read the report and discuss.

Appendix 1: Medical Vacancy Position

Scarborough

Specialty	Consultant					Middle Grades					Training Grades (inc Trust Grades)					Foundation Grades					Total				
	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %
Anaesthetics	18	2	0	1	**5.6%**	3	2	0	0	**66.7%**	12	2	0	0	**16.7%**						33	6		1	**15.2%**
Child Health	12	4	0	1	**25.0%**	1	0	0	0	**0.0%**	9	0	0	0	**0.0%**	4	0	0	0	**0.0%**	26	4		1	**11.5%**
Elderly Medicine	6	1	0	0	**16.7%**	2	0	0	0	**0.0%**	11	6	0	0	**54.5%**	4	0	0	0	**0.0%**	23	7			**30.4%**
Emergency & Acute	7	3	0	0	**42.9%**	9	2	0	0	**22.2%**	15	6	0	1	**33.3%**	4	1	0	0	**25.0%**	35	12		1	**31.4%**
General Medicine	16	5	0	1	**25.0%**	4	0	0	0	**0.0%**	20	7	0	3	**20.0%**	18	0	0	0	**0.0%**	58	12		4	**13.8%**
General Surgery & Urology	13	6	0	0	**46.2%**	3	1	0	0	**33.3%**	10	4	0	0	**40.0%**	9	0	0	0	**0.0%**	35	11			**31.4%**
Head & Neck						3	0	0	0	**0.0%**						1	0	0	0	**0.0%**	4				**0.0%**
Obstetrics & Gynaecology	8	0	0	0	**0.0%**	3	1	0	0	**33.3%**	8	1	0	1	**0.0%**	2	0	0	0	**0.0%**	21	2		1	**4.8%**
Ophthalmology	4	2	0	1	**25.0%**	3	2	0	1	**33.3%**	1	1	0	0	**100.0%**						8	5		2	**37.5%**
Radiology	6	2	0	0	**33.3%**						1	1	0	0	**100.0%**						7	3			**42.9%**
Specialist Medicine	3	0	0	0	**0.0%**	3	0	0	0	**0.0%**	2	0	0	0	**0.0%**						8				**0.0%**
Trauma & Orthopaedics	8	0	0	0	**0.0%**	5	0	0	0	**0.0%**	5	1	0	1	**0.0%**	2	0	0	0	**0.0%**	20	1		1	**0.0%**
Total	**101**	**25**	**0**	**4**	**20.8%**	**39**	**8**	**0**	**1**	**17.9%**	**94**	**29**	**0**	**6**	**24.5%**	**44**	**1**	**0**	**0**	**2.3%**	**278**	**63**	**0**	**11**	**18.7%**

York

Specialty	Consultant					Middle Grades					Training Grades (inc Trust Grades)					Foundation Grades					Total				
	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac
Anaesthetics	49	2	0	1	**2.0%**	9	1	0	0	**11.1%**	20	5	0	0	**25.0%**	3	0	0	0	**0.0%**	81	8		1	**8.6%**
Child Health	17	0	0	0	**0.0%**	1	0	0	0	**0.0%**	15	2	0	0	**13.3%**	5	0	0	0	**0.0%**	38	2			**5.3%**
Elderly Medicine	15	0	0	0	**0.0%**	2	0	0	0	**0.0%**	13	1	0	0	**7.7%**	7	0	0	0	**0.0%**	37	1			**2.7%**
Emergency & Acute	18	1	0	1	**0.0%**	9	4	0	0	**44.4%**	18	1	0	0	**5.6%**	7	0	0	0	**0.0%**	52	6		1	**9.6%**
General Medicine	38	2	0	0	**5.3%**	9	2	0	0	**22.2%**	32	4	0	0	**12.5%**	22	0	0	0	**0.0%**	101	8			**7.9%**
General Surgery & Urology	32	3	0	2	**3.1%**	10	1	0	1	**0.0%**	15	2	0	2	**0.0%**	11	0	0	0	**0.0%**	68	6		5	**1.5%**
Head & Neck	19	0	1	0	**5.3%**	14	1	0	1	**0.0%**	13	1	0	0	**7.7%**						46	2	1	1	**4.3%**
Laboratory Medicine	14	2	0	0	**14.3%**	1	0	0	0		6	1	0	0	**16.7%**						21	3			**14.3%**
Obstetrics & Gynaecology	12	1	0	0	**8.3%**	2	0	0	0	**0.0%**	9	1	1	0	**22.2%**						23	2	1		**13.0%**
Ophthalmology	18	1	0	1	**0.0%**	6	2	0	0	**33.3%**	5	2	0	0	**40.0%**						29	5		1	**13.8%**
Radiology	25	2	0	1	**4.0%**	1	0	0	0	**0.0%**	7	0	0	0	**0.0%**						33	2		1	**3.0%**
Sexual Health	2	0	0	0	**0.0%**	8	1	0	0	**12.5%**	2	1	0	0	**50.0%**						12	2			**16.7%**
Specialist Medicine	37	7	0	2	**13.5%**	3	1	0	0	**33.3%**	13	1	0	0	**7.7%**	3	0	0	0	**0.0%**	56	9		2	**12.5%**
Trauma & Orthopaedics	13	0	0	0	**0.0%**	6	0	0	0	**0.0%**	9	3	0	0	**33.3%**	4	0	0	0	**0.0%**	32	3			**9.4%**
Total	**309**	**21**	**1**	**8**	**4.5%**	**81**	**13**	**0**	**2**	**13.6%**	**177**	**25**	**1**	**2**	**13.6%**	**62**	**0**	**0**	**0**	**0.0%**	**629**	**59**	**2**	**12**	**7.8%**

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 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 7 financial position for York Teaching Hospital NHS Foundation Trust.

The Trust is reporting an Income and Expenditure deficit of £6.2m against a planned deficit of £6.6m after including all PSF adjustments. The Trust is currently reporting a £0.4m favourable variance to plan.

Recommendation

The Board is asked to note the report.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: November 2018

1. Month 7 Summary Financial Position

Including all sustainability funding adjustments the month 7 income and expenditure position is a deficit of £6.2m against a planned deficit of £6.6m. The Trust is therefore reporting a £0.4m favourable variance against plan.

Excluding Provider Sustainability Funding (PSF) the month 7 control total was a £12.2m deficit. This position has been improved on with an actual reported deficit of £11.2m. As the Board are aware sustainability funding eligibility is assessed at the end of each quarter, the month 7 position assumes receipt of month 7 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 quarterly reconciliation process.

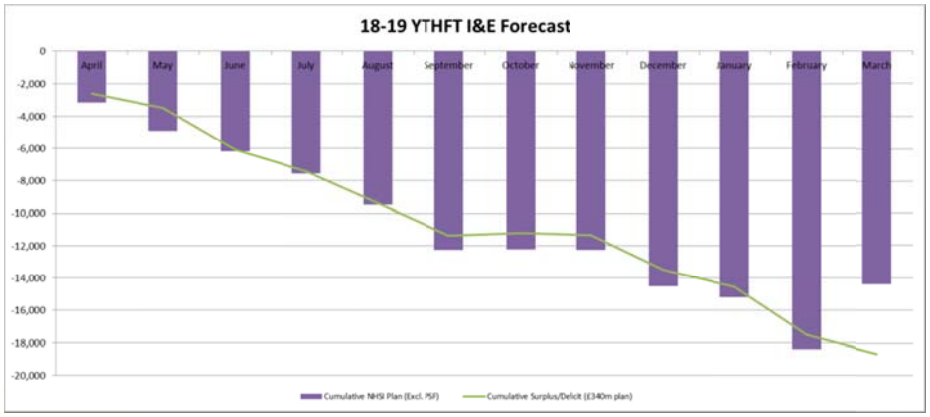
To date the reported financial position therefore assumes all sustainability funding with the exception of quarter 1 ECS.

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 in October of £41.3m. This is in line with the average monthly spend for the first six months of the financial year at £41.2m.

Expenditure is not falling as per the planned run rate reductions. The most material reason for this is that the Trust's expenditure profile assumed delivery of £10m of QIPP (demand and cost reduction) over the 8 month period August to March. In the Trust's (fixed) plan income and expenditure were reduced equally by £10m. The reduction in demand through the QIPP work is not happening and so both income and expenditure are running above plan, by £3.8m year to date.

The Trust's reported operating expenditure position continues to benefit from CIP delivery being ahead of plan for the year to date by £4.0m. With this in mind, and following the Board's discussion last month as to the most likely outturn position, detailed forecasting work has been undertaken and will be refined each month going forward. The chart below summarises the current I&E projection before PSF.



The forecast work uses current spend trends, takes into account additional winter initiatives, non-delivery of QIPP is assumed, income risk-share principles have been applied and CIP is assumed to return to planned levels. The forecast work shows the Trust tracking its plan right through to, and including, month 11. The variance at month 12 is simply linked to the NHSI approved plan including an assumption around historic VAT recovery from the ADM that has not been factored into the forecast outturn position. This has been excluded from the forecast at this stage so the Board can see the underlying I&E position.

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 7 this suggests a spend cap of £8.7m. The actual reported agency expenditure was above cap at £9.2m but reductions in agency expenditure still remain evident from the 2017/18 outturn position. Notable in-month pressures include consultant and junior medical staff spend each at circa £0.1m above in-month cap. This represents a deterioration in the reported variance from last month.

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 £0.9m. 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.

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 £14.8m (68%) delivered in full year terms to date; notably £8.4m delivered recurrently. Plans for delivery now sit under either transformational or transactional scheme programmes. Transformational scheme plans total £4.9m with £1.7m delivered year to date and transactional scheme plans total £16.8m with £13.0m delivered year to date.

Last month I advised the Board of potential emerging cash issues in December that would require an application through NHSI for working capital support in November. This position has materialised as expected and the Board will be asked this month to support a working capital loan application of £6m.

Significant Finance Risks

- The Board should be aware that QIPP is still 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 accellerate 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.

