York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

Wednesday 30 January 2019

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 30 January 2019

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

TIME	MEETING	LOCATION	ATTENDEES
8.30 – 12.55	**Board of Directors meeting held in private**	**Boardroom, Foundation Trust Headquarters**	**Board of Directors**
1.15 – 1.55	Remuneration Committee	Boardroom, Foundation Trust Headquarters	Non- Executive Directors
2.00 – 5.15	Board of Directors meeting held in public	Boardroom, Foundation Trust Headquarters	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 • Dianne Willcocks	Chair	Verbal	-	2.00 – 2.05
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	9	
3.	**Minutes of the meeting held on 28 November 2018** To receive and approve the minutes from the meeting held on 28 November 2018.	Chair	B	15	
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	Verbal	-	2.05 – 2.15

	SUBJECT	LEAD	PAPER	PAGE	TIME
6.	**Chief Executives Update** To receive an update from the Chief Executive	Chief Executive	C	31	2.15 – 2.30
7.	**5 Year Strategy Update** To receive an update on the 5 Year Strategy including: • The Communication Plan • The Five Year Strategy Objectives	Chief Executive	D To follow	-	2.30 – 2.40
	Strategic Goal: To deliver safe and high quality patient care				
8.	**Chief Nurse Reports** To receive updates from the Chief Nurse including: • Nurse and Care Staffing • Nursing & Midwifery Strategy – Caring With Pride • Q3 Patient Experience • Q3 Director of Infection Prevention Quarterly Infection Prevention and Control	Chief Nurse	 E1 E2 E3 E4	 35 53 83 93	2.40 – 2.55
9.	**Medical Director Report** To receive the Medical Director Report.	Medical Director	F	105	2.55 - 3.10
10.	**Performance Report** To receive the Performance Report.	Chief Operating Officer	G	185	3.10 – 3.25

	SUBJECT	LEAD	PAPER	PAGE	TIME
11.	**Out of Hospital Care Development** To receive a report on the development of Out of Hospital Care	Chief Operating Officer	H	201	3.25 – 3.35
	Short Break				3.35 – 3.45
12.	**Director of Estates & Facilities Report** To receive the Director of Estates and Facilities Report. • Carter Metrics • SGH Capital Bid	Director of Estates & Facilities/ LLP MD	I	211	3.45 – 4.00
	Strategic Goal: To support an engaged, healthy and resilient workforce				
13.	**Director of Workforce Report** To receive the Workforce Report.	Acting Director of Workforce & OD	J	233	4.00 – 4.15
14.	**Freedom to Speak Up/ Safer Working Guardian Report** To receive the Freedom to Speak up 2nd Annual Report and the Quarter 3 Guardian of Safer Working Report.	FtSU/SW Guardian	K	247	4.15 – 4.30
	Strategic Goal: To ensure financial sustainability				

	SUBJECT	LEAD	PAPER	PAGE	TIME
15.	**Finance Report** To receive the Finance Report and a Procurement Report. • Finance Report • Procurement Report	Finance Director	 L L1	 265 283	4.30 – 4.45
16.	**Efficiency Report** To receive the: • Efficiency Report • 2019/20 Operational Planning & Contracting – Productivity and Efficiency Guidance • Transformation Reports	Finance Director	 M M1 M2	 289 295 305	4.45 – 4.55
	Governance				
17.	**Governance Documents** The Board is asked to approve the Reservation of Powers and Scheme of Delegation, Standing Orders, Standing Financial Instructions.	FT Secretary	N	327	4.55 – 5.05
18.	**Reflections on the meeting** • BAF 'at a glance'	Chair	O	329	5.05 – 5.15
19.	**Any other business**	Chair	-	-	5.15
20.	**Time and Date of next meeting** The next meeting will be held on Wednesday 30 March 2019 in the Boardroom, Foundation Trust Headquarters, York Hospital.				

Items for decision in the private meeting: Board Resolution – Guarantee and Indemnity in favour of CHG-MERIDIAN Computer Leasing UK Limited

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
January 2019

York Teaching Hospital
NHS Foundation Trust

Additions:

Changes:

Deletions:

A

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

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	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

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

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Public Board Minutes – 28 November 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 (by phone)
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

In Attendance:

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

Trust Staff

Mrs L Provins	Foundation Trust Secretary

Observers:

Sheila Miller - Public Governor – Ryedale and East Yorkshire
Jeanette Anness - Public Governor – Ryedale and East Yorkshire
Michael Reakes – Public Governor – York
Quentin Summerfield – Insight Programme
Emma Palmer – Therapy Department
Lindsey Parkin – Occupational Therapy Department
Meg Saynell – OT Student
Holly-Anne James – OT Student
Emily Payton – Johnson & Johnson

Ms Symington welcomed everyone to the meeting at Scarborough. Ms Symington stated that the Board had taken part in a number of walkrounds in the hospital before the meeting which was a good discipline for the Board as it sets the tone for the discussions at the Board. She provided an overview of the Board schedule which included a public meeting following by a working dinner and then a private meeting and a stakeholder meeting tomorrow.

18/73 Apologies for absence

Mrs McAleese was unable to attend the meeting, but joined by phone.

18/74 Declarations of interest

No further declarations of interest were raised.

18/75 Minutes of the meeting held on the 26 September 2018

The minutes of the meeting held on the 26 September 2018 were approved as a correct record subject to the following amendment:

Minute No: 18/67 Finance Report Resolution – should read it was resolved that the Board noted the report.

18/76 Matters arising from the minutes

No further items were discussed.

18/77 Patient Story

The Board received the video which had been prepared for the Celebration of Achievement event in October and which gave an overview of the Trust's year to date. The film provided a high level overview of the year gone by and caused the board to reflect on the key events of the year. It was agreed that the video should be posted on the Trust's website.

Action: Mrs Brown to ensure the video goes on the website.

It was resolved that the Board reflected on a busy and challenging year.

18/78 Chief Executive Update

CQC System Visit – Mr Proctor stated that the CQC had been to look at the York system which included the Trust, social care and the voluntary sector. This was a follow up visit to the one conducted last year to see what progress had been made. He stated that currently only verbal feedback had been received and that Cllr. Runciman, the Chair of the Health & Wellbeing Board, would receive the final report. The verbal feedback noted that progress had been made in some areas, but not as much as there should have been.

Mr Proctor stated that some really good areas of practice were noted with front line staff working together to make improvements for patients, however, it was stated that a vision

for the whole system had not been created. The Place Based Board included various organisations and had been key to developing good relationships, but the pace of change needs to quicken in relation to strategic issues. There was also concern about the churn as there would be a new Director of Adult Social Care and a new YTHFT CEO. Mr Proctor stated that the CQC felt that commissioning was largely transactional and not transformational enough. He felt that the comments were fair, but had the impression that they had surprised some partners. The visit the previous year was now seen as a kick start, but that this visit needed to drive greater improvement. Mr Proctor stated that the Place Based Board had not met since the review. It is likely that the report will be received at the end of the month.
Prof. Willcocks stated that the feedback was helpful as it chimes with criticisms of the Healthcare Partnership which needs more cultural shift to enable transformation.

East Coast Review

Mr Proctor stated that the final Clinical Reference Group had taken place with clinicians from both primary and secondary care involved. Feedback from the review has not yet been received. When the final report is received the partners will consider the next steps.

New roles and new ways of working

Mr Proctor stated that his report emphasised the importance of constant change and the need to work in different ways. He stated that he had recently shadowed a physician who was performing the Acute Physician in Charge role which was a change to the way patients are managed. The role allowed for patients to be treated without being admitted. He stressed the need to change the way the Trust works in order to keep up with demand and that change can be perceived as a threat, but the Trust needs to challenge that view.

Business Continuity

Mr Proctor stated that the Black Start undertaken at York had been successful and a similar event was planned at Scarborough.

Humber Coast and Vale Health and Care Partnership

Mr Proctor stated that Simon Pleydell was leaving following 12 months of leading the STP and that as yet he was unaware of his replacement. He also noted that a new Regional Director for the regulator was also due to be appointed.

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

18/79 Chief Nurse Report

Nurse Staffing - Mrs Geary reminded the board that it was agreed at the last meeting that the staffing report would come to the Board on a quarterly basis with exception reporting each month. She advised the board that the figures were better this month, as was often seen as this time of year due to the new intake of nurses which creates a reduction in the net vacancy rate. Mrs Geary highlighted the actual versus planned rate on pages 38 to.
Ms Symington commented that this looked like a remarkable achievement and that the Board were really encouraged by the graph showing where the two lines overlapped.

Safeguarding Children Annual Report – Mrs Geary stated that the report was for information, but she needed to highlight that she had come directly from the Safeguarding Governance Group which was multi-agency and one of the questions had been around Child Protection Medicals. Concerns had been raised around medicals on the Scarborough site and she had been asked to go back and check the information. She highlighted that this figure did reflect the information received.

Mrs Geary stated that there had been a joint targeted inspection around Looked After Children which had noted an improvement in the system especially around the Sexual Assault Referral Centre (SARC). The overall finding had been the NHS Providers are better positioned to drive things forward. She noted that agencies around the table had commended the Trust's Safeguarding Team especially since operationalising groups so that child protection specialist nurses were introduced in to ED to ensure early identification of those at risk.

Winter - Ms Symington stated that she had visited Lilac Ward before the Board meeting and had been very reassured about the preparations there for winter. She noted the concerns around flu, but that there was optimism that it would not be as bad this year. Mrs Geary stated that a look back exercise had been done around last year and teams had worked well together on the Scarborough site in particular. She also noted that disposable curtains had been ordered this year and the IPC team would visit on a daily basis. Mrs Geary stated that she still had concerns around the use of nightingale wards and an SOP had been developed to ensure at risk patients were not nursed in those areas.

Mr Keaney asked if the funding had been received for the winter plan and Mr Bertram stated that the Trust were committed to providing the £500k for the priority schemes, but the CCGs had confirmed that there would be no extra money following receipt of the letter from the Chair. However, he did note that the quarter two AIC overtrading position had been agreed and included things like Aspen Ward and extended stay and it was noted that provision had also been made for these in the second half of the year.

Mr Keaney stated that the full winter plan detailed the need for £1.6m otherwise patients would be put at risk. He asked what else was being done. Mr Bertram noted that Mrs Geary had a meeting planned with her opposite numbers at the CCGs. Mr Proctor noted that this had obviously been fed upwards as the Head of Emergency Care at the centre wanted to meet with the CEOs, leads and responsible officers of several systems and this area was on the list. Mrs Scott stated that at the recent COO network meeting recently she had had the opportunity to raise it formally with Pauline Philip. She noted that only about five providers in the room had had their plans funded.

Mr Keaney stated that this was a significant concern as the CCGs know the Trust will have to treat patients and this will result in an overspend for the Trust. Mr Bertram stated that this had been discussed at Corporate Directors and he noted that no schemes have been stopped from progressing as the Trust did have £500k available and had been given a further £100k which left a gap of £1m. He stated that a close eye will be kept on the situation.

Mrs Adams noted that the safeguarding liaison in ED had been funded by the commissioners in York but not in Scarborough. Mrs Geary stated that a funding plan had

been identified and a joint post would be put in place. It was noted that the adult safeguarding information was contained in the dashboard, but Mrs Adams asked whether a narrative could be added to make it easier to understand.

Ms Mellor stated that she had been on a walk round before the meeting and felt very assured by the amount of preparation on Lilac Ward for winter. It was noted that patient feedback is being built into the plan.

Mrs Geary noted that some of the actions are completed on the work plan, but some are still underway. She noted the example of 1.14 which stated that an educator had been recruited as part of the action, but there was an element of the action remaining around a 12 month focus on child mental health training which was still ongoing.

Mrs Geary stated that matrons are moving to 7 day working with the Scarborough site choosing to adopt this early, but the York site were waiting for the go live date of 1 December 2018. There has been some very positive feedback from the move on the Scarborough site.

Mr Bertram stated that the planned provider event for internal recruitment noted on page 42 had stalled (this had been discussed by Corporate Directors the previous day) due to the continual delays due to a regional review of procurement processes. It had been decided to proceed in any event as and Ms McMeekin noted that she planned to use three different providers.

It was resolved that the Board noted the report and in particular the challenges facing the Trust around nurse recruitment and the continual changes being introduced such as the matrons going to 24/7 working which was proving positive in Scarborough. The Board recognised the preparations which were taking place in readiness for winter.

18/80 Medical Director's Report

Mr Taylor stated that his report summarised the key points.

Sepsis – Mr Taylor noted the improving situation with screening and the delivery of antibiotics within the first hour. However, this needed to be looked at from a whole healthcare perspective (primary care, the ambulance services and community) where it could be argued that the biggest improvements could be made as many patients who come to the Trust have already developed sepsis before their admission.

Ms Symington stated that the third paragraph stated that there had been an improvement, but this was not very big. Mr Proctor stated that it was tricky to provide treatment within an hour and it should be remembered that the patient may have been ill for some time which meant it was key to extend the thinking and involve other services such as YAS and GPs. Dr Boyd stated that some of it was around improving GP information/training as GPs see loads of minor infection and only see a major one every once in a while so care needs to be taken not to overwhelm the system. Mr Taylor stated that GPs used to carry penicillin and that meningitis is similar to sepsis which meant that GPs would be in a position to give an early dose of antibiotics.

Cancer clinical harm reviews – Mr Taylor stated that the Trust had been doing these reviews for many years and that a new more robust framework was introduced in 2016. There are some variations but the Trust is expected to look at every patient by 104 days which it is now doing. However, all these reviews can be adhoc and the idea was to bring them all together. He noted that the data in the quality pack provided more detail and it needed to be considered what the data could be used for. Mrs Adams was concerned about the potential harm to patients if they have to wait too long. Mrs Scott stated that the Trust has had support from the NHS Elective Intensive Support Team who have been onsite working alongside staff in a range of areas. Clinical harm reviews have been flagged as the Trust's approach is not as robust as it could be. The Cancer Board were responsible for the reviews and will be increasing the scrutiny and challenge and this would be fed-up into Executive Board. It was acknowledged that a key issue was the availability of diagnostic capacity.

Mr Taylor stated that it had been a good month for recruitment with an ITU consultant for York recruited last week and an appointment panel for a Scarborough physician being held on the 29 November.

Mr Taylor stated that wet macular degeneration treatment was relatively new and it was this disease which was driving capacity issues currently in ophthalmology. Mr Taylor explained that there is one expensive drug licensed to treat this condition, but there is also another drug which provides good outcomes which is unlicensed for this condition, but much cheaper, however, the drug company will not put it through the process to get it licensed as it owns both drugs. Currently there is a High Court judicial review taking place to see whether the drug can be used off licence. It is likely that Novartis will appeal any outcome in favour of trusts using the drug off licence. It was noted that the drug would save a lot of money, but only 20% of patients will be eligible to use it and use of the drug would require more frequent attendances at the outpatient clinic.

Ms Mellor asked if there were any other drugs that would benefit from the judicial review, but it was noted that this is an individual court action and an unusual situation.

Mrs Adams noted the issues with the rapid access chest pain clinics and Mrs Scott stated that this had been discussed at some length at the AIC Board in order to find a way to recover the position.

Mr Taylor stated that dementia screening was a tough issue and that a reminder about this had been sent out to clinical colleagues as the last Executive Board had been a time out. It was agreed earlier that this will be raised at the December Executive Board.

Dr Boyd asked why gynae were standing out on the CQUIN targets for antimicrobial prescribing on page 94. Mr Taylor to investigate.

Action: Mr Taylor to report back to the Board on why gynae are standing out on the CQUIN targets for antimicrobial prescribing.

It was resolved that the Board noted the report.

18/81 Performance Report

Mrs Scott stated that ECS in October was at 90.9% against a planned trajectory of 90%. York ED had seen a rise in the number of attendances which was 661 more than last year and was creating some difficulties. She stated that the Trust is beginning to feel the pressure of winter and that the ECS is currently at 89.55% for November and there is a significant risk of not achieving the target. There is a current tolerance of 23 breaches a day, but she noted that there had been more than that across the Trust today. Acuity of patients is also increasing and added to this there had been the bed closures at York due to Norovirus. However, Mrs Scott remained optimistic and that the Trust is at 90.27% for this quarter.

Mrs Scott stated that the Trust was not where it would like to be in relation to ambulance handovers and was currently considered an outlier. Work is taking place and actions include getting the NHSI Emergency Care Support Team Ambulance lead on site checking through the actions being taken. The Lead has previously been involved in working across the Northwest to improve performance. The Scarborough position has significantly improved over the last few weeks, but the challenge will be to sustain the improvement.

Cancer waiting times are deteriorating with the 14 day fast track at 83.8% in September against a target of 92%. Dermatology patients made up 52% of the breaches and it should be noted that 86.6% of those did not have cancer. Dermatology and colorectal areas are challenging and staff are working with colleagues to ensure the referrals being received are appropriate. Referrals are being triaged and 10% of dermatology referrals are turned around at this stage. Different ways to try and moderate demand are being used.

Two week waits are up 9% on September last year so the Trust is seeing more patients quicker, but the downside of this is the need to carve out more space to see these patients from the patients having to wait routinely. In relation to 62 day fast track, the Trust achieved 76.6% against a target of 85% and some of the delays in this area are about patients being able to access diagnostics in a timely way.

Mrs Scott suggested a focused discussion on cancer at January's Board and that it would be helpful to have David Alexander and Kim Hinton invited to present the current position context and what the Trust is doing to alleviate it. Ms Symington stated that this would help the Board to determine how it could help.

Mrs Scott stated that the waiting list target was to have a figure that was no larger at the end of March 2019 than it was at the end of March 2018. The Trust is currently over the March 2018 figure, but there are plans in place to close the gap. Conversations are being held with the CCGs and regulators about outsourcing and how this can be funded.

In relation to RTT a number of things are being done including changing follow up appointments to first appointments and putting in place four additional patient trackers to close clocks to ensure we retain the position.

Mr Keaney stated that great efforts were being made with the ECS target and together with the increased attendances, this is a marvellous achievement. He expressed concern about the waiting list figure as funds were scarce and noted that the DTOC position had

increased in October. It was noted that York were worse than North Yorkshire, but there had been a recent allocation invested by York City Council in packages of care as it was likely there would be a surge of patients in January who needed discharging, however, the LA were also struggling to recruit staff. Mr Keaney stated that the Trust would desperately need the beds as the position was worsening now and the Trust was only at the start of winter. Mrs Scott stated that she and Mr Proctor had raised the issue. Mr Proctor described the position as shameful and that he had briefed the CQC in order to raise the profile.

Mr Keaney asked if there was anywhere to escalate concerns and it was noted that this would be to the CQC and the regulators. Mr Bertram stated that it was likely it would feature in the CQC report.

Dr Boyd stated that DTOC and the readmission rate needed to be kept an eye on. Mrs Scott stated that Mrs Adams had previously flagged the readmission rate and she had looked at it to see what was driving it and nothing was emerging. There had been a debate at Corporate Directors and it was thought to be a data anomaly. Mr Proctor stated that the discussions noted that the system made it easier to click discharge and readmit than transfer which had caused a significant increase. However, he noted that if the readmission rate was at zero, then the Trust was not trying hard enough as it was a fine balance.

Prof. Willcocks welcomed the focus on cancer and thought it was a perfect issue to be brought to the Board. She stated that it would also be useful to see how voluntary sector partnerships in this area could be developed further especially as initiatives like the cancer garden were an important part of what the Trust offered.

Mrs Adams asked about the urology issue and whether the Malton facility is being fully utilised. Mrs Scott stated that the Trust is seeing a drift of activity to Harrogate, but the Trust is considering what other one stop services can be provided. Mr Bertram stated that plastics are using Malton. Mrs Adams was surprised that patients were not choosing the one stop service at Malton and Mr Proctor thought patients are probably ill informed about the service, which is to do with GPs providing appropriate information.

Mrs Adams noted that the 36 week waiter figure was creeping up and Mrs Scott responded that this is looked at each week and each patient journey gone through.

Mrs Scott stated that any feedback on the report and its content would be gratefully received.

It was resolved that the Board noted the report and asked to be kept informed of the any issues. David Alexander and Kim Hinton to be invited to present the current position context on cancer and what the Trust is doing to alleviate it at the January Public Board.

18/82 Director of Estates & Facilities Report

Mr Golding stated that there had been leadership walk rounds in ICU and Lilac Ward before the meeting, which showed the best and worst of the Trust's estate. He noted that staff were really motivated and wanted to provide the best care, but were struggling with

the estate. He stated that some of the estate required a significant rebuild and this was a risk for the Trust. Mrs Geary noted that backlog maintenance also appeared as a high risk on her risk register.

Mr Golding highlighted his summary report on page 137 which noted that the operational functions of Estates and Facilities transferred into YTHFM LLP on the 1 October 2018. The first pay run had been very successful, although there were a number of anomalies, but due to the number of staff there would have been a percentage of anomalies with pay in any event. The second pay run was due today which should settle any further nervousness down.

Clinical Waste – Mr Golding stated that the Board had previously informed that the clinical waste contractor had been found in breach of legislation so the contract had been cancelled. Business continuity plans had been put in place and Hugh Stelmach had done a sterling job keeping the service running for 9 to 10 weeks which was longer than initially planned. It was envisaged that the plans would be kept running until the end of next month. Mr Golding stated that a new contract was in place and would ensure a new service was up and running. This had all been put into place without any disruption to clinical services no reputational damage.

Mr Golding noted that the initial contactor had taken legal action for breach of contract against all 17 trusts who had cancelled their contracts, but this would be defended regionally by NHSI. Mrs Brown stated that a number of FOI requests had been received, but nothing further had developed.

Black Start – Mr Golding stated that Mr Proctor had already mentioned the Black Start exercise and he stressed that it should not be underestimated what it takes to make that sort of exercise happen and that the Trust were the first Trust he had worked at that had carried this sort of exercise out. He stated that it had all been down to team work and scores of people positioned around the Trust communicating by radio. There had been some small technical issues to deal with, but as with the clinical waste issues, business continuity plans had worked.

Mr Golding stated that the summary included a schedule of open claims at page 139 and he provided a brief overview of the new claims. No public liability claims or RIDDOR reports had been received.

Ms Mellor asked whether the Black Start exercise had been used as a PR tool. Mr Golding stated that NHSE were currently on a site strategic asset visit which all providers were required to have and they had been shown the LIVEX detail, the emergency planning self-assessment and action plan together with the Internal Audit review. NHSE had commented that they were unaware of any other Trust who had done this work so comprehensively which evidenced the Trust was taking it seriously.

Ms Symington stated that this should provide assurance to the population that the Trust serves.

Mrs Brown stated that communications were continually being relayed about the work being done.

Mr Golding stated that the Trust needed to further apply itself to the Model Hospital work.

Sustainable Development Annual Report – Mr Golding stated that this work was headed by Jane Money and the Sustainable Development Group. The BAF also recorded a strategic risk in relation to the Trust's failure to develop a trust wide environmental sustainability agenda. The report noted the proposed work programme on page 145 and that the most significant project was around awareness raising and the implementation of champions.

Mr Golding highlighted that he will be doing some work with the UK director of Schneider who are keen to work with the Trust on developing their business offering. They offer several tiers of service including:

- How to use the building management system better – making it smarter
- How can get the best out of the system

Mr Golding stated that the Trust is in the top 3 trusts for national reporting for the second year running and this is about the information provided in the annual report. The chart on page 154 of the pack showed the Trust's carbon footprint per patient contact and this evidences a significant downward trend especially as the Trust is seeing more patients. Page 156 shows specific energy usage which shows a four year downward trend and is to do with the introduction of the combined heat and power plants with overall carbon emissions down significantly.

Travel Plan – Mr Golding stated that this work is overseen by a Group who have developed a five year plan which will be published in the next month or two. He noted that parking at York from a patient and staff perspective it is set to get worse as the Trust starts to build on some of the car parking spaces. The Trust has been pushing the Council for many years for a park and ride system. The Council and the Trust jointly appointed Dan Braidley initially as Transport Manager; however, he has since been fully employed by the Trust in that role and continues to make significant improvements. The Trust is exploring setting up a park and ride provision with First Travel from April. The cost of £225k will be off-set by the fares, but there may be some revenue consequences to this. However, this is a fantastic opportunity for the Trust as the service will look to run from 6.30am to 8.30pm.

Ms McMeekin noted that one of the top reasons for staff leaving was stated as car parking which is very challenging at York.

Mrs Adams noted that car parking was a very emotive issue at Scarborough too and Mr Golding responded that there were some trust wide initiatives in the plan, but also some site specific ones. Ms McMeekin noted that there were also some members of staff on the travel group. Mrs Adams stated there also needed to be work on the ability to use technology instead of travelling.

Prof. Willcocks stated that the use of technology would also help some of the groups meet and Ms Symington noted that there needs to be a review focussing on whether all the groups added value.

Mr Golding stated that the key performance management document between the LLP and the Trust was at page 175. The document was not complete yet and he was not content with where the LLP were performing at the moment. One of his first objectives was to get the policy compliance up to 100% by the end of the year.

Mr Golding stated that page 183 provided a summary of the PLACE scores which were extremely disappointing as organisational performance was poor except for Selby. This may be due to the training programme which had been used to develop the people who carried out the inspections, but could also be down to the lack of capital funding to invest. Mr Golding stated that future reports may initiate discussions on whether the Trust wanted to invest capital or were prepared to carry the risk around maintenance of the estate.

Mrs Adams was disappointed in the food scores as money had been invested in this area.

Mrs Geary stated that some of this could be due to the inspectors now knowing what they are looking for following the training. One example was about lack of dining room space and patients having to eat beside the bed and other issues could be to do with hand washing facilities which can be addressed.

Prof. Willcocks stated that it could be to do with raised expectations.

Mr Golding stated that he would bring the Carter metrics data to the next meeting.

Action: Mr Golding to bring the Carter metrics to the next meeting.

It was resolved that the Board accepted the report and would be paying close attention to the improvement of the PLACE position which was very disappointing for all Board members.

18/83 Director of Workforce Report

Ms McMeekin highlighted that the monthly sickness absence rate in September was 4.49% which was not great news. She highlighted that the rate had been climbing quite steeply for 3 months in a row which was out of line with seasonal trends. A number of initiatives were running in relation to stress, anxiety and depression and MSK and these were being constantly reviewed. Support was also being offered in the self-certification stage, but success was generally a result of how proactive individual managers are. Ms McMeekin noted Line Management training was now being offered as a result of feedback from the freedom to speak up work and really positive feedback was being received from those who had completed the training. The training looked less at the mechanics of the processes and more at some of the softer line management skills. There is now a waiting list of 83 for the training and HR is looking at devising a train the trainer scheme.

Ms McMeekin highlighted that staff engagement is low across the organisation and that staff resilience is also low and the Trust is currently seeing that play out so there is a possibility that the staff survey may reflect this. Ms McMeekin stated that the percentage uptake of the staff survey is 41% if the LLP are included and 45% if the LLP is excluded. The response from LLP staff was 16% which is a fraction of what it was last year. Mr Golding stated that he had expected the LLP response rate to be lower especially as they are not usually desk based. Mr Golding stated that a key objective for the LLP was to

engage with this group of staff better. The response rate for the survey last year was 47% which was following a strong campaign on social media and twitter. The new provider of the survey is reminding staff every week to complete the survey. Mr Proctor and Mr Bertram both thought that the response rate was good and it was noted that the national average was only 43%.

Mrs Adams asked about sickness rates and Ms McMeekin stated that the particular groups of staff which had high sickness rates were Estates and Facilities and Nursing and that the reasons for sickness remained fairly consistent.

Prof. Willcocks stated that when reflecting on the poor response rate from the LLP, it could be about the use of inclusive language and perhaps talking about the Trust as a family. She asked that Mrs Brown reflect on this. Mrs Brown stated that this was already being done, but unfortunately staff side are constantly telling staff that they no longer belong to the NHS undermining the trusts intention and actions to remain one NHS Family.

Ms McMeekin stated that in relation to medical recruitment the information on page 209 was already out of date and changes on a daily basis. She noted that a consultant anaesthetist, 9 trust grades and an ED locum have been engaged. She stated that start dates will be agreed once visas are in place and then the tables will be updated.

Ms Symington stated that this was very good news.

Mr Keaney stated that it was useful to have the medical recruitment details and Mrs Geary noted that she provided the full nursing figures quarterly with updates provided monthly.

Ms Symington noted the fragility with staffing levels across the trust.

Mrs Adams asked how the Trust measured up with the Model Hospital work and where the Trust is understaffed. It was noted that there had been a recent business case approved which looked at electronic job planning; the fourth cohort of ACPs had started with approval for 15, 10 of which would be based in ED at Scarborough. There is also the second cohort of trainee nursing associates due to start with the first cohort finishing in February. Coventry University have taken on 20 trainee nursing associates specifically for the Scarborough site and will shortlist another 21 early in December. HEE have funded a further 20 places at York, however, York University are not in a place to run a course so the Trust is currently negotiating with Hull University. Hull University will come and provide training on this site for a minimum of 20 places, but there is concern over funding for the back fill. HEE is keen to achieve regional targets so there may be additional funding to pay for the back fill.

Finally, Ms McMeekin noted that the EU settlement scheme is using health and social care staff to pilot the scheme for those EU citizens who wish to settle in the UK post withdrawal from the EU on the 29 March 2019. The pilot will start at the end of November and run to the 21 December. Applicants have to apply online using an android device only and pay a £65 fee. Ms McMeekin stated that there are about 324 applicants which the Trust is trying to support on an individual basis.

It was resolved that the Board noted the report and that the assurance around the various recruitment schemes, but remained concerned about the fragility of staffing across the trust.

18/84 Finance Report

Mr Bertram stated that the report details the 2018/19 month 7 financial position for the Trust which is the right side of the plan. The Trust is reporting an Income and Expenditure deficit of £6.2m against a planned deficit of £6.6m after including all PSF adjustments. Mr Bertram stated that month 7 PSF has been included in October, but this may need to be adjusted at the end of the quarter. The spend rate for October is also consistent.

Mr Bertram stated that there was a discussion last month about CIP being ahead of trajectory and whether this was masking anything. Further detail is provided on page 212 which shows a chart that is the product of a complicated spreadsheet. The chart includes a projected position for the final 5 months with the bar in March at £14.4m. The information in the spreadsheet contains a significant proportion of detail around the AIC, calendar information, compromised income, assumptions around winter and cost pressures are built in. The chart shows the deficit as £4m adrift at £18m, but what is not included in the March I & E position is the impact of the receipt of the historical VAT which is enough to close the gap. Mr Bertram stated that the Trust is still forecasting nothing unexpected and therefore on track for delivery.

Mr Bertram stated that agency spend has gone up and is due extra spend on consultants and junior medical staff. The position has seen a slight deterioration to £9,2m against a plan of £8.7m which still represents a significant reduction on last year.

Ms Symington asked Mr Bertram about any specific areas of concern he would wish to bring to the attention of the board. Mr Bertram stated that it was about having controls in place which is the case with nursing and medical spend. He confirmed this area is heavily reviewed and the Trust is constantly pushing back at some individuals who want outrageous rates of pay to work as a locum. Ms McMeekin noted that there is a group that meets on a Monday morning to look at any escalated concerns, but most decisions are taken on the grounds of patient safety.

Mr Bertram stated that the AIC quarter one and two positions have been agreed with no shocks and quarters three and four have been agreed without prejudice. He noted that the cash position would be discussed at the private meeting, but that he had previously alerted the Board that it would need to enter the distressed cash regime, but that this had been held off for as long as possible.

Good progress was being made on the CIP process, 68% has been achieved which was higher than usual. The papers contained details of all the transactional and transformational schemes and Mr Bertram noted that the Trust is still relying heavily on transactional schemes, but further work is being done on theatre productivity and OPD.

Pages 232 – 233 detailed the QIA CIP scheme process. Mr Bertram stated that the report for last month was not that clear. He highlighted that there was a new process which required the Medical Director and Chief Nurse to look through the high risk schemes. Out of the seven schemes which had been high risk, four schemes had been removed as

these were no longer progressing due to other reasons. The remaining three schemes had been assessed and page 233 contained details of those schemes and documented actions from EDG were recorded. He stated that the risk may not have been accepted and gave an example of the Hull York laboratory service collaboration which the directorate had listed the turnaround times for test results which was premature as there are no proposals set out as yet.

The staffing vacancy factor scheme had been stated as high risk, but after director review, it was changed to low risk.

The changes to the linen service were also highlighted by Mr Bertram as it was noted with this scheme that the linen on beds is changed every day regardless of whether it needs to be despite having a policy in place. This is a high financial risk as money is being spent that the Trust does not need to. Mrs Geary stated that this was about staff knowing and understanding the policy and had been a good issue to escalate.

Ms Symington asked about the November position and Mr Bertram stated that the position may fluctuate slightly but he was not concerned at this stage.

Mr Keaney asked about debtors and whether there was any chance of recovering the outstanding money. Mr Bertram noted that Harrogate Trust owes the Trust about £500k, but the Northern Doctors debt has significantly reduced. He noted that intra NHS debt is mirrored around the country as many Trusts are struggling with cash. Mr Bertram highlighted that the quarter two PSF for July, August and September has not been received yet and it is not expected until early in the New Year despite the Trust asking, which means the Trust will need to borrow in December and then pay interest on the borrowing.

Mr Bertram stated that capital spend is not being allowed to slip, due to the main component being loan agreements.

It was resolved that the Board noted the report and in particular the information around CIPs agency spend.

18/85 Efficiency Report

This report was covered during the Finance Report item.

18/86 Reflections on the Meeting

BAF – Ms Symington stated that the BAF high scoring risks had been covered except for Digital and that the risks were reflected in the construction of the agenda. She recognised that the board needs to find a way to ensure technology/digital is integrated into all board discussions.

It was agreed that the risk around a healthy engaged and resilient workforce will need further discussion once the staff survey results were known.

18/87 Any other Business

No further business was discussed.

18/88 Date and Time of next meeting

The next public meeting of the Board will be held on Wednesday 30 January 2019 in the Boardroom at York Hospital.

Outstanding actions from previous minutes

Minute No. and month	Action	Responsible Officer	Due date
18/69	Risk Management Framework to be reviewed following the revision of the committee structure	Ms Jamieson/ Mrs Geary	Jan 19
18/77	Mrs Brown to ensure the video goes on the website.	Mrs Brown	Jan 19
18/80	Mr Taylor to report back to the Board on why gynae are standing out on the CQUIN targets for antimicrobial prescribing.	Mr Taylor	Jan 19
18/81	David Alexander and Kim Hinton to be invited to present the current position context on cancer and what the Trust is doing to alleviate it at the January Public Board.	Mrs Provins	Jan 19
18/82	Mr Golding to bring the Carter metrics to the next meeting.	Mr Golding	Jan 19

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NHS

York Teaching Hospital

NHS Foundation Trust

Board of Directors – 30 January 2019
Chief Executive's Overview

Trust 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 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.

Recommendation

For the Board to note the report.

Author: Mike Proctor, Chief Executive

Director Sponsor: Mike Proctor, Chief Executive

Date: 30 January 2019

1. NHS Long Term Plan

As has been widely publicized, the NHS Long Term Plan has now been published. Wide-ranging input was sought from frontline health and care staff, patients and others who attended events and made submissions.

The pan sets out the long terms ambitions for the NHS to develop sustainable services that offer the most value for patients.

The aims of the NHS Long Term Plan include:

- making sure everyone gets the best start in life
- delivering world-class care for major health problems
- supporting people to age well

Delivering these ambitions, and tackling some of the current challenges, will require focus on specific key areas. These are:

Doing things differently – increasing the focus on integration and giving people more control over the services they receive

Preventing illness and tackling health inequalities – paying particular attention to the most significant causes of ill health, such as smoking, alcohol and Type 2 diabetes

Backing our workforce – increase the workforce and making the NHS a better place to work

Making better use of data and digital technology – better access to digital tools, records, services and health information for the benefit of both patients and staff, and improving service planning and delivery based on data analysis.

Getting the most out of taxpayers' investment in the NHS – improving efficiency including procurement, and reducing spend on administration

Next steps:
Sustainability and Transformation Partnerships and Integrated Care Systems now need to develop and implement their own fie year strategies. This will offer further opportunity for staff, patients and the public to shape these plans at a local level.

We have some time in the afternoon section of our Board agenda this month to consider the Plan in more detail.

2. Operational review

Following the briefing given at the last Board of Directors meeting, work has been progressing to put in place a new structure for the operational management of the Trust to ensure we are organized in a way that we can best meet the needs of our complex group of hospitals and services.

We have agreed to move from a large number of directorates to six care groups. Unsurprisingly, a change of this size and scale is no small task, and a huge amount of work has been done in ensuring that all the elements are place before we make a start. This includes writing job descriptions, tying down structures, and ensuring the costs of the new approach are worked through. By the time we meet as a Board, the consultation with affected staff should have started, and briefings for the wider organisation are also taking place.

We are all fully aware that these changes might be causing some anxiety for people, and we are making sure that there are clear and timely communications throughout the process, with plenty of opportunities to ask questions.

I will keep Board colleagues up to date with key developments, including announcements about key appointments.

3. Exit from the EU

As the Government continues to debate the terms of our exit from the European Union, all NHS organisations have been asked to consider how we will operate in the event of a 'No Deal' Brexit. Guidance has been issued by the Department of Health and Social Care which asks us to consider seven key areas:

- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Supply of non-clinical consumables, goods and services
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access

A group has been formed comprising the leads for these areas, and they have reviewed the guidance, assessing the potential risks against our business continuity plans.
In terms of public-facing messages, and what we are required to be advising patients and the public, Patients should be encouraged not to stockpile their own medication, and staff are being asked not to issue longer prescriptions.

An action plan has been developed, which will be shared with the Board of Directors in due course.

4. Treating sepsis

Finally, I was delighted to receive the news of the huge improvements the ED teams have made in delivering antibiotics to sepsis patients within one hour. We started the year with only 35% of severely septic patients receiving antibiotics within one hour. We end the year with the performance at Scarborough and York being 63% and 50% respectively, exceeding the target we had set ourselves. I know this has involved a huge amount of work and has been delivered at a time when the departments are under huge pressure.

The reality is that lives have been saved which otherwise might not have been.

Thank you to everyone involved and I hope that, buoyed by this success, the improvements will continue.

Board of Directors – 30 January 2019
Nurse and Care Staffing

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

This report aims to provide assurance on both the strategic and dynamic management of nurse and care staffing.

The regulatory requirement to deliver monthly planned versus actual staffing numbers is included with a narrative summary for areas which appear challenged.

Each Head of Nursing has provided a summary of local highlights and actions for their areas. The acute hospital sites adult care wards / departments are identified as the most challenged and will be reported quarterly.

In addition, the formal use of SafeCare data is included. The use of this data is embedded and compliance with collecting the census data is gradually improving. The information can now be used in daily planning. The work to achieve full compliance continues.

Executive Summary – Key Points

Nurse and care staff vacancies continue to present a challenge; this is reported on the Trust Corporate Risk Register.

This report includes the nationally mandated requirements for reporting. It also includes specific information at Trust and local level.

SCBU on Scarborough site is experiencing significant challenges due to the current number of RN vacancies, immediate mitigating actions have been put in place

including; changing admission criteria to 34 weeks gestation, Band 7 leadership from the York site and rotation of midwives into the unit.

Average fill rates for both registered nurses and care staff on both day and night shifts is now above 92%, which is a 3% improvement from October 2018, this takes into consideration the long shift efficiency.

The report includes the second set of information from the SafeCare Tool. SafeCare is a software package that was procured in 2017; to enhance both managing safe staffing levels on a daily basis to provide assurance and clear information of which areas are challenged from staffing perspective and includes information on acuity and demand.

Compliance in the use of SafeCare has significantly improved and work continues to ensure that reported data is up to date and accurate.

Recommendations

The board are asked to accept the monthly staffing report.

Author: Helen Hey, Deputy Chief Nurse

Executive Sponsor: Beverley Geary, Chief Nurse

Date: January 2019

1. Introduction and Background

Due to the current number of vacancies, Nurse and care staffing continues a key area of focus.

The report includes the data related to the Safe Staffing return which is a mandated requirement (Appendix 1). Detail is provided for areas which has been identified as challenged, Heads of Nursing provide assurance through the Deputy Chief Nurse for local assurance and mitigation.

Debate continues related to the value this data adds. It has not maintained pace with the local innovations and does not capture developments such as the Associate Practitioner role or the Nursing Associate role at Band 4 and whilst it gives an overview it does not detail new workforce models or alternatives that have been introduced to mitigate risk.

The Chief Nurse Team has worked closely with colleagues in finance and human resources ensure the vacancy position is the most accurate and up to date. The team is working with recruitment and monitoring newly qualified nurse recruitment for September 2019 closely, there are currently 37 newly qualified nursing due to commence in September 2019.

In order to ensure ward to board oversight and ownership of this agenda the Heads of Nursing now provide commentary for the areas they cover, these include:

- Acute and Emergency Medicine
- Elderly Care
- General and Specialist Medicine
- Surgery and Anesthetics

There are a number of areas which are less challenged and these will be reported on an exception basis

- Child Health
- Midwifery
- Community

The expectation is that the ward, unit, department and team level data is fully understood and owned at directorate level and escalated to the Head of Nursing for that area. The directorates will work with their human resource and finance colleagues every month to ensure that risks are effectively managed.

2. Planned versus actual staffing and CHPPD

The Trust data for Safe Staffing is attached at Appendix 1.

New guidance has been published in relation to including ward based allied healthcare professionals (AHPs) in the CHPPD data collection. This will create a more meaningful approach to measuring how much care is being delivered on wards. The associated work is not insignificant and the first step is to engage with AHPs to understand how they will be added to a roster and how they will be managed as part of a ward team. The Chief Nurse Team has commenced early discussions with Allied Healthcare Professionals and some ward teams to explore the opportunity for integration. There are some regional and national examples of this work being delivered which the team is keen to explore. Of note, the revised Safe Staffing (Unify) return has now included separate AHP columns from January 2019. These have been removed from our local report as there is currently no data to input.

The data is now being delivered by the Workforce Information Team and is taken directly from the electronic roster system. The system is not adequately sophisticated to report the benefit of the long day efficiency, but work has routinely been undertaken manually each month and given an estimation of actual hours worked. Moving forward there will be a twice yearly audit of the number of staff who work long days. This figure will be applied to the overall planned versus actual data and an overall figure will be delivered.

December 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
93.2%	92.7%	120.3%	118.5%

From the data in Appendix 1, 16 wards are identified as challenged from an RN perspective (below 80% fill rate). However, 3 wards had low activity and the number of patients being managed did not warrant the planned staffing levels, these wards were:

- ICU Scarborough
- Kent Ward Bridlington
- Lloyd Ward Bridlington

Lloyd Ward at Bridlington planned versus actual staffing has now been identified for 3 consecutive months. The planned staffing is not required for the planned activity for the unit. The Operational Management Team has been asked to examine the use of the unit and whether the service delivery requirements can be formally established. Currently staff employed are routinely moved around as they are not required which is neither sustainable in terms of planning nor satisfactory for staff experience.

Ward / Unit	Day shift		Night Shifts		Notes
Ward	**Average fill rate RN (%)**	**Average fill rate Care Staff (%)**	**Average fill rate RN (%)**	**Average fill rate Care Staff (%)**	
Ann Wright	68.2%	151.9%	100%	99.9%	RN shifts backfilled with HCA. No escalation related to safety or quality
Cherry	57.4%	106.9%	67.8%	100.8%	Undergoing staffing review aligned to work across acute medicine in Scarborough. Band 4 team not included in numbers / skill mix review will deliver new model
CCU Scar	68.4%	100.4%	76.9%	209.5%	No safety or quality concerns to escalate
Holly	73.8%	140.3%	98.4%	140.3%	No safety or quality concerns to escalate
Oak	77.7%	100.9%	94%	108.4%	No safety or quality concerns to escalate
Stroke	70.6%	114.8%	82.9%	100%	No safety or quality concerns to escalate
Ward 23	65.2%	114.9%	100.1%	100.1%	RN backfill with HCA, No safety or quality issues to escalate
Ward 26	76.5%	131.2%	103.2%	127.6%	RN backfill with HCA, No safety or quality issues to escalate
Ward 29	64.2%	96.6%	93.5%	112.7%	Transitioned from elective orthopedics to winter medical elderly ward. Ward being closely monitored but no specific concerns to escalate
Ward 35	66%	133.3%	101.9%	117.3%	RN backfill with HCA, No safety or quality issues to escalate
Ward 39	73.6%	132.4%	99%	145.4%	RN backfill with HCA, No safety or quality issues to escalate
AMU	66.7%	93.7%	90.8%	103.9%	Really challenged days shifts. Teams from AAU and AMC working effectively across the acute floor. Challenging vacancy position.
AMB	66.6%	102%	89.6%	104%	Really challenged days shifts. Teams from AAU and AMC working effectively across the acute floor. Challenging vacancy position.
ESA	77.7%	66.8%	99.9%		Transitioned to winter pressures ward. Closed capacity to 10 beds when safe staffing level not achieved. Ward activity being closely monitored
G1	76.9%	128.7%	65.8%	216.4%	Transitioned to accept more winter capacity outliers. Backfill with HCA effective. A number of patients requiring high levels of supervision and to support staff rotation has resulted in very high HCA cover, specifically at night

2.1 Role development and Changing Landscape

There have been a number of national, regional and local changes to the development of the nurse and care staff workforce over the past 5 years. These should help care providers align their work to the people we provide care for and they should open up career and development opportunities for people who want to enter the profession.

In October 2018, the Nurse Staffing Board paper presented the current changing and complex position of reporting nurse staffing levels and set the context and some of the developments being planned and delivered.

The Board are aware Trainee Nursing Associates (TNAs) were introduced in 2017. The Trust has 15 TNAs who are due to qualify in March 2019. This remains an exciting time, with all 15 individuals choosing to work in our Trust.

The work with Coventry University has progressed with 29 individuals starting their trainee nursing associate programs this month. The work with York University is at the development / NMC approval stage and the teams are working collaboratively to deliver a further program for 30 individuals in September 2019. Whilst all these staff will not qualify until 2021; it demonstrates our commitment to innovation and safe staffing levels.

In addition, the Chief Nurse Team advertised externally to test whether the Trust could attract and support Nursing Associates and Associate Practitioners who had trained elsewhere. The positive news is that this process attracted 10 applicants who have all been shortlisted and are prospective employees. They will join our locally trained Nursing Associates and Associate Practitioners and be offered the same preceptorship program opportunity.

Key to effective workforce redesign is how senior nurses support the introduction of new roles. A debating session has been arranged in March 2019 to provide a platform for Band 4 to Band 7 care staff to feedback how new skill mixes can work most effectively; raise some of the challenges and work towards solutions.

2.2 Nurse Recruitment

The board are aware that due to the number of vacancies generic nurse recruitment was commenced. Some areas felt that this was restrictive and more locally owned approaches have now been adopted.

This bespoke advertising scheme is operational and early indications are that the ward and units are able to be more responsive to prospective employees. In addition, the more flexible and locally owned process for intra-ward transfers has been very positively received.

The Deputy Chief Nurse has met with the Manager for Recruitment and agreed some additional schemes that will hopefully help York, Scarborough and the east coast become the first choice for York University graduates. The Trust has already attracted 37 individuals who are due to qualify in September 2019, the previous 'Getting on Board days will be reintroduced with a refreshed focus.

Options are being considered in relation to the projected vacancy position at Scarborough and the east coast with some bespoke engagement events for people from Scarborough who are currently in training in York, Hull and South Tees being planned.

2.3 Trust wide and site nurse and care staffing data

The following data is for December 2018 for Trust wide, which includes community units and teams and midwifery.

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
1,655.75	57.11	909.14	1,387.70	60.48	859.39	24.62	0.00	5.60	19.00	0.00	8.52	273.67	-3.37	46.83	16.53%	-5.90%	5.15%

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
849.34	42.35	475.01	712.07	42.28	448.12	15.62	0	3.6	11.6	0	0	141.29	0.07	30.49	16.64%	0.17%	6.42%

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
501.26	14.76	307.71	378.82	17.80	293.63	5	0	1	5	0	8.52	122.44	-3.04	6.56	24.43%	-20.60%	2.13%

The data shows the slightly lower net % vacancy figure across the Trust, which reflects the less challenged areas of midwifery, community and child health.

The net % vacancy figure at Scarborough and Bridlington remains a concern and the Chief Nurse Teams welcomes the results of the east coast review and how staffing models may be developed to align to the needs of the local population.

The positive news is that the Coventry University, Scarborough Campus BSc program started with 28 new nurses in training. This cohort will qualify in 2021 and the Matrons from Scarborough are already engaging with the delivery of the program.

The data demonstrates some of the challenges that have not been fully addressed in introducing the Band 4 roles and how this is not fully reflected in workforce planning. The Deputy Chief Nurse is meeting with ODIL in January to establish a work program to review the workforce skill mix on wards which will support the alignment of the Band 4 role.

The total number of newly registered nurses recruited and due to start in the next 3 months is 35.6 WTE and will reflect some of the people who qualified in September 2018 but deferred their start date.

Care staff recruitment is not currently a challenge.

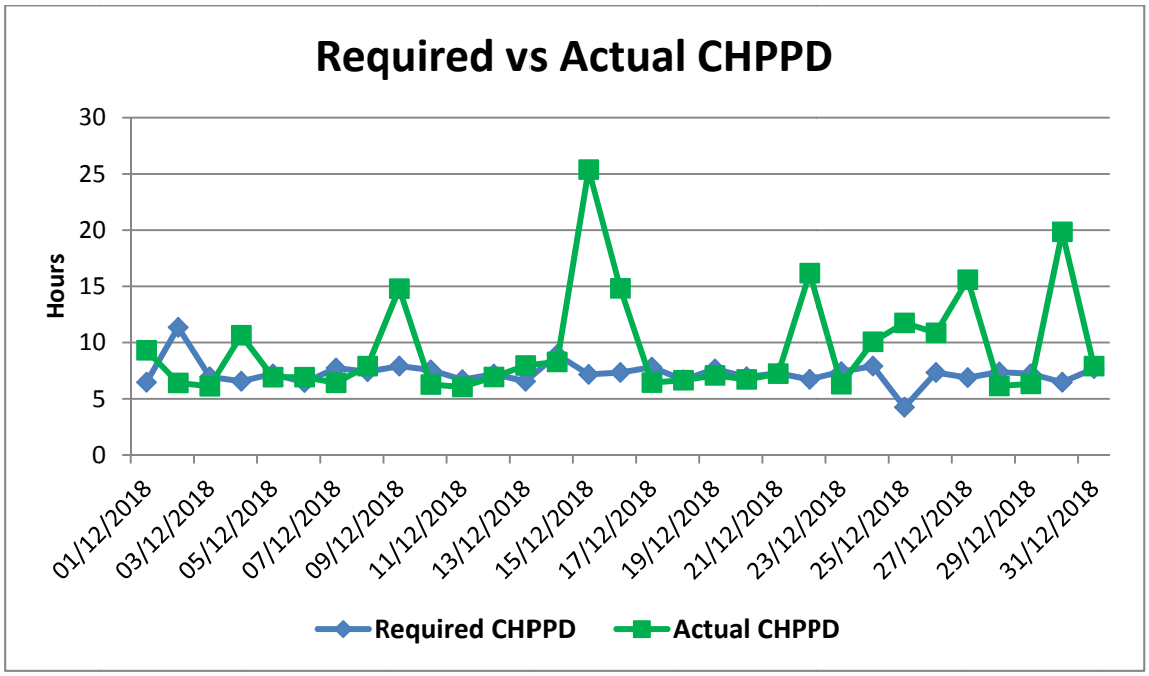
The following reports are headline reports for particular care groups. It presents both the vacancy position and the SafeCare information.

2.4 Acute and Emergency Medicine – Head of Nursing Report

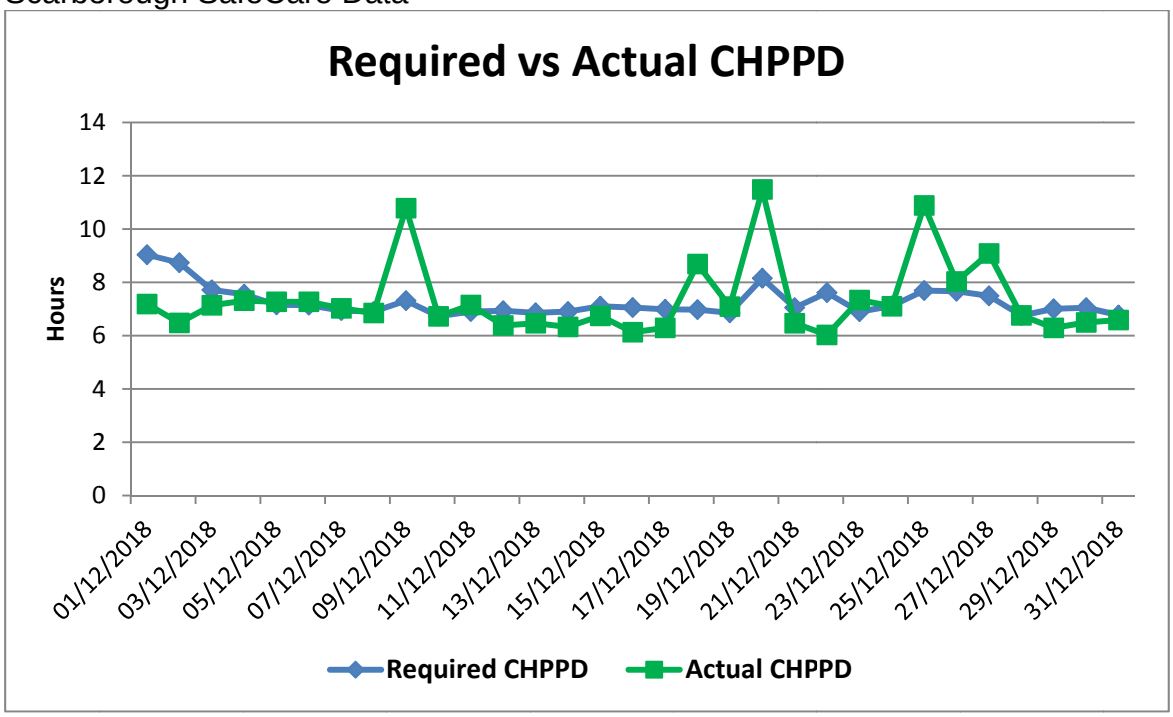
Acute Medicine and ED

	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
York																		
ED	66.04	5.60	24.10	55.84	6.00	27.80	0	0	0	1	0	0	9.20	-0.40	-3.70	13.93%	-7.14%	-15.35%
Wards	33.93	3.00	28.38	24.99	2.00	23.40	0	0	1	0	0	0	8.94	1.00	5.98	26.35%	33.33%	21.07%
Scarborough																		
ED	38.66	10.76	16.13	26.50	2.00	16.80	0	0	0	0	0	2.6	12.16	8.76	-3.27	31.45%	81.41%	-20.27%
Wards	31.95	0.00	26.49	20.67	6.00	23.00	2	0	1	0	0	1	13.28	-6.00	3.49	41.56%	0.00%	13.17%
Total	**170.58**	**19.36**	**95.10**	**128.00**	**16.00**	**91.00**	**2.00**	**0.00**	**2.00**	**1.00**	**0.00**	**3.60**	**43.58**	**3.36**	**2.50**	**25.55%**	**17.36%**	**2.63%**

York SafeCare Data



Scarborough SafeCare Data



The above data has been populated from the Safecare system for Emergency and Acute Medicine at York and Scarborough Hospitals.

It is noteworthy that compliance with Safecare has improved in recent months. Acute Medicine in Scarborough Hospital has been the first to achieve 100% compliance

with Safecare. We must now focus on maintaining this and mirroring across all areas in order to continually report the most accurate representation of CHPPD.

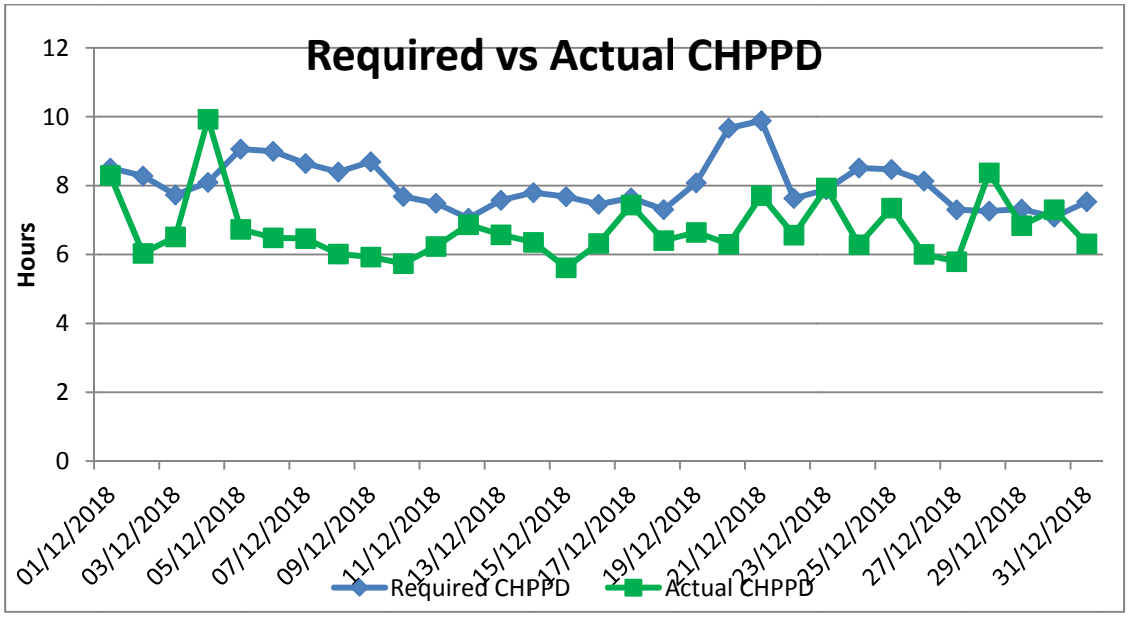
A staffing review of Scarborough ED has recently completed and we are awaiting the final reports. A consultation has also commenced with the Dales Unit (AMC) at Scarborough Hospital to provide and extra 2 hours per day of AMC capability in the newly completed Ambulatory Emergency Care unit. This is an exciting offer for the Ambulatory Care staff.

Currently, there are a number of block bookings of agency staff covering the shortfall of registered nurses in Acute and Emergency Medicine across both sites this helps with continuity of care and team involvement.

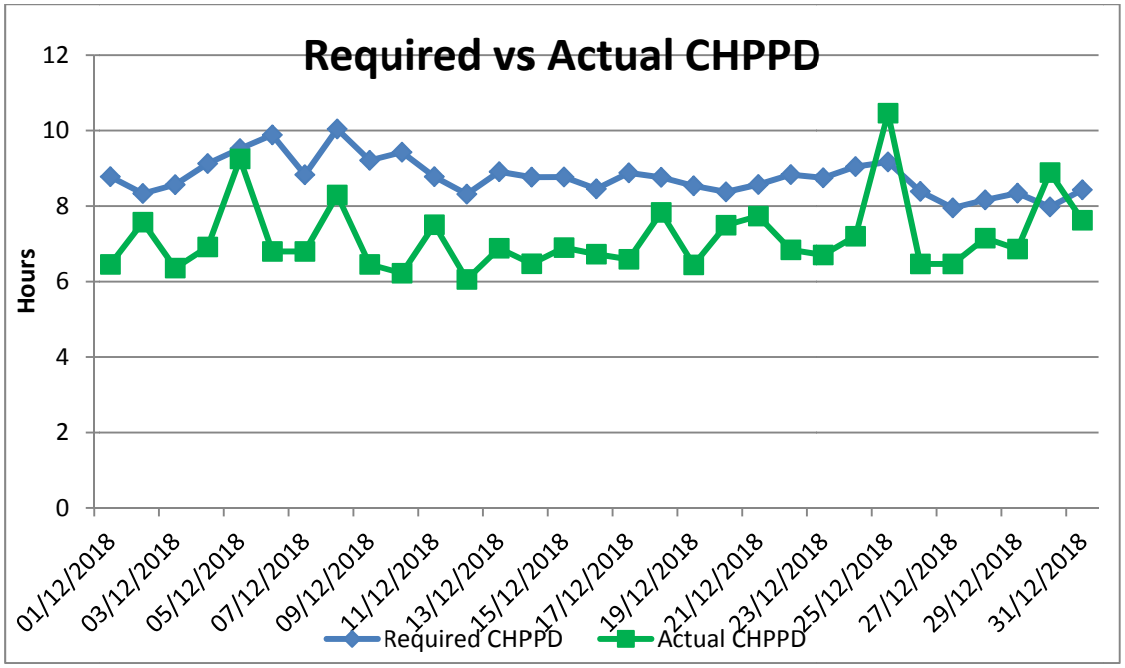
2.5 Elderly Care – Head of Nursing report

	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
York																		
Wards	128.88	15.20	129.47	91.00	15.20	125.79	2	0	2.6	6	0	0	33.88	0.00	6.28	26.29%	0.00%	4.85%
Scarborough / Bridlington																		
Wards	76.05	0.00	70.82	58.24	0.00	57.51	0.8	0	1	0	0	4	18.61	0.00	10.31	24.47%	0.00%	14.56%
Total	**204.93**	**15.20**	**200.29**	**149.24**	**15.20**	**183.30**	**2.80**	**0.00**	**3.60**	**6.00**	**0.00**	**4.00**	**52.49**	**0.00**	**16.59**	**25.61%**	**0.00%**	**8.28%**

Scarborough SafeCare data



York SafeCare data



Within the Older Peoples Directorate the vacancy percentage for Registered Nurses Band 5 -7 remains static from the last report in October 2018 across both sites indicating the attrition rate is stable this is 25.98 % in York and 27.57% in Scarborough and Bridlington.

The Safecare acuity and dependency audit (above) indicates that on the whole the Required CHPPD is higher than the Actual CHPPD. This suggests an increase in acuity and dependency but also reflects the RN vacancies within this directorate. It should be noted that compliance with the completion of SafeCare audit is variable and therefore the data should be viewed with some caution. There has, however been an improvement over the past 3 months with all wards (with one exception) achieving over 80% compliance. This now represents a more accurate picture in relation to 'Required' and 'Actual' CHPPD across the older peoples wards. (Matrons check the data compliance regularly and escalate to the ward where there is non-compliance).

In order to mitigate risk, and depending upon acuity and dependency, RN's are redeployed on a shift by shift basis across the wards to ensure patient safety, this is monitored by the Older Peoples Matron and Matron of the Day.

Recruitment continues and new role such as the generic support workers are being introduced to ensure care is delivered.

We continue to pilot the role of Patient Service Assistant on Ward 35 and plan to advertise this across all wards by March 2019. This role incorporates drink rounds, bed making, porter duties, cleaning and menu completion, this role has been

received very positively by staff and patients and we will review its effectiveness 6 months post substantive recruitment.

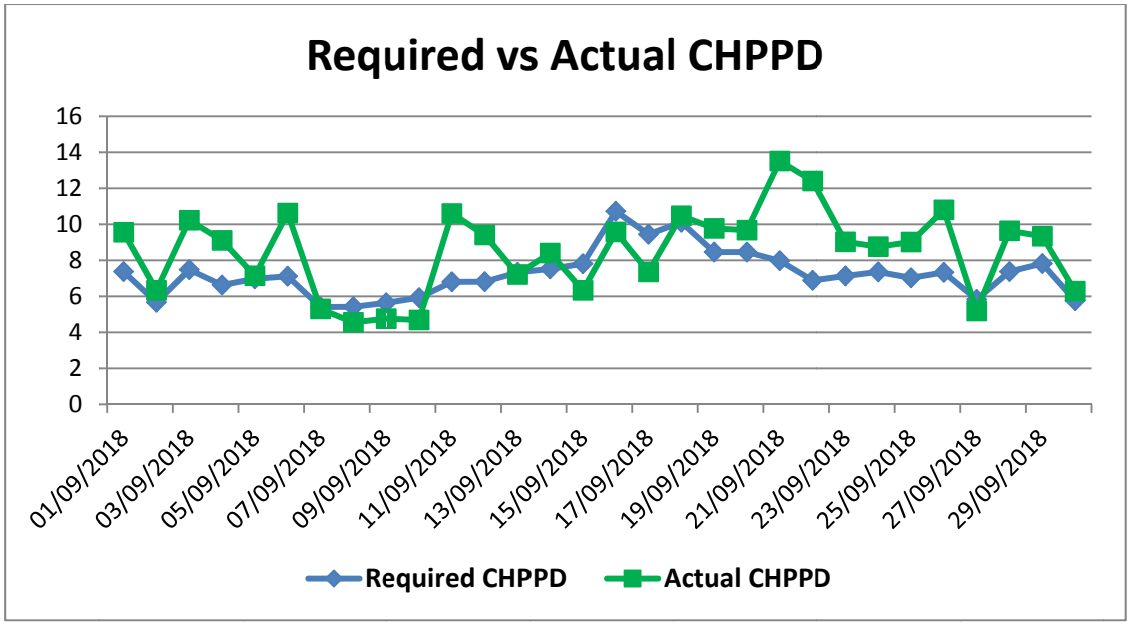
We are now implementing a full review of ward establishments across all in- patient wards with the Head of Nursing, Matron, Ward Sister and Finance Manager. The team is undertaking a workforce prediction to consider what the workforce might look like in the next 2 years with the introduction of the new roles including the Associate Practitioner and Nursing Associate Role (Band 4); this aims to enable the team to calculate what will be required for the future and how we can achieve this.
As part of the review we are also considering that every ward will have two Band 6 posts to ensure an increased leadership presence within the older peoples care wards alongside the Band 7 post to improve morale and senior nursing presence.

2.6 General and Specialty Medicine – Head of Nursing Report

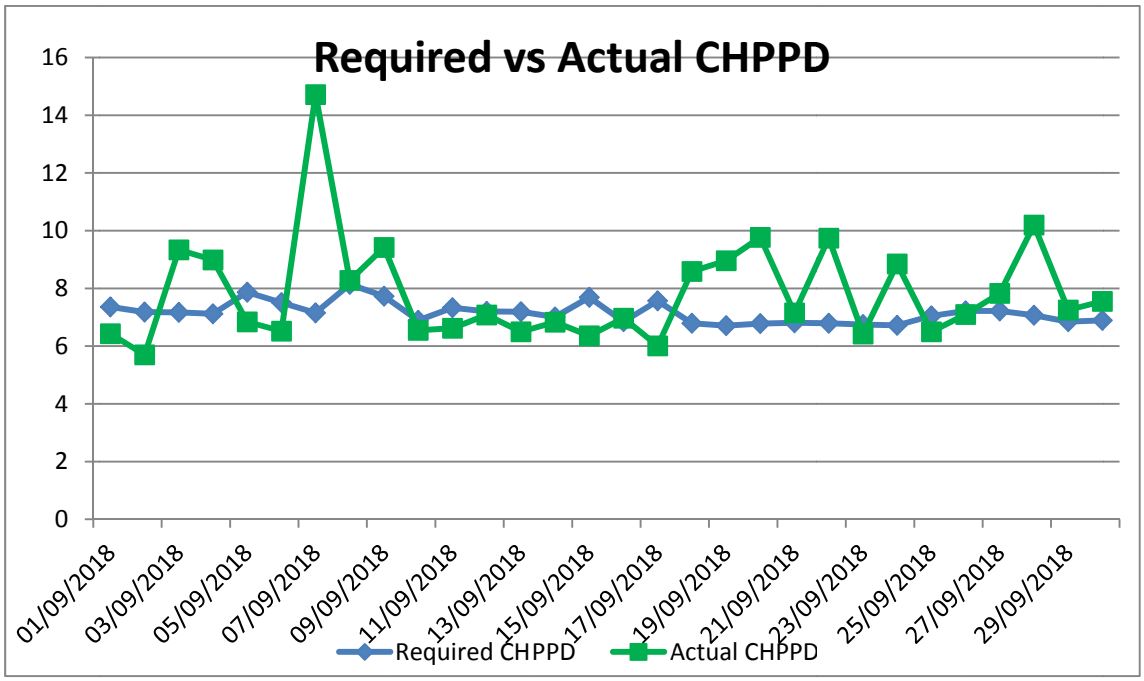
General and Specialty Medicine

	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
York																		
Wards	178.79	1.00	94.74	149.03	5.00	81.80	4.6	0	0	8	0	1	26.36	-4.00	11.94	14.74%	-400.00%	12.60%
Scarborough																		
Wards	75.42	0.00	49.88	56.63	5.00	45.94	2	0	1	1	0	0	19.79	-5.00	4.94	26.24%	0.00%	9.90%
Total	**254.21**	**1.00**	**144.62**	**205.66**	**10.00**	**127.74**	**6.60**	**0.00**	**1.00**	**9.00**	**0.00**	**1.00**	**46.15**	**-9.00**	**16.88**	**18.15%**	**-900.00%**	**11.67%**

General Medicine



Specialty Medicine



Registered nurse vacancies within the General and Specialty Medicine Directorate are currently at 15.20 % in York and 17.69 % in Scarborough, showing an improvement on the Scarborough Site since October 2018. We have recently recruited a number of newly qualified registered nurses across the inpatient wards; CCU in Scarborough has shown a significant improvement in recruitment. We will also be welcoming the new Nursing Associates to some medical wards in March 2019 and the Associate Practitioner role is now embedded on a number of areas with a positive impact.

Within the General Medicine Directorate the graph taken from the SafeCare acuity (above) indicates that the majority of the time the Required CHPPD and the Actual CHPPD are parallel and therefore there is no requirement to deploy staff across the medical wards. Matrons monitor this daily and do redeploy staff if required.

Within Speciality Medicine the graph indicates Ward 31only and shows their Actual CHPDD compared to the 'Required' does increase at certain times and we continue to redeploy staff across the site to support other wards. This will be monitored and reviewed as we collate more data in relation to acuity and dependency.

SafeCare data input shows varying compliance and Matrons continue to monitor this. If this continues to be the case consideration will be given to whether a deep dive is required to understand why compliance is not improving and what support an be offered.

Bespoke recruitment campaigns for the medical and speciality wards continue.

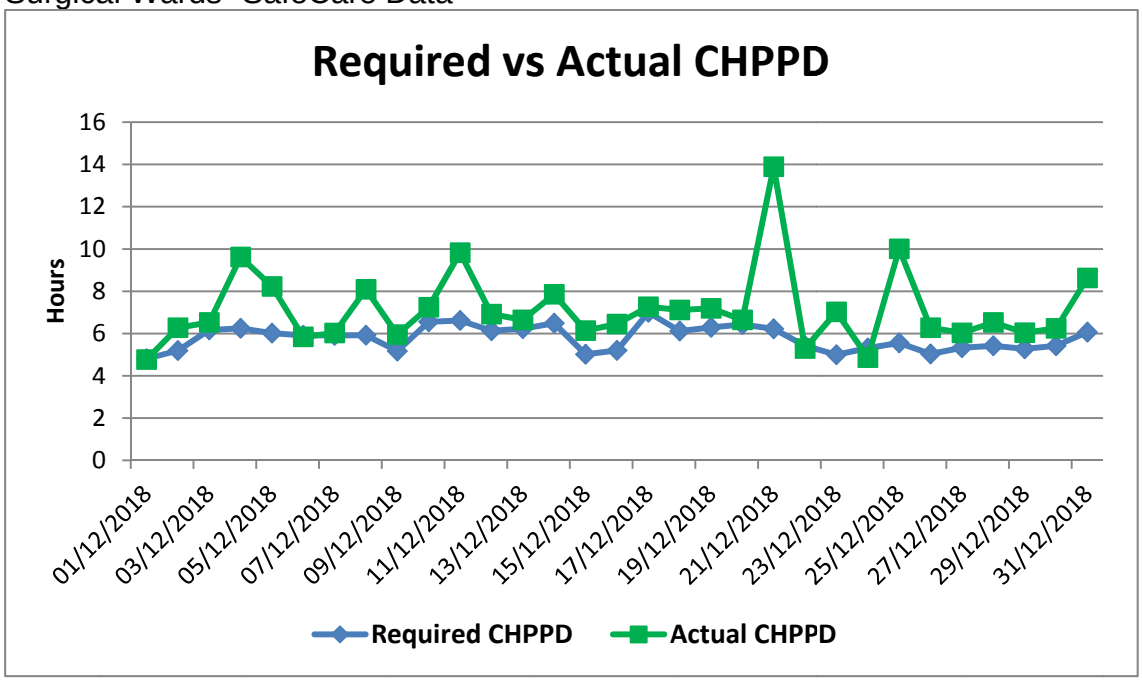
2.7 General Surgery and Anaesthetics – Head of Nursing Report

General Surgery and Anaesthetics

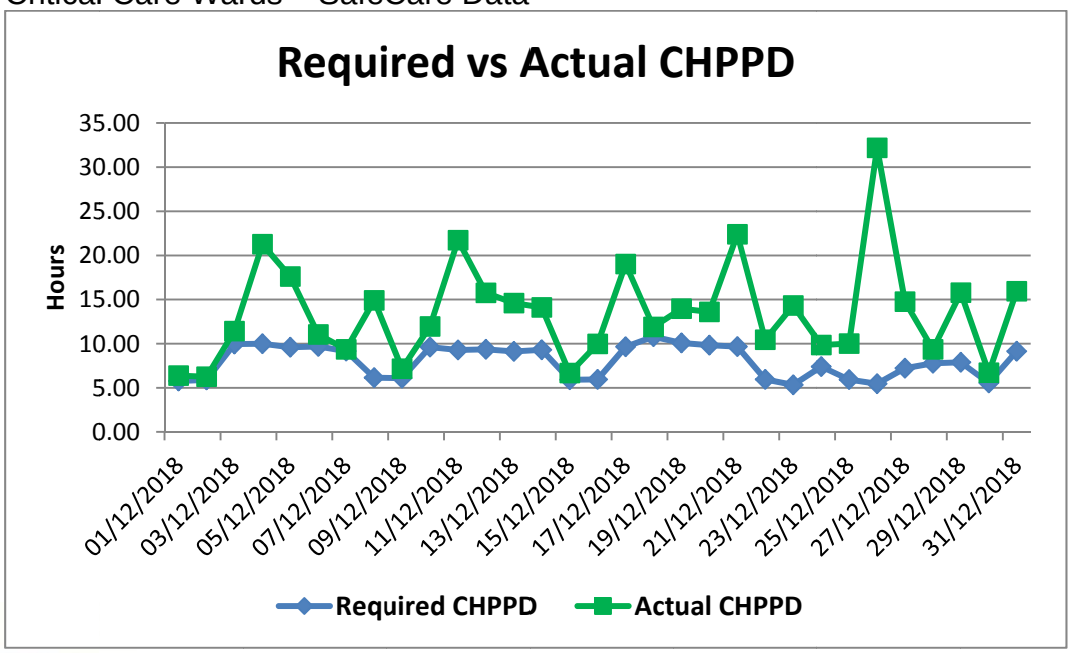
General Surgery and Anaesthetics

	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
York																		
Theatres	92.90	2.00	39.20	78.22	2.76	38.62	0	0	0	2.6	0	0	12.08	-0.76	0.58	13.00%	-38.00%	1.48%
Wards	293.50	13.32	148.08	255.89	9.60	136.32	9.42	0	2.6	3	0	0	44.03	3.72	14.36	15.00%	27.93%	9.70%
Scarborough / Bridlington																		
Theatres	78.78	3.00	26.87	66.80	3.00	25.57	0	0	0	0	0	0.52	11.98	0.00	0.78	15.21%	0.00%	2.90%
Wards	170.81	0.00	105.18	133.23	1.80	96.94	1	0	0	2	0	1.6	36.58	-1.80	6.64	21.42%	0.00%	6.31%
Total	**635.99**	**18.32**	**319.33**	**534.14**	**17.16**	**297.45**	**10.42**	**0.00**	**2.60**	**7.60**	**0.00**	**2.12**	**104.67**	**1.16**	**22.36**	**16.46%**	**6.33%**	**7.00%**

Surgical Wards- SafeCare Data



Critical Care Wards – SafeCare Data



The SafeCare data displayed on the graphs relates to all the inpatient wards for surgery and orthopaedics across both sites. The data for critical care is displayed separately.

Compliance with completion of the SafeCare census data improved slightly in the first two weeks of December but this deteriorated over the Christmas period work to ensure 100% compliance continues.

The spikes on the graphs for actual CHPPD show where extra care hours have been requested for enhanced care for patients.

A recruitment open day is planned for 19 January for the new endoscopy unit at York; there has been significant interest from staff expressing a desire to work in the new unit.

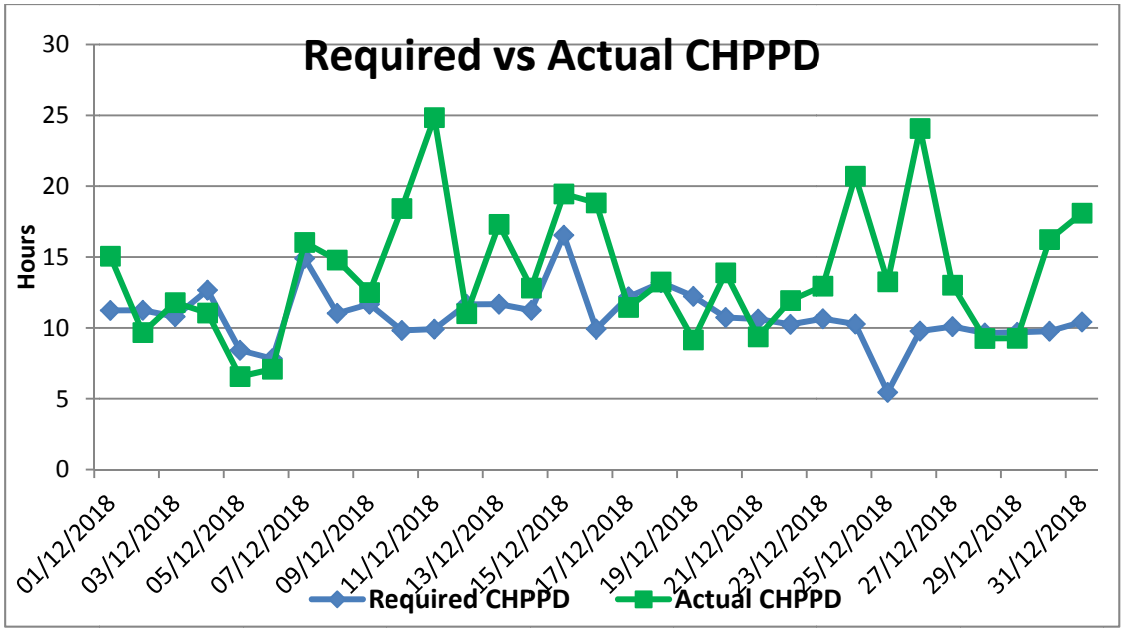
Staffing within critical care at the Scarborough site continues to be challenging due to the vacancies and has been identified as a priority area for overseas recruitment. The management of the challenges is overseen by the Matron for the area and the Matron of the day at Scarborough provides support and advice in her absence.

2.8 Child Health – provided by the Head of Midwifery

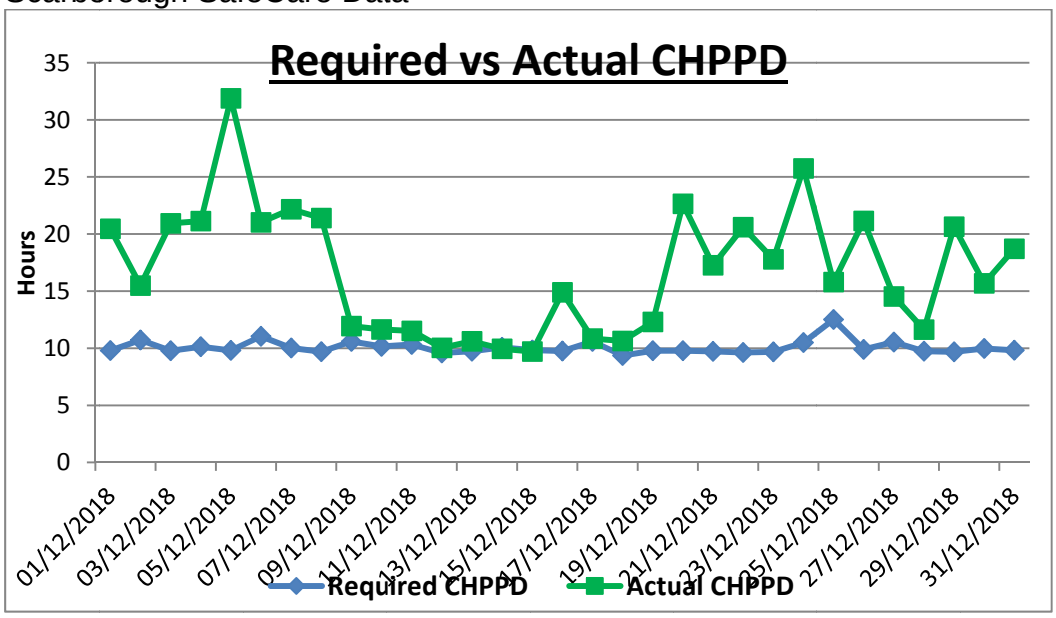
Child Health In patient care

	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
York																		
Wards	55.30	2.23	11.04	50.52	4.72	11.29	2.6	0	0	1	0	0	6.38	-2.49	-0.25	11.54%	-111.66%	-2.26%
Scarborough																		
Wards	27.92	1.00	12.34	20.75	1.00	11.63	1	0	0	1	0	0	7.17	0.00	0.71	25.68%	0.00%	5.75%
Total	**83.22**	**3.23**	**23.38**	**71.27**	**5.72**	**22.92**	**3.60**	**0.00**	**0.00**	**2.00**	**0.00**	**0.00**	**13.55**	**-2.49**	**0.46**	**16.28%**	**-77.09%**	**1.97%**

York SafeCare Data



Scarborough SafeCare Data



Due to the planned increase in opening hours of the Child Assessment Unit (and a resultant movement of activity) York Child Health in-patient wards now have a reduced bed-base this has brought nurse staffing levels on Ward 17 &18 in line with national recommendations for a children's ward.

