

Board of Directors (Public Meeting)

31 July 2019



BOARD OF DIRECTORS MEETING

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

On: 31 July 2019

In: Boardroom, Trust HQ, 2nd Floor, York Hospital

TIME	MEETING	LOCATION	ATTENDEES
8.30 – 11.30	Quality Committee	General Medicine Seminar Room, York Hospital	Directors Non-Executive Directors
8.30 – 11.30	Resources Committee	Boardroom, Trust HQ, 2 nd Floor, York Hospital	Directors Non-Executive Directors
11.00 - 11.30	Resources/Quality Committee – Items for Escalation Discussion	Boardroom, Trust HQ, 2 nd Floor, York Hospital	Directors Non-Executive Directors
12.00 – 1.45	Board of Directors meeting held in private	Boardroom, Trust HQ, 2 nd Floor, York Hospital	Board of Directors
2.00 – 4.45	Board of Directors meeting held in public	Boardroom, Trust HQ, 2nd Floor, York Hospital	Board of Directors Members of the public
4.45	Farewell to the Chief Executive	Boardroom, Trust HQ, 2nd Floor, York Hospital	Board of Directors Members of the public



Board of Directors (Public) Agenda

SUBJECT	LEAD	PAPER	PAGE	TIME
<p>1. Apologies for absence and quorum</p> <p>To receive any apologies for absence</p>	Chair	Verbal	-	2.00 – 2.05
<p>2. Declaration of Interests</p> <p>To receive any changes to the register of Directors' declarations of interest or to consider any conflicts of interest arising from this agenda.</p>	Chair	A	7	
<p>3. Minutes of the meeting held on 29 May 2019</p> <p>To receive and approve the minutes from the meeting held on 29 May 2019.</p>	Chair	B	11	
<p>4. Matters arising from the minutes and any outstanding actions</p> <p>To discuss any matters or actions arising from the minutes</p>	Chair	Verbal	-	
<p>5. Patient Story</p> <p>To receive the details of a patient experience.</p>	Chief Executive	Verbal	-	2.05 – 2.15



SUBJECT	LEAD	PAPER	PAGE	TIME
6. HYMS Academic Year To receive a presentation on HYMS work in the Trust	HYMS Clinical Dean	Presentation		2.15- 2.45
7. Chief Executives Update To receive an update from the Chief Executive	Chief Executive	C	23	2.45 – 2.55
Strategic Goal: To deliver safe and high quality patient care				
8. Quality and Resources Committees Chair to brief items for escalation to the Board to include: <ul style="list-style-type: none"> 29.5.19 Minutes for information 	Chair	D D1	31 39	2.55 – 3.05
9. Integrated Board Report To review and discuss the Integrated Board Report including items escalated from the Committees and triangulating issues from the executive reports (for information section) to Board.	Chair	E	<i>Separate report</i>	3.05 – 3.45
Short Break				3.45 – 3.55
10. Home First Update To receive an update on home First	Chief Operating Officer	E	51	3.55 – 4.00



SUBJECT	LEAD	PAPER	PAGE	TIME
11. Outpatient Transformation Programme Update To receive an update on the OPD transformation programme	Chief Operating Officer	G	55	4.00 – 4.20

Strategic Goal: To support an engaged, healthy and resilient workforce

12. Freedom to Speak Up/Safer Working Guardian Update To receive an update from the Freedom to Speak Up and Safer Working Guardian	FTSU – SW Guardian	H H1	79 87	4.20 – 4.35
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Strategic Goal: To ensure financial sustainability

Governance

13. Reflections on the meeting <ul style="list-style-type: none"> Corporate Objectives - BAF 'at a glance' 	Chair	J	93	4.35 – 4.45
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14. Any other business <ul style="list-style-type: none"> Mike Proctor retires from the NHS and so as Chief Executive of our trust on 31 July. Simon Morritt takes up his post as Chief Executive on 5 August. In the interim, 31 July-4 August, Andrew Bertram, Deputy CE and Director of Finance will act as our Accountable Officer. 	Chair	Verbal	-	4.45
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SUBJECT	LEAD	PAPER	PAGE	TIME
15. Items for Information				
• Medical Directors Report		<u>J</u>	95	
• Chief Operating Officer Report		<u>J1</u>	107	
• Director of Estates Report		<u>J2</u>	121	
• Director of Workforce & OD Report		<u>J3</u>	155	
• Finance & Efficiencies Reports		<u>J4</u>	165	
• Digital Report		<u>J5</u>	177	
• HCV Update		<u>J6</u>	197	

16. Time and Date of next meeting

The next meeting will be held on 25 September 2019 in the Discussion/Dining Room, Post Graduate Centre, Scarborough Hospital.

Items for decision in the private meeting:

The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to issues concerning individual people (staff or patients). On this occasion the Chair will ask the Board to resolve:

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.



Additions: Steve Holmberg

**Changes: Heather McNair to be added
Jim Dillon to be added**

Deletions: Helen Hey, end of acting up term.

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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 <i>(Chair)</i>	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 <i>(Non-Executive Director)</i>	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
Michael Keaney <i>(Non-Executive Director)</i>	Nil	Chair —YTHFM LLP	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Jenny McAleese <i>(Non-Executive Director)</i>	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 <i>(Non-executive Director)</i>	Nil	Equity Partner Millfield Surgery	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Lynne Mellor <i>(Non-executive Director)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Position with BT (telecom suppliers)

Director	Relevant and material interests					
	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
Mr Steve Holmberg (Non-Executive Director)	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Dillon (Non-Executive Director)						
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 Executive)	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 representative	Nil
Mrs Heather McNair (Chief Nurse)						
Mr James Taylor (Medical Director)	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mrs Wendy Scott <i>(Director of Out of Hospital Care)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Brian Golding <i>(Director of Estates and Facilities)</i>	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 Trustee of St Leonards Hospice
Ms Polly McMeekin <i>(Director of Workforce & OD)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Lucy Brown <i>(Acting Director of Communications)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil

Board of Directors – 31 July 2019 Public Board Minutes – 29 May 2019

Present: **Non-executive Directors**

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

Executive Directors

Mr M Proctor	Chief Executive
Mr A Bertram	Deputy Chief Executive/Director of Finance
Mrs H Hey	Acting Chief Nurse
Mrs W Scott	Chief Operating Officer
Mr J Taylor	Medical Director
Ms P McMeekin	Director of Workforce & OD

In Attendance:

Corporate Directors

Mrs L Brown	Acting Director of Communications
Mr B Golding	Director of Estates and Facilities/LLP Managing Director

Trust Staff

Mrs L Provins	Foundation Trust Secretary
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Observers: Ms D Sweeney, Deloitte
Mrs Sheila Miller, Governor

Ms Symington welcomed everyone to the meeting to the public Board meeting at Scarborough Hospital.

19/41 Apologies for absence

No apologies were received.

19/42 Declarations of interest

No further declarations of interest were raised.

19/43 Minutes of the meeting held on the 27 March 2019

The minutes of the meeting held on the 27 March 2019 were approved as a correct record subject to the following amendment:

Minute No: 119/26 Chief Executives Update – Park and Ride Service – should read the service had been ‘underwritten’ not ‘funded’ by the Charity.

19/44 Matters/actions arising from the minutes

Minute No: 119/26 Chief Executives Update – Cancer Alliance – Breast Oncology Service – Mrs Adams asked about the Cancer Networks and Mrs Scott stated that the meetings were ongoing and there was some really positive work, but no silver bullet. The Network was discussing a potentially different model and Mrs Scott would bring an update to the June Board.

Action: Mrs Scott to bring an update on the Cancer Network work on the breast oncology service to the June Board meeting.

Action Log:

18/69 – the Risk Management Framework will be brought to the July meeting.

18/82 – the Carter Metrics are on the June Board agenda.

No further items were discussed.

19/45 Patient Story

Mr Proctor read out a story about a patient transferred from Scarborough to York who did not have any money with them to get home, fortunately the friend that came with them did. Mr Proctor highlighted that if they had gone to staff, help would have been provided, but that often patients see it as their own responsibility. In this case the worry about transport had detracted from the good treatment provided.

Ms Symington explained that she was very interested to know whether further information could be provided around transport to help patients and also whether the charity could help.

Mr Bertram stated that several years ago the responsibility for transport had been taken away from the Trust and was now the CCGs responsibility. He noted that the Trust has people with experience around transport but they are not included in the CCG discussions. He also noted that the Trust does provide taxis if patients are unable to get home.

Mrs Brown was concerned that transport was a grey area especially when the Trust moves services further away from where people might live.



Ms Symington stated that in the first instance providing practical help with good information about buses and trains was essential.

Mrs Hey noted that the CQC had been in ED asking patients about transport services as part of their inspection of YAS.

It was resolved that the Board felt that more practical information was required for patients on travel. SS will work on this with LB.

19/46 Chief Executive Update

System Finance – Mr Proctor stated that the Trust now had to operate as a part of a system financially, but this also meant that the system needed to take ownership of performance and quality and safety to make services work.

Care Group Structure – Mr Proctor stated that it had been a huge task to change from directorates to a care group structure which would come into place on the 1 August. Further appointments are still being made and the teams are excited and there is a really positive atmosphere.

Ms Symington stated that she is keen to find ways for the new care groups to interact with the Board and Mr Proctor stated that this would be easier with just 6 care groups instead of 15 directorates.

Mrs Scott stated that she and Mrs Provins were looking at a governance framework for the care groups and would bring something to the July Board meeting so that assurance could be provided on governance and the performance management arrangements before the August change.

Action: Mrs Scott and Mrs Provins to bring the Care Group governance and performance management arrangements to the Board in July.

Mrs Adams asked about current contact with directorates and Mr Bertram stated that currently his CCIP team was still meeting with directorate managers and this could continue as the care groups did not officially exist until August.

Mrs Scott stated that it was envisaged that care groups would have something like a Board with two to three sub groups and the Executive Team would interact with the Board and the teams with the subgroups. She noted the groups would have dashboards which could come as part of the Board report and inform discussions.

Ms Symington thought it may be worth asking the Care Group Directors to the private Board in August which was off site.