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 Performance Report

October 2018

Produced November 2018

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

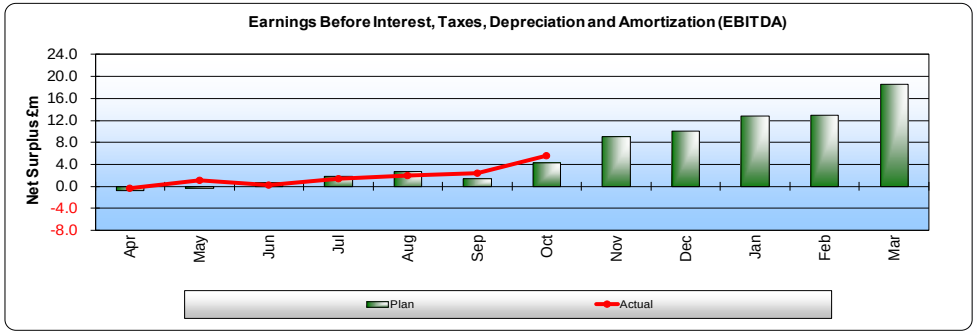
To ensure financial stability

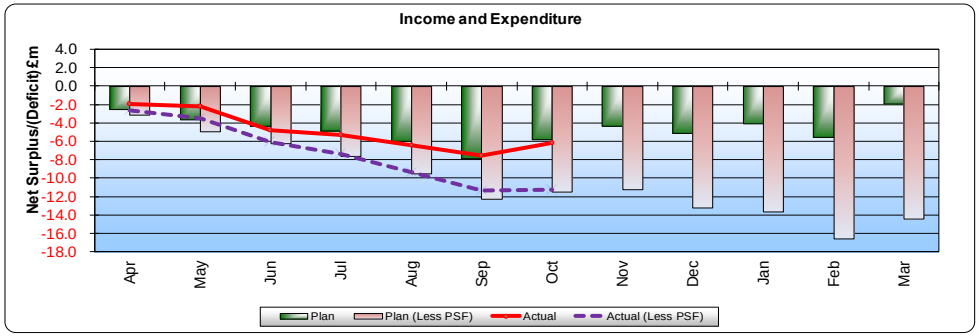
Summary Income and Expenditure Position
Month 7 - The Period 1st April 2018 to 31st October 2018

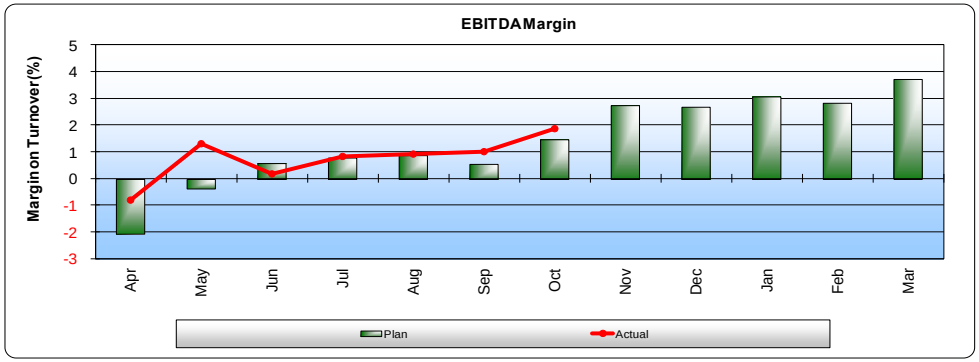
York Teaching Hospital NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £6.2m, placing it £0.4m ahead of the operational plan.
* Income is £5.1m ahead of plan, with clinical income being £5.4m ahead of plan and non-clinical income being £0.3m behind plan.
* Operational expenditure is ahead of plan by £3.8m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £5.5m (1.87%) compared to plan of £4.2m (1.46%), 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	22,637	14,695	15,217	522	22,637	0
Planned same day (Day cases)	35,358	22,030	23,600	1,570	35,358	0
Non-Elective Income	115,233	67,261	70,096	2,835	115,233	0
Outpatients	58,848	34,574	35,317	743	58,848	0
A&E	15,390	9,362	9,794	432	15,390	0
Community	20,181	12,109	12,110	1	20,181	0
Other	114,719	66,177	65,289	-888	114,719	0
Pass-through excluded drugs expenditure	44,215	25,909	26,060	151	44,215	0
	426,581	**252,117**	**257,483**	**5,366**	**426,581**	**0**
Non-NHS Clinical Income						
Private Patient Income	1,042	608	546	-62	1,042	0
Other Non-protected Clinical Income	1,692	987	1,079	92	1,692	0
	2,734	**1,595**	**1,625**	**31**	**2,734**	**0**
Other Income						
Education & Training	15,416	8,653	9,146	493	15,416	0
Research & Development	3,315	1,934	2,044	111	3,315	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	623	363	292	-71	623	0
Other Income	32,534	17,317	17,012	-304	32,534	0
Sparsity Funding	2,600	1,517	1,517	0	2,600	0
PSF	12,479	5,616	5,054	-562	11,917	-562
	66,967	**35,399**	**35,066**	**-333**	**66,405**	**-562**
Total Income	**496,282**	**289,111**	**294,174**	**5,064**	**495,720**	**-562**
Expenditure						
Pay costs	-336,692	-192,692	-196,792	-4,100	-336,692	0
Pass-through excluded drugs expenditure	-44,215	-25,909	-26,797	-888	-44,215	0
PbR Drugs	-5,673	-3,730	-4,396	-666	-5,673	0
Clinical Supplies & Services	-47,743	-28,328	-29,892	-1,563	-47,743	0
Other costs (excluding Depreciation)	-51,815	-30,207	-30,783	-576	-51,815	0
Restructuring Costs	0	0	0	0	0	0
CIP	6,868	-4,029	0	4,029	6,868	0
Total Expenditure	**-479,270**	**-284,895**	**-288,660**	**-3,764**	**-479,270**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**17,012**	**4,216**	**5,515**	**1,299**	**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	-6,252	-6,833	-581	-10,717	0
Depreciation - donated/granted assets	-395	-230	-230	0	-395	0
Interest Receivable/ Payable	130	76	75	-1	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	-517	-524	-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	-3,891	-4,209	-319	-6,670	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**-1,906**	**-6,598**	**-6,166**	**432**	**-2,468**	**-562**

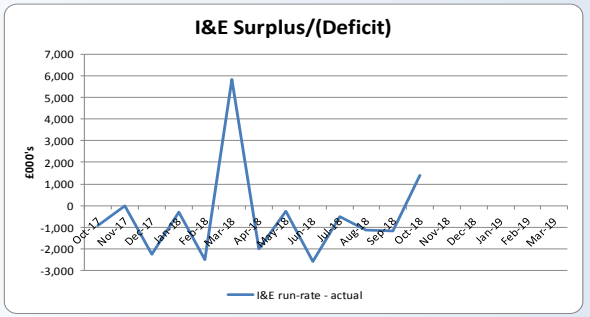
Summary Trust Run Rate Analysis
Month 7 - The Period 1st April 2018 to 31st October 2018

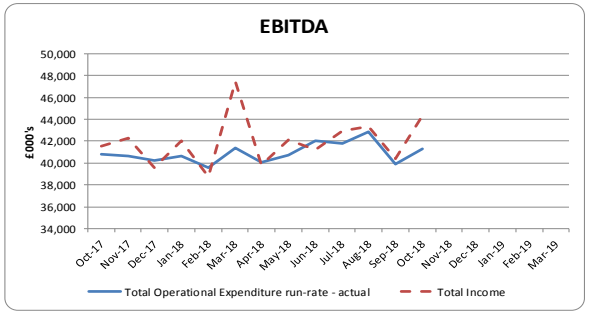
York Teaching Hospital NHS Foundation Trust

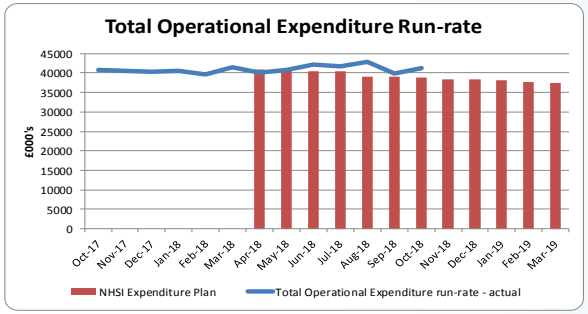
Key Messages:

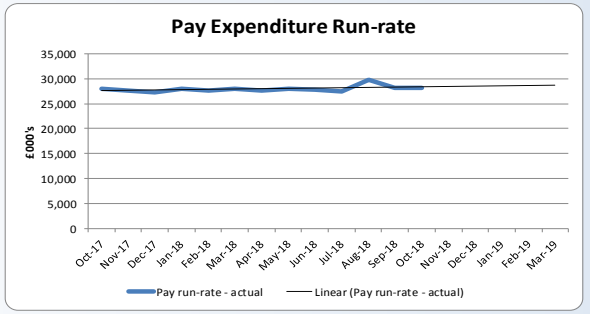
* The total operational expenditure in October was £41.3m. The average total operational expenditure in the previous twelve months was £40.9m. Resulting in an adverse variance of £0.4m.

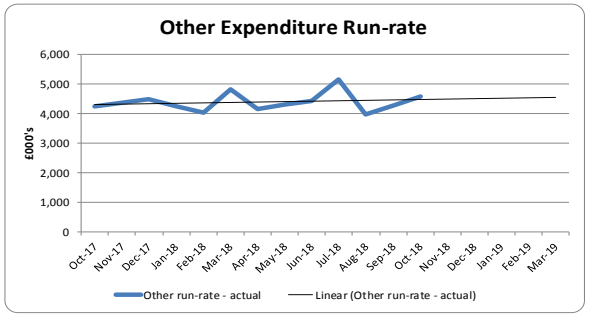
* In month operational income exceeded expenditure by £3.1m, resulting in a positive EBITDA for the month.