Initial impact from the extended opening is very positive, this will be evaluated formally where impact on A&E attendance (of children) and patient experience will be reviewed.

SCBU nurse staffing on the Scarborough remains challenged due to vacancies; and despite significant effort recruitment has been unsuccessful.

In order to mitigate this risk access has raised from 32 to 34 weeks gestation, midwives will rotate into SCBU for 6 months to provide cover (and in the longer term increase skills of midwives to work in this area). Band 7 leadership will be provided from the York cross site and York SCBU nursing staff have been providing support and cover when able. The specialist agency nurses is also providing some support. Child Health are currently exploring different ways to manage this area safely in the longer term.

Scarborough Child Health inpatient ward (Duke of Kent) is developing a Child Assessment area with increased HCA cover for this area to help improve the flow of children from A&E (to reduce activity in A&E and improve the patient experience). The CHPPD appears that there are times when the actual staffing levels is much higher than required, especially on the Scarborough site. This can be reflective of activity, as it is more unpredictable than adult wards, however, the teams still have some work to deliver to achieve 95% compliance.

A six months review of midwifery staffing is currently being undertaken and will be reported to trust board as part of the Midwifery annual report

3. Next Steps

The provision of safe staffing levels continues to be a priority, monthly CHPPD and exception reporting will continue with quarterly detailed reporting for high risk areas.

The Chief Nurse Team is working with colleagues in non-medical education and education providers to deliver the TNA programs for the Trust in 2019. Work with finance and human resources continues in order to ensure the funding model for future apprenticeship development and backfill requirements is fully explored.
In addition work with the Directorates will continue to ensure that local recruitment processes are supported and evaluated.

During January and acuity and dependency audit is being undertaken, the results of which will be reported to Board in the coming months.

A review of the new Matron evening and weekend working will be undertaken in April

4. Detailed Recommendation

The Board of Directors are asked to accept the safer staffing report with the oversight of the work being undertaken to innovatively deliver the best nurse and care staffing solutions possible.

Appendix 1

		Day				Night				Care Hours Per Patient Day (CHPPD)						Day		Night	
Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
430 - GERIATRIC MEDICINE		1,344.00	920.08	837	1,271.08	682	681.75	682	681	517	3.1	3.8	0.0	0.0	6.9	68.5%	151.9%	100.0%	99.9%
100 - GENERAL SURGERY		865	878.5	839.18	779	651	651.5	0	326	390	3.9	2.8	0.0	0.0	6.8	101.6%	92.8%	100.1%	-
300 - GENERAL MEDICINE		1,261.50	1,155.25	1,705.25	1,510.83	1,023.00	993.17	1,023.00	1,029.00	974	2.2	2.6	0.0	0.0	4.8	91.6%	88.6%	97.1%	100.6%
326 - ACUTE INTERNAL MEDICINE	300 - GENERAL MEDICINE	2,109.50	1,211.50	1,661.50	1,776.50	1,666.25	1,129.50	1,333.00	1,343.75	650	3.6	4.8	0.0	0.0	8.4	57.4%	106.9%	67.8%	100.8%
301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,262.50	1,220.50	1,476.75	1,433.00	682	682	1,023.00	966.5	838	2.3	2.9	0.0	0.0	5.1	96.7%	97.0%	100.0%	94.5%
320 - CARDIOLOGY		2,422.75	1,656.50	852	855.83	1,362.00	1,047.50	341	714.5	572	4.7	2.7	0.0	0.0	7.5	68.4%	100.4%	76.9%	209.5%
420 - PAEDIATRICS		1,515.50	1,245.33	526.5	485	682	683	341	341	275	7.0	3.0	0.0	0.0	10.0	82.2%	92.1%	100.1%	100.0%
430 - GERIATRIC MEDICINE		969.5	839	1,032.50	1,222.75	682	680.75	682	711.5	545	2.8	3.5	0.0	0.0	6.3	86.5%	118.4%	99.8%	104.3%
501 - OBSTETRICS		2,480.25	2,454.00	861.75	848.25	2,127.50	2,127.50	713	713	176	26.0	8.9	0.0	0.0	34.9	98.9%	98.4%	100.0%	100.0%
110 - TRAUMA & ORTHOPAEDICS		1,253.75	924.75	1,004.75	1,410.00	651	640.75	651	913.5	581	2.7	4.0	0.0	0.0	6.7	73.8%	140.3%	98.4%	140.3%
192 - CRITICAL CARE MEDICINE		2,809.00	1,813.25	839.75	342	2,139.00	1,732.42	356.5	23	123	28.8	3.0	0.0	0.0	31.8	64.6%	40.7%	81.0%	6.5%
101 - UROLOGY		1,699.58	1,396.08	1,597.08	2,018.83	651	961	651	1,168.75	923	2.6	3.5	0.0	0.0	6.0	82.1%	126.4%	147.6%	179.5%
100 - GENERAL SURGERY		1,653.08	1,550.50	1,044.17	1,078.67	976.5	1,049.50	651	641.5	575	4.5	3.0	0.0	0.0	7.5	93.8%	103.3%	107.5%	98.5%
430 - GERIATRIC MEDICINE		1,662.00	1,292.00	2,163.75	2,183.00	1,023.00	962	1,023.00	1,109.00	1,002	2.2	3.3	0.0	0.0	5.5	77.7%	100.9%	94.0%	108.4%
328 - STROKE MEDICINE		1,582.00	1,117.00	811.5	931.3	977	809.5	325.5	325.5	484	4.0	2.6	0.0	0.0	6.6	70.6%	114.8%	82.9%	100.0%
430 - GERIATRIC MEDICINE		1,015.50	947	1,390.00	1,354.50	651	629.25	325.5	336	748	2.1	2.3	0.0	0.0	4.4	93.3%	97.4%	96.7%	103.2%
110 - TRAUMA & ORTHOPAEDICS		1,146.00	860	894.75	590	651	420	0	42	87	14.7	7.3	0.0	0.0	22.0	75.0%	65.9%	64.5%	-
100 - GENERAL SURGERY		942.5	329.25	630	277	157.5	42	178.5	42	5	74.3	63.8	0.0	0.0	138.1	34.9%	44.0%	26.7%	23.5%
100 - GENERAL SURGERY		1,647.75	1,424.75	977.5	1,373.50	682	688.25	682	987	844	2.5	2.8	0.0	0.0	5.3	86.5%	140.5%	100.9%	144.7%
100 - GENERAL SURGERY		2,280.25	1,844.00	1,424.50	1,451.50	1,047.50	1,017.75	713	756.75	682	4.2	3.2	0.0	0.0	7.4	80.9%	101.9%	97.2%	106.1%
100 - GENERAL SURGERY		2,098.45	1,950.20	1,002.75	997	1,364.25	1,274.50	682	725.5	774	4.2	2.2	0.0	0.0	6.4	92.9%	99.4%	93.4%	106.4%
420 - PAEDIATRICS		1,251.50	1,052.75	378	357.5	1,023.00	1,009.00	341	377	346	6.0	2.1	0.0	0.0	8.1	84.1%	94.6%	98.6%	110.6%
430 - GERIATRIC MEDICINE		1,455.50	949	1,151.50	1,323.50	651	651.42	976.5	977	881	1.8	2.6	0.0	0.0	4.4	65.2%	114.9%	100.1%	100.1%
430 - GERIATRIC MEDICINE		1,399.07	1,171.57	1,161.75	1,431.75	651	653.25	976.5	1,271.25	647	2.8	4.2	0.0	0.0	7.0	83.7%	123.2%	100.3%	130.2%
430 - GERIATRIC MEDICINE		1,513.25	1,157.08	1,243.00	1,631.08	651	671.75	976.5	1,246.50	910	2.0	3.2	0.0	0.0	5.2	76.5%	131.2%	103.2%	127.6%

110 - TRAUMA & ORTHOPAEDICS		1,577.75	1,347.25	1,166.25	1,281.40	651	644.75	976.5	1,103.50	698	2.9	3.4	0.0	0.0	6.3	85.4%	109.9%	99.0%	113.0%
110 - TRAUMA & ORTHOPAEDICS		1,619.50	1,040.50	777	750.25	651	608.75	325.5	367	527	3.1	2.1	0.0	0.0	5.2	64.2%	96.6%	93.5%	112.7%
370 - MEDICAL ONCOLOGY		1,789.00	1,599.75	834	845.5	966	851.75	325.5	419.5	542	4.5	2.3	0.0	0.0	6.9	89.4%	101.4%	88.2%	128.9%
320 - CARDIOLOGY		1,665.25	1,514.25	1,216.50	1,406.42	682	693.07	1,023.00	1,391.25	820	2.7	3.4	0.0	0.0	6.1	90.9%	115.6%	101.6%	136.0%
301 - GASTROENTEROLOGY		1,550.50	1,415.67	1,163.48	1,112.67	651	662.25	976.5	1,011.33	893	2.3	2.4	0.0	0.0	4.7	91.3%	95.6%	101.7%	103.6%
340 - RESPIRATORY MEDICINE		1,594.50	1,502.33	1,197.00	1,063.50	682	861.75	1,023.00	954	890	2.7	2.3	0.0	0.0	4.9	94.2%	88.8%	126.4%	93.3%
430 - GERIATRIC MEDICINE		1,405.33	927.92	1,228.50	1,638.17	651	663.5	976.5	1,145.25	895	1.8	3.1	0.0	0.0	4.9	66.0%	133.3%	101.9%	117.3%
430 - GERIATRIC MEDICINE		951.75	981	1,536.00	2,235.92	651	651	651	1,239.50	631	2.6	5.5	0.0	0.0	8.1	103.1%	145.6%	100.0%	190.4%
328 - STROKE MEDICINE		1,290.00	949.75	1,380.50	1,827.58	651	644.5	651	946.75	668	2.4	4.2	0.0	0.0	6.5	73.6%	132.4%	99.0%	145.4%
328 - STROKE MEDICINE		1,692.50	1,572.17	1,388.25	1,426.00	976.5	962	976.5	1,108.25	620	4.1	4.1	0.0	0.0	8.2	92.9%	102.7%	98.5%	113.5%
326 - ACUTE INTERNAL MEDICINE		2,299.00	1,534.00	1,593.97	1,492.98	1,364.00	1,238.17	1,023.00	1,063.00	775	3.6	3.3	0.0	0.0	6.9	66.7%	93.7%	90.8%	103.9%
430 - GERIATRIC MEDICINE		1,973.67	1,314.75	1,581.50	1,612.58	1,364.00	1,222.75	1,023.00	1,064.00	775	3.3	3.5	0.0	0.0	6.7	66.6%	102.0%	89.6%	104.0%
320 - CARDIOLOGY		1,761.00	1,417.25	285.5	265	1,364.00	1,174.00	0	55	201	12.9	1.6	0.0	0.0	14.5	80.5%	92.8%	86.1%	-
100 - GENERAL SURGERY		2,639.25	2,050.75	1,978.00	1,321.25	441	440.5	0	70	296	8.4	4.7	0.0	0.0	13.1	77.7%	66.8%	99.9%	-
120 - ENT		1,698.90	1,307.15	830.48	1,068.98	1,023.00	673.5	341	738	586	3.4	3.1	0.0	0.0	6.5	76.9%	128.7%	65.8%	216.4%
501 - OBSTETRICS		1260	1170	695.5	549.5	835	775	335.75	336	323	6.0	2.7	0.0	0.0	8.8	92.9%	79.0%	92.8%	100.1%
501 - OBSTETRICS		930	870	463.5	350	682	671	0	0	218	7.1	1.6	0.0	0.0	8.7	93.5%	75.5%	98.4%	-
192 - CRITICAL CARE MEDICINE		5,234.00	4,791.00	431.5	442.25	4,433.00	4,096.50	341	311	372	23.9	2.0	0.0	0.0	25.9	91.5%	102.5%	92.4%	91.2%
925 - COMMUNITY CARE SERVICES		1,185.00	962.33	1,135.75	1,306.00	682	463	341	578.75	576	2.5	3.3	0.0	0.0	5.7	81.2%	115.0%	67.9%	169.7%
925 - COMMUNITY CARE SERVICES		875	805.25	996.25	1,092.50	651	512.75	325.5	555.25	586	2.2	2.8	0.0	0.0	5.1	92.0%	109.7%	78.8%	170.6%
925 - COMMUNITY CARE SERVICES		587.25	496.5	622	581	372	361.5	372	371.5	265	3.2	3.6	0.0	0.0	6.8	84.5%	93.4%	97.2%	99.9%
925 - COMMUNITY CARE SERVICES		930.5	851	1,015.75	1,240.75	651	554	325.5	557	687	2.0	2.6	0.0	0.0	4.7	91.5%	122.2%	85.1%	171.1%

E2

NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Nursing & Midwifery Strategy Update Report – Caring With Pride

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

The Trust's Nursing and Midwifery Strategy, Caring with Pride was launched in October 2017 and is a three year strategy. The strategy's foundations are the Trust Values and the Leading Change Adding Value 10 commitments.

There are four key areas of focus which are experience and communications; workforce; safe, quality care and partnership and efficiency.

A detailed implementation work plan supports the delivery of the strategy. This report presents the second update of the actions taken to January 2019.

Executive Summary – Key Points

The Trust's Nursing and Midwifery Strategy, Caring with Pride Strategy was launched in October 2017.

This paper details highlights of the work delivered in the last six months. Appendix 1 provides a detailed account of the progress being made.

Changes in portfolio, lines of reporting and responsibilities have changed and may change as a result of the Operational Review. The principles, ambitions and delivery of the work plan will remains relevant.

Recommendations

The board are asked to receive the update on progress of the nursing and midwifery strategy

Author: Helen Hey, Deputy Chief Nurse

Executive Sponsor: Beverley Geary, Chief Nurse

Date: January 2019

1. Introduction and Background

The Trust's Nursing and Midwifery Strategy, Caring with Pride Strategy was launched in October 2017. The strategy focuses on the four key areas of focus:

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

A detailed implementation plan is attached in Appendix 1 and this supports the delivery of the strategy. This report provides a headline summary of the progress against the implementation plan to January 2019.

The principles, ambitions and delivery of the Nursing and Midwifery, Caring with Pride Strategy remain relevant. It is acknowledged that as some leadership portfolios have altered, that the reporting lines may need adapting. In addition, the impending Operational Review may lead to a position where some elements of the work plan may need adapting.

2. Experience and Communication

There are four sub-sections to experience and communications, namely:

- Patient Experience
- Staff Experience
- Communications
- Involvement

The Chief Nurse Team (CNT) has some well-embedded processes and governance structures aligned to patient experience.

The Patient Experience Team has adapted their working patterns on a temporary basis. This has afforded individuals the opportunity to developed, experience secondments and seek promotion. The team has a new lead for volunteering. This role has resulted in the emergence of a more creative and ambitions volunteering outlook. The Trust is currently bidding for a grant to increase volunteering in the Emergency Departments on both sites.

The nursing and midwifery workforce across all care areas have received excellent levels of recognition over the last six months through the Trust Star Award scheme. In addition, all Gold Accredited wards and units have received specific visits and have been invited to a Gold Award Afternoon Tea to celebrate their achievements.

The Chief Nurse Team has welcomed the presentation from Health Assured and encouraged staff to download the app to their mobile devices.

3. Safe, Quality Care

There are three sub-sections to safe, quality care, namely:

- Reporting and escalating
- Learning lessons
- Investigating and improving

The CNT have some excellent processes in place that ensure risk and patient safety is effectively managed. This work is underpinned through the Ward Accrediation Tool process. The tool is currently undergoing its annual review and being revised following a number of engagement sessions with ward teams. A revised tool and schedule of inspections will be published in April 2019.

The CNT recognised that oversight of risk, patient safety and escalation is better during the week than out of hours and at weekends. Through effective consultation the Chief Nurse Team has delivered evening and weekend Matron cover, which has been effective from mid-December 2018 across both sites. The new working pattern will be formally reviewed in April 2019 (post Easter). Early indication indicates that the model of working needs encompassing in the Operational Review planning

4. Workforce

There are four sub-sections to workforce, namely:

- Educating and training
- Leadership
- Recruitment and retention
- Future proofing

There is a well-established preceptorship program that was established 2 years ago. The program is continually reviewed and adapted in response to participant evaluations. There are currently three cohorts undertaking their first year which the team are supporting through preceptorship. The team will welcome the 15 trainee nursing associates onto the spring cohort in 2019.

An important aspects of undertaking skill mix reviews is to examine how new roles are both welcomed and embedded into teams. In order to support this activity the Chief Nurse Team are delivering an event in March 2019 to explore some of the opportunities and challenges the Associate Practitioner and Nursing Associate Roles are presenting.

The CNT supports senior nurses at Band 8a and above to undertake both internal and external leadership development programs, these include director / board level development programs and senior leaders programs. Two senior nurses have completed a Trust Board level program and there are a number of nurses being supported with the NHS Leadership Academy to undertake masters level leadership studies.

The CNT have delivered the first pilot of trainee nursing associate program. This responsibility for leading this work is now aligned to Human Resources. The CNT is working with colleagues to deliver more opportunities in 2019. This has resulted in 29 trainee nursing associates commencing a program with Coventry University Scarborough Campus in January 2019 and the intention to deliver an additional program with York University in September 2019.

Whilst the team has worked hard with local higher education institutes there is recognition that the landscape for education is changing. The CNT have excellent links with all local education providers have attended a range of formal and informal meetings over the last three months.

5. Partnership and efficiency

There are three sub-sections to partnerships and efficiency, namely:

- Education providers
- Make every penny count
- Health, social care and voluntary sectors

The CNT has excellent links with local universities and the Deputy Chief Nurse is the current chair of the Strategic Partnership Group at York University.

The Patient Experience Team welcomed a new lead for volunteering and links with HealthWatch and HelpForce are excellent. The individual is also working in collaboration with York Cares to ensure all opportunities for joint working are developed.

The Patient Experience Team has achieved representation on the Trust Capital Development Group. This link ensures that patients' views can be encompassed in any new schemes.

6. Next Steps

Continue to deliver the Nursing and Midwifery Strategy, Caring with Pride. Specific focus required to either respond to or review the elements that as yet have not commenced.

7. Detailed Recommendation

Quality and Safety Committee are asked to accept this report as assurance on the delivery of the Nursing and Midwifery Strategy, Caring with Pride.

Appendix 1

York Teaching Hospital NHS Foundation Trust

CARING WITH PRIDE

The Nursing and Midwifery Strategy 2017-2020

Work Plan

Experience and Communication				
Patient Experience				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Monitor patient experience through complaints; compliments; surveys and Friends and Family Test	Matrons HoN PET	• Directorate PE dashboards • Survey Reports • Survey Action Plans • Complaints Action Plans • FFT response rate and ratings data • FFT themes and actions • Action logs from OPAMs and EPAMs • Monitoring dissatisfied complaints • Ombudsman referrals and reports	Embedded system in place to deliver PE dashboards to each directorate Inpatient 2018 report received and reported through Patient Experience Steering Group FFT response and satisfaction rates reported quarterly and discussed at performance management meetings Maternity Survey 2018 report and received and reported to the Patient Experience	

			Steering Group 15 Steps maternity survey undertaken and action plan developed Maternity Bereavement Experience Measure embedded in practice. Feedback is positive. Action plans will be developed as appropriate Cancer Survey 2018 report received. New quarterly Complaints Operational Group formed and performance now managed through OPAM / EPAM performance management structures.	
Continue to develop the ability of directorates to demonstrate learning and actions following patient feedback	Matrons PET	• Complete Complaints Action Plans • Directorate PE dashboards • Escalation of outstanding actions through OPAMs • PET support for directorate meetings action logs from meetings	PET deliver Patient Experience dashboards to Directorate Managers so that ownership and monitoring delivery is localised. Patient Experience dashboard developed and used at OPAMs	

			New Complaints Operational Group formed and performance now managed through OPAM / EPAM performance management structures. First meeting in December 2018.	
Demonstrate openness and transparency by fully introducing Duty of Candour, monitored through panels and the Accrediation Tool	Matrons HoN Sisters Charge Nurses Lead Nurses	• Include Duty of Candour Question in Ward Accrediation Tool (WAT) • WAT report on Duty of Candour awareness • Monitor Duty of Candour performance for falls and pressure ulcer SIs and Clinical SIs assigned to nursing	Duty of Candour monitored through WAT First report from WAT indicates 75% of staff questioned know how to enact Duty of Candour. The revised WAT scheduled for use from April 2019 has developed a more generic question rather than only applying DoC to falls and pressure ulcers	
Staff Experience				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Develop a platform where all staff can share and celebrate positive stories	Chief Nurse Deputy Chief Nurse HoN HoM	• Collection of compliments reported in performance report • Analysis of positive comments from FFT cards • Positive patient stories	Compliments reported quarterly in Patient Experience Report Patient stories delivered at all nursing forums Multiple stories highlighted on	

		shared at Professional Nurse Leads Forums • Highlight positive stories through the full range of media, including Staff Matters and social media platforms	Trust Facebook and Twitter feeds WAT Gold Accrediation Tea Party held on both sites to recognise the teams that achieve this high level	
Ensure through the Star Awards and Celebration of Achievement that nursing and midwifery is recognised for excellent work	Chief Nurse Deputy Chief Nurse HoN HoM	• Effective communication to support people to complete nomination forms for nurses and care staff to receive Star Awards • Effective communication to encourage people to nominate nurses and care staff for the annual Celebration of Achievement Awards • Encourage staff to apply for and nominate others for national awards	June – December 2018 There were 125 either individual nurses or midwives or nursing or midwifery teams nominated for a star award Of the 125 nominations 18 individual or teams were finalists	
Continue to develop staffs awareness of raising concerns and ensure they are listened to and responded to	Chief Nurse Deputy Chief Nurse HoN HoM	• Include raising concerns in all newly qualified preceptorship programmes • Encourage staff to utilise their line management structure to raise concerns • Make the information about the Freedom to	Currently 3 (2 York and 1 Scarborough) preceptorship programmes underway all programmes have access to the Chief Nurse Team Chief Nurse Staff Surgeries undertaken Time planned for newly	

		Speak Up Guardian accessible to all staff • As a senior team allocate time to individuals or groups who want to raise concerns • Equip middle management nurses to develop listening and escalation skills appropriate to their level and ensure they are supported when complex issues arise	qualified Nursing Associates in ward teams to examine the new skill mix, delegation and role integration Speak Up Guardian now included in Preceptorship Programmes	
With human resources, occupational health and ODIL develop formal and informal systems to support nurses and healthcare assistants physical and mental health wellbeing	Chief Nurse Deputy Chief Nurse HoN HoM	• Structure and reporting to be agreed	Health Assured presentation delivered to Senior Nurses. Information and access welcomed. Matrons asked to ensure that information is widely disseminated and encourage staff to download the app	
Conduct listening exercises to hear first-hand staff experiences	Chief Nurse Deputy Chief Nurse HoN HoM	• Undertake regular Staff Surgeries across the Trust footprint • Arrange bespoke staff engagement sessions when particular topics or concerns arise • Undertake walk-arounds that are only aimed at listening to staff and	Formal staff surgeries undertaken by Chief Nurse & HoM Full consultation to deliver evening and weekend working for Matrons delivered. Review to be undertaken in April 2019	

		seeing them in their workplace		
Communication				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Maintain a schedule of Chief Nurse surgeries across all sites	Chief Nurse	• Schedule of surgeries	Schedule in place and undertaken	
Undertake a review of how nursing issues are communicated and celebrated across all services	TBA	• Review report analysing 3 months of nursing communication which will conclude with recommendations for improvement	To commence	
Maintain nurse management team attendance at each preceptorship day	Deputy Chief Nurse HoN	• Allocate Preceptorship in diaries • Monitor of attendance	All dates in Heads of Nursing Diaries Good attendance for either formal or informal sessions	
Review the process for patient level communication in conjunction with the communications teams	Deputy Chief Nurse Head of Communications	• Review process and analyse the results which will conclude with recommendations for improvement	Discussion regarding best approach at January 2019 Patient Experience Steering Group meeting. Analysis of activity in other organisations and exploration of what would be helpful to patients to be undertaken.	
Review the process for patient written information in conjunction with the Risk and Legal team	Deputy Chief Nurse Deputy Director of Risk and Legal	• Review process and analyse the results which will conclude with recommendations for improvement	No evidence	

Involvement				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Undertake a programme of work that ensures patients help to shape services	Patient Experience Manager Matrons	• Evidence that patients and service users have helped to shape the services delivered	Newly appointed lead started in the PET in July 2018 Patients views used to influence change to visiting times Complaints survey (experience of the complaints process) will take place in March 2019 PET now has representation on the Trusts Capital Development Group. This is an opportunity to ensure patients feedback is included in new schemes Women's Health have set up Maternity Voices Partnership on both sites in line with Better Births recommendations Women's Health involved service users in their 15 steps Maternity Survey	
Develop services that support and recognise carers and family members contribution to patient	Patient Experience Manager	The work required to deliver this needs to be agreed (Johns campaign active within our		

care	Matrons	hospitals)		
Safe, Quality Care				
Reporting and Escalating				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Have systems in place which ensure all nurses and healthcare assistants know how to report using DATIX	Matrons	• Evidence of education at local induction • Evidence of reporting • Targeted work where reporting has not been undertaken or lower than expected reporting areas	Reporting systems and the importance of them is now included in the Preceptorship programme. Good evidence of reporting from nursing and healthcare assistants reported at Quality and Safety Group No requirements for targeted work in a specific area identified	
Have systems in place which ensure all staff know what a serious incident and a never event is	Matrons	• Ensure staff attend induction training • Evidence of teaching through preceptorship programme • Questions included in Accreditation Tool Process	Preceptorship modules on risk and escalation delivered Analysis of associated questions on Accrediation Tool to be presented in future reports Improvement in sharing learning using serious incident reports and never event reports through senior nurses groups.	

			Deputy Director of Patient Safety allocated standard agenda item quarterly at senior nurses to group to present and debate specific themes There are some good local examples of how information and learning is shared through emails cascades / service level newsletters / safety briefs / highlight reports.	
Have systems in place whereby all staff fully understand how to escalate matters of clinical concern and safety in and out of standard working hours	Matrons	• Ward visits to examine understanding of escalation (Senior Leaders) • Report / understanding when escalation has not worked and ensure learning is both documented and cascaded • Ensure a culture of openness is fostered and be confident that all staff can describe easily who they would inform if they had a clinical concern	The Chief Nurse Team has a high level of confidence that risk and escalation work well. The Chief Nurse Team has delivered senior nursing (Matron) presence at evenings and weekends which is providing greater opportunity for nurses and healthcare assistants to raise matters of clinical concern out of hours. This new working pattern will be reviewed in April 2019.	

Learning Lessons				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Through a standard assurance framework the nurse management team will be assured that lessons are being learned and actions taken to mitigate risks	HoN	• Standard reporting framework • Monthly reporting structure • Thematic work on falls and pressure ulcer SIs	The HoNs have a standard assurance document that they discuss with the Deputy Head of Nursing monthly The Deputy Director of Patient Safety has delivered a review of falls and identified themes for focussed work. A review of pressure ulcers is planned	
Adopt and standardise a model of continual peer review via the Accrediation Tool process; and support staff to improve the care environments and the care delivered through action planning	Deputy Chief Nurse	• Accreditation Tool process in place • Action plans delivered and reported through Executive Nurse Forum	Revised tool in place. Further revisions, as part of the annual review process, will be adopted in April 2019 New schedule being delivered Action plans for bronze wards / units being reported to Executive Nurse Forum	
Have systems in place to monitor continuous substandard performance (dashboards) and assist wards / units / teams to improve by supporting with enhanced measures	HoN Matrons	• Wards / Units identified through the Accrediation Tool process are escalated • Specific measures put in place when continuous substandard performance is identified	System is working well	
Celebrate improvement and continuous high level achievements	Chief Nurse	• Gold award recognition	Reports in Staff Matters	

through nurse and management team communications and recognition systems		system in place • Teams celebrated in Staff Matters	Certificates delivered by Chief Nurse	
Investigating and Improving				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Link complaints, human resources and risk investigation training to realise the similarities	PET Deputy Director of Human Resources Deputy Director of Risk and Legal	• Evidence of joint delivery and attendance records for training	Attendance records to be reported from next report. Records maintained by Risk and Legal Team	
Continue to deliver complaints specific training	PET	• Examples of either individual or group delivery of training	There has been a high number of new Matron and Deputy Directorate Management appointments since the delivery of complaints training. PET are tasked with procuring training for new appointees	
Use the standard assurance framework to ensure nurses undertaking investigations are completing investigations, and writing and presenting reports to a timely and professional standard	Matrons HoN	• Work undertaken by Matrons and nurses is monitored by HoNs and reported	A good process for assurance, which includes proofreading, is in place for Matrons and nurses. This is delivered by the HoNs	
When teams / individuals are falling below the standard expected either deliver group or individual support to continually improve standards	Matrons HoN	• Both performance management and identification of additional support requirements is	In the last 6 months 2 directorates performance management of complaints has been escalated to their	

		managed through OPAM	Deputy COO 1 directorate has been identified as requiring additional support (capacity) and this was delivered. The process of performance management and identification of additional support needs is through OPAM	
Workforce				
Educating and Training				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Monitor and support staff to undertake and maintain their statutory and mandatory training requirements	HoN Matrons	• Statutory and Mandatory training reported through dashboards	Process established which ensure all nursing and midwifery training is reported at all levels Any underperformance is picked up and addressed through the Matrons Assurance process Concern identified related to PREVENT L3 training. System established to achieve compliance being monitored by Safeguarding Adults Team	
Work with Clinical Skills team to	Deputy Chief	• Training needs analysis	First four projects identified.	

ensure that staff access and develop expert knowledge and skills; including specialist skills	Nurse	required to assess skills gap • Priorities agreed and work plan development	This includes some work with the Trusts Bank only workers • Care and hygiene needs in the acute setting (schedule to be agreed) • Improving hydration management (March 2019) • Undertaking observation and escalating (Bank only workers) (schedule to be agreed) • Moving and Handling Training (Bank only workers) (To be managed through Bank Office and Occupational Health Team) (schedule to be confirmed)	
Work with Practice Learning teams to develop the best learning environments for non-medical learners	HoN Matrons Ward Sisters and Charge Nurses	• Work based learning environment report • Feedback from non-medical learners	To be reported in next report	
Review and deliver the preceptorship programme for new nurses	Deputy Chief Nurse	• Delivery of preceptorship programmes • Evaluation of programmes • Reviews and changes to the programme	4 cohorts of preceptorship are currently being delivered Planning underway to deliver 3 cohorts in September 2018 depending on new starters	

			Process in place to ensure all sessions are fully evaluated and that the programme is adapted to the learners needs 2019 Programme review undertaken and some adaptations made to meet needs and in response to feedback Opportunities being explored with York and Coventry Universities to offer some joint teaching, especially for final year students, that will support transition from student to registrant.	
Develop and deliver programmes of education and training which support the development of associate practitioners and nursing associates	Deputy Chief Nurse	• Delivery of AP programme • Delivery of NA programme	AP program delivered. The management of this has transferred to Human Resources and Work based Learning. DCN provides professional advice. 15 trainee nursing associates are due to qualify in March and all have been placed in substantive roles. An external advert has attracted 10 application from	

			other training places for individuals who are due to qualify in March who have chosen York as their first place to work. Shortlisting and interviews to be arranged. Coventry University Scarborough Campus is currently delivering 2 cohorts of trainee nursing associates (29 learners) for Scarborough Hospital and the east coast, planned completion January 2021. York University is planning a cohort of 30 trainee nursing associates (20 for York Hospital / York Community and 10 for TEWV). Providers and York University are working collaboratively on approval and delivery. If successful, planned completion will be September 2021.	
Leadership				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Establish a programme of work for future senior nursing leaders	Chief Nurse Deputy Chief	• Support and attendance at external programmes	Two senior nurses completed Director of Nursing Talent	

	Nurse	for senior nurse leaders • Support for individuals to undertake senior leaders programme • Chief Nurse to deliver Time Out events to support leadership development	Programme with Leadership Academy One Senior Nurse and one Matron undertaking EGA Leadership Programme with Leadership Academy New Matrons are applying and being supported to undertake the Senior Leaders programme Senior Nurse Team Time Out undertaken with future event planned for April/May 2019	
Develop the leadership potential of all healthcare assistants and nurses	HoN Matrons	To be completed at the next review		
Develop a culture where access to personal development and coaching is promoted	Chief Nurse Deputy Chief Nurse	To be completed at the next review		
Support an annual programme of developments that ensures the nurse management team and senior nurses have 'time out' for reflection and development	Chief Nurse Deputy Chief Nurse	• Evidence of Time Out sessions for the Chief Nurse Team and Senior Nurses Teams	Senior Nurse Team Time Out with a section on resilience and mindfulness delivered in April 2018 Chief Nurse Team Time out held December 2018	
Recruitment and Retention				

Item	Lead(s)	Evidence	January 2019 Update	BRAG
Review and maintain the recruitment, retention and reporting nurse and midwifery staffing levels meeting	Deputy Chief Nurse HoN	• Monthly workforce report presented by Chief Nurse to Board • Recruitment and retention monitored and reported • RRR Group delivers against work plan	Monthly reports delivered Accurate reporting of recruitment and retention RRR Group and sub-group meetings disestablished. In collaboration with Human Resources and Work based learning colleagues a smaller, more responsive set of meetings has been established from January 2019. The process is more action focussed and is aimed at generating more local ownership at ward / unit / team level, specifically for recruiting and reporting. Early feedback from nurses is that the new approach feels much more responsive and that they feel more engaged.	
Use the principles of the Calderdale Framework to develop the right staff, with the right skills	HoN Matrons	• Evidence that for staffing / workforce changes that the principles of the Calderdale Framework are adopted • Evidence through	Business cases are now routinely presented that demonstrate appropriate use of tools to review skill mix Calderdale principles used to	

		business cases that appropriate workforce reviews and modelling has been undertaken if this involves changes to nursing or midwifery staffing	review the following teams: Tissue Viability Urgent care Centre Vascular Nursing Team Deputy Chief Nurse schedule meetings with ODIL and have a schedule for priorities for workforce reviews. This is important work, in light of altering some skill mixes to accommodate the emergent Band 4 roles. The first areas to be reviewed between October and December 2018: • ED Scarborough • Orthopaedics York • Endoscopy (to support the opening of the new unit)	
Develop a career framework for associate practitioner positions	Work based learning	• Clear career framework in place	There is a clear route into the AP programme Work for career progression is required to ensure individuals can progress to registrant positions if they want The responsibility for this action has been transferred to work based learning	

			Engagement event scheduled for 4 March 2019 to explore the opportunities and concerns of staff where teams are integrating the Band 4 role into traditional team structures	
Develop a career framework for nursing associate positions	Deputy Chief Nurse	• Clear career framework in place	Awaiting formal approval and detailed information in relation to regulation from regulators A change in the delivery of the NA programme will mean this work will need to be deferred until the lines of academic progression are agreed between the FEIs and HEIs The responsibility for this action has been transferred to work based learning Engagement event scheduled for 4 March 2019 to explore the opportunities and concerns of staff where teams are integrating the Band 4 role into traditional team structures	
Undertake annual skill mix reviews, and acuity and dependency audits with 6 monthly update	Chief Nurse Deputy Chief Nurse HoN Matrons	• Implement SafeCare across all wards / units • Programme of skill mix reviews established	SafeCare established on York site. Awaiting delivery on Scarborough site Skill mix review programme	

	Senior Sisters Charge Nurses		now being delivered. SafeCare is now fully rolled out. Specific work undertaken to deliver a high level of compliance with data entry. First reports using SafeCare data presented to Trust Board First Acuity and Dependency Audit using SafeCare will conclude in February 2019 to be reported to Trust Board in March 2019 In Women's Health – annual desktop birth-rate plus exercise to assess workforce requirements. A workforce strategy is in place and includes aspirational development opportunities. Birth-rate plus is used to assess acuity and dependency for labour wards.	
Succession Planning				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Establish an active programme of talent development for Band 5 and	HoN	• It's My Ward Programme delivery	IMW Programme delivered autumn 2018. Programme	

Band 6 nurses		• Review options post preceptorship for ongoing Band 5 and 6 development • Review options for clinical and non-clinical training in light of reductions in SSPRD funding	evaluated positively from participants. Senior Nurses to review the content in 2019 to ensure it remains fit for purpose	
Understand the nursing age profile and actively succession plan for roles at Band 7 and senior nurses	HoN Deputy Chief Nurse	• Age profile for all nursing and midwifery workforce across all services	Age profile of community nurses undertaken and workforce model presented and approved. Work to commence to enact new model. Age profile for specific wards and units collated. Workforce plans aligned to local and national priorities and guidance to be ratified	

Partnership and Efficiency

Education providers

Item	Lead(s)	Evidence	January 2019 Update	BRAG
Work with colleges, universities and other education providers to develop appropriate training for the care staff needed for the Trust	Deputy Chief Nurse	• Evidence of meetings with HEIs and FEIs • Work on new Nursing Curriculum • Work on New Midwifery Curriculum when	Meetings held over last two months with York University; York St John's University; York College and Coventry University Scarborough Campus	

		published • Evidence of successful routes into nursing through NA, AP programmes • Evidence of development of advanced roles • Evidence of engagement in the apprenticeship agenda	Deputy Chief Nurse is Chair of Strategic Partnership Group at York University Senior Nurse Team and Work based with HEIs to develop register nurse training aligned to the new curriculum Curriculum development meeting schedule established TNA and AP programme continue to progress Work with Workforce Development on an apprenticeship model for care staff underway Midwifery Careers Event held Teams work jointly with all university on their recruitment activity. Using values based recruitment approach.	
Develop programmes of education that are innovative and give opportunity, where possible, for local people to deliver skills to enter into and be promoted through health	Deputy Chief Nurse	• AP programme delivery • Delivery of maths and English for people new to care • Delivery of the Care	Model for HCA recruitment through apprenticeship being developed which includes support to pass maths and English at L2	

care careers		Certificate		
Work with local schools to promote nursing and care professions	Chief Nurse Deputy Chief Nurse HoN Matrons	• Evidence of work with schools and colleges that promote careers in care professions	The Chief Nurse Team has delivered some school level sessions. The leadership for this activity has now transferred to Human Resources	
Efficiency				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Improve understanding across all nursing on Trust finances and efficiency targets	HoN Matrons	• All senior nurses to complete HMFA Training on line • DoF to attend Nursing meetings for education and Q+A sessions • Information about financial performance to be cascaded through Staff Brief processes • Ensure there is senior nurse oversight for any moderate to high risk cost improvement plans	All senior nurses have access and are in the process of completing training DoF attended Nursing and Midwifery conference and delivered several breakout sessions and took part in a Q+A session Processes for effective cascade of staff brief to be ratified	
Put systems in place which support nurses to drive efficiency and innovation	HoN Matrons	• Ensure process are in place for nurses and midwives to generate ideas that contribute to financial efficiency • Record and celebrate	Nurses involves with procurement Nursing product group	

		nursing and midwifery innovations in efficiency and innovations		
Health, social care and voluntary sectors				
Item	Lead(s)	Evidence	January 2019 Update	BRAG
Improve understanding of other local healthcare providers and how best to develop joint services	PET Chief Nurse Deputy Chief Nurse	• PET to report on opportunities available to work with other local healthcare providers in relation to the development of joint services	Significant progress made with engagement through York Cares and opportunities being explored whereby this community of business and services can work collaboratively Significant progress made with the volunteers profile and how the Trust is shaping volunteers with partners. This work is being undertaken with support from HelpForce and affords a mechanism for sharing the Trusts achievements and learning from others.	
Improve understanding of opportunities to work across social care sector	Chief Nurse Deputy Chief Nurse	• Clear opportunities to be explored through examples of joint working / joint appointments • Service development to be reported through Chief Nurse Report	Limited progress. The Deputy Chief Nurse has started some early conversations with York University in relation to future programmes of study that may provide an opportunity to link nursing and social care education.	

Work towards improved integration by jointly reviewing acute and community roles and shaping nursing services around patients' needs	Chief Nurse Deputy Chief Nurse HoN	• Implement the Community Nursing Services Review • Appoint to nursing delivery lead role • Report on improved integration in Chief Nurse Report	Post appointed to. Engagement work has commenced.	

BRAG Reporting	
Blue	Programme of work on track to deliver and assurance delivery is viable
Red	Programme of work is behind schedule and there is a high chance of non-delivery
Amber	Programme of work requires significant input to maintain delivery and may be dependent on factors which require negotiation with external influencers
Green	Programme of work is being delivered and there is a high level of confidence that delivery will continue

York Teaching Hospital
NHS Foundation Trust

Board of Directors – January 2019
Q3 Patient Experience

Trust 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 sustainability**

Recommendation

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

Purpose of the Report
This report gives an update on the Q3 Patient Experience activity and identifies priorities for the coming months.

Executive Summary – Key Points
This report has given an overview of the work being undertaken by the Trust in managing and improving the patient experience and responding to patients' concerns.

The Trust complies with statutory regulations for complaint handling i.e. The NHS and Social Care complaint Regulations 2009

Key areas of achievement:

- Reached final stage of opportunity to receive £75,000 HelpForce grant – final decision end January 2019

Key area of concern:

- Response times for complaints and PALS concerns

Recommendation
The report will be presented to the Patient Experience Steering Group on 14 January 2019. Committee to approve report.

Authors: Justine Harle, Lead for Complaints & PALS
Catherine Rhodes, Lead for Patient Surveys & Volunteering
Director Sponsor: Beverley Geary, Chief Nurse

Date: 9 January 2019

1. Introduction and Background

At York Teaching Hospital NHS Foundation Trust we want to learn from feedback in order to improve the experiences of our patients and their carers. As part of this commitment the Patient Experience Team presents collated patient feedback quarterly to the Steering Group for information and discussion.

2. Detail of Report and Assurance

The report will be presented to the Patient Experience Steering Group for approval and actions are monitored by the group.

2.1 Patient Surveys

National cancer survey

2017 headline results:

- Average rate of care (1-10) : 8.9
- 79% were involved as much as they wanted to be in decisions about care
- 90% found it quite or very easy to contact their Clinical Nurse Specialist
- 89% were always treated with dignity and respect while in hospital

Detailed results were shared in October 2018 and a further report written by Jackie Fraser, Macmillan Lead Cancer Nurse, was shared at Patient Experience Steering Group in January 2019. Action plans are developed individually (tumour site specific) and form part of the Quality Surveillance required documents. Each directorate and tumour site own the action plans and will be responsible for taking them forward.

2018 survey

The survey for patients seen in April-June 2018 was due to be sent out in November 2018 however there have been significant delays caused by Quality Health querying our sample. Last year only ~450 patients were sent the survey. This year due to a change in the interpretation of the guidance ~890 patients are to be sent the survey. Patient experience team members have been working with Systems and Networks to provide the assurance needed to finalise the sample.

National maternity survey 2018

Headline results:

- 154 responses (45% response rate)
- Our results were better than most to the following four questions:
  - During antenatal check-ups, did a midwife ask how you were feeling emotionally?
  - During labour, were you able to move around and choose the position that made you most comfortable?
  - Did you have confidence and trust in staff caring for you during labour and birth?
  - When you were at home after the birth of your baby, did you have a telephone number for a midwife or midwifery team that you could contact?
- Our results were worse than most Trusts for the question:
  - Were you offered any of the following choices about where to have your baby?

Full details were sent to the Head of Midwifery in January 2019 and presented to the Patient Experience Steering Group in January 2019.

National inpatient survey 2018

Headline results:

Our results were better than most Trusts for the following three questions:

- Was your admission date changed by the hospital?
- How would you rate the hospital food?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Our results were worse than most Trusts for 11 questions, including:

- Did you know which nurse was in charge of looking after you?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- During your hospital stay, were you ever asked to give your views on the quality of your care?

Friends and Family Test (FFT)

The inpatient response rate was 31.7% in November 2018 against a national average 24.9%. The ED response rate remained stable at 12.3% (national average 12.2%). Satisfaction rates have remained stable.

% likely to recommend	Sept 18	Oct 18	Nov 18	National Av (Oct 18)
Inpatient	96	97	97	96
Emergency Department	85	85	88	87
Maternity	97	98	98	98

As always, the overwhelming theme was thanks to our staff. Over recent months, comments regarding long waits for procedures and in the Day Unit at York Hospital have been made. However, the Matron and Ward Sister have been working hard to identify any potential improvements and in December 2018 the number of comments reduced considerably.

Long waiting times and communication about waiting times continue to be the main concern in EDs, particularly at York Hospital. This is something we hope to improve by increasing our volunteer presence in ED.

Following demand for text messaging to be used across more outpatient areas we are introducing text messaging across all of outpatients starting February 2019. The team is submitting a proposal to the Patient Experience Steering Group to introduce text messaging in ward areas, following a successful pilot in Endoscopy, the Medical Elective Service and Rheumatology.

NHS England is progressing plans to change the Friends and Family Test to the Fast Feedback Tool which will ask patients a different question, yet to be confirmed. The Lead for Patient Surveys and Volunteering is involved in a working group about this change and will continue to update the group as required.

2.2 Volunteering

At present we have 260 active volunteers across the Trust. The next recruitment campaign is open 27 January – 10 February and we are hoping to recruit a further 40 volunteers during this time, primarily dining companions for elderly wards in Scarborough.

A survey was recently sent to all volunteers, 57 have been completed (22% response rate). Nearly half of respondents have been volunteering for 5 years or more, and over 70% volunteer for 3 or more hours per week. There were a number of comments about the slow recruitment process. The team is currently trying to streamline this and hopes to secure assistance from the HR/Recruitment team.

Our recent application for a £75,000 grant from HelpForce to scale up our volunteer service in our Emergency Departments is through to the final 15, with at least 10 being awarded a grant. Final interviews are taking place on 16 January 2019 and the decision will be announced soon after. If successful there will be a requirement to appoint a Project Manager to lead the work.

2.3 Complaints

The Trust received 113 new complaints in Q3 compared to 99 in Q1 and 116 in Q2. In addition, there were 21 dissatisfied cases this quarter.

Twelve cases were managed via the de-escalation process without the need for a formal investigation. For the same time period 128 cases were closed.

One case had a risk code of extreme but was not upheld. 28 had a risk code of high of which 2 were upheld, 14 partially upheld and 10 were not upheld. Two of these cases have not yet been assigned an outcome code by the investigating officer. 58 cases had a risk code of medium. Of these 7 were upheld, 32 partially upheld and 16 were not upheld. Three of cases have not yet been assigned an outcome code by the investigating officer.

Of the 38 classed as low risk; 8 were upheld, 16 partially upheld and 14 were not upheld.

Complaints by directorate 2018-19

	Oct 2018	Nov 2018	Dec 2018	Total
Allied Health Professionals	0	1	0	1
Child Health	4	2	2	8
Community Services	0	0	0	0
Elderly Medicine	5	4	4	13
Emergency Medicine	6	4	6	16
Estates & Facilities	0	0	1	1
General Medicine	5	5	5	15
General Surgery & Urology	6	7	7	20
Head & Neck	3	2	2	7
Laboratory Medicine	1	0	0	1
Medical Governance	0	1	0	1
Nursing & Improvement	0	0	0	0
Obstetrics & Gynaecology	2	3	2	7
Ophthalmology	2	2	1	5
Orthopaedics & Trauma	4	2	2	8
Pharmacy	0	0	0	0
Radiology	1	0	0	1
Sexual Health	1	0	0	1
Specialist Medicine	1	0	0	1
Systems & Networks	0	0	1	1
TACC	5	0	1	6
Total	46	33	34	113

NHS Digital has published the national complaint dataset for Q2 2018-19. This quarterly collection is a count of written complaints made by (or on behalf of) patients. There were 29,613 new HCHS written complaints in the second quarter of 2018-19.

Over the period 27,701 complaints were resolved, of these 8,999 (32.5 per cent) were upheld, 8,562 (30.9 per cent) were partially upheld and 10,140 (36.6 per cent) were not upheld. For the same period (Q2), the Trust upheld 7% cases whilst 64% were partially upheld and 29% were not upheld.

Data is collected via the KO41a returns for complaints about NHS Hospital and Community Health Services (HCHS) in England, providing benchmark information for complaint numbers per 1000 staff. The KO41a is a collection of data that organisations have a statutory responsibility to collect and submit on a quarterly basis.

For NHS acute trusts in Q2 2018-19:

Organisation(s)	**Number of complaints received per 1000 staff**
All NHS acute trusts	24.8 (↓ Q1 25%)
York Teaching Hospitals	16.5 (↑Q1 13.6)

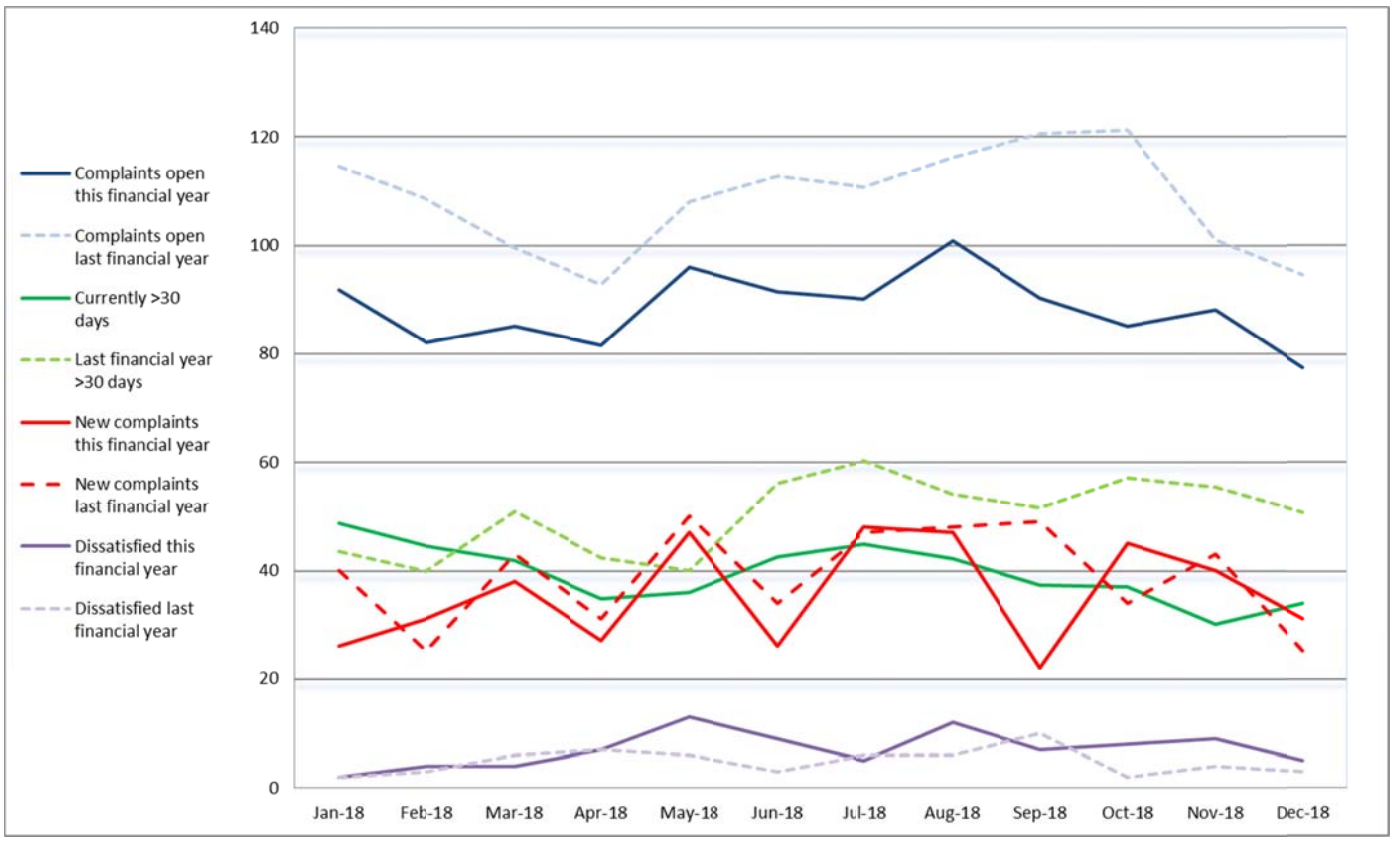
The range of scores for acute trusts is 2.7 to 72.8 with a median of 13.2.

Complaints Handling Performance

Work to address the timeliness of response rates continues, as on average only 37% of closed cases in Q3 met the Trust target of 30 working days

Complaint response times continue to be monitored and reported to the Chief Nurse for directorate performance assurance meetings and investigating officers are offered support when cases are complex or contentious. However, work should be undertaken in individual directorates to achieve the organisation target of 30 days.

Responses within target timescale	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Number of cases closed	35	37	34	37	32	50	30	60	35	47	38	43
No. cases closed within 30 days	8	10	8	9	10	16	12	17	11	16	18	13
%	**23%**	**27%**	**24%**	**24%**	**31%**	**32%**	**40%**	**28%**	**31%**	**34%**	**47%**	**32%**



Parliamentary and Health Service Ombudsman (PHSO)

The PHSO is the final tier of complaint for people unhappy with their experience of the NHS in England and Government departments. Last year it received 31,444 new complaints, 88% about the NHS." UK Parliament, April 2018

The PHSO looks at how we handle complaints from people who use our services. Two new cases were received in Q3.

One of the complainants stated that a doctor at the Trust may have incorrectly diagnosed her in August 2016

The second complaint relates to care and treatment the deceased husband received at Scarborough Emergency Department in 2016.

In quarter 3, one case was closed and partially upheld (General Surgery & Urology). The PHSO highlighted that the Trust failed to communicate with the family clearly enough to provide them with a full understanding of the patient's medical condition. The Trust accepted that our failings hindered the family in making informed decisions in relation to the patient's treatment. The Trust was required to send a letter of apology and an action plan.

In addition, the Trust received two new requests for information about cases which the PHSO will consider before deciding whether to conduct formal investigations. The Trust also worked with the PHSO to resolve four cases without the need for formal investigations. This included providing updated action plans and additional information. The Trust also contributed to a PHSO investigation in to the care provided by another Trust.

2.4 Patient Advice & Liaison Service

The PALS dealt with 395 cases in Q3. This figure does not include the cases where simple advice was given or callers were signposted to other services and organisations for support.

The top four issues were communication (79), appointments (78), clinical treatment (77) and staff values and behaviours (70).

Complaints by directorate 2018-19

	Oct 2018	Nov 2018	Dec 2019	Total
Allied Health Professionals	2	2	1	5
Chairman and CEO	0	0	0	0
Child Health	8	5	1	14
Community Services	4	1	3	8
Elderly Medicine	6	17	7	30
Emergency Medicine	17	13	16	46
Estates & Facilities	9	9	3	21
External to Trust	1	0	0	1
Finance and Performance	0	0	0	0
General Medicine	21	17	5	43
General Surgery & Urology	27	20	10	57
Head & Neck	9	13	5	27
Laboratory Medicine	0	0	0	0
Nursing & Improvement	0	1	0	1
Obstetrics & Gynaecology	7	6	4	17
Operations	2	3	0	5
Ophthalmology	9	12	7	28
Orthopaedics & Trauma	7	11	6	24
Pharmacy	0	1	1	2
Radiology	5	5	8	18
Sexual Health	0	0	0	0
Specialist Medicine	11	11	4	26
Systems & Networks	1	3	2	6
TACC	7	5	4	16
Total	153	155	87	395

On average, 72% of cases were resolved by directorates within the ten working day target (Q2 average was also 72%). However, the response time for dealing with PALS cases within 10 working days dropped to 63% in December 2018.

Responses within target timescale	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**
Number of cases closed	219	183	158	178	149	160	180	172	110	143	172	83
No. cases closed within 10 working days	173	146	122	128	107	119	127	132	73	99	136	52
%	**79%**	**80%**	**77%**	**72%**	**72%**	**74%**	**71%**	**77%**	**66%**	**69%**	**79%**	**63%**

2.5 Complaints Management Audits Q2

A retrospective audit of ten cases closed in quarter two was undertaken to check for evidence that actions had been undertaken. There were 14 actions in total for these cases.

Evidence existed that 9 actions had been completed (64%).

2.6 Patient Experience Reporting

The patient experience team has recently developed new Datix reports that enable directorate management teams to review the cases they contributed to in the last quarter, in addition to those that they lead on. This data will contribute to directorates understanding of their complaint themes and trends.

The team has also been working with the Revalidation Support Officer (PGME) and set up access to the Professional Standards Datix Dashboard. This will allow the support officer to monitor complaints received that include the name of a doctor in training.

In addition the information governance officer has been provided access to the Information Governance Datix Dashboard. This includes all cases relating to a Breach of Confidentiality and all those cases that the information governance team has been notified of so that trends can be identified.

2.7 Cross Team Working

Improved opening times for the Childrens Assessment Unit
From Monday 12 November 2018 new extended opening times were introduced to the Childrens Assessment Unit on Ward 18 which has seen children fast tracked from the hospital's Emergency Department. The extended opening times run from 09:00 to 12:00 seven days a week. The new hours will help improve patient experience by avoiding unnecessary overnight admissions, catering for patients who require shorter stays in hospital and improve accessibility for incoming referrals.

Care Opinion and Choices
As well as contacting the Trust directly with feedback, patients can use independent feedback websites such as NHS Choices and Care Opinion. 29 comments were made and responded to in this quarter, 22 of which were compliments, mostly relating to positive values and behaviours of staff, and clinical treatment.

Comments are collated and sent to Directorates one per quarter as an opportunity to highlight the thanks from the public, and so that consideration can be given to any potential improvements. Those who post negative comments are encouraged to contact PALS in an attempt to help investigate and resolve the issues raised.

Compliments
1447 compliments were recorded for Q3. From September 2018 the way compliments are captured and reported has changed. Only written compliments (e.g. letters, cards and emails) are now counted formally, although it is recognised that teams do continue to

receive gifts and verbal thanks. 1218 'Other Compliments' were received in addition to the above written compliments.

3. Next Steps

- The patient experience team is developing a complaints training package
- HelpForce interview January 2019

4. Detailed Recommendation

This report has given an overview of the work being undertaken by the Trust in managing and improving the patient experience and responding to patients concerns.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Director of Infection Prevention Quarterly Infection Prevention and Control Report Q3

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

As required by legislative and regulatory requirements, the Trust continues to acknowledge its responsibility to provide safe and effective infection prevention practice with the aim of reducing harm from avoidable infection that occurs either as a direct result of intervention or from contact with the healthcare setting.

This report summarises performance against these requirements and aims to provide assurance of progress against interventions initiated to reduce the increased incidence of HCAI.

Executive Summary – Key Points

During Q3, there were a ward closures due to norovirus leading to increasing operational pressures.

Despite a successful but limited decant and deep clean program on the York site, there remain significant challenges associated with the environment, with inadequate side room capacity to isolate all patients with infections, a difficult to clean environment in many areas.

The Board of Directors is asked to:

- Receive the IP report for Q3.
- Acknowledge the risks highlighted and the actions/ interventions implemented to mitigate and reduce HCAI incidence to improve patient safety, experience and outcomes.

- Consider the Infection prevention risks associated with the general clinical environment and isolation capacity when planning capital projects.

Recommendation

The Board of Directors is asked to:

- Receive the IP report for Q3.
- Acknowledge the risks highlighted and the actions/ interventions implemented to mitigate and reduce HCAI incidence to improve patient safety, experience and outcome.
- Consider the Infection prevention risks associated with the general clinical environment and isolation capacity when planning capital projects.

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

Director Sponsor: Beverley Geary, Chief Nurse, Director of Infection Prevention and Control (DIPC)

Date: January 2019

1. Introduction and Background

As required by legislative and regulatory requirements, the Trust continues to acknowledge its responsibility to provide safe and effective infection prevention practice with the aim of reducing harm from avoidable infection that occurs either as a direct result of intervention or from contact with the healthcare setting.

This report summarises performance against these requirements and aims to provide assurance of progress against interventions initiated to reduce the increased incidence of HCAI.

2. Celebration of Achievement awards

The Chief Nurse commendation was awarded to the Infection Prevention team, Ward 23 and Microbiology laboratory staff, in recognition for work undertaken to manage influenza last winter. Many individuals worked outside their normal roles or normal working hours to ensure the trust coped with the pressures of a difficult influenza season and to protect patients.

3. New Post Infection Review process and multi-agency review meeting

The new process for PIR is working well. Meetings are held as early as possible, and always within 5 days, on the ward where the case occurred. This allows investigation while the events are still fresh.

The first joint Healthcare Associated Infection review meeting with community Infection Prevention and CCG representatives was held in November, to continue monthly. Initially the focus is on C. difficile, although this will expand to include other infections in future.

4. Staffing

The Infection Prevention Lead nurse (band 8a) post remains vacant, after 2 failed recruitment the 3rd round to be held is ongoing. Christine Morris (Matron) is providing leadership support to the team with oversight from Tom Jaques Head of Nursing.

The band 7 vacancy (Community/ education lead) – is currently being shortlisted together with a 22.5 hour band 6 vacancy based in Scarborough.

The new band 4 roles in Scarborough and York have been filled and we are working with these individuals on competency development in Infection prevention.

Due to the reduced staffing levels, there has been less surveillance activity beyond the mandatory surveillance. It is anticipated that the Band 4 team members will be trained to take this on, including increased audit against guidance.

5. Ward refurbishment and deep clean

A well maintained, easy to clean environment, in conjunction with an effective cleaning programme, is essential to minimise the risk of transmission of infection. Hydrogen peroxide vapour (HPV) is a useful addition to reduce the number of organisms that can persist in the environment.

A successful decant and deep clean program was established in York over 6 weeks from October to December, using ward 15 as a decant facility. 5 wards identified as having high infection risk were deep cleaned with hydrogen peroxide vapour:

There remains very limited capacity for deep clean and refurbishment in Scarborough. This leads to an increased risk of transmission of infection due to buildup of infectious particles, particularly in a harder to clean environment.

A growing number of wards need refurbishment in order to maintain or restore a safe, easy to clean environment. It is imperative that we use ward 15 to facilitate refurbishment in York, and find a way to do the same in Scarborough.

6. Side room capacity

Inadequate side room capacity is continuing to lead to risks associated with being unable to isolate patients with diarrhoea, respiratory infections and multi-drug resistant bacteria. Both hospital sites were reviewed to identify any extra capacity that can be created, although this is likely to remain a significant clinical and operational risk until a substantial capital project is undertaken which addresses this. This remains on the Corporate Risk Register.

7. Influenza planning

It has agreed that Lilac ward and ward 23 would be the respiratory virus cohort wards if required during the winter period. Cohort bays were opened on both sites over December/ January 2018. As this function is new for Lilac ward, extensive training took place with Infection Prevention and support from ward 23 staff.

It has not been possible to avoid the use of the Nightingale wards (Ann Wright and Graham ward) for elderly inpatients. To mitigate the risk of respiratory virus or outbreaks as much as possible, an SOP has been designed to prevent admission of patients with respiratory infections from being admitted to these wards. Antimicrobial disposable curtains are being trialed. A bed space has been removed to improve space between patients and access to hand hygiene facilities.

A communications campaign has been launched to ask visitors with symptoms of respiratory virus or gastroenteritis to avoid non-essential visits.

Long stay patients who should be offered influenza vaccination are being identified and vaccinated where possible.

The in-house respiratory virus laboratory testing is allowing rapid diagnosis and targeted isolation or cohort nursing – the laboratory will extend working hours when enough swabs are being received.

8. Directorate Working

Directorate working remains a quality priority, but has been held pending expected changes to the directorate structure.

9. Central and long lines

A business case is being written for a line insertion, monitoring and support service.

10. Outbreaks and Clusters of Infection

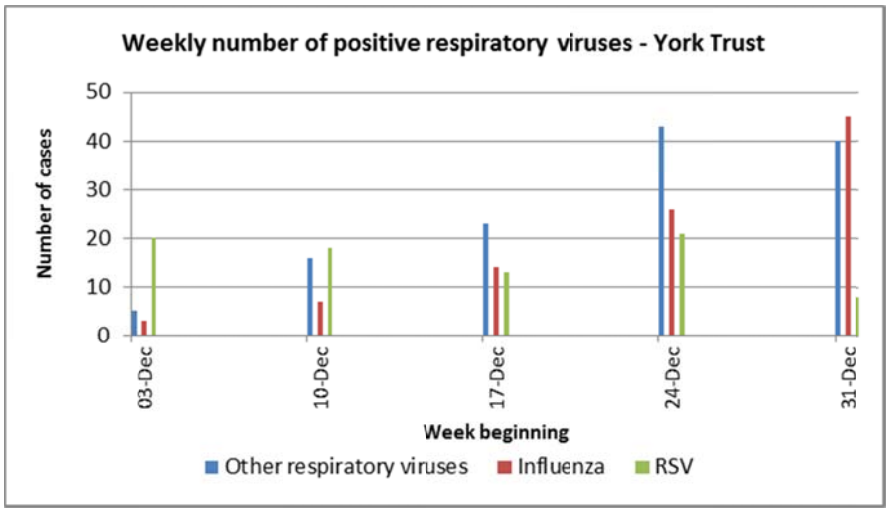
Viral gastroenteritis

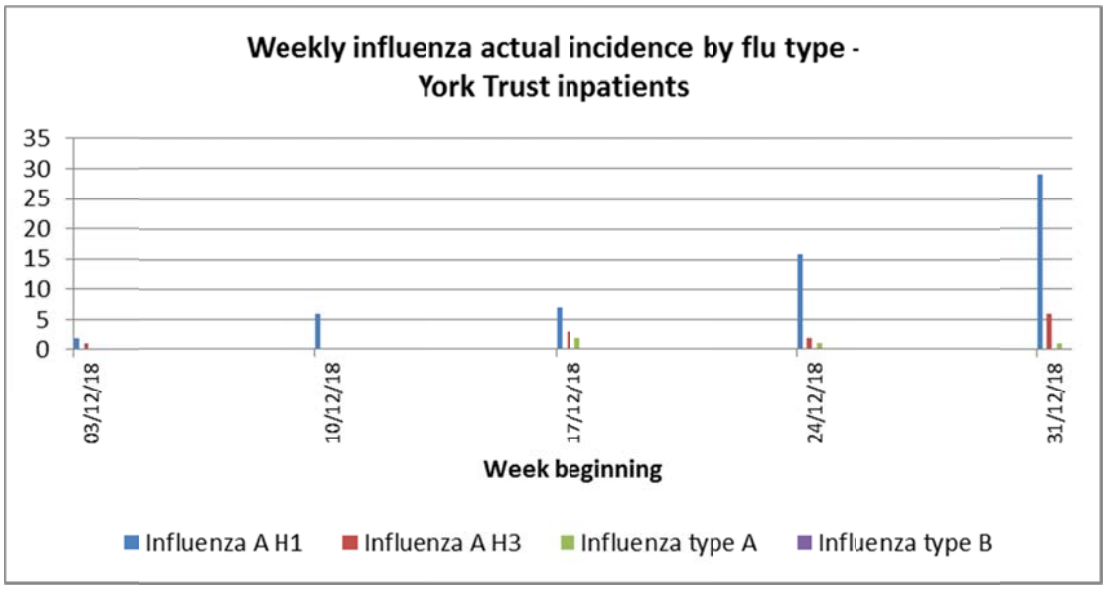
November – Norovirus outbreak ward 23, 37 and 39 (39 unconfirmed). Total of 24 days full ward closure.

December – Graham ward closed with Norovirus on 28th December and reopened on 8th January. (4 days in Q3). The Nightingale ward layout precludes cohort nursing and partial reopening, potentially leading to longer outbreaks and ward closures.

Respiratory viruses

No full ward closures during Q3, but at the end of December cases of winter respiratory virus, and especially influenza, were rising and starting to exert operational pressures, leading to opening of cohort bays on both acute hospital sites.





MRSA in SCBU (York)

In December a further colonization of MRSA (the SCBU outbreak strain) was identified on screening, (it is important to note that there was no clinical infection). The previous case had been in June (twins), and prior to that September 2017.

Public Health England are providing support to investigate for a source, although the very low frequency of cases make this challenging. There have to date been no invasive infections associated with the outbreak.

11. Orthopaedic Surgical Site Infection (SSI)

Deep surgical site infection can be reported until 12 months post-surgery, so figures are subject to change.

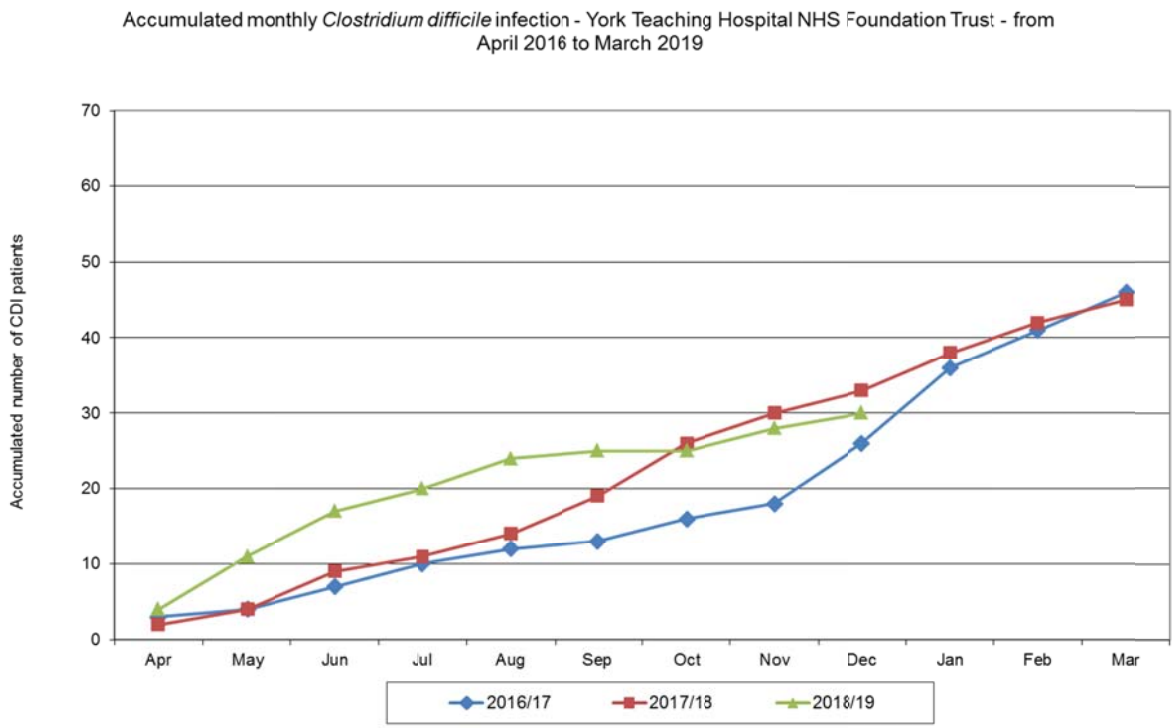
There have been a total of 5 cases reported for 2018/19 –

Q1 – 0
Q2 – 4 (Bridlington 2, Scarborough 1, York 1)
Q3 – 1 (Bridlington)

Post infection review is being carried out for all cases, and the surgical site infection reduction group continue to implement the action plan.

12. Healthcare Associated Infection (HCAI) incidence and performance

12.1 Clostridium difficile



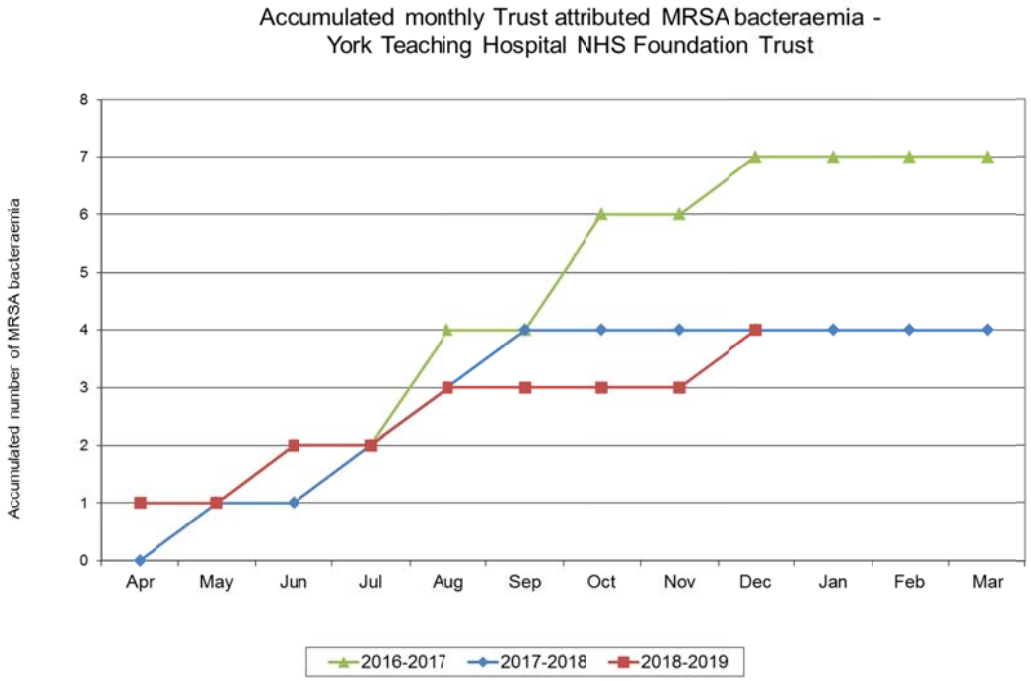
There were 5 cases of C. difficile infection in Q3. This is a reduction compared with previous quarters, bringing the cumulative total to 30 against an annual target of 47 – within trajectory at present, but entering into the difficult winter period.

Recently it has been noted that patients are often not isolated at onset of diarrhea, only when the C. difficile positive result is available. The new, more immediate, PIR process has established that the escalation process is appropriately followed but there is often inadequate side room capacity to isolate patients.

26 cases have been reviewed by the CCG – of these, it has been agreed that there were no lapses of care in 15 cases.

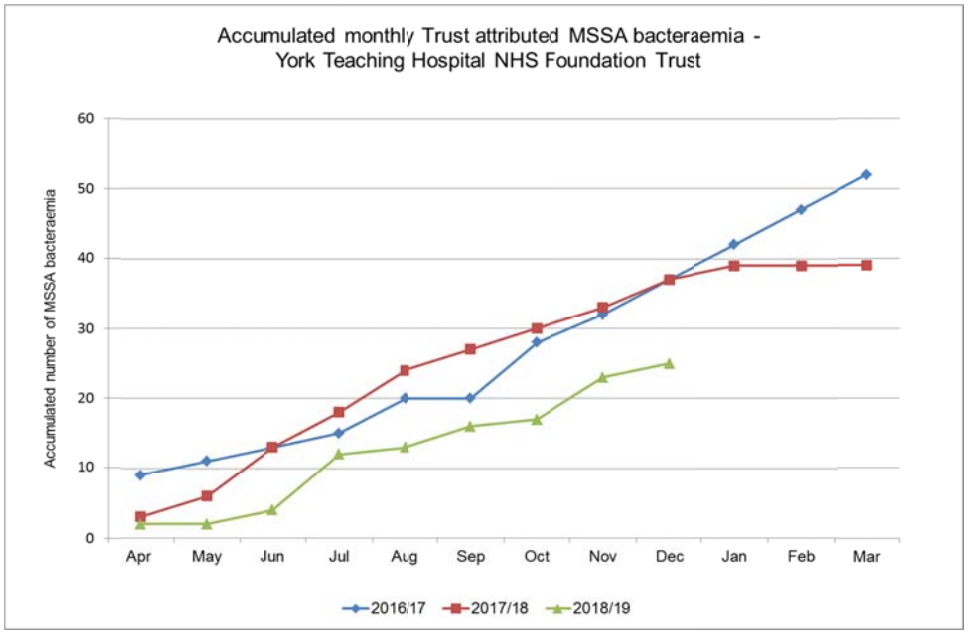
12.2 MRSA

There was 1 trust attributed MRSA bacteraemia in Q3. This was from a wound infection – the wound was not swabbed on admission, but may have already been colonized. The action plan includes staff reminders to include wound swabs in MRSA screens, and a review of communication of MRSA positive results over the weekend.



12.3 MSSA

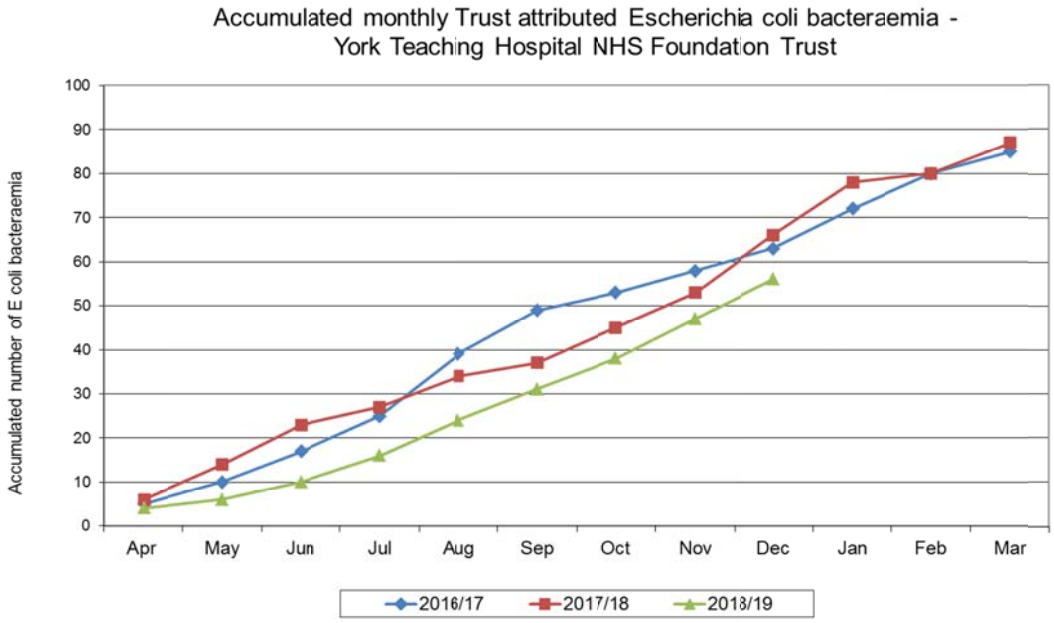
There were 9 trust attributed MSSA bloodstream infections in Q3. against an annual target of 30. The *Staphylococcus aureus* bacteraemia reduction group continues to support the rollout of non-ported cannulas and cannula insertion packs, as well as twice daily VIP scoring and ANTT training – both improving but there is still progress to be made.



12.4 Escherichia coli

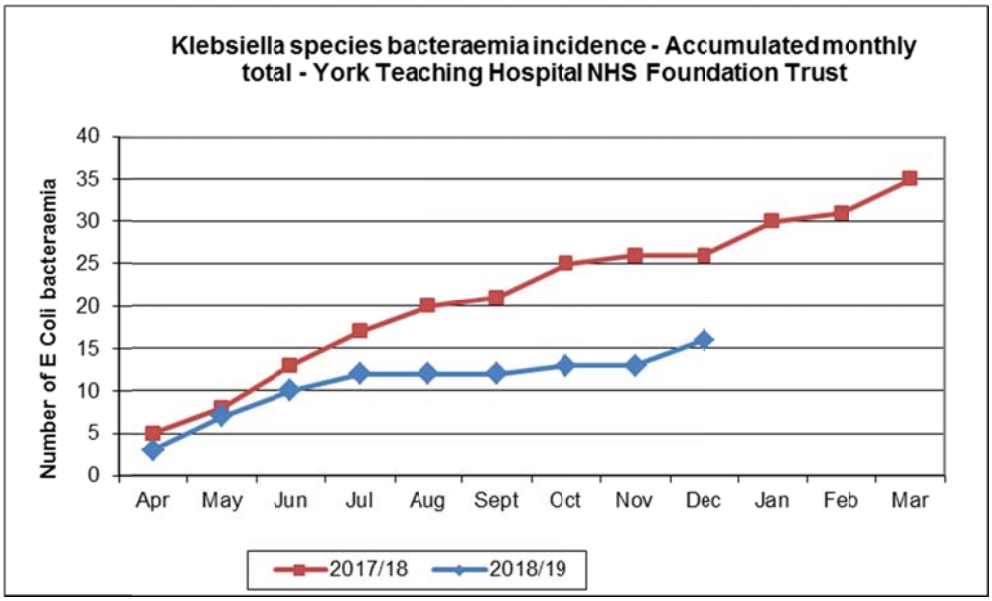
There were 25 E. coli bacteraemias this quarter, with total numbers lower than the same time over last 2 years. Reducing gram negative bloodstream infections across the health economy is a significant national objective, and work involving the CCG and community

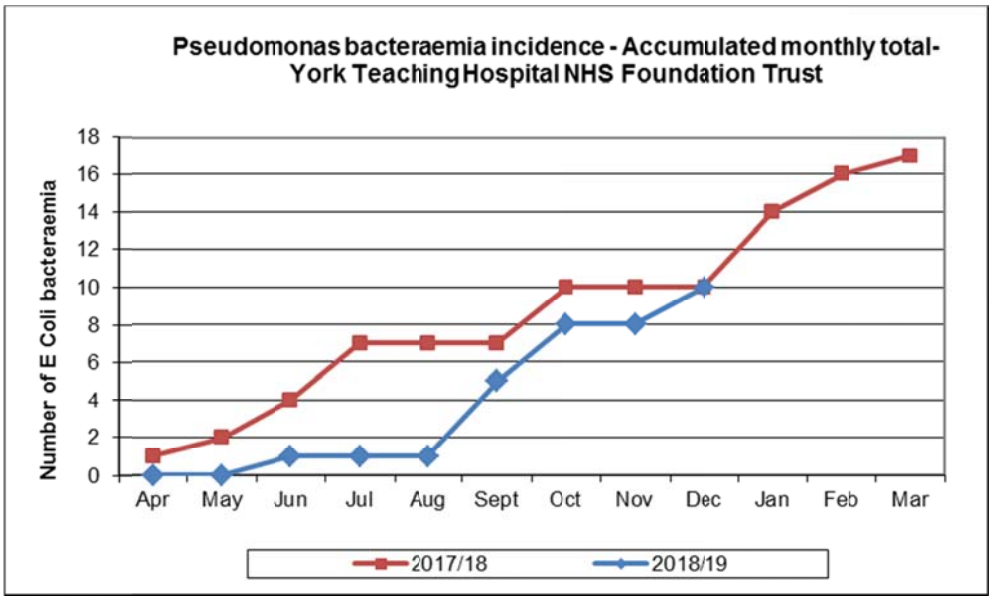
partners, as well as NHS improvement, is under way. Initial targets for improvement are hydration and care if urinary catheters.