Mrs Scott noted that various development days were being put in place for the care group directors and managers which were supported by NHS Elect and the ODIL Team. Mrs Hey asked for the senior nurses and allied health professionals who are part of the quadrumvirate not to be left out and Mrs Scott responded that some of the development was about the care groups working as a team. .



Ms Mellor stated that this was great and especially the sharing of key trends and schemes, which needed to elevate up to avoid silo working.

Scarborough Acute Services Review – Mr Proctor noted that phase two was well under way.

Celebrating Success - Mr Proctor also wished to note a number of events that had taken place which were about celebrating success; HYMS awards, Junior Doctors Awards, the SLAM event and the York Long Service Awards (the Scarborough Long Service Awards are in June). He stated that it had been both a pleasure and a privilege to attend all of these events.

CQC – It was noted that information had been received that the Well Led date letter was in the process of being sent by the CQC which would mean the window for unannounced visits was between receipt of the letter and the well led date which could mean an inspection at the end of June, beginning of July. The Use of Resources date was the 2 July. Mr Proctor stated that the Trust knows what its problems are and it is really about what the Trust is doing as a consequence.

Ms Symington asked about preparations and Mrs Brown stated that briefings have been going out for a number of weeks and there is information on the intranet with regular additions to the documentation. Mrs Hey stated that two tools are being trialled and that feedback would be brought back. Mrs Hey stated that the PIR had been submitted with no further information requests to date.

Mr Proctor noted that a couple of MPs had been lobbying the Health Secretary and that the McKinsey review was providing valuable information for this as Scarborough Hospital was difficult to run sustainably under the current tariff.

It was resolved that the Board noted the report including the celebrations of staff and the imminent CQC inspection.

19/47 Quality & Resources Committees – Items for escalation

Ms Symington stated that items would be escalated to this meeting for discussion so that the Board could seek assurance around some key issues. Ms Symington noted that the items for discussion in the public Board were in relation to capital and the impact on digital and infection control. Ms Symington also expressed concern that there needed to be an executive lead at the Board who could speak to the digital agenda.

Capital – Mr Golding stated that a capital paper had been taken to the Resources Committee and that after paying loans the Trust had approximately £8.5m to spend which was a real squeeze. The concern was in relation to back log maintenance and Mr Golding stated that condition surveys had been carried out which enable the Trust to be assured that the £2m being spent on backlog maintenance was targeted at the right areas. However, it would be difficult if any requirements came out of left field.

Mr Proctor stated that there was also national pressure to reduce capital spend and that early release of the Scarborough £44m bid monies had been refused until a strategic outline business case was submitted in September.



Mrs Adams was worried that £2m for backlog maintenance for the Trust sites was not very much and meant the backlog would grow. Ms Symington concurred and was concerned that Bridlington needed quite a bit of work, but that the £44m for Scarborough would at least address issues on that site. She noted that the Trust can only keep going and hope that things change.

Mr Bertram stated that Trusts had received letters asking them to review capital spend and try to reduce it. The Trust had confirmed that there was nothing that could be removed. However, this could result in a possible mandated reduction in spend.

Mrs Hey stated that she was not keen on naming things after people, but wondered if there was any mileage in getting organisations to sponsor the environment. Mr Bertram stated that the Charity was already pursuing this.

Mrs Adams stated that there was also an issue around the digital programme which required £1.8m capital just to keep on top of replacing the old hardware. Ms Symington stated that this was why it was useful to link into the Building a Digital Ready Workforce scheme. Mr Bertram also noted that the team had been successful in linking into a number of bids for cash. Mrs Scott stated that she was meeting with James Freer from HEE around the OPD transformation programme and he seemed quite keen to help.

Terms of Reference - Mrs Provins stated that the terms of reference had been through both Committees and that they would be further reviewed in due course. She noted that the work programmes would continue to evolve as the Committees got further established. The Board approved the terms of reference and noted the minutes of the meetings in March which were submitted for information.

It was resolved that the Board approved the Committee terms of reference and noted the concerns around the lack of capital and the digital agenda.

19/48 Chief Nurse Report

Mrs Hey stated that the presentation of the Complaints Annual Report was a regulatory requirement. She stated that the number of complaints remained relatively static and that it is the area where complainants are dissatisfied with the response that the Trust is working on. Referrals to the Ombudsmen were low. Mrs Hey stated that the Trust was also focusing on learning from complaints and any actions required. The July Patient Experience Steering Group was being used as a workshop for the Care Group Leads and deputies to provide training on how to manage formal complaints and influence the response.

Mrs Hey stated that she had received the first element of feedback from the national inpatient survey and due to the low national response rate the administration was being changed so the final cut had still not been received. One item which had been picked up was that staff were not introducing themselves and the Trust did not score well on patients knowing which nurse was looking after them. Therefore, a decision had been taken to relaunch the 'Hello my name is' campaign and this would start in September. Ms Symington stated that this project received the Board's full support.



Mrs Hey stated that there were ongoing concerns with staffing on the Scarborough site and this was compounded by issues with infection control so she asked the Board to focus on infection, prevention and control on any walk rounds that they were involved in. The Trust had had 24 cases of C Dif attributed to it, against a target of 61, which was 10 over trajectory for this time of year. She noted that there was an external spotlight on the Trust and she was working with the Medical Director to ensure that the basics were in place. Public Health England is helping the Trust with some of this, but the staffing position is so tight there is the need to balance the risk. Mrs Hey noted that the Norovirus plan for the system has been done and it is about the system coming together to manage viral outbreaks this winter.

Mrs Hey stated that there had been an outbreak of 6 cases of MRSA in SCBU in York, but the outbreak was at an end. Staff and the environment had been looked at, but it was acknowledged that the environment was old and difficult to clean. Remedial actions had been taken and PHE had identified that this was likely to be one member of staff that transiently carried MRSA. She noted that three epidemiologists had met with the Trust's microbiologists and her team was supporting staff with the findings. She noted that this had concerned staff, but that PHE actually found it unusual and were highly motivated about the find which would be written up.

Mrs Adams congratulated Mrs Hey on the progress made in relation to increasing volunteering.

It was resolved that the Board noted the report and the concerns around infection control and would support the request to focus on this during any walk rounds.

19/49 Complaints Annual Report

This item was covered during the Chief Nurse Report.

19/50 Medical Director's Report

Mr Taylor stated that his summary notes the increasing ability to triangulate reports from SIs, learning from deaths and cancer harm reports and the same issues are coming up. In addition to that there is also a correlation of patient safety issues, but there was a need to think about how to make summaries better before reporting them as it would help to consolidate the lengthy reports the Quality Committee receives.

Mrs McAleese stated that the Committee needed to be clear what was expected from the report and Mr Taylor stated that it would help if he was able to simplify the message as this makes a better message. Dr Boyd stated it would help if the report was kept to 'these are the things that have happened and this is what can be done them'.

Ms Symington stated that in respect of triangulating Mr Taylor's report and Ms McMeekin's report, she noted that there is nothing about MHPS cases. Mr Taylor noted that there were only a small handful of cases which were being dealt with informally and quickly and these would be reported in Ms McMeekin's report. Mr Taylor stated that the culture had been changed around MHPS and more work was being done informally.



Mrs Adams stated that she echoed what Mr Taylor said and that it was about triangulating themes like delays to clinical or diagnostic pathways, cancer complex pathways when another provider is involved or internal diagnosis delays due to radiology capacity and what is reported into the public Board using the information pack.

Mrs McAleese stated that it is worrying that some of these issues still have not been sorted. Mr Taylor stated that there is movement on some things like Duty of Candour, but some harm is not noted in the first couple of weeks and they only come to light later.

Mr Taylor stated that the 7 Day Service Audit would be reported next month as there were some issues with the data.

It was resolved that the Board noted the report and the update around MHPS cases.

19/51 Performance Report

Mrs Scott stated that the Emergency Care Standard plan would be submitted tomorrow. She noted that she had provided a paper for the Quality Committee on ambulance hand over and turnaround as this was a top priority for the region. The ECIST diagnostic report and action plan went to the Committee and there were four elements to the plan which she listed. The plan contained nominated leads for each of the workstreams. Mrs Scott stated that the Trust was an outlier and the number of patients waiting over 30 minutes continued to increase.

Ms Symington asked if the work in relation to flow would help and Mrs Scott stated that the exit block from ED was described and multiple actions were required.

Ms Symington also asked about the surge policy and Mrs Scott stated that it did relate to this work as there were conversations being had about surges in the number of ambulances and what this looked like especially as ED was constantly under pressure. A time out was planned with clinicians to look at how the assessment floor worked.

Mrs Adams noted that there were different problems at each of the EDs and Mrs Scott noted that Dr Jones had a number of ideas on what to do in the Scarborough ED which was why Dr Lord had been brought over to give him the opportunity to work on some of these.

Mrs McAleese asked about the engagement by other clinicians and Mrs Scott stated that it had been noted by the NHSI team there was areas of silo working. Mr Taylor stated that ECS was the Emergency Care Standard and should not be put down to just the ED team.

Mrs Adams noted a poor delayed transfer of care (DTOC) figure this month and more so in York. Mrs Scott stated that the system response to DTOC was hopefully changing as the City of York Council had a new Director who had come from an area with zero tolerance to delays. A time to think unit was being set up in York which would provide more support during winter. The Council were looking to buy or lease a Nursing Home in York which would take patients clinically fit to leave hospital which would free up bed capacity in York Hospital. Mr Proctor stated that it was important this facility did not have an NHS sign on it. The property being looked at had capacity for 25 to 60 beds.



Ms Mellor asked if it was worth throwing a challenge out to the 6 Care Group leads as an objective about changing behaviours. Mrs Scott noted that she had been in touch with a behavioural psychologist following a discussion with one of the Directors from Morecambe Bay who stated they had employed him and it had been the best intervention their Trust had ever taken.

Ms Mellor stated that the SPC charts were now much easier to read.

It was resolved that the Board noted the report and asked to be kept informed on the developments in ED, ambulance handovers and delayed transfers of care.