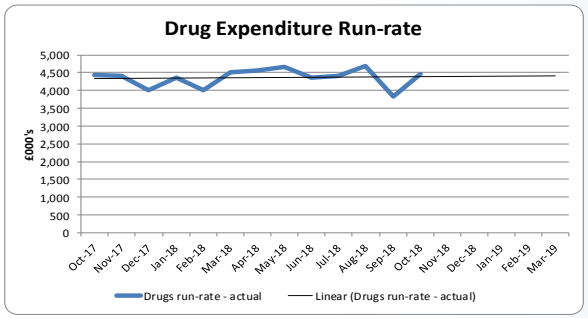


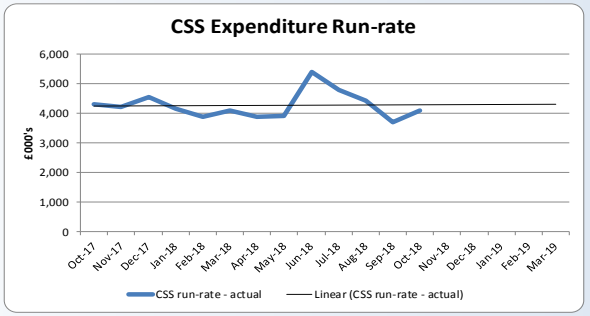












	Monthly Spend																	Monthly	
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Ave	Variance
Total Income	41,538	42,272	39,613	42,003	38,738	47,400	39,791	42,110	41,183	42,970	43,367	40,406	44,347	0	0	0	0	0	41,783	2,564
Pay Expenditure	-27,901	-27,678	-27,214	-27,902	-27,651	-28,002	-27,550	-27,881	-27,852	-27,465	-29,766	-28,099	-28,178	0	0	0	0	0	-27,913	-265
Drug Expenditure	-4,438	-4,411	-4,013	-4,369	-4,008	-4,507	-4,549	-4,651	-4,368	-4,402	-4,691	-3,835	-4,465	0	0	0	0	0	-4,354	-112
CSS Expenditure	-4,285	-4,196	-4,522	-4,132	-3,877	-4,070	-3,871	-3,895	-5,392	-4,790	-4,413	-3,692	-4,071	0	0	0	0	0	-4,261	190
Other Expenditure	-4,217	-4,358	-4,484	-4,225	-4,017	-4,807	-4,140	-4,296	-4,424	-5,131	-3,959	-4,258	-4,575	0	0	0	0	0	-4,360	-215
EBITDA	697	1,629	-620	1,375	-815	6,014	-319	1,387	-853	1,182	538	522	3,058	0	0	0	0	0	895	2,163

Contract Performance

Month 7 - The Period 1st April 2018 to 31st October 2018

York Teaching Hospital NHS Foundation Trust

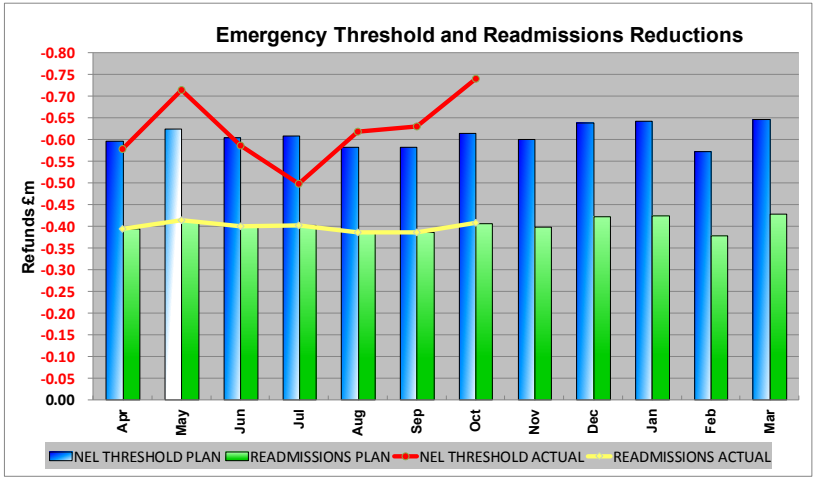
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	219,316	128,557	133,659	5,102
Scarborough & Ryedale CCG	77,783	45,887	47,789	1,902
East Riding CCG	42,696	24,906	25,623	717
Other Contracted CCGs	17,372	10,229	10,480	251
NHSE - Specialised Commissioning	43,499	25,359	25,588	229
NHSE - Direct Commissioning	15,340	8,955	8,302	-653
Local Authorities	4,456	2,599	2,578	-21
Total NHS Contract Clinical Income	**420,462**	**246,492**	**254,019**	**7,527**

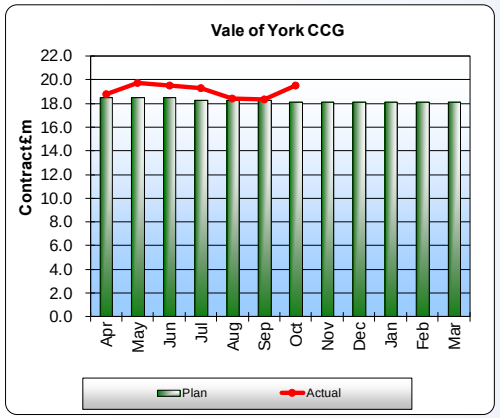
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	12,087	7,051	4,981	-2,070
Risk Income	-5,968	-1,426	0	1,426
Total Other NHS Clinical Income	**6,119**	**5,625**	**4,981**	**-644**

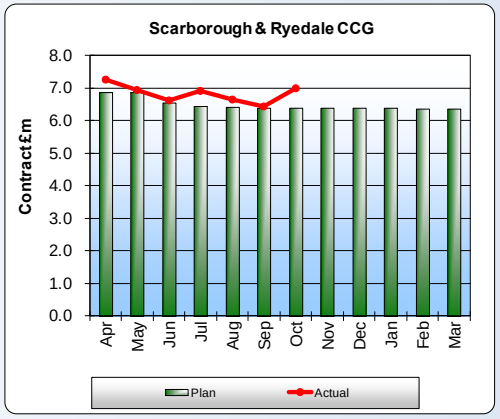
Sparsity funding income moved to other income non clinical	-1,517
Winter resilience monies in addition to contract	0

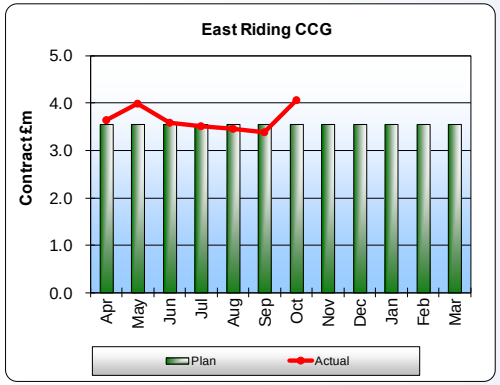
Total NHS Clinical Income	**426,581**	**252,117**	**257,483**	**5,366**

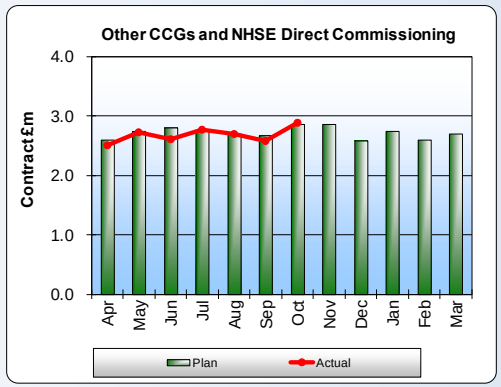
Activity data for October is partially coded (76%) and September data is 92% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

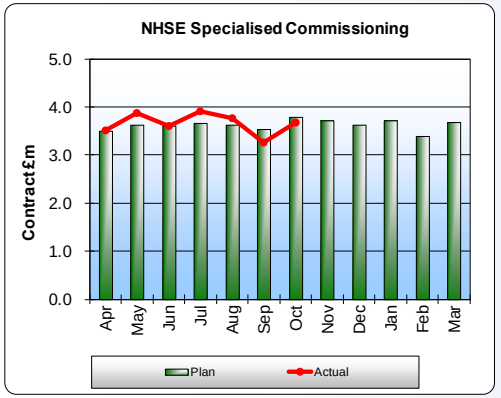


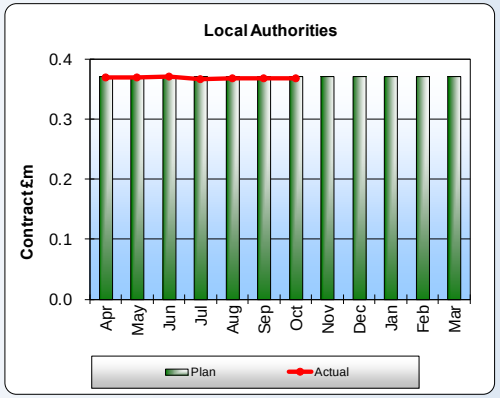












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Agency Expenditure Analysis

Month 7 - The Period 1st April 2018 to 31st October 2018

York Teaching Hospital NHS Foundation Trust

Key Messages:

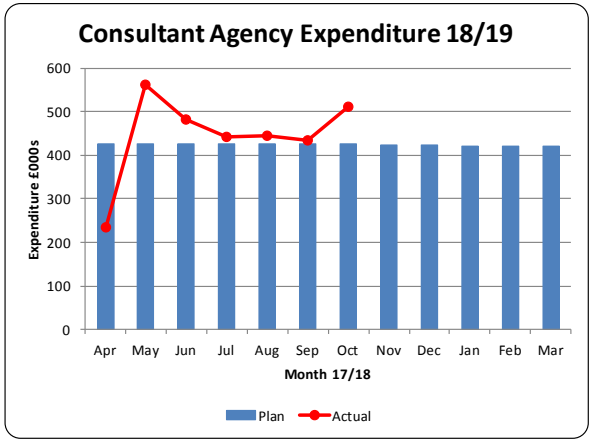
* Total agency spend year to date of £9.2m, compared to the NHSI agency ceiling of £8.7m.

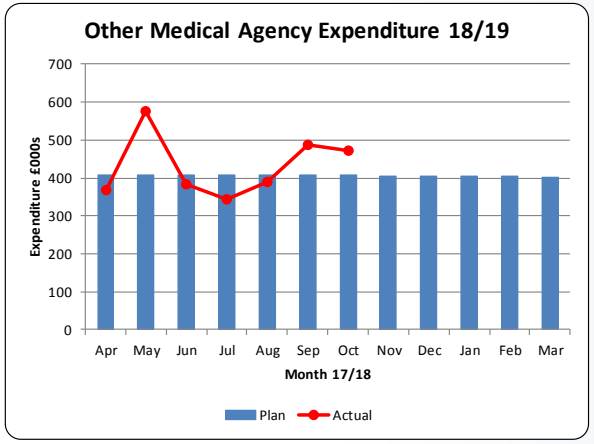
* Consultant Agency spend is £0.1m ahead of plan.