12.5 Other gram negative infections

National reporting of Klebsiella and Pseudomonas, other gram negative bacteria, is now mandatory. No targets have been set but there have been lower numbers than last year.





13. Conclusion

The trust is over trajectory for MSSA, MRSA and E. coli bacteraemias, although an improvement has been seen compared with previous years. Work is ongoing to address these. C. difficile cases are below trajectory to the end of Q3.

During Q3, there were ward closures due to norovirus, and in December; an increasing number of cases of influenza, leading to increasing operational pressures.

Despite a successful decant and deep clean program on the York site, there remain significant challenges associated with the environment, with inadequate side room capacity to isolate all patients with infections, a difficult to clean environment in many areas, and patients vulnerable to infections being nursed in close proximity. Staff throughout the trust work hard to undertake risk assessment and mitigate these risks as much as possible. This risk should be taken into account when planning capital projects.

14. Recommendation

The Board of Directors is asked to:

- Receive the IP report for Q3.
- Acknowledge the risks highlighted and the actions/ interventions implemented to mitigate and reduce HCAI incidence to improve patient safety, experience and outcome.
- Consider the Infection prevention risks associated with the general clinical environment and isolation capacity when planning capital projects.

15. References and further reading

Relevant Legislation and Guidance:

- The Health and Social Care Act 2008:Code of Practice on the prevention and control of infections and related guidance, updated July 2015
- NICE Infection and Prevention Quality Standard 61 April 2014
- Epic 3: National Evidence-Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England 2014

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Medical Directors Report

Trust 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 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

Chaperone Policy – For information; approved at Executive Board on 16 January 2019

Learning from Deaths policy – For information; approved at Executive Board on 16 January 2019.

Deteriorating Patient and Escalation
The report includes summaries of both the internal audit into deteriorating patients and escalation, and the re-audit of unplanned admissions to ITU.

Re-audit of unplanned admissions to ITU
A retrospective case note review on 43 patients who had an unplanned admission to Critical Care. All patients assumed to be for escalation. The audit analysed the care 48 hours prior to Critical Care admission. Data was obtained from both the case notes and CPD

Purpose
To assess appropriate undertaking and frequency of observations
To assess documented response to NEWS triggers
To assess medical response to NEWS trigger and patient deterioration
To assess escalation and response of senior medical staff
To assess escalation and response of critical care outreach
To assess the timeliness of the response and escalation

Results
75% having 4rly observations or more
90% observations completed on time hospital wide
85% escalated by Registered Nurse on CPD
85% seen by home team within 1 hour post trigger
90% seen by Critical Care team on ward
93% seen by home team Consultant in previous 24hrs
70% admitted ICU <1 hour
87.5 % re-assessed on ward
86% ADCDE assessment
97% management plan documented

30% had high NEWS for longer than 12 hours
30% had 1 hourly observations post trigger
Poor DNACPR / COC

Internal Audit of patient deterioration April 2018
This was a cross site, retrospective look at patients (25 at YH, 8 at SGH) who had NEWS <4 and then >6 within their admission i.e. significant deterioration.
It included an analysis of the response with reference to the escalation policy. Data was obtained from both the case notes and CPD

The following patients **did not** have their observations performed within 20 minutes of admission / attendance in ED:

- Scarborough - 5/8 occasions (4/8 not within an hour)
- York - 16/25 occasions (8/25 not within an hour)

Observations: NEWS >7
The audit team reviewed how frequently observations were recorded after the NEWS had triggered above 7. It was found that repeated observations **were not p**erformed within the 15-30 minute time frame on:

- Scarborough - 5/8 occasions

York - 14/25 occasions

Medical Review
In terms of a medical review, the policy states that a ST3 Grade Doctor (or above) should be contacted and asked to review a patient within 15 minutes of a NEWS>7.

- Scarborough - 5/8 patients **did not** receive this level of care
- York - 15/25 patients **did not** receive this level of care

However, if the patient was not seen by an ST3 or above, it was noted what action was taken in its place. There was often a review performed by a lower grade Doctor but this was found to be generally outside of the 15 minute timeframe.

Ceiling of Care (CoC)
All in-patients should have a ceiling of care recorded on CPD. However often this is written in the notes rather than recorded electronically.

The following number of patients **did not** have a CoC recorded on CPD:
Scarborough 6/8 patients. However, 5/6 patients had the CoC recorded in their paper

notes.
York 7/25 patients.

Escalation to Critical Care Outreach Team (CCOT)
There were twelve patients in the sample who were admitted to York Hospital and were considered 'for escalation'. Seven of these were not escalated to the CCOT.
All patients in the sample who were considered 'for escalation' at Scarborough Hospital, had been escalated to the Critical Care Outreach Team (CCOT).

Common Themes between audits
Poor recorded of ceiling of care
Non-adherence to expected frequency of Observations post trigger

Explanation for different outcomes
Different patient cohorts
All patients assumed for full escalation in ICU audit
Different NEWS triggers 5 versus 7

NB: the number of cardiac arrests over the last 4 years is as follows:
2015 116
2016 137
2017 85
2018 85

The remaining content of the Medical Director's report is for information. This includes summaries of clinical audits and changes to the anti-coagulation service at York Hospital. An update on the HSIB investigation into maternity is also included focussing on the RCOG Each Baby Counts criteria plus maternal death up to 42 days.

Recommendation

Board of Directors members are asked to note the Medical Directors Report for January 2019.

Author: Rebecca Hoskins, Deputy Director of Patient Safety

Director Sponsor: Mr. James Taylor, Medical Director

Date: January 2019

1. Introduction and Background

Patient Safety

- chaperone policy
- HIV/GUM on call
- Anticoagulation

Clinical Effectiveness

- new consultants to the Trust
- HSIB maternity investigation
- Junior doctor safety improvement group
- Learning from deaths
- Deteriorating patient audit
- Clinical effectiveness group minutes
- annual clinical audit
- National Paediatric Diabetes Audit (NPDA)
- Decompensated Cirrhosis care in first 24 hours

Patient Experience

- Antibiotic prescribing audit

2. Patient Safety

2.1 Chaperone Policy

The scheduled review of the Chaperone policy has been completed and approved at Executive Board on 16 January 2019. The revised policy can be found in Appendix A.

2.2 HIV/ GUM on call

Board of Directors are asked to note that there is no longer an on-call HIV/ GUM service. Patients with HIV related illness are now expected to be managed in regional units which for the Trust is Castle Hill Hospital.

For reference, the Post Exposure Prophylaxis flowchart can be found in Appendix B

2.3 Anticoagulation

The anticoagulation clinic at York Hospital will close fully at the end of January 2019 after twenty years of providing warfarin monitoring to patients throughout York, Tadcaster, Selby and the surrounding areas. It has been decommissioned by the Vale of York CCG and warfarin monitoring is to be done within GP practices. Five practices decided not to take on this enhanced contract, (Tadcaster, Sherburn-in Elmet, Beech Tree, East Parade and Escrick); however Intrahealth will be their new service provider from February 2019.

A discharge pathway has been devised which will be approved by the VTE Committee on 16th January and posters will be provided for each ward area.

Junior Dr's, Consultants, ward sisters and ward clerks have been briefed regarding actions that need to be followed when discharging a warfarin patient.

Patients need to know their dose of warfarin at discharge and must have follow up booked for their next INR blood test. The GP practices must be notified at discharge and until changes can be made to eDN's on CPD, the warfarin chart must be faxed to the practice, or emailed via NHS.net to allow the practices to be able to safely dose. Arrangements have been made for ward clerks to have NHS.net accounts.

Staff from the anticoagulant clinic will be redeployed into other roles.

3. Clinical Effectiveness

3.1 New consultants to the Trust

The following consultants joined the Trust in November:

Jacqueline Tang
Consultant Obstetrics & Gynaecology
York

The following consultants joined the Trust in December:

Kalani Weerasinghe
Consultant Neurologist
York

3.2 HSIB maternity investigation (Escalated item from the Patient Safety Group)

HSIB was established by an expert advisory group following recommendations from a government inquiry into clinical incident investigations. HSIB became operational on 1 April 2017 funded by DoH (until 2020), hosted by NHSI, independent of both, and of other NHS organisations and the Care Quality Commission (CQC).

Investigation team includes people with a professional investigation background in health, aviation and the military.

HSIB purpose is to conduct effective investigations, and by sharing what is learnt, improve patient safety, raise standards, and support learning across the healthcare system in England.

Maternity investigations
In November 2017, the Secretary of State for Health, announced a new maternity safety strategy. The strategy called on HSIB to undertake approximately 1000 independent maternity investigations as important element of the national strategy to improve maternity safety.

Maternity investigations will commence on 3 December 2018. The criteria for investigation is the RCOG Each Baby Counts criteria (outlined below) plus maternal death up to 42 days (excluding suicide)

York Trust will report cases to HSIB from 3 December. If any case is classified as a Serious Incident the Trust is expected to carry on as normal and report (STEIS) and commence the SI process, including Duty of Candour, until verbal consent is obtained from parents upon which HSIB will take over the SI process including engagement with family.

The investigation process will include interviewing members of staff (recorded interviews), taking a copy of medical records and photographic evidence of the environment and equipment if required.

HSIB will keep this evidence and produce a report with recommendations for the Trust and parents. The process can take up to 6 months.

Recommendations will be made publically available on the HSIB website along with sharing good practice and shared learning.

Criteria for inclusion:
All term babies (at least 37+0 completed weeks of gestation) born following labour who have one of the following outcomes;
Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.
Early neonatal death: when the baby died within the first week of life (0-6) days of any cause.
Severe brain injury diagnosed in the first 7 days of life, when the baby:
Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE)
OR
Was therapeutically cooled (active cooling only)
OR
Had decreased central tone AND was comatose AND had seizures of any kind.

Maternal Deaths: Direct or indirect maternal deaths in the perinatal period (during or within 42 days of the end of pregnancy). Coincidental maternal deaths will not be investigated. Death from suicide is not included.

3.3 Junior doctor safety improvement group (Escalated item from the Patient Safety Group)

The Junior Doctor Safety Improvement Group (JDSIG) was set up over 4 years ago after a small team of junior doctors decided to make attempts at addressing difficulties they were encountering. These meetings provide a link between front line staff and the executive team which is key to not only identify areas of improvement, but implement practical and sustainable changes.

In addition the group has links to a variety of Trust Meetings that encourage junior doctor representatives. This is another avenue of providing ward level expertise to higher level decision making, whilst also spreading understanding of organisational priorities to the

junior doctor workforce. Trust meetings include: Serious Incident Group, Medication Safety Group and Infection Prevention Steering Group amongst others.

Ru Rupesinghe has been Chair since October 2017 and has appointed a new Vice Chair, Sarah Pearson, a Foundation Year 2 trainee currently based in Scarborough.

Over the last year, meetings have been run on a thematic basis. The topics have chosen based on patient safety incidents, CQC reports or at the request of colleagues who want to access input from junior doctors on their projects, and have included:

- Prescribing errors
- SAFER
- Maintaining High Professional Standards (MHPS)
- Freedom to Speak Up Guardian
- FIT Testing
- Learning from Deaths
- Deprivation of Liberty and Mental Capacity
- The Deteriorating Patient

Where opportunities present themselves, the Board of Directors are asked to encourage junior doctors to join the JDSIG.

3.4 Learning from deaths

The scheduled review of the Learning from Deaths policy has been completed and approved at Executive Board on 16 January 2019 The revised policy can be found in Appendix C.

3.5 Deteriorating Patient Audit

The report includes summaries of both the internal audit into deteriorating patients and escalation, and the re-audit of unplanned admissions to ITU.

Re-audit of unplanned admissions to ITU

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3.6 Clinical Effectiveness Group minutes

The minutes of the last meeting can be found in Appendix D.

3.7 Annual Clinical Audit

Please see appendix E.

The following 2 summaries form part of the Trust's scheduled audit programme.

3.8 National Paediatric Diabetes Audit

The NPDA is part of the Quality Account and National Clinical Audit and Patient Outcomes Programme (NCAPOP) and investigates acute emergency hospital admissions where the primary diagnosis is related to diabetes in children and young people cared for in Paediatric Diabetes Units (PDUs) in England and Wales.
The 2015/2016 Annual Report was published in 2017 and is the 3rd report from this National Audit.

The primary aim of the NPDA is to examine the quality of care in children and young people with diabetes and their outcomes against NICE CG15: Type 1 Diabetes: Diagnosis and Management of Type 1 Diabetes in Children, Young People and Adults recommendations.

Results

	York		Scarborough		National
	2014/15	2015/16	2014/15	2015/16	2015/16
HbA1c recorded (all ages)	99.3%	100%	100%	98.60%	99.30%
% <58mmol/mol	19.4%	21.4%	42.80%	48.20%	47.50%
% >80mmol/mol	22.1%	18.2%	18.80%	14.50%	17.90%
Blood Pressure	99%	100%	100%	95.60%	90.80%
Body Mass Index	88%	100%	100%	97.20%	97.90%
Albuminuria	46.7%	30%	51.20%	44.40%	66%
Eye Screening	82.2%	66.7%	97.70%	62.20%	66.20%
Foot Examination	41.3%	0%	44.20%	17.80%	65.80%
Thyroid Disease	0%	0%	79.50%	65%	77.70%
Coeliac Disease on Gluten Free Diet	38.5%	0%	64.40%	72.70%	62.30%
Received Structured Education	12%	12%	95%	95.70%	71%
No psychology referral required	0%	0%	N/A	0%	59.70%
Referred and seen by psychology services	23.8%	0%	63%	98%	30%

In York measures of care outcomes have improved with better results for the key target of HbA1c levels.

Recording of care processes (Blood pressure, BMI, albuminuria, eye screening, and thyroid function) has improved although there still needs to be further improvement in the completion and recording of foot checks, albuminuria and thyroid function at annual reviews to achieve national standard.

The completion and documentation of foot examinations for patients with Type 1 Diabetes has significantly fallen in York from 41.3% in 2014/15 to 0% in 2015/16.

There is also a need identified to improve how well recording is completed for structured education.

In Scarborough the percentage of patients seen with a Hba1c <58mmol/mol remains comparable to national level, whilst the percentage with a Hba1c >80mmol/mol has reduced and is now below the national level.

The completion and documentation of foot examinations for patients with Type 1 Diabetes has also significantly fallen in Scarborough from 44.2% in 2014/15 to 17.8% in 2015/16.

There was a reduction in the percentage of patients recorded as having thyroid disease screening, albuminuria screening and eye screening, indicating that action needs to be taken to ensure all patients achieve all of the 7 key care processes at the Scarborough site.

Positively the number of children and young people referred to and seen by psychology service has improved and compares well to national figures and this demonstrates the benefit of having a named clinical psychologist as part of the MDT who attends clinics.

Conclusion
This is the 3rd report from this National Audit and the comparison against the current report findings and the data reported between 2014/15 evidences that year on year both Scarborough and York Hospitals are making steady improvements against the audit criteria. However the areas where there has been a decline in performance against the National Standards needs to be addressed.

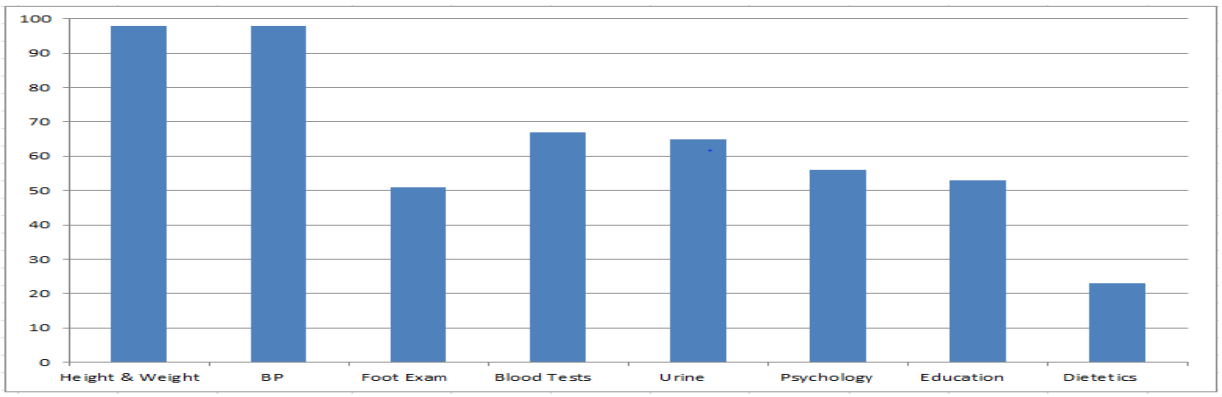
Nationally the results show that the national improvements in diabetes control and completion of health checks has not been accompanied by reductions in the number of diabetes related admissions to hospital. Furthermore, the National report does not demonstrate any improvement in the rate of ketoacidosis in those with newly diagnosed Type 1 diabetes across three consecutive years.

Update on progress.
Progress since this audit was undertaken has shown significant improvements, particularly in relation to foot care. Improved completion of annual review checks has been achieved. It is acknowledged that there is a need to find a way to record annual education review every year and dietetic review when repeated as currently this is only entered once.

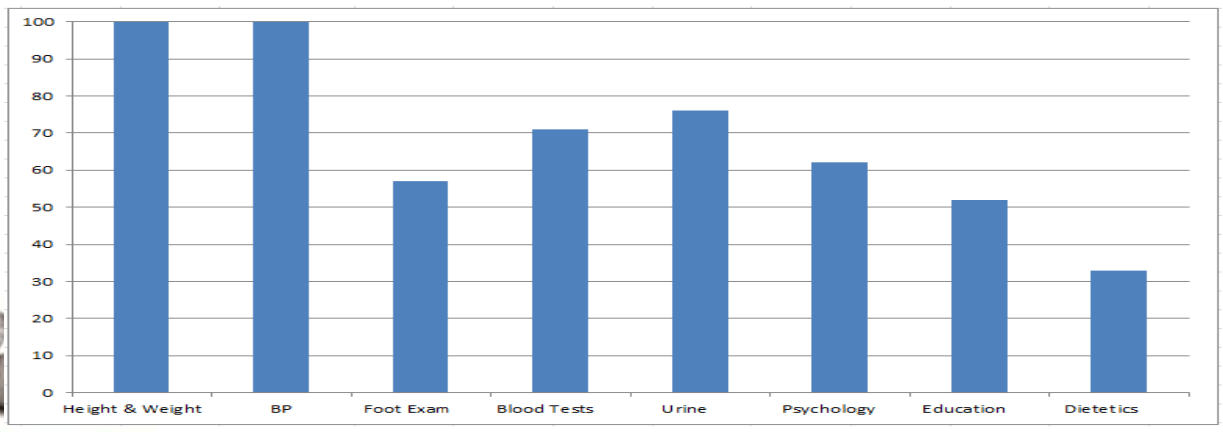
There is opportunity to improve performance further before end of current audit period April/May 2019.

Performance taken from clinic data January 2018 – January 2019:

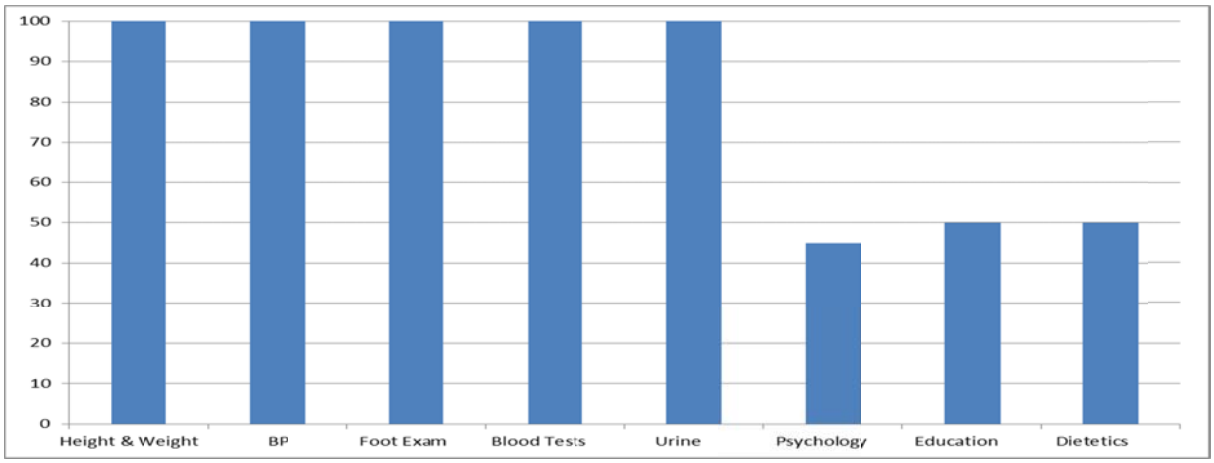
Transition Clinic



Teenage Clinic



Selby Clinic



3.9 Decompensated Cirrhosis care in first 24 hours

This audit was undertaken in 2015. Cirrhosis is known to have high mortality rates in case of decompensation and NCEPOD report in 2013 showed that 53% of patients receive suboptimal care. In response to this, a liver care bundle was designed by physicians under the auspices of BASL to streamline and provide guidance for first 24 hours for optimal management of such patients. This audit aimed to assess if the Trust is following BASL/BSG guidance on decompensated liver disease, at Scarborough Hospital site

Findings

Audit criterion	Result		Aim
	Number	Percentage	
Ascites treatment according to BASL Liver Bundle	5/14	35%	*100%*
Variceal Bleed treatment according to BASL Liver Bundle	2/2	100%	*100%*
Encephalopathy treatment according to BASL Liver Bundle	6/11	54%	*100%*
SBP treatment according to BASL Liver Bundle	0/4	0%	*100%*
AKI treatment according to BASL Liver Bundle	3/3	100%	*100%*
Other Infections treatment according to BASL Liver Bundle	6/6	100%	*100%*

Conclusion

The audit has established that all patients with variceal bleeds are being given antibiotics and terlipressin (all cirrhotic patients with sepsis were covered with antibiotics) and all patients presenting with AKI had their nephrotoxic drugs stopped and fluid resuscitation given as per the BASL/BSG guidance.

However we are not performing satisfactorily against the following BASL/BSG guidance, with:

- 35% patients receiving Ascitic Tap in first 24 hours

- 0% of SBP patients having had HAS 20% on day 1 and day 3
- 27% patients having had Ca/Mg/Po4 investigations
- 54% patients having had Encephalopathy Treatment Prescription
- 68% patients having had VTE prophylaxis if cirrhotic.

Update on progress
A core medical trainee at York, supported by Dr William Lea, is working with the hepatology consultants to undertake a quality improvement project to improve the initial management of decompensated cirrhosis at York Hospital.

The aim of this improvement project is to ensure that 100% of patients admitted with decompensated cirrhosis are managed according to the BASL/BSG care bundle.

Baseline data collection has been completed and demonstrated similar deficiencies in the care of patients with decompensated cirrhosis as to the Scarborough data.
The model for improvement and a plan-do-study-act approach will be taken to achieve the projects aim. Although this project is at an early stage progress, initial findings will be shared in the coming months.

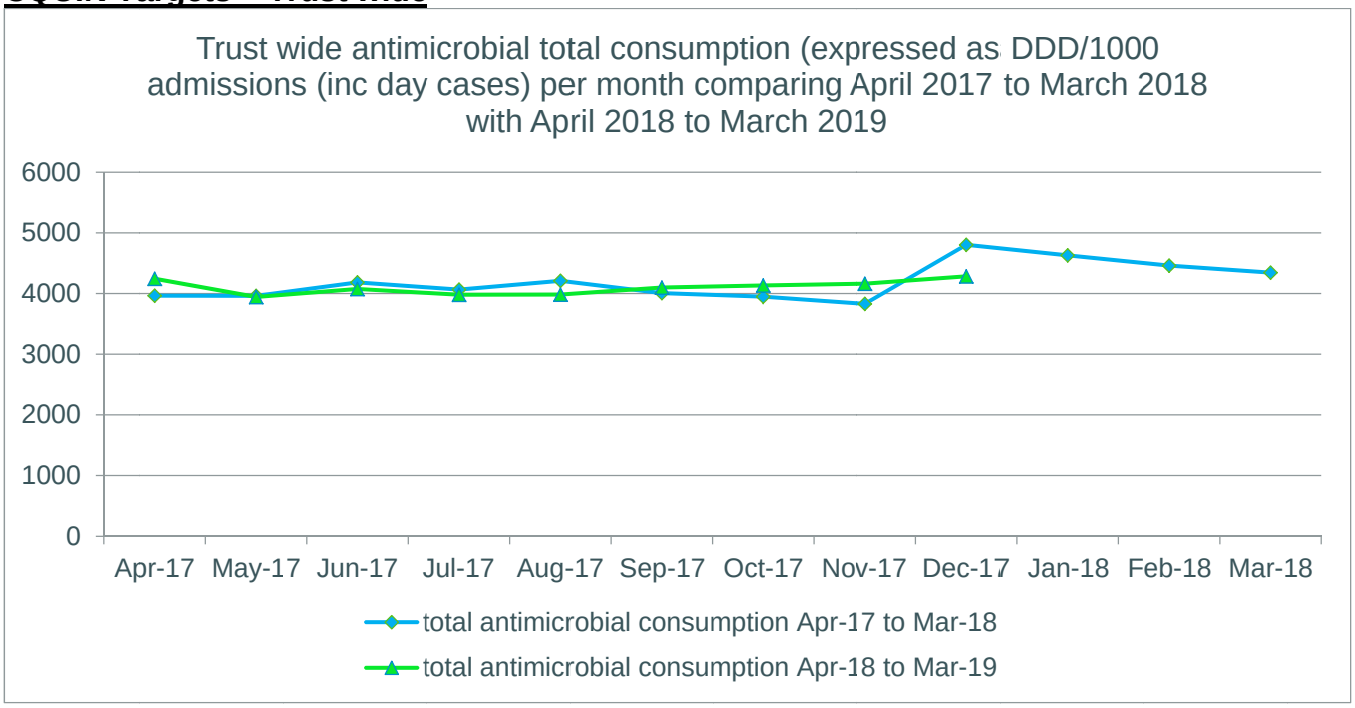
4 Patient Experience

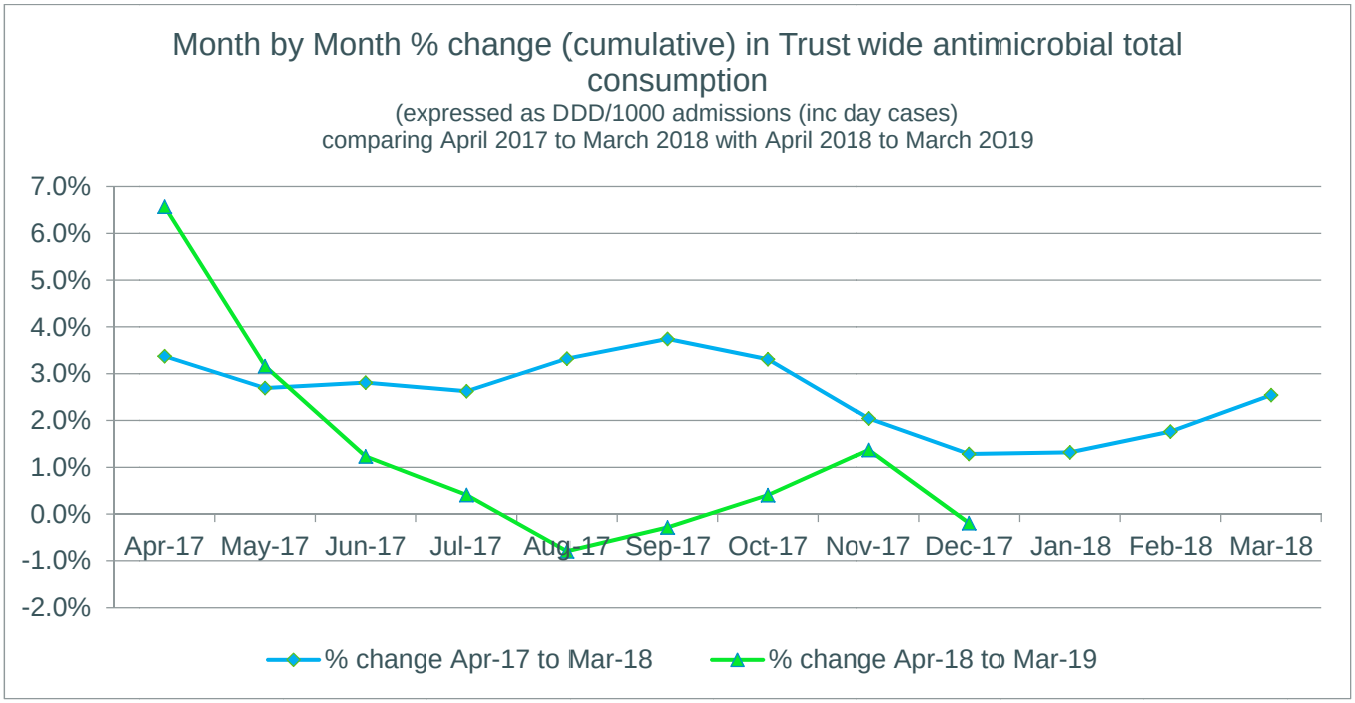
4.1 Antibiotic prescribing audit

This report details a summary antibiotic consumption data for the Trust that was extracted from the Rx Info web site at the beginning of November and reports on antimicrobial usage up to December 2018.

Consumption data % change of cumulative totals 2017/18 vs 2018/19 as detailing results for December 2018.

CQUIN Targets – Trust wide



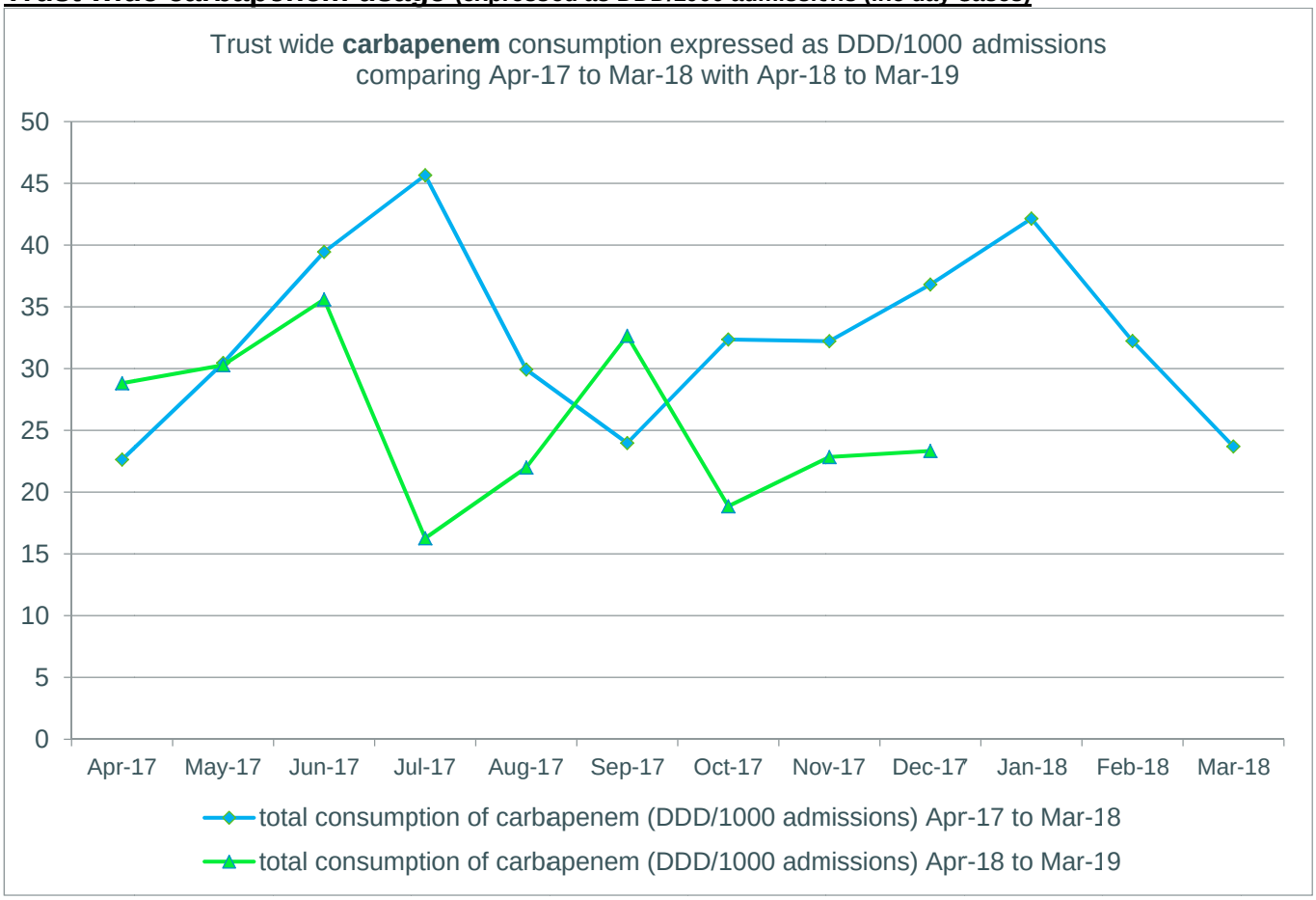


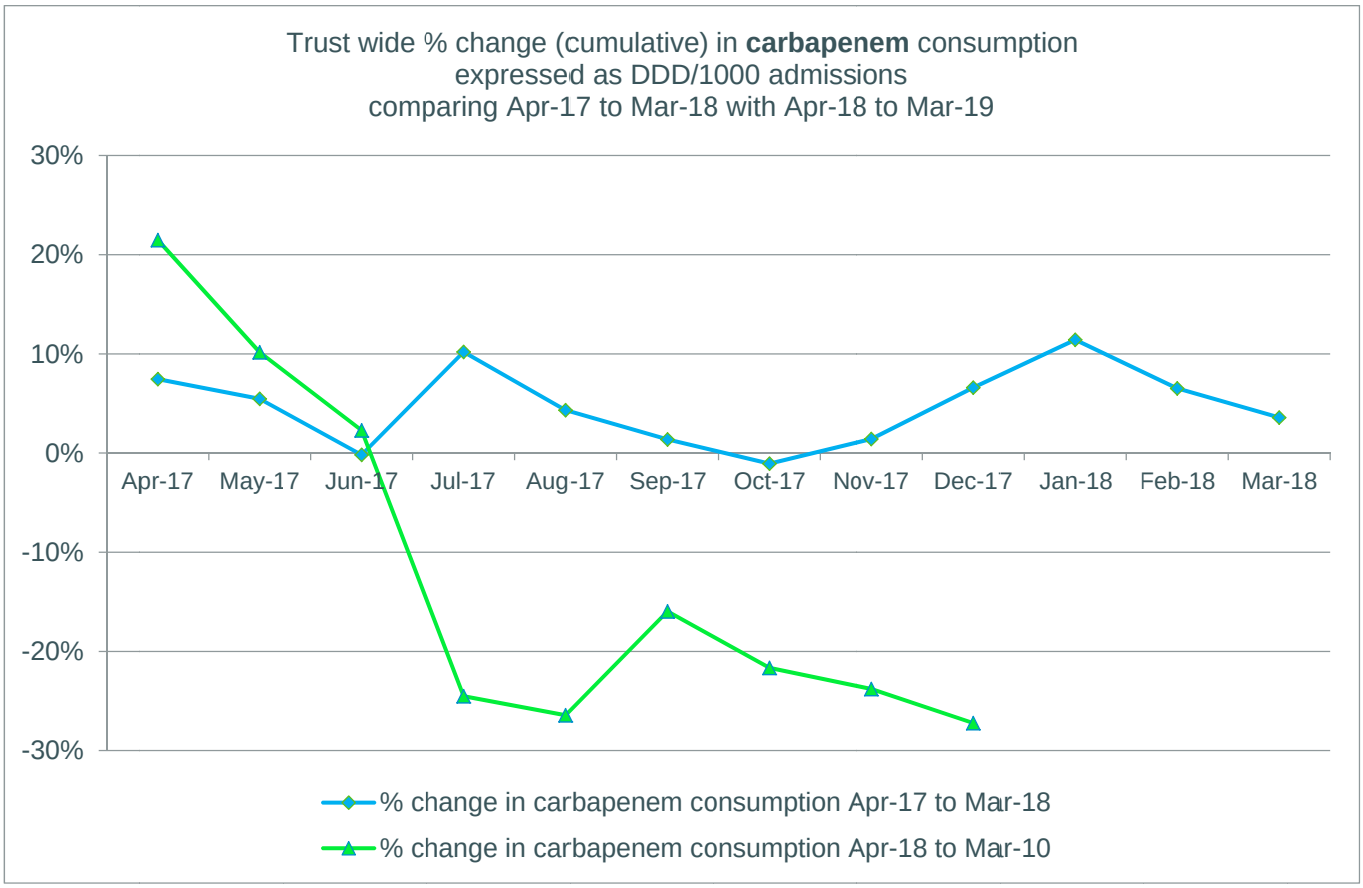
Comments: In the previous reports for this year it was noted that there were improbable fluctuations in the percentage changes of total volume of prescribing given the large numbers involved. As a result the data was re-analyzed and the attached graphs produced. It is noted that the new adult treatment formulary was introduced at the end of June 2018. The ARK study in Medicine in York was also introduced in June. This study provides a tool which gives a degree of certainty in the prescribers mind that they are treating an infection. This facilitates review and possible stopping. The results so far, show an increase from 10% to 20% of antibiotics stopped. This will have contributed to the reduction in prescribing.

Scarborough implemented EPMA during November 2018. The current iteration of EPMA makes it difficult to see at a glance the number of doses of antibiotics a patient has received. However the antimicrobial team are working with the IT team to improve EMPA in relation to antimicrobials, particularly for review.

The first graph shows a more gradual increase in the winter pattern of antimicrobials compared to the previous year. It is worth noting that seasonal flu had already escalated during December 2017, but this has not yet occurred. At the time of writing the seasonal flu activity is much lower than the corresponding period last year. This may, in part, explain the lower relative use for December.

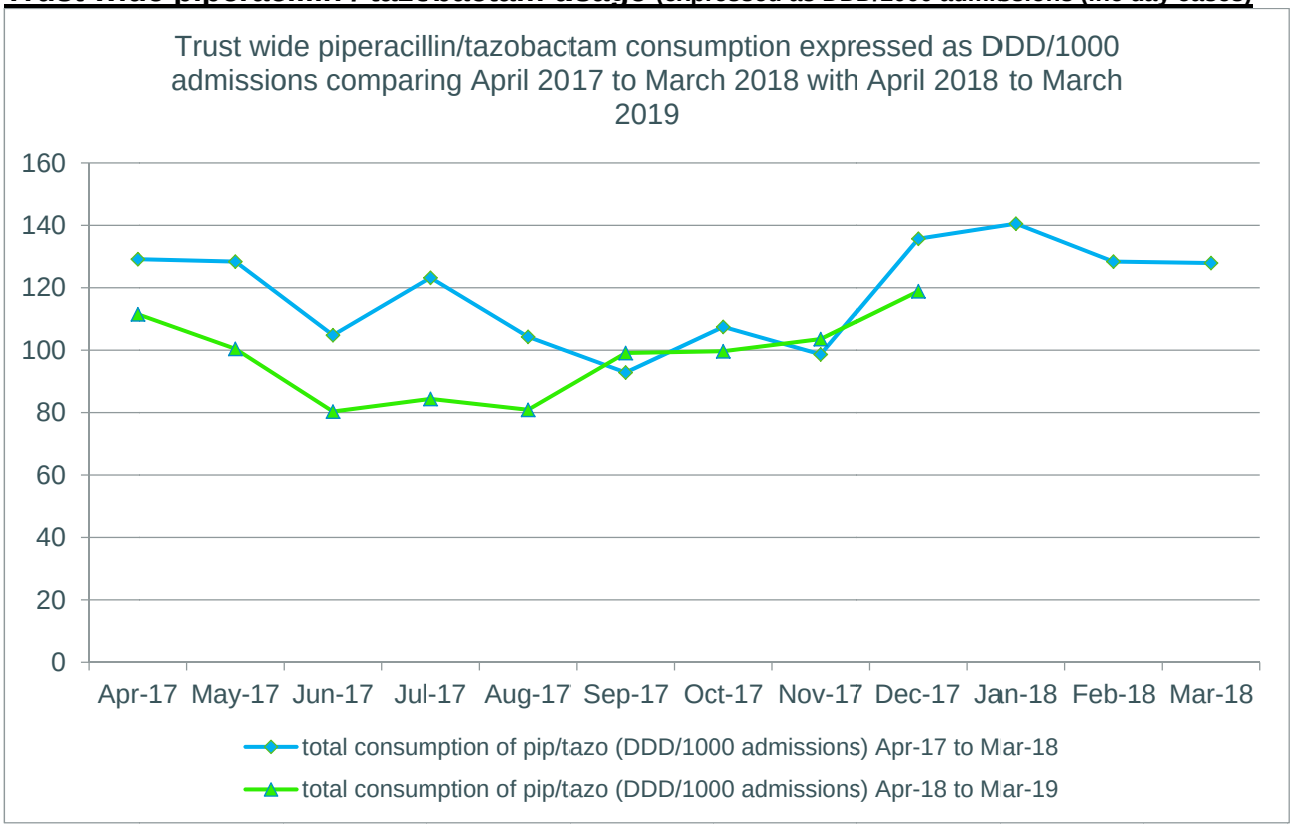
Trust wide carbapenem usage (expressed as DDD/1000 admissions (inc day cases)





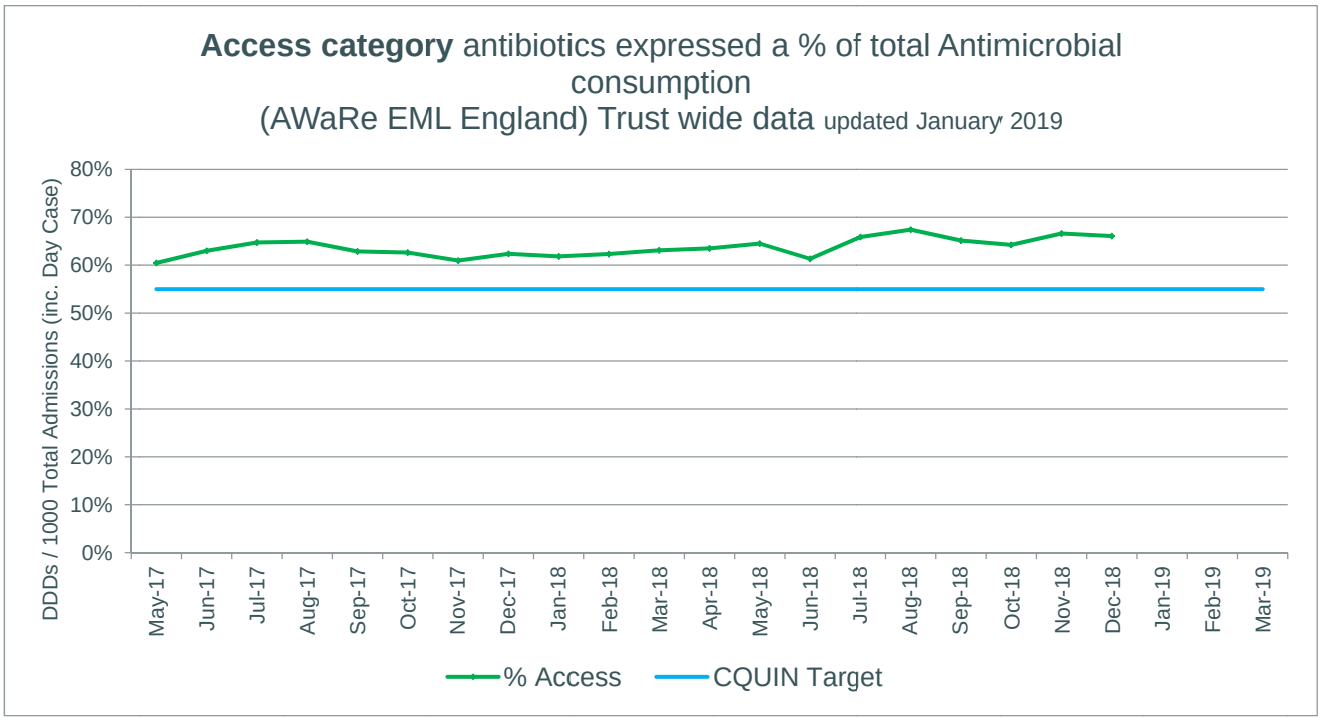
The total volume of carbapenem prescribing is very low in the trust, which means that changes of just one or two patients produce a large percentage change which is reflected here.

Trust wide piperacillin / tazobactam usage (expressed as DDD/1000 admissions (inc day cases)



Although the volume of Pip tazo prescribing is no longer a CQUIN target the antimicrobial team continues to monitor its prescribing as it is a broad spectrum antibiotic likely to promote the antimicrobial resistance. Pip tazo and the carbapenems remain the focus of the antibiotic ward rounds week by week. The volume of pip tazo prescribing remains significantly lower than the previous year.

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



The percentage of the Access category remains well above the target of greater than 55% and has now reached 66%.

Monthly audit
As mentioned previously the monthly audit is being reviewed following the Trust wide implementation of EPMA. Staff shortages have hampered this development and it may take until the March report before there is something suitable in place.

5. Recommendation

The Board of Directors is asked to note the Medical Directors Report for January 2019.

York Teaching Hospital NHS Foundation Trust

Chaperone Policy

This policy and procedures may evoke safeguarding adults concerns and as such please refer to the Safeguarding Adults Policy or contact the Trust Safeguarding Adults Team for guidance.

Author:	Rebecca Hoskins-Deputy Director of Patient Safety
Owner:	Mr. James Taylor Medical Director
Publisher:	Healthcare Governance Directorate
Date of first issue:	July 2008
Version:	5
Date of version issue:	October 2018
Approved by:	Executive Board
Date approved:	
Review date:	
Target audience:	All Clinical Staff
Relevant Regulations and Standards	N/A
Links to Organisational/Service Objectives, business plans or strategies	N/A

Executive Summary
This policy describes in which circumstances a chaperone should be offered, who can provide a chaperone service, the role of the chaperone and the standard of documentary evidence required.

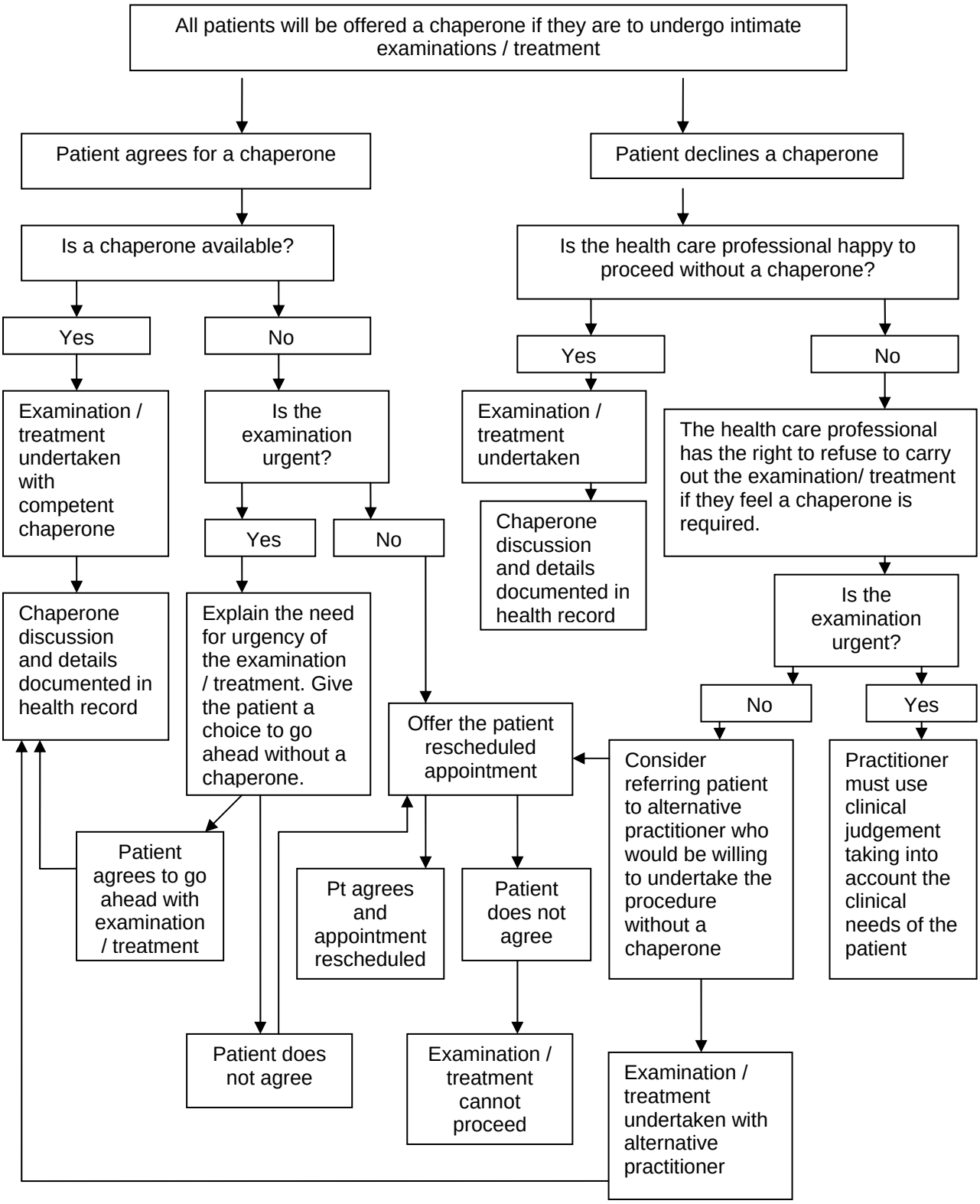
This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.

Version History Log
This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1	July 2008	Michelle Carrington	Horizon – York	New policy
2	January 2011	Becky Hoskins	Horizon – York	New template. Includes additional GMC guidance. Includes processes relevant to Radiology. New format to include policy précis and procedures at front of document.
3	April 2014	Michelle Carrington	Staff Room	New template. Integrated policy. Contains updated GMC guidance, sexualised behaviour, anaesthetised patients and standards for the examination / treatment.
4	September 2016	Helen Noble	Staff Room	Includes updated references and removal of Appendix 4 Virtual Policy Review Group Checklist as per new format.
5	October 2018	Rebecca Hoskins	Staff Room	Inclusion of chaperones in patients' own homes. Includes reference to chaperones for non-intimate examination in clinics.

Content

Process flowchart – Chaperone Policy



1 Introduction & Scope

All clinical consultations, examinations and investigations are potentially distressing. Many patients find examinations, investigations or imaging involving the rectum, genitalia or breasts particularly intrusive (these examinations are collectively referred to as 'intimate examinations'). Consultations involving dimmed lights, the need for patients to undress or for intensive periods of being touched may make a patient feel vulnerable (NHS Clinical Governance Support Team 2005).

The Clifford Ayling Inquiry identified that there is a need for each NHS Trust to develop a Chaperone Policy, to make this explicit to patients and to resource it accordingly. This must include training for the role and the identification of a managerial lead with responsibility for policy implementation (DOH 2004). This is the Medical Director.

General Medical Council (GMC) guidance states a chaperone should be offered when undertaking intimate examinations (GMC 2013). This guidance is mirrored by other professional bodies and recommendations such as the Royal College of Obstetricians and Gynaecologists (2002), the Faculty of Sexual and Reproductive Healthcare (2011), Joint Speciality on Genitourinary Medicine (2003) and the Nursing and Midwifery Council (NMC 2008).

Health Care Professionals are at an increased risk of their actions being misconstrued or misinterpreted if they conduct such examinations where no other person is present. It is vital therefore those discussions regarding chaperone decisions and actions are clearly documented.

This policy applies to all healthcare professionals working within the trust including medical staff, registered nurses, health care assistants (HCAs), image support workers (ISWs) allied health professionals (AHPs), student nurses, medical students and complementary therapists.

The principles of the policy apply irrespective of the gender of patient or Health Care Professional as recommended following the Moyhing case (Employment alert 2006).

Midwifery - In circumstances where male midwives may be conducting intimate examinations a chaperone should be offered and the principles set out in this policy followed. For female midwives it is thought that their practice is widely accepted by the public to be appropriate and acceptable without the *routine* need for a chaperone.

This policy must be read in conjunction with the Consent to Examination and Treatment Policy and also Raising Concerns Policy.

2 Definitions / Terms used in policy

Chaperone – for the purposes of this policy a chaperone is a health care professional working for the trust or students in training under our jurisdiction who fulfil the role outlined in the policy. It does not include family members, carers or friends who may accompany the patient.

Intimate examination refers to examination of the breasts, genitalia or rectum.

Intimate procedure or treatment refers to any procedure carried out by the practitioner on the breasts, genitalia or rectum.

Gillick Competence / **Fraser Guidelines** - Whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required.

The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent (NSPCC 2009).

A child can consent to treatment without parental consent if Gillick competent / meets Fraser Guidelines or has reached the age of sixteen. If a child refuses treatment though deemed Gillick competent / meets Fraser Guidelines a parent can consent to treatment if the child is under 18 years of age.

It is in the best interest of the child and their family that there is consensus of agreement for any interventions.

3 Policy Statement

This policy outlines in which circumstances a chaperone should be offered, who can provide a chaperone service, the role of the chaperone and the standard of documentary evidence required.

When to offer a chaperone:

A chaperone should be offered to all patients undergoing an intimate examination or treatment.

A chaperone should also be considered where a patient may perceive an examination or treatment to be intimate or when the needs of the specific patient require it. Examples of this may be:

- Where the examination includes anatomy in close proximity to intimate areas e.g. abdominal or chest examination.
- Where English is not the patient's first language.

- Patients who have suffered sexual abuse or previous traumatic intimate examination or treatment.
- The Health Care Professional examining entirely alone when the patient is vulnerable e.g. intoxicated or lacks capacity.
- Where cultural or religious differences may mean intentions could be misinterpreted or misunderstood.
- Where the patient may feel uncomfortable or embarrassed to be cared for by a member of the opposite sex.
- Where the patient requests a chaperone.

Anaesthetised patients:
Before an intimate examination or treatment is carried out on an anaesthetised patient consent must be obtained in advance, usually in writing (GMC 2013). In an emergency this may not be possible and a 'best interest' decision must be made.

Examination / treatment without a chaperone:
The patient has a right to decline to have a chaperone present and this must be documented in the patient's health record. This includes children who are Gillick competent / meets Fraser Guidelines. For children who are not Gillick competent / don't meet Fraser Guidelines, intimate examination / treatment must not be undertaken without a chaperone.

The Health Care Professional has the right to refuse to carry out an intimate examination or procedure if they feel they require a chaperone and the patient refuses. This must be documented in the patient's health record. **The Trust strongly supports staff who refuse to carry out an examination or procedure without a chaperone even if this leads to a delay in diagnosis or treatment for the patient.**

An alternative may be to offer to refer the patient to another professional prepared to proceed without a chaperone, although for some specialties Royal College guidance states patients **must not** be examined without a chaperone. The Health Care Professional must use their professional judgement to proceed without a chaperone or not. It may be that the patient's examination or treatment is postponed until the matter can be resolved.

If the patient requests a chaperone but one cannot be provided the patient must be given the opportunity to reschedule their appointment within a reasonable timescale or give the patient the choice to go ahead without a chaperone. This may make the patient feel under pressure to

go ahead with the examination / treatment and this therefore should be avoided where possible.

In an emergency situation it may not be possible to provide a chaperone. Best interest decision making must be applied.

Standards for conducting an intimate examination or treatment:

Patient information for planned intimate examinations / procedures: Where intimate examination / treatment is planned in advance e.g. outpatient or day case departments, patients should be provided with printed information which explains the intimate nature of the procedure, if they are required to undress and if the procedure may be carried out by the member of the opposite sex. It is also good practice to explain if a chaperone is provided routinely to allay any concerns the patient may have. Patients should be given the opportunity to bring a family member, carer, friend (known as an informal chaperone) with them if appropriate to do so. This may not be possible if the examination / treatment is to take place in an operating theatre. The patient should be given the opportunity to contact the department in advance to discuss any concerns and any requests accommodated where reasonably possible in order to maintain the patient's dignity and reduce anxiety.

Before the examination / treatment:

- Assess the patient's capacity and explain why the examination / treatment is necessary and what it entails so they can give fully informed consent where able.
- Record the consent discussion in the health records in line with the Consent to Examination and Treatment Policy.
- If possible use a chaperone the same sex as the patient.
- Where possible allow the chaperone to hear the explanation of the examination / treatment and the consent.
- Facilities should be available for patients to undress in a private undisturbed area. Staff should only help the patient undress if absolutely necessary. There should be no undue delay prior to the examination once the patient is undressed.
- Intimate examinations or treatment must take place in a closed room or, in a ward setting, in screened bays which should not be entered without consent while the procedure is taking place.
- Examination or treatment should not be interrupted by telephone calls or messages unless absolutely necessary.

- Chaperones can be provided for non-intimate examination or treatment if the patient requests this.

During the examination / treatment:

- Ensure patient's privacy and dignity is maintained at all times.
- Position the chaperone where they can see the patient and how the examination / treatment is being conducted.
- For examination / treatment of the vagina or rectum gloves must be worn on both hands by the clinician.
- Stop the examination / treatment if the patient asks you to. For patients who are unable to tell you they wish you to stop you must take action if you believe their behaviour is suggesting they wish you to stop.
- Ensure that you maintain professional boundaries and do not behave in a manner which could be interpreted as 'sexualised' (see next section).

After the examination / treatment:

- Allow the patient time to get redressed in private. Staff should only help the patient redress if absolutely necessary.
- The chaperone can leave the room following the examination / treatment to allow the consultation to continue in private unless it is deemed more appropriate for the chaperone to remain.
- Document any discussion regarding chaperones and the outcome in the health record. Document that a chaperone was used when conducting the examination / treatment using the approved sticker (outpatients) or in the health record. It is important to document the name and job title of the chaperone used. Document if a chaperone was offered but declined in the health record.

Patients in their own homes:

For patients being examined / treated in their own homes requiring intimate care, the patient must be asked as part of the initial care planning if they require a chaperone. If so arrangements must be made for an appropriate chaperone, to attend the patient visit with the Registered Nurse or Health Care Assistant performing the intimate care. If the patient declines a chaperone on initial care planning they must be informed that they have the right to request one at any later stage during their treatment. The outcome of this discussion must be documented in the patients SystmOne record.

Sexualised behaviour and duties to report colleagues:
To maintain the trust of patients and the public, staff must never display sexual behaviour e.g. making inappropriate sexual comments (not necessarily involving touching the patient) or touching the patient in a way that may be interpreted as sexual behaviour (GMC 2013). Staff are required to maintain professional boundaries at all times (GMC 2013 and NMC 2008).

All staff must be able to identify and raise concerns in relation to 'sexualised behaviour' including either excessively familiar behaviour in a clinical setting or the performance of sensitive or intimate examinations in a fashion which is unprofessional or which causes distress either to the examinee or to an impartial observer.

If you observe or a patient tells you about a breach of sexual boundaries, or you have reason to believe that a colleague has, or may have, displayed sexual behaviour towards a patient, you must promptly report your concerns to your line manager and professional lead i.e. Medical Director / Chief Nurse. You should respect patient confidentiality when reporting your concerns but the safety of patients must come first. If you are satisfied that it is necessary to identify the patient you must seek their consent to disclose the information. If consent is refused but you judge disclosure to be in the public interest, you must tell the patient of your intention to disclose. In all cases you should only disclose relevant information.

Who can provide a chaperone service?
A chaperone is a Health Care Professional working for the Trust or students in training under our jurisdiction who fulfil the role outlined in the policy. It does not include family members, carers or friends who may accompany the patient. Family members, carers and friends are 'informal' chaperones who may provide emotional and physical support for patients but who cannot take part in the procedure or witness the procedure directly. If the patient requests an informal chaperone you should comply with a reasonable request to have such a person present *in addition* to the chaperone.

Any Health Care Professional can provide a chaperone service providing they are fully aware of the policy and comply with the principles herein. Students in training can provide a chaperone service for other Health Care Professionals undertaking the intimate examination or treatment but cannot be chaperones for other students.

Role of the chaperone:
The chaperone's role is to ensure that the privacy and dignity of the patient is protected. The chaperone also provides witness to the Health Care Professional undertaking the intimate examination / treatment and may therefore help protect them from allegations of abuse.

The chaperone:

- Should ideally be the same sex as the patient
- Must be familiar with this policy and the expectations of the role.
- Should ideally be familiar with the examination / treatment.
- Must check with the patient that their presence is acceptable and if not an alternative member of staff should be found.
- Must introduce themselves to the patient.
- Must behave in a sensitive and respectful manner.
- Must be able to stay throughout the procedure.
- May be able to assist with the examination / treatment but must be competent to do so.
- Must be able to advocate for the patient by suggesting stopping the examination / treatment if the patient wishes or if they witness behaviour or actions of the Health Care Professional which raises concerns.
- Must be able to raise concerns with their line manager / professional lead if such behaviour or actions are witnessed.

4 Equality Analysis

In the development of this policy the Trust has considered evidence to ensure understanding of the actual / potential effects of our decisions on people covered by the equality duty. A copy of the analysis is attached at Appendix 1.

5 Accountability

Operational implementation, delivery and monitoring of the policy resides with:-

- Clinical Directors, Service Leads, Community Locality Managers and Matrons
- All managers must ensure that their staff (including temporary staff) are made aware of this policy
- All staff must adhere to the contents of this policy.

Appendices

Appendix 1: Equality Analysis

Appendix 2: Checklist for Review and Approval

Appendix 3: Plan for the dissemination of a policy

Appendix 1 Equality Analysis

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy	
1.	**What are the intended outcomes of this work?** To protect patients and staff when undergoing intimate examinations / treatment by provision of a chaperone service.
2.	**Who will be affected?** Staff and patients.
3.	**What evidence have you considered?** Committee of Inquiry – Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling. Department of Health, 2004. Chaperoning: The role of the nurse and the rights of patients. RCN, 2006. The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives. NMC 2018. Intimate examinations and chaperones. General Medical Council Standards Committee 2013. Maintaining a professional boundary between you and your patient. General Medical Council Standards Committee 2013. Sexual behaviour and your duty to report colleagues. General Medical Council Standards Committee 2013. Guidance on the Role and Effective Use of Chaperones in Primary and Community Care settings. Model Chaperone framework. Clinical Governance Support Team 2005. Intimate Examinations in Genitourinary Medicine Clinics. Endorsed by the Royal College of Physicians, London. Karen Rogstad 2003. Employment Appeals Tribunal finds that chaperone arrangements infringe discrimination law. Employment Alert. June 2006. NSPCC (2009) Safeguarding information service. Gynaecological Examinations: Guidelines for Practice. Royal College of Obstetricians and Gynaecologists 2002. Service Standards for Sexual and Reproductive Healthcare. Royal College of Obstetricians and Gynaecologists 2011. Equalities Act 2010
a	**Disability** This policy is inclusive and does not differentiate between people on the basis of this characteristic.

b	**Sex** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
c	**Race** This policy is inclusive and does not differentiate between people on the basis of this characteristic. Interpreters will be organised for patients as appropriate.	
d	**Age** This policy is inclusive and does not differentiate between people on the basis of this characteristic. This policy includes paediatrics.	
e	**Gender Reassignment** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
f	**Sexual Orientation** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
g	**Religion or Belief** This policy is inclusive and does not differentiate between people on the basis of this characteristic. Patients with different religion or beliefs are covered in section 3 'when to offer a chaperone'.	
h	**Pregnancy and Maternity** This policy is inclusive and does not differentiate between people on the basis of this characteristic. This policy covers maternity patients.	
i	**Carers** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
j	**Other Identified Groups** No other groups identified.	
4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	Yes see appendix 2 of the policy
b.	How have you engaged stakeholders in constructing the policy	Circulation of the document with a request for comments.
c.	If so, how have you engaged stakeholders in constructing the policy	As above
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs Please see appendix 2 Key output is a usable policy to provide guidance to staff on chaperones.	

5.	**Consultation Outcome**	
a	Eliminate discrimination, harassment and victimisation	Positive impact i.e. promotes equality, eliminates discrimination.
b	Advance Equality of Opportunity	Neutral no impact i.e. doesn't promote or impact adversely.
c	Promote Good Relations Between Groups	Positive impact i.e. promotes equality, eliminates discrimination.
d	What is the overall impact?	No group is discriminated against
	Name of the Person who carried out this assessment: Rebecca Hoskins, Deputy Director of Patient Safety	
	Date Assessment Completed October 2018	
	Name of responsible Director Mr. James Taylor, Medical Director.	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Apendix 2 Policy Management

1 Consultation, Assurance and Approval Process

1.1 Consultation Process

The Trust will involve stakeholders and service users in the development of its policies.

Consultation has taken place with the following stakeholders:

- Chief Nurse Team
- Executive Board
- Clinical Governance Leads
- Matrons
- Patient Safety Team
- Patient Safety Group
- Healthcare Governance Team
- Medical and Dental Professional Standards Team

1.2 Quality Assurance Process

Following consultation with stakeholders and relevant consultative committees, this policy has been through quality assurance checks prior to being reviewed by the authorising committee to ensure it meets the NHSLA standards for the production of policy and equalities legislation and is compliant with the Development and Management of Policies policy.

1.3 Approval Process

The approval process for this policy complies with that detailed in section 6.3 of the Development and Management of Policies Policy. The approving body for this policy is the Executive Board.

The Checklist for Review and Approval has been completed and is included as Appendix 2 and the completed Virtual Policy Review Group Checklist is included as Appendix 4.

2 Review and Revision Arrangements

On reviewing this policy, all stakeholders identified in section 6.1 will be consulted. The person responsible for review is:

- The Medical Director

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the Executive Board.

3 Dissemination and Implementation

3.1 Dissemination

Once approved, this policy will be brought to the attention of all relevant staff working at and for York Hospital NHS Foundation Trust following the completed Plan for dissemination of the policy (See Appendix 3)

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

3.2 Implementation of Policies

This policy will be implemented throughout the Trust by all Trust staff.

Compliance with this policy will be monitored from:

- Adverse incident reports
- Complaints
- Audit of compliance with documentation.

4 Document Control including Archiving Arrangements

4.1 Register/Library of Policies

This policy will be stored on Staffroom, in the policies and procedures section and will be stored both in an alphabetical list as well as being accessible through the portal's search facility and by group. The register of policies will be maintained by the Healthcare Governance Directorate.

If members of staff want to print off a copy of a policy they should always do this using the version obtainable from Staffroom but must be aware that these are only valid on the day of printing and they must refer to the intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet based system.

4.2 Archiving Arrangements

On review of this policy, archived copies of previous versions will be automatically held on the version history section of each policy document on Q-Pulse. The Healthcare Governance Directorate will retain archived copies of previous versions made available to them. Policy Authors are requested to ensure that the Policy Manager has copies of all previous versions of the document.

It is the responsibility of the Healthcare Governance Directorate to ensure that version history is maintained on Staffroom and Q-Pulse.

4.3 Process for Retrieving Archived Policies

To retrieve a former version of this policy from Q-Pulse, the Healthcare Governance Directorate should be contacted.

5 Standards/Key Performance Indicators

None applicable

6 Training

There is no formal training associated with this policy. All managers should ensure that their staff are aware of this policy and the requirement for them to adhere to this.

Managers are responsible for arranging appropriate training for staff as required.

7 Trust Associated Documentation

- Consent to Examination and Treatment Policy
- Raising Concerns Policy

8 External References

DH, Committee of Inquiry – Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling. Department of Health, 2004.

NHS Clinical Governance Support Team – Guidance on the Role and Effective Use if Chaperones in Primary and Community Care Settings. Model Chaperone Framework. Department of Health, 2005.

RCN - Chaperoning: The role of the nurse and the rights of patients. Royal College of Nursing, 2006.

NMC - The Code: Professional standards of Practice and behaviour for Nurses and Midwives. Nursing and Midwifery Council, 2015.

GMC - Intimate examinations and chaperones. General Medical Council Standards Committee, 2013.

GMC - Maintaining a professional boundary between you and your patient. General Medical Council Standards Committee, 2013.

GMC - Sexual behaviour and your duty to report colleagues. General Medical Council Standards Committee, 2013.

RCP - Intimate Examinations in Genitourinary Medicine Clinics. Endorsed by the Royal College of Physicians, London. Karen Rogstad 2003.

Employment Appeals Tribunal finds that chaperone arrangements infringe discrimination law. Employment Alert. June 2006.

NSPCC - Safeguarding information service. National Society for the Protection of Children, 2016.

RCOG - Gynaecological Examinations: Guidelines for Practice. Royal College of Obstetricians and Gynaecologists, 2016.

RCOG - Service Standards for Sexual and Reproductive Healthcare. Royal College of Obstetricians and Gynaecologists, 2013.

9 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

APPENDIX A

9.1 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and to ensure that the minimum requirements of the NHSLA Risk Management Standards for Acute Trusts are met, the policy will be monitored as follows:-

Minimum requirement to be monitored	**Process for monitoring**	**Responsible Individual/ committee/ group**	**Frequency of monitoring**	**Responsible individual/ committee/ group for review of results**	**Responsible individual/ committee/ group for developing an action plan**	**Responsible individual/ committee/ group for monitoring of action plan**
a. A chaperone is offered for all intimate examinations / treatments	Audit of documentation in health records. Adverse incidents and complaints.	Healthcare Governance Team	Annual	Executive Board	Medical Director	Executive Board
b. Document any discussion regarding chaperones and the outcome in the health record.	Audit of documentation in health records. Adverse incidents and complaints.	Healthcare Governance Team	Annual	Executive Board	Medical Director	Executive Board
c. Chaperones must be familiar with this policy and the expectations of the role.	Staff questionnaire / interviews	Healthcare Governance Team	Annual	Executive Board Executive Nurse Forum	Medical Director Executive Nurse Forum	Executive Board Executive Nurse Forum

Appendix 3 Plan for the dissemination of a policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	**Chaperone Policy**
Date finalised:	**October 2018**
Previous document in use?	**Yes**
Dissemination lead	**Helen Noble, Head of Patient Safety**
Which Strategy does it relate to?	**N/A**
If yes, in what format and where?	**N/A**
Proposed action to retrieve out of date copies of the document:	**Healthcare Governance Directorate will hold archive**

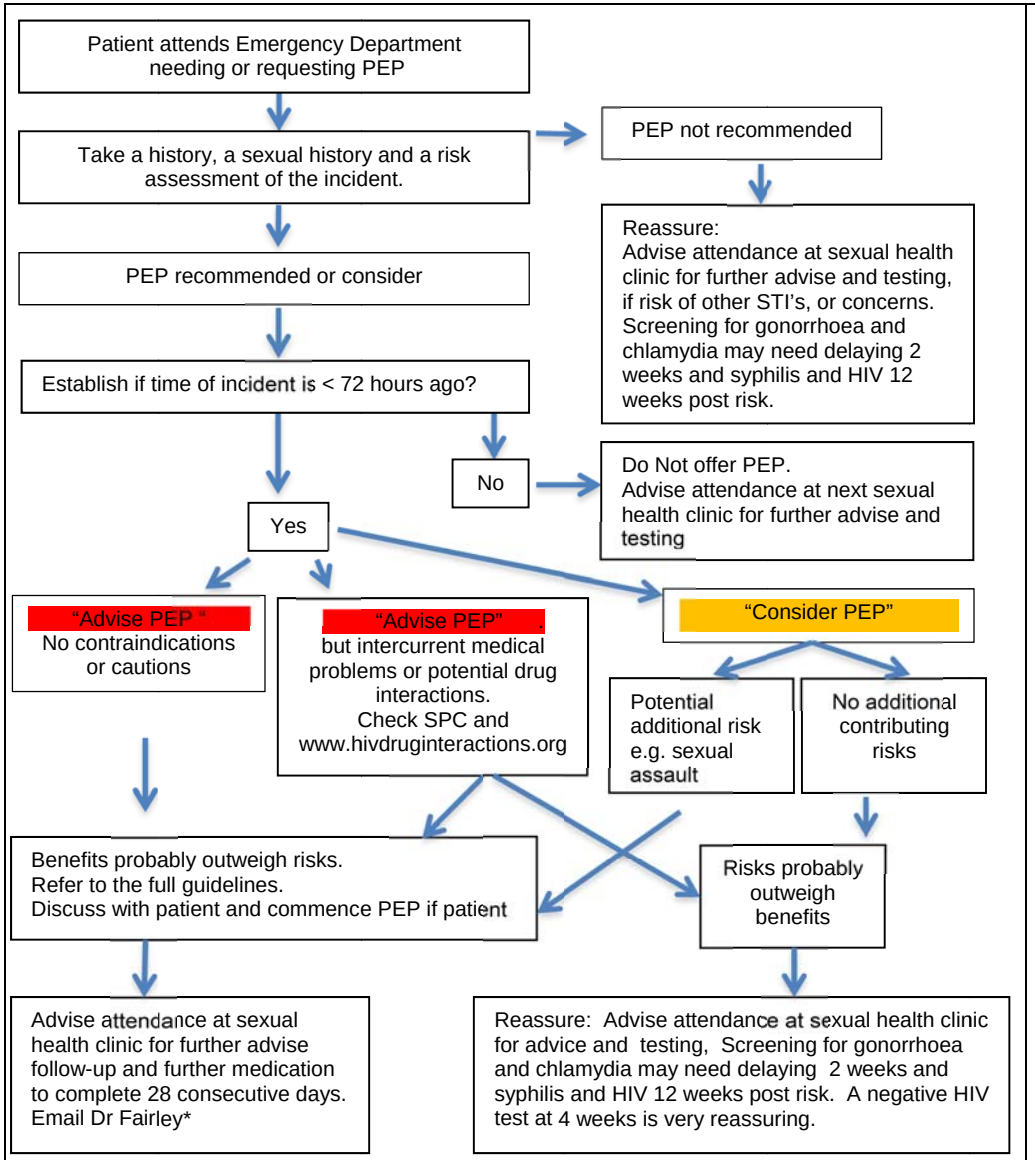
To be disseminated to:	**1) Executive Board**	**2) Senior Managers, Directorate Managers, Matrons and Heads of Department**
Method of dissemination	**Via Staff Brief. Staff Room**	
who will do it?	**Helen Noble, Head of Patient Safety**	
	On approval	
Format (i.e. paper or electronic)	**Electronic**	

Dissemination Record

Date put on register / library	
Review date	
Disseminated to	
Format (i.e. paper or electronic)	
Date Disseminated	
No. of Copies Sent	
Contact Details / Comments	

APPENDIX B

Post Exposure Prophylaxis for HIV in the Emergency Department



	Known HIV positive		HIV status not known	
Exposure Risk	HIV positive Viral load unknown	HIV positive Viral low undetectable	High risk group e.g. high risk country, A man who has had sex with men (MSM)	Low risk group
Receptive anal sex	ADVISE PEP	Do Not give PEP	ADVISE PEP	Do Not give PEP
Insertive anal sex	ADVISE PEP	Do Not give PEP	Consider PEP	Do Not give PEP
Needle Sharing IVDU	ADVISE PEP	Do Not give PEP	Consider PEP	Do Not give PEP
Receptive vaginal sex	ADVISE PEP	Do Not give PEP	Consider PEP	Do Not give PEP
Insertive vaginal sex	Consider PEP	Do Not give PEP	Consider PEP	Do Not give PEP
Oral sex	Do Not give PEP	Do Not give PEP	Do Not give PEP	Do Not give PEP
Splash to eye	Do Not give PEP	Do Not give PEP	Do Not give PEP	Do Not give PEP
Discarded Needle injury	Do Not give PEP	Do Not give PEP	Do Not give PEP	Do Not give PEP

Source individual known to be HIV-positive
PEP for receptive anal sex with a HIV-positive partner with an Undetectable plasma HIV VL (confirmed VL<200 copies/ml sustained for >6 months and high adherence to ART) is not-recommended. The dates and results of the source's last viral load tests should be confirmed with their clinic for a minimum of the last 6 months and recorded in the PEP assessment. If there is any doubt about the source's viral load or adherence to ART then PEPSE should be given as a precaution following unprotected anal intercourse.

Needlestick injury in the community
In general, PEP is not recommended following a community needlestick exposure as it is usually not possible to determine: (i) whether the needle has been used and for what purpose; (ii) the HIV status of the source and; (iii) the interval between the needle use and the exposure. Once blood has dried, HIV becomes non-viable within a couple of hours. In studies where only small amounts of blood are in the syringe viable HIV cannot be detected after 24 hours.

Oral sex
PEPSE is 'not-recommended' for oral sex even following fellatio with ejaculation as the risk is <1/10,000.

Sexual assault
It is believed that transmission of HIV is likely to be increased as a result of any trauma following aggravated sexual intercourse (anal or vaginal). Clinicians may therefore consider recommending PEPSE more readily in such situations, particularly if the assailant is from a high prevalence group.
It is likely that the uptake will be lower in UK settings if the assailant is from a low prevalence group after the balance of risks and benefits are discussed with the patient.

Commercial sex workers
Historically in Western Europe, HIV prevalence among female sex workers has remained low <1% and does not greatly alter the decision not to give PEP. Prevalence of HIV is also low in Central Europe (1% - 2%) but is higher in Eastern Europe ranging between 2.5% and 8%.

Pregnancy
Pregnancy is not a contraindication to receiving PEP

York and North Yorkshire sexual health clinics: for walk in clinic times see www.yorsexualhealth.org.uk or contact 01904 721111 for times, appointments or advise.
*Please send an email to Dr Ian Fairley advising him that PEP has been commenced: ian.fairley@york.nhs.uk

York Teaching Hospital
NHS Foundation Trust

Learning from Deaths Policy

Author:	Peter Wanklyn, Helen Noble
Owner:	Medical Director
Publisher:	Medical Governance
Version:	1
Date of version issue:	September 2018
Approved by:	Executive Board
Date approved:	September 2018
Review date:	September 2020
Target audience:	All clinical staff
Relevant Regulations and Standards	National Quality Board guidance
Links to Organisational/Service Objectives, business plans or strategies	

Executive Summary
This policy describes the process by which the Trust learns from mortality reviews and how the Board will be informed of the learning.

This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.

Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1	September 2017	Peter Wanklyn, Helen Noble	Staff Room	
2	October 2018	Peter Wanklyn, Helen Noble	Staff Room	Clarity about: reporting arrangements for MSG, what constitutes severe mental health issue, role of directorates, and relationship to SIs. Updated letter to next of kin.

Contents

1. Introduction

Mortality data from each NHS Trust is freely available in the public domain, and comparisons in rates between Trusts are made and used as part of the overall assessment of the quality of care provided. The Keogh review (2013) examined the quality of care and treatment provided by 14 NHS Trusts that had shown persistently high mortality rates over the previous two years, and as a result of the findings the 14 Trusts were put into “special measures” by Monitor.

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). In February 2017, the CQC set out new requirements for the investigation of deaths for all Trusts to run alongside the local existing processes. This was followed by the publication by the National Quality Board in March 2017 providing further guidance for Trusts entitled ‘A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care’. This policy relates to all patients aged 18 or more who die in hospital.

The Trust has investigated deaths since 2013 through the use of a structured proforma, in addition to the formal investigation of deaths reported through the incident management process.

Investigations of all maternal, still birth and neonatal deaths have been carried out for a significantly longer period.

2. Purpose

The purpose of this policy is to describe the process by which we learn from mortality reviews and how we will keep the Board informed of the learning. This will enable us to identify areas for improvements in patient care and experience. It will also allow us to take action to reduce the mortality rate at the Trust and, where death is inevitable, to ensure the highest possible quality of care is delivered.