19/52 Home First Update

Mrs Scott highlighted that the Primary Care Networks now have clinical directors which is hugely important and she thought it may be useful to get the clinical director to come to talk to the Board. Mrs Scott stated that most of the clinical directors for the Primary Care Networks were known in York, but they had not been appointed yet in Scarborough. She felt that these were 11 new clinical directors the Trust can engage with and build relationships which was a really important development which would allow defined working over geographies.

Mrs Scott highlighted the delays in relation to the Complex Discharge Group despite positive relationships and that staff on the ground found the relationships with partners helpful on a day to day basis.

Mrs Scott noted that the Community Response Teams were absorbing more and more activity and all were experiencing an increase in demand due to aging populations. Dr Boyd noted that more people were dying at home and or in their preferred place which was a huge improvement.

It was resolved that the Board noted the report and the positive developments around Primary Care Networks. The board wish to invite a clinical PCN lead to the board to learn more about the evolution of PCNs.

19/53 Director of Estates & Facilities Report

Mr Golding stated that the same report had gone to the Resource Committee held this morning and the high-level summary could be found on page 124-5.

Band 1 to 2 Change – Mr Golding noted that a third of staff had transferred to band 2 and this may encourage more over time when they saw that it was virtually the same job. However, for a number of staff the extra money would affect benefits. A further third had failed to respond, but the important message was that band 1 was now closed.

Health & Safety Report - Mr Golding stated that there were no RIDDORs reported, but that one had been received since the report was drafted. He wondered whether it would be useful to write to those staff who were subject to RIDDOR as these often led to claims.

Premises Assurance Model – Mr Golding noted a significant dip in relation to safety, but assured the Board that this was as a result of the transfer of data and issues with links. He



stated that the data issues would be sorted in the next six months and the Board would see an improvement at the end of the financial year.

Sustainable Development – Mr Golding noted that the group's terms of reference were in the pack and he highlighted the governance structure on page 160 which showed the functions he is responsible for. Anything else is reported to the LLP Management Group.

Energy Procurement – Mr Golding highlighted that he had granted approval for a Flexible Set and Reset Strategy.

Mrs McAleese thanked Mr Golding for his report which contained key information; however she was concerned about the PLACE assessment. Mr Golding stated that this happened once a year and was national and so remained the same. He signposted the TAPE assessments carried out by the Trust on a quarterly basis which was the same as PLACE and were improving, but there was some concern around disability access in Bridlington. The next PLACE assessment has been delayed to September, but there should be fewer reds.

Mrs Adams expressed concern about the catering and theatre hygiene issues at the Resources Committee and had asked Mr Golding to take these back to the Management Group.

It was resolved that the Board noted the report and reassuring information provided by Mr Golding.

19/54 Director of Workforce Report

Ms McMeekin stated that page 175 provided a breakdown of medical staff numbers and there had been a slight increase in the vacancy rate to 9.7% (7.2% in York and up 2.2% taking it back to 15.5% in Scarborough) which she had discussed at the Resources Committee. This was due to seven middle grade doctors stepping back onto formal training - which was a good thing. She noted that the Trust were working with a new group, Patchwork, who were led by junior doctors and they were seeing great results and had helped convert 30 shifts from agency to bank in March.

Ms McMeekin noted the gender pay gap and the national report which had a 12-month time lag. The Trust had seen a very marginal improvement and she noted that bonus payments such as clinical excellence awards for medical and dental staff can skew it, but a number of initiatives were underway. One thing she stated would help was a nursery based near York Hospital.

Mr Golding stated that he had informally met with a Director of the organisation taking on the Bootham Park site and they were apparently planning a nursery as well as residential care. He noted that their master plan did not sound dissimilar to the one the Trust had had with the Council.

Mrs Adams asked about the Cherry Trees doctors' accommodation at Scarborough and Mr Golding stated that a business case was being prepared and the Trust was looking for a partner. He also noted that the Trust was working with Coventry University who were looking at providing student accommodation in Scarborough Town Centre. The Trust had



indicated that it would be interested in having 50 places. This accommodation would be ready in September 2021.

It was resolved that the Board noted the report including the updates on the Bootham and Cherry Trees sites.

19/55 Finance Report

Mr Bertram had reported to the Resources Committee the good start to the financial year and that the Trust were the right side of the plan. The run rate spend was up in April due to the second year of the pay award, which had been known about and planned for, however it does cause a blip in the run rate. Mr Bertram stated that it is predicted the Trust will hit the quarter one PSF target which is now only financial and does not include an ECS element. He noted that agency spend was an issue and this was in the main due to nursing which had already been discussed at length in the Resources Committee. Mr Bertram stated that spend on agency was not the wrong thing to do, but he assured the Board that spend would continue to be scrutinised in order to provide assurance.

Mr Bertram stated CIP performance had made a good start and was £3.18m against a full year target of £17.1m and driven by last year's recurrent part year effect being carried over. He reminded the Board that the Trust had its own £17m CIP programme to deliver and £3.5m of that still had no plans against it and £1.2m was considered high risk.

Mr Bertram stated that the contracts were all agreed and there was nothing outstanding, although contracts were now fixed in respect of an upper limit which meant there was no automatic right to extra support if the Trust was busier than the plan. Mr Bertram stated that it was about system ownership of the plan. Mr Bertram stated that there were no cash issues to bring to the Board, however, he did not that the Trust was still waiting for the PSF for quarter four and the bonus attached to this.

Mrs Scott asked if the Trust could use some of its CIP achievement to supplement the system requirements and Mr Bertram stated that this would only make it harder for the Trust to achieve its own CIP target and create a reliance on the Trust. He stressed the Trust still had a £17m target to achieve on its own, and that any overachievement could be used by the system and he thought this was how it may turn out. Mr Proctor stated that the Trust could overachieve to benefit the system, but Mr Bertram also noted that the Trust may choose to put any overachievement into pressured areas, to supplement the cash position or into the capital programme. Mrs Scott stated that when discussed with clinicians they may come up with further ideas which could benefit the system and it was acknowledged that currently the boundaries were blurred. Mr Bertram stated that if the Trust can deliver the £17m total recurrently it would be the first year this had happened. However, Dr Boyd stated that the Trust should also keep the pressure up on the rest of the system to also deliver savings, not just the Trust.

Ms Mellor asked if any savings could be made by using growth and whether there were any opportunities for growth across the system. Mr Bertram stated there were opportunities for growth, but the Trust's three main commissioners were all financially challenged which meant they could not support any growth, but anything out of area or private self pay could be used.



Mrs Adams noted that she was concerned about plans. Mr Bertram stated that the Trust has been through the plans with the regulators and the system was required to operate within its finance limit.

It was resolved that the Board noted the report and that the Trust had made a good start to the year, but that the PSF funding was outstanding including the bonus.

19/56 Efficiency Report

Efficiency was covered during the Finance item.

19/57 Reflections on the Meeting

BAF – Ms Symington noted that the Executive Team were going to review some of the scoring on the BAF in light of the discussions at the private Board.

Dr Boyd thought that the discussions had been integrated across all the agenda with everyone contributing. Mr Proctor stated that the Board needed to be careful about alluding to earlier conversations as the public would not be aware of those discussions. Mrs Scott stated that there needed to be more definition between meetings so that some were not just a repetition of an earlier discussion.

Ms Symington wondered whether it may be better to use the integrated board report as the key document for the public meeting which would require less papers and give full and proper focus to the high quality information provided in the integrated board report. However, Mrs Hey felt that nursing were not quite ready for that and Ms McMeekin stated the board report was more quantitative than qualitative.

19/58 Any other Business

CQC – Ms Symington reminded everyone that the CQC were due to inspect the Trust in the next few months and asked everyone to ensure they were prepared.

Year-end – Ms Symington thanked Mrs Provins and the admin team for all their work getting papers out for numerous meetings especially as it was also year-end.

No further business was discussed.

19/59 Date and Time of next meeting

The next public meeting of the Board will be held on 31 July 2019 in the Boardroom, Foundation Trust Headquarters, 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	Ms Jamieson/	Jan 19 Feb 19

	structure. Reviewed at CRC – 14.3.19	Mrs Geary	Apr 19 July 19
18/82	Mr Golding to bring the Carter metrics to the next meeting.	Mr Golding	Jan 19 Feb 19 Apr 19 June 19
19/44	To bring an update on the Cancer Network work on the breast oncology service.	Mrs Scott	June 19
19/46	To bring the Care Group governance and performance management arrangements.	Mrs Scott Mrs Provins	July 19



Board of Directors – 31 July 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	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input type="checkbox"/>		

Purpose of the Report

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

Executive Summary – Key Points

The report provides updates on three key areas, and reflections from the Chief Executive on his retirement:

1. Moving to a care group structure
2. CQC inspections
3. Small rural hospitals network

Recommendation

For the Board to note the report.

Author: Mike Proctor, Chief Executive

Director Sponsor: Mike Proctor, Chief Executive

Date: July 2019

1. Moving to a care group structure

The structure comes into effect on 1 August, with the creation of six care groups:

1. Acute, emergency, elderly medicine and community services (York)
2. Acute, emergency and elderly medicine (Scarborough)
3. Surgery
4. Cancer and support services
5. Family health
6. Specialised medicine

This new structure has three broad aims:

- To strengthen clinical leadership, helping to ensure we are truly a 'clinically led and managerially supported' organisation.
- To reduce 'silo working' between specialties and professions, by more intuitive grouping of specialties side by side, and by having a 'quadrumvirate' leadership team comprising clinical, nursing, allied health professional and general management staff.
- To improve the connection between the Board and the rest of the organisation through a reduced number of care groups, aiding more streamlined operational and performance management.

The majority of key appointments have now been made, and I would like to take this opportunity to wish the teams every success in their new roles.

There is the opportunity to discuss the new care groups in more detail when we discuss the governance framework in the private part of today's meeting.

2. CQC inspections

The main components of our CQC inspection have now been completed. The CQC's unannounced inspection into the Trust's core services took place between the 18-20 June. As part of this inspection the CQC team spent time in Scarborough Hospital, speaking to staff and patients. Since that initial inspection visit we have had further correspondence with the CQC, where they have requested some further information, and they have also returned to Scarborough Hospital to visit other areas.