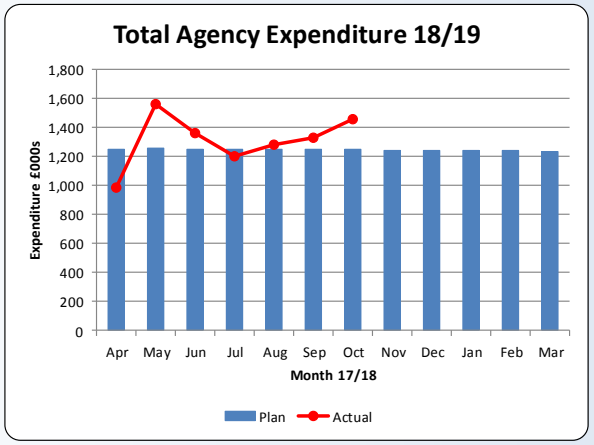
* Nursing Agency is broadly on plan.

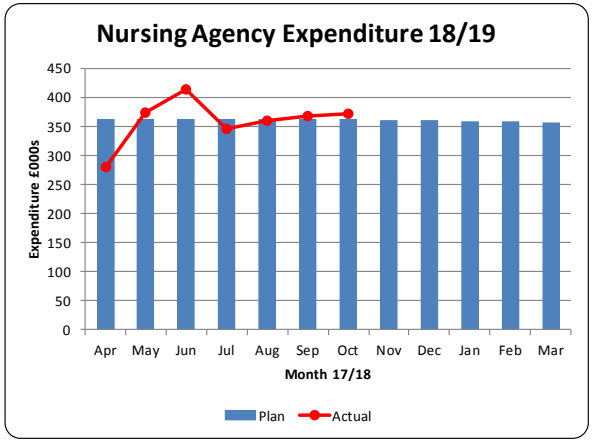
* Other Medical Agency spend is £0.2m ahead of plan.

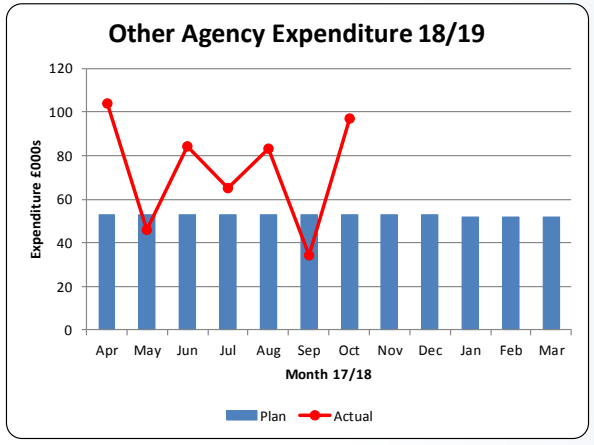
* Other Agency spend is ahead of plan £0.1m.

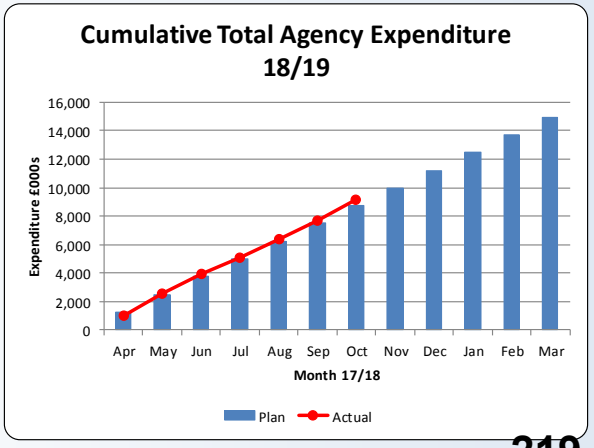












Expenditure Analysis

Month 7 - The Period 1st April 2018 to 31st October 2018

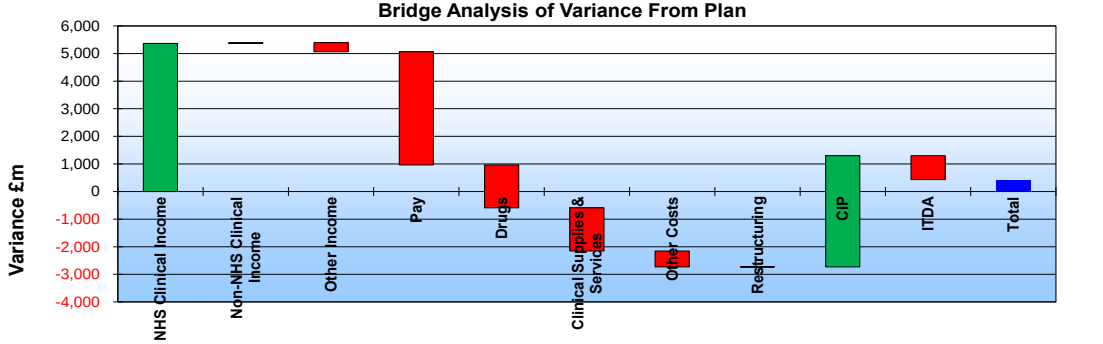
York Teaching Hospital NHS Foundation Trust

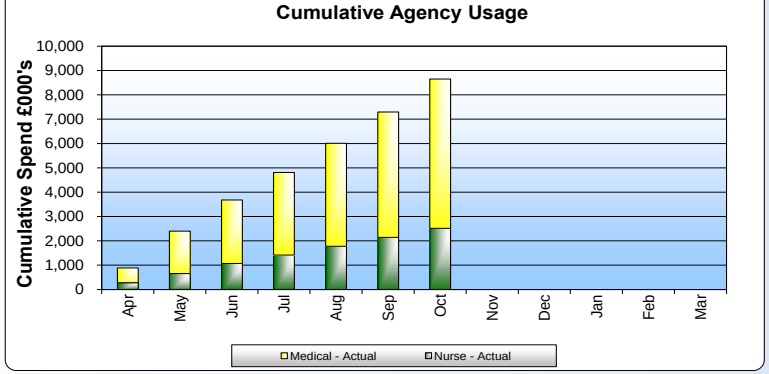
Key Messages:

There is an adverse expenditure variance of £3.8m at the end of October 2018. This comprises:

* Pay expenditure is £4.1m ahead of plan.
* Drugs expenditure is £1.6m ahead of plan.
* CIP achievement is £4m ahead of plan.
* Other expenditure is £2.1m ahead of plan.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	59,772	34,498	30,722	-	914	-	3,113	34,749	-251	0	
Medical and Dental	31,829	18,009	19,098	-	132	-	3,020	22,250	-4,241	0	
Nursing	92,406	53,218	45,251	232	80	5,873	2,512	53,948	-730	0	
Healthcare Scientists	13,506	6,159	6,304	5	7	4	115	6,436	-276	0	
Scientific, Therapeutic and technical	16,517	9,558	8,715	46	0	21	129	8,911	647	0	
Allied Health Professionals	26,235	15,305	13,608	62	111	3	86	13,871	1,434	0	
HCAs and Support Staff	49,003	28,388	25,212	435	50	26	95	25,817	2,571	0	
Chairman and Non Executives	186	108	97	-	-	-	-	97	10	0	
Exec Board and Senior managers	15,729	9,084	8,451	2	-	-	-	8,168	915	0	
Admin & Clerical	39,198	22,579	21,535	86	37	63	89	21,810	769	0	
Agency Premium Provision	4,241	2,474	-	-	-	-	-	0	2,474	0	
Vacancy Factor	-13,123	-7,382	0	-	-	-	-	0	-7,382	0	
Apprenticeship Levy	1,192	695	735	0	0	0	0	735	-40	0	
TOTAL	**336,692**	**192,692**	**179,728**	**868**	**1,332**	**5,990**	**9,158**	**196,792**	**-4,100**	**0**	





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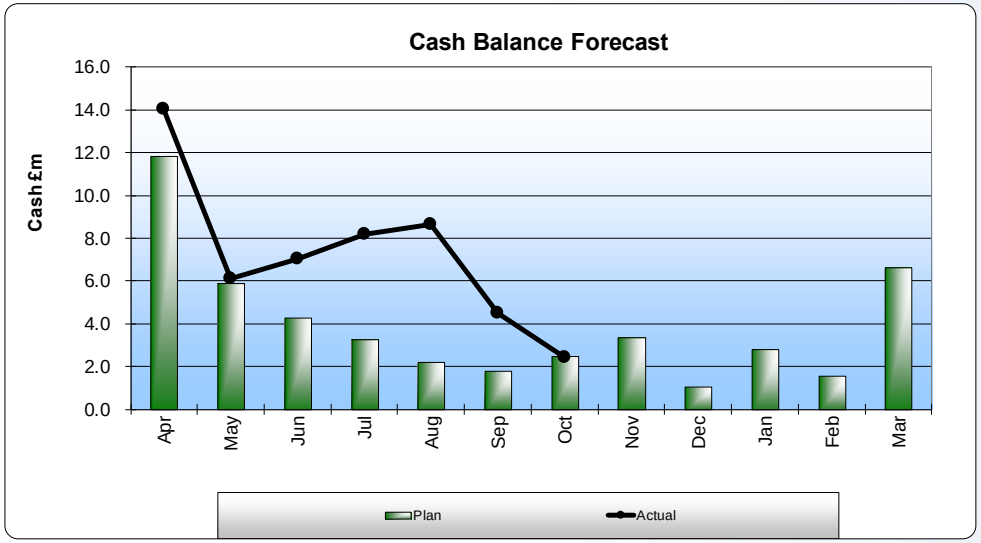
Cash Flow Management