The policy will ensure that there is a consistent and coordinated approach to undertaking mortality reviews, and reporting on findings, with implementation of identified actions. It will also clarify how the process for mortality review dovetails with other investigation processes within the Trust. This will facilitate a streamlined and coordinated interface with serious incident (SI), complaint, inquest and legal claims investigations, where applicable.

Completion of timely and proportionate mortality reviews will also enable the Trust to identify recurring and emerging issues and to be able to respond quickly to any questions raised by external organisations, e.g. CCG, CQC, in relation to mortality trends.

3. Definitions

The definitions or explanation of terms relating to this document are:

SHMI Summary Hospital-level Mortality Indicator is published quarterly by the Department of Health. It is calculated in a similar way to HSMR, but includes deaths in all clinical classifications, and also deaths occurring up to 30 days after discharge.

4. Duties (Roles and Responsibilities)

Duties within the Organisation

The Board of Directors will keep the learning from death process under constant review. It will receive reports relating to mortality review findings, and request additional reviews and actions as a result.

The Medical Director has executive responsibility for the mortality review process and implementation of improvements. Operational responsibility for the mortality review programme, including reporting its findings and ensuring Directorates implement improvements, is delegated to the Clinical Lead.

The Clinical Lead for Learning from deaths will chair the Mortality Steering Group (MSG) and be responsible for ratifying the minutes. They will also ensure that SJCR training is offered. They will offer support to Clinical Directors (CDs) and Clinical Governance (CG) leads in individual cases as required. Finally they will assist completion of the quarterly Mortality dashboard and Board report by ratifying the contents.

The nominated Non-Executive Director has responsibility for scrutinising the Trust's process for learning from deaths in hospital and gaining assurance that themes are detected and lessons learnt to prevent recurrence.

The Coding Team will ensure that the patient's care is coded as soon as possible, ideally within seven working days of the patient's death. The notes will then be returned to the responsible Consultant without delay.

Systems and Networks will review local data sources and national benchmarking tools, i.e. SHMI provided by the Healthcare Evaluation Data (HED), and additional information provided by NHS Digital for early warning signs. Any areas of concern will be flagged to the Clinical Lead who will initiate a coordinated and proportionate investigation.

Bereavement staff will provide information (including the booklet which explains the mortality review process) and support. They will also determine whether the bereaved have any concerns about the care delivered. If so, they will escalate it to their manager who will decide if an SJCR is required and contact the patient safety team. They will keep a record of the key family member who is coordinating the arrangements following the death with whom it would be most appropriate to communicate.

Individual Consultants responsible for care will complete the initial mortality review within a week of receiving the notes. They will indicate if there were significant problems in care using the overall care score and indicate whether a structured judgement casenote review (SJCR) is required. If necessary, they will meet the bereaved to explain the investigation report and what action will be taken to reduce recurrence risk.

Clinical Governance (CG) leads will all receive training in the SJCR methodology and ensure an adequate number of colleagues in their specialty have also done so. They play a central role in coordinating the process and ensuring that learning and action from adverse events is completed. They will evaluate the initial reviews and commission an appropriate level of investigation and inform the Patient Safety team. They will ensure that support is provided to colleagues in communicating the report to the bereaved if that is required. This will involve ensuring that a summary of the

Structured Judgment Case Review (SJCR) is sent to the family, if they wish to receive it, and arranging meetings with them as required. They will work with the CD to decide on an individual case by case basis which members of staff should attend a meeting. This may include themselves, the treating Consultant, SJCR reviewer, CD and matron depending on the issues which are raised. They will ensure all SJCRs are discussed in the directorate governance meeting and the action plan is agreed and implemented. They will also produce a quarterly report of the SJCRs which have occurred in their directorate and what action has ensued. This report will be sent promptly to the Patient Safety Team.

Mortality Reviewers will complete and return SJCRs within 2 weeks using the National Mortality Case Record review (NMCRR) data capture form. They will also produce an interim suggested action plan based on the themes identified. Reviewers must flag any difficulties in undertaking reviews to the Patient Safety Team. If the bereaved wish to receive further information, the reviewer will produce a summary of the SJCR findings. They may need to attend a meeting with the family if necessary to explain their findings.

Directorate managers/Clinical Directors will provide support to colleagues if poor care is identified. They will help coordinate meetings with the bereaved in some cases. They will also analyse and help address any recurrent poor care themes within the directorate.

The Patient Safety Team will coordinate the mortality review process, maintaining an up-to-date spreadsheet of reviewers and cases, and ensure that cases are allocated appropriately. They will ensure the GP has been informed of the SJCR outcome in cases with poor overall care or avoidable death. They will obtain quarterly reports from all Clinical Governance Leads which include action plans for improving care where required. This will be incorporated into the quarterly Board report for the quality account.

The Mortality Steering Group will review and analyse the results of mortality reviews with poor overall care, ratify the quarterly report of findings for the Board of Directors, review all cases of possible avoidable death obtained from SI investigations, SJCRs, complaints, inquest reports and medico-legal claims. The MSG will also be responsible for the development of the Learning from Deaths (LfD) programme and quality assuring that actions are undertaken. The Group report to the Patient Safety Group who will receive all the minutes.

The Medical Examiner (ME) role will be developed and put in place soon (as early as April 2019). MEs will scrutinise all deaths as soon as possible, and usually within 24 hours of the event. They will replace the initial reviewer and recommend cases for SJCR. This will allow the first part of the process to be completed in a more timely and consistent manner.

5. Process for conducting mortality reviews

5.1 Reviews of individual patients

Learning from individual deaths will be performed using an initial screening review proforma followed, in some cases, by a more detailed retrospective structured judgement case note review (SJCR). Some deaths will automatically trigger a SJCR independent of the initial review.

A standard operating procedure has been developed to ensure standardisation of the process (appendix 1).

5.1.1 Initial screening review

All deaths in hospital will be reviewed by the responsible Consultant using a screening mortality review proforma. The aim of this screening review is to establish whether the care delivered was timely and according to current best practice.

The initial reviewer will be required to provide an overall score for the quality of the care provided on a scale of 1 to 5 as below (Royal College of Physicians 2016)

1 Very poor care
2 Poor care
3 Adequate care
4 Good care
5 Excellent care

The reviewers will be asked whether any harm occurred from omissions or actions in care delivered which impacted on the patient's death for example a patient fall or medication error with harm. If harm is observed from the review this should be reported, if not done already, on Datix. In addition, the Consultant should consider whether there was any evidence of a need to report the case as a possible SI at this point. If an SI is declared, then no SJCR will be required as well, but a copy of the SI report will be obtained and scrutinised by the MSG to determine if the death was avoidable. The SI will utilise the rigorous SJCR methodology for the casenote review component of the investigation.

If any SJCR is felt to be needed, the CG lead will ensure that it is commissioned and the next of kin have been informed it is taking place by sending the letter in appendix 6. The letter should be sent to the individual who has been noted by the bereavement team to be the contact point.

5.1.2 Action following screening

The process following the initial screening review is managed according to the overall quality of care score as outlined in the flowchart in Appendix 2.

Cases where the care was felt to be adequate, good or excellent and when no healthcare related harm was identified, will result in no additional investigation unless raised through the mandatory review triggers, request from an external agency or the complaints process.

Cases where harm was noted relating to care or the overall care was assessed as poor or very poor will be subject to a SJCR. This will be commissioned by the directorate governance lead who will inform the patient safety team and family/carers.

5.1.3 Structured judgement reviews

The SJCR will be performed by a clinician specifically trained in the methodology using the Royal College of Physicians programme. Cases will be identified from initial screening but the following categories of case are mandated to receive a SJCR (although this list is not exhaustive, see flowchart appendix 2)

- Deaths where families have raised a significant concern about the quality of care provision
- All deaths of patients with Learning Disabilities (in conjunction with the LeDeR process), or significant mental health conditions. The latter await definition nationally but until then, we shall examine all those under Section of the Mental Health Act or who have been transferred from an inpatient psychiatric unit.
- Deaths following elective procedures

Consideration will also be given to the following deaths:

- SHMI alerts or condition specific outliers
- Random samples of specific groups or conditions
- Cases where death was not expected
- Deaths where the learning will inform improvement work
- Incidents with harm
- Cases going to coroner's inquest
- Claims
- Child, still born and perinatal and maternal deaths (in conjunction with the existing review processes)

In cases flagged for a mandatory SJCR, the Patient Safety Team will directly either allocate the case to a reviewer who is independent from the direct care of the patient or ask the CG lead to do so. SJCRs should be completed within two weeks of allocation. They will also inform the Consultant involved and the CG lead who will then send a letter to the key family contact identified by the bereavement office staff. The senior nursing team, PALS and risk and legal teams also need to be informed when a review is commissioned.

All completed SJCRs will be returned to the Patient Safety Team for thematic analysis and will be recorded on a database.

Cases given an overall care score of 1 - 2 with harm caused will be reported on Datix and referred to the weekly serious incident (SI) panel to agree the level of further investigation. This will usually be either to refer for investigation, root cause analysis and action planning by the directorate or to investigate as an SI. (see escalation flowchart – appendix 2).

Cases given an overall care score of 3 or more but with a care score in any phase of 1 or 2 and harm caused will be reported on Datix and returned for

action by the directorate through the CG lead (see escalation flowchart – appendix 2).

Any case investigated by one Directorate which finds potential concerns with care in another Directorate will pass on the draft report for comment before ratification. There should be a rapid response and completion of a final report.

Any cases with all care scores of 3 or more will not require further action by the MSG but will be returned for discussion by the directorate through the CG lead. In cases leading to Inquest or following a complaint, the next of kin will be receiving information from other Trust sources than just the SJCR report. It is crucial that these reports are consistent. For this reason, the risk and legal department and patient experience team respectively must be made aware that the SJCR is ongoing and receive a copy of the report. This should be incorporated into the response to the Coroner or complainant.

5.2 Family and carer involvement

The central role of bereaved families and carers has been further clarified recently by the National Quality Board (July 2018) a "Guidance for NHS Trusts on working with bereaved families and carers" Family and carers will be informed about the Trust process for Learning from death in the Bereavement information booklet. Bereavement office staff will enquire if the bereaved have any concerns about the care provided and escalate to their manager as required. If a SJCR is commissioned, they will be informed and invited to be involved with the review and offered a summary of the report (appendix 6)**.** They must be treated with respect, sensitivity and compassion and should be treated as partners in an investigation, if they so wish, as they can offer a unique and equally valid source of information.

All deaths reported as serious incidents will be communicated to the bereaved family or carer as part of the duty of candour requirements and they will have the opportunity to have their concerns investigated. Further details are covered in the Being open with patients policy.

Bereaved family and carers who choose to make formal complaints will have their concerns investigated and this will include a mortality review. This is included in the concerns and complaints policy and procedure available on the intranet.

The bereaved family and carers will be asked if they wish to receive a summary of the SJCR report and whether they would like to meet with relevant staff to discuss the findings. If an SJCR has detected significant poor care and/or harm the report will be sent to the risk and legal department before sharing externally.

5.3 Reviews of clusters of cases as a result of alerts / horizon-scanning

5.3.1 Identification of cases

Systems and Networks with Patient Safety Team will monitor for early indications that mortality is rising in a specific clinical classification area.

Findings will be discussed at the MSG to determine appropriate action. This may include commissioning a review of a small sample of SJCR's on these clinical cases. This process will involve the directorate (where relevant) from the outset.

5.3.2 Scope of review

The informatics team will notify the Medical Director via the MSG with relevant information regarding alerts. The MSG will agree the level of review, terms of reference, sample size and time frames.

5.4 External Mortality Reviews

5.4.1 Child deaths

Deaths of all children from birth to 18 years in the area are notified to the Safeguarding Children Boards Joint Child Death Overview Panel (JCDOP) including children in our care. Whilst all deaths are notified to the JCDOP and a core data set collected, not all deaths will be reviewed in detail. Particular consideration shall be given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention. The team will determine and review on a regular basis which deaths are to be reviewed in an in-depth manner using the SJCR methodology or as a SI.

5.4.2 Maternal deaths

All maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports will be presented to the MSG.

(Further information can be found in the Maternal Death Guidelines.

5.4.3 Still born and Perinatal deaths

All still born and perinatal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. Each case is subjected to a 1st and 2 level review process using the NPSA review proforma. Quarterly reports will be presented to the MSG.

(Further information can be found in the Care of women and families experiencing the death of a baby).

5.4.4 Learning Disabilities Mortality Review Programme (LeDer)

The LeDeR Programme is run by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to make improvements in the quality of health and social care for people with learning disabilities, and to reduce premature deaths in this population. LeDeR will support local areas in England to review the deaths of people with learning disabilities aged 4 – 75 at the time of their death. All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process will

run alongside our internal mortality reviews and will not replace out internal process. See appendix 3 for LeDeR reporting process.

6. Reporting of findings

6.1 Datix reporting

If the SJCR gives an overall care score of 1-2 with harm caused it will be reported on Datix and escalated to the Serious Incident Panel to determine the level of further investigation.

In addition, any mortality case review where an incident resulting in harm has been identified should be reported on Datix.

All other cases will be reviewed and actioned by the directorate through the CG lead.

6.2 Learning from Death Reports

6.2.1 The Patient Safety Team, with the Clinical Lead, will produce a quarterly report of trust-wide mortality review findings which will be presented to the Board. These reports will include;

- The total number of deaths and the number of mortality reviews performed
- How many deaths were judged to have overall poor care
- Themes and trends arising from the reviewed cases
- A summary of the key findings of cases with either poor or very poor care
- Any learning points, recommendations and actions
- Assurance that action plans and the Duty of Candour process have been completed

The report is to be presented to the Mortality Steering Group (MSG), Directorate Governance Meetings, and the findings escalated to the Patient Safety Group and Quality and Safety Committee as appropriate.

6.2.2 Findings of “cluster reviews” will be presented to the MSG, and shared with the relevant directorate who will be responsible for delivering an appropriate action plan. The MSG will continue to monitor mortality within that speciality/condition to ensure improvement is seen.

6.3 Action planning and learning

Each Directorate is primarily responsible for action plans from SJCRs.

The MSG will review all SJCRs with an overall care score of <3 and approve any recommendations identified in the quarterly report, and any action plan including timescales and action owners.

The Patient Safety Team will ensure the action plan is circulated to the action owners, and will monitor progress and completion, which will be included in the ensuing reports.

Opportunities for learning will be delivered through newsletters, clinical governance meetings and patient safety events.

6.4 Real time data

A folder has been developed on the Trust Q drive called “SJCR in depth reviews”. There are sections for investigation tools, completed reports, reviewers training and a database of ongoing reviews.

7. Training and Implementation

Training for initial screening Reviewers: all Consultants have been offered training in the SJCR methodology. In addition a brief summary sheet has been developed and circulated to guide assessing care standards and scoring for those who have not been able to attend. Short sessions in Clinical governance meetings have been provided. Staff who are experiencing difficulties eg in forming conclusions from their reviews, may seek advice and support from a reviewer colleague, or from the Clinical Lead. A Q drive folder has been created which includes all training tools, a list of trained reviewers and documents on good quality reviews with hints and tips. We have also listed all SJCRs ongoing and completed with minutes of the MSG and each quarterly mortality dashboard.

Training for Structured judgement reviews: this training will be provided by staff who have already received training from the Improvement Academy in the RCP programme. New staff will be offered training periodically now that the main training programme has been completed.

Implementation: Upon ratification, this document will be available to all staff via the Guidelines page on the Trust’s Intranet. The ratification of the document will also be communicated to staff via Directorate communication routes.

8. Trust Equalities Statement

This policy has been through the Trust’s EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

9. Monitoring Compliance

Compliance with this process will be evaluated from the quarterly mortality reports, which will include a section on process and performance, as well as findings.

10. Associated Documents

This document should be read in conjunction with the Serious incidents (SI’s) policy and procedure.

11. References

This document was drafted with reference to the following documentation:

CQC (2016) *Learning, candour and accountability: A review of the way NHS Trusts review and investigate deaths of patients in England* http://www.cqc.org.uk/content/learning-candour-and-accountability

Hogan et al (2012) *Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.* BMJ Quality & Safety 22 (2): 182

Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf*

NHS England (2017) *National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

Royal College of Physicians (2016) *National Mortality Case Record Review Programme. Using the structured judgement review method. A guide for reviewers (England)*

https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

Parliamentary and Health service Ombudsman (2016) *Learning from mistakes* https://www.ombudsman.org.uk/sites/default/files/page/Learning%20from%20mistakes%20-20An%20investigation%20report%20by%20PHSO.pdf

NHS England (2018). *Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers.* https://www.england.nhs.uk/ourwork/part-rel/ngb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/

Appendix 1: SOP for mortality reviews

Purpose

The purpose of this SOP is to define the two stage process by which mortality reviews are completed. This is part of the Trust's 'Learning from Deaths' policy. This SOP applies to mortality reviews in all specialties:

Agreed Procedure

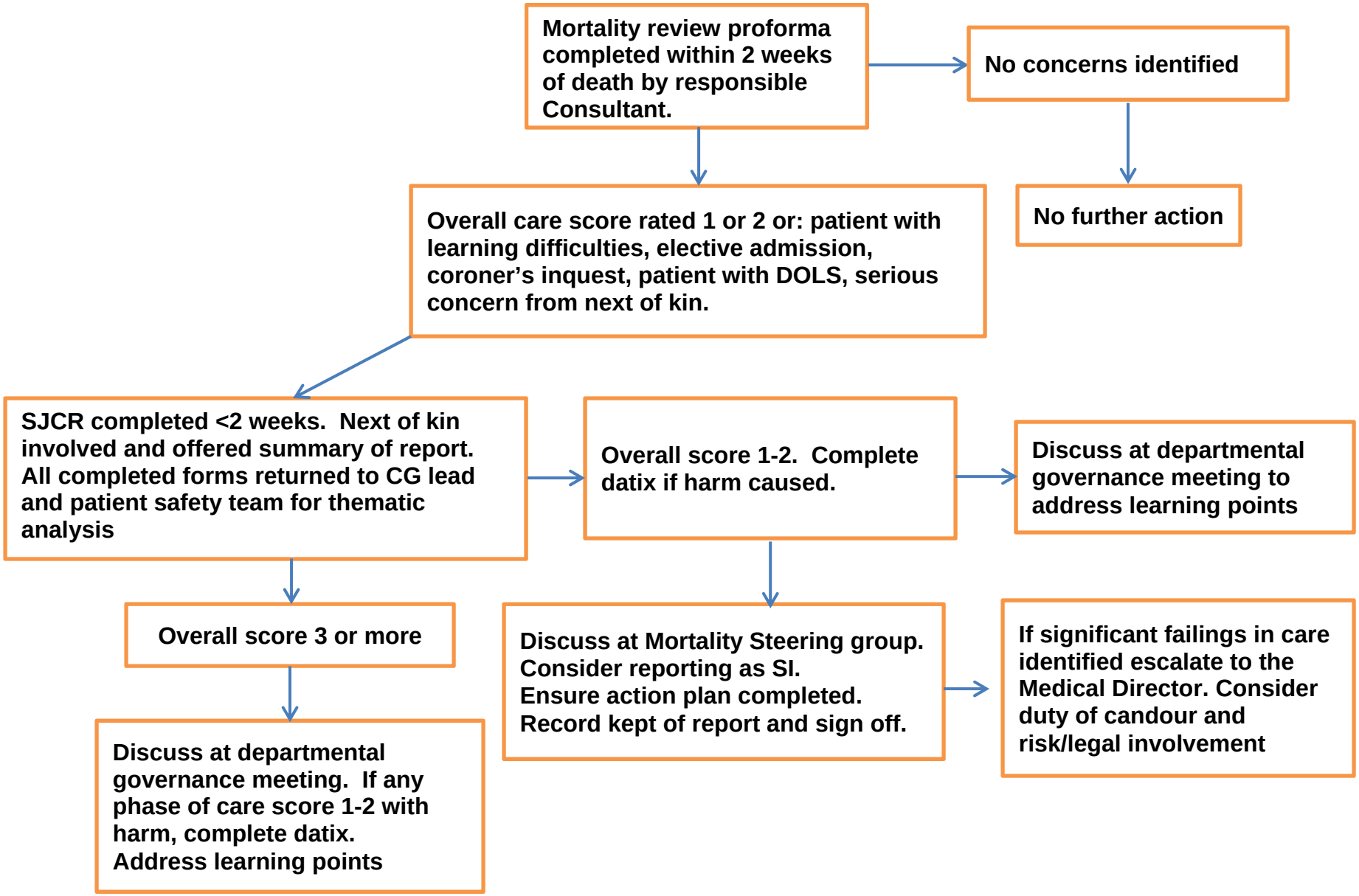
- All patients who die in hospital will have an initial screening review performed by the responsible Consultant. This should include the Emergency Departments on both sites. This will no longer be necessary once the Medical Examiner service is in place.
- Deaths which occur on ICU will have an initial review by the responsible Consultant (physician or surgeon) and an ICU consultant. This is because both are involved in delivering care so both perspectives need to be considered.
- It is expected that the initial reviews will be completed within two weeks of the patient's death using the Trust proforma.
- Any reviews with an overall care rating of either 1 or 2 will trigger a second level review called a structured judgement casenote review or SJCR.
- The responsible Consultant should also note the cases triggering a mandatory SJCR and indicate this on the form which is returned to the directorate governance lead.
- Once a case is identified for a SJCR the Patient Safety team will be informed by the directorate governance lead who will commission the report. The CG lead will send a letter to the key family member or carer identified by the bereavement staff explaining the process and that an investigation is ongoing (appendix 6).
- PALS and the risk and legal team will be informed when an SJCR is commissioned.
- The Patient Safety team may also identify mandatory cases for SJCR from other information sources e.g. concerns expressed to bereavement office staff, and the responsible consultant and directorate governance lead will be informed in these cases. The CG lead should once again ensure that the key family member/carer receives information about the process and their right to be involved if they wish using the standard letter. Support is available from the Learning from deaths Clinical Lead, Dr P. Wanklyn, or Helen Noble, Head of Patient Safety.
- SJCRs must be undertaken by a clinician trained in the methodology and be independent of the responsible consultant. The reviewer will usually be from the same specialty but this is <u>not</u> essential.
- SJCRs should be completed within 2 weeks of allocation using the NMCRR data capture form and sent to the CG lead and patient safety team for collation and thematic analysis.

- The bereaved will receive a summary of the SJCR report if they wish, which will be written by the reviewer. This will be clearly explained and avoid jargon. The overall context and implications of any poor care will be explained and the actions planned to reduce recurrence should be outlined. If the care was judged as poor the summary should be sent to the risk and legal department for comment before it is shared.

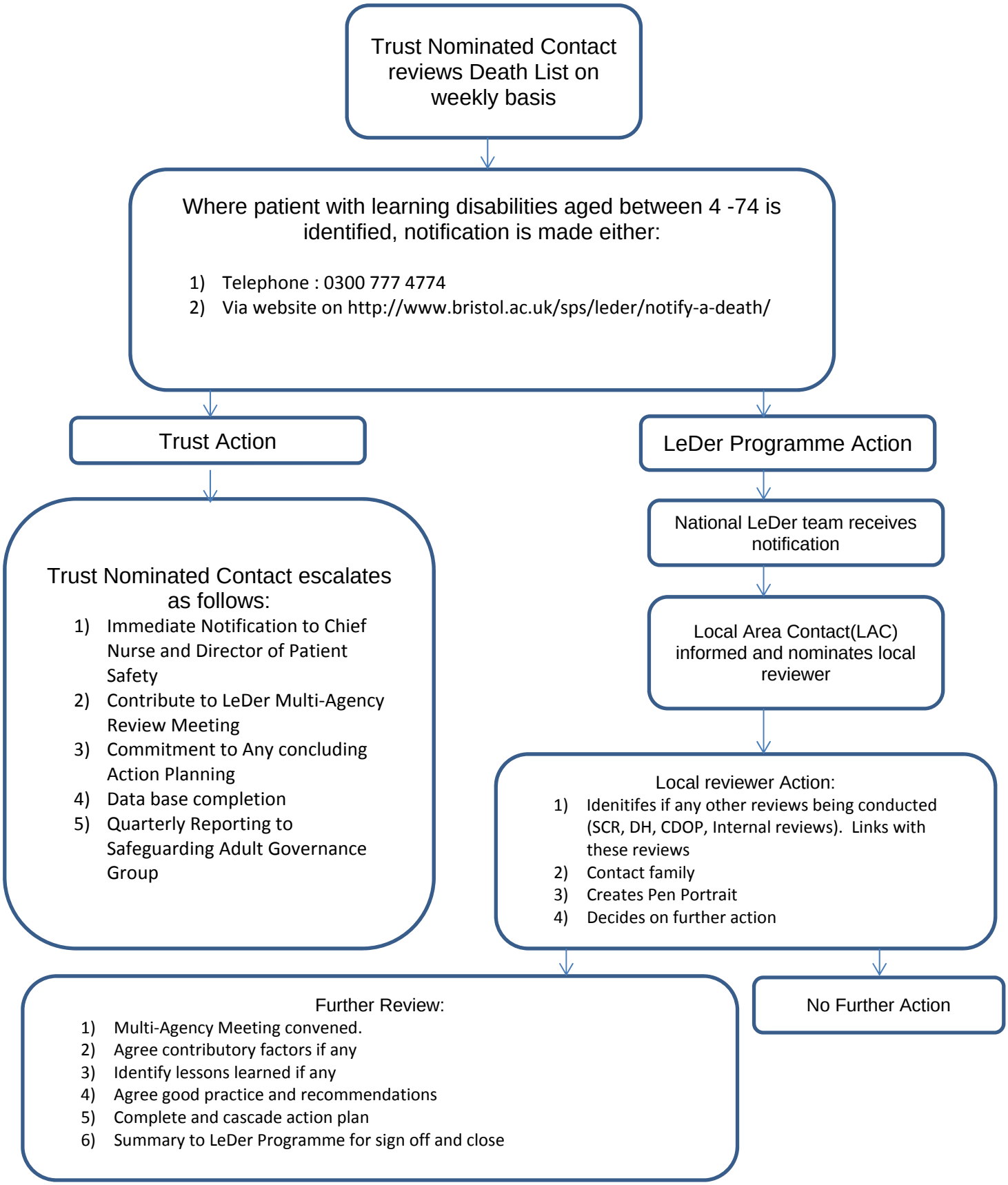
- Any SJCR with an overall score of 1 or 2 will be discussed at the MSG. If harm was caused by identified poor care a datix will be completed. In this situation, the case will be reported as a possible SI. If serious failings are identified, the Medical Director will be made aware at that point.
- Any review with an overall care score of 3 or more will be discussed at the directorate governance meeting to scrutinise any themes of good or poor care and produce an action plan. If any single phase of care scored 1 or 2 and harm occurred, a datix will be completed.
- Deaths which occur in the Emergency Department will be investigated using the same methodology.
- In cases where an SI is declared, an SJCR is not required and the investigation will follow the Trust's policy. The clinical review will utilise the SJCR methodology so all SI investigators need training in this process. In cases where the investigator has yet to complete the training, the mortality clinical lead will perform the SJCR component of the investigation.
- Each directorate governance lead will submit the cumulative findings from reviews in that specialty to the MSG every three months. This should include progress on any specific actions or learning from reviews. This will be integrated into the Trust quarterly mortality dashboard.

Appendix 2: Mortality Review Process

York Teaching Hospital NHS
NHS Foundation Trust



Appendix 3: LeDer Programme



Appendix 4: Care Review – Bereavement Information

The Trust has a fundamental obligation to be open and honest in the event of an incident where patient harm has occurred. **ALL** moderate and severe harms must be handled and reported under Being Open, the pivotal feature of which is early acknowledgement, explanation and apology.
All NHS Trusts are required to review the care of people who have died in hospital. The reason for this is to ensure we learn more about the circumstances and manner of the death. We want learn from any good practice or to identify and improve upon any examples of poor care.

Please do let the Bereavement team know if you have any concerns about any aspects of care during the last hospital admission.

The Consultant looking after your relative /friend will examine the care records and judge whether anything could have been done more effectively. On the rare occasions this is so, another independent Consultant will perform a detailed review of the medical notes and decide if care was adequate or not. They will make recommendations on how to avoid it happening again. We shall inform you if this is going ahead and will ask you to comment on the draft report if you wish.

There are some patient groups whose death has to be investigated in detail by an independent Consultant. These groups are: young children, pregnant women, those with learning difficulties, those whose family have serious concern about the care provided, and those who deteriorated unexpectedly or in some cases where an inquest is held.

In the large majority of cases, care is very good and no concerns are raised.

If there are concerns raised, we shall contact you to give you a named contact and contact number. If good practice standards were not met we shall offer to discuss this with you and explain what we shall do about the problem.

We apologise if this causes distress but we believe in continuous improvement and being open as an organisation.

Appendix 5: Mortality Steering Group Terms of Reference

York Teaching Hospital NHS
NHS Foundation Trust

Mortality Steering Group
Terms of Reference
1. Membership
Medical Director- Chair Consultant Physician /Lead for Mortality– Vice Chair Head of Patient Safety Anaesthetist Acute Physician Doctor- Care of the Elderly Doctor- General Surgery Junior Doctor representation Lead for Critical Outreach Information Department Representation On the occasions when a member is unable to attend it is important that a deputy is nominated to attend who will form part of the quoracy. The Deputy Medical Director and Consultant Physician /Lead for Mortality will share the Chair and Vice Chair of the group.
2. Quoracy
The group will be quorate with four members of the group in attendance plus the Chair, if the Chair is unable to attend the meeting the Deputy Chair or Vice Chair will deputise on behalf of the Chair. The group must include the following members (one nurse, two doctors and a member of the Patient Safety team).
3.Purpose of the Committee-Operational functions:
• To work towards the elimination of all avoidable in-hospital harm and mortality. • To review on a monthly basis, the benchmarked mortality rates of the Trust. • To facilitate and consider mortality data in conjunction with clinical data and identify areas for future investigations. • To investigate any alerts received or identified e.g. CQC, SHMI. • To assign clinical leads to address raised mortality in particular clinical areas with the implementation of strong evidence based interventions such as care bundles. • To work with each junior doctor intake to ensure the latest guidelines on care protocol implementation and clinical coding best practice. • To review and monitor compliance with other Hospital policies including

DNACPR/ Ceiling of care/ End of life care and Death Certification.

- To monitor and consider the information from review of all in hospital deaths.
- To review information available to identify all avoidable deaths which occur in the Trust. This can only occur when the committee is quorate.

4.Strategic Functions:

- To act as the strategic hospital mortality overview group with senior leadership and support to ensure the reduction of all avoidable deaths.
- To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training etc. This will be reviewed on an annual basis by the Medical Director.
- Sign off action plans and methodologies that are designed to reduce morbidity and mortality across the Trust.
- Sign off all regulatory mortality responses.
- To report to the Patient Safety Group
- To report on Mortality performance to the Board.

5. Meeting arrangements

The Mortality Steering Group will meet every other month and all supporting papers will be circulated 7 days in advance of the meeting.
The Chair of the Mortality Steering Group has the right to convene additional meetings should the need arise and in the event of a request being received from at least 2 members of the Group.
Where members of the Mortality Steering Group are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the Medical Director and provide a deputy in order that the meeting of the Group can be quorate.

6.Review and monitoring

The Head of Patient Safety will maintain a register of attendance at the meeting. Attendance of less than 50% will be considered inadequate and escalated to the Medical Director, who will decide what action may be taken. The attendance record will be reported as part of the annual report to the Patient Safety Group. The Terms of Reference will be reviewed every 2 years.

Author	**Helen Noble – Head of Patient Safety**
Owner	**Jim Taylor – Medical Director**
Date of issue	**September 2018**
Version	**V2**
Approved by	**Mortality Steering Group**

Appendix 6: Form letter for Bereaved Families | Structured Judgement Casenote Reviews

York Teaching Hospital
NHS Foundation Trust

The York Hospital
Wigginton Road
York
YO31 8HE
01904 631313

[Date]

Dear [name]

First, we would like to offer our sincerest condolences following the death of Mrs/Mr x. We realise that this must be a very difficult and emotional period for you and your family, and we are sorry to be contacting you at this time.

We are writing to explain the process we follow if someone dies while in our care. As a Trust we must abide by national rules and examine the medical case-notes following a person's death to see if any part of their care could have been done differently.

Some cases are looked at in more depth if the consultant in charge feels it is needed. Other cases must be reviewed for instance, if there were learning difficulties, severe mental health problems, there has been a complaint about care or if admission to hospital was for non-emergency treatment.

In this case we feel that a more detailed review is needed and we shall ask an independent senior doctor, who has not been involved in the care, to examine the case notes and give their opinion.

They will look for evidence of good care and where it could have been better. After the review process is finished we will share the outcome with you if you wish. We have a so called "duty of candour", which means if we identify mistakes these will be shared with you.

We will also share with you what we believe went well and we would welcome your comments on this too. The case investigation process should help us to find out what went well, in addition to detecting areas for improvement. This way we can learn and improve and this is the purpose of the process.

If you wish to be involved with this review before it is completed please contact us. You can do this via the Patient Safety Team who coordinates this work by phoning 01904 723221. Their hours of office opening are Monday to Friday 8.00am-4.00pm.

After a loved one has died it is natural to feel lost and bewildered. Our Bereavement teams have experience in supporting people and helping to guide them through this time. If you feel that you may require help, support is available from the Bereavement Office at York Hospital (tel: 01904 725445) or at Scarborough Hospital (tel: 01723 385178). They are available between 08.30am-4.30pm Monday to Friday. Our PALS staff are also available for advice and support. They can be contacted on on 01904 726262, Monday to Friday 8.30am-4.30pm.

Yours sincerely

Dr [name]
Clinical Governance Lead
York Teaching Hospital NHS Foundation Trust

Dr Peter Wanklyn
Consultant Physician
York Teaching Hospital NHS Foundation Trust

Helen Noble
Head of Patient Safety
York Teaching Hospital NHS Foundation Trust

Appendix 7: Policy Management

1 Consultation Process

Consultation has taken place with both the Mortality Steering Group and the Patient Safety Committee.

2 Quality Assurance Process

The author has consulted with the following to ensure that the document is robust and accurate:-

- Clinical Director Paediatrics
- Clinical Director Obstetrics
- LeDeR/Safeguarding Lead

The policy has also been proof read and the review checklist completed by the Policy Manager prior to being submitted for approval.

3 Approval Process

The approval process for this policy complies with that detailed in the Policy Guidance.

4 Review and Revision Arrangements

The authors will be responsible for review of this policy in line with the timeline detailed on the cover sheet.

Subsequent reviews of this policy will continue to require the approval of the Executive Board.

5 Dissemination and Implementation

Dissemination and implementation will comply with the process detailed in the Policy Guidance document.

6 Register/Library of Policies/Archiving Arrangements/ Retrieval of Archived Policies

Please refer to the Policy Development Guideline for detail.

7 Standards/Key Performance Indicators

- National Quality Board Guidance

8 Training

See Section 7 of this Policy.

9 Trust Associated Documentation

- Serious Incident Policy & Procedure

10 External References

See Section 11 of this Policy.

APPENDIX C

11 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and ensure effective review, the policy will be monitored as follows:-

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. Process & performance	Quarterly Monitoring reports	Mortality Steering Group, Patient Safety Committee	Quarterly	Mortality Steering Group, Patient Safety Committee	Mortality Steering Group, Patient Safety Committee	Mortality Steering Group, Patient Safety Committee

Appendix 8: Dissemination and Implementation Plan

Title of document:	Learning from Deaths
Date finalised:	September 2018
Previous document in use?	Yes
Dissemination lead	Patient Safety
Implementation lead	Patient Safety
Which Strategy does it relate to?	

Dissemination Plan	
Method(s) of dissemination	Staff Room
Who will do this	Policy Manager
Date of dissemination	September 2018
Format (i.e. paper or electronic)	Electronic
Implementation Plan	
Name of individual with responsibility for operational implementation, monitoring etc	Patient Safety Lead
Brief description of evidence to be collated to demonstrate compliance	Internal Trust re-audit to take place in early 2019

York Teaching Hospital NHS Foundation Trust

Clinical Effectiveness Group Meeting Minutes

Tuesday, 06 November 2018, 15.00
Neurosciences Seminar Room, York
VC from Orchard Room, Scarborough

Attendance: Fiona Jamieson (FJ), Glenn Miller (GM), Claire Scotter (CS), Emma George (EG), Anne Hallam (AH), Jane Crewe (JC), Sara Collier-Heald (SC), Lorraine Clennett (LC), Sue Urwin (SU), Gemma Williams (GW), Nicola Topping (NT), Donald Richardson (DR) and Sheila Vass (SV)

Apologies: Greg Quinn and Vicky Robins

PART ONE

Minutes of meeting held on 02 October 2018
The minutes from the meeting held on 02 October 2018 were reviewed and agreed by the Group.

Matters Arising
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 explained that the action should be for Becky to speak with the Patient Safety audit team.

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

Two TAs are currently pending (within 90 days of publication) that require ratification by the CCG Board:

- 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

Action Log
The Group agreed for 13 completed actions to be removed from the Action Log and the outstanding actions where reviewed:

Action 1 *(Oct-17) Clinical Audit C3124 Catheter Associated Urinary Tract Infection Surveillance*

EG confirmed the Catheter Passport is under review and requires an IPC Lead to move forward, which we are in the process of recruiting to.

Further Action: EG to speak to Katrina Blackmore and/or Damian Mawer for guidance to progress the roll-out of the Catheter Passport.

Action 4 *(Jan-18) Clinical Audit C3140 BriefCASE to review together with the Patient Safety Team audit results*

GM updated that Becky Hoskins was discussing with the Patient Safety audit team and Internal Audit the required re-design of this audit.

Further Action: Clinical Effectiveness Team (CET) to follow-up with Becky Hoskins for progress update on where they are with re-designing their audit and the evidence required.

Action 10 *(Apr-18) NCEPOD NIV 'Inspiring Change'*

EG confirmed the ICU Team provides NIV cover out of hours.

Action agreed as complete.

Action 26 *(May-18) National Prostate Audit update*

GM confirmed that patients diagnosed with prostate cancer are mostly referred to Hull; hence the Trust data for this national audit was submitted and reported as part of the Hull & East Yorkshire Hospitals MDT network.

Action agreed as complete.

Action 36 *(Jun-18) Clinical Audit B5029-1 Fall Prevention and Management in Community Hospitals (Re-audit)*

To date we have not received any responses from Becky Hardy to our follow-up attempts to obtain a progress update for this audit.

Further Action: CET to send a CEG Letter to Becky Hardy asking to provide an update on the re-audit results.

Action 39 *(Jun-18) Clinical Audit 2778-3 Sharps Audit*

CS informed the Group that we do not capture the same information for needle stick incidents on Datix hence comparison will not be possible. FJ advised that the action should be for contact to be made with Colin Weatherill as the information required is the comparison between the numbers of sharps incidents reported on Datix compared to the number of attendances at Occupation Health for sharps injuries.

Further Action: CET to contact Colin Wetherill to ask for a copy of his report which provides this comparison.

Action 52 *(Jul-18) NCEPOD Chronic Neurodisability: Each and Every Need (2018)*
SV had met with Dr Highet and assisted in completing the Trust Self-assessment Checklist and appropriate action plan. Dr Highet will take the completed checklist for discussion and approval at their directorate meeting.
Further Action: SV to follow-up and take the completed Trust Self-assessment Checklist to the next CEG meeting.

Action 53 *(Jul-18) Mental Health in General Hospitals: Treat as One (2017).*
The Trust Self-assessment Checklist was returned to Dr Martin for further information relating to action plan and timescales.
Further Action: SV to follow-up and take the completed Trust Self-assessment Checklist to the next CEG meeting.

Action 61 *(Oct-18) NICE NG65 Spondyloarthritis in over 16s: diagnosis and management*
Awaiting response from Dr Ferguson.
Further Action: CET to take the updated Baseline Assessment to the next CEG meeting.

NICE Report

CS presented the NICE Report.

There have been 1,043 NICE guidance published in total, of which **448** are relevant to the Trust.

To date we have **252** NICE guidance with which the Trust is confirmed as being compliant; **4** with which the Trust is not compliant; **128** which are assessed as being partial with action plan and **46** which have been agreed by the Clinical Effectiveness Group as being partial compliant but no action required.

There are currently **18** Baseline Assessments being undertaken in the Trust; **9** which are less than 3 months from publication and **9** with more than 3 months since publication.

The Group expressed their thanks for the work undertaken by the CET for having made significant improvements on the number of outstanding Baseline Assessments, enabling a greater level of assurance regarding the compliance status for the Trust against published NICE guidance.

NICE Baseline Assessments
The following NICE Baseline Assessments were reviewed by the Group:

Compliant with Evidence

NG104 *Pancreatitis (September 2018)*
QS24 *Nutrition support in adults (November 2012)*

Partial with Action Plan

CG132 *Caesarean Section (November 2011, updated August 2012)*
QS25 *Asthma (February 2013, updated September 2018)*
QS66 *IV Fluid Therapy (August 2014)*
QS173 *Intermediate care including re-ablement (August 2018)*

Partial No Action Required

CG110 *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (September 2010)*
CG188 *Gallstone disease (October 2014)*
NG95 *Lyme disease (April 2018)*
NG103 *Flu vaccination: increasing uptake (August 2018)*
QS104 *Gallstone disease (December 2015)*

Not Applicable

IPG628 *Intravesical microwave hyperthermia and chemotherapy for non-muscle-invasive bladder cancer (September 2018)*
IPG629 *Transurethral water jet ablation for lower urinary tract symptoms caused by benign prostatic hyperplasia (September 2018)*
MTG16 *The E-vita open plus for treating complex aneurysms and dissections of the thoracic aorta (December 2013, updated September 2018)*
MTG39 *iFuse for treating chronic sacroiliac joint pain (October 2018)*

The Group agreed the compliance status of the abovementioned NICE guidance.

There were no Baseline Assessments for escalation to the Group this month.

NICE Action Plans

There are **212** outstanding actions arising from completed NICE Baseline Assessments. Work is ongoing to ensure all outstanding actions arising from completed NICE Baseline Assessments are reviewed with the designated leads to establish those which are still applicable and those which have been superceded either by NICE guidance or alternative actions having been implemented. CS advised the Group that this work will have been completed before the next meeting in order for report and escalation.

NCEPOD Report

CS presented the NCEPOD Report.

NCEPOD Studies – Trust Participation

There are **3** NCEPOD studies currently open to submit data for in 2018-19.

The Trust is eligible to participate in **all 3** studies which we are actively undertaking:

- Acute Bowel Obstruction (ABO) 2018
- Long Term Ventilation (LTV) 2018
- Pulmonary Embolism (PE) 2018

NCEPOD Action Plans

There are **42** actions arising from completed NCEPOD studies of which **27** are still outstanding to date. Work is ongoing to ensure all outstanding actions are reviewed with the designated leads to establish those which are still applicable and those which have been superceded by alternative actions having been implemented. CS advised the Group that this work will have been completed before the next meeting in order for report and escalation.

The Group agreed the current status/ progress of the abovementioned NCEPOD outstanding actions.

To celebrate 30 years of NCEPOD studies:

- A report has been released highlighting a selection of common themes that have emerged from reports over the last 30 years titled: “Themes and Recommendations Common to all Hospital Specialties”, available on the NCEPOD website. This has been shared with relevant colleagues.

- An event will be held on Tuesday 18 December 2018 at the Royal College of Physicians of London. To attend this event, please see the NCEPOD website. This has been shared with relevant colleagues.
  Action: Forward the invite- link to Donald Richardson.

There were no other NCEPOD issues or actions for escalation to the Group this month.

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 Trust Annual Audit Programme 2018-19.

At the time of this report **62** audits have been added following identification either by the Directorate Governance Leads or Clinical Directors as arising priorities for audit; therefore there are now **312** audits on the 2018-19 Annual Audit Programme of which **146** (47%) have been registered to date.

At the end of October 2018, **25** audits have been registered and completed from this year's Annual Audit Programme.

Registrations
There are **14** new clinical audits registered with CET during 19 September - 25 October 2018 which included **10** local audits, **2** re-audits and **2** national audits.

Audit Reports
25 Audit Reports were reviewed by CET since the last Clinical Effectiveness Group (CEG) meeting.

11 Audit Reports were reviewed by the Group:

National Audit

742	*National Bowel Cancer Audit (NBoCA)*
A7260	*National Comparative Audit of Blood Transfusion Repeat Audit (2017) of Red Cell and Platelet Transfusion in Adult Haematology Patients*
C3077	*Therapeutic Mammaplasty TeaM*

NICE Audit

C3161	*Routine Enquiry for Domestic Abuse Is Undertaken In Pregnancy on Two Occasions*
C3165	*An Audit into Management of Suspected Ectopic Pregnancy-Pregnancy of Unknown Location*
D9150	*Albuminuria in Paediatric Diabetes*
D9151	*An Audit of Intravitreal Anti-Vascular Endothelial Growth Factor (VEGF) in Anti-VEGF naïve Diabetic Macular Oedema Patients: 12 months results*
2018-0013 (R)	*Re-Audit of Ultrasound and HCG in EPAU*
2018-0017 (R)	*Re-Audit of Unscheduled Admission to ICU*
2018-0033	*Elective DC cardioversion (DCCV) in AF- An evaluation of current practice*
2018-0051	*Purple Ribbon Scheme*

The Group approved the findings and actions with no amendments for all of the abovementioned clinical audits.

There were no other Clinical Audit issues or actions for escalation to the Group this month.

Clinical Audit Strategy

The Trust's processes for clinical audit were reviewed by Internal Audit (Ref. Clinical Audit Y1875) end of last year that provided 'Satisfactory Compliance'. One of their recommendations was for the Trust to have a clinical audit strategy. CS asked the Group if this is something we should have in place.

The Group decided that a separate strategy document will not be required as the Quality Improvement Group is due to develop the Trust's Quality Improvement Strategy which will cover all Quality Improvement processes including clinical audit.

Action: CS to liaise with the Quality Improvement Group (Donald Richardson/ Gail Dunning) to ensure that Clinical Audit is included in the new Quality Improvement Strategy.

CS to inform Internal Audit of the Group's decision that with the development of the Trust's Quality Improvement Strategy which will include clinical audit, it does not require a separate clinical audit strategy.

Escalation to Quality & Safety Committee

FJ updated the Group that the Q&S Committee had postponed their meetings until January 2019. As a result it was agreed that the required monthly National Audit Reports will continue to be included as part of the Medical Director's Report for escalation to the Board.

GM asked that the substantial improvements made to the Trust's assurance for compliance with NICE should be escalated to Trust Board.

Action: CS and Simon Hearn to prepare the NICE Report for the Medical Director reflecting the significant the improvements made over the previous 12 months.

Any Other Business

CS highlighted that the Group had previously considered Claims as a topic to be included at future CEG meetings.

PART TWO Governance Leads Updates & Shared Learning

Theatres, Anaesthetics & Critical Care

SU provided the Group with an update on their progress against the Annual Audit Programme (AAP) 2018-19:

Clinical Audit

- Clinical Record Keeping Audit – *due to start*.

- Timely Review of all CVC Lines by means of a CXR (York process to be replicated in Scarborough) – *named lead had been made aware, to follow-up.*
- PACU Temperature and Highest Pain Scores and Presence of Nausea or Vomiting – *in planning stage.*
- Pain Duration prior to New Patient Pain Clinic Appointment – *named lead had left the Trust employment, and no longer a priority for the Directorate.*
  The Group agreed this should be removed from the AAP 2018-19.
  Action: CET to remove.
- Paediatric Tonsillectomy Pain Score and Nausea – *audit completed and presented.*
- Incidence of Residual Paralysis in Paralysed Patients (York) – *new process has just been introduced,*
  Action: CET to move to AAP 2019-20.
- Unplanned Admissions after Elective Adult Case Surgeries – *audit completed.*
- Audit of the Process of Pre-theatre Checklist and Pre-anaesthetic STOP – *ongoing.*
- Height and Weight Measurements for Patients Attending Theatre – *ongoing.*
- Audit of Unscheduled Admission to ICU – *ongoing.*
- Lung Protective Ventilation in Patients with ARDS - are ideal tidal volumes being used satisfactorily in the first 24hrs of admission? – *analysing results.*
- Cardiac Arrest: audit of post out of hospital cardiac arrest management in intensive care – *discussed with CS, ongoing.*
- Completion of ICU Admission and Daily Review Checklists – *named lead had left the Trust employment, to re-assign to new lead.*
- Syringe Labelling in Critical Care Areas – *audit completed.*
- Inter-hospital Transfer of Intensive Care Patients – *named lead had been made aware, to follow-up.*
- Management of Postpartum Haemorrhage – *ongoing.*
- York ICU-HDU Nutrition Audit
  Action: CET to move to AAP 2019-20.
- Tracheal Tube Cuff Pressure Monitoring during Anaesthesia – *audit completed.*
- Patient Temperatures in Elective CS – *registered, ongoing.*
- Capnography in PACU (York) – *audit completed and presented.*

<u>Clinical Audit Actions</u>

- B5021-1 Re-audit of Tracheal tube cuff pressure monitoring during Anaesthesia – *it was identified that 2018-19 is too early to start the re-audit, plan to re-audit in 2020.*
  Action: CET to change the re-audit date to 2020.

- B5051-1 Re-audit to assess whether resuscitation trolleys are fully equipped on hospital wards – *SU highlighted that this is not a Theatre's re-audit.*
  The Group agreed that this should be on the Resuscitation Team's Annual Audit Programme, as not a Theatre's audit.
  Action: CET to remove from the Theatre's AAP and to discuss the re-audit with Sandra Tucker-Quinn.
- B5053 Incidence of Residual Paralysis in Paralysed Patients in *York – all actions resulting from this audit has been delayed.*
  Action: CET to change the re-audit date to 2019-2020 and move to AAP 2019-20.
- B5091 Analgesia in major lower limb amputation.
  Action: SU to follow-up with leads, return of audit report to CET.
- B5100-1 Audit on AAGBI standards of monitoring in recovery – *named lead on sabbatical, therefore unlikely to obtain the report for this audit.*
- C3109-1 Capnography in PACU – *actions 1, 2 and 3 confirmed by SU as completed. Re-audit planned for AAP 2019-20.*
  The Group agreed actions 1, 2 and 3 can be closed as completed. Re-audit to be placed on AAP 2019-20.
  Action: CET to close actions 1, 2 and 3 and ensure the re-audit goes onto AAP 2019-20.
- C3118 Perioperative thermoregulation in patients undergoing fractured neck of femur surgery – *re-audit delayed.*
  Action: CET to change the re-audit date to 2019-20 and ensure on AAP 2019-20.
- C3125 Extubation technique in intensive care – *no national protocol in place.*
  The Group agreed this action can be closed.
  Action: CET to remove from NICE Action Log.
- C3127 Appropriateness of midline use – *new lead: Greg Purssord.*
  The Group agreed that this should also be audited in York and once the report is obtained it needs to be shared with the Vascular Consultants.
  Action: CET to send audit registration form and audit tool to Andy Thompson and request he completes (or nominates someone to complete) the audit for York.
- C3129 York ICU-HDU Nutrition Audit – *all actions delayed.*
  Action: CET to change the re-audit date to 2019-20 and ensure on AAP 2019-20.

<u>NICE Actions</u>

- CG50 Acutely ill adults in hospital: recognising and responding to deterioration Recommendation 7 – *provided by the Deteriorating Patient Team (part of Induction Training/ Preceptorship).*

Action: CET to contact Clare Scott for confirmation and then close this action as completed.

- CG50 Acutely ill adults in hospital: recognising and responding to deterioration Recommendation 12 – *Trustwide issue.*
  The Group agreed that if this is confirmed as being on the Directorate Risk Register, the action can be closed.
  Action: CET to confirm whether on Directorate Risk Register, then action can be removed.
- CG65 Hypothermia: prevention and management in adults having surgery Recommendation 4 – *planned to start in Q4 2018-19.*
- CG83 Rehabilitation after critical illness in adults Recommendations 1, 2 – *resources issue, and business case is being developed to address each of the outstanding resource actions.*
  Action: CET to ask the Directorate to include on Risk Register. When on Risk Register these actions can be closed/ removed.

Ophthalmology

NT provided the Group with an update on their Annual Audit Programme (AAP) 2018-19:

Clinical Audit

- National Ophthalmology Audit – *IT and data collection issues, but highlighted what data they are able to submit is being submitted.*
- Clinical Record Keeping Audit – *audit completed, next cycle started.*
- *Annual Cataract Audit – NT advised that this is ongoing data collection by all clinicians but is not a formal audit.*
  The Group agreed this can therefore be removed from the AAP 2018-19.
  Action: CET to remove from AAP.
- CVI Registration Rates at Bridlington Hospital – *audit completed, re-audit move to AAP 2019-20.*
  Action: CET to move to AAP 2019-20.
- Safety of keratoconus monitoring clinics led by optometrists - adherence to monitoring patient with corneal ectasia guidelines – *named lead has now left the Trust therefore this audit will not be undertaken as planned.*
  Action: CET to remove from AAP 2018-19.
- Macular Hole Audit – *ongoing.*
- Retinal Detachment – *ongoing.*
- Diabetic Vitrectomies – *ongoing.*
- Audit of LocSSIPs compliance – *awaiting approval of documentation, which is currently with the Board for approval.*
- Pre-treatment electrophysiological characteristics of local Birdshot chorioretinopathy (BCR) patients – *audit completed, Audit Report submitted.*

- Pain in Intravitreal Injections – *audit completed, Audit Report submitted.*
- Risk stratification in glaucoma with colour coding system – *Audit completed and report submitted. CS advised that this also provides closure for one of the Directorates SI actions.*

Clinical Audit Actions

- 2784-1 Re-Audit for Ophthalmology Emergency Admissions Audit – *all actions ongoing.*
- C3242 Assessing the diagnostic value and outcomes of vitreous biopsies performed in York Hospital over a two year period – *Audit Report submitted to CET.*
- D9151 An audit of intravitreal anti-vascular endothelial growth factor (VEGF) in anti-VEGF naïve diabetic macular oedema patients – *Audit has been completed.*
- D9166 Timescale from Referral to Start of Treatment for Wet AMD Patients – *ongoing.*

NICE Actions

- NG81 Glaucoma: diagnosis and management Recommendation 1.6.3 – *Locum is now in post.*
  The Group asked if on Directorate Risk Register and if it is, to be removed from NICE Action Log.
  Action: CET to check if on Directorate Risk Register and remove this action if on Risk Register.
- QS7 Glaucoma in Adults Recommendation 5
  The Group asked if on Directorate Risk Register and if it is, to be removed from NICE Action Log.
  Action: CET to check if on Directorate Risk Register and remove this action if on Risk Register.
- NG82 Age-related Macular Degeneration Recommendation 1.4.10 – *NT informed that Summer 2019 is the anticipated start date, but most likely going to be 2020 before virtual clinic is up and running.*
  Action: CET to amend completion date to April 2020.

Shared Learning

The following topics were presented:

RCEM Severe Sepsis & Septic Shock in Adults National Audit 2017 Report
GW presented the improvements made as a result of the Sepsis CQUIN data and which reflect improvements from the actions set out following this national audit. The Group discussed the related improvement projects.

Is Smoking Status Documented & Smoking Cessation Advice Offered To New Patient Admissions on Acute Medical Wards at York Teaching Hospital?

CS presented the improvements made across the Trust resulting from this audit.

Next Meeting

Tuesday, 04 December 2018, 15:00 – 16:30
Neurosciences Resource Room, York / VC from Orchard Room, Scarborough

APPENDIX E

York Teaching Hospital
NHS Foundation Trust

Meeting of the Audit Committee 4 December 2018 Progress on the Annual Clinical Audit Programme 2018/19

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 Audit Committee on the current progress on the Annual Clinical Audit Programme 2018/19.

Executive Summary – Key Points

The report details that

- Of the 320 clinical audits on the Annual Clinical Audit Programme for 2018/19, 174 Audits have been registered as of 31 October 2018
- That Directorates are scheduled over the year to provide a progress update to the Clinical Effectiveness Group on their audit programme
- Additions or removals from the plan are approved by the Clinical Effectiveness Group
- A shared learning session has become part of the Clinical Effectiveness Group Agenda

Recommendation

The Audit Committee is asked to note the report.

Author: Fiona Jamieson: Deputy Director of Healthcare Governance

Director Sponsor: James Taylor: Medical Director

Date: November 2018

• Introduction and Background

Members of the Committee will be aware that the organization has an active Annual Programme of Clinical Audit that focuses on mandatory, national, local, NCEPOD, NICE and NPSA audits.

This report aims to provide an update on the progress made against the Annual Audit Programme in the first 6 months of the financial year,

1. Current Status

Of the 320 audits currently on the Annual Programme there are a number that have been carried forward from 2017/18 where winter pressures prevented the full audit programme from being completed. These have become part of the 2018/19 programme.

As of the end of October 2018, 174, that is, 50% of the audits on the annual programme have been registered. This means that the audit is either currently underway or has been completed.

The table below provides details of the split of audits that are currently registered by Quarter.

Registered by Category	Total on AAP	Q1	Q2	Q3	Q4	Total Registered
Quality Account	**53**	43	7	1	0	**51**
Compliance with NICE	**12**	0	3	2	0	**5**
Local Clinical Audit	**126**	27	32	18	0	**77**
Re-Audit	**102**	5	9	8	0	**22**
New Procedure Audit	**3**	0	0	1	0	**1**
NPSA Audit	**5**	0	0	1	0	**1**
National Audit	**19**	11	3	3	0	**17**
Total	**320**	**86**	**54**	**34**	**0**	**174**

2. Clinical Effectiveness Group

Clinical Effectiveness Group has oversight of the Annual Clinical Audit Programme. It meets monthly and reviews a selection of completed Clinical Audits to look at both good practice and those issues that need to be escalated organization. The Group also considers organizational compliance with NICE Guidance. T

The Clinical Effectiveness Group has a programme of inviting directorates to provide a progress update on their Annual Audit Programme. This provides directorates with the opportunity to discuss any proposed changes to their audit programme in terms of additions and removals and for the changes to be approved by the group.

The Group has also introduced a session on shared learning coming out of clinical audit. The first session looked at the National Audit on Sepsis that reported in 2017, it focused

on learning for the organization and how the organisation has made improvements. This was well received. All Clinical Governance Leads are invited to this part of the meeting.

- **Next Steps**

The Clinical Effectiveness Team will continue to monitor participation in the Annual Clinical Audit Programme. Good progress has been made in the first six months of 2018/19, although we might expect this to slow down in Quarter 4 as winter pressures mean workforce are involved in the operational delivery of care.

- **Recommendation**

The Audit Committee are asked to note the progress of the Annual Clinical Audit Programme for the period 1 April 2018 – 31 October 2018.

NHS
York Teaching Hospital
NHS Foundation Trust

G

Performance and Activity Report

December Performance 2018

Produced January 2019

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	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
Emergency Care Attendances		▲	16236	14712	13719	15845	16374	17985	17242	18903	18215	17073	16960	16191	16571
Emergency Care Breaches		▲	2766	2728	2499	2983	2439	1786	1722	2266	1366	1650	1545	1686	2059
Emergency Care Standard Performance	95%	▼	83.0%	81.5%	81.8%	81.2%	85.1%	90.1%	90.0%	88.0%	92.5%	90.3%	90.9%	89.6%	87.6%
ED Conversion Rate: Proportion of ED attendances subsequently admitted		▲	41%	41%	40%	39%	39%	38%	38%	37%	38%	38%	38%	39%	41%
ED Total number of patients waiting over 8 hours in the departments		▲	791	833	668	872	607	195	159	260	110	212	216	242	324
ED 12 hour trolley waits	0	◀▶	5	14	15	40	13	0	0	0	0	0	0	0	0
ED: % of attendees assessed within 15 minutes of arrival		▼	57%	63%	61%	57%	64%	67%	63%	62%	70%	61%	65%	63%	63%
ED: % of attendees seen by doctor within 60 minutes of arrival		▲	41%	45%	43%	40%	41%	42%	40%	41%	50%	42%	45%	49%	50%
Ambulance handovers waiting 15-29 minutes	0	▲	823	702	679	784	702	762	765	785	766	883	891	840	1083
Ambulance handovers waiting 30-59 minutes	0	▲	537	424	360	471	325	317	260	355	342	360	345	389	463
Ambulance handovers waiting >60 minutes	0	▲	548	390	367	419	302	152	110	216	104	238	132	197	233
Non Elective Admissions (excl Paediatrics & Maternity)		▲	4572	4515	4085	4520	4430	4783	4599	4834	4723	4577	4643	4568	4726
Non Elective Admissions - Paediatrics		▼	934	736	654	844	703	732	638	665	535	689	862	1044	941
Delayed Transfers of Care - Acute Hospitals		▲	865	660	885	1010	1134	1092	1020	1071	1336	1180	1251	1059	1212
Delayed Transfers of Care - Community Hospitals		▼	506	483	357	266	464	358	262	307	301	381	357	358	337
Patients with LOS 0 Days (Elective & Non-Elective)		▼	1311	1400	1172	1321	1388	1518	1448	1571	1476	1431	1447	1372	1341
Ward Transfers - Non clinical transfers after 10pm	100	◀▶	113	99	106	94	106	58	71	73	38	76	83	85	85
Emergency readmissions within 30 days		▼	877	771	765	807	782	885	822	914	830	855	835	-	-
Stranded Patients at End of Month - York, Scarborough and Bridlington		▲	402	474	412	430	413	377	366	385	369	379	403	363	368
Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▲	361	414	405	420	399	357	342	347	325	371	398	374	376
Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	126	161	139	157	150	123	118	125	118	132	159	132	116
Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▼	112	131	147	149	156	124	113	115	115	125	142	147	129

Operational Performance: Planned Care	Target	Sparkline / Previous Month	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
Outpatients: All Referral Types		▼	16188	19352	17400	19135	18993	20018	19365	20206	18658	17832	20691	19595	16727
Outpatients: GP Referrals		▼	8247	10280	9219	10223	10066	10437	9925	10548	9726	9233	10776	10177	8565
Outpatients: Consultant to Consultant Referrals		▼	1889	2147	1967	2065	2073	2188	2147	2253	1978	1925	2404	2238	1936
Outpatients: Other Referrals		▼	6052	6925	6214	6847	6854	7393	7293	7405	6954	6674	7511	7180	6226
Outpatients: 1st Attendances		▼	8032	9742	8605	9107	8900	9959	9586	9700	9056	8469	10249	10167	8069
Outpatients: Follow Up Attendances		▼	14703	17573	15388	16544	16133	17565	16738	17100	15638	15548	17743	17624	14520
Outpatients: 1st to FU Ratio		▲	1.83	1.80	1.79	1.82	1.81	1.76	1.75	1.76	1.73	1.84	1.73	1.74	1.80
Outpatients: DNA rates		▲	6.1%	6.3%	6.2%	6.3%	5.7%	5.8%	5.9%	6.5%	6.4%	6.1%	6.0%	5.8%	6.4%
Outpatients: Cancelled Clinics with less than 14 days notice	180	▼	133	210	213	194	168	149	145	184	173	160	180	163	162
Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▼	702	949	757	844	849	728	885	945	1070	884	941	865	802
Diagnostics: Patients waiting <6 weeks from referral to test	99%	▼	97.5%	98.1%	97.9%	97.0%	96.1%	96.1%	96.3%	95.6%	93.5%	94.9%	96.2%	93.9%	90.8%
Elective Admissions		▼	597	566	603	527	635	774	752	736	612	576	766	722	604
Day Case Admissions		▼	5105	5957	5412	5724	5462	6059	6049	6094	6116	5713	6591	6302	5357
Cancelled Operations within 48 hours - Bed shortages		▲	74	118	129	168	62	18	7	10	4	34	68	12	33
Cancelled Operations within 48 hours - Non clinical reasons		▼	169	191	189	205	117	103	89	98	96	106	137	131	91
Theatres: Utilisation of planned sessions		▼	86%	83%	85%	84%	88%	92%	92%	92%	93%	91%	90%	93%	88%
Theatres: number of sessions held		▼	542	599	543	520	565	628	636	608	553	555	674	661	523
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		◀▶	76	74	50	105	76	60	61	74	63	76	79	66	66

Assurance Framework Responsive

Performance Summary by Month – Trust level continued

18 Weeks Referral To Treatment	Target	Sparkline / Previous Month	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
Incomplete Pathways	92%	▼	85.8%	85.3%	84.8%	83.3%	83.8%	84.2%	84.1%	84.5%	83.7%	83.1%	83.4%	82.0%	81.5%
Waits over 52 weeks for incomplete pathways	0	▼	0	0	1	2	1	14	9	0	0	1	1	1	0
Waits over 36 weeks for incomplete pathways	0	▲	238	260	297	356	409	450	438	390	369	298	361	355	431
Total Admitted and Non Admitted waiters	26303	▼	25006	25185	25334	26303	26967	27480	27425	27796	27756	27525	27616	27164	26433
Number of patients on Admitted Backlog (18+ weeks)		▲	1623	1818	1928	2223	2303	2334	2330	2273	2272	2245	2219	2299	2352
Number of patients on Non Admitted Backlog (18+ weeks)		▼	1816	1880	1921	2179	2070	2002	2041	2023	2245	2401	2369	2578	2550

Cancer (one month behind due to national reporting timetable)	Target	Sparkline / Previous Month	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
Cancer 2 week (all cancers)	93%	▲	92.5%	94.4%	94.7%	93.6%	93.9%	93.7%	93.5%	86.6%	86.6%	83.8%	90.2%	92.1%	-
Cancer 2 week (breast symptoms)	93%	▼	94.0%	94.6%	99.1%	98.9%	96.2%	96.1%	93.6%	94.7%	97.4%	99.0%	100.0%	93.3%	-
Cancer 31 day wait from diagnosis to first treatment	96%	▼	99.6%	99.2%	98.6%	98.7%	98.2%	99.2%	98.9%	98.4%	99.2%	97.6%	98.6%	98.4%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	▼	96.9%	93.9%	100.0%	97.1%	96.6%	97.4%	100.0%	97.6%	94.3%	92.9%	96.9%	93.2%	-
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%	▼	87.2%	85.0%	81.0%	85.9%	78.0%	78.4%	82.0%	72.0%	81.1%	76.6%	82.3%	75.3%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	▼	89.5%	95.5%	95.1%	93.6%	90.9%	84.3%	96.5%	91.3%	93.0%	87.7%	93.6%	92.9%	-

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	Green	Green
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	Work ongoing with Wards	Work ongoing with Wards
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	Work ongoing with Wards	Work ongoing with Wards
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	Work ongoing with Wards	Work ongoing with Wards

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	Achieved	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	Achieved	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	Achieved	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	Achieved	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	Achieved	No risks identified	Green

Assurance Framework Responsive

Emergency Care Standard and Unplanned Care

Operational Context

The Trust did not achieve the planned trajectory of 90% for the Emergency Care Standard (ECS) achieving 87.6% and did not achieve the Q3 Provider Sustainability Funding (PSF) requirement of 90% achieving 89.4%. Although failing to achieve the Q3 PSF target the Trust has demonstrated a significant improvement from Q3 2017/18 when performance was 86.97%. The Trust outperformed the national position for December (86.4%).

Unplanned care continued to be challenging during December, Trust attendances increased compared to December 2017; 2%, +335 attendances. Type 1 attendances were up by 6%; 531 attendances. The Scarborough Locality experienced a 1% reduction (-77 attendances) overall however this was due to a reduction in Type 3 attendances. The main Scarborough ED saw a significant rise compared to December last year; up 6%, +187 attendances resulting in significant pressure on the service. York locality services continues to rise, attendances were up 5% (+412 attendances) compared to December last year. Mirroring Scarborough the rise was primarily seen at the York ED which saw a rise of 5% compared to the same period last year; a rise of 344 attendances equating to 11 extra attendances a day during the month.

Year to Date (YTD) Type 1 and 3 attendances are up 5% on last year (up 4% on plan). In total an extra 7,736 patients have attended the main EDs, UCCs and MIUs this year compared to last year with the main EDs (Type 1) seeing and treating an additional 6,420 patients; a rise of 8%. This is in contrast to the national position which has seen 1% Type 1 growth over Q3, compared to the same period last year, and type 3 growth on the same basis was 5%.

It is worth noting that the Trust ECS performance for Christmas week (24th to 30th December) was 85.6%.The same period in 2017 saw performance of 78.3%, therefore the Trust achieved a 7.3% ECS improvement this year despite a 7% rise in Type 1 attendances and a 6% rise in non-elective admissions from the same period in 2017.

The number of ambulance arrivals showed no change when comparing December 2018 to December 2017. However there was a significant reduction of 36% in the number of ambulances delayed for over 30 mins (1,085 in December 2017 to 696 in December 2018). Ambulance Handovers remain an area of concern and risk as the winter months continue, the NHSI ECIST team are offering support to both Scarborough and York Hospitals, following on from the *Action on A&E* work to support handover processes. The Trust in line with ED providers will be reporting Ambulance Handover numbers weekly to NHSI over the winter. Healthwatch North Yorkshire has recently been welcomed by the Trust into the Scarborough Emergency Department to review the experience of people waiting in ambulance queues in the Emergency Department. Healthwatch did not raise any immediate issues and the Trust awaits their report.

The Trust has in line with previous years seen an increase in bed pressure, with both Scarborough and York Hospitals having only 12 days between them below a bed occupancy of 90% at midnight. The Delayed Transfers of Care (DToC) position worsened in December, primarily in the York Locality and is the second worst this financial year. The recent rise has been affected by lack of care home capacity and shortage in the 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.

Targeted Actions in December

- Ongoing implementation of the Single Improvement Programme for Scarborough Hospital emergency, elderly and acute medicine and Emergency Care Transformation Plan at York.
- £950k capital works to create the assessment area at Scarborough Hospital handed over on 21st December and went live in January 2019.
- System Winter plan enacted.
- 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, mirroring the best practice hub established at York Hospital.

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 December 2018 was 90%.

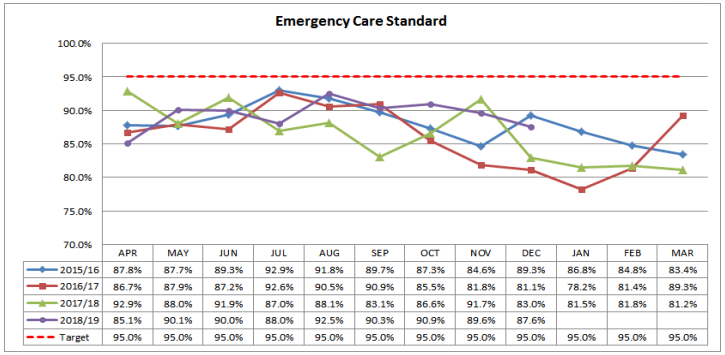
Consequence of under-achievement

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

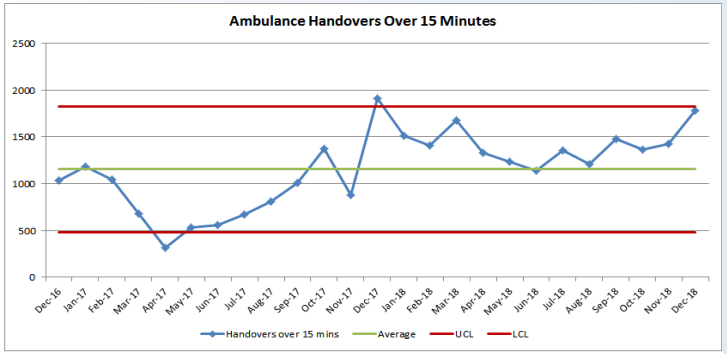
Performance Update:

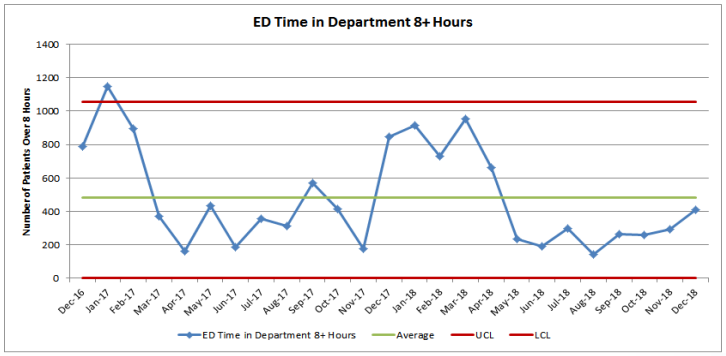
- The Trust achieved 87.6% in December 2018 against the planned trajectory of 90%.
- The main Scarborough ED saw a significant rise compared to December last year; up 6%, +187 attendances resulting in significant pressure on the service. York locality services continues to rise, attendances were up 5% (+412 attendances) compared to December last year.
- The number and percentage of patients waiting over 8 hours decreased by 59% (-467) compared to December 2017.
- Ambulance Handovers remain a challenge, with 696 handovers over 30 mins.

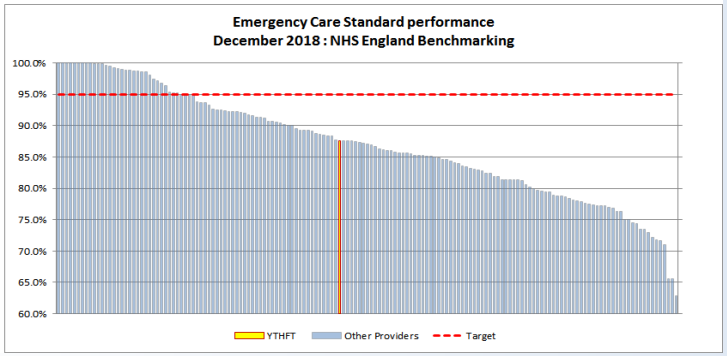
Performance:



	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%	89.6%	87.6%			
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%







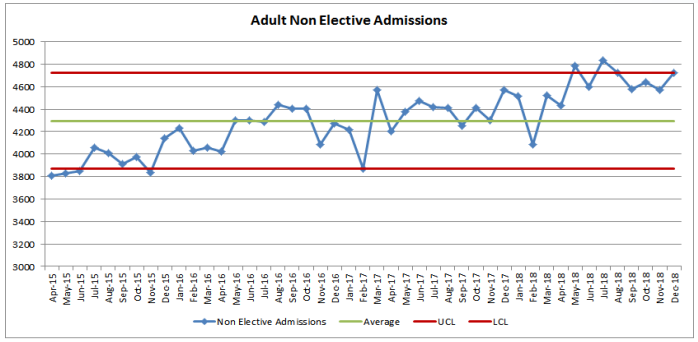
Assurance Framework Responsive

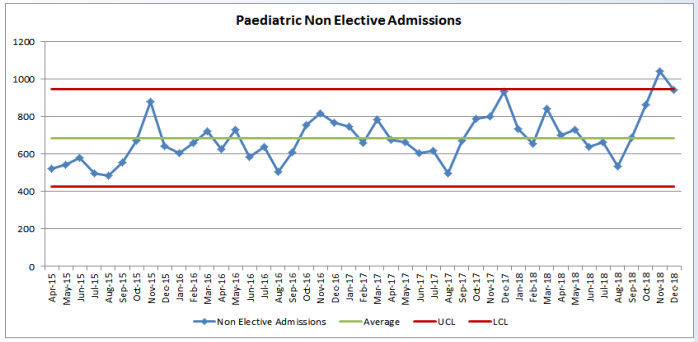
Unplanned Care

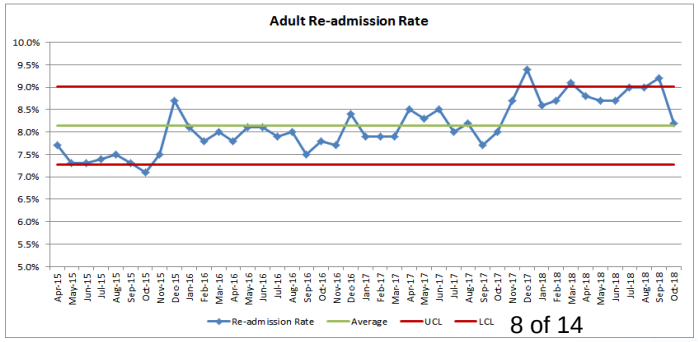
Performance Update:

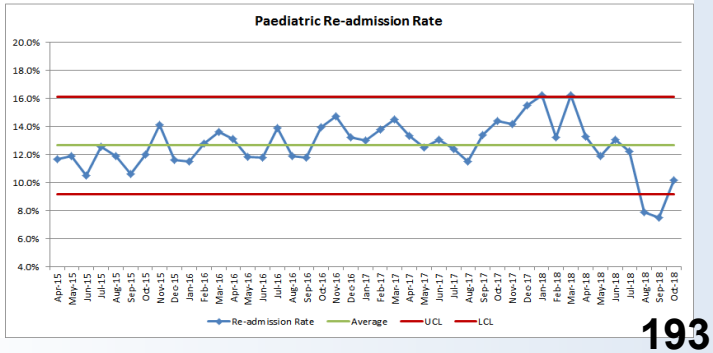
- The number of non-elective admissions in December 2018 has increased by 3% compared to December 2017 (+154) and remains over plan year to date (+3.5%). The Trust has seen continued increases in non-elective admissions in General Surgery, Urology and Trauma & Orthopaedics at York Hospital. Paediatric admissions continue to be high with December seeing the second highest number of monthly admissions in the last 4 years. This rise is on both sites with the increase at York linked to the opening of the Child Assessment Unit to 'pull' patients from ED to a more appropriate environment. The growth at Scarborough is due to respiratory complaints in young children (and the admissions are appropriate).
- The adult readmission rate fell to 8.2% for October 2018 (the rise in previous months is being investigated by the Trust's analytics team). Paediatric readmissions rose but remain well below the average position over the last 4 years.
- Acute DTOCs have increased in December, the Trust is actively planning to mitigate the pressures from increased demand, and delayed patients through the Winter Plan.
- The number of stranded patients at month end was the on a par with November, up slightly (+6), the number of beds occupied by super stranded patients (patients who stay more than 21 days) fell against November and has seen a Year to Date reduction (up to October) of 18%, against a national target of 25% by December 2018.

Performance:









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 November at 92.1%, this is however a continued improvement on previous months and has a provisional December performance of 94.5%. National performance for November was 92.5%. The Trust position continues to be affected by the ongoing issues within the Dermatology Service, with 77.2% of Dermatology Fast Track referrals seen within 14 days. However significant progress is being made in terms of recovery, with December provisionally showing 89% of Dermatology FT referrals being seen within 14 days.

The Trust continues to experience high demand for Cancer Fast Tracks, with an 18% (+248) increase in FT referrals in November compared to November 2017. Due to this rise the Trust is undertaking more Cancer activity with a 16% rise YTD in referrals seen (2017; 10,825 to 12,584 in 2018, +1,759), but this is impacting on the capacity available for routine outpatient appointments, particularly in Dermatology, Urology and Colorectal services.

The 62 day target from referral to treatment deteriorated from October (75.3% from 82.3%). National performance for November was 79.2%. Performance equated to 134 patients treated in November, with 33 accountable breaches (40 patients). These were spread across a range of tumour pathways, with the highest number of breaches seen in prostate and kidney cancers. Of the reported patient breaches, 62.5% relate to delays to diagnostic tests or treatment plans/lack of capacity, 25% relate to complex or inconclusive diagnostics and 10% were due to patient not attending or unavailability. The prostate and colorectal pathways are priority areas for the Humber, Coast and Vale Cancer Alliance. The Trust secured £242,000 in additional funding for diagnostics towards improving the 62 day performance. £150,000 was 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 secured for additional radiographic support to our third CT scanner on the York site; to support a pilot of the lung fast track pathway. All three schemes are now operational and are functioning at full planned capacity although it is too early to quantify the impact.

The Trust also failed the 31 Day Surgery in November. All other Cancer Waiting Time targets were met. The Trust has had a recent post-implementation review of progress against the changes made, results from the last visit by 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 a detailed review of Cancer performance at Board is planned for February.

Progress towards the April 2020 target to diagnose 95% of patients within 28 days; up to 70.3% in November from 60% in August, this target is currently being shadow reported.

Targeted Actions in December

- Continued implementation of the Standard Operating Procedure (SOP) for removing patients from the Cancer Patient Tracking List (PTL) commenced, with weekly monitoring has seen over 500 patients removed from the PTL since mid November.
- 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 have been mobilised; a new partnership for MRIs at Thorpe Park Clinic in Leeds has been set up as part of this work.
- Finalisation of Directorate options to increase 7 day Fast Track capacity in the operational plan for 2019-20.
- Review of sustainable provision of Dermatology pathways across the YTHFT and CCGs.

Assurance Framework Responsive

14 Day Fast Track – Cancer Waiting Times

Standard(s):

Fast Track referrals should be seen within 14 days.