As with previous inspections, the inspectors complimented the open and honest approach of the staff they met and commented on the commitment and care demonstrated in all parts of the Trust.

Much of the initial feedback focussed on the areas we would all recognise and expect, in particular nurse staffing, medical cover (particularly at night) and consistency of record keeping.

The feedback letter received from the CQC after the first unannounced inspection is attached to this report. The CQC acknowledge that we recognise all our challenges and are starting to deal with them.

We experienced the Use of resources assessment on 2 July. This was carried out by NHS Improvement/NHS England, however it will feed in to the CQC process and our overall ratings report. This assessment involved a day of panel interviews looking at our use of resources in five areas: clinical service, clinical support services, corporate services, people and finance.

The CQC has also carried out the 'Well led' part of the review between 16-18 July, interviewing key staff in relation to this particular domain of the CQC inspection framework.

I would like to thank you all for the manner in which you approached the inspection and welcomed the team into your wards and departments. This was much appreciated also by the inspection team.

We now await our final report, which we do not expect to receive for a number of months.

3. Small rural hospitals network

Board colleagues will recall that, on the 70th birthday of the NHS last year I met with the then Secretary of State for Health Jeremy Hunt, and urged him to support us in creating a supportive network of 'unavoidably small' rural hospitals.

I am really pleased to report that this work is now progressing. Contact has been made with Trusts with hospitals in similar geographic situations in other parts of the country and a small rural hospital network has been formed with the involvement of NHS Improvement and Nigel Edwards at the King's Fund.

The network met formally for the first time earlier this month, and both myself and Chief Operating Officer Wendy Scott presented on the Scarborough Review and Workforce challenges and solutions.

The intention of the network will be to look at potential common service models and possible financial solutions to the particular issues facing our organisations.

4. Thank you and goodbye/last words...

As this is my final Board meeting I just want to thank all my colleagues for the help and support they have offered me for the period of 15 months during my time as Chief Executive. We have lived through very difficult and challenging times but I think we have achieved a lot. We have all looked after each other and when things have got particularly difficult we maintained a sense of balance and there has always been someone to lighten the mood. I also want to thank Sue, our Chair. We have been a good partnership I feel, and both share the same ambition to make the care we offer to patients in our organisation as good as it can be.

Throughout my time as a Director at York, either as Director of Nursing, Chief Operating Officer (on several occasions, both those things), Deputy Chief Executive, Interim Chief Executive at Scarborough and latterly as Chief Executive for the whole organisation I have attended well over 200 Board meetings, worked alongside more than 40 Executive

Directors and more than 30 NEDs. To me it has been an honour and a privilege to work in the NHS but in this organisation in particular. When I joined York in 1993 I was told the organisation was the 'graveyard of ambition', yet the organisation has given me more than I ever dreamed possible for a working class, council house lad from a less than salubrious part of Sheffield, leaving school with very few examination successes. Thank you to everyone for putting up with me, my short fuse, my impatience and all my other faults and mistakes and forgiving me for them.

I leave the Trust with a great team for Simon to lead, don't mess it up (joking). Seriously despite all the challenges we face and will face (the unknown unknowns), there can't be a better team to deliver on those tests. I'll be keeping a distant eye on things but I won't be providing a commentary, just make sure I am looked after when the inevitable continued deterioration in my health needs intervention!



Sent by email

Our reference: RCB
Michael Proctor,
Chief Executive,
York Teaching Hospitals NHS FT,
Wiggington Road,
York,
North Yorkshire.
YO31 8HE.

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Date: 24 June 2019

CQC Reference Number: INS2-5828786661

Dear Mr. Michael Proctor

Re: CQC inspection of (Name of York Teaching Hospitals NHS FT, Scarborough and Bridlington Hospitals)

Following your feedback meeting with Linda Oliver and Kerri-Anne Davies on 20 June 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to your colleagues Sue Symington, Andrew Bertram, Wendy Scott, Helen Hey, Polly McMeekin, Mr. James Taylor, Dr Donald Richardson and Brian Golding at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 20 June 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:
Key issues

- Nurse staffing levels – particularly on the medical wards
- Medical staffing – some vacancies and number of temporary staff

- Environmental issues including – ED- no paediatric areas, mental health - no dedicated room, all consulting rooms could be locked from the inside and had ligature points. Lilac ward was not conducive for care of the elderly patients due to the lack of visibility.
- Access and flow were an issue for ED, medical outliers and throughout the hospital.
- Records – we found gaps in records in relation to record keeping standards and, of particular concern, were the numbers of incomplete risk assessments or those overdue reviews. There was no regular audit / oversight of records.
- Equipment checks were not always completed, this included resuscitation equipment and medicine fridges.
- There was concern at Bridlington regarding band 5 members of staff holding the hospital bleep without appropriate training.

Positives

- Staff were open, receptive and overall very positive.
- Patient feedback was very positive, and we observed positive patient care.
- Despite the challenges wards had a calm atmosphere.

Next steps

- The inspection window is not yet finished, and well-led inspection will be 16 – 18 July 2019.
- CQC will hold a management review to discuss the inspection findings and determine if any additional action or information is needed outside of the usual data request.
- Some data requests have already been made for the core services and we have asked for a quick turnaround for this due to the proximity of the well-led inspection.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Deborah Turner at NHS Improvement

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate

Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dronsfield
Head of Hospitals Inspection

c.c.

Deborah Turner - NHSI
CQC regional communications manager

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Board of Directors – 31 July 2019 Quality Committee Minutes – 29 May 2019

Attendance: Lorraine Boyd (LB) (Chair), James Taylor (JT), Helen Hey (HH), Fiona Jamieson (FJ), Wendy Scott (WS), Neal Harris (NH), Rebecca Hoskins (RB), Jenny McAleese (JM)

1. Apologies for Absence

No apologies have been received, it was agreed the committee was quorate.

Observing: Danni Sweeny from Deloitte – Well Led Review

2. Declaration of Interests

No declarations of interest in relation to any agenda item were noted.

3. Minutes of the meeting held on the 27 March 2019

One change required, page 12, Donald Richardson role should read Chief Clinical Information Officer.

4. Matters arising from the minutes and any outstanding actions

None to report

5. Escalated Items

5.1. The Committee noted the request from the Resource Committee that the reasons for increased premiums for clinical indemnity are understood and assurance that lessons from the claims are being learnt. LB fed back on a meeting held with FJ on the provision of assurance to the Committee on the claims profile and the potential implications for organisations insurance premium. FJ outlined the process involved in managing a claim, and that where early notification of intention to claim is made to NHS Resolution, an indicative amount is attached by NHR to the claim. FJ advised that she will bring a paper that focuses on the Trust claims profile to the next meeting of the Committee. Claims reference in patient safety will be included in the revised Terms of reference for the new Care Groups. It was agreed to monitor the claims process more closely and schedule reporting twice a year. FJ advised Datix has been developed to capture more information.

5.2. Clinical Effectiveness Group are reviewing existing groups, realigning clinical committees.

6. Board Report

The committee did not have anything further to raise from the Board report which would not be picked up by the reports supplied to the committee this month.

7. Chief Nurse Report

BAF 1,2,3,4,5,6,7

Highlighting Nurse Staffing, Infection Control specifically C diff position & MRSA on SCBU, Hello My Name Is...

Lengthy discussion encompassing key current risks around Infection Prevention and challenges of maintaining safe levels of nurse staffing particularly RGNs and the Scarborough site. Current performance challenges discussed in this context and interdependencies acknowledged. Potential solutions and their wider impacts debated. Need to make unpalatable choices acknowledged and agreement that in the face of these challenges maintaining Patient Safety remains paramount.

Reassured by shared understanding of issues faced and contributions from all Exec Directors and their teams to the debate and evaluating the options. Evidence of collaborative working across Executive team demonstrated.

Case for refresh of 'Hello My Name Is' presented and committee supported the proposed relaunch.

HH advised the group that the AMTS report has not been included for this meeting due to the switch over to NEWS 2 last week; report will be presented at the next meeting.

7.1. Q4 – Pressure Ulcer Report

The Pressure Ulcer report was discussed. BH advised the group that there was no change in the number of Pressure Ulcers and level of harm for this quarter. There has been a change in the national guidance for reporting Pressure Ulcers which will mean a possible increase in pressure ulcer reporting as the 72hr rule has been removed. Themes reported from Root Cause Analysis investigations centred around poor documentation and patient concordance. Staff have identified further training requirements as part of the Root and Branch review which will be brought to the next meeting.

The Committee noted the report and associated improvements and learning.

7.2. Q4 – Falls Report

The committee discussed the Falls report. BH reported there has been a reduction in falls over the last quarter and a sustained improvement shown by the step change in reporting data. Seven wards had falls with moderate harm, 4 out of 5 patients had risk assessments and interventions in place. 35 actions have recommended in the root and branch review one of which is an update to the COMFE Tool. The CQUIN falls bundles for next year looks at patients over 65, WS and BH will be looking at how to audit.

The Committee noted the report and improvements as a result of initiatives throughout the year

7.3. Q4 – Patient Experience Report

There will be a relaunch of the Fast Feedback Tool (formally Friends and Family survey) in September to coincide with the new staff intake. Themes from the survey include staff not introducing themselves to patients and family, waiting times and communication in ED. The working group has been stepped down, but will reconvene when the new organisational structure is in place.

Actions: The Committee noted and commended the significant increase in Volunteers
The Committee noted the ongoing work across the Trust around patient experience and complaints management as a driver for improvement.

7.4. Regulation 18 Complaints Report

There is a waiting times app in current development by Systems and Network services which will enable staff / patients to make an informed decision on attending the emergency department.

The July Workshop on Complaints for Care Groups was welcomed.

The Committee noted the report and look forward to further updates and improvements as the Complaints process become embedded into the new Care Group Structure.