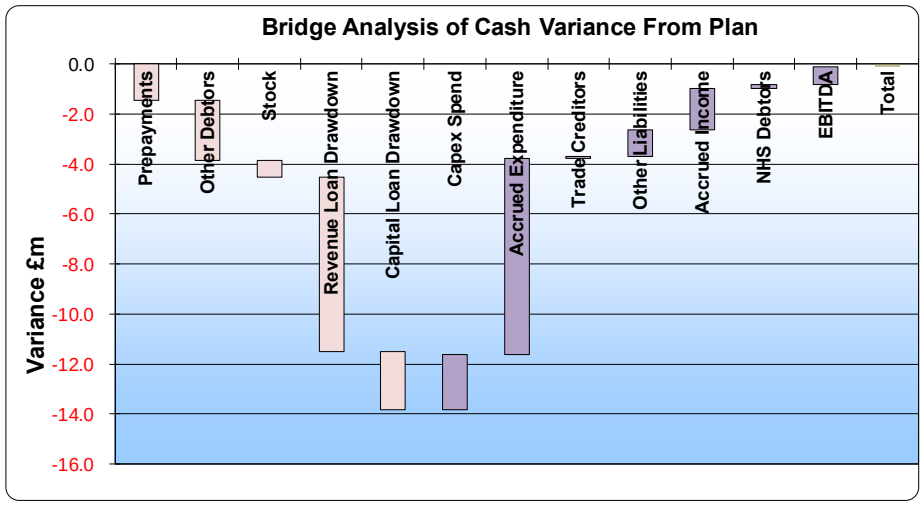
Month 7 - The Period 1st April 2018 to 31st October 2018

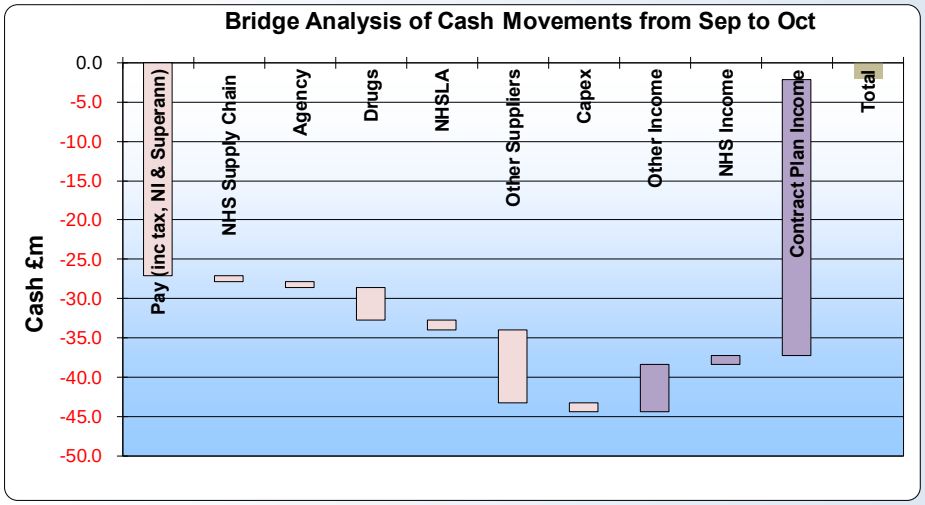
York Teaching Hospital NHS Foundation Trust

Key Messages:

* The cash position at the end of October was £2.4m, which is on plan.
* In month progress with key aged debtors has influenced the cash position.
* The Trust planned to access a total of £7m Revenue Support funding by the end of October, however this has not been required, but is expected to be required in the coming months.







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Cash Flow Management

Month 7 - The Period 1st April 2018 to 31st October 2018

York Teaching Hospital NHS Foundation Trust

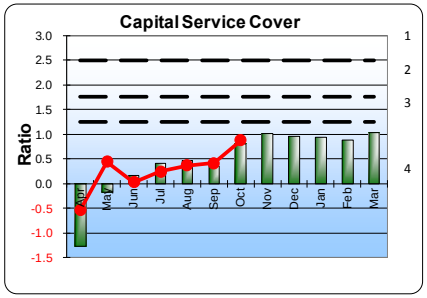
Key Messages:

* The receivables balance at the end of October was £12.6m, which is on plan.
* The payables balance at the end of October was nearly £18m 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 October, and is reflective of the I&E position.

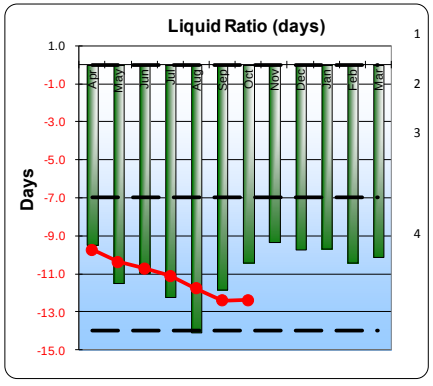
Significant Aged Debtors (Invoices Over 90 Days)

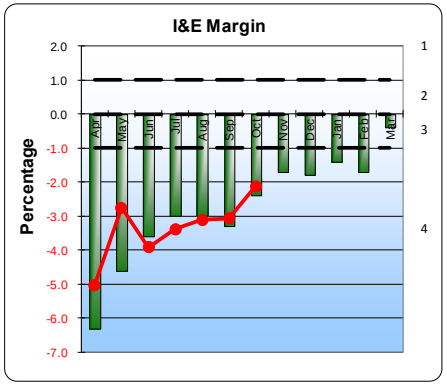
Harrogate & District NHS Foundation Trust	**£435K**
NHS Property Services	**£275K**
Northern Doctors Urgent Care (Vocare)	**£259K**
Humber NHS Foundation Trust	**£228K**

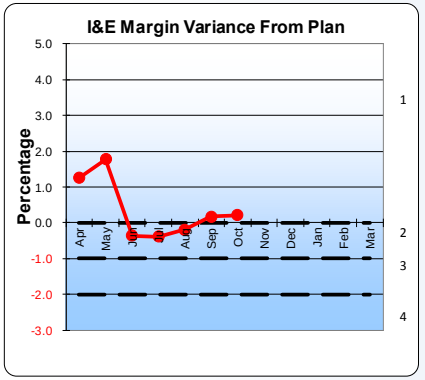
	Current	1-30 days	31-60 days	Over 60 days	Total
	£m	£m	£m	£m	£m
Payables	5.73	3.98	3.31	4.88	17.90
Receivables	6.78	1.97	0.43	3.44	12.61

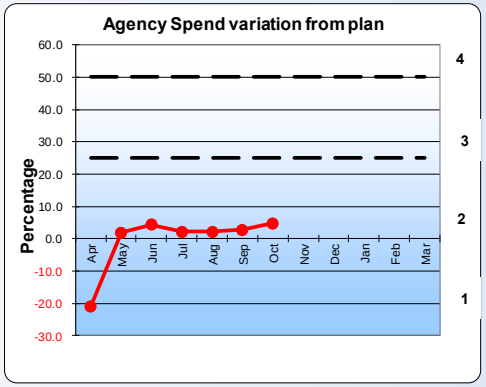


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (20%)	3	3	3	3
Capital Service Cover (20%)	4	4	4	4
I&E Margin (20%)	3	4	4	3
I&E Margin Variance From Plan (20%)	1	1	1	2
Agency variation from Plan (20%)	1	2	2	1
Overall Use of Resources Rating	**3**	**3**	**3**	**3**









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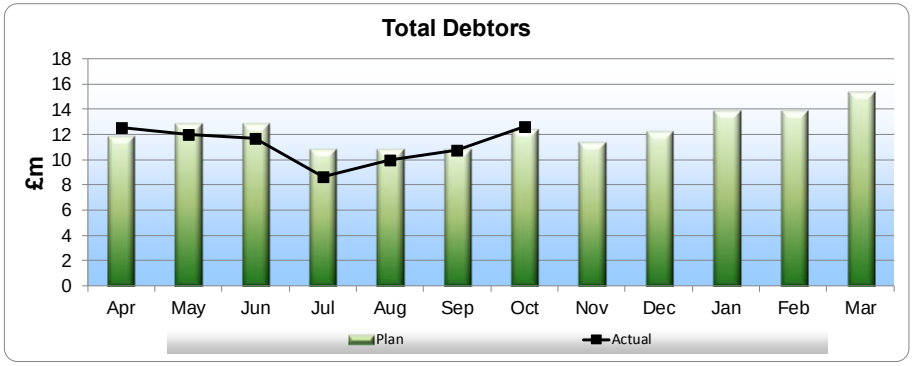
Debtor Analysis

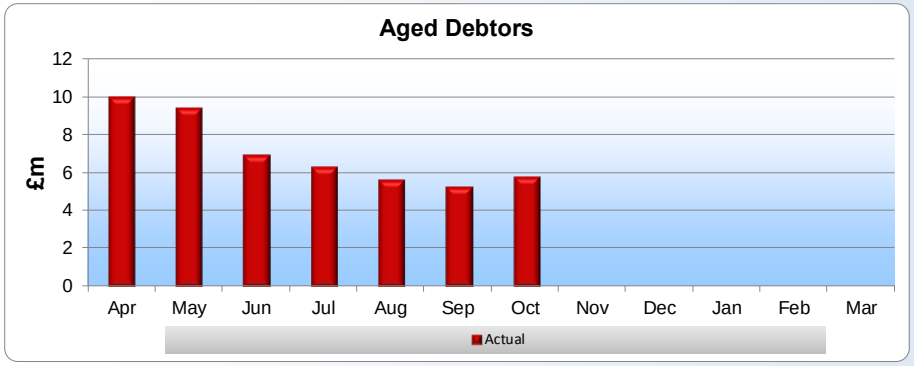
Month 7 - The Period 1st April 2018 to 31st October 2018

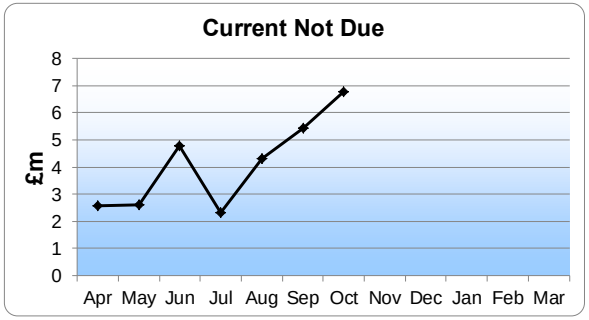
York Teaching Hospital NHS Foundation Trust