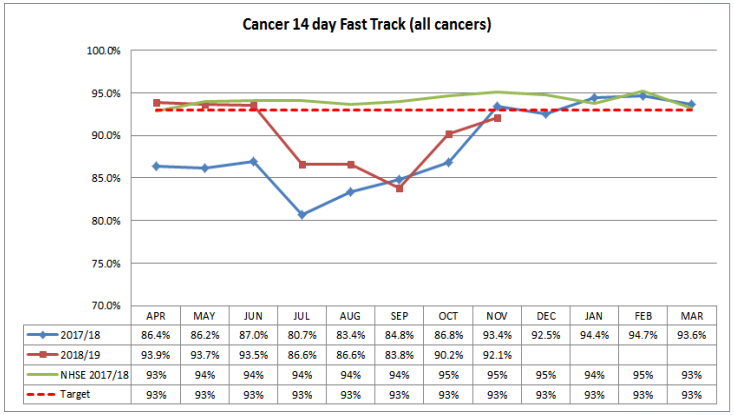
Consequence of under-achievement:

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

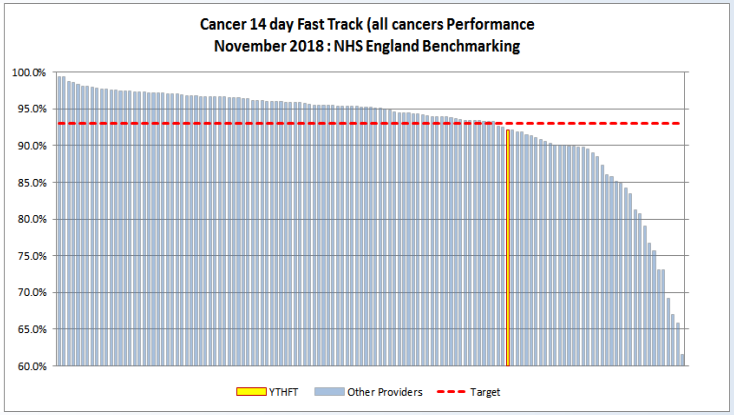
Performance Update:

- The Trust achieved 92.1% against the 93% target in November 2018.
- Of the 127 patient breaches, the Dermatology patients accounted for 55% (70). Of the Dermatology breaches, 90% of patients were found to have no cancer.
- 36% of the breaches were due to patient choice (e.g. did not attend or could not attend within target).
- FT referrals increased 18% (+248) in November compared to November 2017.

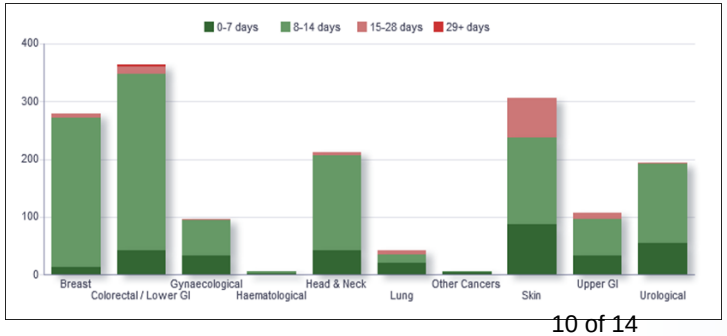
Performance:

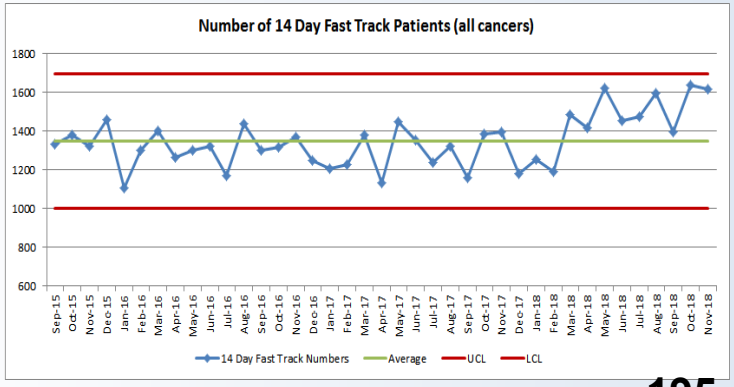


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2017/18	86.4%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%
2018/19	93.9%	93.7%	93.5%	86.6%	86.6%	83.8%	90.2%	92.1%				
NHSE 2017/18	93%	94%	94%	94%	94%	94%	95%	95%	95%	94%	95%	93%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%



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.

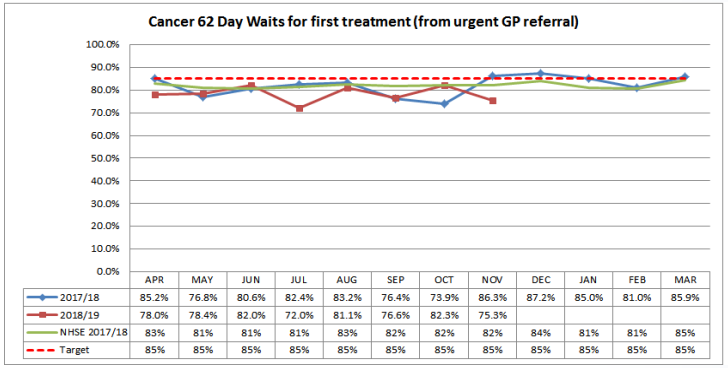
Consequence of under-achievement:

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

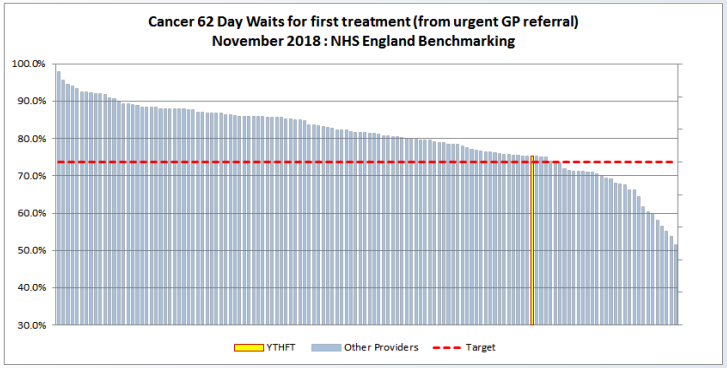
Performance Update:

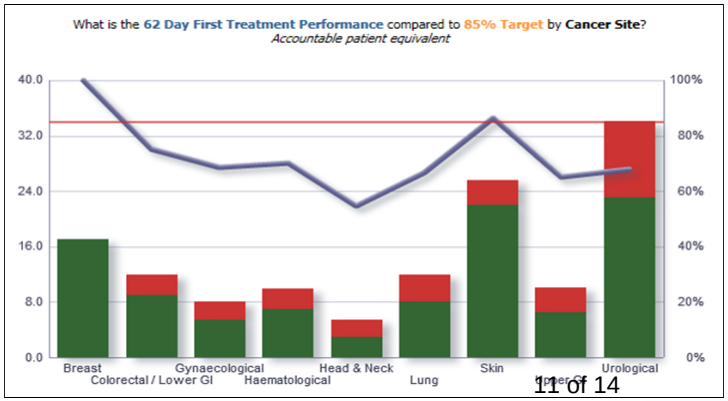
- The Trust achieved 75.3% against the 85% target for November, equating to 33 accountable breaches (40 patients).
- There were breaches across a range of tumour sites with highest number of breaches in Urology (14 patients). Urology also comprised the highest percentage of long wait patients, with 5 patients treated over 104 days.
- Of the reported patient breaches, 62.5% relate to delays to diagnostic tests or treatment plans/lack of capacity, 25% relate to complex or inconclusive diagnostics and 10% 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%	82.3%	75.3%				
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 provisionally seen a 3% decrease in the total incomplete waiting list in December, falling to 26,433 (140 above the March 2019 target). The primary actions to reduce the waiting list commenced in late November with full validation of the incomplete waiting list commenced mid-December. The Trust has seen a 3% increase in referrals YTD compared to last year (+4,964). GP referrals had been moving back towards plan, but are up 2% year to date compared to 2017/18 with a 4% rise being seen in December 2018 compared to December 2017. 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 (26,303).

The Trust's RTT position has provisionally declined from November, at 81.5%. This is 2.9% lower than the Trust trajectory for the end of December. The backlog has increased across admitted pathways. The Trust has increased the validation resource for the PTT pathway, with the new posts in place from mid-November. Full validation of the RTT waiting list commenced in mid-December and there is the potential that in achieving the reduction in the total waiting list will negatively impact on waiting list performance (against the 92% target) as validation is more likely to remove patients waiting under 18 weeks. 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 are being developed for Cardiology and Respiratory.

The number of long wait patients (those waiting more than 36 weeks) has increased in December. These delays are across multiple specialities, with weekly monitoring in place by the Corporate Operations team. There were zero patients waiting over 52 weeks at the end of December.

The Trust remains on plan for elective work overall, with an increase in day case (YTD) off setting a reduction in elective work compared to plan. The reduction in elective care was impacted in April 2018 by ongoing winter pressures, and by ward closures in October 2018 and thus not achieving the planned increased level of activity. The Trust plan allows for a reduction in elective activity in January and February.

The Trust has provisionally seen a deterioration in the national 6 weeks diagnostic target at 91.1%, 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, repeated attempts at recruitment have so far been unsuccessful. The radiology recovery plan is in development and includes identification of a sustainable approach to managing MRI GA, which primarily relate to children. An extra MRI GA list per month has been operational since the beginning of January.

Targeted Actions in December

- 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
- RTT recovery plan in place and mobilised from November to target clock stop activity within financial constraints – focus on 1:FU switch and full WL validation.
- 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.
- Elective plan is to maximise outpatient capacity through the winter period to support Total Waiting List.

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:

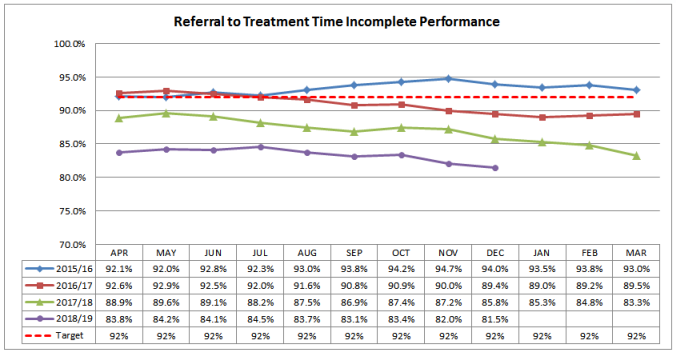
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

Performance Update:

RTT figures are provisional and subject to change.

- The Trust provisionally achieved 81.5% RTT at the end of December 2018, with 4,902 patients waiting over 18 weeks.
- The total number of patients on the RTT Incomplete pathway was 26,433 at the end of December 2018, a 2.7% (-731) improvement on the end of November position (27,164). This is 680 clocks (3%) above the Trust trajectory for the end of December.
- There were 16,727 referrals received in December 2018, an increase of 3% (+539) on December 2017. GP referrals were 4% higher (+318) than December 2017.
- The Trust 'Did Not Attend/Was Not Brought' (DNA) rate rose to 6.4%, work is ongoing to move the Trust from an opt-in 1-way text reminder to a 2-way opt-out service. Those receiving text message reminders have a 1-1.5% lower DNA rate than those who don't.

Performance:



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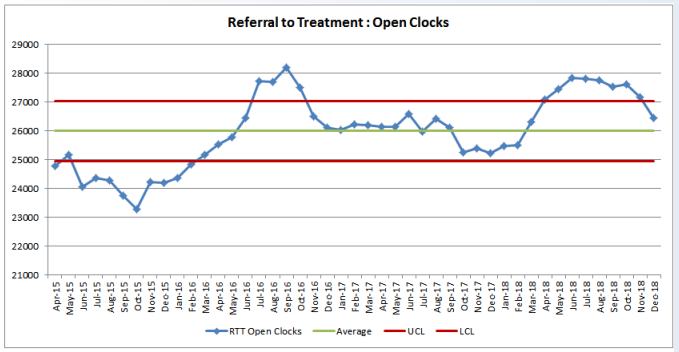
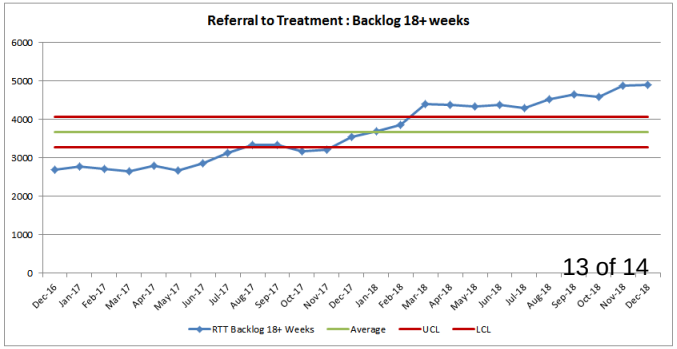
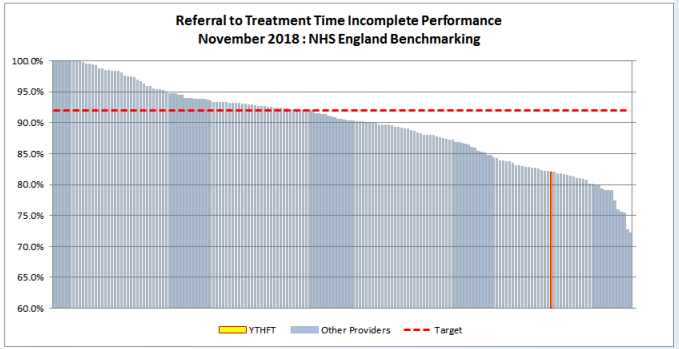
2015/16	92.1%	92.0%	92.8%	92.3%	93.0%	93.8%	94.2%	94.7%	94.0%	93.5%	93.8%	93.0%
2016/17	92.6%	92.9%	92.5%	92.0%	91.6%	90.8%	90.9%	90.0%	89.4%	89.0%	89.2%	89.5%
2017/18	88.9%	89.6%	89.1%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%
2018/19	83.8%	84.2%	84.1%	84.5%	83.7%	83.1%	83.4%	82.0%	81.5%			
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.

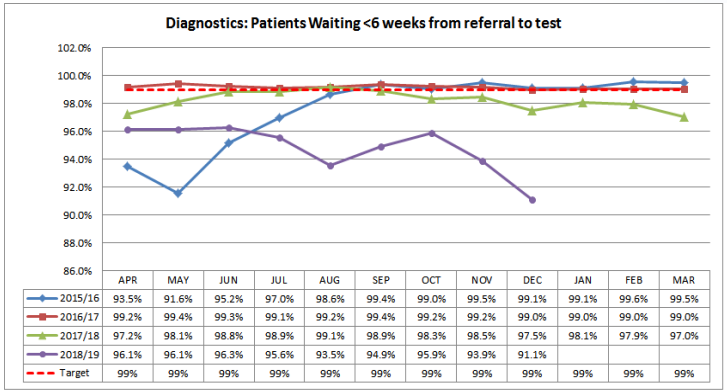
Consequence of under-achievement: Patient experience, clinical outcomes, timely access to treatment and regulatory action.

Performance Update:

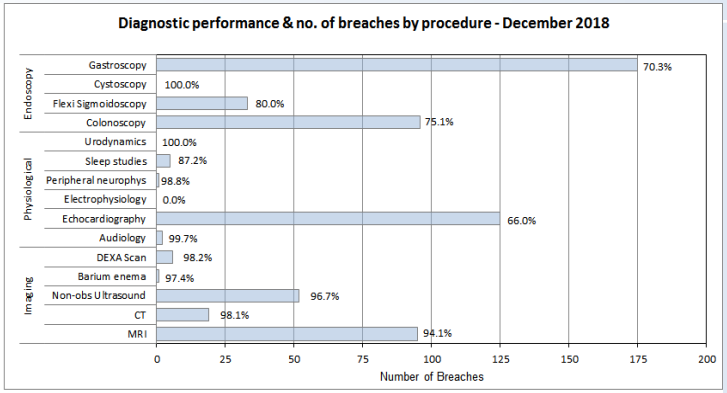
Diagnostic figures are provisional and subject to change.

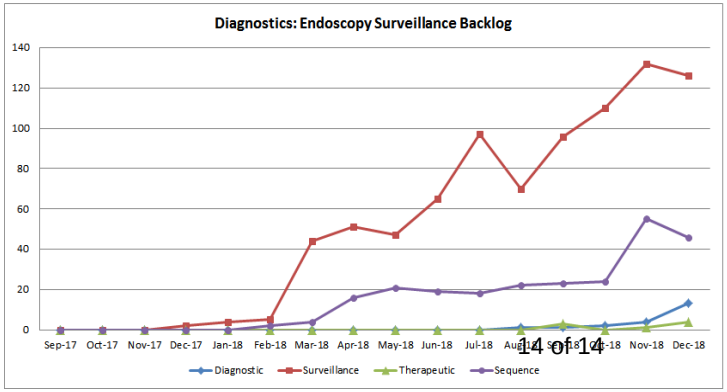
The Trust has provisionally seen a deterioration in the national diagnostic target at 91.1%, against the standard of 99%. There are particular pressures in endoscopy, Echo CT and MRI and MRI under General Anaesthetic (MRI GA). Echo-cardiographs have been affected by staff shortages and the service is concentrating on actions to mitigate the pressures, repeated attempts at recruitment have been unsuccessful. The radiology recovery plan is in development and includes identification of a sustainable approach to the MRI GA, which primarily relate to children. An extra MRI GA list per month has been operational since the beginning of January.

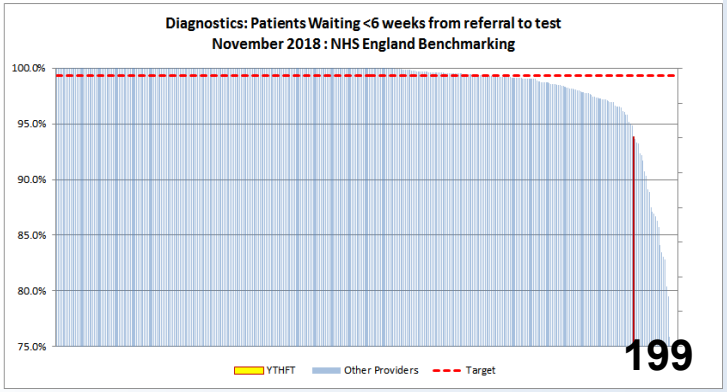
Performance:



	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%	93.9%	91.1%			
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%







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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Out of Hospital Care Quarterly Strategic Update

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

This report provides the Board of Directors with an overview of developments in providing care outside of hospital including the recent CQC review of the City of York health and care system and their recommendations for improvement.

Executive Summary – Key Points

The CQC undertook an initial review in October 2017 to understand how older people in the City of York experienced the interface between health and social care. This resulted in 13 recommendations being made and a local improvement plan was developed to address these.

In November 2019 the CQC carried out a follow up review to understand what progress had been made. They found that older people were experiencing more joined up care and that relationships across the system had improved, particularly for operational teams. However, they also noted that the pace of change had not been as fast as it could have been and that progress was limited in joint commissioning, shared electronic care records and system-wide workforce planning. A further eight recommendations were made.

Updates are provided on the redesign of the community nursing workforce, integrated working in the North Locality, Allied Health Professionals supporting the sustainability of primary care and the start of the home based intravenous antibiotic service.

Recommendation

The Board of Directors is asked to consider the recommendations of the CQC Review and how these will be incorporated into the Trust's strategic plan.

The Board of Directors is also asked to note the positive developments in out of hospital care as part of our Home First strategy.

Author: Steve Reed, Head of Strategy

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: January 2019

1. Introduction and Background

This report provides the Board of Directors will an update on the recent CQC review of the City of York together with an overview of recent developments in providing care outside of hospital.

The Out of Hospital Care Board Sub-Committee Report in February 2018 presented the findings of the CQC Review of the Health and Social Care Interface in the City of York. The terms of the review were to look at the experience of older people (those aged over 65 years) moving between health and social care services. This concentrated on three key areas:

1. How people are supported to stay well and independent in the community;
2. How people are supported in a crisis and;
3. Where people are admitted to hospital, how they are supported to return home as soon as possible.

The City of York was identified as a priority area for review as the social care interface dashboard (released July 2017) showed the City of York Council (CYC) system ranked 145th out of 152 local authority areas across 6 key performance metrics of the health and social care interface. This includes weekend discharges (148th), effectiveness of reablement (134th), access to reablement (108th), delayed transfers of care (97th), emergency admission rates (89th) and length of stay (75th).

Although the findings were wide-ranging, some key themes emerged from the report.

1. System leadership – with a history of difficult relationships and a turnover of key roles;
2. Integrated commissioning – with limited joint commissioning of services and capacity constraints in the care market;
3. Disconnected services – with services for older people often disconnected and leading to duplicated assessments;
4. Key enablers – such as a shared electronic care record and a system-wide workforce plan were not in place.

An action plan was developed to address the 13 recommendations arising from the review. The action plan detailed 92 actions.

The July 2018 interface dashboard showed that despite progress in some areas (length of stay was ranked 32nd) the City of York remained 144th out of 152 areas. Appendix 1 provides more detail on the dashboard findings. Due to these results, and the changes in senior leadership positions since the previous review, the CQC identified York as one of three areas in which it would carry out a follow up review.

2. Update

2.1 Out of Hospital Care Developments

Workforce transformation in community nursing

A new workforce and care framework will be implemented across community nursing in York, Selby, North Ryedale and South Hambleton by 2020 to improve the experience of patients receiving care and the daily experience of staff working in the service. This will be addressed in two ways. Firstly, by responding to the current workforce challenges within current resources to deliver safe care and, secondly, to work on future models with partners. The model for district nursing (DN) across the Trust has changed little over the last 30 years, but the requirements and needs of patients have changed significantly. This means the current ways of working are not the best for patients or our staff.

Caseload review has shown that the majority of care does not need to be delivered by a registered nurse. Using the opportunities from newly developed apprenticeships new roles will be added to the workforce at bands 2 and 4 providing an attractive career structure between bands 2-8a that will support staff recruitment and retention.

Progress to date has included:

- the development of new care plans that teams will use to support more efficient and safe management of care;
- realignment of all job descriptions across the band 3 workforce;
- staff training to support clinical skills for the unregistered workforce which will free up senior staff to be prescribers of care and provide holistic care to more complex patients.

Integrated care in the North Locality

Three Health Care Assistants have been appointed jointly to community nursing teams and primary care in the North Locality (Easingwold and North Ryedale). This has enabled workloads to be shared, reduced duplication and is enabling shared learning between community nursing teams and practice nursing. This is the first step in locality integration and has been received positively by all who are involved. It is expected that this model will grow and facilitates conversations regarding the optimal staffing model required to support communities – particularly in view of the Long Term Plan expectation of integrated care being provided by integrated teams serving populations of 30-50,000 people.

AHPs supporting primary care

A number of pilots are underway that see allied health professionals (AHPs) support primary care.

These include:

- The development of a pilot of First Contact Practitioner (FCP) roles. Patients presenting with musculoskeletal (MSK) problems represent up to 20% of primary care consultations and 10% of GP referrals to secondary care. Enabling people to

self-refer to MSK FCP services can speed up access to treatment, reduce GP workload and associated costs, reduce unnecessary diagnostic referrals, increase self-management and reduce inappropriate referrals to secondary care;
- Enabling direct referral from care homes for physiotherapy, occupational therapy, speech and language therapy and dietetics means that GPs don't have to see the patient and complete a referral form prior to getting the assessment and intervention they need;
- Development of service level agreements for physiotherapy sessions to support GP Improved Access (evening and weekend routine primary care sessions) by providing therapists to work as part of the primary care clinical workforce.

AHP job planning

Historically there is a lack of detailed information on demand, capacity and activity within AHP services (physiotherapy, occupational therapy, speech and language therapy and dietetics). Having detailed information of demand and activity to ensure accurate capacity planning will demonstrate AHP impact to system working. The current work programme will ensure that demand and activity data is available for each service by end of July 2019 and is standardised in line with NHSi guidance (which will be mandated in September 2019). The project will continue with all AHPs having job plans which we can then use to benchmark against similar sized originations and model hospital and indentify potential financial efficiencies to support CIP delivery.

Home intravenous antibiotics

In December 2018, the first patients were supported at home to receive their long term course of antibiotics by a new Trust service. Recognising the risks of deconditioning, poor patient experience and inefficiency of requiring patients to remain as an inpatient for six weeks, the new service will enable patients to receive treatment at home. Many of these will be able to self-care and those who cannot will be supported by trained community nurses. A clinic-based alternative will also allow those able to travel to receive treatment on an outpatient basis. This service will be available in all areas with the community element provided by Humber Foundation Trust in Scarborough and Ryedale and by City Health Care Partnership in Bridlington. As well as freeing up around 30 inpatient beds, when fully operational the service will also reduce the Trust's carbon footprint by 378 tonnes of carbon dioxide each year.

In the Vale of York, the Trust is currently working with CCG on a plan to implement gentamicin prophylaxis in the community to prevent the need for admission for patients with a urinary infection.

2.2 CQC Review: purpose and methodology

The CQC advised that the purpose of the review was three-fold:

1. To act as a critical friend and support the system to understand the progress that had been made since the initial review;
2. To add to national learning on the enablers and barriers to improving the interface between health and social care;

3. To support the CQC in learning how to review whole systems (as opposed to individual organisations).

The follow up review methodology was less intensive than the initial review. It comprised:

- The system produced an overview of progress made since the initial review;
- The CQC reviewed a range of data relating to older people's experience of care;
- The CQC conducted two days of face to face interviews and focus groups (this review did not include any site visits or individual case tracking);
- The CQC produced a report summarising the review findings which will be presented to Health and Wellbeing Board members in January 2019. *[link to be added once published]*

2.3 Data Review

The CQC looked at how York's performance against the England average had changed since the original data profile was produced, and at how performance had changed over time. Overall their analysis showed that since they produced the original data profile York's A&E attendances for older people have remained lower than the England average, but rates of emergency admissions have remained higher. Performance had deteriorated for admissions from care homes, and was now worse than the England average. York maintained a better than average performance for length of stay. Its performance for delayed transfers of care had initially deteriorated and, more recently, improved but was still above the England average.

2.4 Review Findings

The review found a number of areas where positive progress had been made and identified areas for the system to continue to focus on.

- It noted that relationships in the system had improved, especially at the operational level (for example the Integrated Discharge Hub) but also recognised the impact of the financial situation which was straining relations between the Trust and CCG;
- It praised the progress made with the livewell.org.uk website which has been established to provide a central information point on services available in the city;
- It recognised the establishment of the Place Based Improvement Partnership and the improved links with the Humber, Coast and Vale Health and Care Partnership but advised more work was required to clarify the purpose of the partnership and what it was aiming to achieve;
- The progress against the High Impact Changes to Reduce Delayed Transfers of Care was noted and this needs to continue particularly around 7 day services and trusted assessment;
- Improvements in engaging with the independent care sector were highlighted but there are opportunities to involve them further as strategic partners and there was an lack of a strategic plan for addressing capacity constraints in the care market;
- It noted the positive development of a Home First approach in the Trust, the One Team integration of intermediate care and reablement and development of pharmacists to review the medications of care home residents;
- It also noted the limited progress in joint commissioning, digital interoperability and developing a system-wide workforce strategy;

- Overall it noted the positive progress that had been made but suggested that the pace of change could have been faster.

3. Recommended Next Steps from the CQC review

The CQC made the following recommendations:

1. System leaders should review the York Improvement Plan and assess progress made against the expected impact. Considering this report, system leaders should agree on revised actions, with members of the Place Based Improvement Partnership (PBIP) accountable to the Health and Wellbeing Board for designated actions.
2. At our Progress Review the CQC found that progress against the areas for improvement identified at the October/November 2017 Local System Review was slow. Through the PBIP, system leaders should establish how they can increase the pace of change.
3. System leaders should continue to focus on developing relationships and partnership working across the system. For the PBIP to lead partnership working across the system, partners must agree on the collective system vision and strategy and develop a system wide plan that is agreed and signed up to by all system partners. There should be a system approach to new appointments, especially those at a system leader level.
4. Directors of Finance across health and care should explore opportunities to work more collaboratively, owning organisational challenges as 'system challenges'. Directors of Finance should also work with commissioning leads to develop plans to facilitate joint commissioning.
5. Commissioners should ensure that a joint commissioning strategy is developed as a matter of priority. Commissioners should also focus efforts on strengthening performance metrics and data collected at a local level to provide a greater understanding the impact of commissioned services and schemes.
6. The system should accelerate the development of a system workforce strategy co-produced with independent care providers and VCSE partners.
7. The system should continue to work with independent providers and utilise engagement forums to move towards a seven-day service model and co-produce a model for trusted assessment.
8. The system should continue to develop and promote the Live Well York website across the system and strengthen information available for people who fund their own care.

The recommendations will be discussed by system leaders at a Health and Wellbeing Board development session, attended by the CQC review team, in January 2019.

4. Detailed Recommendation

The Board of Directors is asked to consider the recommendations of the CQC Review and how these will be incorporated into the Trust's strategic plan.

The Board of Directors is also asked to note the positive developments in out of hospital care as part of our Home First strategy.

APPENDIX 1

NHS-Social Care Interface Dashboard 2018

The 2018 dashboard showing the indicators CQC use to assess the interface between the NHS and social care in local systems has been released. It shows the City of York is ranked 144th out of 152 systems (was 145th in 2017).

The table below compares the individual components – all except delayed discharge days and weekend discharges are for people aged over 65.

	2017 Figure	2017 Rank	2018 Figure	2018 Rank
Admissions/100k pop	26,056	89	29,325	103
90th percentile LoS	21	75	18	32
Delayed discharge days	14.2	97	13.5	109
% reablement customers at home 91 days	75.7	134	79.2	111
% population receiving reablement	2.2	105	0.8	149
% weekend discharges	17.2	148	17.5	148

In terms of where the system ranks lowest – the % weekend discharges covers the whole Trust so includes Scarborough but shows how little progress has been made in increasing the rates of weekend discharge across the Trust. This is despite having weekend social worker/DLT presence since the winter (figures are the whole of 17/18 so this would only affect the later months but we know from local monitoring it is still not making a significant impact), however they only affect a small portion of overall discharges and are reliant on having services to discharge into – but their earlier intervention is likely to be helping the length of stay figure.

% of the population receiving reablement appears to be a lot worse – it is a counting change as CYC had previously included health intermediate care patients and then decided that this wasn't within the guidance. The figure is for 2016-17 (social care ones are a year behind) but we know 17/18 is the same percentage so will keep holding us back. The council have invested in additional reablement capacity (40%) and referrals for the first 4 months of the year are 24% higher but this will not massively change the figure in this report – large amounts of reablement capacity continue to be occupied providing long term care awaiting packages to start.

Better news on the % reablement customers at home 91 days post discharge – again a data issue as the earlier figures included patient who should have been on an end of life pathway – has improved in this report but will go up to 92.5% in the 17/18 figures (2019 dashboard) which would rank in the top 20 authorities.

DToC has slightly improved (fewer days lost) but at a slower rate to others hence the falling rank. We know the council are investing more to try and improve this but against a backdrop of closing care homes, inability to recruit carers and CHC delays (both brokerage and assessments). It appears we are counting more DToCs than we did previously – other metrics such as the numbers of excess bed days (Vale of York CCG has 26.8 days per 1000 population – national average is 37.8) or % beds occupied by patients who are super-stranded (latest ECIP report for past six weeks shows YFT at 16.3% beds occupied against north region average of 19.3%) show York as being above average performers so there is a disconnect.

Admissions per head of population have deteriorated (given the relatively small fall in rank for what looks like a big increase suggests a similar trend elsewhere) – other areas will be impacting depending on how they count their ambulatory patients although conversely this will be helping the length of stay figure.

Length of stay – puts the system in the top quartile for at least one measure and provides some evidence of the impact of all the action that is being taken. This has been driven by a number of developments - overall referrals to the 'One Team' services were up by 13% on Q1 last year, the Hub in York continues to integrate

and get involved earlier with patients, weekend working for social workers and DLT, front door frailty, SAFER and the council are trying to invest in services and put a significant focus on DToCs.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Director of Estates and Facilities Report – January 2019

Trust 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 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: January 2019

1. Director's Overview

January brings fresh challenges for the Estates and Facilities department who are working with colleagues to ensure winter resilience plans are in place across the Trust with the objective of achieving minimal disruption to our services.

Our Capital Projects team is working closely with Humber, Coast and Vale Health and Care Partnership to understand the processes involved in the delivery of the strategic capital project at Scarborough Hospital. A proposed governance structure has been prepared and a copy of this is attached for information purposes (Appendix 1).

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 December 2018. A copy of this report is attached for information and assurance (Appendix 2).

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

2.2 Health and Safety Non-Clinical Risk Group

The Health and Safety Non-Clinical Risk Group is responsible for overseeing health and safety and for identifying the implications of any emerging non-clinical risks to ensure they are being appropriately managed with action plans in place.

The Health and Safety Non-Clinical Risk Group met on 3 December 2018 and the members of the group wish to highlight the following items to the Board of Directors:

a. Concerns have been raised by the Trust's legal team that incidents are not being fully investigated at the appropriate time. The group is keen to address this and it was agreed that a briefing package would be prepared to reinforce the expectations in relation to incident reporting. It is important to ensure that, as part of the progression of the LLP, Estates and Facilities staff have robust processes in place within each department to ensure staff members feel connected and supported when dealing with incidents.

b. The group reviewed training information provided by the Corporate Learning and Development Team and felt that further investigation is required to ensure that gaps in training provision are identified and addressed. Representatives from the Medical Devices Training team and Corporate Learning and Development will be invited to the next meeting of the group to discuss the next steps in relation to gap analysis.

c. Ongoing issues have been highlighted via meetings of the Trust's Risk Review Group and Radiation Safety Group in relation to clinical staff members using the log ins of other staff members which presents numerous patient safety risks. Colin Weatherill will be contacting the Trust's Medical Director to discuss this further and Fiona Jamieson will be raising the issue via the Trust's Information Governance Committee.

Summary Note: Board members are asked to note the update from the Health and Safety Non-Clinical Risk Group.

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".*

Sustainability workstreams are progressing well with the next meeting of the Sustainable Development Group arranged for 25 January. A further quarterly update report will be presented to the Board of Directors at their February meeting.

4. Facilities Management Compliance

A copy of December's Monthly Facilities Management Compliance Report is attached for information purposes (Appendix 3).

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

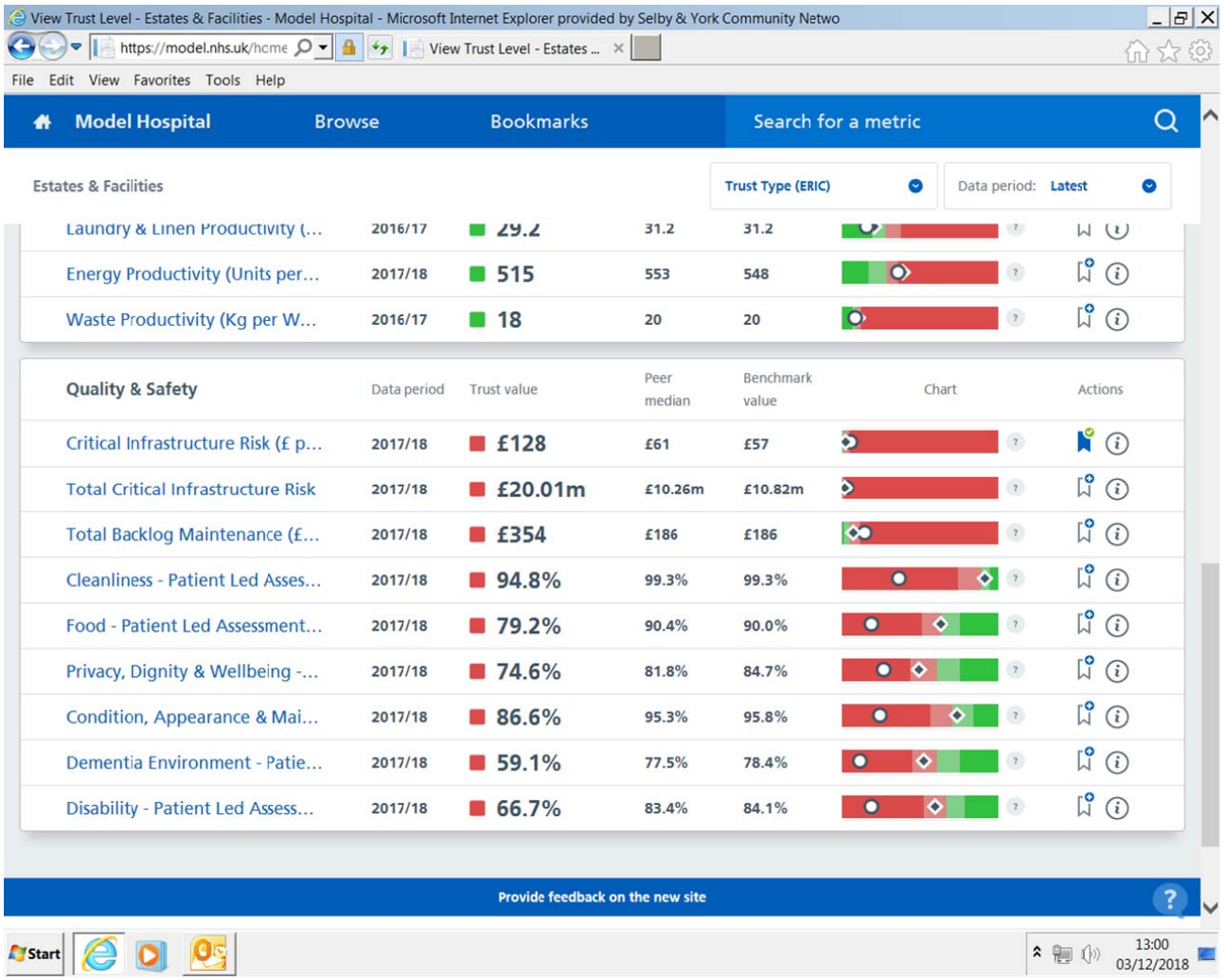
5. Performance Against Lord Carter Metrics

Revised Lord Carter metrics and new model hospital data have now been issued for 2017/18 and information is available to Estates and Facilities staff via the NHS Model Hospital online portal.

The latest data has been reviewed and, currently, the Trust is performing well against a number of the efficiency and productivity metrics related to Estates and Facilities provision including Estates property and maintenance costs, portering service costs and energy costs. Achievement of benchmarks in the following areas associated with cost efficiency requires some improvement:

Grounds and gardens maintenance costs
Cleaning costs
Water and sewage costs

In relation to safety benchmarks, the information which is based on ERIC and PLACE Returns for the year is shown below:



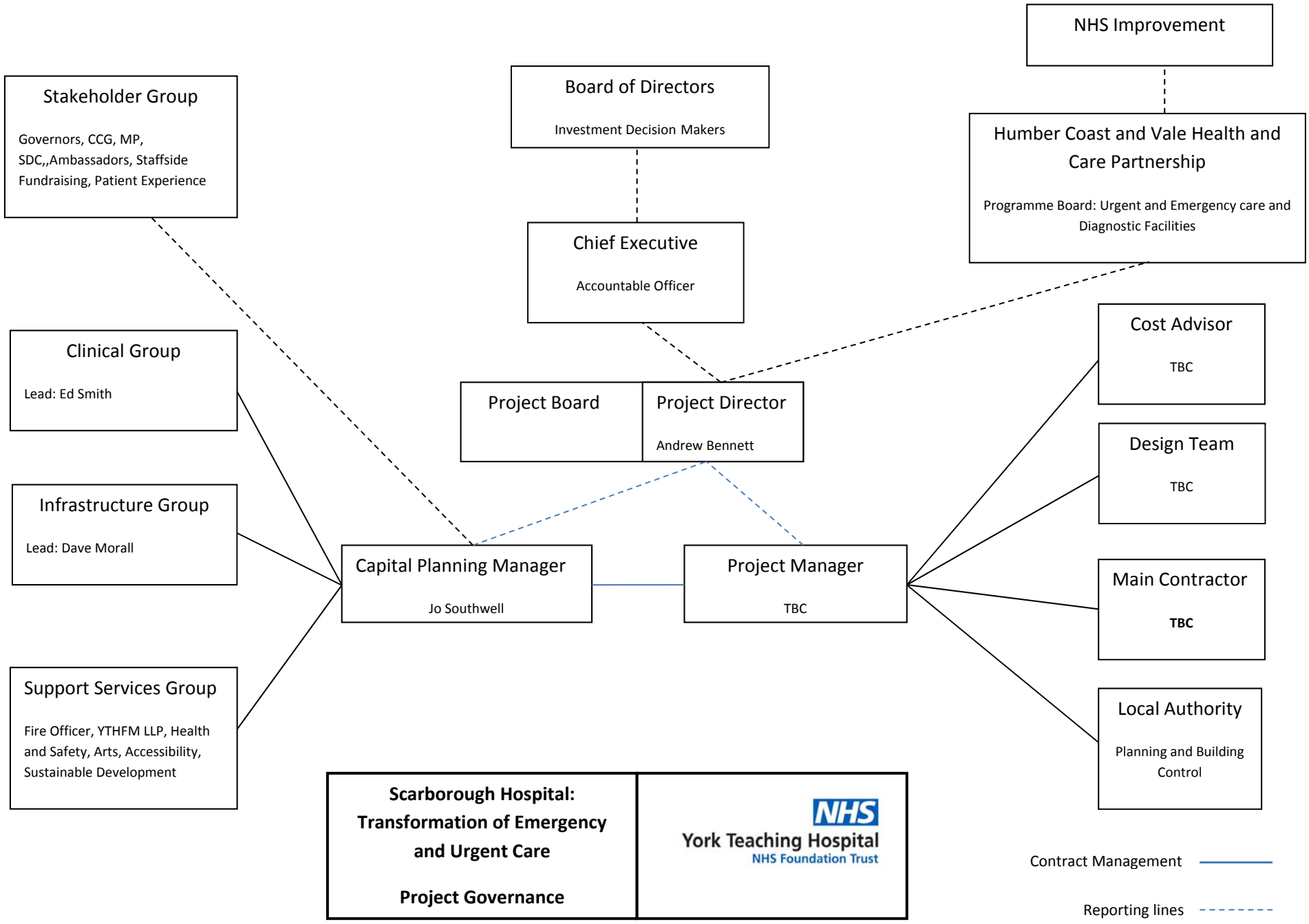
The position will be monitored and further updates will be provided in due course.

6. Next Steps

A further report will be prepared for the Board of Directors in February 2019.

7. Detailed Recommendation

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


NHS Improvement
Board of Directors
Investment Decision Makers
Stakeholder Group
Governors, CCG, MP, SDC,,Ambassadors, Staffside Fundraising, Patient Experience
Humber Coast and Vale Health and Care Partnership
Programme Board: Urgent and Emergency care and Diagnostic Facilities
Chief Executive
Accountable Officer
Cost Advisor
TBC
Clinical Group
Lead: Ed Smith
Project Board
Project Director
Andrew Bennett
Design Team
TBC
Infrastructure Group
Lead: Dave Morall
Capital Planning Manager
Jo Southwell
Project Manager
TBC
Main Contractor
TBC
Support Services Group
Fire Officer, YTHFM LLP, Health and Safety, Arts, Accessibility, Sustainable Development
Local Authority
Planning and Building Control
Scarborough Hospital: Transformation of Emergency and Urgent Care
Project Governance
NHS
York Teaching Hospital
NHS Foundation Trust
Contract Management
Reporting lines

Health and Safety Non-Clinical Risk Summary Report – December 2018

1. Introduction

This report relates to December 2018 and summarises health and safety and non-clinical risk performance throughout the month. The report is to provide assurance on the non-clinical risk and health and safety activity in York Teaching Hospital NHS Foundation Trust (Trust) and York Teaching Hospital Facilities Management LLP (YTHFM).

The report summarises reported statistics via the Trust Accident and Incident Reporting System (Datix) in relation to accidents, incidents and near-miss events, reported patient experience data from the Patient Advice and Liaison Service (PALS) and key initiatives or challenges in the Trust and YTHFM. The report provides an update on health and safety management issues relevant to the Trust and YTHFM all of which form part of the wider Trust's management approach of non-clinical risk.

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

2. December Summary

Opened Employee and Public Liability Claims

Trust Claims

In December there were:

2 employee liability claims which consisted of:
- An alleged injury when moving and lifting a patient
- A slip when responding to a crash call

1 public liability claim; this was a GDPR-related claim concerning the unauthorised access of medical records.

LLP Claims

No claims were logged against YTHFM for December.

A letter was received in November 2018 in connection with an accident relating to a trip in a car park at Scarborough Hospital. Initially, this was dealt with as a potential claim in person against YTHFM however on review of the detail set out in the letter, this has not progressed to a claim and has been dealt with as a complain. The complaint has now been closed by both YTHFM and YTHFM's insurance company, Newline Insurance; if the situation changes further details will be reported at that time.

Reported Non–Clinical Serious Incidents

No non-clinical serious incidents were reported for December 2018.

Health and Safety Performance Monitoring - Summary of December

Review of Datix reported incidents for December in the main remained in line with the Trust's monthly[1] averages for each reporting category.

The reporting categories and the associated number of incidents reported are detailed in Table 1 shown below:

Incident Type	Dec-18	Average Record Month
E&F Contact With	0	0
Slips, Trips & Falls (Patient & Others)	241	248
Staff Incidents	91	83
Security	22	26
E&F Equipment Issues	25	25
E&F Facilities	17	14
E&F Fire	3	6
E&F Health & Safety	5	7
Cumulative Total Month	404	410
Total Datix	1295	1281

The reporting mechanism for Datix incidents is currently under review with the Datix Manager to ensure an accurate and categorised reporting system is in place for both Trust-related incidents and LLP-related incidents. Further updates will be provided in relation to this in coming months.

For December 2018, YTHFM LLP (Estates and Facilities) reported 20 incidents on Datix, equating to 1.54% of the total number of incidents reported on Datix for the whole Trust and LLP.

The 20 incidents reported by the LLP can be categorised as follows:

- 1 twisted ankle – investigations are ongoing to identify causes and the staff member visited the Emergency Department to receive treatment
- 2 incidents relating to damaged medical devices – the damaged devices have been removed to avoid further incidents.
- 10 security incidents – 1 investigation is ongoing; the remaining 9 cases have been closed. It was noted that the correct protocols have been duly followed for all 9 incidents.

[1] Recorded incidents from Oct 2015

- 3 incidents relating to the internal transport of clinical waste using unsuitable equipment - all 3 incidents have been escalated to the Head of Safety and Security and actions are now being taken to resolve this matter.
- 1 road traffic incident involving staff members – investigations are currently ongoing however all staff members are unharmed.
- 1 injured finger – investigations are ongoing to identify causes; the staff member was treated for a minor cut.
- 1 near collision involving incorrect use of the one-way system at York Hospital – this has been investigated and feedback has been provided to the staff member concerned to avoid future incidents.
- 1 incident relating to the segregation of waste - this is detailed in the section below.

YTHFM LLP (Estates and Facilities) are also responsible for leading on investigations into 53 incidents on Datix equating to 4.09% of the total number of incidents reported on Datix.

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

For December 2018, one accident was reported on Datix[2]. This related to a member of staff slipping whilst crushing a cardboard box and being absent from work for a period of more than 7 days. Investigations are ongoing to identify safer working practices to avoid future incidents.

The frequency of these reports is monitored; as of date of the production of this report (08/01/19), it has been 35 days since the last RIDDOR reportable incident occurred. The total number of RIDDOR incidents for 2018/19 is 10 (year to date), compared to 7 for the same period in 2017/18. If reporting continues at this rate the estimated year-end number of RIDDOR for the 2018/19 will be 13.

5 of the 10 incidents reported for the whole YTH group related to YTHFM staff.

Amendment Note

At the time of November's report (04/12/18) it was stated there had been no RIDDOR incidents reported on Datix for the month. Due to the date of occurrence of the accidents and the accidents falling into RIDDOR >7 day absence category 2 RIDDOR incidents were subsequently reported for the month of November. 1 RIDDOR involved Trust staff and 1 involved YTHFM staff.

[2] Reporting year 01 April 2018 to 31 March 2019

Patient Advice and Liaison Service (PALS) Data

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

For December 2018, non-clinical and environmental (EFM) PALS are summarised below:

	Dec-18
Complaints	1
Concern	1
Compliment	0
Enquiry	0
Comment	2
Total	4

The general themes from the reported categories are detailed below:

- Patient transport issue – this was resolved by Directorate Managers in the Operations team as this is part of wider ongoing concerns.
- Parking issues at Springhill Close in Scarborough – a response has been provided; this is part of an ongoing parking concern which Scarborough Council representatives are aware of.
- Issue with the sensors on lifts at the main entrance area of Scarborough Hospital – a response was not required however these comments have been passed onto Dave Morrall, Assistant Head of Estates and Facilities (East Coast), for consideration.
- A complaint regarding paying for parking at York Hospital – the Directorate concerned agreed to validate the complainant's parking for their visit. A response was also issued from the Car Parking and Security team to address the complainant's wider concerns. The complaint has now been closed.

3. External Authorities

There were no reported H&s/Non-clinical interventions from external authorities for the month of December.

4. Conclusion

This report highlights the performance of health, safety and non-clinical risk in the Trust and YTHFM LLP for December 2018, forming part of the ongoing oversight of the Trust's Health Safety and Environmental functions.

5. Recommendation

The Board of Directors and the YTHFM LLP Management Group are asked to note the contents of this report.

Author: Colin Weatherill, Head of Safety and Security, York Teaching Hospital NHS Foundation Trust

Executive Sponsor: Brian Golding, Managing Director YTHFM LLP/ Associate Director of Estates & Facilities York Teaching Hospital NHS Foundation Trust

Date: 08 January 2019 V1.0

York Teaching Hospital
NHS Foundation Trust

FM Contract (YTHFM)

Monthly FM Compliance Report

Month	December **2018 (9)**
David Biggins	Head of FM Compliance & Performance
(Quarter) /Year	(3) 2018/2019
Version	1.0

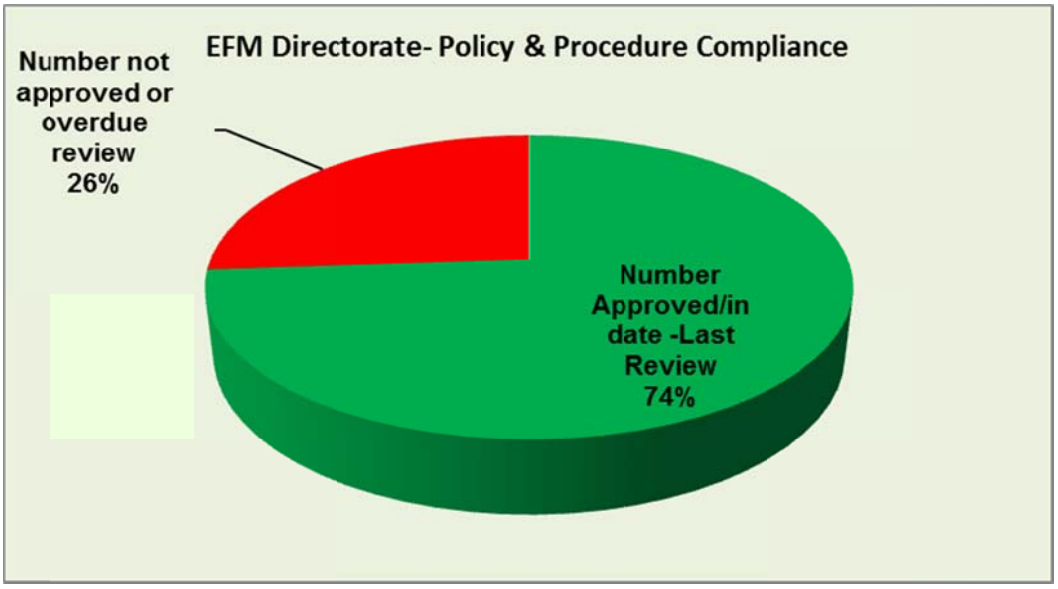
Faciliites Management Key Performance Indicator Dashboard- Month 9- December 2018

Metric Description	KPI	York Site	SGH Site	Brid Site	Selby Site	Malton Site
Policies & Procedures identified on the Policy and Procedure Register are approved and within review dates	100%	73%	73%	73%	73%	73%
TAPE Assessment						
All sites are achieving KPI against the Trust Assessment of Patient Environment (TAPE)	80%	79.80%	64.90%	66.20%	80.50%	71.40%
NHS Premises Assurance Model						
The **Trust** is demonstrating less than 20% amber or red ratings against NHS Premises Assurance Model; **Efficiency, Effectiveness and Governance Domains**	<20%	7.70%	2.50%	3.90%	2.50%	3.90%
YTHFM is demonstrating less than 20% amber or red ratings against NHS Premises Assurance Model; **Safety and Patient experience Domains**	<20%	48%	52.00%	44.00%	47.00%	58.00%
PLACE Assessment						
Cleanliness Domain	98%	95.20%	92.90%	96.80%	100%	85.80%
Food Domain	78%	78.80%	81.30%	70.10%	83.80%	79.20%
Conditon, Apperance & Maintenance Domain	85%	85.60%	86.60%	87.10%	98.40%	87.80%
Dementia Domain	78%	58.90%	58.70%	52.40%	78.00%	63.10%
Disability Domain	67%	67.10%	68.20%	50.20%	78.40%	66.70%
Environment & Equipment						
Catering Hygiene surveillance	87%	63%	69%	76%		
Grounds & Gardens Surveillance	92%			42.80%		
Building Accessibility	90%			<55%		
Medical Equipment Surveillance	90%	83.50%	96.00%	98.00%	97%	
Cleanliness Technical Audits						
Very High Risk Areas (av)	>98%	96.58	98.03	97.43	97.84	
High Risk Areas (av)	>95%	88.6	95.77	96.73	80.42	87.11
Significant Risk Areas (av)	>85%	89.88	83.73	91.2	86.09	
KPIs Met		2	4	4	8	1
KPIs Partially Met		6	5	6	3	4
KPIs Not met		6	5	6	2	5
KPIs measured in period		14	14	16	13	10

		Nov-18	%	Dec-18	%
Green	KPI ratings within a range that indicates operational arrangements are effective and generally being met	14	21.20%	19	28.40%
Amber	KPI Ratings within a range that indicates some elements of good practice but also elements that require moderate improvement	27	41.00%	24	35.80%
Red	KPI ratings within a range that indicates weak operational controls and significant improvement required	25	37.80%	24	35.80%

1. Policy and Procedure Compliance- Directorate

	Estates & Facilities Directorate Policies & Procedure Register						
	Title	Format	Current Status	Policy in date or outstanding	Next Review Date	Authors	Approving Group/Committee
1	Asbestos Management	Policy	Approved		Oct-20	K Needham	Health & Safety Committee
2	Asset Management & Maintenance	Procedure	Approved		TBC	J Dickinson	Premises Assurance Group
3	Environmental Cleaning Policy	Policy	Approved		Oct-19	TBC	Environment & Estates Committee
4	Health & Safety Policy	Policy	Approved		Mar-19	C Weatherill & K Needham	Health, Safety & Non Clinical Risk Group
5	Catering	Procedure	DRAFT		TBC	S Mollier	Environment & Estates Committee
6	Medical Gas Management Policy	Policy	Approved		Oct-19	D Moon	Medical Gas Committee
7	Non Piped Gas	Procedure	DRAFT		TBC	J Dickinson	Health & Safety Committee**
8	Water Safety & Legionella	Policy	Approved		Sep-18	D Moon	Water Safety Group
9	Electrical Safety	Plan	Approved		Feb-18	P Johnson	Electrical Safety Group
10	LOLER/Lifts	Procedure	DRAFT		TBC	J Dickinson	Health & Safety Committee
11	Ventilation & Air Conditioning	Procedure	Approved		Dec-19	J Dickinson	Ventilation Steering Group
12	Pressure Systems	Procedure	Approved		TBC	J Dickinson	Health & Safety Committee**
13	Decontamination	Policy	Approved		Jun-19	D Biggins/J Brockway	Decontamination Steering Group
14	Fire Safety	Policy	Approved		Jan-19	M Lee & K Hudson	Environment & Estates Committee
15	Waste Management	Policy	Approved		May-21	C Weatherill.	Health, Safety & Non Clinical Risk Group
16	Medical Device Management	Policy	Approved		Mar-20	J Wilsher	Medical Device Management Group
17	Security	Policy	Approved		Sep-19	J Mason	Security Committee
18	Travel & Transport Policy	Procedure	Approved		Jun-18	J Money	Transport & Travel Committee
19	Pest Control	Policy	Approved		Jul-20	J Knott	Health & Safety Committee
20	Switchboard & Patient Multimedia	Procedure	Approved		Jul-19	L David	Premises Assurance Group
21	Portering	Procedure	Approved		Jul-18	J Louth/H Stelmach	Premises Assurance Group
22	Heatwave	Plan	Approved		Mar-19	C Weatherill.	Health & Safety Committee
23	Capital Projects Policy	Policy	None		TBC	A Bennett	CPEG

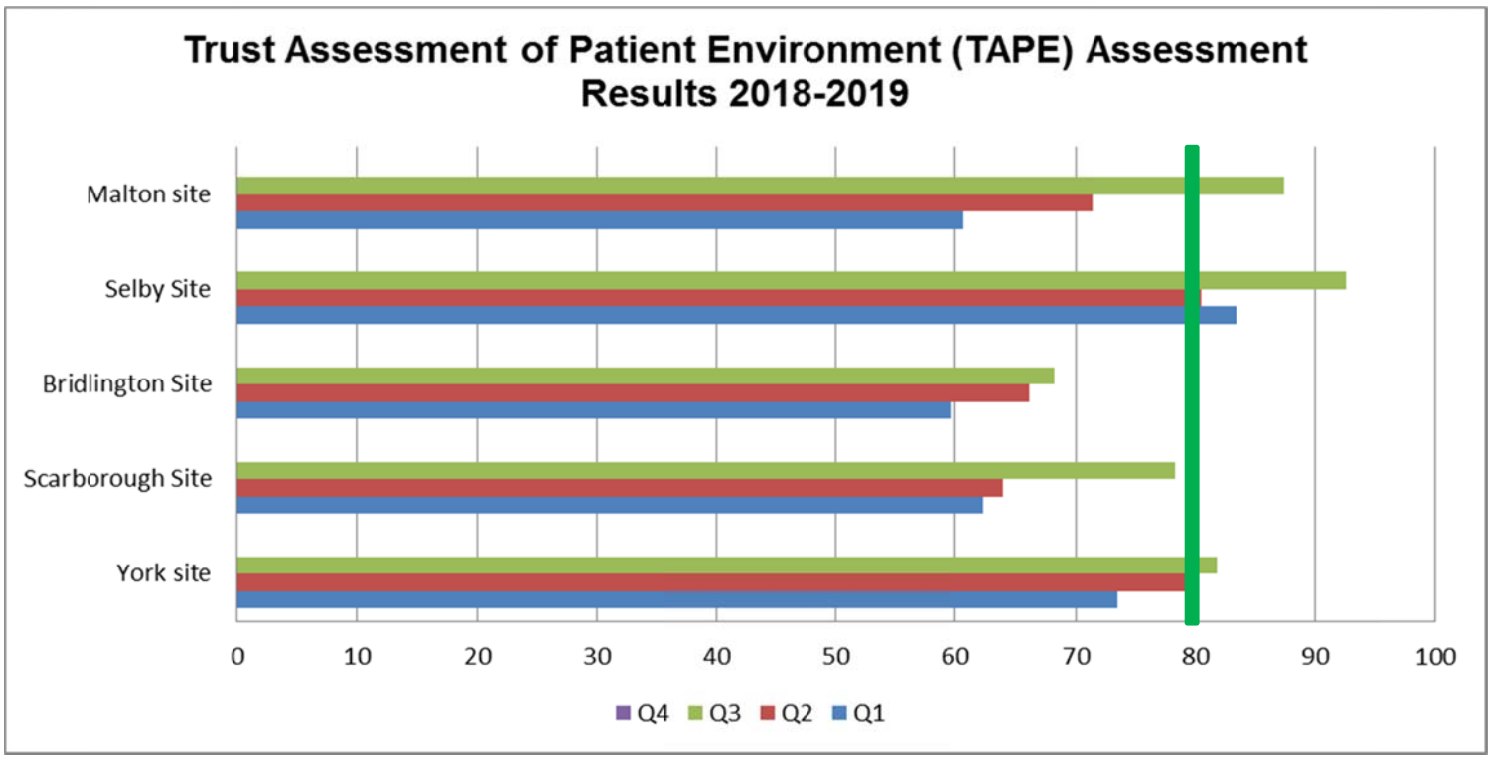


2. Decontamination of Reusable Medical Devices- Site

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										

Trust Assessment of Patient Environment (TAPE) - Site

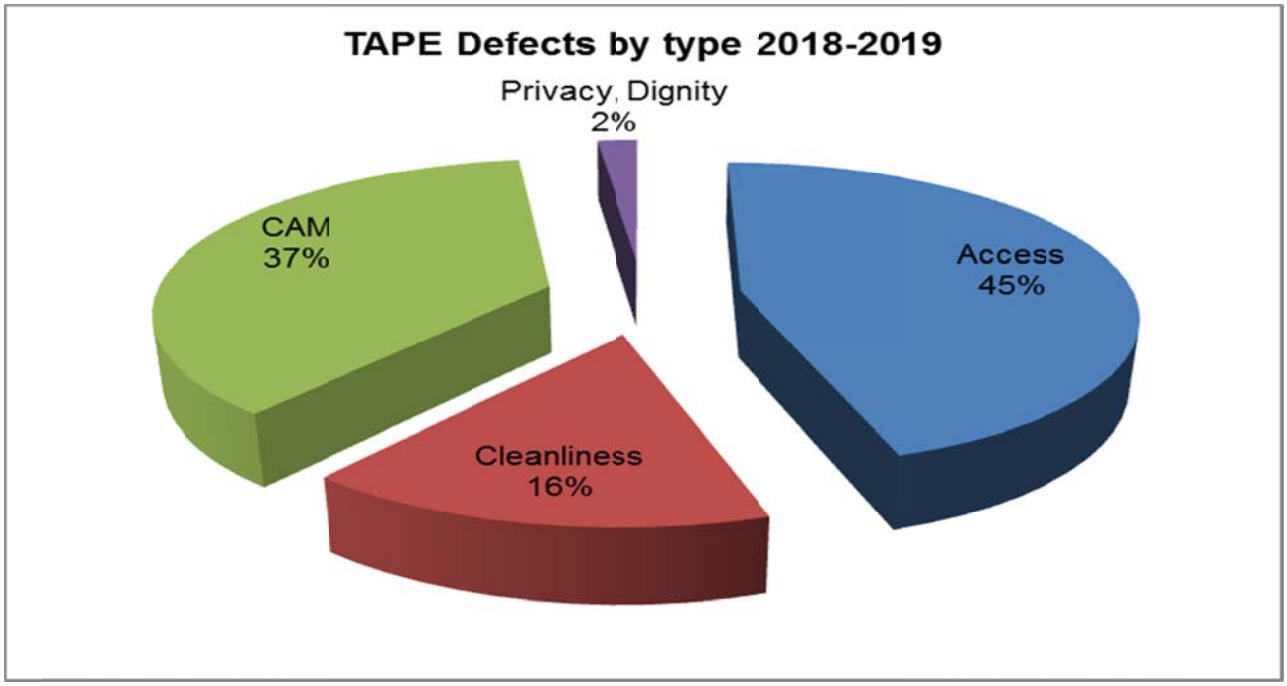
Quarter 3 results indicate improvements against TAPE Assessment key eprformance indicators with 3 sites meeting the performance range. Main Hospital sites at Scarborough and Bridlington are not currently meeting the key performance indicator however have improved against Quarter 2 assessment as shown in the graph below.



There are currently 176 TAPE Defects recorded on the defect register. The defect register has been distributed to FM Managers within the LLP with the expectation that corrective actions will be taken against defects reported.

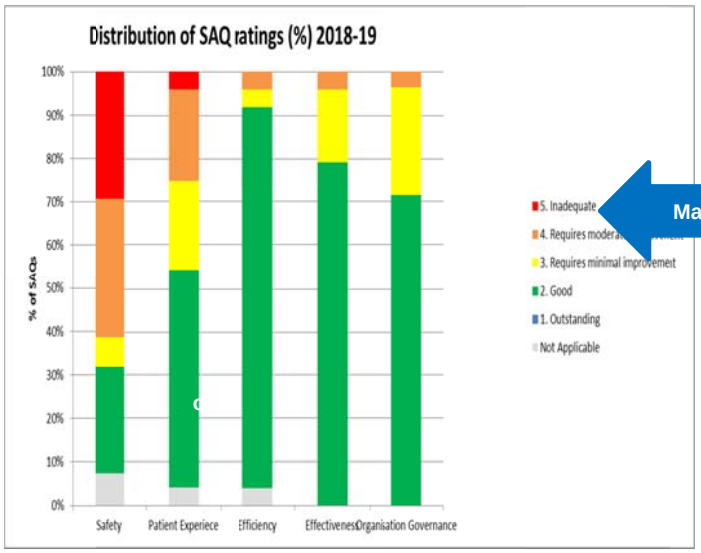
The FM Compliance team monitor progress with defect rectification through ad hoc surveillance.

The profile of defects identified at TAPE Assessments for Quarters 1-3 of 2018/2019 is shown below:

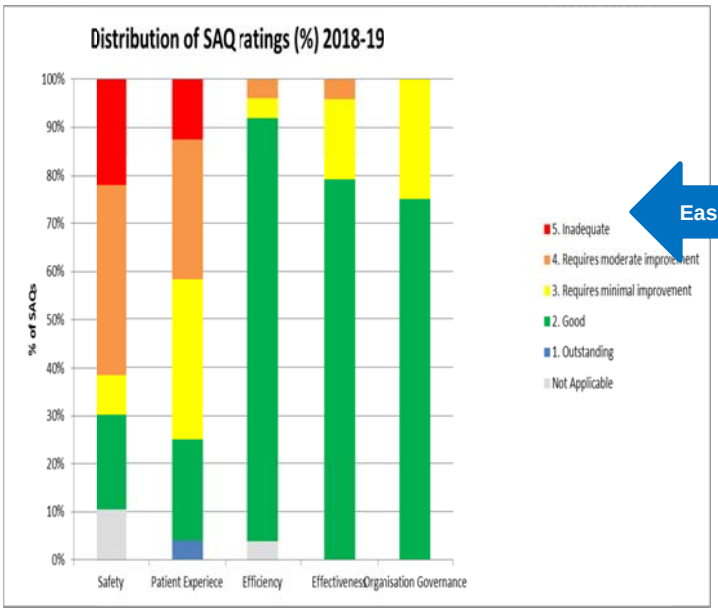


NHS Premises Assurance Model Position (By site)

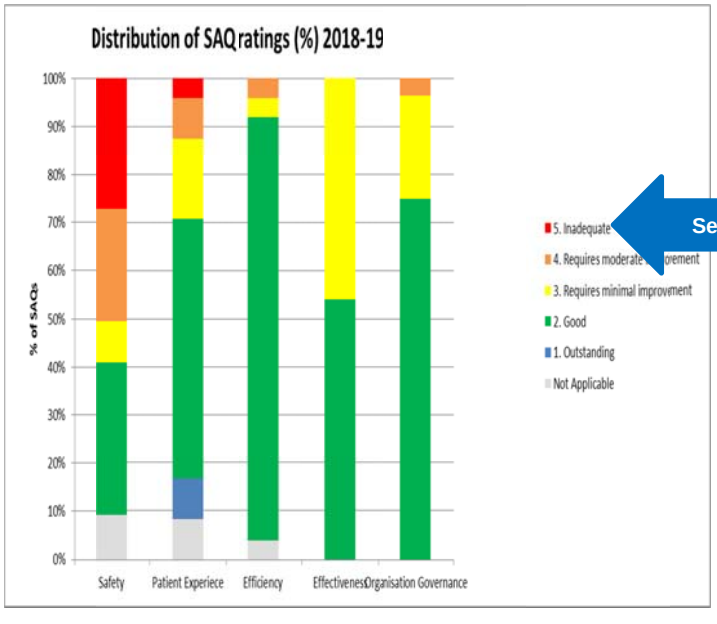
23rd November 2018



Malton

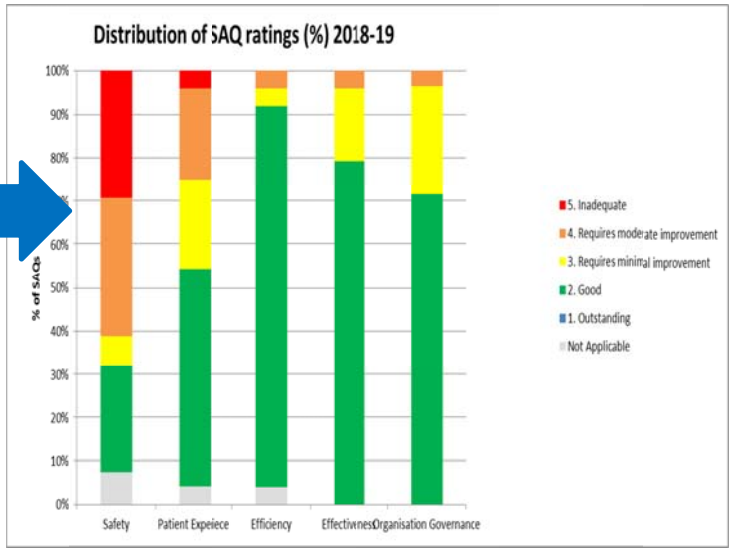


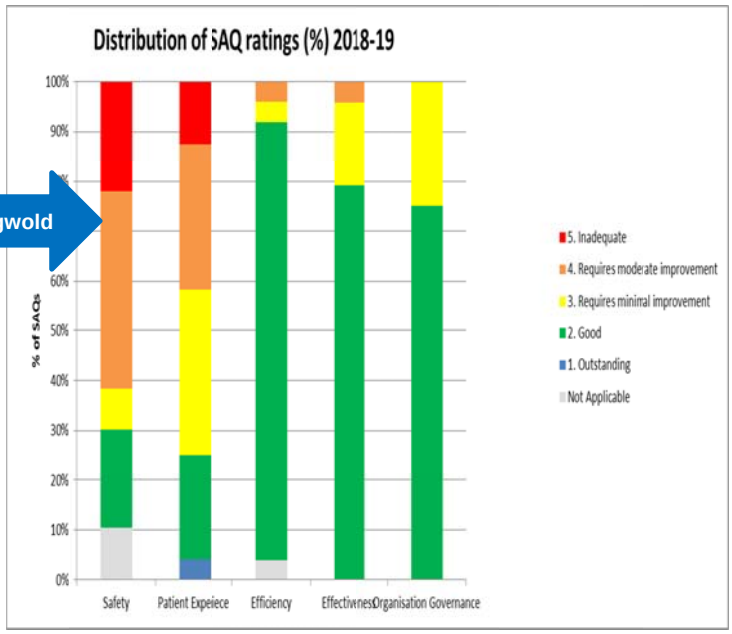
Easingwold

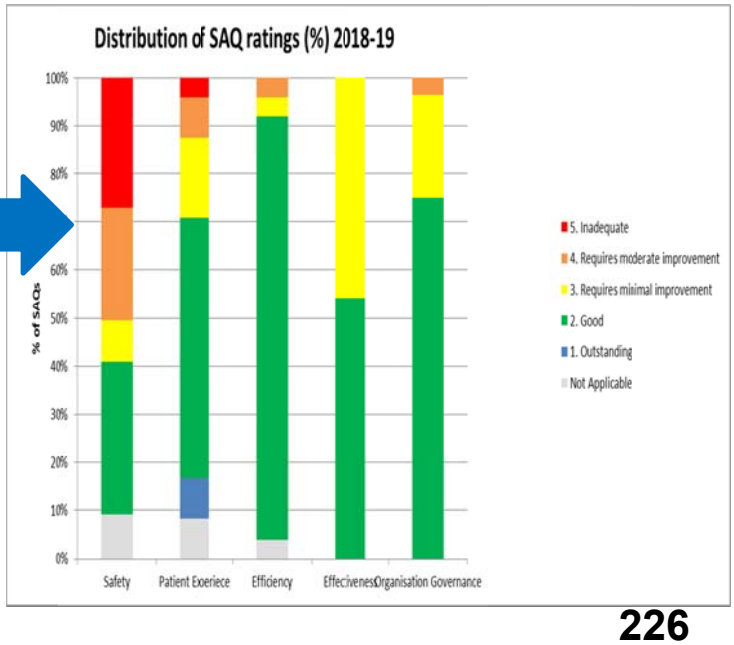


Selby

28th December 2018

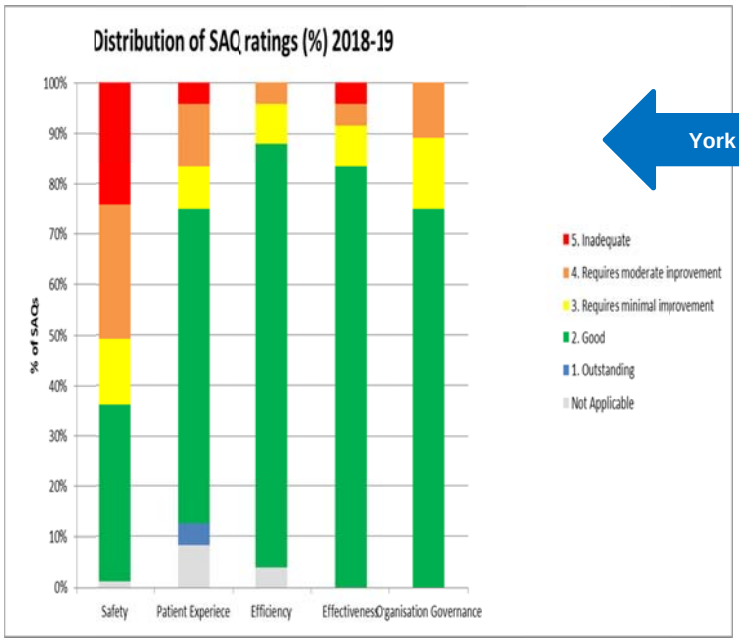




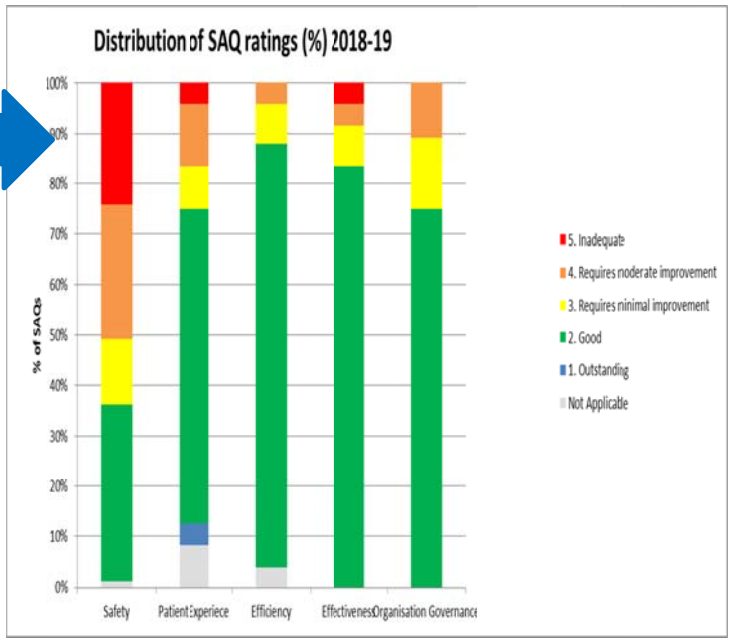


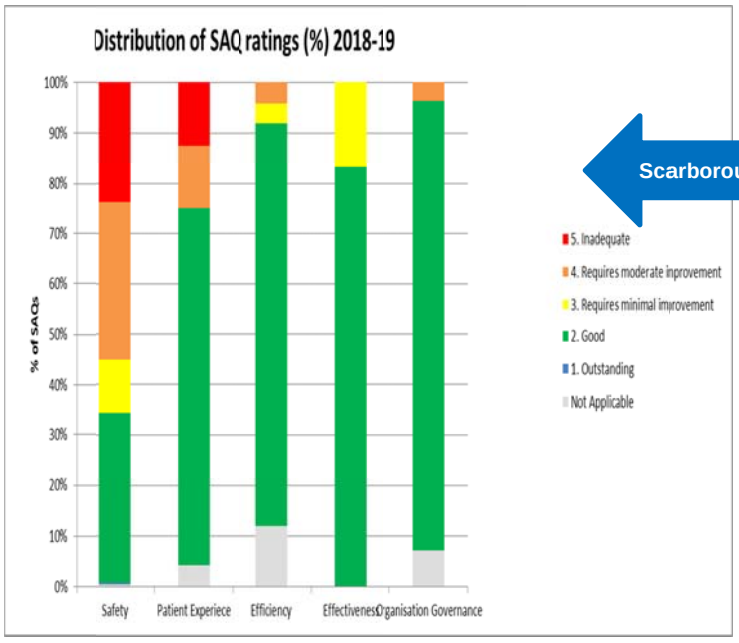
23rd November 2018

28th December 2018

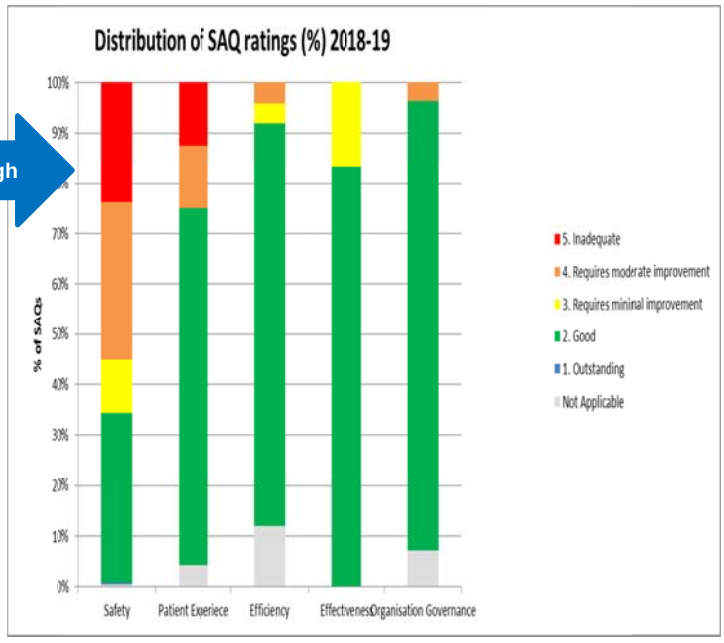


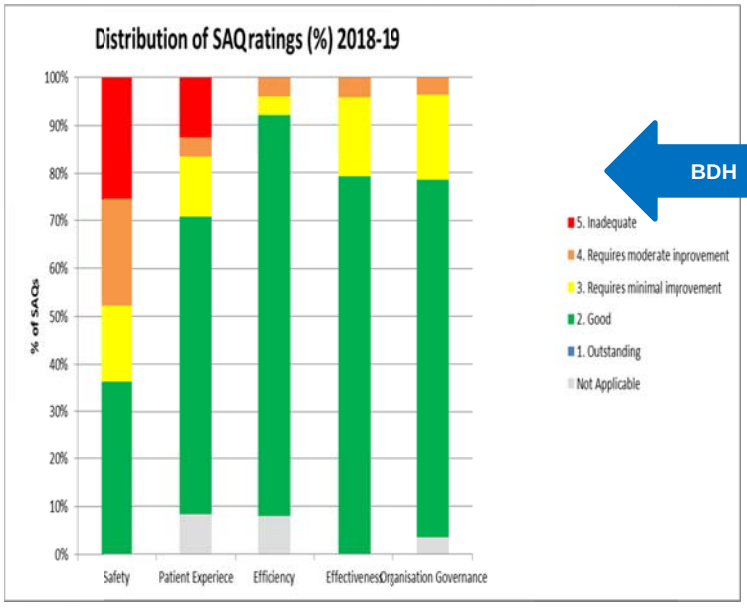
York



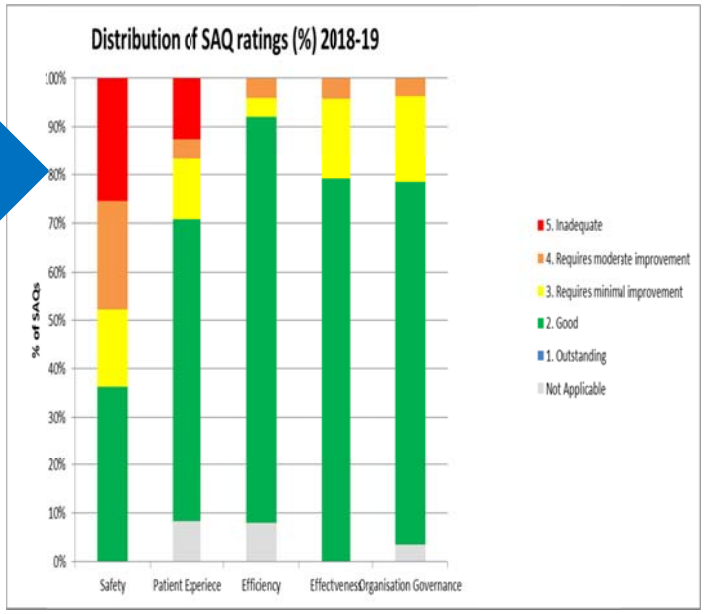


Scarborough





BDH



NHS Premises Assurance Model Position

The organisation`s performance in demonstrating compliance with the NHS Premises Assurance Model has again remained static over the last month 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.

It should be noted that YTHFM now provide compliance information relating to NHS PAM to the Trust representative.

YTHFM are responsible for demonstration of compliance with safety and patient experience domains, The Trust FM Compliance team is responsible for the remaining 3 domains (Efficiency, Effectiveness and governance).

Compliance is broadly being achieved against the efficiency, effectiveness and governance domain however the safety and patient experience domains are showing poor performance and as NHS Premises assurance model monitoring forms part of the Trusts board assurance e framework it is recommended that this continued poor performance against both safety and patient experience indicators is made known to the board of directors.