7.5. Q4 – CNST Action Plan

Reviewing the CNST action plan, the committee were advised that good progress was being made on midwifery and anaesthetic training, an update will be made in July. Progress will be monitored by Helen Hey, Freya Oliver and 8a Midwives.

7.6. Q4 – DIPC Report

It was reported that there has been a decline in performance with significant increases in C-diff, Norovirus and MRSA issues. Review work has evidenced that IPC practices are deficient e.g. hand hygiene, bare below the elbow etc. and that work needs to be undertaken to address the issues. The Medical Director and Interim Chief Nurse are working closely together to reinforce the importance of basic infection control procedures to all frontline staff.

The Interim Chief Nurse provided an update on the CDiFF outbreak in Scarborough and advised that many of the issues were related to environment and the difficulties around enabling a deep clean and HPV wards due to operational pressures, the lack of equipment and the inability to decant patients from the ward to perform these tasks effectively. Our ability to quantify the cost of the risks, clinically and financially, was questioned. The Board of Directors is already sighted on this issue and it is acknowledged that work needs to be done to address these issues and provide solutions.

The Interim Chief Nurse reported that the lead microbiologist for IPC is now Dr Damian Mawer and that Tom Jacques had returned to the role of Lead IPC Charge Nurse.

Action: The Committee accepted the report and noted the ongoing challenges and mitigating actions.

7.7. Acuity and Dependency Report

The Interim Chief Nurse presented the report and asked the Committee to note

- The ongoing roll out of the Safe Care Tool
- The difficulty in recognising contributions to safe care of AHPs and others and ongoing work to reflect this
- The ongoing challenges as result of staff shortages .Staffing is a significant issue within adult inpatient wards with 38% Registered nurse vacancies across site with 4 wards experiencing 50% registered nurse vacancies. With the help from Health Education England there will be 40 recruits until then the committee discussed how to ensure patients are safe. WS asked how many shifts are needed to bring the current staffing levels to 100%,

Action: HH to establish how many shifts are required to be filled in order to bring current staffing levels to 100%.

8. CQC update

Action: The Committee noted the preparations to date and support the ambition to a Move to a Good

9. ATAIN Action Plan

Action: The Committee accepted the plan and await further evidence for full compliance in

10. Medical Director Report

BAF 1,2,3,5,6,7

The Medical Director highlighted the March SIs, Seven Day Service Progress, the Safety Standards including 14 hour consultant review, ongoing review and access to diagnosis for particular discussion.

10.1 SI & Incident Themes Report incl. Medication errors – SI Group

The committee discussed the SI report. Key trends identified were delays in diagnosis, due to either delays in radiology reporting or capacity issues in outpatient; and a failure to escalate the deteriorating patient. JT advised that this is however consistent with the national picture and is attributed by capacity, diagnostic reporting, pathways, increases in delays when external agencies are involved, communication issues and complexity of patient and pathways. JT reported there had been 2 never events, the majority of which were wrong site surgery in a non-theatre environment.

JT gave an example of how an SI and cancer harm reviews had led to the review of the complexity of the lung cancer pathway.

It was noted that the SIs presented represent a distillation of a lengthy and significant investigation and local learning and actions. A challenge was raised around our ability to identify and capture potential system or cultural issues and risks, resulting in further discussion.

The committee discussed the CQC SHMI report. JT advised the Committee that the Trust is within control levels for SHMI, but has been identified as an outlier for Sepsis. The CQC had requested the review of 30 cases where it was found there was an increase in coding as Sepsis where it would have previously been reported as pneumonia.

The Committee noted the delayed implementation of NEWS2 which commenced earlier this month and look forward to further updates on implementation and resultant improvements in Patient Safety.

The Committee noted the report and look forward to further updates and improvements as the SI process become embedded into the new Care Group Structure.

10.2 Q4 – Mortality Report

It was noted that there were many examples of good care. Completion of SJCRs in shows poor engagement on the Scarborough site, consultants from York are to help with the completion of SJCRs. Scarborough lead Medical Examiner has been appointed, with a team yet to be recruited, they will review each death freeing up time for the consultants. It was pointed out that there is an automatic SJCR for patients with learning difficulties.

LB asked how the sepsis screening tool will be populated. He explained that a paper copy of the tool is ready for launch but that the electronic version is delayed. The electronic version will prompt to screen if NEWS2 exceeds 5. Concern was raised around the risk of a hybrid paper/electronic patient record and discussed.

LB asked how we ensure wide visibility of DNACPR and Ceiling of Care information. JT replied that DNACPR, Ceiling of Care is recorded on CPD and in the case notes, community DNACPR is to be brought in with the patients. There is currently a disconnect between paper and electronic versions

The amended Mortality Outlier Report was noted.

10.3 Q4 – Clinical Audit and Effectiveness Report

The request from Audit Committee requesting increased scrutiny of the Clinical Audit programme was noted.

The committee discussed the clinical audit outliers with the identified actions have been followed up. FJ advised that clinical leads often site quality of data is the main issue and this was demonstrated in the response to the outlier alert on the NBoCA National Audit.

It was suggested that the Data Quality Group be asked to look at the cancer pathways.

Action: Data Quality Group to be asked to place scrutiny of the data associated with Cancer Pathways.

Action: the report and its evolving nature was noted.

10.4 Radiology Backlog

JT advised that the Trust has experienced an increase in complex scans with 1000 unreported scan despite an increase in capacity from outsourcing. The plan is to introduce

a monitoring system to track scans, however this will take about a year to link to CPD, and in the interim period this will have to be done manually.

In terms of staffing Radiology are currently carrying 8WTE Radiologist vacancies. This is reflective of a national issue.

The Radiology Reporting Hub which enables home reporting will be up and running this year. It was also noted that there has been an increase in urgent referrals.

There was some discussion as to how the risk to individuals on the waiting list might be managed.

Action: The reduction in the reporting backlog was noted although it remains significant
The workforce challenge and actions to address this were noted
The position and next steps were noted

Attention to the Board: The Board are sighted on radiology reporting issues.

The Committee noted that there were no reports to receive from meetings of the Clinical Effectiveness Group and Patient Safety Group. BH explained these meetings were being reviewed in the light of the new Care Groups and their functions may become embedded within this governance structure

The Medication Safety Strategy Action Plan was received. No concerns were raised

Action: plan noted

11 Performance Report

BAF 1,2,3,4,6,7,8

The Performance Report was discussed and the multiple challenges were discussed and debated in detail acknowledging the interdependency with the workforce challenge and maintaining a safe service in the context of the current financial constraints. The importance of ensuring safety and quality remain the focus of prime importance was agreed.

The RTT challenge was noted. LB asked how we can be sure that individual patients are being managed safely as they sit in the pathways. It was suggested that this should be seen as a system problem and should be worked through with System Partners.

WS reported that Steve Lord, Emergency Care Consultant in York will come to Scarborough to support Ed Smith with Emergency Department floor work. Dr Donald Richardson will assist Dr Tim Houghton in a focus on General Medicine.

11.1 Ambulance Handover Action Plan

The findings of the ECIST report for York was discussed and the outcome of the Scarborough review is awaited

April saw the highest level of delay in ambulance handover, WS will bring an action plan to streamline handover to the group to include diversionary pathways, culture change etc.

Action: the action plan was noted

11.2 2019-2020 CQUINS

The committee discussed the previous CQUIN results, 2018-2019 showed good performance. 5 out of 7 CQUIN indicators have been chosen for 2019-2020. An operational lead and an executive lead will develop KPIs and provide regular updates to board. It was agreed that a conversation needs to take place with Occupational Health on how to improve flu vaccination uptake.

Action: The 2018/19 achievement was noted and thanks expressed to all contributors for their hard work

The 2019/20 proposals were noted and the Committee looks forward to regular progress reports

12 Final Quality Report including 18-19 Quality Priorities and Q4 position

BAF 1,2,3

LP reported to the committee that an extra column has been added to Patient Safety – we said table to compare between years. Pg. 344, Dementia Governance data to update 2018 - 2019 to 73%. In Operational measures Pg. 269, remove bullet point 4 as PSQ-PAM as these meetings no longer take place.

Action the Committee noted the Quality Account and looks forward to quarterly progress reports.

13 Board Assurance Framework – Corporate Risk Register

BAF 1,3,5,6,7,9,10

Next review is June, minor changes, Systems and Network Services risk changed.

Conversation to be had with Andrew Bertram regarding System Finance.

Clinical risk – IT systems not robust enough.

Staffing and Patient Safety – to be escalated for discussion.

14 Reflections on the meeting

HH advised the committee that there will be 13 papers for the next meeting, it was agreed that the main focus of the committee is to discuss areas of concern.

FJ advised the group there has been an increase in some of the corporate risk scores and will make appointments to discuss.

15 Any other business

No other business to discuss.

Action Log

Date of Meeting	Action	Responsible Officer	Due Date	Comments
27/3/19	To share operational plan 19/20	WS	25/5/19	Completed
27/3/19	Add to Quality Priorities: ambulance handover, new CQUINs, management of viral infections, complaints satisfaction survey, new care groups, lessons learnt, volunteering – End of Life, expand discharge lounge to Scarborough	LP	25/5/19	Completed
27/3/19	A short narrative or expected completion date to be included in the Target Completion date column.	FJ	25/5/19	
27/3/19	Patient Safety Strategy: an executive summary to be included, and leaflet to be handed out to staff.	JT	25/5/19	Completed
27/3/19	Forward an expected update document on SHMI to the Chair	JT	25/5/19	Completed
25/5/19	Update on review of Clinical Effectiveness and Patient Safety Group	BH	July 19	
25/5/19	AMTS report to follow	HH	July 19	
25/5/19	HH to establish how many shifts are required to be filled in order to bring current staffing levels to 100	HH	July 19	
25/5/19	Full compliance with ATAIN action plan to be confirmed	HH	July 19	
25/5/19	Data Quality Group to be asked to place scrutiny of the data associated with Cancer Pathways.	FJ	July 19	

Board of Directors – 31 July 2019

Resources Committee minutes – 29 May 2019

Attendance: Jennie Adams (JA) (Chair), Lynne Mellor (LM), Mike Keaney (MK), Andrew Bertram (AB), Graham Lamb (GL), Adrian Shakeshaft (AS), Brian Golding (BG), Steven Kitching (SK), Polly McMeekin (PM), Kevin Beatson (KB) Jonathan Hodgson (JH), Lynda Provins (LP) (for items 1-5 only), Tracy Astley (TA) (minute taker)

Apologies for Absence:

No apologies were received.