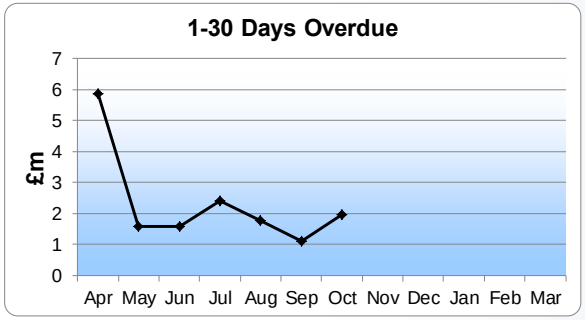
Key Messages:

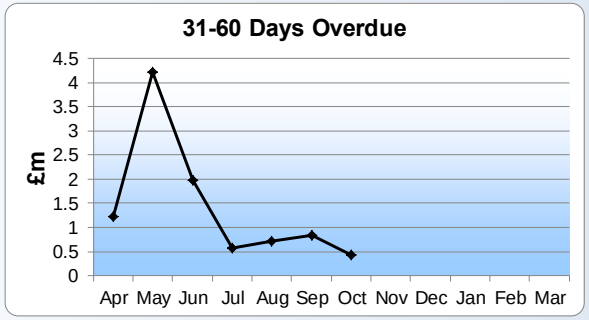
* At the end of October, the total debtor balance was £13m, which is on plan. £6.8m of this relates to 'current' invoices not due.
* Aged debt totalled £5.8m. This is a marginal increase on last month, however it still represents an improvement on the equivalent 17/18 October position.
* Long term debtors (Over 90 Days) remain at low levels but continues to be a focus for the Trust.
* Accrued income is signifcantly above plan. This requires focus to ensure invoices are in the system to secure cash payments.

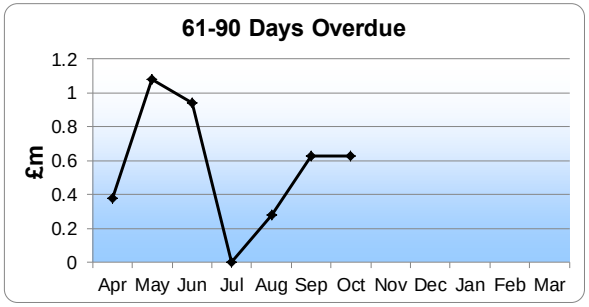


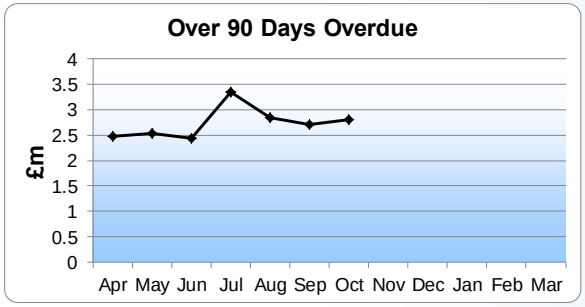


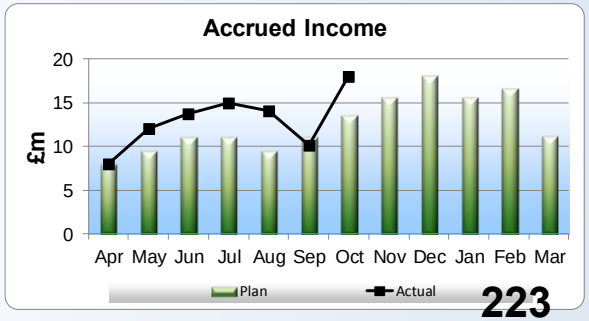












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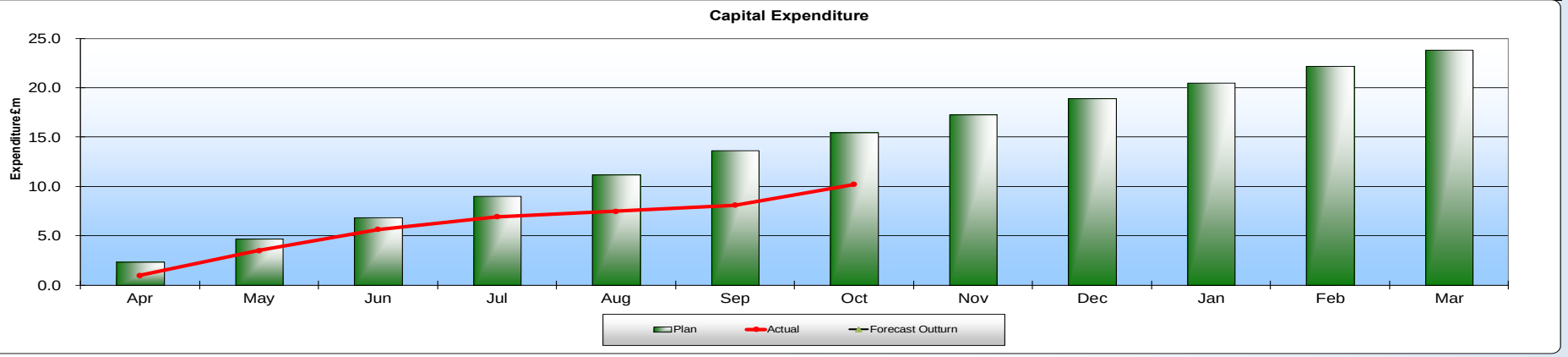
Capital Programme
Month 7 - The Period 1st April 2018 to 31st October 2018

NHS York Teaching Hospital NHS Foundation Trust

Key Messages:

* Current spend to the end of October is £10.2m against a plan of £15.4m
* Slippage is mainly due to the VIU Extension which is in the detailed design stage.
* Completed Schemes are the Lifts in Scarborough Radiology, the MRI in York and replacement of the VIU and Cardiac labs in York
* Schemes nearing the end of completion are the MRI and Xray rooms in Scarborough, roll out of EPMA in Scarborough and the Fire Alarm Scheme in York



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
SGH /York MRI Replacement	1,999	1,152	1,999	0	
SGH X ray Rooms	660	70	660	0	
York VIU/Cardiac Equipment	1,379	117	1,379	0	
Radiology Lift Replacement SGH	860	753	860	0	
Fire Alarm System SGH	1,529	592	1,529	0	
Other Capital Schemes	650	1,546	650	0	
SGH Estates Backlog Maintenance	1,000	230	1,000	0	
York Estates Backlog Maintenance - York	1,265	442	1,265	0	
Cardiac/VIU Extention	3,000	339	3,000	0	
Medical Equipment	450	87	450	0	
SNS Capital Programme	1,200	506	1,200	0	
Capital Programme Management	1,455	559	1,455	0	
Endoscopy Development	8,000	2,802	8,000	0	
Charitable funded schemes	623	370	623	0	
Fire Alarm System York	1,120	641	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**	**10,206**	**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	4,011	5,538	0	
Loan Funding b/fwd	2,401	773	2,401	0	
Loan Funding	11,000	3,637	11,000	0	
Charitable Funding	623	370	623	0	
Strategic Capital Funding	4,026	1,415	4,026	0	
Sale of Assets	215	0	215	0	
TOTAL FUNDING	**23,803**	**10,206**	**23,803**	**0**	

Key Messages:

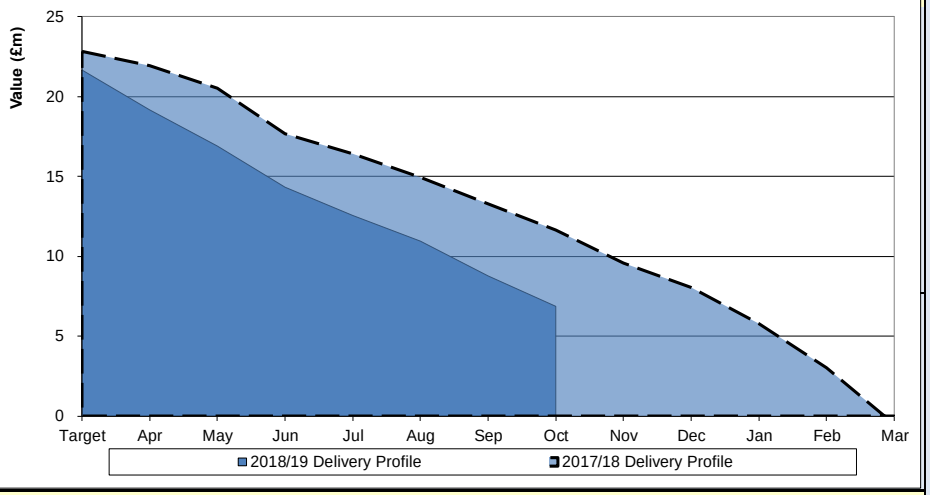
* Delivery - £14.8m has been delivered against the Trust annual target of £21.7m, giving a shortfall of (£6.9m).
* Part year NHSI variance - The part year NHSI variance is £4.0m.
* In year planning - The 2018/19 planning surplus is currently £0.0m.
* Four year planning - The four year planning surplus is £7.8m.
* Recurrent delivery - Recurrent delivery is £8.4m in-year, which is 39% of the 2018/19 CIP target.