PLACE ASSESSMENT 2018 - Results

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%

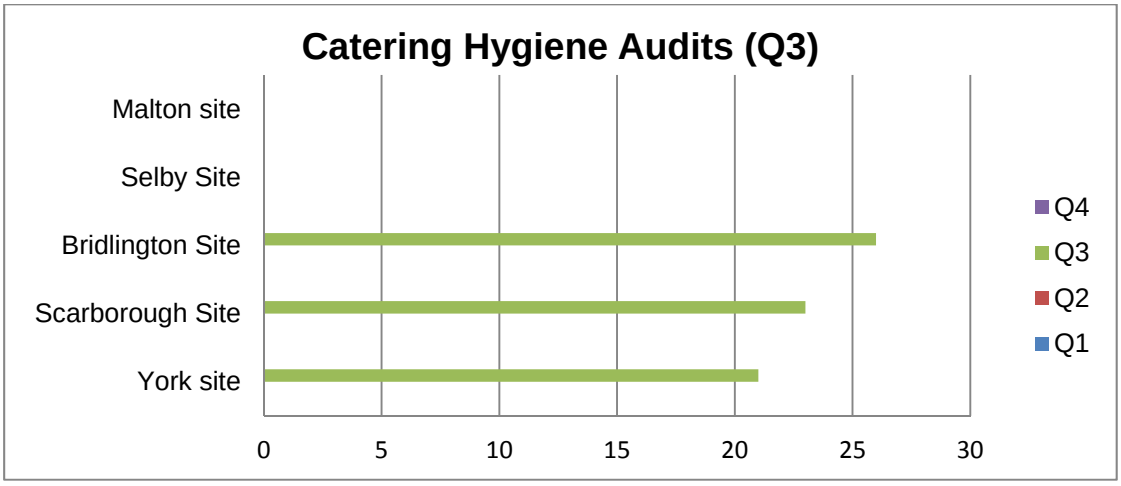
- Not meeting National Average
- Meeting national average
- Not meeting national average but improvement on previous year
- Not meeting National average and worse positon than previous year

Catering Hygiene Audits

Quarterly Catering Hygiene audits for main food production units and kitchens were commenced in November and provide a more detailed appraisal of environmental hygiene in these areas in order to enable further validation of TAPE Assessment data.

An initial KPI of 87% compliance with the audit tool has been set which is 3% lower than that specified in the current DRAFT service specifications that have been issued to YTHFM, adjustment to the KPI will be increased to 90% after a three month implementation period.

Additional sites that were not subject to audit in Q3 will be audited from Q4 onwards.

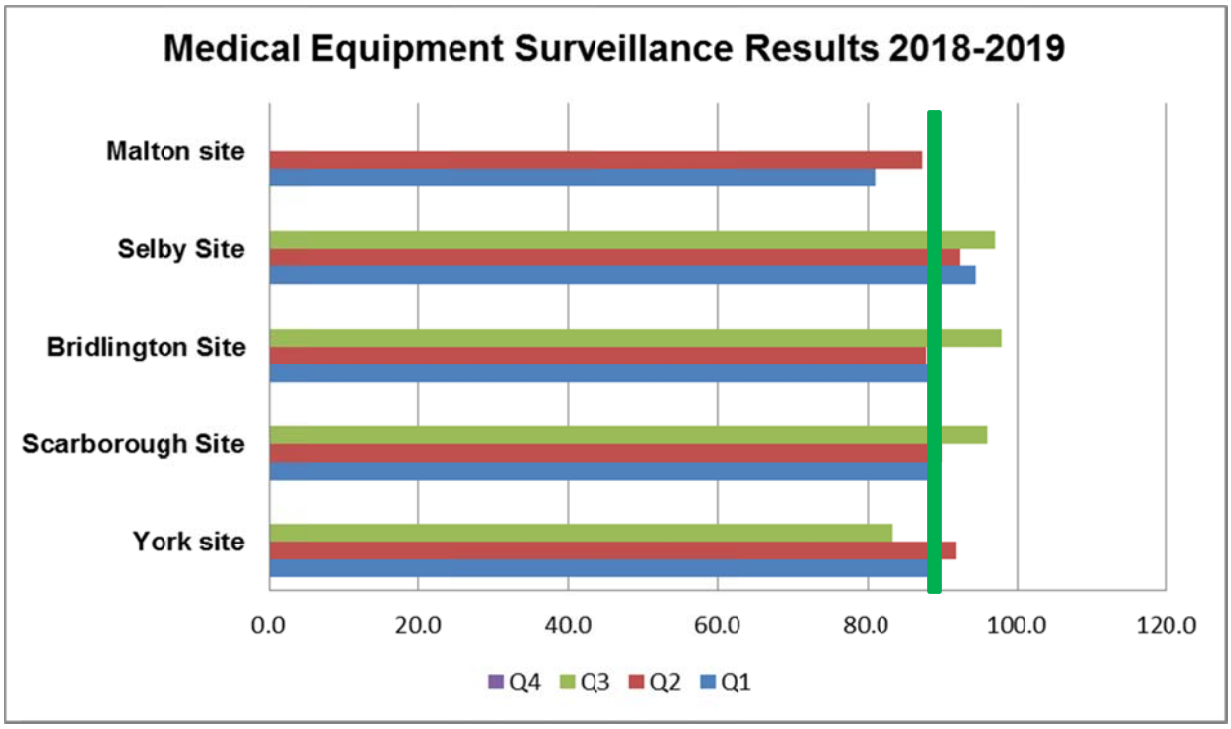


Medical Equipment Surveillance Results

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 (: green line) which in terms of the audit allows 25 defects against the audit criteria.



Cleanliness Monitoring Results

The tables below show results for operating theatres at the 3 main sites, attention is drawn to the poor results in week 4 at York theatres and week 3 at Vanguard Theatres on the Bridlington site.

Audit Type	Hospitals	Areas	DATE OF WEEK COMMENCING			
Facilities	YH	Theatres				
FUNCTIONAL AREA	**ZONE**	**RISK LEVEL**	**1**	**2**	**3**	**4**
			02/12/18	09/12/18	16/12/18	23/12/18
Theatres - Patient Areas	Theatres	Very High	97.67	98.28	98.44	96.29
Day Theatres	Theatres	Very High	97.27	98.86	97.05	97.63
Eye Theatres	Theatres	Very High	98.63	98.80	99.48	97.59
Key Performance Indicator			98	98	98	98

Audit Type	Hospitals	Areas	DATE OF WEEK COMMENCING			
Facilities	SGH	Theatres				
FUNCTIONAL AREA	**ZONE**	**RISK LEVEL**	**1**	**2**	**3**	**4**
			02/12/18	09/12/18	16/12/18	23/12/18
Main Theatres	Theatres	Very High	98.33	98.72	98.39	98.37
Key Performance Indicator			98	98	98	98

Audit Type	Hospitals	Areas	DATE OF WEEK COMMENCING	
Facilities	BDH	Theatres		
FUNCTIONAL AREA	**ZONE**	**RISK LEVEL**	**1**	**3**
			09/12/18	23/12/18
Main Theatres	Theatres	Very High	98.56	99.54
Vanguard	Theatres	Very High	97.14	92.66
Shepherds Daycase Theatre	Theatres	Very High	97.80	97.04
Key Performance Indicator			98	98

Building Accessibility

The Trust has commissioned through its Equality Objectives for 2018 a series of Building access audits to be undertaken across our sites over the coming 18 months in order to better understand patient, visitor and staff experience in terms of accessibility and measure compliance against relevant standards, namely The Building Regulations 2010 Approved Document M (2015 Edition and BS 8300; 2018.

To date an access audit has been completed at the Bridlington Hospital site and an access report disseminated to YTHFM Management team, the KPI rating for the site against this audit is shown on the dashboard on page 2.

Further access audits of ED at Scarborough site and main reception at the York hospital site have been completed with results forwarded to Estates & Facilities Management team

All access audits are being undertaken by the FM Compliance team in order to avoid costs associated with 3rd party audit providers, (a cost of around £15,000) has been avoided.
The head of FM Compliance has agreed to attend formal access audit training via the Centre for Accessible environments in early December after which remaining access audits across sites will be completed.

The proposed KPI associated with Access audit findings is shown below:

Green	>92 %	KPI ratings within a range that indicates operational arrangements are effective and generally being met
Amber	55-92%	KPI Ratings within a range that indicates some elements of good practice but also elements that require moderate improvement
Red	<55%	KPI ratings within a range that indicates weak operational controls and significant improvement required

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Workforce Report – January 2019

Trust 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 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 December 2018).

Executive Summary – Key Points

- The monthly sickness absence rate in November for the Trust was 4.39%. Sickness absence for York Teaching Hospital Facilities Management is now reported separately and their monthly sickness absence rate was 6.93%.
- The turnover rate in the year to December for the Trust was 10.25% and 9.97% based on headcount and FTE respectively. Voluntary turnover accounted for 7.0% of the overall turnover rate (based on headcount).
- Turnover for YTH Facilities Management over the same timeframe was 13.37% based on headcount and 12.05% based on FTE. Just over a quarter of staff leavers since October 2018 moved back to roles within NHS organisations.

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: January 2019

1. Introduction and Background

January's Workforce Report details a number of key workforce metrics, with commentary around the Trust's current sickness absence levels, turnover rates and the current levels of temporary medical and nurse staffing utilisation within the Trust. The report also includes updates on a number of activities including electronic Job planning, the 2019 Trainee Nursing Programme as well as an update on Schwartz Rounds.

2. Detail of Report and Assurance

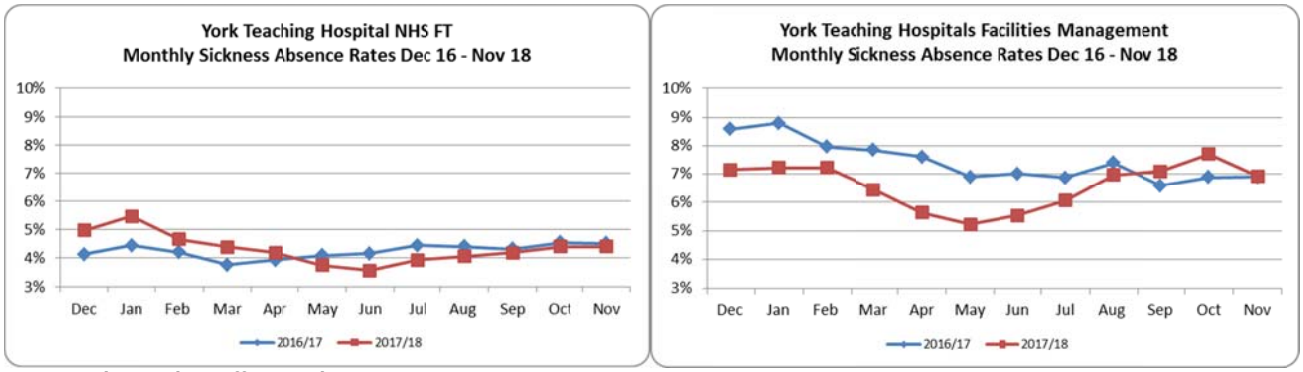
The work referred to in the report forms part of regular discussions around workforce, including at Staff Side Committees.

2.1 Sickness Absence

Graph 1 shows the monthly sickness absence rates for the period from December 2016 to the end of November 2018. On 1 October 2018, staff within the Estates and Facilities directorate transferred over to York Teaching Hospital Facilities Management and therefore, for the purpose of this report, sickness information for the York Teaching Hospital Facilities Management is now reported separately (and benchmarked against the Estates and Facilities directorate absence rate figures prior to the transfer.)

The monthly absence rate in November 2018 for the Trust was 4.39% - no change from the sickness absence rate in the previous month but lower than in the same month of the previous year (the monthly sickness absence rate for November 2017 for the Trust excluding Estates and Facilities Directorate was 4.51%).

Graph 1 – Monthly Sickness Absence Rates



Source: Electronic Staff Record

For benchmarking purposes, the sickness absence rate in October and November 2018 for YTH Facilities Management in graph 1 has been benchmarked against the sickness absence rates for the Estates and Facilities directorate prior to their transfer.

Sickness Absence Reasons

The top three reasons for sickness absence in the year ending November 2018 for the Trust based on both days lost (as FTE) and numbers of episodes are shown in table 1 below:

Table 1 –Sickness Absence Reasons - Year to November 2018

York Teaching Hospital NHS FT

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 22.6% of all absence days lost	Cold, cough, flu – 21.7% of all absence episodes
MSK problems, inc. Back problems – 15.4% of all absence days lost	Gastrointestinal – 21.1% of all absence episodes
Cold, cough, flu – 8.5% of all absence days lost	Anxiety/stress/depression – 7.32% of all absence episodes

Whilst proportionately stress/anxiety/depression and MSK remain the top reasons for sickness absence due to FTE days lost, seasonal sickness absence made up over 40% of the number of episodes of absence in the year to November 2018. Sickness absence due to Cold, Coughs and Influenza has been increasing month on month since August 2018 (from 105 episodes in August to 247 episodes in November, an increase of 135%). Over the same timeframe the number of sickness episodes due to gastrointestinal problems increased from 226 episodes in August to 296 episodes in November.

York Teaching Hospital Facilities Management

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 18.1% of all absence days lost	Gastrointestinal – 21.9% of all absence episodes
MSK problems, inc. Back problems – 16.0% of all absence days lost	Cold, cough, flu – 11.6% of all absence episodes
Gastrointestinal – 6.1% of all absence days lost	MSK problems, inc. Back problems - 11.6% of all absence episodes

Sickness absence due to the reason of stress/anxiety/depression and MSK is also the top sickness absence reasons by FTE days lost for Facilities Management. Seasonal sickness including gastrointestinal problems and cold, cough, influenza also made up a quarter of all sickness absence episodes on November 2018.

2.2 Schwartz Round Update

To support the psychological wellbeing of staff Schwartz Rounds were introduced to the Trust in May 2018. They provide a safe, reflective and non-judgemental forum for staff throughout the Trust to reflect on the emotional impact of providing patient care. They allow staff to share stories with their peers about their work and its impact on them. National evaluation has shown this leads to greater understanding, empathy and tolerance towards colleagues and patients and a statistically significant improvement in staff psychological wellbeing.

Between May and December 2018 there were 6 Schwartz Rounds held on York and Scarborough sites. The topics for the rounds have included “The patient I will never forget”, “In at the deep end”, “When I felt threatened”, “ When I spoke up” and “Tales of the unexpected”. Evaluation taken from the initial 4 Schwartz Rounds last year shows the

response from those who had attended was overwhelmingly positive, with 136 staff attending across the first 4 sessions. Appendix 2 provides some evaluation.

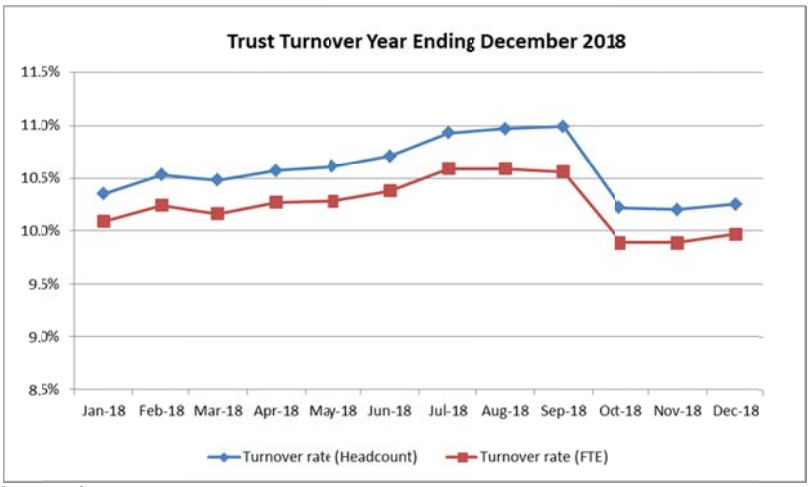
The Trust has now ensured these rounds will continue for the next two years at least, with the funding and support of the Trust's Charitable Funds. This will enable two more facilitators to be trained as well as ensuring future sessions can continue. There are already 6 further sessions scheduled between January and July 2019. This provides us with the ability to properly embed Schwartz rounds into our organisation, with the aim of bringing staff together to share the emotional impact of our work in the Trust.

More information about Schwartz Rounds, including a recent UK study on their effectiveness, can be found on the Point of Care Foundation website: https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/

2.3 Staff Turnover

Turnover in the year to the end of December 2018 for the Trust (excluding YTH Facilities Management) was 10.25% based on headcount. Turnover calculated based on full time equivalent leavers for the same period was 9.97%. This was a small increase from the turnover rate in the year to the end of November 2018 (which was 10.20% based on headcount and 9.98% based on FTE). The turnover rate in the year to the end of December 2018 represented 738 leavers from the organisation.

Graph 2 – Overall Turnover Rates



Source: Electronic Staff Record

The turnover rates shown in the graph exclude all staff on fixed term contracts, including all junior doctors on rotational contracts. This is a common convention used across the NHS for calculating turnover.

Graph 3 below shows a breakdown of the Trust's overall turnover rate based on voluntary leavers (i.e. voluntary resignations due to promotion, relocation, work/ life balance etc.), retirements, employee transfers (On 1 May 2018, 196 therapy staff within the AHP and Community directorates transferred over to Humber NHS Foundation Trust via TUPE) and other leaving reasons (such as dismissals etc.).

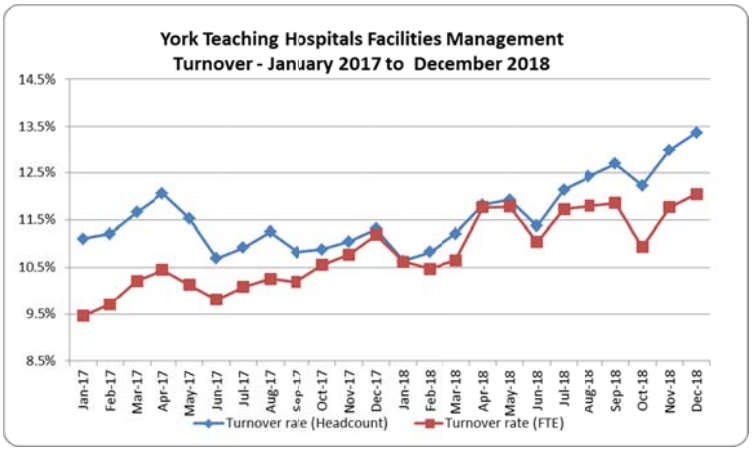
Graph 3 – Voluntary Turnover versus Other Turnover

YTH Facilities Management Turnover

Turnover in the year to the end of December 2018 for the YTH Facilities Management was 13.37% based on headcount and 12.05% based on full time equivalent leavers for the same period. .

For benchmarking purposes the YTH Facilities Management turnover rates from 1 October onwards in graph 4 has been benchmarked against the turnover rates for the Estates and Facilities directorate prior to their move

Graph 4 – YTH Facilities Management Turnover Rates



Since the move to YTH Facilities Management on 1st October, turnover has increased month on month. Overall, there were 37 leavers between October and December. Of these leavers, 62.16% were voluntary resignations and 8.11% were retirements. Additionally, just over a quarter of these staff moved back into roles within NHS Organisations.

2.4 Temporary Staffing

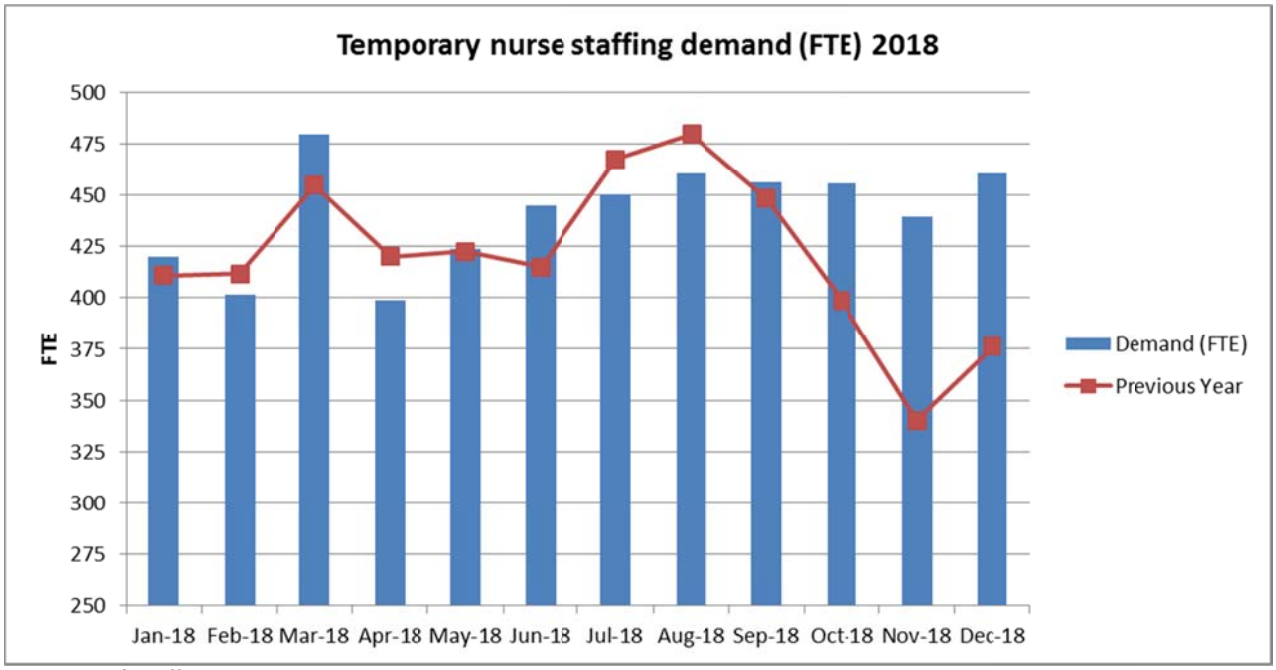
Temporary Medical Staffing

121.10 FTE Medical & Dental roles were covered in December by a combination of bank (36%) and agency (64%) workers. This was an increase from demand in the previous month (108.51 FTE) largely due to the planned increase in cover to deal with demand for Winter.

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of 441 FTE staff per month. Demand in December 2018 equated to 460.84 FTE which was higher than demand in the previous month (demand in November 2018 was the equivalent of 439.43 FTE) and also 25% higher than demand in the same month of previous year (demand in December 2017 equated to 376.16 FTE). The increase in demand in December can be partially attributable to an increased amount of annual leave taken over the Christmas leave period. Graph 6 shows the pattern of demand over the last 12 months compared to the previous 12 months.

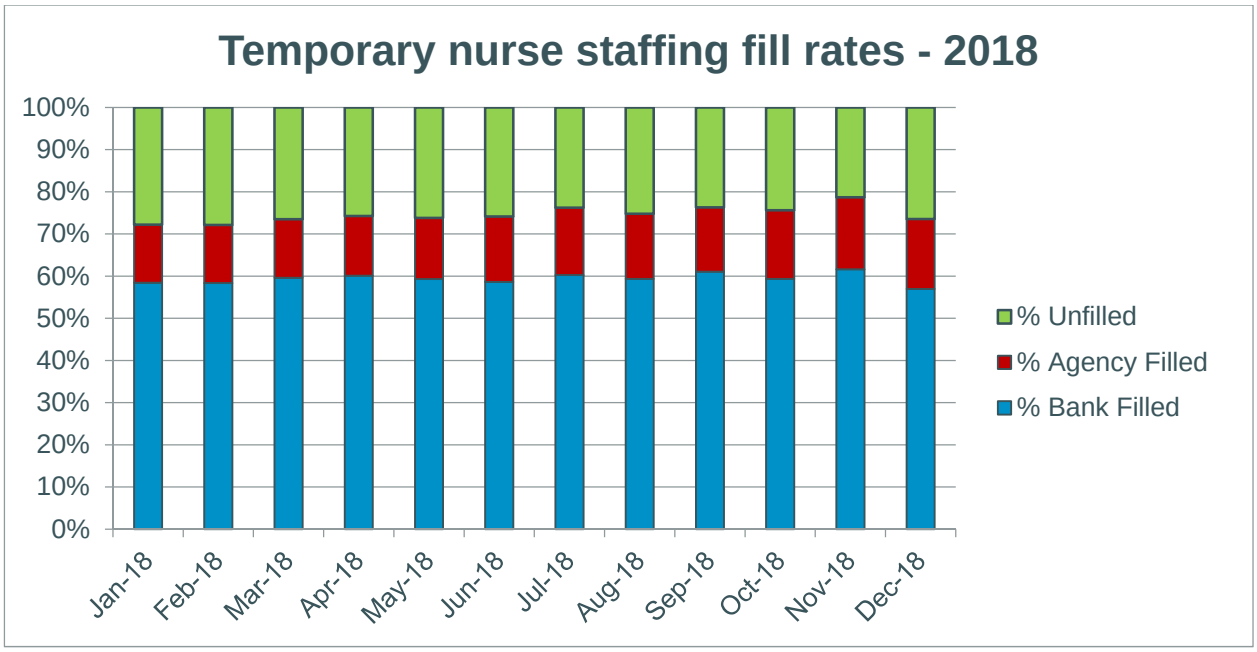
Graph 6 – Temporary Nurse Staffing Demand



Source: BankStaff

Graph 7 shows the proportion of all shifts requested that were either filled by bank, agency or were unfilled. Overall, 56.96% of shift requests in December 2018 were filled by bank staff whist the agency fill-rate was 16.60% - a small decrease from the previous month. The proportion of shifts that remained unfilled in December was 26.44% the highest level of unfilled shift rate since February 2018 and highlights the challenge of securing temporary workforce cover over the Christmas period.

Graph 7 – Temporary Nurse Staffing Fill Rates



Source: BankStaff

2.5 Patchwork (Formerly Locum Tap) Trial Update

The trial of Patchwork (formerly Locum Tap) Bank Management software has been running in the Emergency Department at Scarborough and Paediatrics in York for just under six months. Due to the limitations in relation to the payment model and of running the trial in two such niche areas, it has been difficult to establish tangible benefits. The Trust has negotiated a revised payment model which has facilitated an extended pilot covering the entire Trust. Implementation will commence in late February 2019 with the Emergency Department at York and Paediatrics Scarborough moving to the App, followed by a scheduled programme of departments moving onto the App from March 2019.

Discussions are in the formative stages with DRS (rota management software) and HCL the Trust's master vendor for Medical Locums to interface with Patchwork so we have an end to end system from rota design to the day to day management of rotas covering vacant shifts with Bank or Agency Locums.

2.6 Medical Staffing

Medical Vacancy Position

Although the Trust's medical vacancy position in December remains at 10.1% showing no real change from the end of November there have been a number of developments in December:

- The medical vacancy rate at Scarborough reduced from 19.4% to 17.9% in December;
- Contributing to this reduction have been three accepted offers of appointment to Specialty Doctor positions in Anaesthesia (successful applicants were sourced through a combination of approaches including: the Clinicians Connected portal for

which we have trial membership; word of mouth, referred by someone who attended the Open Day in October; and NHS Jobs);

- A productive campaign in General Surgery has resulted in five new starters lined up (one middle grade and four Trust Grades [two BAPIO] who will work on the lower tier rota). Two of these doctors have agreed start dates from February;
- Six of the doctors from the Scarborough recruitment event commenced with the Trust at the beginning of January;
- Balancing out progress with the Middle Grade recruitment at SGH has been a number of resignations from Middle Grade Doctors in ED. It is understood that this is borne out of unrelated personal reasons and not recent publicity related to services on the East Coast;
- There is strong potential for further short-term improvement in the vacancy rate at Scarborough: we have four more potential appointments via BAPIO (three for General Medicine and one in Anaesthesia), which are subject to further discussions with the department; and the fill-rate for GP Trainees in February will increase substantially (currently, we have approx. 30% filled but in a few weeks this will top 90% (13 posts)).

Appendix 1 shows a detailed breakdown of the medical vacancy position by site.

2.7 eJob Planning

Through the procurement process the Trust selected Premier IT as the electronic-job planning software supplier. This has been announced by the Medical Director and Medical Staffing across the Trust. Since December 2018 the e-job planning working group has been working with Premier IT to configure the e-job planning system and plan the implementation roll out. The system has been configured by the developers at Premier IT and will go live on 18th January 2019. The implementation plan includes practical training sessions led by Premier IT and Medical Staffing, online webinars, e-learning materials and one to one system training sessions.

Training sessions will commence on the 22nd January 2019, initially to system 'superusers,' directorate management teams and job plan sign off users, before being rolled out to the Consultants, Specialty Doctors and Associate Specialists through February and March 2019. Practical training sessions have been arranged to take place on York and Scarborough Hospital sites. Job Planning panels will take place from May 2019.

2.8 Trainee Nursing Associate (TNA) Programme

The 2019 Trainee Nursing Associate Programme began on 7th January with 26 members of staff commencing in the role. 17 members of staff will attend from Scarborough Hospital and they will be joined by 2 others from St Catherine's Hospice. As the lead partner the Trust will be managing the programme in partnership with Coventry University Scarborough Campus (CUSC). 9 learners from York Hospital will also join CUSC and the Trust has negotiated that these learners will be taught onsite as much as possible with an agreement from Health Education England (HEE) to fund travel expenses for sessions taught at the Scarborough Campus for the York staff.

The CSCU programme is an accredited apprenticeship standard which will therefore allow the Trust to draw down £2,500 per learner from the Apprenticeship Levy. The Trust also negotiated increased financial support from HEE for each learner identified prior to 31st December 2018. In total this equates to £7,900 per learner (to support with backfill) as well as £3,200 per learner based at York to support with travel costs.

2.9 Pre-Registered Nurse Recruitment

The Trust has recently been liaising with the University of York to arrange for a bespoke recruitment event at the university for nursing students. This would enable the Trust to strengthen its links and relationship with the University of York as well as increase the number of students recruited.

Students will learn about the Trust's comprehensive preceptorship programme with applications made on a shortened form and the offer of a same day interview. It is anticipated that the event will be held in February or March 2019.

2.10 Flu Vaccination Update

The flu vaccination uptake as at 17th January 2019 was 70.08% for frontline staff. The Trust is aiming to achieve the target of 75% of all frontline staff vaccinated by the end of February 2019.

Drop in clinics continue to be heavily promoted and peer vaccinators are attending areas with low uptake to improve compliance.

2.11 Staff Survey Action Planning

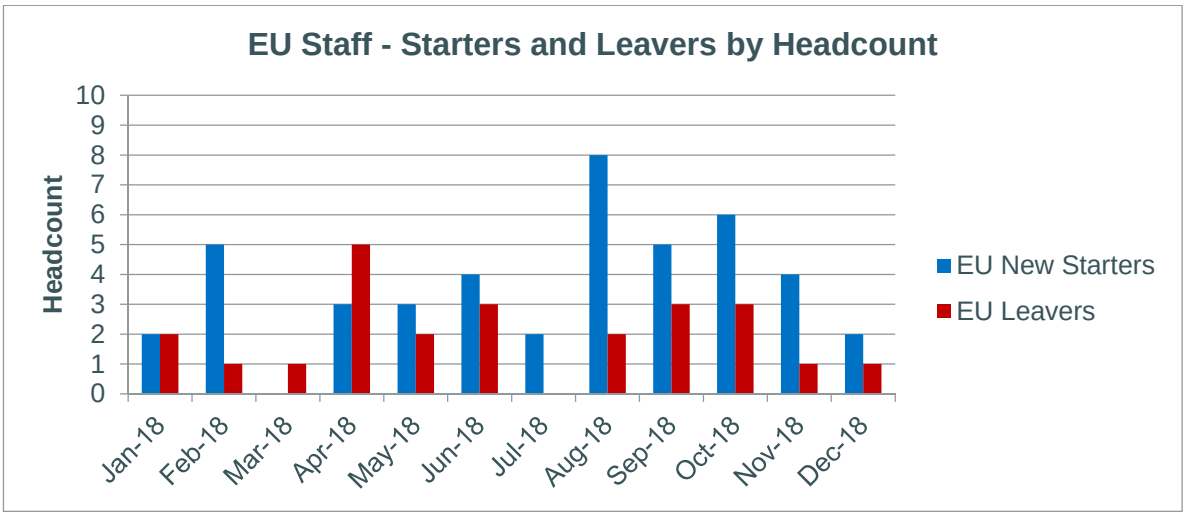
Further to the high level and unweighted staff survey results received in December 2018 the Trust has been recruiting staff representatives to attend working groups with the intention of formulating the action plan. The working groups will meet between January and February and this will coincide with the draft benchmark report being released on 8th February. The intention is to release the action plan on 26th February which is the day the staff survey's embargo is lifted.

2.12 EU Workforce and Brexit

The Department of Health has directed organisations to prepare for a potential Brexit no deal scenario. Part of this is an action plan which includes monitoring the impact of Brexit on our workforce numbers.

As at 31st December there were 333 EU nationals employed by the Trust. In the year to December a total of 44 staff from within the EU joined the organisation whilst 24 staff left over the same timeframe. The turnover rate of EU staff (based on headcount) between 1st January and 31st December was 9.72%.

Graph 8 – EU Staff Starters and Leavers



The Trust promoted the pilot EU Settlement Scheme which ran from 4th to 21st December 2018. In promoting the scheme the Trust also offered to refund the £65 fee. By 18th January 21 employees had requested reimbursement.

2.13 Leadership Development Update

The Trust has commenced a review of the in-house leadership development support which will underpin the revised roles within the proposed Care Group Structure.

Currently all leadership development programs support 'Developing People: Improving Care' (DP:IC) and 'Building Capacity and Capability for Improvement Skills' and aim to enable participants to develop compassionate and inclusive leadership. The programmes include Quality Improvement skills, and delegates are required to complete a small quality improvement project which is used as a vehicle for the application of their learning. The content of all programmes is delivered as a mixture of theory, discussion, interactive exercises, action learning sets, and focus on learning and exploring leadership behaviors and qualities and 'self' in the context of the leadership role. A small number of places are also made available to external partners including the Army and GP practices. The programmes below provide an outline of the current Trust-led leadership development offer:

First Steps in Leadership: A recent addition to the leadership portfolio. It has been designed as an introduction to leadership and what it takes to manage a team. It allows exploration of the skills required to become a compassionate, inclusive, resilient and effective leader and acts as a stepping stone to the emerging and senior leaders' programmers. In 2018 six cohorts have been delivered to 89 participants.

Emerging Leaders Programme: This programme is designed for those in their first leadership role. Whilst this programme has been running for a number of years it has recently been reviewed and revised to support DP:IC. In 2018 four cohorts were delivered to 61 participants; this includes a 'closed' cohort specifically for Band 6 nurses.

Senior Leaders Programme: The programme is offered through facilitator led face to face workshops which are structured over three modules: Leading Self, Leading the Team and Leading in the System. Delegates are provided with the opportunity to engage with leadership concepts and material, to reflect on their application in the workplace and to explore personal leadership challenges through Action Learning Sets. Content has been revised to reflect current thinking on the compassionate leader as described in recent reports and the pivotal role that leadership has in creating cultures of care and continuous improvement. In 2018 three cohorts were delivered to 45 participants, this includes a 'closed' cohort specifically for Band 7 nurses.

Consultant Development Programme: Whilst this content mirrors the Senior Leaders Programme it is adapted to meet the specific needs of consultants and provides them with a "safe", closed environment in which to explore their leadership experiences and development. In 2018 one cohort was delivered to 18 participants.

Clinical Director Programme: Historically this programme has been delivered for those who aspire to, or are new to the role of Clinical Director. The format and content of this programme is currently under review to enable it to reflect the needs of the Clinical Director within the new Care Groups.

Whole System Leadership Programme: Two cohorts have been delivered to 37 senior staff across from eight organisations in health, social care and the third sector. The programme was commissioned by the Trust and delivered in partnership with NHS Elect. The key areas covered via four modules were: personal effectiveness and leadership style; managing change in complex systems; policy landscape and quality improvement techniques; conflict and creativity.

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 by Site

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	20	4	0	1	**15.0%**	5	3	0	3	**0.0%**	10	0	0	0	**0.0%**						35	7	0	4	**8.6%**
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	0	1	**11.5%**
Elderly Medicine	6	1	0	0	**16.7%**	2	0	0	0	**0.0%**	11	5	0	1	**36.4%**	4	0	0	0	**0.0%**	23	6	0	1	**21.7%**
Emergency & Acute	7	3	0	0	**42.9%**	9	2	4	1	**55.6%**	17	5	0	2	**17.6%**	4	0	0	0	**0.0%**	37	10	4	3	**29.7%**
General Medicine	16	5	0	0	**31.3%**	4	1	0	0	**25.0%**	18	5	0	1	**22.2%**	17	0	1	0	**5.9%**	55	11	1	1	**20.0%**
General Surgery & Urology	13	6	0	0	**46.2%**	3	1	0	1	**0.0%**	10	5	0	4	**10.0%**	9	0	0	0	**0.0%**	35	12	0	5	**20.0%**
Head & Neck						3	0	0	0	**0.0%**						1	0	0	0	**0.0%**	4	0	0	0	**0.0%**
Obstetrics & Gynaecology	8	0	0	0	**0.0%**	3	1	0	0	**33.3%**	9	1	0	0	**11.1%**	2	0	0	0	**0.0%**	22	2	0	0	**9.1%**
Ophthalmology	4	2	0	1	**25.0%**	3	2	0	1	**33.3%**	1	1	0	0	**100.0%**						8	5	0	2	**37.5%**
Radiology	6	2	1	0	**50.0%**																6	2	1	0	**50.0%**
Specialist Medicine	3	0	0	0	**0.0%**	2	0	0	0	**0.0%**	1	0	0	0	**0.0%**	1	0	0	0		7	0	0	0	**0.0%**
Trauma & Orthopaedics	9	0	1	0	**11.1%**	5	0	0	0	**0.0%**	5	1	0	0	**20.0%**	2	0	0	0	**0.0%**	21	1	1	0	**9.5%**
Total	**104**	**27**	**2**	**3**	**25.0%**	**40**	**10**	**4**	**6**	**20.0%**	**91**	**23**	**0**	**8**	**16.5%**	**44**	**0**	**1**	**0**	**2.3%**	**279**	**60**	**7**	**17**	**17.9%**

Net vacancy % = (Vacancies + Leavers Pending - Starters Pending) / Establishment
Leavers = currently serving notice
Starters = accepted appointment, now pending start date

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	2	**0.0%**	9	1	0	0	**11.1%**	20	3	0	0	**15.0%**	3	0	0	0	**0.0%**	81	6	0	2	**4.9%**
Child Health	17	0	0	0	**0.0%**	1	0	0	0	**0.0%**	16	0	0	0	**0.0%**	5	0	0	0	**0.0%**	39	0	0	0	**0.0%**
Elderly Medicine	15	0	1	0	**6.7%**	2	0	0	0	**0.0%**	15	1	0	0	**6.7%**	5	0	0	0	**0.0%**	37	1	1	0	**5.4%**
Emergency & Acute	18	0	0	0	**0.0%**	7	1	1	0	**28.6%**	16	0	0	0	**0.0%**	6	0	0	0	**0.0%**	47	1	1	0	**4.3%**
General Medicine	39	3	1	0	**10.3%**	9	1	1	0	**22.2%**	38	2	3	1	**10.5%**	26	0	0	0	**0.0%**	112	6	5	1	**8.9%**
General Surgery & Urology	33	2	0	1	**3.0%**	11	1	0	1	**0.0%**	16	2	0	1	**6.3%**	14	0	0	0	**0.0%**	74	5	0	3	**2.7%**
Head & Neck	20	2	0	1	**5.0%**	11	0	0	0	**0.0%**	14	0	0	0	**0.0%**						45	2	0	1	**2.2%**
Laboratory Medicine	13	2	0	0	**15.4%**	2	0	0	0	**0.0%**	6	2	0	0	**33.3%**						21	4	0	0	**19.0%**
Obstetrics & Gynaecology	12	1	0	0	**8.3%**	2	0	0	0	**0.0%**	13	2	0	1	**7.7%**	2	0	0	0	**0.0%**	29	3	0	1	**6.9%**
Ophthalmology	20	3	0	1	**10.0%**	6	2	0	0	**33.3%**	5	0	0	0	**0.0%**						31	5	0	1	**12.9%**
Radiology	25	2	0	1	**4.0%**	1	0	0	0	**0.0%**	6	0	0	0	**0.0%**						32	2	0	1	**3.1%**
Sexual Health	2	0	0	0	**0.0%**	7	1	1	0	**28.6%**	2	1	0	0	**50.0%**						11	2	1	0	**27.3%**
Specialist Medicine	35	5	0	2	**8.6%**	5	3	0	2	**20.0%**	12	1	0	1	**0.0%**	3	0	0	0	**0.0%**	55	9	0	5	**7.3%**
Trauma & Orthopaedics	13	0	0	0	**0.0%**	6	0	0	0	**0.0%**	9	3	0	0	**33.3%**	4	1	0	0	**25.0%**	32	4	0	0	**12.5%**
Total	**311**	**22**	**2**	**8**	**5.1%**	**79**	**10**	**3**	**3**	**12.7%**	**188**	**17**	**3**	**4**	**8.5%**	**68**	**1**	**0**	**0**	**1.5%**	**646**	**50**	**8**	**15**	**6.7%**

Appendix 2 – Schwartz Rounds Evaluation

Schwartz Round-Up: York Teaching Hospital NHS Foundation Trust

This report is a six month summary of feedback from staff attending the Rounds.

The total number of attendees over these Rounds was 136

The percentage of feedback forms returned was 84%

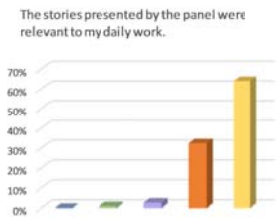
These Rounds ran in the months of 43250 43234 43278 43299 Required Required

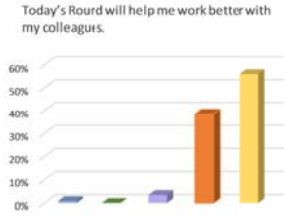
The number of Rounds run within this time was squired

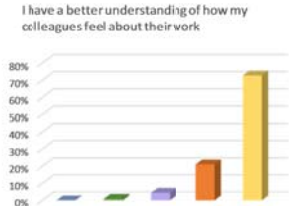
The topics of these Rounds were 1 A patient I'll never forget 2 A patient I'll never forget 3 In at the deep end 4 In at the deep end 5 Required 6 Required

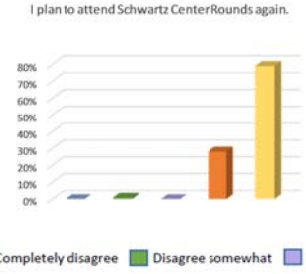
The breakdown of professional afflications over these Rounds

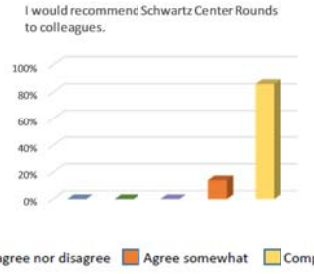
Doctor 9%	Ward clerk 2%	Physio 3%	Domestic 0%
Junior doctor 1%	Ward sister / manager 2%	Speech therapist 1%	OT 2%
GP 0%	Radiographer 0%	Volunteer 1%	Fundraiser 0%
Nurse/midwife 25%	Psychologist 8%	Manager 11%	Other 11%
HCA 2%	Pharmacist 2%	Board member 1%	Missing 9%
Dietician 0%	Social worker 1%	Porter 0%	
Chaplain 1%	Admin & Clerical 12%	Security 0%	

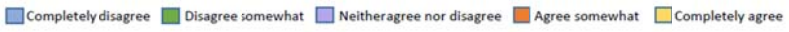












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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Freedom to Speak Up Guardian Annual Report
January – December 2018

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

To update the Board of Directors on Freedom to Speak Up

Executive Summary – Key Points

There has been an significant increase in the number of staff raising concerns to the FTSUG in the last 12 months.

Recommendation

The Board of Directors are asked to:

- Note the increase in numbers of staff 'speaking up'
- Note the on-going positive work to develop an open culture

Author: Lisa Smith, Freedom to Speak Up Guardian

Director Sponsor: Mike Proctor, Chief Executive

Date: January 2019

1. Introduction and background

It is widely acknowledged that what happened in Mid Staffordshire NHS Foundation Trust was caused by a range of factors, not least allowing a culture of fear and poor style of leadership to take hold. Sir Robert Francis highlighted the dangers of losing sight of human concerns in healthcare, the importance of engaging with patients and staff, and the risks to patients when the delivery of care becomes depersonalised. He insisted on the urgent importance of transforming the culture of NHS organisations away from one that is fearful and defensive and towards one that is open, honest and willing to listen.

The Guardian role was issued in April 2016; reactive, it requires independence as well excellent partnership working with the senior leadership team and to gain the trust of workers throughout the organisation.

This is the second annual report produced by the Trust's Freedom to Speak Up Guardian (FTSUG) and will use comparative data to highlight the impact the role is making in the organisation.

2. National picture

The National Guardian's Office (NGO) has now undertaken a total of five case reviews, most recently in Royal Cornwall Hospitals NHS Trust. The recommendations from each case review are shared with senior leaders in the Trust by the FTSUG and actions are taken to implement where necessary.

It also publishes quarterly data on speaking up information from 227 hospital Trusts across England. In Q2, the Trust remained in the top five of highest number of speak up contacts per quarter nationally.

Trust outliers (2018) compared to some annual national data (2017-2018):

	Anonymous cases	**Elements of Bullying / Behaviours**	**Patient Safety/Quality**	**Doctors Speaking Up**
Trust Data	Nil	72%	13%	13%
National Data	18%	45%	32%	7%

It is encouraging that the Trust FTSUG has not received any anonymous concerns and that the number of doctors speaking up remains significantly higher that the national average. However, more concerning is the Trust's figures on bullying behaviour cases compared to national data.

In May 2018 the NGO published 'Guidance for Boards on Freedom to Speak Up' and following this, a 'self review tool' for Boards to complete. The Trust was already fully meeting 68% of the expectations set by the NGO. An action plan has been developed to deliver on the remaining 32%.

2.1 Regionally

Yorkshire and Humber FTSUG network continues to develop and is currently considering the configuration of regional networks to re-align with NHSI/NHSE.

The network has trained two 'train the trainers' who are able to support Trusts in the network to deliver training to new guardians or champions.

The Trust FTSUG is the buddy to three other network guardians.

2.2 Locally making a difference

2.2.1 Listening exercises

One of the key components of developing an open and honest culture is to remove the barriers to people speaking up. Barriers to speaking up include apathy and fear of reprisal.

'Listening in order to improve' is one of the Trust values and we can only do this by engaging with staff in a meaningful way.

One of the approaches the Trust uses is to hold 'listening exercises' which provide opportunities to listen to groups of staff. This can be done in a number of ways including:

1. Being led by a senior manager when they need to gather staff feedback on a specific issue (for example Chief Nurse surgery)

2. Being led by a manager with support from HR (for example following staff survey or friends and family test results)

3. Staff side involvement in supporting and advising staff with concerns

4. A manager commissioning an independent listening exercise led by ODIL and OD practitioners, conducted on an individual or group basis. Sessions are confidential and themes are written up anonymously and a summary report prepared for the sponsoring manager.

5. A manager commissioning independent listening exercise to be led by the Freedom to Speak Up Guardian and supported by Fairness Champions (for example where a number of staff have raised concerns) and a number of these exercises have now been commissioned across the Trust.

2.2.2 Fairness Champions

Although we recruited a further eleven Fairness Champions earlier this year, three have now left the Trust.

This means there are now 38 Fairness Champions who have been through induction and 3 more that have been interviewed and are awaiting induction.

There have been 73 requests for support (or 'cases') recorded of which 2 are currently open. However we know that many cases have not been recorded as official requests for support and estimate the actual cases to be more than 100.

Added to this, being a Fairness Champion is about more than just responding to official requests for support. Our core purposes include increasing consciousness of unintended bias, prejudice / inequality and helping others to demonstrate the Trust values – challenging when they are not being met. This involves many informal discussions and support which are not recorded as a 'case'.

In 2019, we will launch our Fairness Champion experience survey – to be issued after each request for support – which will in part help tackle the issue of under reporting. We will also instigate a new system of recording the amount of time spent on Fairness Champion activities – similar to the recording system used currently for staff-side representatives.

- The most prevalent themes are policy/procedural issues followed by bullying / harassment. However it is of note that if the categories of 'mental health', 'stress' and 'sickness absence' are grouped together, then they would be the largest theme
- The staff group most frequently requesting support is 'Administrative and Clerical' followed by Allied Health Professionals
- Twelve have been referred to the Freedom to Speak Up Guardian from Fairness Champions
- Five have involved support at a formal meeting.

2.2.3 Education and training

The new Challenging Bullying and Harassment Policy was ratified in October 2018 and roll out will be completed in January 2019. All new Bullying and Harassment cases will be managed under the new policy which puts greater emphasis on tackling inappropriate behaviours at an informal level and to restore relationships to continue with a team working environment.

A new Management Training course was developed throughout 2018 and was piloted between September and December. Focusing on how to challenge inappropriate behaviours and create an open culture, the training is for anyone with supervisory responsibility. Initial feedback from the course was extremely positive and the focus is for this to be cascaded out in Directorates throughout 2019 as a partnership between Human Resources (HR), staff side and the FTSUG. Alongside this a mangers handbook, containing tips and tools for 'concerns and how to handle them' has been produced.

The FTSUG now has regular teaching slots on 'speaking up/culture' at all staff induction programmes and on the nurse preceptorship development days, feedback has been excellent.

The FTSUG has also undergone the Trust's new RAFT training to support staff that have experienced high levels of stress/trauma following an incident at work.

2.2.4 Schwartz Rounds

"Schwartz Rounds" were introduced into our organisation in 2016/17. The FTSUG is an active member of the steering committee, and suggested a Round with the title "When I spoke up". We delivered the Round on 24 October 2018 to mark national 'Speak Up Month' and 56 colleagues began by hearing the experiences of three panel members, an Occupational Therapist, a Physiotherapist and a Stroke Consultant.

There were common themes of feeling isolated and afraid of being blamed. Two of the panel had approached the Trust's FTSUG during their experiences, and had felt great relief at speaking to someone who was prepared to listen and could validate that they had "done the right thing".

The emotional impact for staff of "speaking out" was evident, with one panel member becoming tearful as she spoke of how it led her to feel as though she didn`t want to come into work, for the first time in her career. Another panel member talked about experiencing around 18 months of stress, and being preoccupied at home, and irritable with his children. Many of the audience fed back after the Schwartz Round how poignant it had been, and it made them realise that it was difficult to speak up, whatever your profession and even if you were in a very senior role.

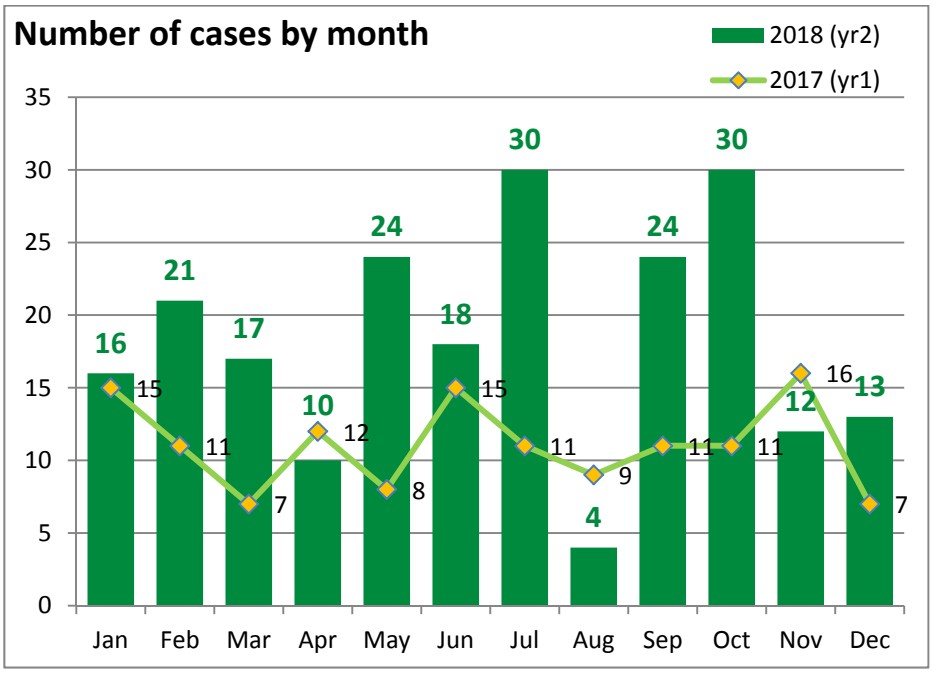
Hopefully together with initiatives like Schwartz Rounds, our organisation can move increasingly towards an open, non-blaming and supportive culture.

2.3 Concerns

The total amount of concerns raised during this 12 month period is 219 compared to 120 for the same period last year.

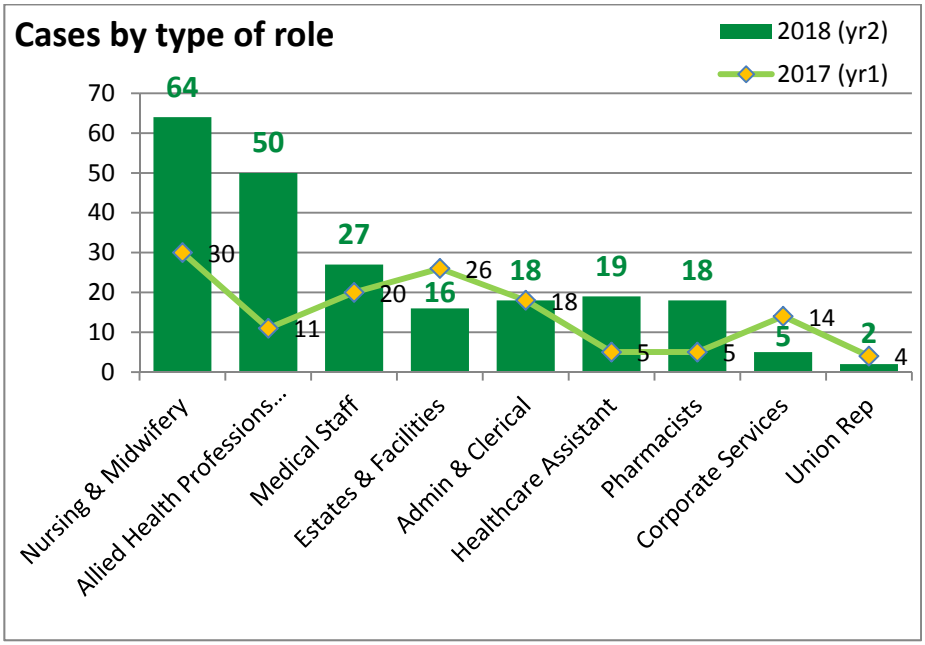
The NGO requires Trusts to count individual staff as opposed to collective concerns as each individual will have a different experience of speaking up, even if they are raising the same concern such as in the listening exercises described above. Each individual requires a follow up by the FTSU G.

The following information charts show comparative data from year 1 (2017) to year 2 (2018).

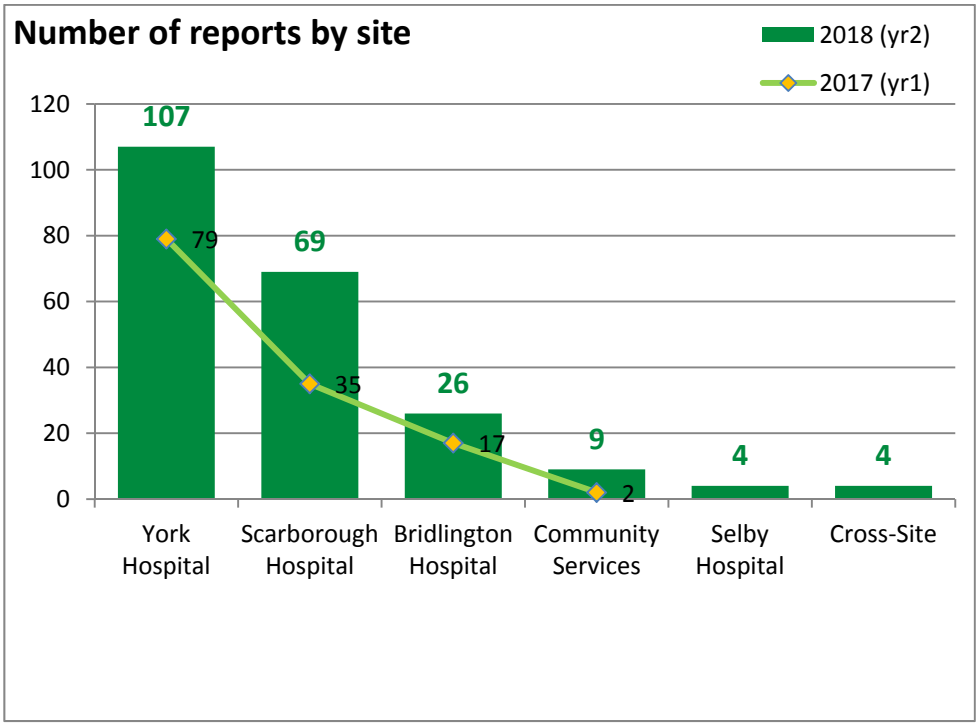


Listening exercises were undertaken in the following departments which may account for an increase in certain months.

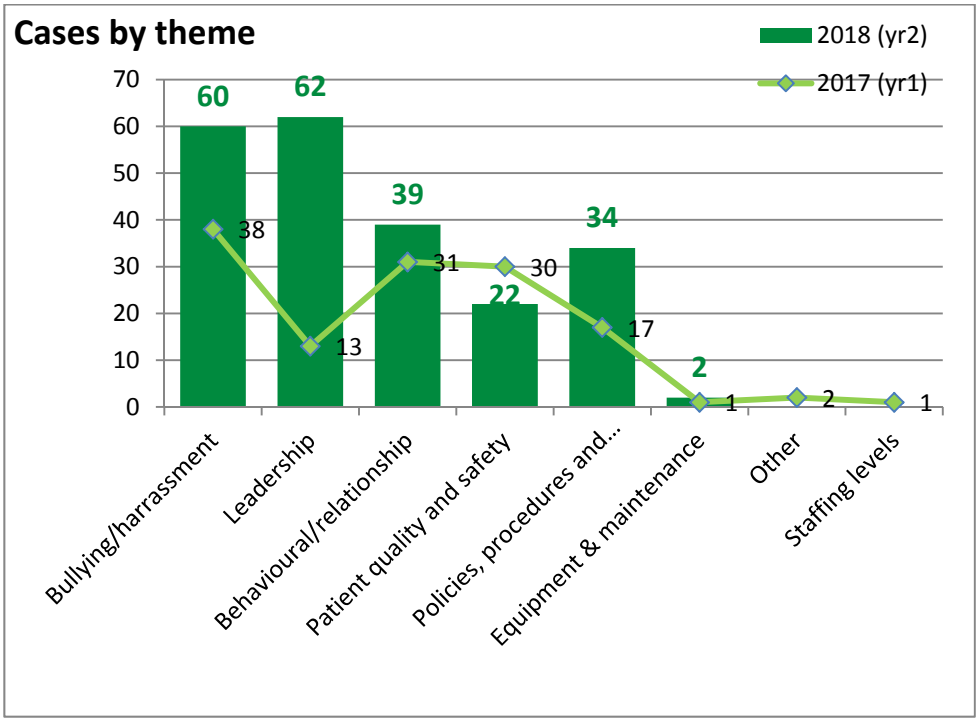
- ED SGH – February
- Pharmacy – February
- Bank Staff – May
- Kent Ward – Bridlington – June
- AHP – October
- Theatres SGH – December.



Again the increase in certain roles can be attributed to listening events held with particular staff groups such as pharmacist and therapists. It is positive to note the decrease in concerns being raised by estates and facilities staff.



2.4 Themes



Unfortunately there has been an increase in all themes with the exception of patient safety concerns which has slightly reduced.

2.5 Feedback

In December 2018, Internal Audit completed the review of raising concerns and whistle blowing which included the walkthrough of an anonymised case. An opinion of Significant Assurance on the effectiveness of the processes in place to enable staff to raise concerns and whistle blow was given to the Trust.

Our staff survey results this year show that 70% of staff are aware of the FTSUG (compared to 51% last year) and 53% said they feel more confident about speaking up/escalating concerns knowing the role is there, (compared to 51% last year).

Every 'speak up' receives a follow up questionnaire, some of the questions being asked were very subjective so the survey was reviewed at the end of 2018 and amended with revised questions which now include:

- Did you feel your concern was addressed appropriately by the Freedom to Speak up Guardian?

- Is there anything else you would have liked the Guardian to have done for you?

Numbers of returns are small since the introduction of the revised questionnaire but initial results are as follows:

- 97% say their concern was taken seriously
- 74% say based on their experience they would speak up again
- 71% say they feel their concern has been appropriately addressed by the FTSUG
- 87% say they were treated confidentially
- 79% say they have not received any unfair treatment since speaking up.

As well as the formal questionnaire, the FTSUG receives a significant amount of informal feedback, some of which has been updated from last year and is captured below.

2.6 Priorities for year 3

- Continue with the 'pro-active' work with promoting a culture where staff feel safe to speak up at the appropriate level, reducing the need to escalate concerns to the FTSUG.
- Monitor the impact of the new line management training on reported behaviours through partnership working with HR.
- Continue to support the development of the existing Fairness Champions and ensure appropriate governance.
- Implement the action plan developed from the NGO 'self review tool'.

3. Conclusion

Our organisational culture, along with our strong Trust values – 'the way we do things around here' is what shapes the behaviour of everyone in the organisation, affects staff morale and directly affects the quality of care we provide. Huge strives have been made in the last 12 months to engage with staff and some of the work described above demonstrates the move towards a culture that is open and transparent and how the Trust

supports staff to address concerns and challenge inappropriate behaviour. The expectation is that the number of staff escalating concerns to the FTSUG will reduce over time as staff feel safe to speak up at the appropriate level.

4. Recommendations

The Board of Directors are asked to:

1. Consider the comparative data from years one and two.
2. Support the proposed priorities for 2019.
3. Receive bi-annual reports from the FTSU Guardian.

Board of Directors – 30 January 2019
Guardian of Safe Working Q3 Report: October – December 2018

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

The Guardian of Safe Working (GoSW) was introduced into the Trust in 2016 as part of the 2016 Terms and Conditions for Junior Doctors and aims to provide the Trust with assurance over the safe working of junior doctors and alert the Board to any areas of concern and is required to report to the Board on a quarterly basis.

Executive Summary – Key Points

Two years on, exception reporting has given valuable insight into working practices of trainees and the problems they face. They have also helped to direct improvements in working conditions and practices to support safe working.

Recommendation

The Board of Directors are asked to:

- Support and encourage all staff to value junior doctors
- Note the progress being made on the *Eight High Impact Actions* project

Author: Lisa Smith, Guardian of Safe Working

Director Sponsor: Mike Proctor, Chief Executive

Date: January 2019

1. Introduction and Background

This is the Q3 2018 report to the Board from the Guardian of Safe Working (GoSW) required by the 2016 terms and conditions for doctors and dentists in training.

The Quarterly report is for October - December 2018 and details progress with the Junior Doctor Forum (JDF) and the Exception Reporting system, examining issues arising from the process and possible solutions.

2. Detail of Report and Assurance (GoSW Q2 report for October – December 2018)

2.1 Junior Doctors' Forum

The JDF has continued to develop. In September we ran an election for a new vice-chair which resulted in us successfully appointing two vice-chairs; one for the Scarborough site and one for the York site. This was welcomed by junior doctors and seen a positive step to be more inclusive.

We now have a Scarborough Mess President who is being supported by the Deputy Medical Director to develop some social activities once the weather starts to improve, and also about a bridge to a new mess facility until the renovations on the third floor can be completed. There have also been some efforts in terms of peer education.

Following the results of a survey carried out in the summer which showed that junior doctors felt poor morale was having an extremely serious negative effect on training, plus the results of the national GMC training environment report which confirmed the trend nationally, the JDF has decided to carry out a follow up survey of all consultants in the Trust to understand the views on exception reporting and junior doctor morale.

Two new projects have been launched under the *Eight High Impacts Actions Project* – the first ever Trust junior doctor awards and a paired learning project which will run until March 2019.

2.2 Paired learning

Earlier in 2018 a paired learning programme was run in York as part of a research project which received good feedback from junior doctors and managers alike. As a result the Junior Doctor Forum decided to replicate the programme within the Trust on an ongoing basis. The project is being led by the Chief Registrar and the junior doctor contract administrator and we have now successfully signed up seven pairs to pilot the project in York which was launched at the end of December. They include doctors from all grades above FY1 and from a variety of specialties (acute, general surgery, palliative care, T&O, cardiology) and the managers are also from a variety of departments including operational, patient safety, patient experience, service improvement and HR.

It aims to:

- Improve reciprocal knowledge and attitudes between managers and doctors

- Improve relationships between managers and doctors
- Provide cross-professional contacts for future work.

It is a structured 'buddying' scheme between doctors and NHS managers which is flexible and self-directed and run over a four-month period.

2.3 Junior Doctor Awards

There is evidence based research to suggest that due to the rotational nature of junior doctors' training, doctors are often overlooked in organisational efforts to appreciate staff and that a culture promoting regular, positive feedback and learning from excellence currently exists only in small pockets. These factors can leave junior doctors feeling undervalued.

One of the *eight high impact actions* is to 'reward excellence' and we have been trying to develop a Trust award scheme for junior doctors – this happens in most other trusts – and whilst we do often recognise junior doctors as part of our existing 'Celebration of Achievement' and 'Star Awards' there is nothing specifically for them as in other Trusts in our region.

The project group has agreed six categories which are as follows:

- Team player
- Compassionate care
- Outstanding contribution to quality improvement/research or education
- Rising star
- Best Educational or Clinical Supervisor
- Junior Doctors' Forum 'Unsung hero'.

The voting will be online. It opens on 15 February 2019 and closes on 15 March 2019 and a number of executive and non- executive directors have agreed to be part of the judging panel and presentation ceremony which is being jointly sponsored by the Trust and the GMC on 17 May 2019 in Malton.

2.4 Exception reporting and guardian fines

- The 37 reports came from 17 doctors, the majority of reports cited 'staff shortage' as the reason, the second highest reasons was 'patient safety'

- There have been no guardian fines levied for Q3

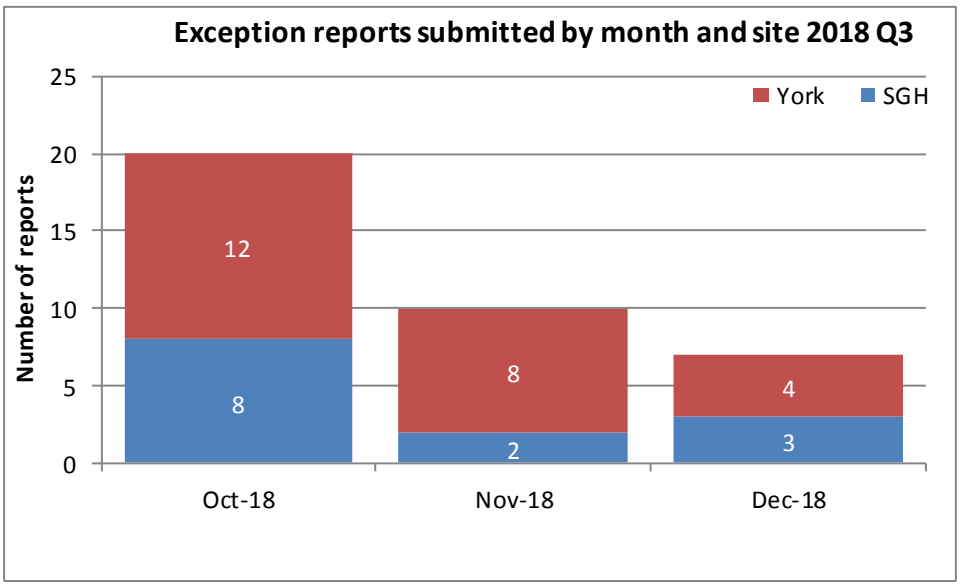
- 75.47% (26) were closed within 14 days

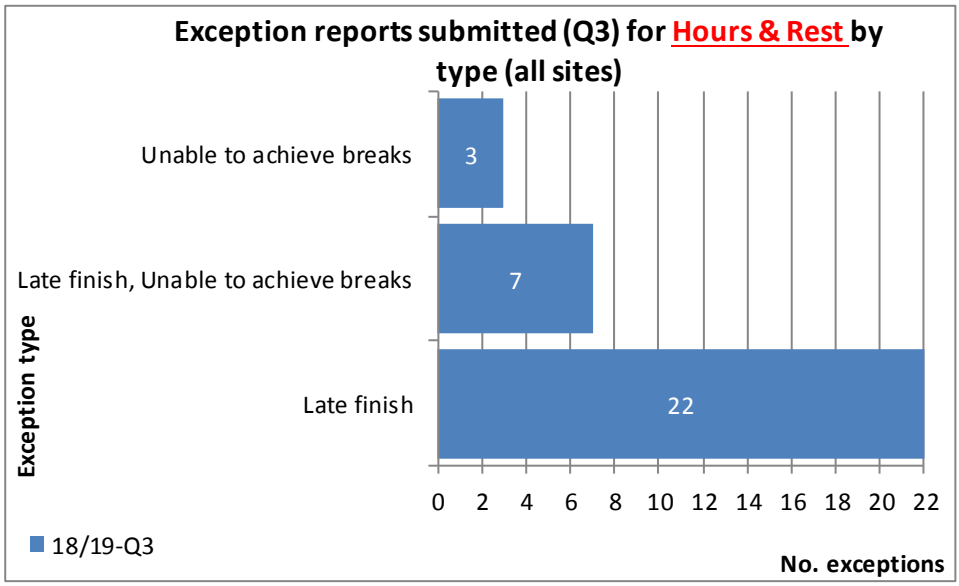
- 8.11% (3) were closed by the clinical supervisor, 81.08% (30) by the educational supervisor and the remaining 10.81% (4) by either the GoSW or the Director of Medical Education

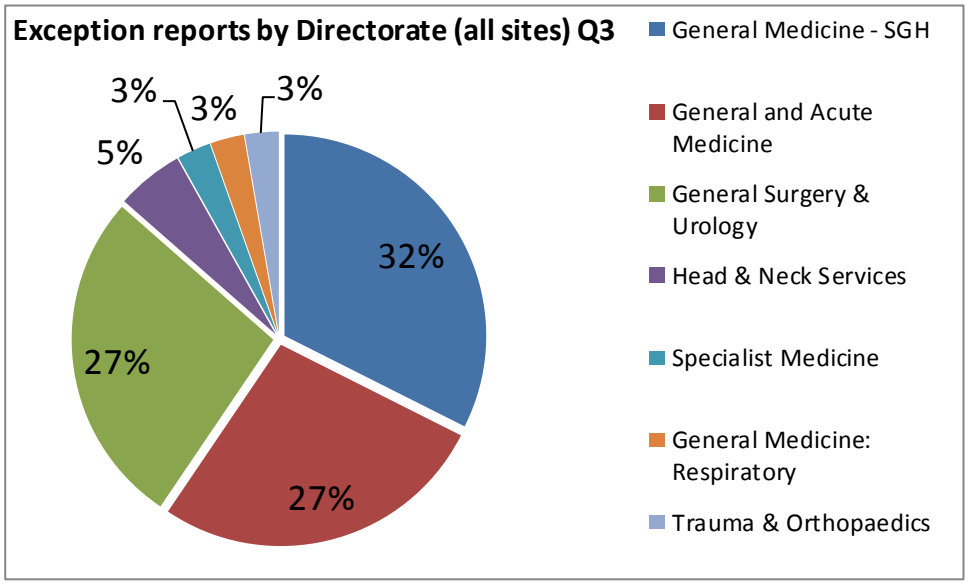
- 43.24% (16) have resulted in payment to the Trainee for additional hours worked (total of 30.25 hours claimed with a value of £413.39)

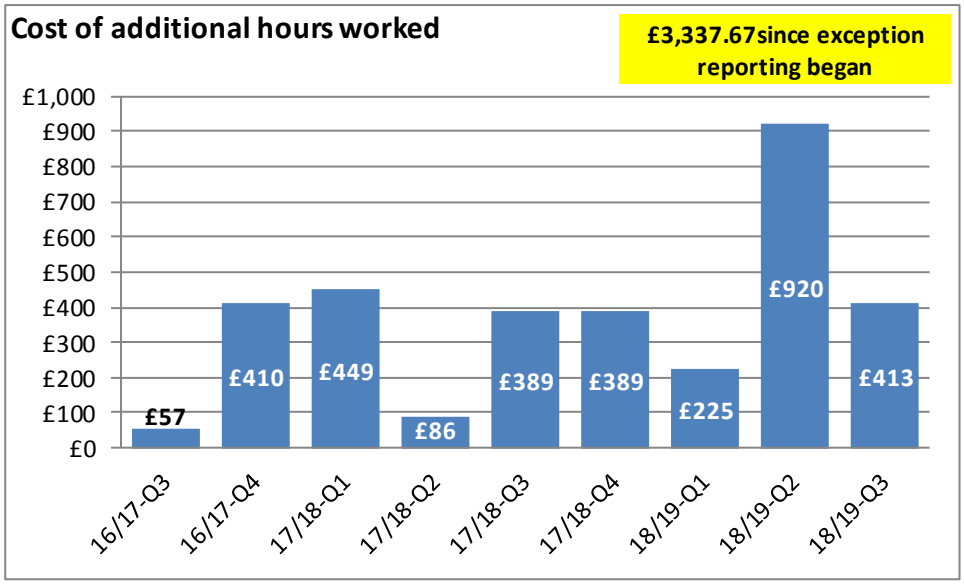
- 37.84% (14) have resulted in TOIL being approved (total of 22.25 hours claimed)
- 10.81% (4) had no impact on TOIL or additional hours (mainly monitoring for missed breaks) (and 8.11% [3] exception reports remain open at time of writing report)
- 86.48% (32) were for Hours & Rest, 2.71% (1) was for Education only and 10.81% (4) were for both Hours & Rest *and* Education.

The following charts detail the number of exception reports received from each site and the reasons for them.









2.5 Positive outcomes

- New process invoked to inform Clinical Directors of rota gaps which are likely to cause significant disruption so that they can hold wider departmental discussions immediately to consider options

- Perceived lack of registrar level support on two medical/acute wards in Scarborough. The issue was escalated to Clinical Directors and care group managers. Feedback from FY1 doctors states a much improved position and positive experience of working there now

- A suggestion came from foundation doctors: for consultants to contact the doctors (particularly Foundation) at the start of their shifts to advise them what they should and should not be contacting them for plus a general introduction to what kind of patients

they would be dealing with. This was recommended to the Clinical Director and Directorate Manager

- The issue of locums taking on shifts which can be unsafe (e.g. working 21 hours in a row, by taking on additional work as a locum immediately after their rostered shift) was raised at the JDF to highlight the importance of taking personal responsibility for their own safe working hours and a potential new process to be introduced by the rota team to minimise the risk of it happening again.

2.6 Summary of rota gaps and actions taken

As of end December 2018, the overall vacancy rate, across all grades and specialties is 10.1%, reducing from the previous quarter. This takes into account a full changeover period from August – October and includes further substantive recruitment to vacant posts.

The below table demonstrates; the training post fill rate, percentage of posts back filled by trust grades and percentage of training posts that remain vacant:

Training post vacancy position			
	Filled by trainees	**Filled by Trust Grade**	**Vacant**
Scarborough	78.2%	7.5%	14.3%
York	92.2%	3.5%	4.3%

General and Acute Medicine in York has temporarily increased the Trust Grade establishment from August 2018, to trial an additional AMU rota alongside the existing cover arrangements and reverting to on-call duties being worked across the whole rota pattern. The medical directorate and rota teams have informally reported the following outcomes:

- Improved junior doctor sickness rates
- Decrease in agency spend
- More robust and consistently better staffing on wards both during the working week, evenings and weekends
- Better support and transition during handover periods, particularly for F1s.

Due to the benefits that have been seen by the introduction / extension of the Trust Grade posts in Medicine, the plan would be to continue to recruit to these roles going forward. Work will commence on rota design and recruitment in February 2019.

3. Next steps

To report back to the Board the outcome of the consultant survey and continue to support junior doctors who wish to exception report as these remain an important measure of safety.

To continue with the number of the *Eight high impact actions* projects which have brought about positive change over the coming months, including the first ever 'junior doctors awards' and a 'paired learning' project for junior doctors and managers and update the board accordingly.

4. Detailed recommendation

The Board of Directors are asked to:

- Note the positive outcomes arising from exception reporting
- Support the junior doctors award as appropriate
- Receive feedback on the paired learning project.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Finance Report

Trust 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 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 9 (Quarter 3) financial position for York Teaching Hospital NHS Foundation Trust.

The Trust is reporting an Income and Expenditure deficit of £8.8m against a planned deficit of £6.4m. The Trust is therefore reporting a £2.4m adverse variance to plan after all Provider Sustainability Fund (PSF) adjustments.

NHSI assess the Trust's underlying performance before PSF. In this case the Trust's target control total deficit at Quarter 3 was £14.7m and an actual deficit of £14.4m has been delivered (using NHSI's assessment criteria). NHSI assess the Trust as, therefore, reporting a £0.3m positive variance to pre-PSF plan.

Recommendation

The Board is asked to note the report.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: January 2019

1. Month 7 Summary Financial Position

Including all sustainability funding adjustments the month 9 (quarter 3) income and expenditure position is a deficit of £8.8m against a planned deficit of £6.4m. The Trust is currently reporting a £2.4m adverse variance to plan after all Provider Sustainability Fund (PSF) adjustments.

NHSI assess the Trust's underlying performance before PSF. In this case the Trust's target control total deficit at Quarter 3 was £14.7m and an actual deficit of £14.4m has been delivered (using NHSI's assessment criteria). NHSI assess the Trust as, therefore, reporting a £0.3m positive variance to pre-PSF plan.

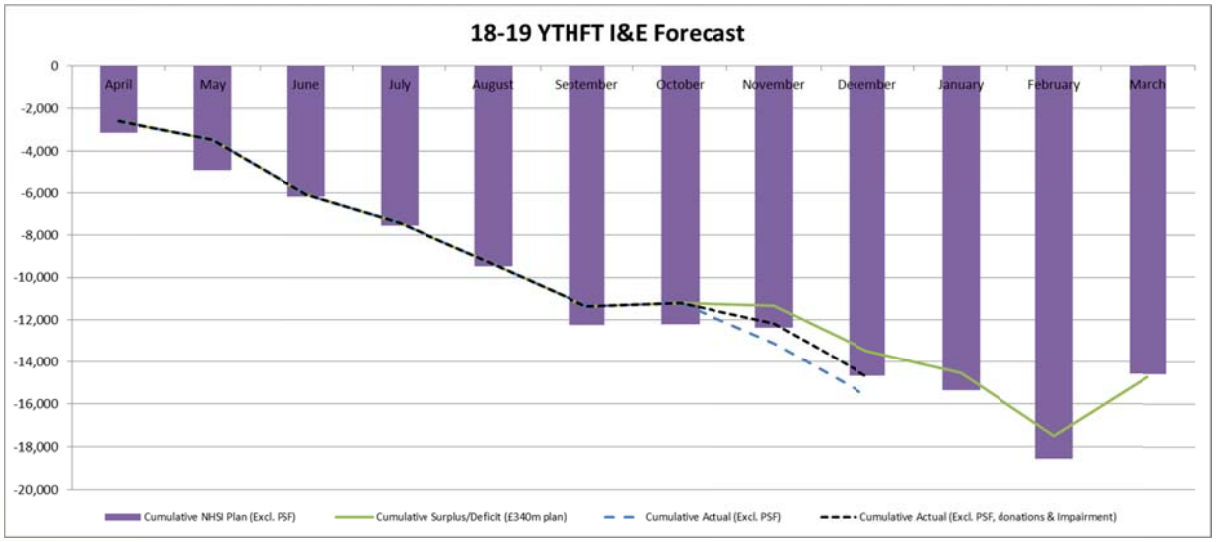
To date the reported financial position assumes all sustainability funding with the exception of quarter 1 and quarter 3 ECS.

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 December of £40.2m. This is £1m below the average monthly spend for the previous eight months of the financial year (£41.4m).

Notwithstanding this reduction in December, 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 £6m 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 £6.0m. Detailed outturn forecasting work continues to be refined each month. 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 broadly tracking its plan right through to, and including, month 12. There is a notable improvement in the deficit position at month 12 linked to the NHSI approved plan including an assumption around historic VAT recovery from the LLP. For completeness this has now been incorporated into the 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 9 this suggests a spend cap of £11.2m. The actual reported agency expenditure was above cap at £12.0m but reductions in agency expenditure still remain evident from the 2017/18 outturn position. Notable in-month pressures include nursing and junior medical staff spend. 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 £0.8m. Under the AIC, reimbursement for the CCG component of this additional spend is only at 50%, and an adjustment to the overall reported income level has been made to reflect this arrangement. The share of excluded drug and device expenditure commissioned by NHSE is not subject to any AIC adjustment.