Observing:

Laura Taylor, Deloitte

JA welcomed everyone and declared the meeting quorate.

Declaration of Interests

There was no new declaration of interests.

Minutes of the meeting held on 27 March 2019

The minutes of the meeting held on 27 March 2019 were approved as an accurate record.

Matters arising from the minutes and Action Log

The following matters arising were discussed:-

Incentives to join the Trust - following on from notes at the last meeting with regard to offering free parking, PM confirmed that they were exploring alternative routes to incentivise staff to join the Trust, including bonus payments, and will pick this up with Heather McNair once she was in post.

No further matters were discussed.

Action Log:

1. Change DQWG to a formal assurance group – AB advised that this was discussed at the last meeting and he wanted to leave it as it was, with the group reporting into the Audit Committee. **Complete**

2. Update Digital section of the BAF/CRR – AS advised that the BAF/CRR had been updated and one risk had been added. **Complete**
3. Add new nurse role ‘Quality Impact Assessments’ into the Workforce section of the BAF – LP confirmed that the BAF had been updated to include the QIA. **Complete**
4. CRR version issue – LP handed out the latest version of the CRR. JA commented that she was pleased to see the review date had been added. **Complete**
5. Use of Skype and WebEx – AS confirmed that he will produce a report giving their different uses, pros and cons of each system and the costs involved for the next meeting. **Further action – see below.**
6. Explore “Grass isn’t Greener” follow up contact with leavers – PM advised that she has had a conversation with Helen Hey who would like to leave it until Heather McNair was in post. PM will pick it up with Heather in July/August. **Further Action – see below**
7. Learning from clinical negligence claims – JA advised that she had spoken to Lorraine Boyd, Chair of the Quality Committee, around gaining assurance that the Trust was learning from these claims. It was decided that LB will raise it at the Quality Committee. **Complete**
8. Capital Work Programme – AB confirmed that meetings were taking place with Directorates and is ongoing. **Additional discussion on the agenda.**

Action: PM to explore “grass isn’t greener” follow up contact with leavers with new CN, Heather McNair.

Action: AS to produce a report on Skype and WebEx uses, pros and cons of each system and the costs involved for the next meeting.

Board Assurance Framework – Corporate Risk Register

LP stated that, because of some actions from the Committees, further updates have been made. June will be the next review and the dates have been arranged with the Executives to review their risks again.

JA requested Committee members to highlight anything they felt might need to be adjusted within the BAF as the meeting progressed. This would then become a recommendation to be escalated to the Board.

Director of Estates & Facilities Report

BG gave an overview of the report and highlighted the following:

1. Following the approval of the MSA two key pieces of work will commence which will include creating a performance management structure which will be Chief Executive led and establishing Performance Management Group bi-monthly meetings.

- 2- Band 1 to Band 2 transition. About a third of staff had expressed an interest in moving to Band 2. The Payroll team was now processing the applications for these staff.

Health & Safety

BAF Ref: 1 (Patient safety) and 7 (Healthy staff)

BG informed the Committee that the report was prepared by Colin Weatherill. It was a report on health and safety across the organisation including LLP that summarises reported statistics via the Trust Accident and Incident Reporting System (Datix), reported patient experience data from PALS and key initiatives or challenges in the Trust and YTHFM. BG welcomed any questions.

JA commented on the recent limited assurance audit of non-clinical incident reporting which found issues with duration of investigations and learning from them. The Chair requested that all limited assurance audits be highlighted to the Committee within executive reports – as was the practice before the Committees were suspended. The idea is to provide assurance to the Audit Committee and the Board that Internal Audits are being acted upon.

Action: Executives to highlight new limited assurance audits in their report to the committee.

JA made reference to the positive feedback she received on her recent walk round on Oak Ward about the Security Team and how responsive they were to concerns of nursing staff.

Compliance

BAF Ref: 1 (Patient safety), 4 (Maintenance of Estate)

BG explained this was a monthly report from Dave Biggins team. Regarding the Annual Premises Assurance Model BG was worried about the safety domain as the scores at all sites have deteriorated. He believed the reason for this was due to the transition to the LLP. Documents have been lost in the transition. His team will focus in the next six months on finding them.

JA raised the issue of the cleanliness audit at York Hospital operating theatres. BG replied that when the scores dip there were action plans put in place that have been agreed with the LLP Management team.

Catering was another area of poor performance and this was triangulated with a recent limited assurance internal audit. BG acknowledged this.

BG commented on the TAPE assessment and informed that the scores last year were poor. They have introduced their own quarterly inspection of which this was the first quarterly report. Hopefully, when the PLACE assessment takes place shortly the scores will have improved.

LM commented that Selby Hospital was achieving very good scores across the board and asked what was the secret of their success. BG replied that Selby was a smaller district

hospital with fewer footfalls than York or Scarborough. The estate was fairly new and people looked after it.

Sustainable Development

BAF Ref: 10 (Sustainable Environment)

BG gave an overview of the report which focused on the latest sustainability scores. He explained that last year they scored nothing on sustainable care models and was pleased to inform that there had been significant improvements in this area.

BG referred to the Sustainable Development Group TOR and informed that it had been reviewed by the Group and asked that the Resource Committee approve the TOR. The Committee noted the TOR and approved it.

BG moved on to the Energy Procurement report and informed that the LLP have awarded their gas procurement contract to Laser Energy under the leadership of Kent County Council. They have chosen a 3 monthly fixed price model. The committee acknowledged this decision.

Capital Planning Information

BAF Ref: 4 (Maintain Estate), 1 (Patient safety), 7 (Staff safety), 5 (IT)

BG gave an overview of the report and stated that the funding available to invest in capital projects in 2019-20 can be split into three categories: depreciation-based (internally generated) funding, external loan / lease funding the Trust has secured (e.g. from the Independent Trust Financing Facility, or 'ITFF', for the York Endoscopy and Cardio-Vascular Projects) and, thirdly, charitable funding / fundraising finance.

The total amount of depreciation-based funding in 2019-20 is circa £11.4m but this has been reduced to £8.5m to take account of the requirement to repay the loan funding received from the ITFF. In 2019-20 the loan repayments will amount to circa £2.9m. This severely limits discretionary spending. He referred to the list of projects planned for 2019-20 and stated that they had overcommitted but had done some significant work to bring it back in line to present an expenditure plan of £9.7m, an overspend of £1.2m. No new projects will be added to the programme.

MK queried the three main risks to YTH and asked if there were any risks to patients and staff. BG referred to Appendix 5 of the report to highlight the notes stating the current position which linked into the expenditure plan.

JA referred to the York/SGH Estates Backlog of Maintenance and asked for assurance that the planned £2m of funding it does not present the Trust with a patient safety risk. BG was confident that £2m would cover the very high risk areas.

JA referred to the Community Stadium costs of £2.6m this financial year and asked if the Trust should have committed to that figure considering the financial position. BG confirmed that the Trust was now committed to this spend. AB added that discussions about the Community Stadium had been ongoing for the past two years and it was difficult to predict the restraints that have occurred within the NHS over this period of time. The Trust had committed jointly with York Council to deliver the project.

LM asked if there was any leeway to back out due to unforeseen circumstances and if York Council could generate funds from elsewhere, for instance from local businesses. AB informed that there was funding for major developments, typically used to fund schools, etc., and they had been doing some work to see if they could obtain funding for the Community Stadium project. AB informed that it was the Trust's cash/deficit position that was the problem. He explained that when the Trust borrowed working capital it could not be used to support the capital programme. York Council had offered to loan the Trust the money but their terms are not favourable.

MK expressed concern about the risks highlighted in the report and made reference to the significant issue of the fire alarms 2 years ago and asked if there were any other issues of such significance that the Committee needed to know about. BG replied that there was nothing at that level of significance that he wanted to highlight.

The committee requested to see more detailed information from BG on current backlog maintenance requests and the risk levels attached to them. BG said that this information was available and that he would present this to the next committee.

LM suggested that given the level of risks outlined in the report that the BAF be revisited to look at the scores.

Action: BG to provide next committee with breakdown of backlog maintenance requests and risk assessment.

Escalate to Board: Shortage of capital across the Trust.

Escalate to Board: Review the BAF in relation to scores.

Health & Safety Policy Review

BG advised that there had been no significant changes and asked the Committee to approve the policy. The Committee noted the policy and approved it.

Director of Workforce Report

BAF Ref: 6 (Appropriate workforce), 7 (healthy workforce), 1 (patient safety/quality of care), 3 (national standards), 8 (leadership)

PM gave succinct points on the following topics: -

Recruitment

PM advised that the Quality Committee will be discussing the nurse vacancy factor with Helen Hey. Trust wide, the vacancy rate stood at 16.7% and the organisation was really feeling the pressure, especially Scarborough Hospital. PM gave an overview of the initiatives to support recruitment.

- International recruitment was underway. Three individuals have joined the Trust this week at York Hospital. The programme was to recruit 100 of which 20 were earmarked for Scarborough Hospital. They should arrive between July and August next year.

- The Trust has partnered with HEE Global Learning Programme to secure 40 places on a 3-year programme which will hopefully lead to recruitment on a permanent basis. The 40 places will be for Scarborough Hospital. It has been piloted in the NHS for the past 3 years with huge success.
- A package of incentives for general recruitment of nurses at Scarborough Hospital has been approved by the Corporate Directors. These incentives were the result of feedback from nursing staff and included: -
 - paying for relocation costs for two months; or
 - a year's membership of a gym; or
 - a year's travel pass.

Unfilled rota rate for May stood at 21.9% trust wide. Fill rates through the nurse bank were better at Scarborough Hospital than at York Hospital. The Chief Nurse Team continue to manage shift by shift rotas because of the patient safety issues. It was an agenda item at the Board meeting last week. To incentivise further uptake of the bank staff who do several shifts on the bank, say 10, will receive payment for an extra shift.