Efficiency - Total CIP

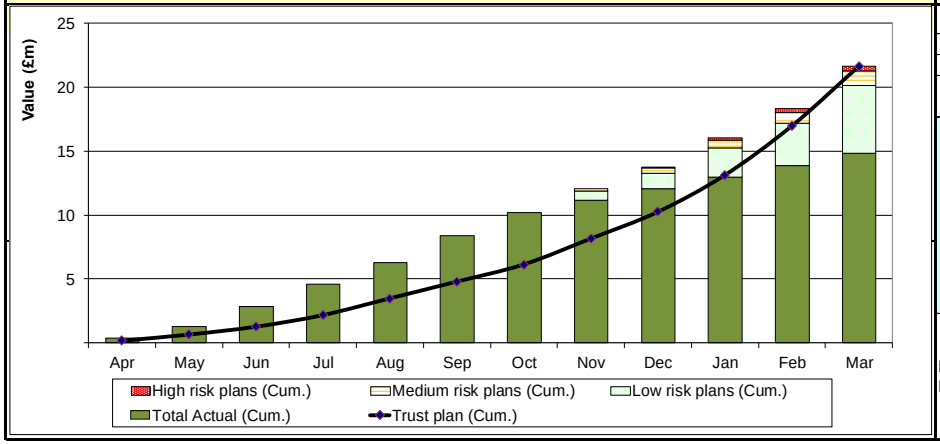
Executive Summary

	£m
2018/19 CIP Target	**£21.7**
In Year Delivery	
NHSI YTD Target at Month 7	£6.1
Actual Delivery at Month 7	£10.2
NHSI Variance Month 7	**£4.0**
Recurrent Delivery	£8.4
Non Recurrent Delivery	£6.4
Total Delivery	**£14.8**
In Year Gap to Delivery	**-£6.9**
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	£58.3
4 Year Planning (Gap)/Surplus	**£7.8**

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	817
Total Number of Assessed Schemes - Directorate	621
Total Number of Assessed Schemes - Signed Off	577

Probability/ Likelihood	Negligable - None				Catastrophic/death
Almost Certain	2	0	0	0	0
	2	1	0	0	0
	3	7	1	1	0
	6	17	4	0	0
Rare	558	9	8	2	0
	Consequence/Severity				

High Risk Plans: 3 : Elderly (1) high level of nursing vacancies; Lab Med (1) Consolidation of Services with HEY, E&F (1) Linen Changes - Directorate to reassess score. Moderate Risk Plans: 34

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Key Messages:
* Transactional CIP schemes represent £16.8m of the £21.7m Efficiency Target.
* Delivery at Month 7 is £13.0m of which £6.6m is recurrent.

Efficiency - Transactional CIP

Executive Summary

	£m
2018/19 Transactional CIP Target	**£16.8**
In Year Delivery	
NHSI YTD Target at Month 7	£5.2
Actual Delivery at Month 7	£9.2
NHSI Variance Month 7	**£4.0**
Recurrent Delivery	£6.6
Non Recurrent Delivery	£6.4
Total Delivery	**£13.0**
Gap to Delivery	**-£3.7**
In Year Planning	
Forecasted Delivery	£16.8
Forecasted Planning (Gap)/Surplus	**£0.0**
Long Term Planning	
4 Year Transactional CIP Target (18/19 to 21/22)	**£42.3**
4 Year Plans	£50.1
4 Year Planning (Gap)/Surplus	**£7.8**

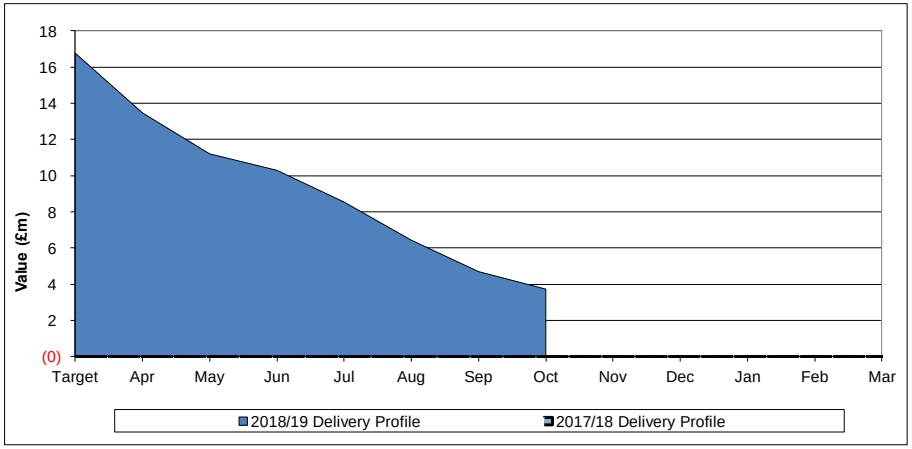
Governance Risk Heat Map

Total Number of Schemes	801
Total Number of Assessed Schemes - Directorate	607
Total Number of Assessed Schemes - Signed Off	566

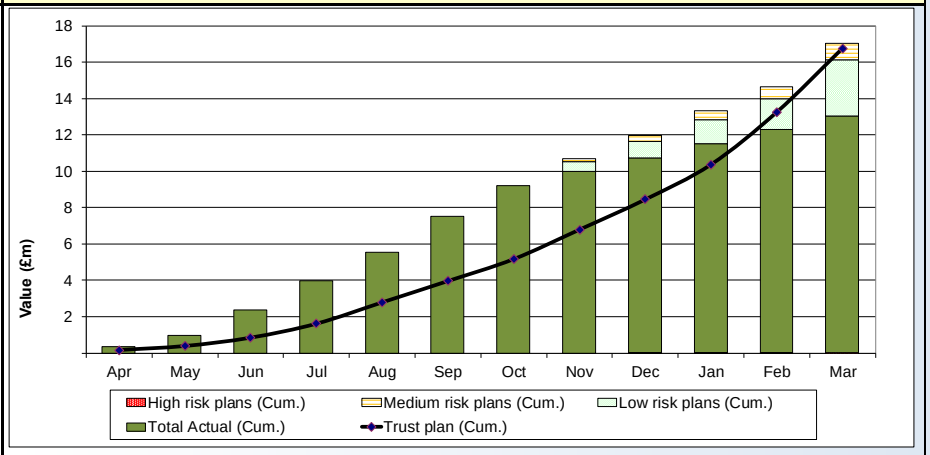
Probability/ Likelihood	Negligable - None				Catastrophic/death
Almost Certain	2	0	0	0	0
	2	1	0	0	0
	3	7	1	1	0
	6	16	4	0	0
Rare	548	9	5	2	0
		Consequence/Severity			

High Risk Plans: 3 : Elderly (1) high level of nursing vacancies; Lab Med (1) Consolidation of Service with HEY: E&F (1) Linen Changes - Directorate to reassess score. Moderate Risk Plans: 33

Gap to delivery - 2018/19



In Year CIP Delivery and Future Plans by Risk



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Key Messages:

* 16 Transformational schemes represent £4.9m of the £21.7m Efficiency Target.
* Delivery at Month 7 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	**£4.9**
In Year Delivery	
NHSI YTD Target at Month 7	£1.0
Actual Delivery at Month 7	£1.0
NHSI Variance Month 7	**£0.0**
Recurrent Delivery	£1.7
Non Recurrent Delivery	£0.0
Total Delivery	**£1.7**
Gap to Delivery	**-£3.1**
In Year Planning	
Forecasted Delivery	£4.9
Forecasted Planning (Gap)/Surplus	**£0.0**
Long Term Planning	
4 Year Transformation CIP Target	**£8.2**
4 Year Plans	£8.2
4 Year Planning (Gap)/Surplus	**£0.0**

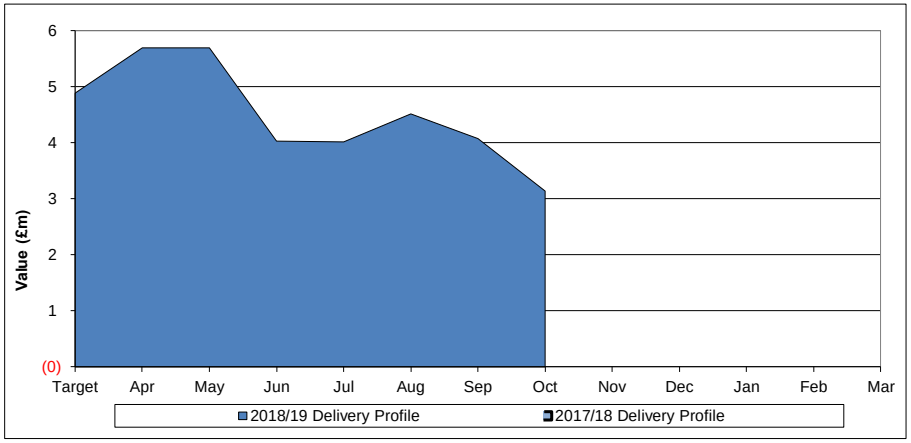
Governance Risk Heat Map

Total Number of Schemes	16
Total Number of Assessed Schemes - Directorate	14
Total Number of Assessed Schemes - Signed Off	11

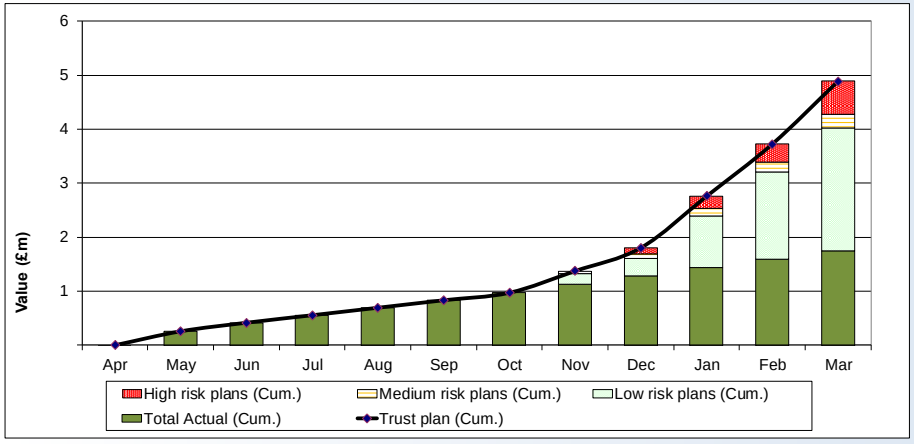
Probability/ Likelihood	Negligible - None		Consequence/Severity		Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	1	0	0	0
Rare	10	0	3	0	0