Work has been progressing through the AIC Management Group on the detailed understanding of the trading position under the AIC agreement. The Trust's plan assumes £10m of QIPP delivered in the contract agreements with our three AIC commissioners. The activity position currently confirms QIPP is not delivering and therefore the Trust is overtrading on the agreed contract. The Trust's reported income position reflects the risk share agreement. In addition to non-delivery of the QIPP the Trust is delivering higher levels of activity than the Trust's initial activity projections. These are notable in non-elective activity particularly. A further adjustment has been made to Trust income levels to reflect the marginal cost of delivery chargeable under the AIC for this additional work. Work to reconcile this position with the CCGs has confirmed the position for quarters one and two and reconciliation work for quarter three is now underway.

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 £19.9m (92%) delivered in full year terms to date; notably £11.0m delivered recurrently. Plans for delivery now sit under either transformational or transactional scheme programmes. Transformational scheme plans total £5.5m with £4.4m delivered year to date and transactional scheme plans total £16.1m with £15.4m delivered year to date.

There are no cash issues this month that I wish to draw the Board's attention to.

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 final quarter of the financial year our internal CIP requirements will accelerate and it is important that we see the monthly expenditure run rate reduce. Expenditure discipline has been enhanced, whilst recognising key patient safety considerations.
- Pressure on our agency position is causing this to run ahead of the NHSI cap (Trust plan).
- There are a number of smaller financial risks emerging that are placing pressure on the Trust's forecast outturn position. Notably we have a pressure from the Trust's new clinical waste contract, following the high profile national issues with the previous supplier. Operating charges are between three and four times the previous rate; in full year terms this pressure will be around £0.5m.

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
- First draft medium-term financial planning completed with commissioners and presented to the November Board meeting. The second iteration now being worked on now the national operating framework and business rules have been released.

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

December 2018

Produced January 2019

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 9 - The Period 1st April 2018 to 31st December 2018

York Teaching Hospital NHS Foundation Trust

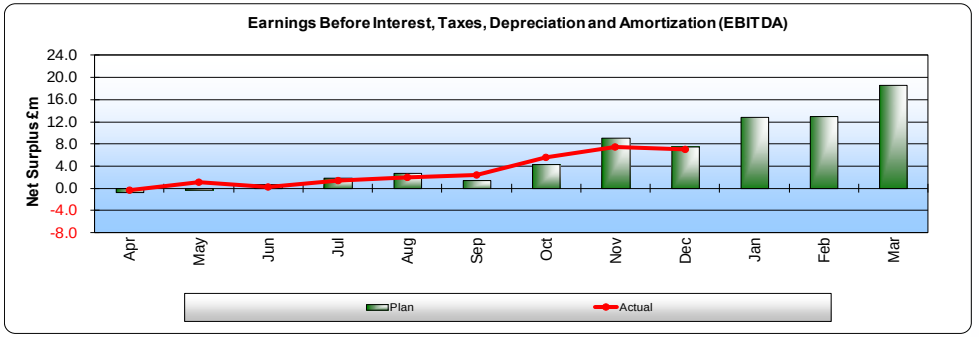
Summary Position:

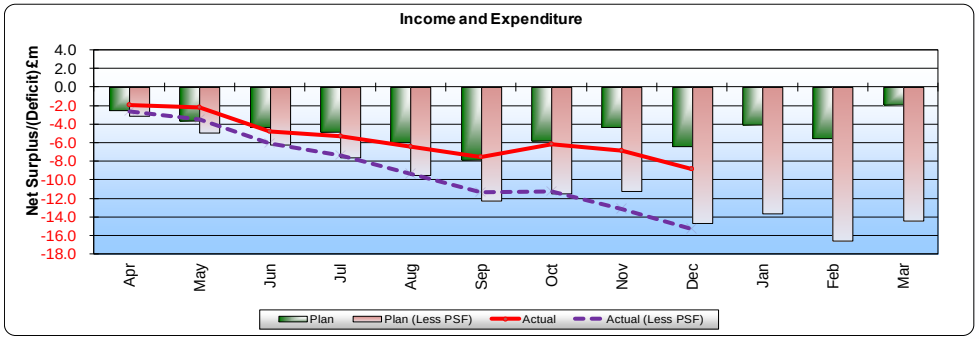
* The Trust is reporting an I&E deficit of £8.8m, placing it £2.5m behind the operational plan.

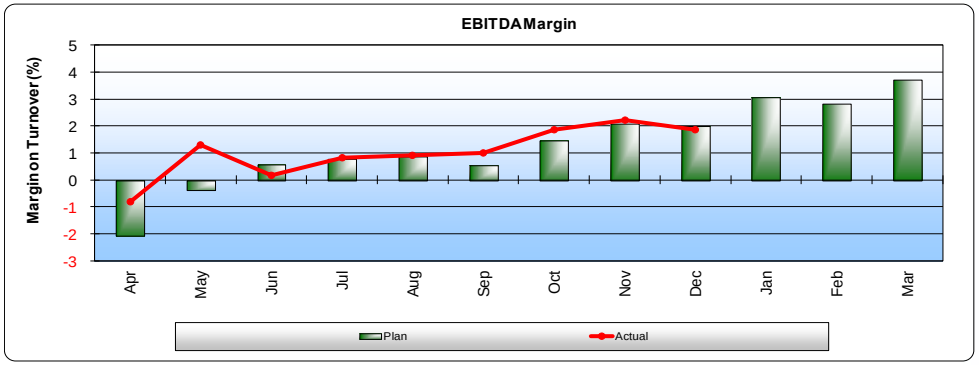
* Income is £7.1m ahead of plan, with clinical income being £6.9m ahead of plan and non-clinical income being £0.3m ahead of plan.

* Operational expenditure is ahead of plan by £7.5m, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £7.1m (1.87%) compared to plan of £7.5m (2.01%), 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	18,829	19,228	399	22,637	0
Planned same day (Day cases)	35,358	27,384	28,941	1,557	35,358	0
Non-Elective Income	115,233	86,681	90,209	3,528	115,233	0
Outpatients	58,848	44,192	44,904	712	58,848	0
A&E	15,390	11,864	12,354	490	15,390	0
Community	20,181	15,336	15,385	49	20,181	0
Other	114,719	84,945	85,431	486	114,719	0
Pass-through excluded drugs expenditure	44,215	33,270	32,910	-360	44,215	0
	426,581	**322,501**	**329,362**	**6,861**	**426,581**	**0**
Non-NHS Clinical Income						
Private Patient Income	1,042	781	774	-7	1,042	0
Other Non-protected Clinical Income	1,692	1,269	1,391	122	1,692	0
	2,734	**2,050**	**2,165**	**115**	**2,734**	**0**
Other Income						
Education & Training	15,416	11,358	12,005	647	15,416	0
Research & Development	3,315	2,486	2,625	139	3,315	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	623	467	303	-165	623	0
Other Income	32,654	22,221	23,422	1,201	32,654	0
Sparsity Funding	2,600	1,950	1,950	0	2,600	0
PSF	12,479	8,112	6,427	-1,685	9,484	-2,995
	67,087	**46,594**	**46,732**	**138**	**64,092**	**-2,995**
Total Income	**496,401**	**371,145**	**378,260**	**7,114**	**493,406**	**-2,995**
Expenditure						
Pay costs	-335,257	-247,965	-254,638	-6,673	-335,257	0
Pass-through excluded drugs expenditure	-44,215	-33,270	-34,038	-769	-44,215	0
PbR Drugs	-5,141	-4,074	-5,526	-1,452	-5,141	0
Clinical Supplies & Services	-47,230	-35,628	-37,989	-2,361	-47,230	0
Other costs (excluding Depreciation)	-49,417	-36,777	-39,012	-2,235	-49,417	0
Restructuring Costs	0	0	0	0	0	0
CIP	1,771	-5,967	0	5,967	1,771	0
Total Expenditure	**-479,489**	**-363,682**	**-371,203**	**-7,521**	**-479,489**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**16,912**	**7,464**	**7,056**	**-407**	**13,917**	**-2,995**
Profit/ Loss on Asset Disposals	0	0	41	41	0	0
Fixed Asset Impairments	-300	0	-936	-936	-300	0
Depreciation - purchased/constructed assets	-10,717	-8,038	-8,785	-747	-10,717	0
Depreciation - donated/granted assets	-395	-296	-296	0	-395	0
Interest Receivable/ Payable	130	98	104	6	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	-867	-617	-619	-2	-867	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	-5,002	-5,412	-410	-6,670	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**-1,906**	**-6,392**	**-8,846**	**-2,455**	**-4,901**	**-2,995**

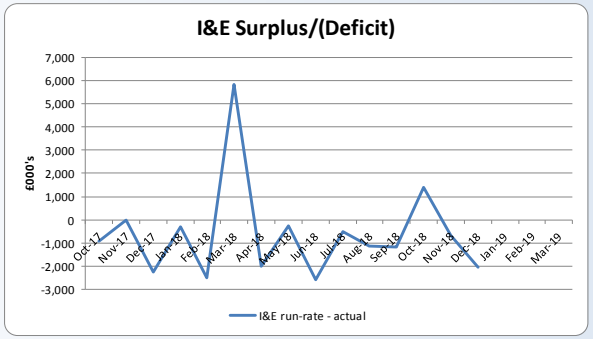
Summary Trust Run Rate Analysis
Month 9 - The Period 1st April 2018 to 31st December 2018

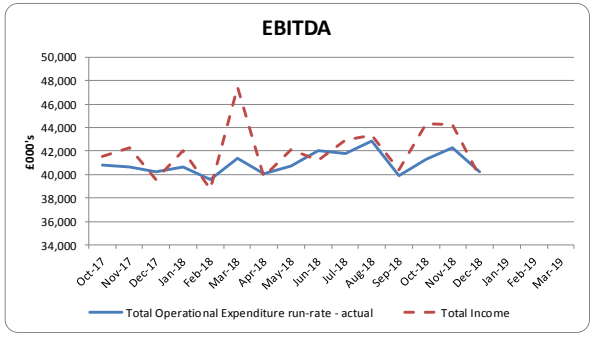
York Teaching Hospital NHS Foundation Trust

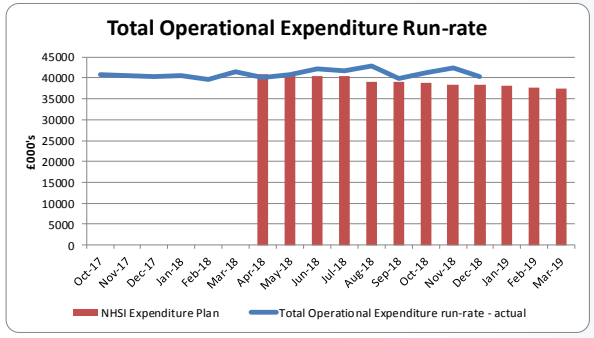
Key Messages:

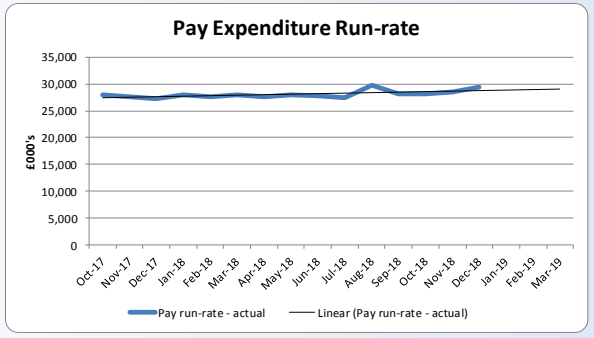
* The total operational expenditure in December was £40.2m. The average total operational expenditure in the previous thirteen months was £41m. Resulting in a favourable variance of £0.8m.

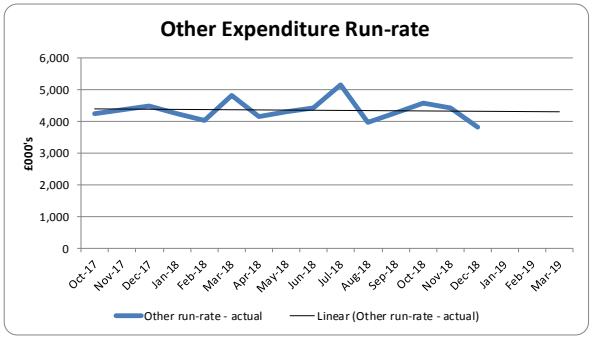
* In month operational expenditure exceeded income by £0.4m, resulting in a negative EBITDA for the month.

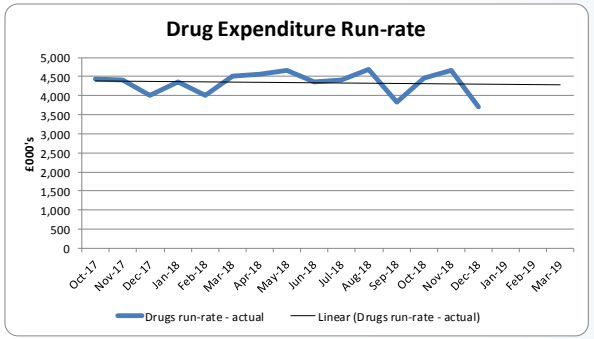


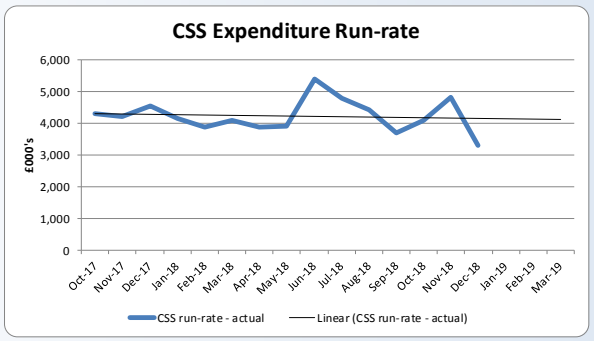












	Monthly Spend																		Monthly Ave	Variance
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		
Total Income	41,538	42,272	39,613	42,003	38,738	47,400	39,791	42,110	41,183	42,970	43,367	40,406	44,347	44,277	39,808	0	0	0	42,144	-2,336
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	-28,451	-29,396	0	0	0	-27,971	-1,425
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	-4,660	-3,711	0	0	0	-4,383	672
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	-4,796	-3,301	0	0	0	-4,286	985
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	-4,409	-3,820	0	0	0	-4,379	[illegible]
EBITDA	697	1,629	-620	1,375	-815	6,014	-319	1,387	-853	1,182	538	522	3,058	1,961	-420	0	0	0	1,125	1,541

Contract Performance

Month 9 - The Period 1st April 2018 to 31st December 2018

York Teaching Hospital NHS Foundation Trust

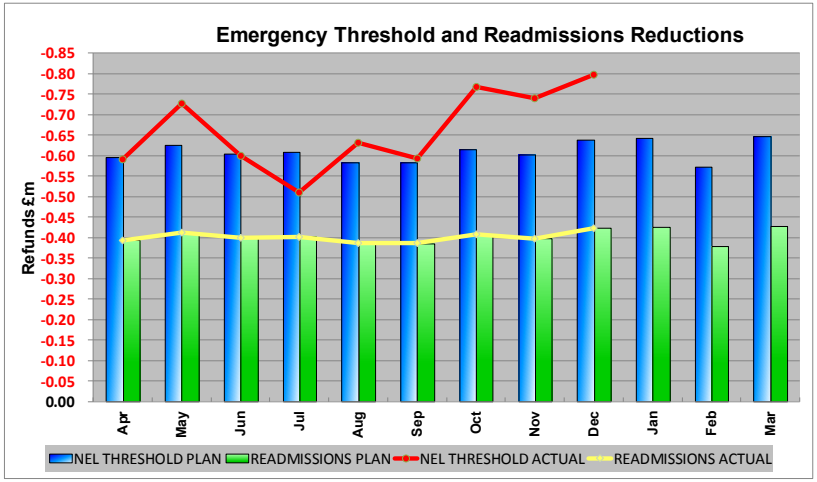
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	219,316	164,917	170,502	5,585
Scarborough & Ryedale CCG	77,783	58,652	60,833	2,181
East Riding CCG	42,696	32,022	32,906	884
Other Contracted CCGs	17,372	13,164	13,438	274
NHSE - Specialised Commissioning	44,368	33,300	32,200	-1,100
NHSE - Direct Commissioning	15,340	11,471	10,620	-851
Local Authorities	4,456	3,342	3,312	-30
Total NHS Contract Clinical Income	**421,331**	**316,868**	**323,811**	**6,943**

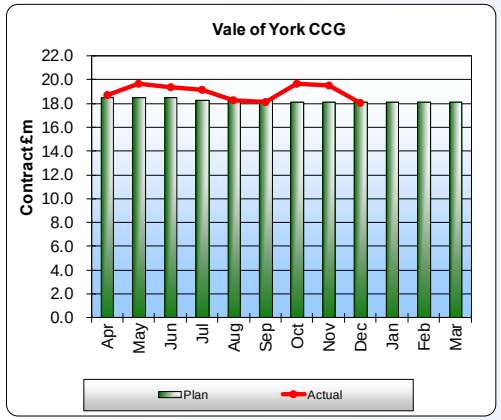
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	12,087	9,095	7,501	-1,594
Risk Income	-6,837	-3,462	0	3,462
Total Other NHS Clinical Income	**5,250**	**5,633**	**7,501**	**1,868**

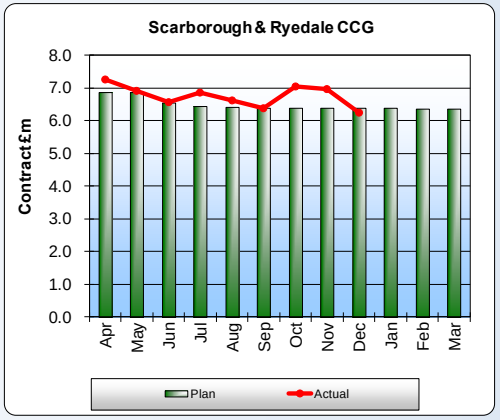
Sparsity funding income moved to other income non clinical	-1,950
Winter resilience monies in addition to contract	0

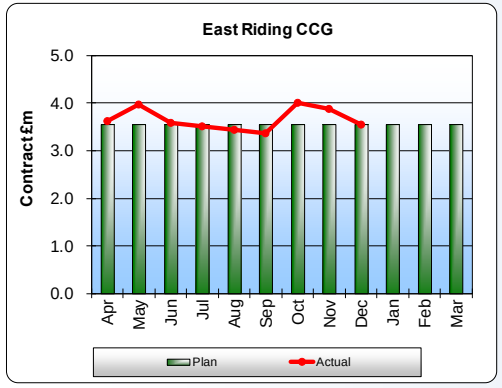
Total NHS Clinical Income	**426,581**	**322,501**	**329,362**	**6,861**

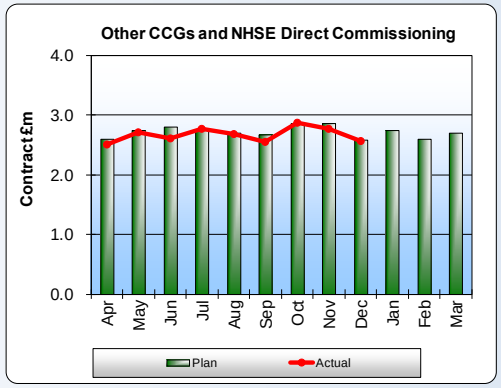
Activity data for December is partially coded (50%) and November data is 90% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

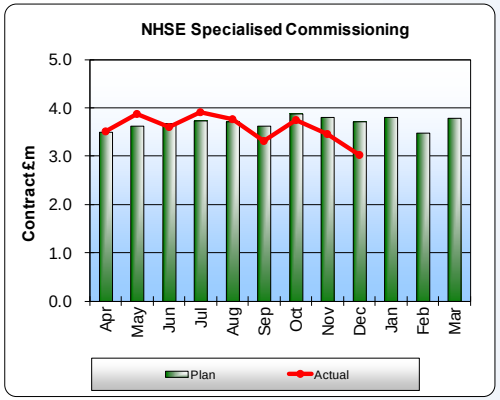


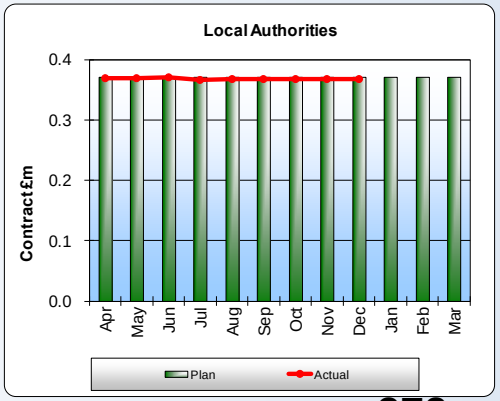












272

Agency Expenditure Analysis

Month 9 - The Period 1st April 2018 to 31st December 2018

York Teaching Hospital NHS Foundation Trust

Key Messages:

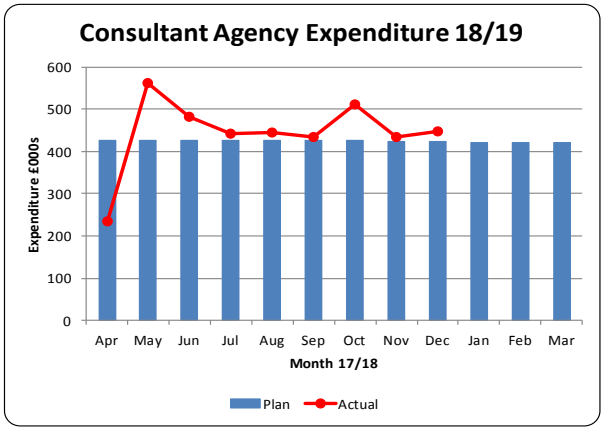
* Total agency spend year to date of £12.0m, compared to the NHSI agency ceiling of £11.2m.

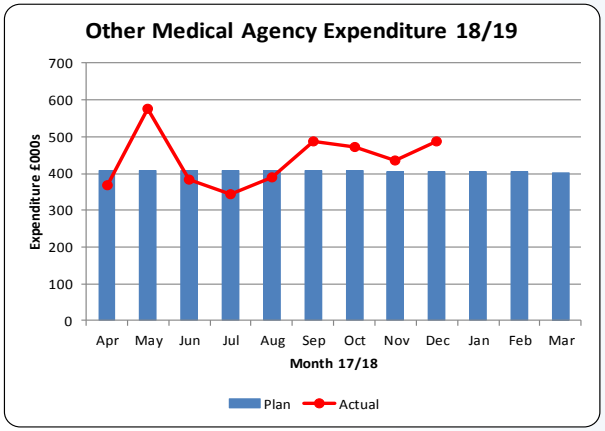
* Consultant Agency spend is £0.2m ahead of plan.

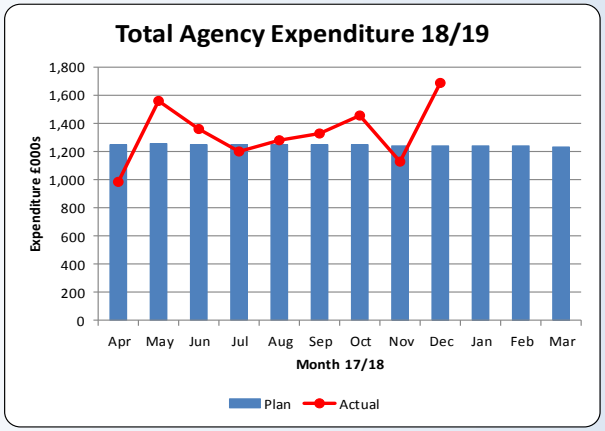
* Nursing Agency is £0.1m ahead of plan.

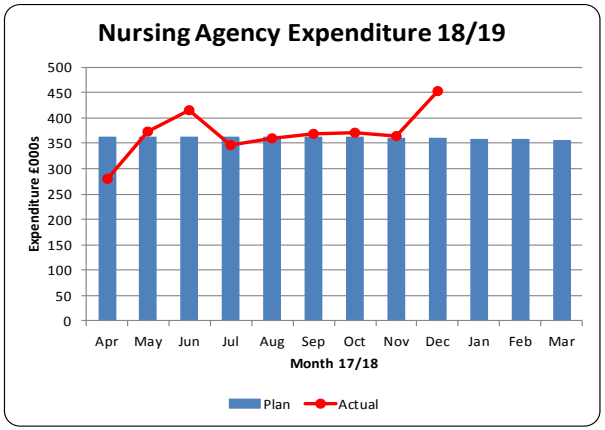
* Other Medical Agency spend is £0.3m ahead of plan.

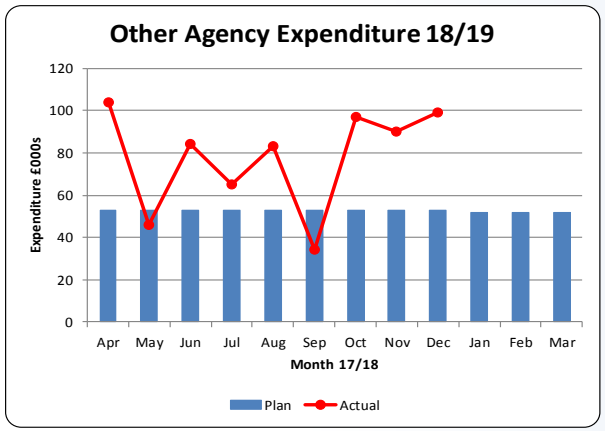
* Other Agency spend is ahead of plan £0.2m.

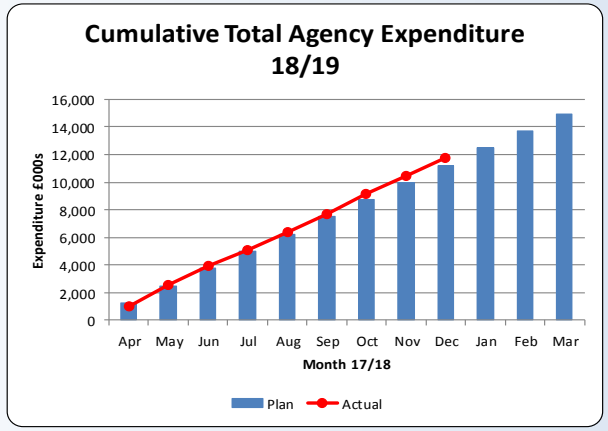












273

Expenditure Analysis

Month 9 - The Period 1st April 2018 to 31st December 2018

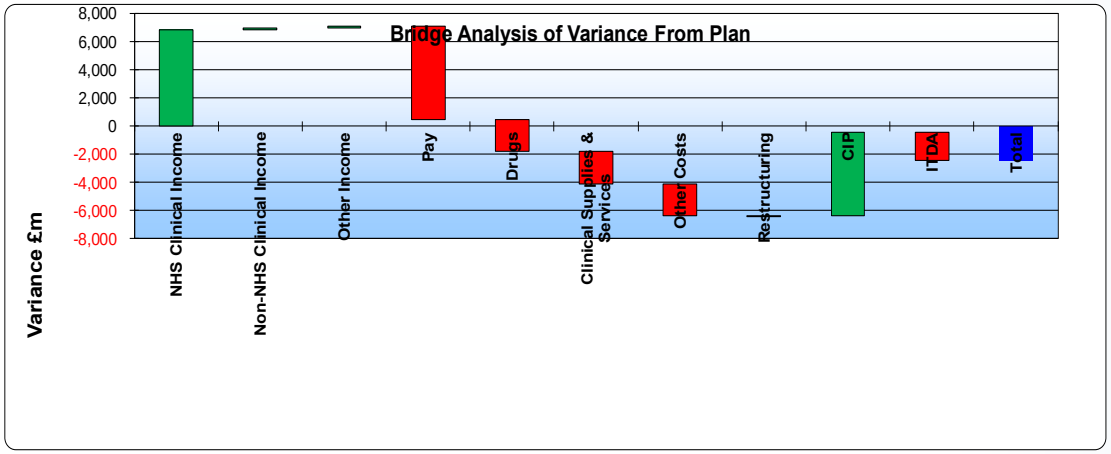
NHS York Teaching Hospital NHS Foundation Trust

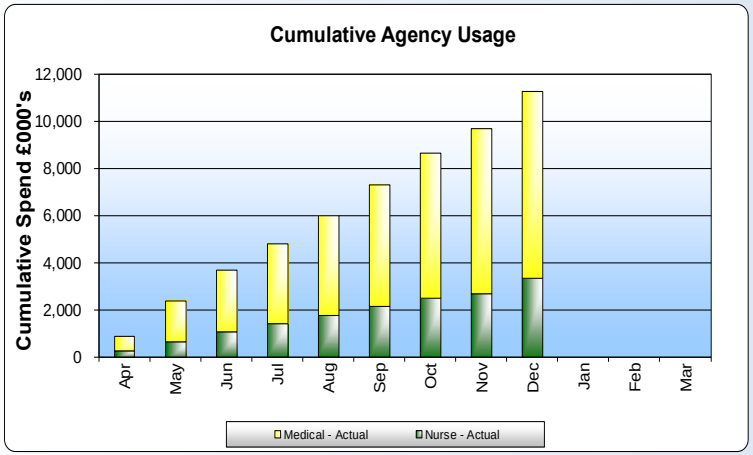
Key Messages:

There is an adverse expenditure variance of £7.5m at the end of December 2018. This comprises:

* Pay expenditure is £6.7m ahead of plan.
* Drugs expenditure is £2.2m ahead of plan.
* CIP achievement is £6m ahead of plan.
* Other expenditure is £4.6m ahead of plan.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	59,815	44,400	39,675	-	1,230	-	3,995	44,901	-501	0	
Medical and Dental	31,180	22,898	25,290	-	161	-	3,942	29,393	-6,495	0	
Nursing	92,280	68,509	58,035	312	101	7,754	3,330	69,532	-1,023	0	
Healthcare Scientists	13,338	8,204	8,293	6	8	6	175	8,489	-285	0	
Scientific, Therapeutic and technical	16,426	12,230	11,218	52	0	26	155	11,452	779	0	
Allied Health Professionals	26,148	19,545	17,433	84	141	4	109	17,770	1,775	0	
HCAs and Support Staff	49,041	36,450	32,635	547	62	31	134	33,410	3,040	0	
Chairman and Non Executives	186	139	125	-	-	-	-	125	14	0	
Exec Board and Senior managers	15,676	11,633	10,389	1	-	-	-	10,390	1,243	0	
Admin & Clerical	39,109	29,019	27,857	118	47	82	128	28,232	787	0	
Agency Premium Provision	4,241	3,181	-	-	-	-	-	0	3,181	0	
Vacancy Factor	-13,376	-9,135	0	-	-	-	-	0	-9,135	0	
Apprenticeship Levy	1,192	894	945	0	0	0	0	945	-51	0	
TOTAL	**335,257**	**247,965**	**231,894**	**1,120**	**1,751**	**7,903**	**11,969**	**254,638**	**-6,673**	**0**	





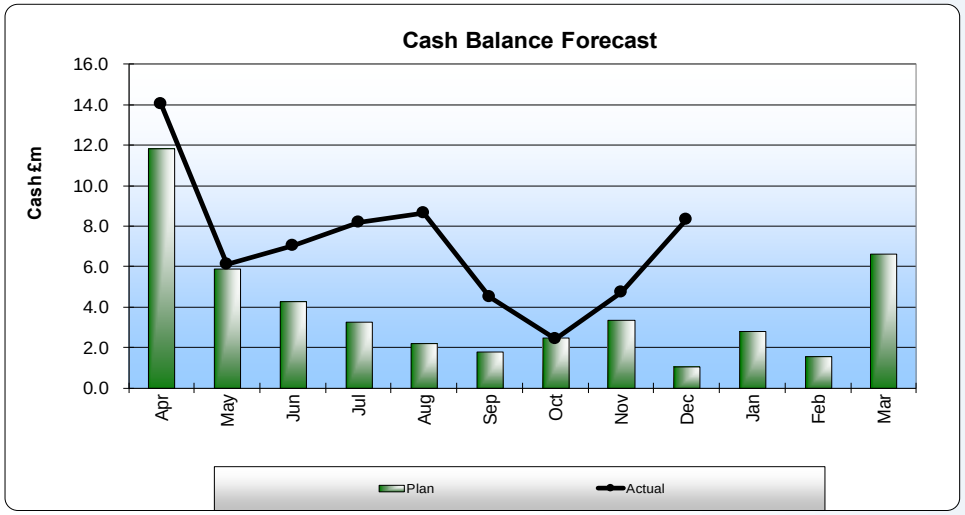
Cash Flow Management

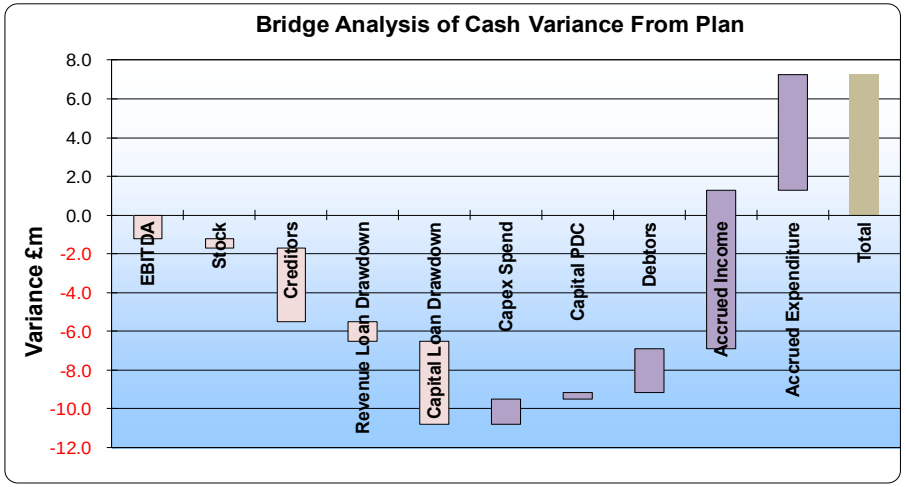
Month 9 - The Period 1st April 2018 to 31st December 2018

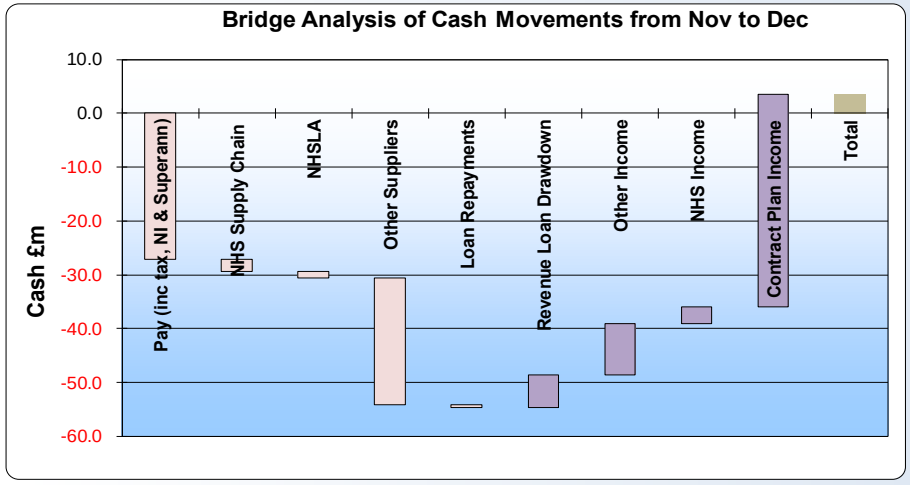
York Teaching Hospital NHS Foundation Trust

Key Messages

* The cash position at the end of December was £8.3m, which is £7.3m above plan. This is mainly attributable to:
* Receipt of Q2 PSF (£2.5m) ahead of the cash forecast.
* Focused cash collection on invoices resulting in a debtors position of £4m below plan.
* The Trust planned to access a total of £7m Revenue Support funding by the end of December. £6m was accessed in December, which is £1m below plan.







* Categorisation of expenditure was unavailable at the time of reporting

275

Cash Flow Management

Month 9 - The Period 1st April 2018 to 31st December 2018

York Teaching Hospital NHS Foundation Trust

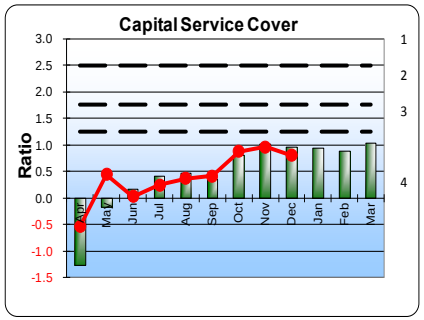
Key Messages:

* The receivables balance at the end of December was £8m, which is £4m below plan.
* The payables balance at the end of December was £19.4m, which is above plan.
* The Use of Resources Rating is assessed is a score of 3 in December, and is reflective of the I&E position.

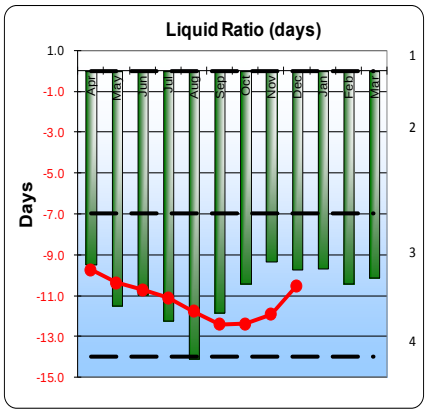
Significant Aged Debtors (Invoices Over 90 Days)

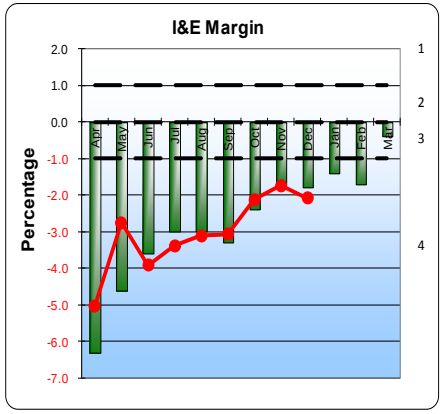
Harrogate & District NHS Foundation Trust	£422K
Tees, Esk & Wear Valleys Foundation Trust	£288K
Humber NHS Foundation Trust	£261K
NHS Property Services	£254K

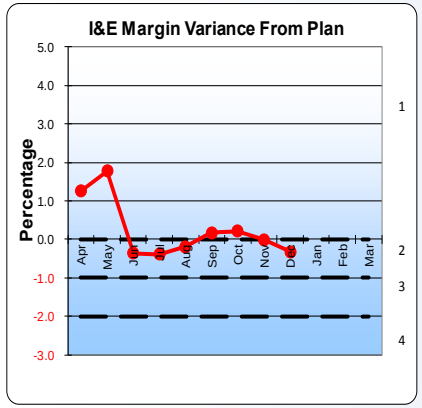
	Current	1-30 days	31-60 days	Over 60 days	Total
	£m	£m	£m	£m	£m
Payables	8.56	2.18	1.58	7.03	19.35
Receivables	3.14	0.73	0.84	3.31	8.02

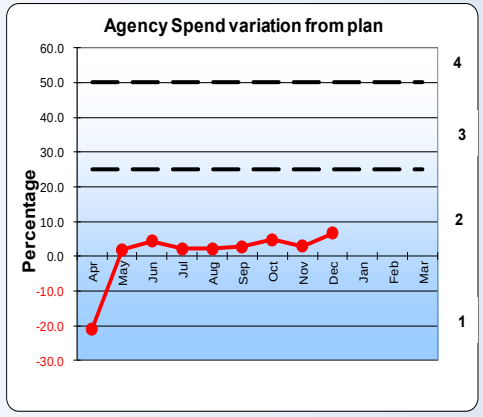


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (20%)	3	3	3	3
Capital Service Cover (20%)	4	4	4	4
I&E Margin (20%)	3	4	4	3
I&E Margin Variance From Plan (20%)	1	1	2	1
Agency variation from Plan (20%)	1	2	2	1
Overall Use of Resources Rating	**3**	**3**	**3**	**3**









276

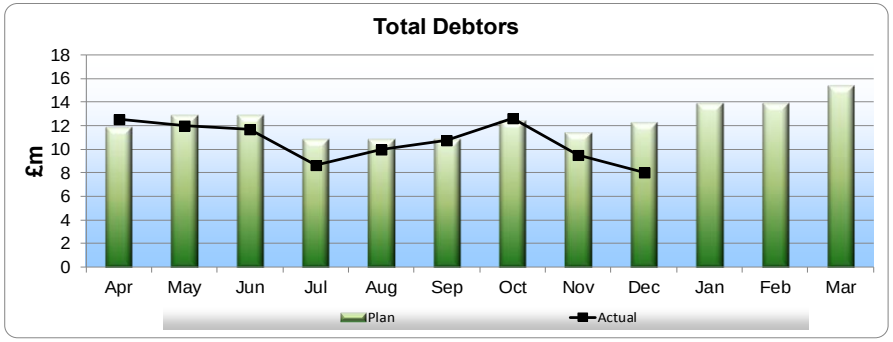
Debtor Analysis

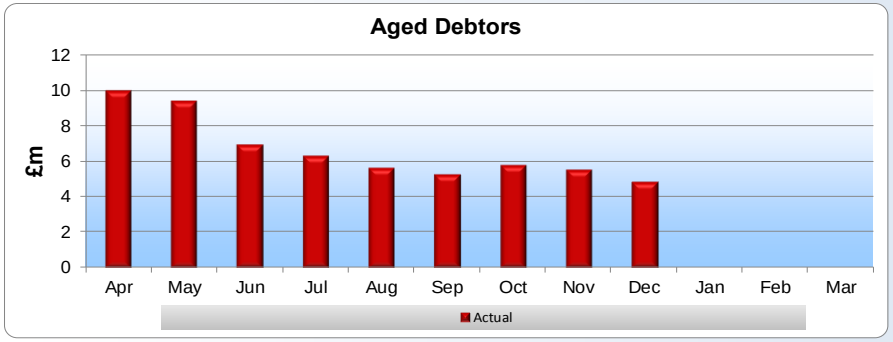
Month 9 - The Period 1st April 2018 to 31st December 2018

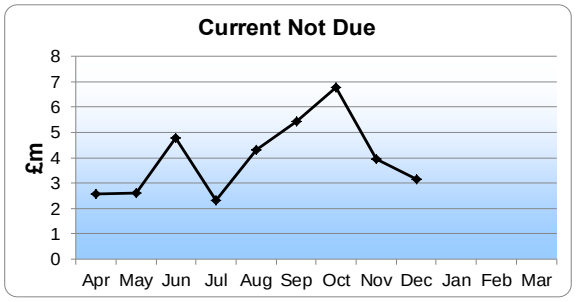
York Teaching Hospital NHS Foundation Trust

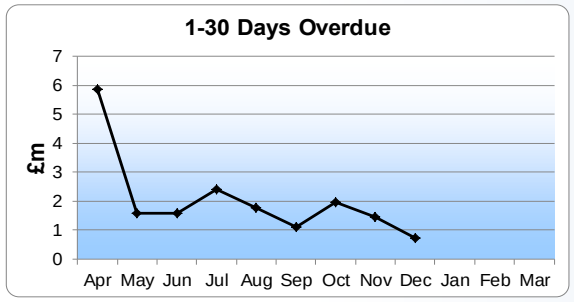
Key Messages

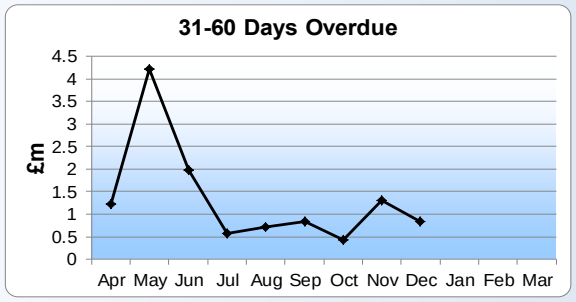
* At the end of December, the total debtor balance was £8m, which is £4.2m below plan. £3m of this relates to 'current' invoices not due.
* Aged debt totalled £4.9m and is at the lowest point this financial year.
* Long term debtors (Over 90 Days) remain at low levels but continues to be a focus for the Trust.
* Accrued income is significantly below plan. This is mainly due to the focus on turning accruals in to invoices to aid cash flow.
* Furthermore, Q2 PSF (£2.5m) was also received in month ahead of the cash forecast. This receipt also contributed to the reduction in the accrued income balance.

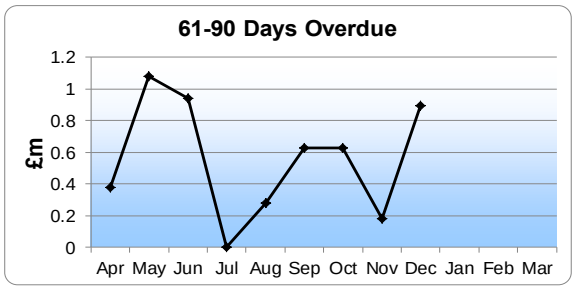


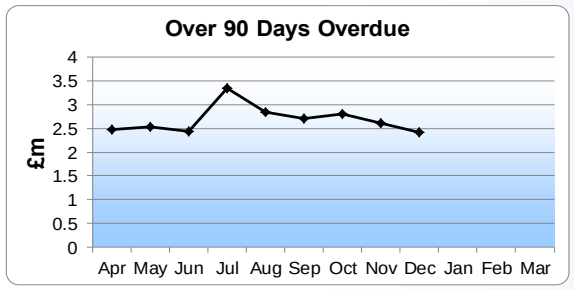


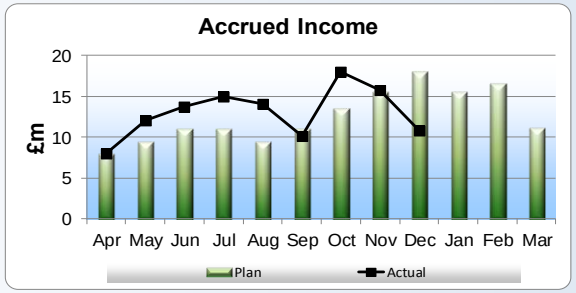












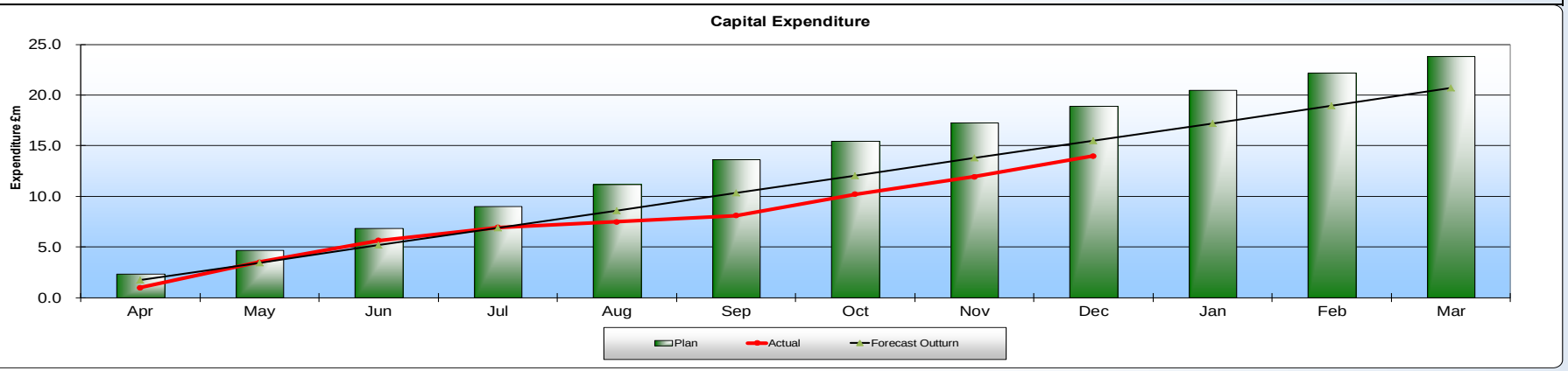
277

Capital Programme
Month 9 - The Period 1st April 2018 to 31st December 2018

York Teaching Hospital NHS Foundation Trust

Key Messages:

* Current spend to the end of December is £14.0m against a plan of £18.9m, the black line on the graph represents the revised forecast outturn.
* 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
* The Trust has been awarded £1.28m in PDC funding; £340k for SNS secondary Wifi and £940k for SGH ED ICAU, these schemes were not part of the original capital plan.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
SGH /York MRI Replacement	1,999	1,161	2,438	-439	
SGH X ray Rooms	660	70	660	0	
York VIU/Cardiac Equipment	1,379	1,442	1,149	230	
Radiology Lift Replacement SGH	860	866	860	0	
Fire Alarm System SGH	1,529	779	1,029	500	
Other Capital Schemes	650	1,667	2,297	-1,647	Include PDC funded schemes total £1.28m
SGH Estates Backlog Maintenance	1,000	277	365	635	
York Estates Backlog Maintenance - York	1,265	476	860	405	
Cardiac/VIU Extention	3,000	315	1,200	1,800	
Medical Equipment	450	87	450	0	
SNS Capital Programme	1,200	1,055	1,090	110	
Capital Programme Management	1,455	651	1,190	265	
Endoscopy Development	8,000	4,128	5,600	2,400	
Charitable funded schemes	623	370	385	238	
Fire Alarm System York	1,120	647	1,120	0	
Slippage to be managed in year	-1,387	0	0	-1,387	
Estimated In year work in progress	0	0	0	0	
TOTAL CAPITAL PROGRAMME	**23,803**	**13,991**	**20,693**	**3,110**	

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	4,860	5,168	370	
Loan Funding b/fwd	1,280	773	1,280	0	
Loan Funding	13,401	6,119	9,201	4,200	
Charitable Funding	623	370	385	238	
Strategic Capital Funding	4,026	1,869	4,396	-370	
Sale of Assets	215	0	263	-48	
TOTAL FUNDING	**25,083**	**13,991**	**20,693**	**4,390**	

278

Key Messages:

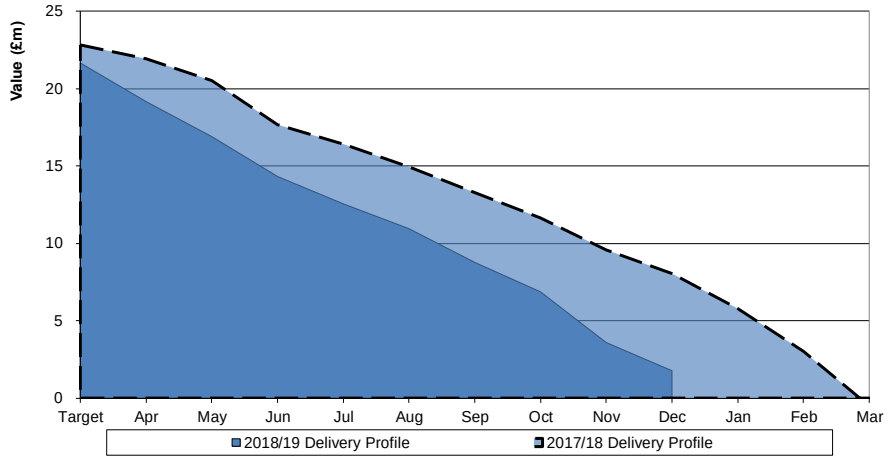
* Delivery - £19.9m has been delivered against the Trust annual target of £21.7m, giving a shortfall of (£1.8m).
* Part year NHSI variance - The part year NHSI variance is £6.0m.
* In year planning - The 2018/19 plannimng surplus is currently £0.0m.
* Four year planning - The four year planning surplus is £8.2m.
* Recurrent delivery - Recurrent delivery is £11.0m in-year, which is 51% of the 2018/19 CIP target.

Efficiency - Total CIP

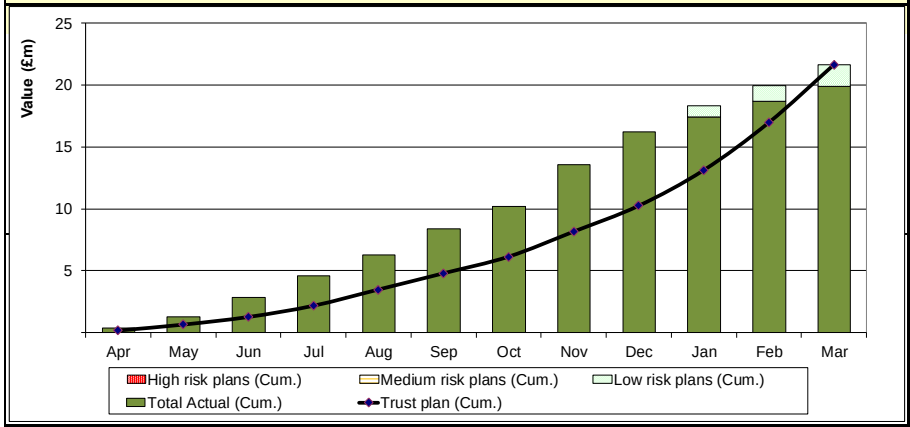
Executive Summary

	£m
2018/19 CIP Target	**£21.7**
In Year Delivery	
NHSI YTD Target at Month 9	£10.3
Actual Delivery at Month 9	£16.2
NHSI Variance Month 9	**£6.0**
Recurrent Delivery	£11.0
Non Recurrent Delivery	£8.9
Total Delivery	**£19.9**
In Year Gap to Delivery	**-£1.8**
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)	**£50.4**
4 Year Plans	£58.7
4 Year Planning (Gap)/Surplus	**£8.2**

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	848
Total Number of Assessed Schemes - Directorate	629
Total Number of Assessed Schemes - Signed Off	584

Probability/ Likelihood						
Almost Certain	2	0	0	0	0	
	3	0	0	0	0	
	2	7	0	0	0	
	6	17	4	0	0	
Rare	564	9	8	2	0	
	Negliable - None				Catastrophic/death	
	Consequence/Severity					

Moderate Risk Plans: 35

Key Messages:

* Transactional CIP schemes represent £16.1m of the £21.7m Efficiency Target.
* Delivery at Month 9 is £15.4m, of which £6.8m is recurrent.

Efficiency - Transactional CIP

Executive Summary

	£m
2018/19 Transactional CIP Target	**£16.1**
In Year Delivery	
NHSI YTD Target at Month 9	£7.2
Actual Delivery at Month 9	£13.2
NHSI Variance Month 9	**£6.0**
Recurrent Delivery	£6.8
Non Recurrent Delivery	£8.6
Total Delivery	**£15.4**
Gap to Delivery	**-£0.7**
In Year Planning	
Forecasted Delivery	£16.1
Forecasted Planning (Gap)/Surplus	**£0.0**
Long Term Planning	
4 Year Transactional CIP Target (18/19 to 21/22)	**£40.9**
4 Year Plans	£49.1
4 Year Planning (Gap)/Surplus	**£8.2**

Governance Risk Heat Map

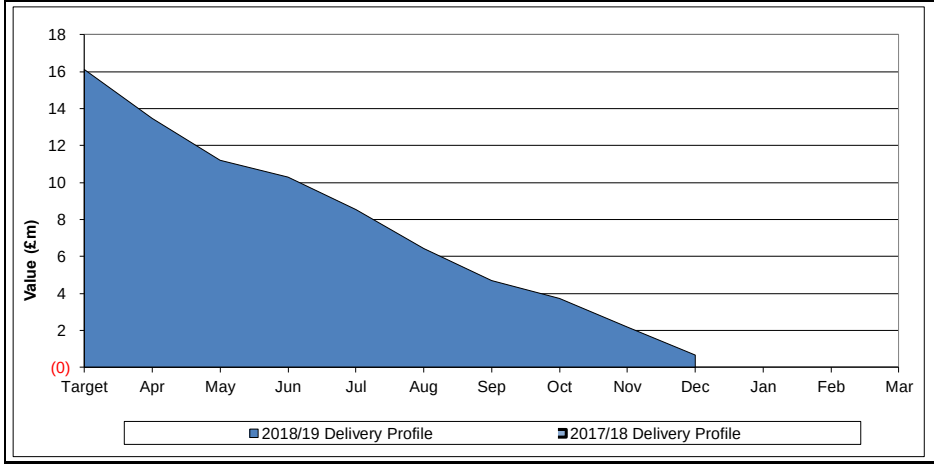
Total Number of Schemes	833
Total Number of Assessed Schemes - Directorate	614
Total Number of Assessed Schemes - Signed Off	572

Probability/Likelihood	Negligable - None				Catastrophic/death
Almost Certain	2	0	0	0	0
	3	0	0	0	0
	2	7	0	0	0
	6	16	4	0	0
Rare	553	9	5	2	0

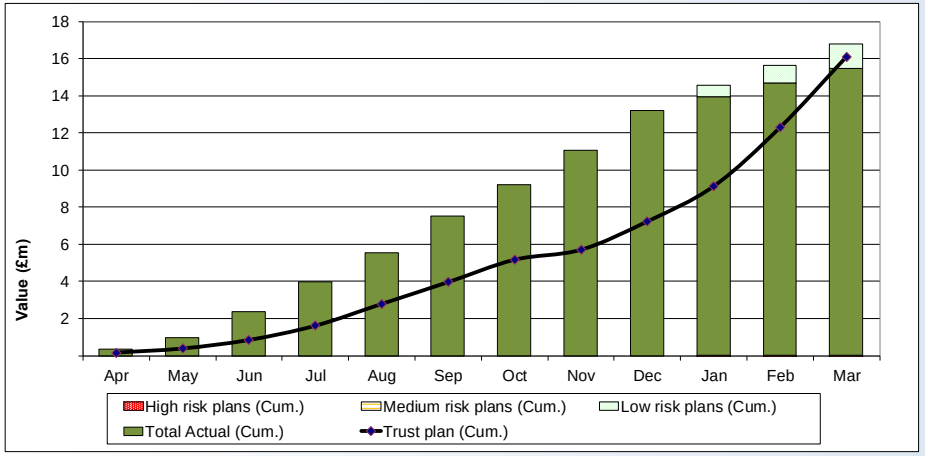
Consequence/Severity

Moderate Risk Plans: 34

Gap to delivery - 2018/19



In Year CIP Delivery and Future Plans by Risk



280

Key Messages:

* 15 Transformational schemes represent £5.5m of the £21.7m Efficiency Target.
* Delivery at Month 9 is £4.4m, of which £4.2m 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	**£5.5**
In Year Delivery	
NHSI YTD Target at Month 9	£3.0
Actual Delivery at Month 9	£3.0
NHSI Variance Month 9	**£0.0**
Recurrent Delivery	£4.2
Non Recurrent Delivery	£0.2
Total Delivery	**£4.4**
Gap to Delivery	**-£1.1**
In Year Planning	
Forecasted Delivery	£5.5
Forecasted Planning (Gap)/Surplus	**£0.0**
Long Term Planning	
4 Year Transformation CIP Target	**£9.6**
4 Year Plans	£9.6
4 Year Planning (Gap)/Surplus	**£0.0**

Governance Risk Heat Map

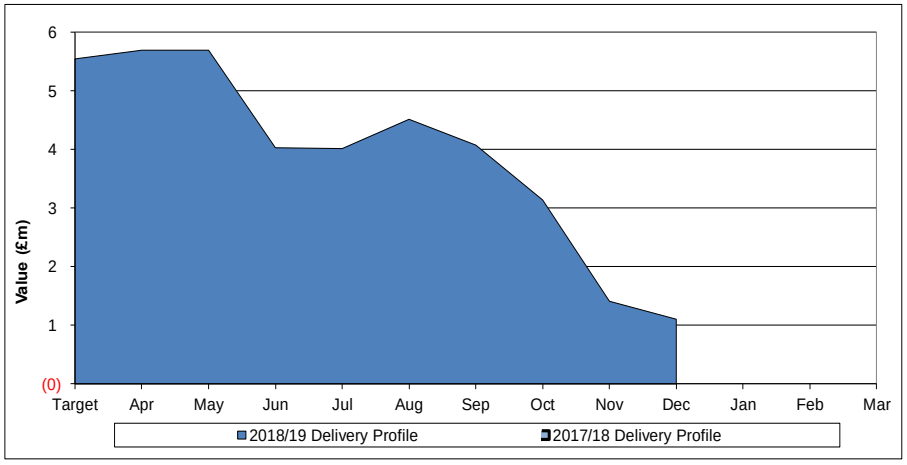
Total Number of Schemes	15
Total Number of Assessed Schemes - Directorate	15
Total Number of Assessed Schemes - Signed Off	12

Probability/ Likelihood	Negligible - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	1	0	0	0
Rare	11	0	3	0	0

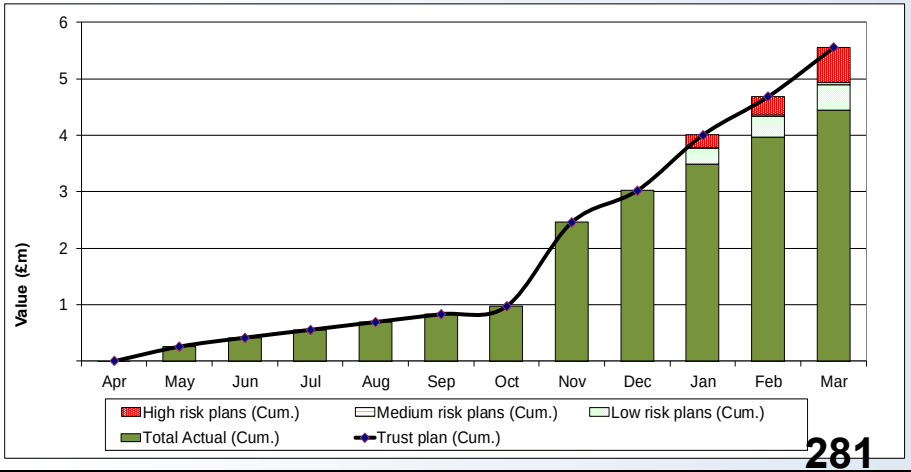
Consequence/Severity

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



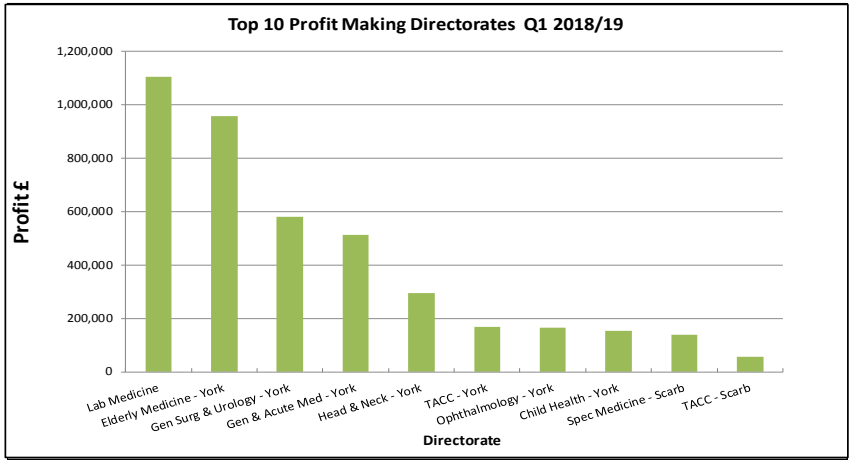
281

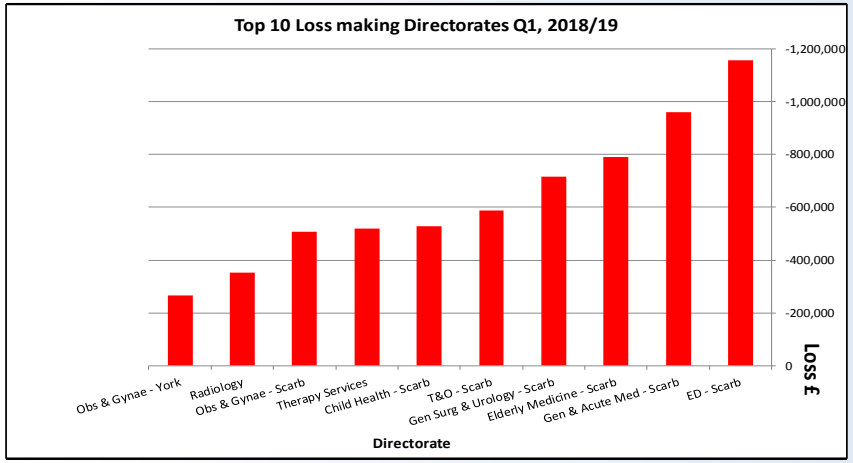
Service Line Reporting
Month 9 - The Period 1st April 2018 to 31st December 2018

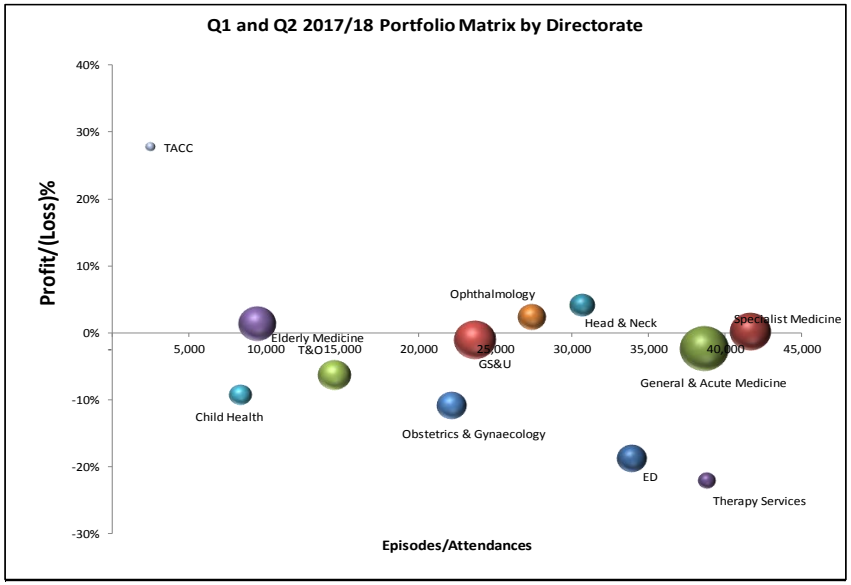
York Teaching Hospital NHS Foundation Trust

Key Messages:

* Current data is based on Q1 2018/19
* 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 and is currently ongoing







DATA PERIOD	Q1 2018/19
CURRENT WORK	* Q2 2018/19 SLR reports and the NHSI Costing Transformation Programme (CTP) requirements are now the key focus for the team. * The Q2 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 and is ongoing.
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**

282

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Procurement Annual Report

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

To provide information and assurance to the Board that the Procurement Department is providing a safe and effective service in support the Trust's overall objectives.

Executive Summary – Key Points

An overview of the last 12 months with actions taken to meet the Lord Carter metrics.

Recommendation

The Board is asked to note the progress made over the previous twelve months and to support the steps being taken to further develop and improve the Trust's procurement function.

Author: Ian Willis, Head of Procurement

Director Sponsor: Andrew Bertram, Finance Director

Date: January 2019

1. Introduction and Background

The Department's ethos is simple; keep the patient at the forefront of everything we do.

We ensure we have the right people in the right place at the right time to support safe, effective and sustainable healthcare, positively influencing the procurement of goods and services by supporting wards, departments, clinicians and non-clinical colleagues to make the very best possible choices and deliver savings now and in the future.

Procurement supports all directorates at all sites and also the new York Teaching Hospital Facilities Management LLP. The team works from three main sites; York Hospital, Scarborough Hospital and at Tribune House (Clifton Moor). Additionally the team includes a Storekeeper Supervisor who supports Bridlington Hospital.

The department places more than 30,000 orders per year with deliveries going to over 900 requisition points throughout the Trust. Last year the Trust spent £158m on goods and services and regularly seeks, where practical and possible, to support local businesses (see appendix 1).

In 2016 Lord Carter's reviewed operational productivity of acute non-specialists trusts.

Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. *An independent report for the Department of Health by Lord Carter of Coles*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

This review looked at productivity and efficiency in English non-specialist acute hospitals using a series of metrics and benchmarks to seek a comparison of where there are significant unwarranted variations. The review estimated this unwarranted variation is worth £5bn in terms of efficiency opportunity and the review makes 15 recommendations designed to tackle this variation and help trusts improve their performance to match the best.

Procurement (as well as clinical staffing/workforce, Pharmacy and medicines, diagnostics and imaging, back-office functions, and Estates and Facilities) were looked at for quality and efficiency, through the lens of clinical specialties, with the results published using an online Model Hospital portal. *https://model.nhs.uk/*

The Procurement module is live with a copy of the most recent report available via the link above.

The Department of Health and Social Care's strategic response to the Carter Report has been the largest 'shake-up' in NHS Procurement for 10 years. This has involved the transformation and re-procurement of the current NHS Supply Chain contract (the nation's largest supplier to the NHS) under the banner of the Future operating Model.

The Department of Health and Social Care estimates that this will save the NHS £615m per year (from year 5) and that 80% of NHS spend will be placed via a single provider. Commercially the Future Operating Model will be organised into eleven Category Towers (covering medical, capital and non-medical areas of procurement spend). This initiative is now moving forward at pace.

2. Detail of Report and Assurance

2.1 The Lord Carter (Model Hospital) Metrics.

The department has been ranked better than average with scores placing the Trust 54th of 136 Trusts nationally. The department is focused on the metrics that comprise this score and seeks to improve its ranking.

The NHS Improvement target for our Trust for non-pay savings in the current year was £2.42m. We have achieved £2.95m so far. Price Performance is an area on the Model Hospital report that will continue to be a particular focus over the next 12 months for the Trust's procurement team.

We are taking steps to improve by engaging in a Partnership Programme with NHS Supply Chain. This has proved worthwhile and in the first six months we have saved an additional £0.25m on top of other savings initiatives.

2.2 Y1802 Departmental Procurement

Significant Assurance. This audit has established that the Trust has robust systems and processes in place to manage high value procurement and the tendering process to ensure it does not breach internal and external regulations.

2.3 Y1841 Non-pay Expenditure

Significant Assurance. The Trust was found to be exceeding two of the targets from within the Modern Hospital Metrics. Approximately 96% of purchase orders could be matched to an invoice and 90% of items were procured through established catalogues.

2.4 Product Masking (reducing unwarranted variation)

NHS Supply Chain is the largest supplier for the Trust. Their online catalogue includes (almost) every conceivable items/product a trust should need.

In order to control demand and limit inappropriate purchases we have masked 98% of their catalogue offering. In practice this means product choice is limited to pre-selected products and end users cannot select a masked product without intervention from the procurement team. An example would be multiple choices of printer paper available in the catalogue but only a single option available for end users to select.

2.5 Apprenticeships, Traineeships and the Procurement Skills Development Network.

We have just concluded hosting our 3rd cohort of procurement apprentices. We have found we get high quality, skilled and committed individuals who bring a real spark to the department and have a zest for learning. All of our previous students have gone on to either find employment within the team, in the wider Trust or have continued with their studies.

Previous apprentices have progressed onto an advanced level traineeship (to build on the knowledge they have previously learnt) and this will see them qualify for the middle tier of the Chartered Institute of Procurement & Supply membership.

Many other procurement staff continue to enhance and refresh their knowledge and skills by attending the Procurement Skills Development Network's learning events. This is a collaborative network provided within the region and supported through subscription from member NHS organisations. The Trust is an active member.

2.6 Procurement Price Index Benchmark & Procurement League Table

Included in Lord Carter's report on operational performance and productivity was a recommendation that a new procurement initiative be developed for benchmarking. The outcome of this was the 'purchase price index and benchmarking tool' or PPIB.

The tool is a database listing products by supplier, price and volume for every NHS Trust in England. Data is supplied monthly on everything the Trust spends. The PPIB allows procurement professionals to evaluate whether supplier-negotiated prices are too high (by allowing users to compare them to other Trust's relative volumes) and this can facilitate better purchasing decisions from improved knowledge and understanding.

We have been using the PPIB tool during the last year for two main purposes;

1. Check what 'good' looks like when we come to re-procuring or retender for items
2. Identifying opportunities to 'buy better' for common items we already purchase.

We have had success with this approach but there is still plenty of scope to improve.

The relative performance of procurement departments (non-specialist NHS acute providers) using PPIB has been assessed and ranked in the format of a league table. It highlights where there are opportunities for improvement and which providers are setting an example. York Teaching Hospital NHS Foundation Trust is 54th (of 136).

https://improvement.nhs.uk/resources/procurement-league-table/

2.7 The NHS Procurement & Commercial Standards – Level 1

As a department we very much focus our efforts on improving our People, Processes and Partnerships. In May 2017 we achieved Level 1 of the NHS Procurement & Commercial Standards*. By March 2019 we aim to have achieved Level 2.

**The NHS Procurement & Commercial Standards are structured to enable Boards and other key stakeholders to assess and benchmark procurement performance and identify areas for improvement. They provide a framework for consistent approaches and practices, delivering benefits across the NHS in procurement performance.*

Skills Development Network
Towards Excellence Procurement
NHS Standards of Procurement – Level 1

3. Next Steps (key highlights)

3.1 NHS Supply Chain Partnership Programme

In April we entered into a partnership programme with NHS Supply Chain to make us 'best-in-class'. This partnership brings their commercial and clinical expertise together with our own with the purpose of two main aims;

- Reduce variation and standardise products and
- Make Savings (an additional £402,000 in 18/19)

3.2 Realignment for FOM (and Procurement 'back-office' rationalisation)

The department is currently aligned to a Directorate-based approach. As NHS procurement changes we are determining if the we should realign the department to a category based approach to mirror the FOM Category Towers or mirror the Trust's proposed and developing Care Group structure.

NHS Improvement has stated that, in their view, there are too many Procurement departments nationally (i.e. duplication of effort). By realigning to a category-based FOM structure we could have the scope to scale this beyond our current Trust geography (i.e. STP-wide). Discussions have begun with the other STP Trusts to look at what this might become in future. If we choose a Care Group based structure there would still be opportunities to work more collaboratively with other STP partners.

3.3 Humber, Coast and Vale STP

We have good dialogue with our neighbouring STP Trusts but our joint working is currently limited but we are working with the other acute trusts on capital procurements, Radiology Reporting, Orthopaedic prosthesis and a SME engagement project for Minor Works.

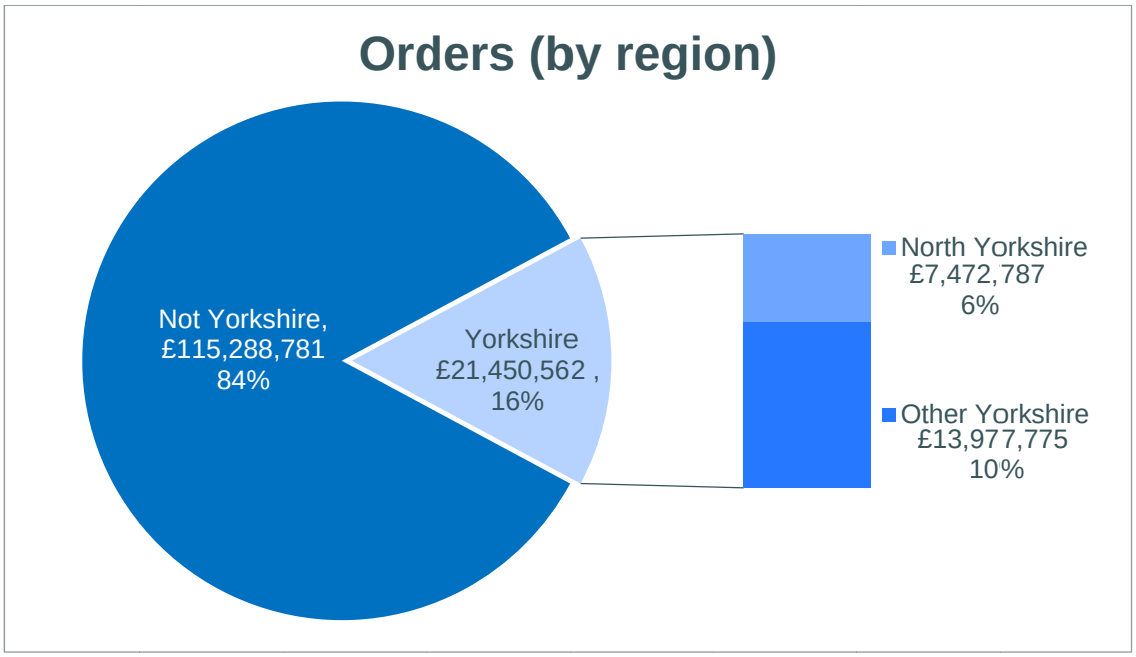
3.4 The NHS Procurement & Commercial Standards – Level 2

The department is working collaboratively with other Trusts across the region to share good practice and make steps towards achieving Level 2 by March 2019. There are very few Trusts nationally accredited to this level and only four in the Yorkshire and Humber region.

4. Detailed Recommendation

The Board is asked to note the progress made over the previous twelve months and to support the steps being taken to further develop and improve the Trust's procurement function.

Appendix 1



Procurement Transformational Plan (updated)

York Teaching Hospital NHS
NHS Foundation Trust

Procurement Transformational Plan
(October 2016 to March 2020)

(A Procurement Strategy for York Teaching Hospital NHS Foundation Trust)

Update (October 2018)

1

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Efficiency Programme Update

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

The Board is asked to note the December 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 full year delivery, as at December 2018 is £19.9m.

Recommendation

For information.

Author: Steven Kitching, Head of Corporate Finance & Resource Management

Director Sponsor: Andrew Bertram, Finance Director

Date: January 2019

Briefing note for the Board of Directors meeting 30 January 2019

1. Summary reported position for December 2018

1.1 Current position – highlights

Delivery – Full year Delivery is £19.9m as at December 2018 which is (92%) of the £21.7m annual target. This position compares to a delivery position of £14.8m in December 2017.

Part year delivery is £6.0m ahead of the profiled plan submitted to NHSI.

In year planning – At December 2018 CIP is 100% planned.

Four year planning – The four year planning shows a surplus of £8.2m. The position in December 2017 was a gap of (£3.5m).

Recurrent vs. Non recurrent – Of the £19.9m full year delivery, £11.0m has been delivered recurrently which is 51% of the overall target for 2018/19. Recurrent delivery is £3.8m ahead of the same position in December 2017.

1.2 Overview

Transactional schemes

Transactional scheme Plans of £16.1m represent 74% of the overall Efficiency Target. Full year Delivery is £15.4m as at December 2018 of which £6.8m is recurrent.

Transformational schemes

Transformational scheme Plans of £5.6m represent 26% of the overall Efficiency Target. Full year Delivery is £4.4m as at December 2018 of which £4.2m is recurrent.

Current live Transformational schemes are Outpatient Productivity, Theatre Productivity/Utilisation, Pharmacy Biosimilars, SNS Paperlite and Printer Strategy, Estates and Facilities ADM.

Summary of Efficiency Programme by Category

The 3 tables below summarise the position of the overall Efficiency Programme by category.

- **Table 1** provides a summary of the over-arching Efficiency programme.
- **Table 2** provides a summary of the Transformational schemes.
- **Table 3** provides a summary of the over-arching Efficiency programme analysed by Carter category. This will include both transformational and transactional schemes.

Table 1: Efficiency Programme Summary

Programme Category	Annual Plan £'m	Full Year Delivery £'m	Full Year Recurrent Delivery £'m	Full Year Non Recurrent Delivery £'m	NHSI Plan YTD £'m	Total Delivery YTD £'m
Transactional	£16.1	£15.5	£ 6.8	£ 8.7	£ 7.2	£ 13.2
Transformational	£ 5.6	£ 4.4	£ 4.2	£ 0.2	£ 3.0	£ 3.0
Total Programme	**£21.7**	**£19.9**	**£11.0**	**£ 8.9**	**£10.2**	**£ 16.2**

Table 2: Transformational Scheme Summary

Transformational Scheme	Annual Plan £'m	Full Year Delivery £'m	Full Year Recurrent Delivery £'m	Full Year Non Recurrent Delivery £'m	NHSI Plan YTD £'m	Total Delivery YTD £'m
Theatre Productivity	£ 0.8	£ 0.1	£ 0.1	£ -	£ -	£ 0.1
Outpatients	£ -	£ -	£ -	£ -	£ -	£ -
ADM	£ 3.7	£ 3.3	£ 3.3	£ -	£ 3.0	£ 2.4
Pharmacy	£ 1.0	£ 1.0	£ 0.8	£ 0.2	£ -	£ 0.4
Paperlite	£ -	£ -	£ -	£ -	£ -	£ -
Printer Strategy	£ 0.1	£ -	£ -	£ -	£ -	£ -
Total Transformational Schemes	**£ 5.6**	**£ 4.4**	**£ 4.2**	**£ 0.2**	**£ 3.0**	**£ 3.0**

Table 3: Efficiency Programme by Carter Category						
Carter Category	**NHSI Annual Plan £'m**	**Full Year Delivery £'m**	**Full Year Recurrent Delivery £'m**	**Full Year Non Recurrent Delivery £'m**	**NHSI Plan YTD £'m**	**Total Delivery YTD £'m**
Carter W/force (Medical)	£ 2.1	£ 1.6	£ 0.9	£ 0.7	£ 1.5	£ 1.2
Carter W/force (Nursing)	£ 1.9	£ 2.7	£ 1.2	£ 1.5	£ 1.4	£ 2.2
Carter W/force (AHP)	£ 0.3	£ 0.6	£ 0.4	£ 0.2	£ 0.2	£ 0.5
Carter W/force (Other)	£ 2.4	£ 3.4	£ 0.4	£ 3.0	£ 1.7	£ 3.3
Carter Procurement	£ 2.9	£ 2.7	£ 1.9	£ 0.8	£ 2.2	£ 2.2
Carter Hospital Medicine & Pharmacy	£ 1.9	£ 1.9	£ 1.6	£ 0.3	£ 1.5	£ 1.3
Carter Corporate & Admin	£ 1.3	£ 2.1	£ 0.8	£ 1.3	£ 1.0	£ 1.9
Carter Estates & Facilities	£ 5.1	£ 3.7	£ 3.5	£ 0.2	£ 3.8	£ 2.7
Carter Imaging	£ 0.4	£ 0.7	£ 0.2	£ 0.5	£ 0.3	£ 0.6
Carter Pathology	£ 0.5	£ 0.4	£ 0.3	£ 0.2	£ 0.3	£ 0.3
Other Savings Plans	£ 2.9	£ 0.1	£ -	£ -	£ -	£ -
Total Programme by Carter Category	**£21.7**	**£19.9**	**£11.2**	**£ 8.7**	**£13.9**	**£16.2**

It should be noted that Transformational Schemes will also be included in the Carter Categories.