PM spoke about the roll out of the Patchwork app where staff can register onto the bank and arrange a shift. Once rolled out it should increase staff uptake to the bank.

JA enquired about recruitment for the summer. PM replied that they used to run generic recruitment campaigns which did not work very well. They found that the uptake was greater when they recruited by specialities. She also informed that the Jupiter campaign will commence soon which included videos on working at the Trust, with the first one focusing on nursing at Scarborough.

The challenge was to keep in touch with those staff who were joining the Trust later in the year, to keep them interested, as it was common for staff to give back word if they received a better offer.

PM informed that the Leadership Courses were continuing to run. In instances where there was strong leadership in ward areas then a buddy up system was in place to share best practice with those colleagues who had a more difficult area to manage.

MK enquired about the link with Coventry University nursing programme. PM informed that the students will have completed one year soon, and they have another two years to go. Regarding the Nursing Associate programme, the assessment will take place next week at which point the Trust will be able to recruit in June.

The Committee discussed the medical vacancy rate by speciality which stood at 7.2% for YH and 15.5% for SGH. MK enquired about the Trust grades. PM replied that these staff were in training and are moving on to their next rotation. It will be monitored.

JA was concerned with the high vacancies on some of the difficult wards and informed of a recent walk round in Oak Ward at SGH which had serious staffing problems.

LM spoke about the recent adverse publicity and asked to what extent had this affected recruitment and how had the Comms Team counteracted this to bring back the feel-good

factor. PM advised that it had affected recruitment by way of one or two staff giving back word. She hoped that the Jupiter campaign would bring out the feel-good factor and offset any bad publicity recently received.

JA was pleased that progress was being made in recruitment to clinical studies. PM informed that as a teaching hospital the Trust needed to be research active and use this on the recruitment front.

Sickness Absence

The monthly sickness absence rate in March for the Trust had reduced from 4.4% to 3.8%. The monthly sickness absence rate in March for YTHFM had reduced from 7.9% to just over 7%. The top reason for sickness absence was anxiety/stress/depression which accounted for 22.7% of all absence days lost.

LM asked if there were any initiatives to tackle anxiety and depression. PM replied that there were several initiatives taking place, including: -

- £30k fund – the Junior Doctor Forum will decide how this will be spent.
- RAFT programme – purpose was to support staff after a serious incident.
- Schwartz rounds – purpose was to support staff who wanted to discuss anything that had happened during their shift.

AB said that the Schwartz rounds were well attended. He gave an example of a situation he had dealt with recently relating to stress and said that stress was not always work related and things could be happening at home that impacted on a person's work life. It made it difficult to offer help in this type of situation.

LM enquired if there were any online programmes. PM advised that there was the employee assist programme called Health Assured. It did not have to be work related for a person to receive help.

MK asked about the work being carried out in the LLP to reduce sickness. PM replied that there were various schemes of work ongoing across the Trust. She stated that the new manager who joined last month at Bridlington had made an impact.

Gender Pay Gap

PM informed that this was the second year of reporting. The Trust published a snapshot of pay within the organisation on 31 March 2018. Compared with the 2016/17 Gender Pay Gap report, the Trust's mean had reduced from 28.7% to 27.7%. From a workforce perspective although 79% were female and 21% were male, the make-up of the Medical and Dental Consultant Group was 30% female and 70% male. Proportionately, more men received bonuses than women.

There were several measures taking place to incentivise female junior doctors, including: -

- Having a nursery on the YH site
- Availability of the Salary Flexible Scheme
- Review of the local CEA to favour those who have no awards

Finance Report

BAF Ref: 9 (Financial plan delivery), 2 (sustainability of services), 10 (partner engagement)

GL gave succinct points of his report: -

- The Trust had met its pre-PSF control total and qualify for PSF and FRF.
- In month one the Trust was £100k ahead of plan.
- Income was still to be validated as the first month's activity coding was yet to be completed but will be reported as £300k shortfall against plan.
- Expenditure showed a £400k better than plan.
- Agency spend for April was ahead of expectations at £1.6m due to the current vacancy pressure and staffing difficulties.
- The Efficiency Programme had contributed £3.8m in month one against the 2019/20 plan of £17.1m.

MK enquired about the additional York/ Scarborough system savings to be made of £11m and how it was shown in the report. AB informed that the £11m savings target was split equally between the Trust and the two CCGs with each carrying a risk of £3.7m each. MK asked what would happen if the Trust succeeded in saving its share and the others did not. AB replied that it would not happen as all organisations share a one system cost reduction plan, and will share any savings achieved equally. MK asked what would happen if the Trust did not reach its control total due to not meeting the savings target. AB replied that it would only be a problem during the final quarter due to how the savings had been profiled in the plan, but he will know well in advance if that was going to happen.

JA stated that at Board last week they discussed how to get the £11m savings and the impact it will make, particularly on waiting lists for patients. Given the current situation, she was concerned that the budget for the admin and clerical staff group was increasing from £51m (last year's outcome) to the projected plan this year of £61m spend and asked why there was such an increase. AB replied that he did not know the cause of the 20% increase but would go away and investigate.

LM stated that clearly discussions had taken place to see how costs could be reduced and asked if there were some things that were shared which could be looked at, for instance from an IT network perspective. AB replied that: -

- from an internal position there were things that could be looked at such as going paperless and looking at the printing strategy which will contribute to the Trust's internal savings programme.
- from a system position IT will play a part in managing the outpatient strategy, and lead on systems to enable virtual consultations.

Over time savings will be made but the £11m saving needs to be made now so the Trust was looking for quick fixes to enable this.

MK asked about the cost to the Trust of storing records at warehouses, and what savings could be made if the Trust went paperless. AB replied that it would be a 7-figure sum. However, it would need everybody on board. LM asked what was needed to facilitate this. KB replied that there was an active work stream looking at this issue. To remove every bit

of paper was virtually impossible. It was a change in working practice, in mind set to go paperless and to ensure efficient workflow. He offered to bring a report to the next meeting to inform the Committee of progress.

Action: AB to investigate the increase in Admin & Clerical and senior management staff group budget to £61m.

Action: KB to bring report to next meeting around going paperless in the Trust.

Internal Audit Plan

JH explained that hopefully the documents were self-explanatory. For the 2019/20 financial year, two internal audit operational and strategic plans had been developed; one for the Trust and one for the LLP. He explained that an annual risk based assessment is undertaken which seeks to identify key areas of focus for the Trust and to provide assurance to the organisation through the Audit Committee. The total size of the combined plans have been assessed and reduced by 100 days in an attempt to align with other NHS organisations and contribute to the efficiency programme.

LM commented that it was a really good report, well laid out and very clear. She suggested that the IMT section be aligned to the Digital Strategy in the 5 year Trust Plan. JH replied that Strategic plan showed which high level areas were planned to audit over the next two years. This is revisited with all Executive leads annually and updated in response to changes to the organisation's risks and assurance requirements. He confirmed that he would be revisiting the IMT section with AS/KB and would have a revised operational plan for submission to the Audit Committee in March 2020 for approval.

JA made reference to the amount of internal audits that had taken place and thought it would be useful to emphasise to the Executives that when requesting audits they need to be really good value for money.

JH informed that they had started introducing quarterly meetings with Executives for forward planning to further agree the timings and scope of planned audit areas. The Committee spoke about the recent event with the waste management system. BG replied that the external suppliers had let them down and he hoped the LLP had safe systems in place. JA queried the value of the planned audit of waste management under the circumstances but BG felt it would be worthwhile for assurance purposes. LM suggested that JH return to the Committee in February prior to compiling the next operational plan for 2020/21.

Action: LP to add Internal Audit slot for progress update to be added to work programme.

National Cost Collection (Reference Costs)

AB gave an overview of the report and drew the Committee's attention to the fact that he had an obligation to ensure an appropriate committee was sighted on this work. He stated that the Board have reviewed the paper and they were happy for AB to sign off the submission of the Trust's reference costs.

MK referred to the index score that had moved up 2 points but still below the national average and asked why the Trust had a deficit whilst at the same time having a reference

cost score of below 100. AB advised that the reference costs were a reflection of the relative cost bases of different Trusts and not directly linked to tariff. This was illustrated by the vast majority of Trusts reporting a deficit position. AB speculated that a Trust would need a reference cost score of around 85 to deliver an income and expenditure balance.

The Committee noted that a new method would be introduced and were happy that the document will be ready for August when AB can sign off and submit.

Efficiency Report

SK informed the committee that the first month recurrent delivery of £3.8m of the £17m internal savings programme had been met. It was a positive start.

In terms of risks, there was a planning gap of £3.6m. It had been flagged by NHSI as a risk. They want a fully planned programme by the end of Quarter 1 which was currently being produced.

The other risk was the Care Group structure and the changeover in terms of the transition period. JA asked if he had been having performance meetings with the new Care Groups. SK replied that there was a programme of meetings arranged with the Care Group Directors and the Care Group Managers.

JA asked SK to explain the GIRFT work. SK explained the makeup of the GIRFT team and stated that it was still early days. He said Liz Hill, Directorate Manager of General Surgery & Urology, had been visited the most and feedback was around having to spend more which was frustrating as it did not support the efficiency element. In general, the programme is starting to turn its attention from quality improvement to efficiency which may be more helpful from the finance team perspective.

Digital Report

BAF Ref: 5 (Failure to maintain and develop IT), 2 (sustainability of services), 1 (patient safety/quality of care), 10 (partner engagement)

AS made reference to the report and stated that they had incorporated suggestions made at the last meeting. He advised that the Digital Strategy was being produced and will bring it to the next Committee meeting.

With regard to capital expenditure, the SNS capital spend allocation for 2019/20 was £1.8m. The focus of much of the capital spend was on reducing risk to the organisation by replacing equipment that will no longer be supported as well as ensuring that critical services have resilience built into them in order to reduce downtime.