Moderate Risk 1 - SNS Paperlite: risk being not having access to patient notes

Gap to delivery - 2018/19



In Year CIP Delivery and Future Plans by Risk



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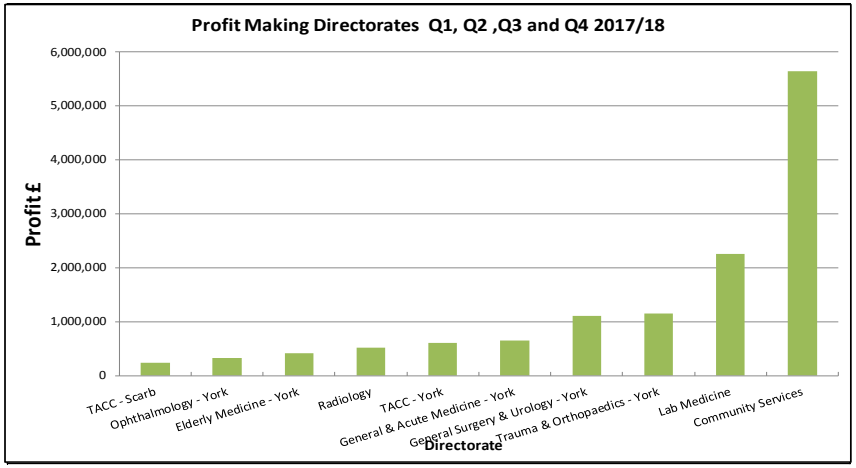
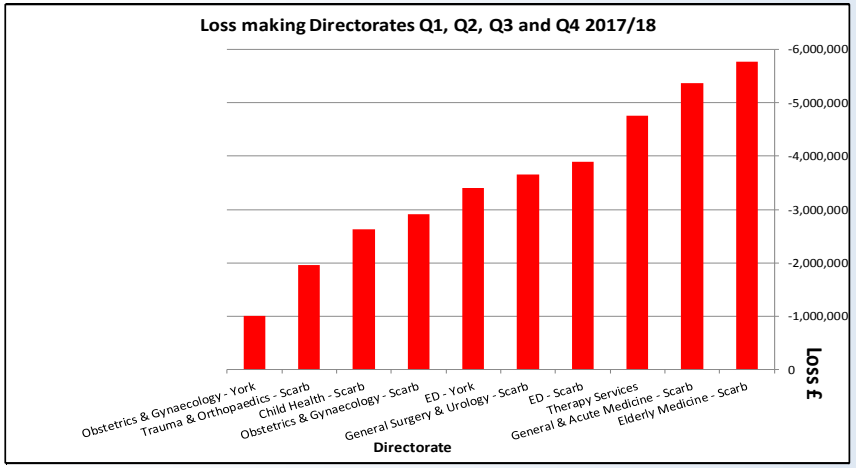
Service Line Reporting
Month 4 - The Period 1st April 2018 to 31st July 2018

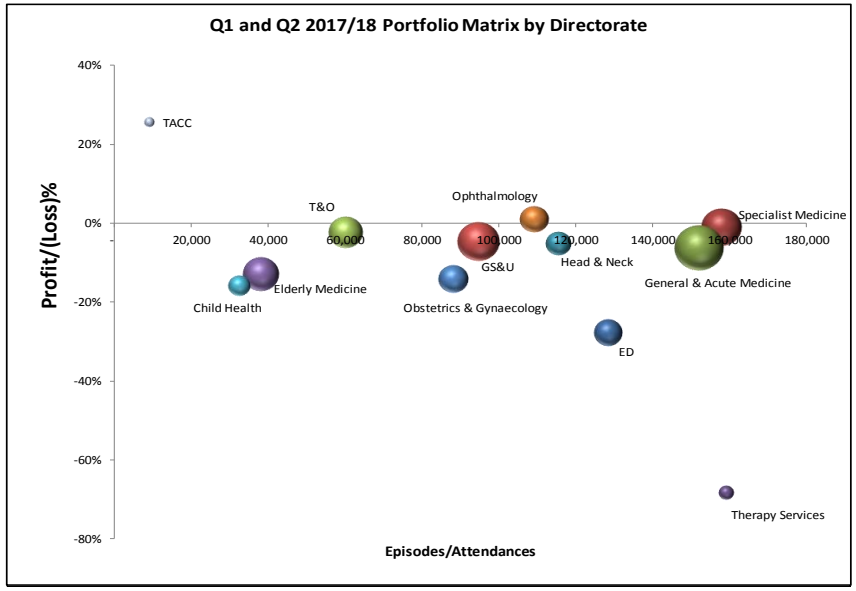
York Teaching Hospital NHS Foundation Trust

Key Messages:

* Current data is based on Q1, Q2, Q3 and Q4 2017/18
* Preparing for the mandatory PLICS submission to NHSI is now a key focus for the team
* Cohort two of the SLR Leadership Programme commenced in September 2018







DATA PERIOD	Q1, Q2 and Q3 2017/18
CURRENT WORK	* Q1 2018/19 SLR reports and the NHSI Costing Transformation Programme (CTP) requirements are now the key focus for the team. * The Q1 2018/19 SLR reports will be delayed while the team work to configure the system for the new CTP requirements. * The first run of the SLR Leadership Programme ended in July 2018 with all the Finance Managers achieving the required confidence level to become SLR champions. Cohort two of the programme commenced in September 2018.
FUTURE WORK	* Directorate reports are continued to be developed to allow the SLR / PLICS data to be more easily interpreted and understood. * System configuration for the NHSI Costing Transformation Programme PLICS submission is planned to run throughout 2018/19.

FINANCIAL BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£3.68m**

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 28 November 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 October 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 October 2018 is £14.8m.

Recommendation

For information.

Author: Steven Kitching, Head of Corporate Finance & Resource Management

Director Sponsor: Andrew Bertram, Finance Director

Date: November 2018

1. Summary reported position for October 2018

1.1 Current position – highlights

Delivery - Delivery is £14.8m to October 2018 which is (68%) of the £21.7m annual target, a movement of £1.9m from September 2018. This position compares to a delivery position of £11.2m in October 2017.

Part year delivery is £4m ahead of the profiled plan submitted to NHSI.

In year planning - At October 2018 CIP is 100% planned.

Four year planning – The four year planning shows a surplus of £7.8m. The position in October 2017 was a gap of (£4.7m).

Recurrent vs. Non recurrent – Of the £14.8m delivery, £8.4m has been delivered recurrently which is 39% of the overall target for 2018/19, a movement of £1.3m from September 2018. Recurrent delivery is £2.6m ahead of the same position in October 2017.

1.2 Overview

Transactional schemes
Transactional schemes of £16.8m represent 77% of the overall Efficiency Target, an increase of £0.9m from the previous month. Delivery at October is £13.1m of which £6.6m is recurrent.

Transformational schemes
Transformational schemes of £4.9m represent 23% of the overall Efficiency Target, a reduction of £0.6m from the previous month. £1.7m has been delivered recurrently. Plans continue to be developed.

Current live Transformational schemes are Outpatient Productivity, Theatre Productivity/Utilisation, Pharmacy Biosimilars, SNS Paperlite and Printer Strategy, Estates and Facilities ADM.

The table below summarises the position of Transactional and Transformational schemes.

Scheme	**Annual Target £'m**	**Delivery FYE £'m**	**Target YTD £'m**	**Delivery YTD £'m**
Transactional	£16.8	£13.1	£ 5.2	£ 9.2
Transformational	£ 4.9	£ 1.7	£ 1.0	£ 1.0
TOTAL	**£21.7**	**£14.8**	**£ 6.2**	**£ 10.2**
Summary of Transformational schemes:				
Theatre Productivity	£ 0.8	£ 0.1	£ 0.1	£ 0.1
Outpatients	£ 0.1	£ -	£ -	£ -
ADM	£ 3.7	£ 1.5	£ 0.9	£ 0.9
Pharmacy	£ 0.2	£ 0.1	£ 0.0	£ 0.0
Paperlite	£ 0.0	£ -	£ -	£ -
Printer Strategy	£ 0.1	£ -	£ -	£ -
Total Transformational Schemes	**£ 4.9**	**£ 1.7**	**£ 1.0**	**£ 1.0**

NHSI Operational Productivity and Model Hospital
Work continues with the Operational Productivity Team and Get It Right First Time (GIRFT). Representatives from the national GIRFT Team visited the Trust in October and will work closer with us to support this programme of work.

High Risk Directorates

There are 12 High Risk directorates in terms of planning and delivery that require support to ensure successful delivery of CIP

Two of the Directorates are being supported through the NHSI Productivity Work and are in the developmental stages; these are Radiology and General Surgery (Endoscopy).

Three Directorates have Transformational schemes that are at various stages in terms of planning and delivery. These are TACC for Theatre Productivity, Outpatients, and Ophthalmology.

There continues to be a significant challenge for Women's Health, Child Health, Medicine for the Elderly Medicine Scarborough and ED Scarborough.

Recurrent delivery of the Efficiency Programme remains a key risk to the organisation.

Quality Impact Assessment (QIA)

Quality Impact Assessments (QIA) are carried out following the Trust's Risk Management Framework.

There were 7 High Risk Schemes across the Efficiency Programme and these have been reviewed by the Efficiency Delivery Group, specifically the Chief Nurse and Medical Director.

Of the 7 High Risk schemes 4 schemes have been removed as no longer progressing. If resurrected in the future then the QIA process will be applied.

3 schemes remain High Risk.

There are 34 medium risk schemes and these are in the process of review.

There are 584 low risk schemes. These have been self assessed by the Directorate clinical teams as low risk under the QIA framework.

The table below summarises the High Risk schemes and their status in relation to the Efficiency Delivery Group risk review.

Respond to Risk:

Scheme No	Scheme	Risk	Action	Risk Accepted by	Date
CIPPATH194	Consolidation of Services with HEY, Histology, Virology and Microbiology	Redundancy and Loss of staff impacting on Turnaround Times and delayed results for patients	Piece of work to be commissioned across STP for consolidation and at this point a full QIA will be completed. Scheme to be removed as no proposal for QIA.	Efficiency Delivery Group	13.11.18
CIP-EMS3	Vacancy factor	High level of substantive vacancies; increase use of temporary transient workforce which could impact on quality and safety with potential decrease in perceived quality of care.	Directorate have re-assessed and revised to Low Risk Scheme. No further action.	Efficiency Delivery Group	13.11.18
CIPE&F024	Frequency of Linen Changes	Wards don't adhere to frequency of change	Scheme reviewed by Chief Nurse. Scheme revised to Low Risk. No further action.	Efficiency Delivery Group	13.11.18

Actions:

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 tolerable and 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.

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York Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

Board Assurance Framework – At a glance

Strategic Goals

- **To deliver safe and high quality patient care as part of an integrated system**
- **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	12 ↑	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