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.

A Programme Board is to be established to manage the GIRFT programme and the outcomes.

High Risk Directorates

There are 10 Clinical and 3 Corporate Directorates at High Risk in terms of planning and delivery.

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 are 0 High Risk Schemes.

There are 35 medium risk schemes.

There are 589 low risk schemes. These have been self assessed by the Directorate clinical teams as low risk under the QIA framework.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
2019/20 Operational Planning & Contracting - Productivity and Efficiency guidance

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

For information and discussion

Executive Summary – Key Points

The Operational Planning and Contracting guidance sets out a number of expectations in respect of productivity and efficiency. This paper details the efficiency ask of the NHS over the next 5 years and the specific expectations placed on Trusts and the wider health economy.

Recommendation

The Board of Directors are asked to note the details in the report.

Author: Steve Kitching, Head of Corporate Finance & Resource Management

Director Sponsor: Andrew Bertram, Acting Deputy Chief Executive & Finance Director

Date: January 2019

1. Introduction and Background

The Government announced a five-year funding settlement for the NHS in June 2018. The new settlement provides for an additional £20.5 billion a year in real terms by 2023/24.

In response, the NHS has developed a long term plan, for which early planning guidance was released in December 2018; the details in this paper have been taken from the productivity and efficiency section of this guidance.

2. Detail of Report and Assurance

Any actions agreed following the presentation of this paper to the Efficiency Delivery Group will form part of the minutes and will be followed up at subsequent meetings as required.

2.1 NHS 5 year efficiency ask

It is recognised in the guidance that the NHS has consistently improved productivity over time and in recent years improvements have outpaced the wider economy, however both commissioners and providers still have the opportunity to go further.

The minimum 'efficiency ask' of the NHS over the next 5 years will be 1.1% per year, these savings need to be cash releasing, with an expectation plans are appropriately phased and not back dated however all Trusts with a deficit control total will be expected to deliver additional efficiency of 0.5% (1.6% in total) which will be retained by the trust to support financial recovery. Although this has significantly reduced from the 4% requirement at the beginning of the 'Nicholson challenge' in 2010 and the 2% requirement since 2016/17, it must be recognised that most of the 'low hanging fruit' has been picked and savings now are required from a renewed and intensified focus on enabling staff productivity, investment in new digital technology & wider infrastructure and through transformative models of delivering services to patients.

It should be noted the Trust efficiency requirement is likely to be in excess of 4% in 2019/20 due to the level of non-recurrent delivery being carried forward from previous years.

2.2 System working

It is expected systems should work together to support the improvement of the NHS estate through the development and delivery of robust, affordable local estates strategies that include delivery of agreed surplus land disposal ambitions across all STP and ICS areas.

All systems will work with the NHS RightCare programme to implement national priority initiatives for cardiovascular and respiratory conditions in 2019/20. They will also be expected to address variation and improve care in at least one additional pathway outside of the national priority initiatives.

All providers, working with their systems, will develop robust efficiency plans taking account of the opportunities identified in the Model Hospital and outlined in published Getting It Right First Time (GIRFT) reports and Lord Carter's reviews.

2.3 Specific Provider actions

Specific provider actions have been identified into 2 categories, as detailed in Table 1 below

Table 1

Category 1 – transformative actions required from providers in 2019/20			
Action required	**Summary of the current trust position**	**Trust executive lead(s)**	**Trust operational lead(s)**
Work across the STPs/ICSs to develop proposals to transform outpatient services by introducing digitally-enabled operating models to substantially reduce the number of patient visits by 1/3 over the next 5 years	Current examples of work being undertaken are:- The Trust is currently developing a model with our health economy partners for a 'Rapid Expert Input' model with the aim of reducing first face to face outpatient appointments by 10% in the first year. The Trust has just approved a business case for a Virtual Fracture Clinic with the aim of reducing physical attendances by 30%. GP's are currently trialing the use of Dermatoscopes in primary care to reduce dermatology attendances at the hospital.	Wendy Scott	Mark Hindmarsh
Improve quality and productivity of services delivered in the community, across physical and mental health, by making mobile devices and digital services available to a significant proportion of staff	The Trust is engaged in the STP for Digital programs and has successfully bid for PDC funding for a number of projects. One of these is for Community Mobile Working, which will build upon the pilot project we have already started. The Trust is currently awaiting news of a further funding allocation, and possibly also additional funds from slippage on other Trust's projects. The plan is to supply laptops with mobile data connections to Community Nursing, Therapies, and Midwives to enable access to System One and CPD, as well as corporate systems (e-mail, files, intranet)	Michael Proctor/ Wendy Scott	Kev Beatson
Category 2 – actions required from providers to accelerate ongoing opportunities			
Focus on concrete steps to	The Trust employs approximately 5200 clinical staff (excluding medical	Polly McMeekin/	Sian Longhorne

improve the availability and deployment of clinical workforce to improve productivity, including a significant increase in effective implementation of E-Rostering and e-job planning standards	and dental). Of these we currently have just over 3000 live on the electronic rostering system. This is almost 60% of our clinical workforce. We currently have roster builds in progress which will take us to 60%. At the start of the new financial year, we will be concentrating on getting the last remaining nursing staff (approximately 350) onto the system. We also have a five year roll out plan (currently in year 2) to extend E-Rostering to all (clinical and non-clinical) staff. The Trust has just procured Premier IT's, eJob Planning System and is committed to implementing electronic plans for its Consultant and Middle Grade doctors for the 2019-20 job planning cycle. The initial focus will be on providing system training January – March 2019	Bev Geary/ Jim Taylor	Will Thornton
Accelerate the pace of procurement savings by increasing standardisation and aggregation, making use of the NHS's collective purchasing powers. Providers should make regular use of the NHS Benchmarking tool (PPIB) to support this work	The Trust entered into a Partnership Programme with NHS Supply Chain to both increase the pace at which savings were achieved (through collective purchasing power) and to standardise to the national provider (supporting the DHSC aim of 80% via NHS Supply Chain). This programme, to date, has been successful and we are on track to achieve 50% via NHSSC very soon and with plans to reach 60% by the end of 2019/20. In terms of PPIB our data we benchmark extremely positively, with our data submitted on time and in full and we are one of the leading users of PPIB across the county, this information is validated on the PPIB dashboard.	Andrew Bertram	Ian Willis
Make best use of the estate including improvements to energy efficiency, clinical space utilisation in hospitals and implementation of modern operating models for community services	The Trust current energy cost per unit is £0.0349p against a benchmark of £0.0485p. The Trust is performing relatively well against the model hospital space utilisation metrics, our amount of non- clinical space sat at 32.4% at the last ERIC data collection in July 2018 against a benchmark of less than 34.5%. The Trust is struggling to hit the 1% empty space metric as an organisation mainly due to the amount of empty space at the Bridlington	Brian Golding	Dave Biggins

	Hospital site.		
Improve corporate services, including commissioners and providers working together to simplify the contracting processes and reducing the costs of transactional services, for example through automation	In 2018/19 the Trust entered into an aligned incentive contract with its main clinical commissioners; this has significantly reduced the bureaucratic burden of managing the contract, this arrangement is expected to extend and further develop in 2019/20. The Trust is actively engaged in the Robotic Process Automation (RPA) project with NHSI, this is at an early stage but a project group has been formed and will be chaired by the Acting Deputy Chief Executive & Finance Director.	Andrew Bertram	Graham Lamb Steve Kitching
Support and accelerate rollout of pathology and imaging networks	**Pathology** A Pathology network involving YTHFT and HEYT has been formed with a Programme Director and Clinical Director appointed to lead it. A Collaborative Network Pathology Board has been established and a detailed work programme has been developed. Links with NLAG are maintained through the HCV Hospital Partnership Board which has the YTHFT, HEYT and NLAG Chief Executives as members. **Radiology** There is an STP wide network group involving the three HCV Acute Provider Trusts which has been established for around 12 months overseeing and developing a collaborative work programme in terms of reporting capacity, workforce and equipment/kit procurement. In recent months, attention has been focused on the procurement exercise for a radiology reporting hub across the three organisations which is intended to identify and pool reporting capacity and reduce outsourcing costs. **Overall Diagnostic Board** A Humber, Coast and Vale STP wide Diagnostic Board (covering	Wendy Scott	Neil Wilson

	Pathology, Radiology and Endoscopy with the three Acute Trusts and Commissioners as members) has recently been established given the outcomes of a recent patch wide capacity and demand exercise.		
Secure value from medicines and pharmacy, including implementation of electronic prescribing, removal of low value prescribing and greater use of biosimilars	**Electronic prescribing** Electronic prescribing and medicines administration (EPMA) has been rolled out on 95% of all of the inpatient areas of the organisation using an in-house designed package. A benefits appraisal is being conduct at present. Priorities over the next year include rolling out to paediatrics and outpatient areas and the development of an automatic drug ordering system to pharmacy from the wards. **Medicines efficiency** The Trust performs well against peers in terms of the NHS improvement top 10 saving target and has achieved all quarters of the NHS England Medicines Optimisation CQUIN. Collaborative work between the pharmacy and clinical teams has achieved 99% of doses being banded for chemotherapy. Maximal use of bought in, ready to administer chemotherapy has released capacity in the aseptic unit and ensures best value. **Biosimilars** The Trust has a proactive approach towards biosimilars and has a high uptake on all biosimilars molecules including infliximab, etanercept, trastuzumab and rituximab. The Trust is currently in the process of transitioning over 650 patients to biosimilar adalimumab. Work is underway to ensure biologic pathways in every specialty area are designed so best value biologics are used first line where clinically appropriate. **Removal of low value prescribing** The Trust has worked with the local CCGs to adopt the NHS England guidance on avoiding low value prescribing. The Trust minimises waste by allowing patients to bring in their own medicines into hospital.	Wendy Scott	Dave Pitkin

In addition to efficiency savings, providers have opportunities to grow their external (non-NHS) income including commercial income growth and overseas visitor cost recovery identified in the Model Hospital	**Potential non NHS income opportunities** The Trust has recently created a wholly owned subsidiary, York Teaching Hospital Facilities Management LLP; this will provide an opportunity for commercial income for the Trust. **Overseas visitor cost recovery** – the Trust is working closely with the NHSI overseas visitor team currently to develop a plan – The additional income identified by NHSI in the Model Hospital is in excess of £400k. **Private patient and other commercial income opportunities** – Within the model hospital there is an opportunity identified of £400k in relation to our peer median position.	Brian Golding Andrew Bertram	Paul Bishop Steve Kitching

3. Next Steps and key actions

All the above actions have been embedded within the overall Trust efficiency programme, within the transformational work stream, with some of these projects having already been established for a number years. These schemes have yielded very significant savings running into £m's. Our Pharmacy and clinical teams have been regional leaders in identifying savings from biosimilar drugs along with our Procurement team working locally, regionally and nationally identifying procurement opportunities, to name a couple of significant examples.

As these actions have been identified specifically within the guidance released, it would be safe to assume an enhanced level of reporting and scrutiny will be expected from our regulators.

The trust will need to work with the NHS RightCare programme to implement national priority initiatives for cardiovascular and respiratory conditions in 2019/20. We will also be expected to address variation and improve care in at least one additional pathway outside of the national priority initiatives; this additional pathway needs to be identified.

4. Detailed Recommendation

The EDG is asked to note and agree the following:-

- Action taken to fully embed the identified actions in Table 1 into the Trust Efficiency Programme and to agree an enhanced level of reporting in relation to these actions

- The specific action relating to working with the NHS RightCare programme to implement national priority initiatives for cardiovascular and respiratory conditions in 2019/20

- The Trust is also required to address variation and improve care in at least one additional pathway outside of the national priority initiatives

5. References

Preparing for 2019/20 – Operational Planning and Contracting document

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Transformation reports

Theatre Without Drama - Update Report

Date: December 2018

Ops lead – Jenny Hey / Gemma Ellison
Clinical lead – Amanda Vipond / Mike Stone
Nurse Lead – Liz Nygaard

Summary Position

- Continue to work closely with gynaecology on a model for theatre procedure scheduling – Weekly meeting with Theatre scheduling development group. Testing of times for model before any pilot through CPD – to ensure as accurate as possible. Data quality issues being rectified as part of this work, requires review and /or update of all drop down procedure lists in CPD.
- Bridlington – Launch event for theatre utilisation in Jan 19. Project plan to be drafted and development work to commence.
- Electronic SLA – commenced development with IT development team
- Present the theatre dashboard for comment to surgical steering grp

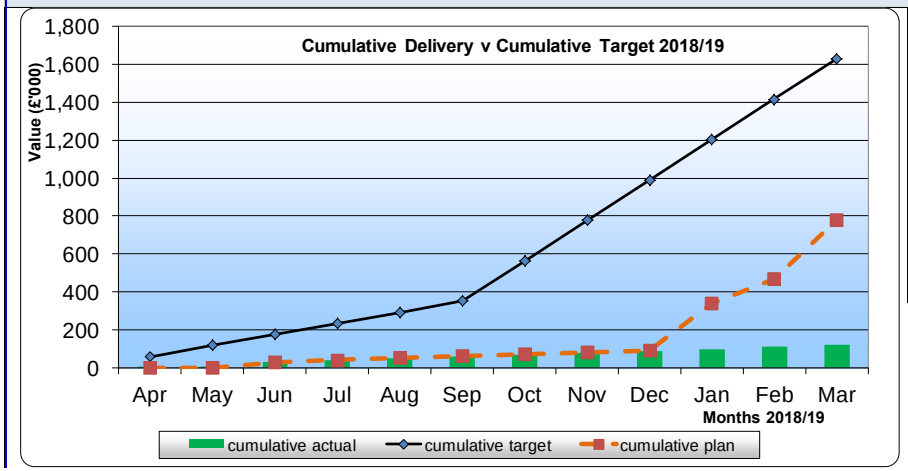
KPI	Baseline	Comments
Increase the number of lists starting on time		See graphs on Page 2 showing utilisation YH, SGH and Brid
Increase in theatre utilisation		See graphs on Page 2 showing utilisation YH, SGH and Brid
Increase in the number of lists finishing at designated time		See graphs on Page 2 showing utilisation YH, SGH and Brid
Reduce the amount of turnaround time in lists		
Reduction in the number of 'on the day cancellations'		See graphs on Page 2 showing utilisation YH, SGH and Brid
Decrease in the number of lists actually used in line with SLA		Finance graph to be attached

Initiative	RAG	Update
1 Production Meetings/ Scheduling	Work ongoing	• Continue to work with gynaecology PDSA for theatre procedure scheduling – testing timings • Attended Cons meetings for maxillofacial re scheduling model & production meeting in Jan. • Commence discussions with Urology, breast, vascular and maxillo facial re data quality and CPD list updates. • Continue development of theatre scheduler/ diary system on CPD
2 Pre admission	Work ongoing	• Electronic blue form discussions with Dev team • Attend Vascular Cons meeting re any issues
3 Protected Team Trial	Work ongoing	• Planning for team lead development time in Dec/Jan supported by CIT and ODIL
4 Service Level Agreement	Work ongoing	• Commenced meetings with IT re SLA electronic template • SLA review update with senior executives
5 Resources to support utilisation	Work ongoing	• 1st draft of theatre dashboard – to be presented to surgical steering grp – Jan 19
6 Bridlington	Work ongoing	• DDM and Theatre Sister to commence Bridlington production meeting review lists and plan ahead • Met with DDM/Theatre Sister Brid to set up launch event for utilisation in Jan 19

Done last month	Next steps
• Meeting planned to discuss scheduling and production meetings with maxillofacial • Attend surgical consultant meetings to brief on plans for procedure scheduling • Planning around theatre team lead development • Theatre list review panels • Waiting list additional resource • Roll out orthopaedics health questionnaire	• Roll out of production meeting to ENT & maxillofacial in Jan/Feb 19 • Continue testing of procedure times until model realised • Continue to work with urology, breast, vascular and maxillofacial on data quality issues • Present 1st draft of theatre dashboard at surgical steering grp • Brid – launch event Jan 19

Finance Summary - December 2018 Position

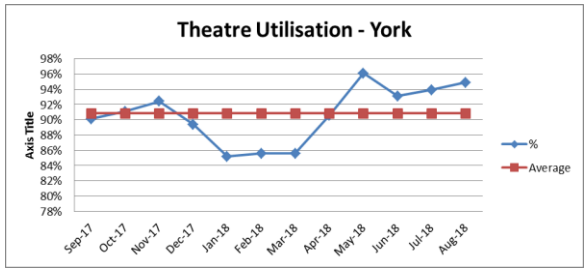
G - Theatres Utilisation

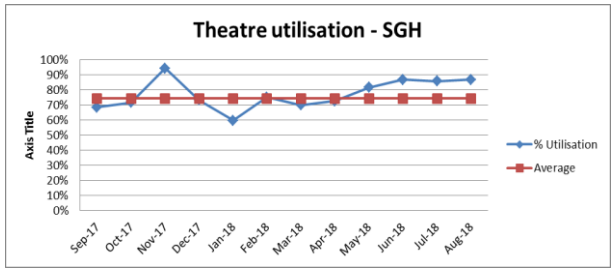


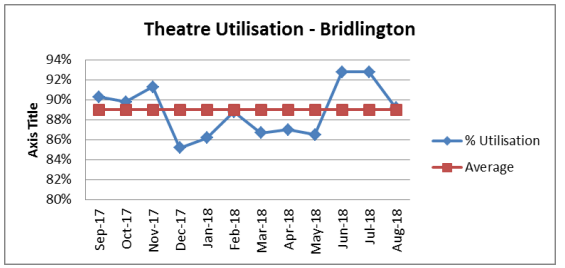
	2018/19 YTD	2018/19 FYE	2019/20	Future Years
	£'000	£'000	£'000	£'000
NHSI Target	990	1,630	0	0
Plan	89	780	1079	0
Actual	89	119	0	0
Variance	-901	-1,511	0	0
Delivery YTD	RED		Quality Impact Assessment (QIA): 8 schemes -7 Low Risk; 1 to be assessed	
Planning		RED		

Delivery: Profile of delivery has changed since original submission of Annual Plan to NHSI. Delivery from December 18 onwards with slippage into 19/20. Directorate reviewing SLA's with users Specialties with view to remove Theatre lists and cost.

Finance Graph – for review and update

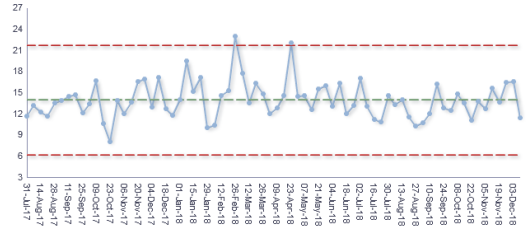






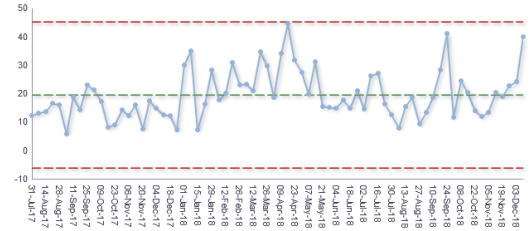
What was the average late start time?

York



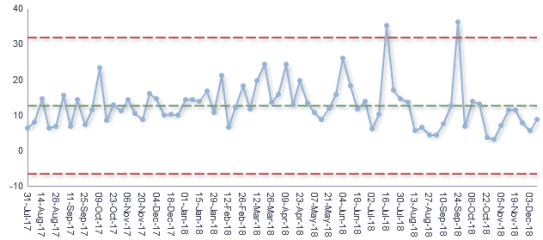
What was the average late start time?

SGH



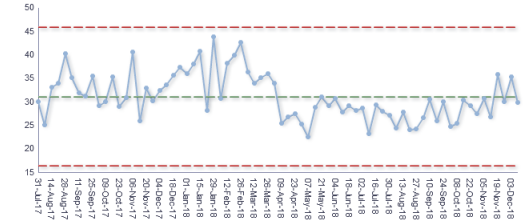
What was the average late start time?

Bridlington



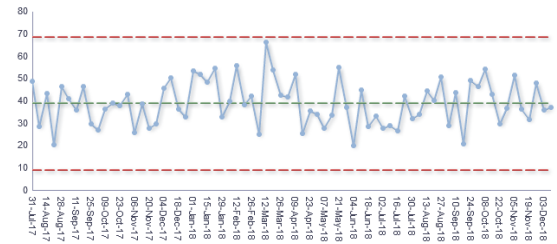
What was the average early finish time?

York



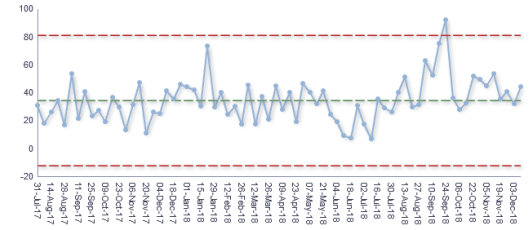
What was the average early finish time?

SGH



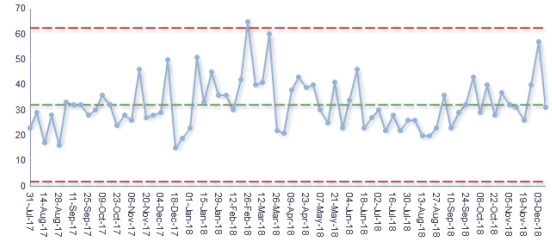
What was the average early finish time?

Bridlington



How many procedures cancelled on the day?

York



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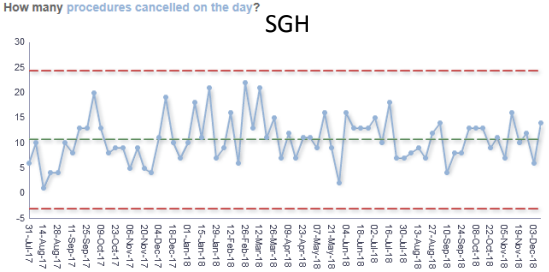
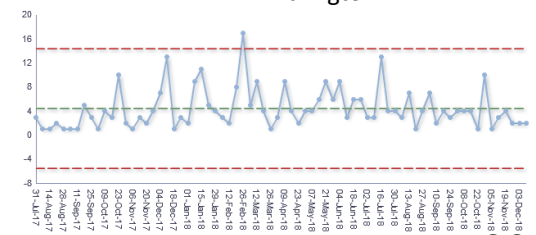
SGH



How many procedures cancelled on the day?

Bridlington



Rapid Expert Input - Update Report

December 2018

York Teaching Hospital NHS
NHS Foundation Trust

Team

Trust Lead – Mark Hindmarsh **CCG Lead** – Sarah Tilston
Clinical Leads – Mark Quinn, Shaun O'Connell & Chris Ives

Summary Update Since Last Period

Following the workshop in November, the governance rule book that we discussed now needs to be updated and re-circulated.

Two "walk in their shoes" visits have now been completed to GP surgeries in York and in Filey, with further visits being arranged to three further practices in the coming weeks. Also, meeting with GP LMC representatives to ensure that as changes begin to be made that they don't adversely impact on practices or patients.

The immediate priorities are to identify some simple changes that can be made to the A&G processes while a detailed spec is developed for the longer term solution.

Initiative		RAG	Update
1	Rules and governance arrangements		On Schedule. Draft document circulated for discussion at workshop on the 21st November. Amendments and updates being incorporated.
2	Clinical Engagement		Meeting held with GP LMC membership to improve engagement and ask for involvement in project team. Presentations completed with GP Governing Bodies.
3	IT		Commence discussion with IT colleagues from across the system to support the development of a full new IT solution

Indicators (to be confirmed/agreed)

KPI	Baseline	Comments
10% reduction in first face to face outpatient appointments	118,000	Once specialty work commences, target to be broken down by specialty
Max. waiting time for any new outpatient appt. should be 12 weeks	56% (179/ 318)	56% of all services on eRS currently have polling range over 12 weeks
Reduce DNA rate	6.5% (July 2018)	

Done last month	Next steps	Support needed / Issues identified
• Draft "Rule Book" circulated to relevant boards for comment • Local GP LMC have nominated a representative to work with the project team • 2 "Walk in Their Shoes" visits completed	• Agree date for practices to visit Trust OP services • Complete presentation to LMC Governing Body and identify common area to work on together • Complete further primary care visits and welcome primary care team to the Trust • Draft a "high level" IT specification, setting out what functions are needed in a new system. • Obtain some patient stories linked to issues with existing systems	1. When a "referral" is sent, when does the clinical responsibility sit? 2. Is having patient info in two IT systems a clinical risk /governance issue? 3. Patient safety – how can we safeguard patients not getting "lost' in the system" 4. Concern that this will result in significant increase in workload for GP practices – how will they be supported?

Operational Transformation Performance measures and quality indicators

Quality and Safety	Access and Flow
Stranded and super-stranded patients	Emergency Care Standard
Reduction in outliers	Number of non-admitted breeches
Friends and Family test/complaints	Number of admitted breeches
	Ambulance handover
Finance and Efficiency	**Balance Measures**
Containment of growth	Number of readmissions within 30 days
Reduced LOS	Mortality indicator - SHMI
Reduction in cancelled ops	Bed occupancy (midnight)

Structure Measures
• Staffing – numbers of medical + nursing staff on shift • Sickness rates • Vacancy rates

York Urgent and Emergency Care Transformation Update Report Date: December 2018

Summary

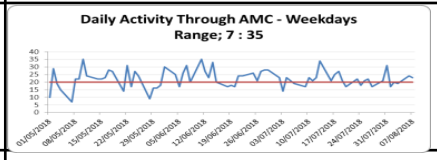
Transformation structure and programme governance in place across the care group and all directorates now have identified clinical priority areas , clinical, nursing and operational leaders assigned to all transformation work streams.

Environment changes to increase the AMC unit capacity have been completed. This has led to the formal co-location of the ambulatory care team and AAU clinical team working as a single unit,. Additionally the extension of the APIC role Monday to Friday has been implemented for the Winter period to support early senior review and to maximise opportunities for Same Day Emergency Care.

Within the ED programme plans to formally create a 'minors' stream supported by a doctor, nurse and HCA is continuing, supporting a reduction in non-admitted breaches and transferring work from the main department into the UCC.

After discussion with clinical teams across the site the discharge lounge have completed a process of revising the current criteria for transfer to this facility. Additionally the opening hours of the D/L have been extended Monday-Friday from 8am-8pm in order to further support patient flow later in the day.

Patient flow has been compromised mainly due to the lack of bed capacity across the site. This has impacted our ability to consistently deliver ECS performance above our agreed trajectory.

KPI	Comments
Reduction in Non-admitted Breaches	Non-admitted breach performance remained higher than planned across first 3 weeks of October. From 22nd new process in place within ED and improvement has been seen.
Increase total number of patients streamed from ED to AMC	
Increase % discharges utilising discharge lounge from baseline to 50%	Current Baselines being established. Approx 25% utilising discharge lounge.
95% ECS standard	York site delivered 91% in October above 90% trajectory. 95% last delivered Aug 18
Number of patients with Zero LoS within main bed stock	Baseline being established. Aim is for a continued reduction of Zero LoS in main acute admitting areas

Initiative	Lead	RAG	Update
Acute Medicine, Ambulatory Care and Assessment	JT	A	AMC Environment extension Now completed. AMC and AAU teams now co-located and operating as a single team, AMC consultant is taking a stronger role in the management of patients on the AAU to support opportunities for Same day emergency care. APIC role formally implemented Monday to Friday 8am-6pm for the Winter period to support early senior review and maximise same day emergency care.
Emergency Medicine	JT	A	Senior Doctor now rostered each day into UCC alongside nurse and HCA. Patients being streamed through 'minors' stream instead of main ED department; early indications show improved non-admitted breach performance. Surge, over crowding and 'Fit to Sit' work being undertaken to support improving ambulance handover times.
Patient Flow and Site Operations	JT	A	Lead nurse for the Discharge lounge appointed escalation protocol revised, directorate level escalation frameworks in Draft and discussed with directorate senior teams. Draft Discharge lounge exclusion criteria agreed and being communicated via clinical teams. Discharge lounge opening hours extended Monday-Friday to 8am-8pm.
Elderly Medicine - Frailty	JT	A	All GP calls to be screened via Geriatrician 'GOD' phone to support appropriate medical triage and patient flow. Frailty specialist role being developed to support RAFA and ED alongside Business Case to support sustainable model for ED RAFA and extend frailty assessment and embed CGA.

Done last month

- Revised Discharge Lounge Criteria agreed
- Geriatrician screening GP calls implemented
- Paper for corporate directors in support of future co-location of ambulatory Care / CDU with ED
- Discharge lounge opening hours extended 8am-8pm
- APIC role in place Mon-Fri for winter period
- Revised AMU SAFER board round process now in place substantively

Next steps

- ED surge and escalation protocol to be revised
- 'Fit to Sit' area to be identified within ED
- ED Safety huddles / Board rounds to be implemented
- ED Overcrowding and full capacity protocol revision
- AMC / AAU to begin triage of all GP calls
- All medical GP patients to be managed via AAU
- NHSI ambulance handover improvement work to begin

Support needed

- Executive support for ED overcrowding and full capacity protocol recommendations
- Support for the transfer of activity from AMC to alternative outpatient services
- Support for co-location of AMC / CDU services with ED

Urgent and Emergency Care Group (York)

York Teaching Hospital NHS
NHS Foundation Trust

"Delivering Outstanding Urgent and Emergency Care"

Operational Excellence – Clinical Transformation Priorities 2018/19 – Progress report

Emergency Medicine

18.19 Priority	Status
Improved efficacy and Revised Model of delivery for the UCC and Minors stream (P3 and P4)	
Embedding of ED board round and shop floor processes	
Development of ED surge and escalation plan	
Revised medical workforce model	

Acute Medicine

18.19 Priority	Status
Increasing the number of pathways accessing ambulatory care (AMC) and Implementation of ACP led pathways	
Implementation of the APIC role and combined AMC / AAU as a single team	
Relocation of AMC / CDU in ED	
Embedding of the SAFER bundle, Board round and ward round model into the AMU	

Patient Flow and Site Operations

18.19 Priority	Status
Implementation of ward level discharge requirements and monitoring framework	
Revision of criteria and increase in % patient utilising the discharge lounge	
Review and revise the trust wide escalation policy and plan	

Elderly Medicine

18.19 Priority	Status
Improvement to overall Acute ward Length of Stay	
Improved Patient flow through acute admitting pathways (York)	
Extension of Front door Frailty	312

Scarborough Single Improvement Programme : PEOPLE Update Report December 2018

Strategic Theme Lead: Natalie Robinson (Care Group HR Business Partner)

Winter staffing, preparing for ACP Cohort 3 and 4 starts and Elderly recruitment will dominate Jan 19 as well commencing full Med Staff review on 24 Jan (to plan for AMM workforce).

Loss of 4 x Specialty Doctors in ED should be mitigated in new year but finding doctors to staff Ambulatory Emergency Care is proving challenging.

Some interest in Brid Site manager role – 3 x external candidates in touch.

Care Group is doing some work to understand the root causes of high sickness rates over Christmas period and rules around notification of sickness absence (esp. for medical staff) are being re-issued.

Intend to establish KPIs for this Strategic Theme (see below) by next report.

Initiative	RAG	Update
1.1 Total Medical Workforce	Work on going	• ACP Cohort 4 recruitment complete; 10 trainees from Jan 19 . • ACP cohort 3 delayed qualified until 7 Feb but new rotas agreed. • AMM Med Staff workshop on 24 Jan 19. • GIM consultant rota to DDM teams from Jan 19.
1.2 Total Nursing Workforce	Work on going	• ED workforce review underway to look at B2/3/4 and B7 requirement. • Further ODIL reviews to commence in the new year.
1.4 Targeted Recruitment	Work on going	• Elderly recruitment campaign to target higher trainees completing training in March 19. • Scarborough Recruitment project extended by 12 months. • BAPIO recruitment ongoing, VCs with individuals to identify training needs.
1.5 Junior Doctor Teaching	Work on going	• Dedicated (HEE funded) ED teaching sessions in place but still need clarity around syllabus and record of attendance to ensure evaluation criteria will be met.

KPI	Base line	Current	Comments
Vacancy Rate (as % of budget est.	Cons: 67%		
	JD: 23%		
	Nurse: 19%		
Sickness Absence	4.97%		
Completed Appraisals	74%		
Agency Spend	69%		
	40%		
	24%		
Teaching Sessions	To be defined		

Done last month	Next steps	Support needed
• ACP rotas for Cohort 3 agreed and will provide 24/7 ACP coverage for First Assessment but issues in training programme mean unable to start until 7 Feb.	• Working on arrangements for ACP Cohort 4.	• Need to bottom out bank rates for ACPs. Proposal to be sent to Asst Headd of Workforce (aware).
• Proposal made to Vocare around Junior Doctor minor injury teaching and ENP shifts on back of mtg held 25 Oct.	• Wrote to Vocare on 21 Dec to seek agreement to see Type 3 patients in ED for JD teaching. Still no reply. Proceeding with plan as agreed. Vocare have accepted current plan of 6 x ENP day shifts , to be reviewed in Apr 19.	• None at this stage.
• Additional winter staffing has proved challenging esp. for ED. Lilac well staffed in NY.	• Continue to work to winter staffing levels.	• None at this stage.

Scarborough Single Improvement Programme : PREMISES Update Report December 2018

Strategic Theme Lead: Jo Southwell

Main effort in Dec has been completing the Trolley space / Assessment area in ED to time and budget. Incredible effort by all concerned to get the area finished.

The Care Group will commence planning and scoping for the Combined Assessment Unit in Jan. Establish strategic vision for the Capital Project so that both aspirations for AMM are met as well as enabling opportunities for wider site improvements further downstream.

Intention is to have initial Project Plan in Draft by end Feb.

As part of "big Build", will need to establish a communications strategy so anticipate some dedicated site Comms input to Project Board. .

Initiative	RAG	Update
3.1 - Deliver Interim Combined Assessment Unit	Complete!	• Trolley space to be used for expanded AEC but with flexibility to use as prototype combined assessment function. • 21 Dec completion date met.
3.2 - Deliver Combined Assessment Unit	On going	• Formal announcement of STP funding provided in Dec 18. • Initial Project / Planning meeting to be held 29 Jan 19.
3.4 - Ward reconfiguration for Winter.	On going	• Lilac and Aspen wards flipped to Medicine for winter period. • Dedicated Med staff for Lilac. • Developing a metric to measure the impact on surgical bed base.
3.6 – Pro-active Infection Prevention Programme	**Not Yet Started**	• Need to engage with IPC and Estates & Facilities to understand deep clean plan for 201

To Be Developed

Done last month	Next steps	Support needed
• Completion of AEC trolley space.	• Launch AEC service 14 Jan 19.	• None.
• Announcement that STP Capital Bid successful.	• Prepare planning for "Big Build" project. Initial Meeting in Jan will begin to scope the project, establish the Project Plan and establish governance arrangements.	• See narrative.
	• Launch Project to understand 2019 ward deep clean plan.	• Will require IPC and Estates input.

Scarborough Single Improvement Programme : PROCESS Update Report December 2018

Strategic Theme Lead: David Thomas

Main effort in Dec has been commencing auto referral for medicine, preparing for AEC launch, maintaining focus on ambulance handovers and preparing the Scarborough bed Base for winter.

A busy and productive month for the SIP. Significant progress in particular, the increased rigour being applied to ambulance handovers to keep long waits to a minimum. The Auto Referral project has successfully been embedded and we are in conversation with eh CIP team to ensure that efficiency credits can be applied where applicable.

Priority Projects for the New Year:

- 2.9 - Single Clerking
- 2.8 – Expanding auto referral to surgery.
- 2.10 – Utilisation of Arrivals Board
- 2.12 – Continue to embed SAFER principles into ward areas.

Need to define and settle on agreed process measures for individual projects and outcome measures for Programme.

KPI	Standard	Oct	Nov	Dec	
Ambulance Handover Rate	<15 Mins				Not avail
	>60 Min	85	97	85	
	>120 Mins	5	23	6	
Time to Streaming	100% <15 Mins	53%	62.6%	Not Avail	
Time to Decision	100% <2 Hours	74.8%	73.8%	Not avail	
AEC activity	25% of ED presentations	-	-	-	Launch 14 Jan
Med Outliers in Surg Bed base	Minimum				Metric being developed

Initiative	RAG	Update
2.1 Ambulance Handover (Joint YAS venture)	On going	• YTH/YAS work ongoing to improve handover function. • Local escalation process agreed to ensure zero 2 hours waits. • Considerable progress made in handover performance. • Await NHSE visit.
2.5 Ambulatory Emergency Care	On going	• AEC area open 21 Dec. Has been used as additional assessment space. • Formal AEC launch set for 14 Jan. Looking at 3 types of AEC patient: (a) GP direct referral; (b) ED pathways and: (c) push/pull from ED for assessment & non-adm breach avoid (off clock). • Opening hours 0800 – 2000. Consultation underway to expand to 2200. • Doctor cover remains a challenge. Nursing cover looks ok at this time.
2.8 Presumed Referral Acceptance and direct pending.	On going	• Direct pending of patient from ED to AMU in place and successful. • Auto referral to medicine in place from 17 Dec. Working well. • Seeking feedback since launch from Med Regs.
2.13 Winter ward reconfiguration	On going	• Dedicated Lilac senior medical team in place wef 3 Dec. • Challenges with junior team – will improve in Jan. • SAFER Board Round established. • Feedback from team is that they feel well supported via Matron and Ops Teams.
2.15 Bridlington	On going	• Site Manager role out to advert. 3 external enquires.

Done last month	Next steps	Support needed
• Auto referral process commenced.	• Obtain feedback from med Regs. Aexpand to surgical referral team.	• None at this stage.
• Stand up Aspen and Lilac as winter medical wards.	• Continue to work with teams to ensure staff feel supported and bed base is being used effectively and safely. Aim to minimise surg outliers but also manage flu.	• None .
• Ambulatory Emergency Care (AEC) functional area opened in time and to budget.	• Preparing for full launch of new AEC unit from 14 Jan.	• Some escalated rates may be required to support medical staffing. Discussion also required to figure a better IT CPD solution to manage AEC patients on single front of House CPD module.

SAFER Update Report Scarborough. Reporting period November 2018 to December 2018

Summary

Not all wards have a senior decision maker at the daily board round, nor is there always cross cover available, which subsequently impacts the ward round and early senior review. Work ongoing to update ward discharge levelling figures and local escalation framework, which forms part of the winter plan. Daily calls and weekly MADEs with external partners are working well to discuss stranded patients. Intermediate care capacity in the community is now being utilised for ERY patients, through collaborative working with Community Healthcare Partnership (CHCP); this is having a positive impact on flow and better utilisation of Bridlington beds.

Ops Lead: David Thomas

Clinical Lead: CD, Matron, Lead Therapist – for each ward/speciality

CIT Support: Paula Graham

Governance: Single Improvement Plan, Process work stream

KPI	Base line	Comments
Increase in number of daily discharges before 10am	5% ave	10am discharges remain low. Increased slightly to 8% from start of Dec18 although not sustained.
33 % of daily discharges before 12 midday	20% ave	Average running at 26% from Dec18 to date. Remains variable (4th Dec18 41%)
Increase in Total number of discharges per day	35 ave	Variation still seen between weekend and weekdays. Run of 6 days above average for weekend discharges – further monitoring needed to see if sustained.
Reduction in number of stranded patients 7 days & over)	110 per day	From Nov-18 the number of stranded patients now running between control limits after peak in Oct-18.
25% reduction in number of stranded patients over 21 days	30 per day	Following the peak in Nov18, super stranded had dropped back within control limits with14th Dec close to LCL.

Initiative		RAG	Update
S	Board round and pm huddles daily senior review	Work on going	Continue to promote daily MDT board rounds and huddles. Having a consultant/senior decision maker at board rounds remains vital to this process if it is to work well and support the daily planning of patients care . Matrons support is vital for nursing.
A	EDD and CDD	Work on going	Setting EDDs and clear plans remains a challenge. Review opportunity for visible EDD on Departure Boards. Help drive from patient perspective and focus on 4 Key Questions.
F	Ward discharge requirements.	Work on going	Add to LDP for CoE – test a junior doctor being released from the ward round to complete EDN/TTOs for todays discharges.
E	Focus on early discharge	Work on going	From 3rd Dec - Ops Flow Practitioner, together with a DLO to support ward DLOs; Pm focus on following days discharges to support flow earlier in the day.
R	Focus on stranded and	Work on going	Continue with daily calls and weekly MADE with external partners.

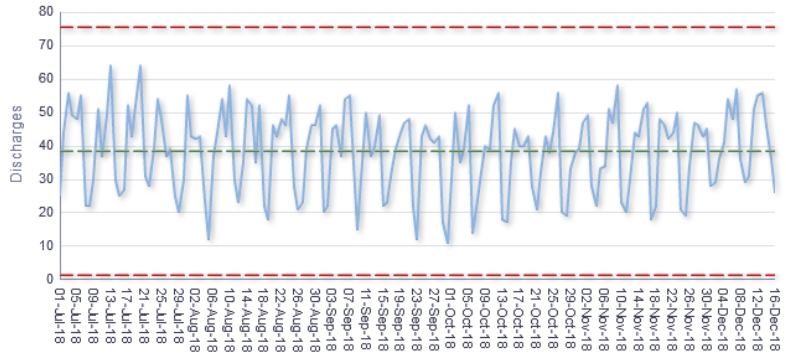
Done last month	Next steps	Support needed
• Progressing with SIP for Scarborough and Bridlington sites. • Training & Education sessions with staff around services in the community. • Board Rounds introduced on Lilac Ward (i.e. the winter escalation ward).	• LDP meeting GIM – tbc. • Establish a local resilience Framework for Scar site. • More engagement and communication around SAFER principles and the impact on the ECS as a 'Quality' standard - take to future Physicians Mtg (the 11th Dec meeting did not go ahead as planned) • Arrange further T&E sessions for therapy, nursing and DLO staff re support services in the community.	• CD, Matrons and lead therapist continue to support their ward teams to own and deliver the SAFER principles to become business as usual • Care Group MDT to prep for LDP discussion inc directorate resilience plans . • Discharge Liaison Team, Patient Flow team, therapy and DLOs to continue to communicate and work effectively together.

SAFER Measures

Excludes deaths and day case patients. Includes only inpatient wards (no paeds/maternity)

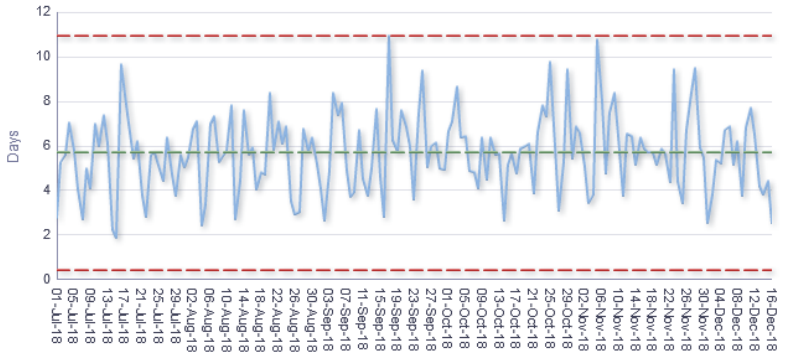
Mon to Sun

The Number of Discharges by Day



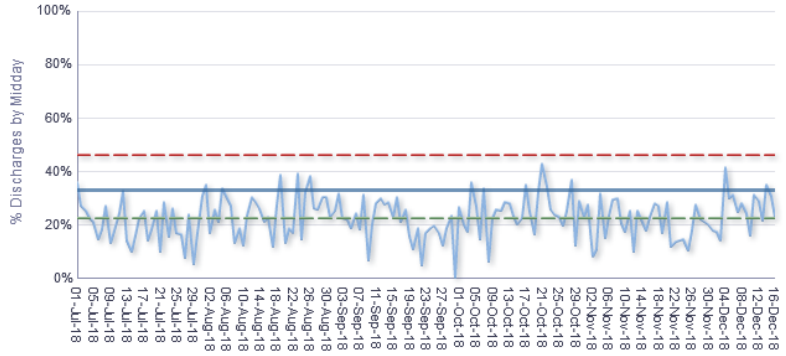
Export

The Average Spell Length of Stay

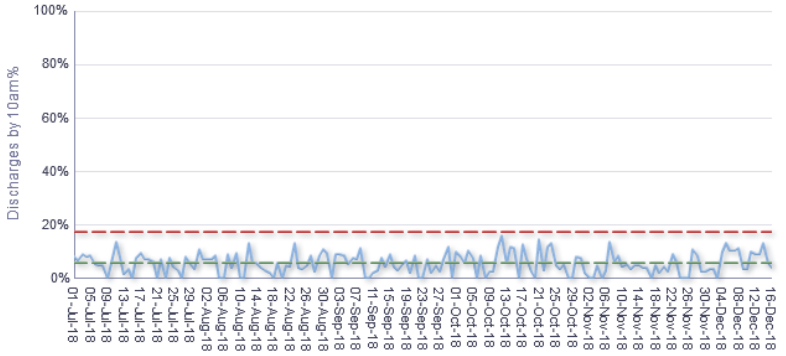


Export

The % of Discharges by Midday



The % of Discharges by 10am



SAFER Measures

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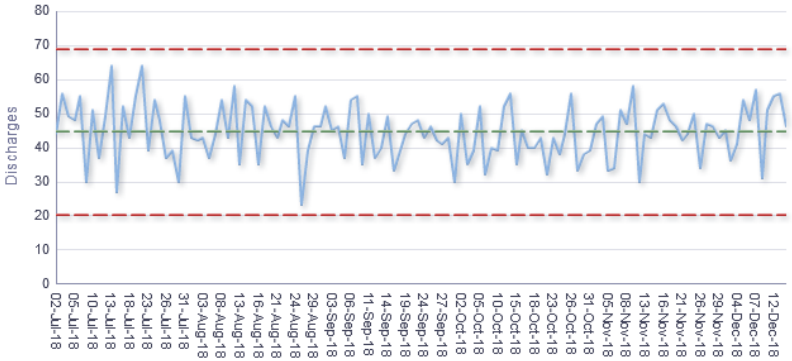
Mon to Fri

The Number of Discharges by Day



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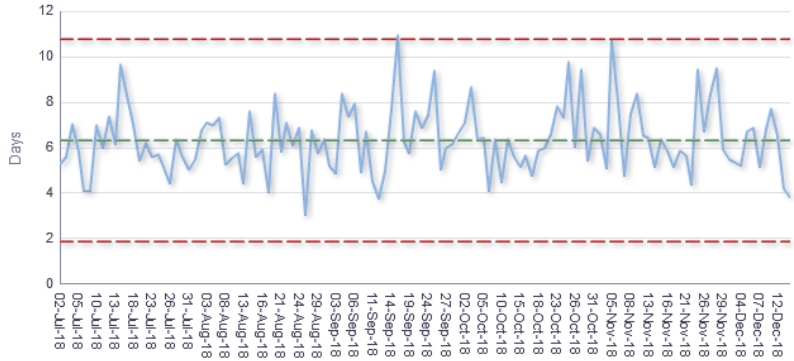
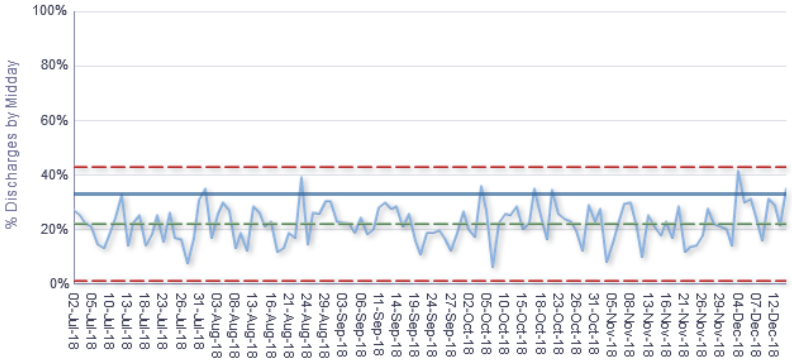
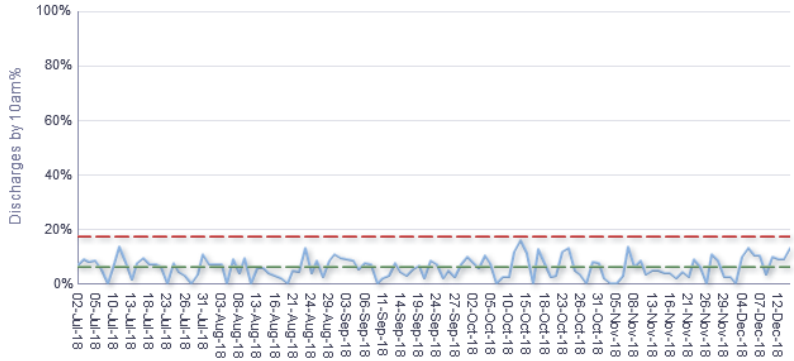


Export

The % of Discharges by Midday



The % of Discharges by 10am

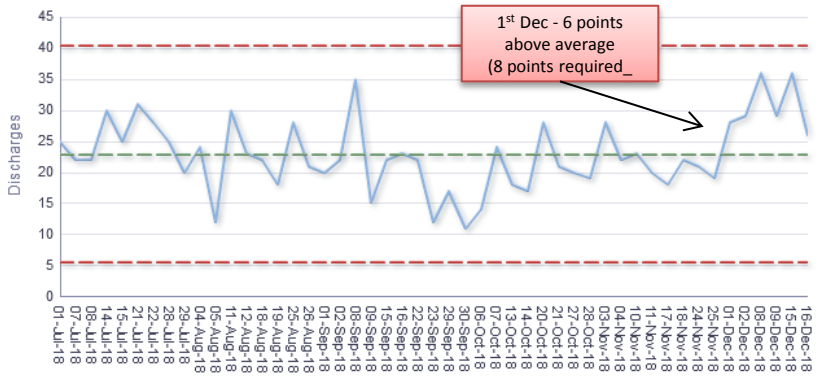


SAFER Measures

Excludes deaths and day case patients. Includes only inpatient wards (no paeds/maternity)

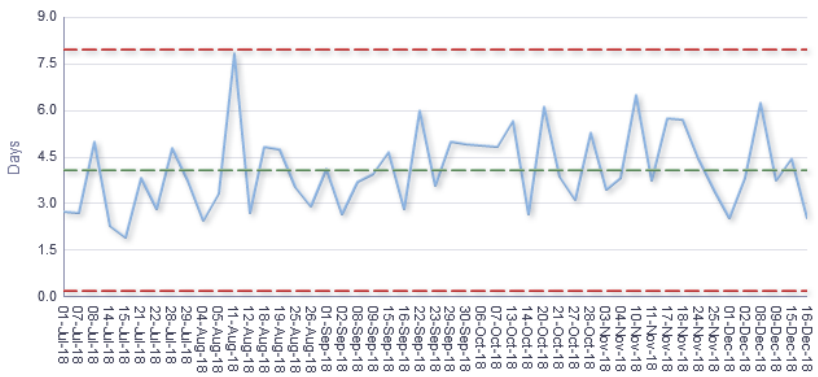
Sat to Sun

The Number of Discharges by Day



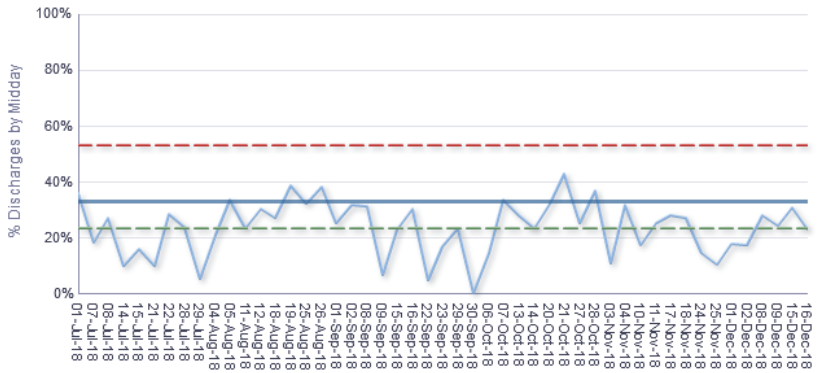
Export

The Average Spell Length of Stay

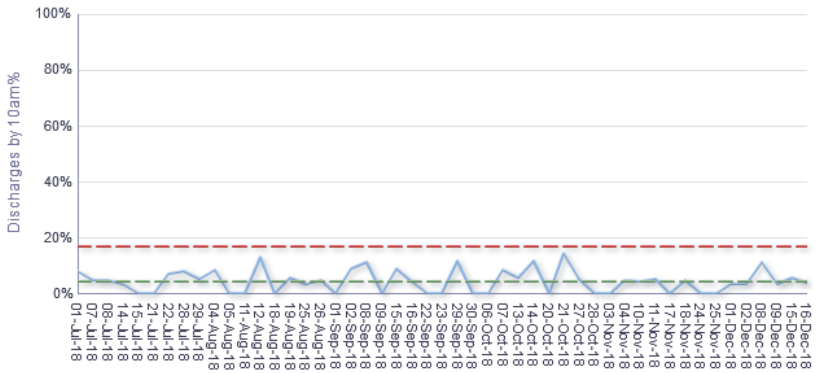


Export

The % of Discharges by Midday



The % of Discharges by 10am

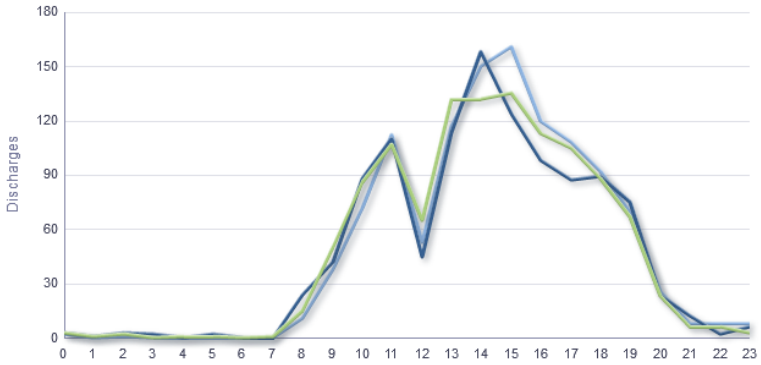


SAFER Measures

Excludes deaths and day case patients. Includes only inpatient wards

Current month for both 'hour of day' charts below set to Nov-18

The Number of Discharges by Hour of Day Current Month, **Number of Discharges by Hour of Day Last Month** and the Number of Discharges by Hour of Day Current Month Last Year.



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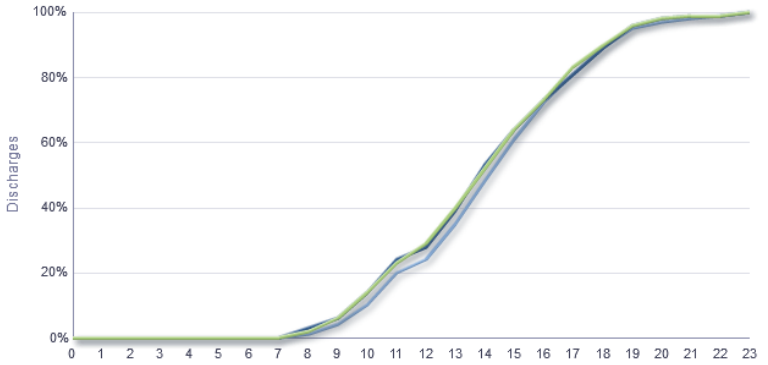
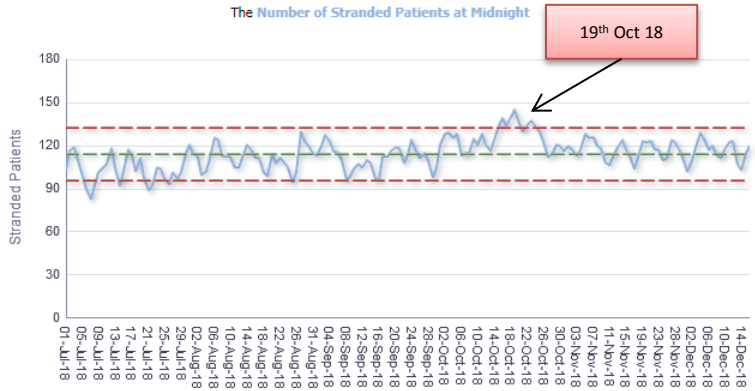
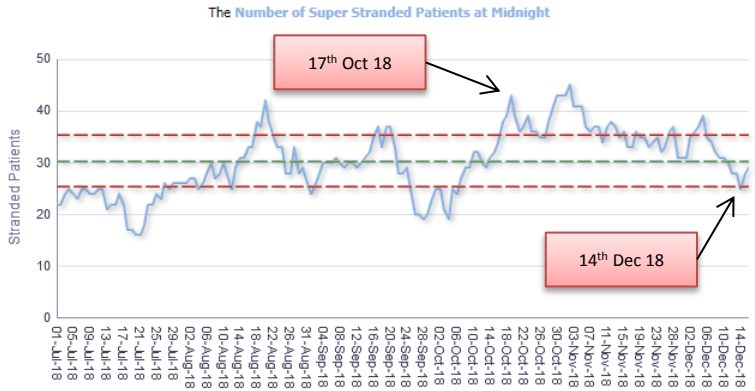


Stranded Patients – Inpatient wards only (no paeds/maternity)

The Number of Stranded Patients at Midnight



The Number of Super Stranded Patients at Midnight



SAFER Update Report York. Reporting period November 2018 to December 2018

Summary

Focus continues on weekly MADE events specifically for patients who are medically fit for discharge but with a delay (total; 57 patients @19 12 08) , CHC assessment and Fast Track placement. Reduction in both number and bed days occupied for super stranded patients now seen since Nov. Patient feedback re lack of involvement in discharge planning remains a key feature, to be explored with HYMS students discovery interviews in Jan to March. Key issue is lack of prior information about discharge plans All directorates working on local resilience plans with emphasis on creating bed capacity to specific time periods during the day to support patients getting to the right beds at the right time to meet their needed .

KPI	Baseline	Comments
Increase in number of daily discharges before 10am	5% site perf-Jan18	10am discharges remain within common cause variation.
33 % of daily discharges before 12 midday	18% site perf -Jan18	12 midday discharges remain within common cause variation.
Increase in Total number of discharges per day	Site average 80 per day	Significant variation seen still between weekend and weekday. Now split between weekdays/weekends
Reduction in number of stranded patients 7 days & over)	200 ave (mean) pts per day -	7 day stranded patients continues to run at the average (232) from Sept-18 onwards, after the drop over the summer period.
25% reduction in number of stranded patients over 21 days	85 ave (mean) pts per day	From the end of Nov-18, 21 day fell back within control limits to an average of 90.

Initiative		RAG	Update
S	Board round and pm huddles daily senior review	Work on going	CoE testing daily process of focus and escalation of stranded patients at daily board round using red 2 green principles . Ward 28 board round requires more focus to become well established
A	EDD and CDD	Work on going	focus on excellence in discharge planning using 4 questions challenge. Links into patient feedback setting EDD remains a challenge. Review opportunities for visible EDD on white boards
F	Ward discharge requirements. Focus on pt lounge	Work on going	Focus on 4 questions to aid discharge planning and release of beds to support flow. Increase use of patient lounge by all wards
E	Focus on early discharge	Work on going	opportunity to use discharge lounge to support release of a down stream bed . Links to 1up OPEL 2
R	Focus on super stranded pts		Multiagency MADE events in place weekly (Wed) for escalation of patients who are waiting for support for discharge

Done last month

- Support to out of hospital SAFER champions to take SAFER work forwards.
- Complete support to surgical wards to test impact of pm huddles
- Work with AMU to continue to improve daily am handover and board rounds
- Work with MADE events to stimulate more solutions to patients who are delayed

Next steps

- Continue to work with MADE events
- Directorates to name a link person for the MADE for all super stranded patients inc MFFD with delay
- Create escalation route to exec team when MADE cannot unblock existing delays for discharge (top 5)
- Support ward 28 to further embed SAFER principles

Support needed

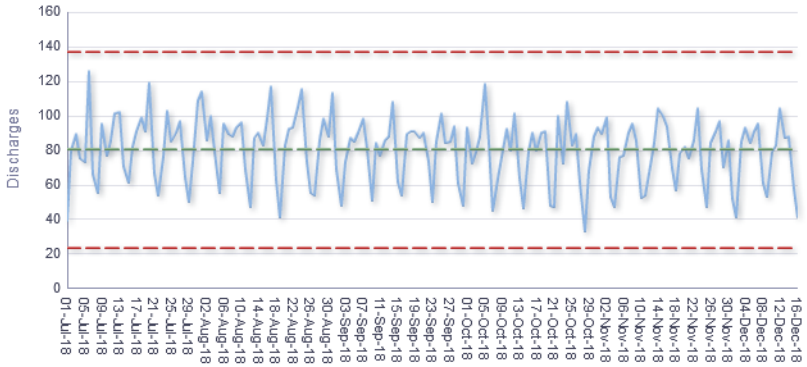
- CD, Matrons and lead therapist continue to support their ward teams to own and deliver the SAFER principles to become business as usual
- Directorate MDT to confirm directorate resilience plans
- Medical support needed to explore CCD and EDD and impact for patient experience and care

SAFER Measures

Excludes deaths and day case patients. Includes only inpatient wards (no paeds/maternity)

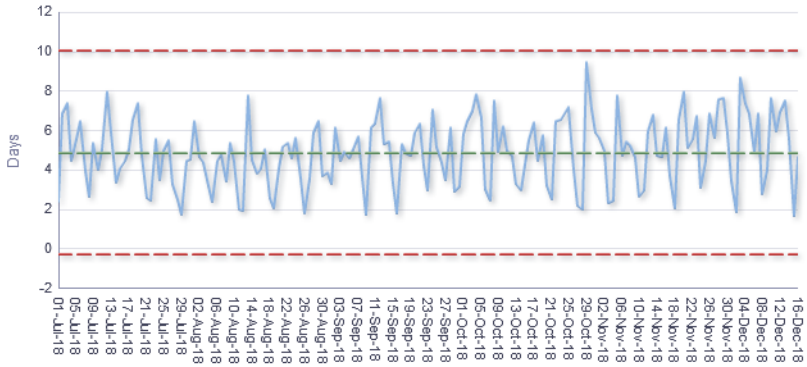
Mon to Sun

The Number of Discharges by Day



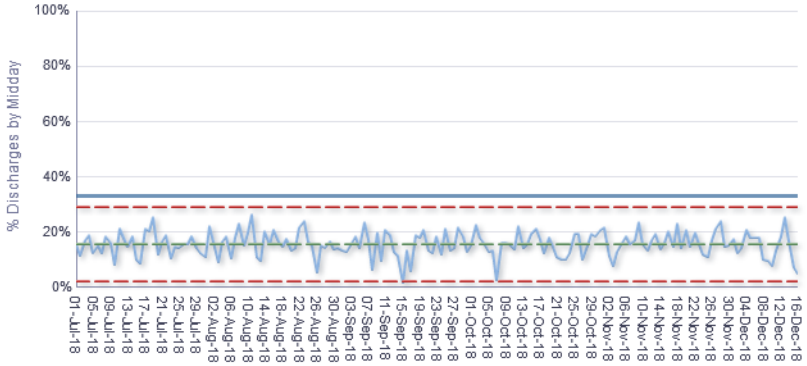
Export

The Average Spell Length of Stay

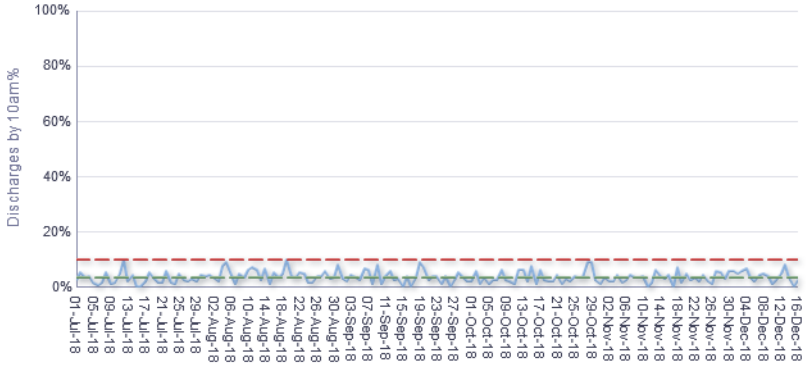


Export

The % of Discharges by Midday



The % of Discharges by 10am



SAFER Measures

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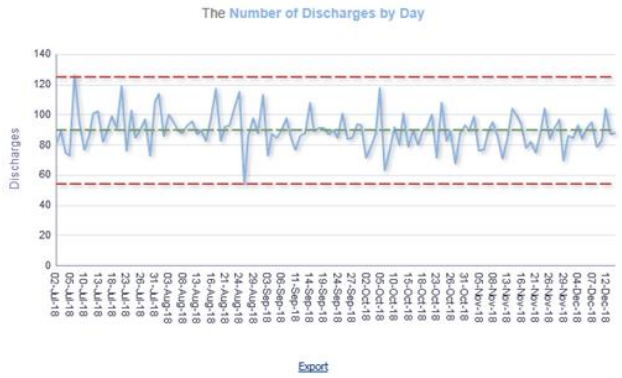
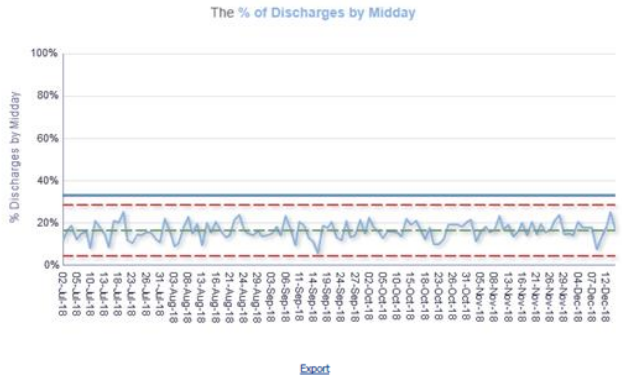
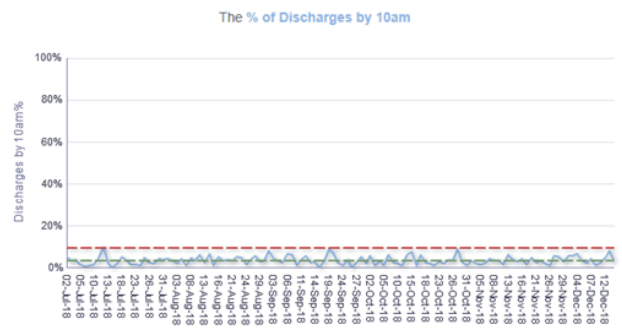
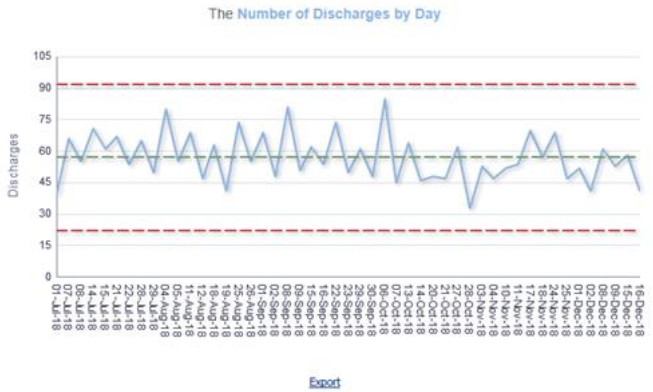
Mon to Fri

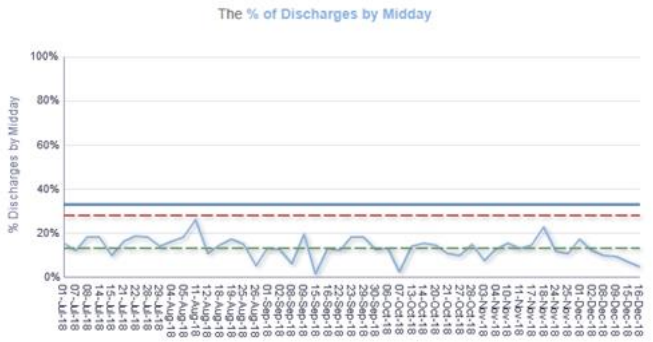


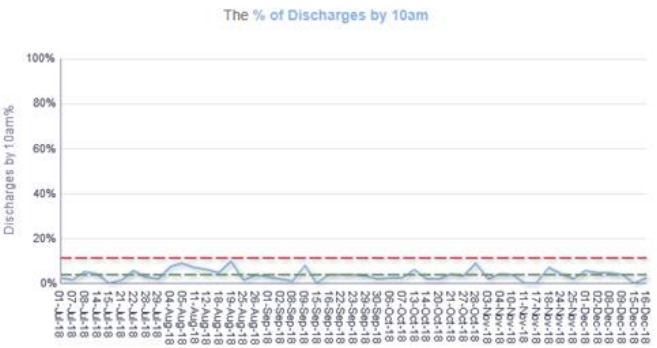




Sat to Sun







SAFER Measures

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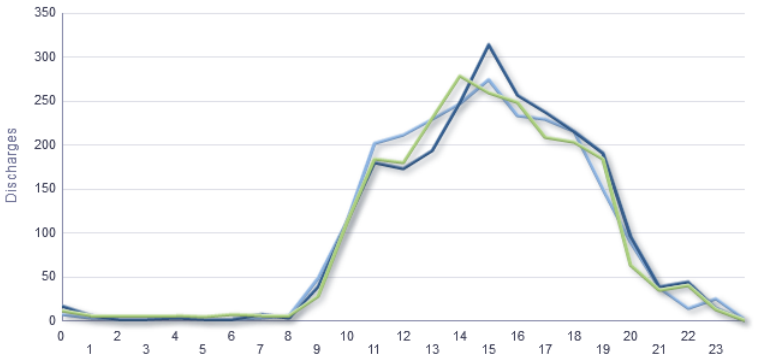

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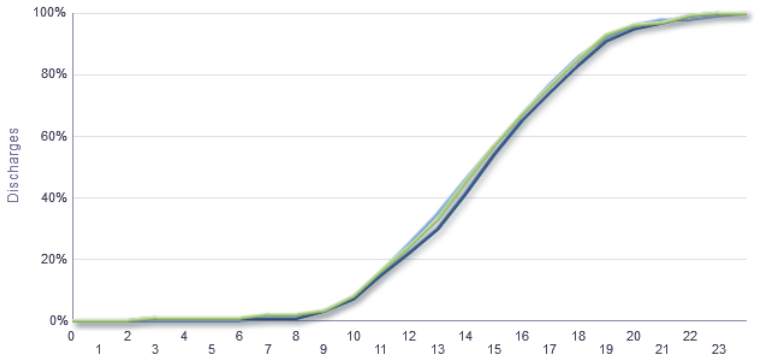

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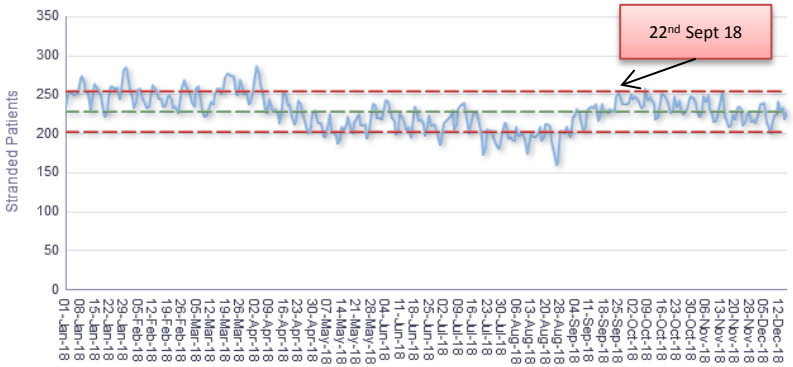
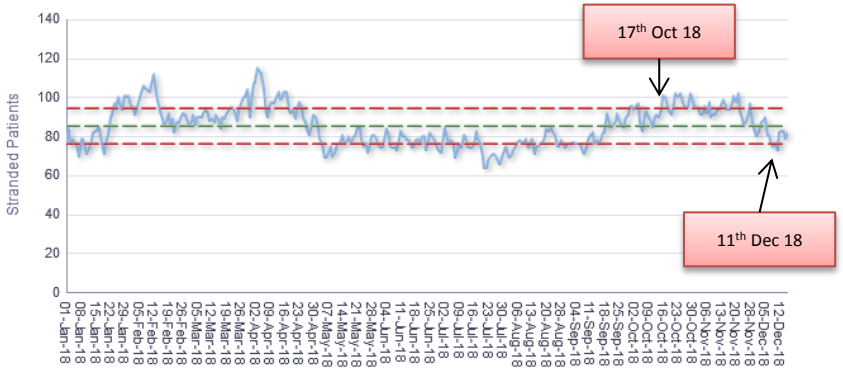


The Number of Super Stranded Patients at Midnight



Complex Discharge Programme Update Report Date: December 2018

Summary Position

The Scarborough Hub continues to develop and strengthen relationships between teams supporting patients on the East Coast with MADE events working well. York MADE events are less effective, Corporate Improvement Team are supporting the process and identifying areas for improvement.

Super-stranded numbers continued to be high through October and November but these have fallen since late November, further progress will be required to hit the national ambition.

The release of clearer national guidance on counting and coding Delayed Transfers of Care has been reviewed as part of the developing 'Why not home? Why not today?' Protocol and a shadow counting exercise will run through January to assess the impact. Improved transparency on delays, linked to the capacity and demand exercise for the York system, will highlight the capacity constraints that need to be addressed to prevent avoidable delays.

Initiative	Lead	RAG	Update
Integrated discharge hub	GY	A	Scarborough Discharge Hub continues to refine and develop its approach, NYCC providing weekend staff on both hospital sites as part of Christmas plans. MADE events in York being reviewed in light of feedback from attendees.
One Team – Intermediate Care and Reablement	VMT	A	Conversations with commissioners regarding intentions/vision continue. Continue to progress with supported discharge pathway whilst longer term plans emerge.
Continuing Health Care	CCG	N/K	Plans for CHC D2A beds at St Monica's continue to be developed by CCG. St Leonards to employ fast track nurse and social worker to be based in discharge hub for 12 months.
Increasing capacity in discharge pathways	LA	A	CYC winter plans for additional capacity coming on stream with beds opened at Chocolate Works and in independent living facility. NYCC winter investment plan still awaited.
Working with care homes	CCG	N/K	Looking to develop Trusted Assessment proposal with Independent Care Group. Ongoing work to improve connection to CCG led projects - virtual team of multi-agency support starting in CYC area.

KPI	Comments (October data)
Ensure DToC account for no more than 3.5% of occupied bed days	Ongoing high numbers of DToC in York Hospital, non-acute delays remain well above the 3.5% target but the numbers in Scarborough Hospital remain below 3.5%.
Reduce length of stay for those aged over 65 by 1 day	Length of stay for older people in Scarborough Hospital remains below baseline but rose above the target level between August and October. Length of stay for older people in York Hospital continues to be well below both baseline but rose in October.
Reduce bed days occupied by those aged over 65 by 10%	In Scarborough, despite the increases in admissions for older people, the number of beds occupied has been around the 2016-17 baseline for the past five months. In York following the increase in LoS there were nearly 1,000 more occupied bed days for older people than in October 2017
Increase weekend discharge rate to 20%	Not consistently achieved
Reduce number of stranded patients by 20%	Both sites saw an increase in the number of patients with a length of stay over seven days.

Done last month

- Continue recruitment for weekend hub workers
- York Integrated Care Team leading multi-agency support to care home teams
- MADE approach in York being reviewed
- Impact of new DToC counting guidance reviewed by multi-agency group

Next steps

- Shadow count using new DToC guidance
- Fast track nurse and social worker to commence in discharge hub
- Explore opportunities for expanding CRT capacity to support D2A expansion
- Develop Trusted Assessment proposal with Independent Care Group

Risks and Support needed

- Trust project manager role currently in VC process – vacancy will impact on delivery of Trust-led projects
- Impact of overall capacity constraints in care markets – capacity and demand exercise by Venn Consulting for City of York to be funded from Better Care Fund

Hospital Out of Hours Update Report

Date: December 2018

Summary Position

The first Steering Group (including clinical directors from main specialties working overnight) was held in December under the leadership of Mr James Taylor. The Group confirmed the need to change and increased the awareness of those not previously involved through the York Acute Care Board.

Links are being made with a number of Trust (nearby and further afield) who have undertaken similar projects to share learning and best practice.

The task allocation proof of concept software has now been demonstrated on both the York and Scarborough sites, providing a list of requirements from users that will be included in the version that goes live in 2019.

KPI	Comments (baseline where known)
Time to clerking	140 mins
% tasks undertaken by medical staff that could be done by others	30-40%
Staff satisfaction	Need to establish baseline
Patient deterioration	Need to establish proxy/baseline
Time to clerking	140 mins

Initiative	Lead	RAG	Update
Additional capacity for team overnight – introduce Clinical Support Worker role	Karen Cowley		Options developed and costed – appraisal to be presented to Corporate Directors, needs to consider sources of funding. Medicine rota being reviewed to explore opportunities for additional out of hours workforce
Develop co-ordinator role	TBC		Meeting arranged for January to develop options and agree preferred model to take forward.
Develop technological solution for task allocation	Kevin Beatson		Engagement sessions now held in York and Scarborough – priority list of developments identified and work commenced to build product.
Team working as one – introduce shared handover process	TBC		Limited activity to date – needs to link to co-ordinator role being in place (and additional capacity to manage surgical concerns)
Engagement programme to support cultural change required	TBC		Engagement in development of proposals – engagement plan to be developed by project manager once in post

Done last month	Next steps	Risks and Support needed
• Design workshop to test IT proof of concept held in Scarborough (7 Dec) • Identified a number of other Trusts undertaking similar projects and links made • First Steering Group meeting held	• CSW options to be presented to corporate directors to seek funding • Continue conversations with other Trusts undertaking similar projects • Working group to be held with leads from services that could be involved in providing the co-ordinator role • Explore any other short term actions that can improve safety • Redesign medicine rota	• Lack of project management support to co-ordinate activities and drive progress • Funding requirements for clinical support worker, IT and co-ordinator roles

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 January 2019
Review of Corporate Documents
(Revision of the Reservation of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions)

Trust 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 sustainability**

Recommendation

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

Purpose of the Report

The purpose of the report is to highlight to the Board that Reservation of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions have been reviewed and the amendments listed for approval. The documents were reviewed and approved by the Audit Committee on the 4 December 2018 and are now recommended to the Board for approval.

Executive Summary – Key Points

The Trust reviews the corporate governance documents on an annual basis.

Reservation of Powers and Scheme of Delegation has been reviewed. The amendments are as follows:

Section	Insertion/Deletion
Accountability	Delete - Delivery of the Financial Recovery Plan and Chief Executive
Capital Investment & Business Cases All Business Cases Review Investment Expenditure variations on capital schemes	Inserted - Any urgent approval can be agreed by the chair of the relevant group (Any urgency must be justified)
Planning & Budgetary Control	Delete – Transfer Insert – Change of use Now reads Virement (planned change in use of resources between directorate or speciality/department budgets – per annum)

Standing Orders have been reviewed. There are no current amendments to standing orders, but these are currently being reviewed by the Constitution Review Group as part of their work programme.

Standing Financial Instructions have also been reviewed. The only amendments to the standing financial instructions are either grammatical or adjustments to spacing.

A copy of the three documents will be available for inspection at the Board meeting, but not sent out with the papers due to the minor amendments requiring approval.

Recommendation

The Board is asked to consider and recommend approval of the revised documents.

Author: Lynda Provins, Foundation Trust Secretary, Steve Kitching, Head of Corporate Finance & Resource Management

Director Sponsor: Mike Proctor, Chief Executive

Date: January 2019

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	1. Failure to maintain and improve patient safety and quality of care	**16**	**9 ↔**	**3**
Patient Care	2. Failure to maintain and transform services to ensure sustainability	**20**	**12 ↔**	**6**
Patient Care	3. Failure to meet national standards	**25**	**12 ↔**	**1**
Patient Care	4. Failure to maintain and develop the Trust's estate	**25**	**12 ↔**	**4**
Patient Care	5. Failure to develop, maintain/replace and secure IT systems impacting on security, functionality and clinical care	**20**	**9 ↔**	**6**
Workforce	6. Failure to ensure the Trust has the required number of staff with the right skills in the right location	**25**	**16 ↔**	**1**
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	**16**	**9 ↔**	**2**
Workforce	8. Failure to ensure there is engaged leadership and strong, effective succession planning systems in place	**16**	**4 ↔**	**1**
Finance	9. Failure to achieve the Trust's financial plan	**25**	**12 ↔**	**6**
Finance	10. Failure to develop and maintain engagement with partners	**16**	**9 ↔**	**4**
Finance	11. Failure to develop a trust wide environmental sustainability agenda	**20**	**4 ↔**	**1**