At present there was not enough capital available to be able to achieve all the desired pieces of work and as a result a continual process of prioritisation was being performed in conjunction with the Operations team and managed through CPEG. Ideally, to expand services, like video, £3.2 million was needed.

AS informed that they had recently sent out a survey to users on how SNS can be improved. The survey has now closed and they were going through the feedback to ascertain what they can take from that.

With the formation of the Care Groups the SNS team were working with them to determine what was needed.

LM commented that it was a very good report and was looking forward to seeing the Digital Strategy to compliment that. With regard to appointment text reminders she asked if this was something that could be rolled out across the Trust to make immediate savings. KB replied that texting reminders were already in use. The next stage would be two-way communication where the patient could reply back. There were some technical issues before this could be achieved.

LM asked if the two-way text reminders would be piloted within a department or rolled out across the Trust. KB replied that this had not yet been explored.

LM suggested that it would be useful to have timescales so they would know when each phase will happen to give an indication of savings.

MK commented that he was pleased to see 500 laptops being distributed into Community Nursing. AS confirmed that roll out would commence at the end of June and completed by end of August. This was to ensure SNS could support the staff as they receive the equipment.

JA enquired about the Windows 10 changeover on all PCs by 2020 and asked if there were any risks attached. AS replied that 400 PCs needed to be replaced in order to upgrade to Windows 10. The timescale was also tight. However, they had received a letter from Microsoft explaining that they would be given support for a further year which would alleviate the pressure a little.

JA commented that it was a very good report and thanked AS/KB for their input. LM added that it was good to see plans to move to the Cloud and was looking forward to seeing how this progresses.

Action: AS/KB to bring Digital Strategy to next meeting in July.

Information Governance Executive Group

The Committee noted the minutes of the last Information Governance Executive Group and no matters were raised.

Reflections on meeting

What went well

- Papers were a good length and informative.
- Good to see a Digital Report and impressed by the content.
- Biscuits

Improvements

- Order of business could be rotated. Will change order of agenda regularly to ensure everybody has the same airtime.

Any other business

No other business was discussed.

Consideration of items to be escalated to the Board or Quality Committee

Items considered for escalation to the May Board meeting included: -

- Nurse staffing
- Gender pay gap
- Shortage of capital
- Review of BAF
- Going paperless
- Amended financial plan

Time and date of next meeting

The next meeting will be held on 31 July 2019 in the Boardroom York Hospital, Wigginton Road, York, YO31 8HE.

Action Log

Meeting Date	Action	Owner	Due Date	Completed
27.03.19 29.05.19	Explore “grass isn’t greener” follow up contact with leavers with new CN	PM	August 2019 or sooner	
27.03.19	Submit a report detailing the Trust’s long term financial performance and progression over the years	AB	July 2019	
29.05.19	Produce a report on Skype and Webex uses, pros and cons of each system and costs involved.	AS	July 2019	
29.05.19	Highlight new limited assurance audits in their report to the Committee.	Executives		
29.05.19	Bring backlog maintenance schedule and risk assessment to next meeting	BG	July 2019	
29.05.19	Investigate the increase in Admin & Clerical Staff Group budget to £61m.	AB	July 2019	
29.05.19	Bring report to next meeting around going paperless in the Trust.	KB	July 2019	
29.05.19	Internal Audit slot for progress update to be added to work programme	JH/LP	February 2020	
29.05.19	Bring Digital Strategy to next meeting.	AS/KB	July 2019	

Board of Directors – 31 July 2019

Home First 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	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input type="checkbox"/>		

Purpose of the Report

The purpose of the report is to provide the Board of Directors with an update in relation to the delivery of the Home First Strategy.

Executive Summary – Key Points

The report provides updates in three key areas:

1. The recent capacity and demand modelling of the health and social care system;
2. The community nursing workforce transformation programme;
3. Developments in mobile working, shared care records and pathway developments to support patients in the community.

Recommendation

The Board of Directors is asked to note the progress to date and discuss the contents of this report.

Author: Steve Reed, Head of Strategy

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: July 2019

1. Introduction and Background

The purpose of the report is to provide the Board of Directors with an update in relation to the delivery of the Home First Strategy.

The Home First Strategy has three key aims:

- Delivering integrated care in localities;
- Improving the interface between acute and community services;
- Moving pathways out of hospital settings into the community.

This is a regular report providing an update on successful changes that have been implemented and emerging risks to achieving the aims of the strategy.

2. Update since previous report

2.1 Modelling capacity and demand for health and care services in the City of York

Venn Consulting were commissioned by the City of York health and social care system to undertake a capacity and demand review. They have created a model based on data supplied by a wide range of providers together with point of prevalence reviews carried out between April and May. The reviews (led by health and care professionals from Venn) identified the needs of individuals who were currently using services (e.g. required bed-based care, nursing needs, therapy needs etc). This was used to quantify demand on the services available in the system and compared to the capacity available.

The headline feedback from their initial sharing of their findings highlighted that the biggest gap between their assessed 'need' and current capacity was in domiciliary care with 104 people on average requiring care but not able to access it. There was also an assessed gap of 16 people who require a care home placement who cannot access it at any given time.

The model then shows how this gap 'backs up' into the rest of the system – with people receiving a higher level of care or support than they require (for example a patient remaining in a community hospital bed who needs a package of care at home) – either due to people awaiting an assessment/decision about their needs or for the required service to be available. They found that the highest number of individuals who were 'backfilling' were in acute hospital wards (51 people on average), intermediate care beds (33 people on average) and intermediate care at home (16 people on average).

Their positive findings from the system include:

- the average length of stay in hospital is good, enabling the system to manage with fewer beds than would otherwise be required;
- 75% of patients in hospital need to be there (the best system they have reviewed was at 78%), so compared to other systems our acute beds are occupied by more people who need that level of care;
- long-term physical community health is in a stronger position than many systems;

- the Community Response Team are effective at supporting step-up care avoiding unnecessary admission.

The challenges they identified include:

- a significant challenge in long term care (home and bed based) – the recruitment challenge is amongst most difficult they have seen;
- pathway enhancements required, including between organisations (for example earlier discharge planning, more standardised discharge planning arrangements);
- the number of patients on fast track/end of life care in beds is higher than other systems;
- that more ward engagement is needed for the discharge hub (i.e. the model is right but communication needs to improve – since the review a ward allocation model has been introduced by the hub to address this);
- they found a high proportion of patients could be discharged without needing additional support on discharge – discharge earlier in the day would have a significant impact;
- the acute assessment areas are supporting flow from ED but absorb patients who require specialty wards;
- 31% of patients in short term services have multiple needs – highlighting the need for further development of a joined up intermediate care and reablement model.

The feedback from the Venn consultants is that York is a very constrained system – it is generally managing, through individuals in the system all going above and beyond to maintain flow despite the capacity constraints, but any pressure (a surge in demand, a ward closed or a care home closing) leads to a rapid crisis and a significant challenge to recover this.

Senior system leaders are reviewing the findings from the capacity and demand modelling and using this to agree priorities for improvement potentially including addressing the domiciliary care shortfall collaboratively and implementing pathways to ensure no permanent placements for care homes are made from hospital. As the review was commissioned through the Better Care Fund, the findings will also be reported back through the Health and Wellbeing Board.

2.2 Transforming the community nursing workforce

As described in previous updates, the transformation of the community nursing workforce continues. The programme aims are to improve the experience of patients supported by the service and the experience of staff working in the service. Recognising that the current workforce model is unsustainable (a third of nurses able to retire within five years), a proposed workforce model will see the development of roles from Band 2 to Band 8a, the implementation of geographical working aligned to primary care networks, the introduction of a 'nurse-in-charge' role for each team and a move to more balanced care delivery across the 24 hour period (rather than the current concentration of tasks being completed before lunchtime).

The transformation will result in significant changes to the skill mix of the community workforce but this is planned to take place over a two year period as existing staff leave and are replaced by new posts, including a number of nursing associate roles. The first stage of this has commenced in July with the introduction of a district nursing administrative service across all teams. This aims to reduce the time currently spent by clinical staff undertaking administrative tasks (previous audits show around a third of time is spent on administration), freeing them up for more face-to-face clinical contact time.

A formal consultation process is underway with community nursing staff regarding potential base moves required to move to the five geographical teams and moving to the new shift pattern. The process will close in August allowing confirmation of the next steps for the programme.

2.3 Other developments

There are a number of other developments taking place in out of hospital care.

The devices for mobile working have been purchased and are expected to be deployed during August. These will reduce the administrative burden on clinical staff in the community by not needing to maintain a duplicate paper and electronic record.

The development of shared care records will be a key enabler to integrating teams in the community around Primary Care Networks. July has seen the national release of a solution that allows the two main systems used in primary care (SystemOne and EMIS Web) to provide read-access to information held on each system. As community teams use SystemOne this means that community teams will be able to view information held by GPs using the EMIS Web system and vice versa. Community teams will also be supporting a pilot of shared care planning software for palliative care patients that can be accessed from the GP record, community record, CPD or the YAS record. The benefits of sharing access to records are improved patient safety, improved communication between teams and reduced duplication.

The community nursing team are working with commissioning colleagues and primary care to develop two new pathways to support patients in their home rather than requiring care in hospital. Introducing prophylactic antibiotics for patients with blocked catheters will reduce the incidence of urinary tract infections (and associated admissions). Delivering sub-cutaneous fluids in community settings will mean that patients, especially those with D&V, can be cared for at home rather than requiring admission to treat their dehydration.

3. Recommendations

The Board of Directors is asked to note the progress to date and discuss the contents of this report.



Board of Directors – 31 July 2019

Outpatient Transformation Programme Progress 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	<input checked="" type="checkbox"/>	For approval	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input type="checkbox"/>		

Purpose of the Report

The Board is asked to:

- Take note of the developments and changes taking place across the Trust relating to outpatients services
- Agree the Standard Operating Procedure and Policy documents in the appendix to this document
- Support the recommendations and actions set out in the document

Executive Summary – Key Points

This paper provides a brief update on five key development areas for Trust outpatient services. These are summarized below:

Removal of faxed and paper referrals

The Trust is already received 100% of its consultant referrals electronically. The aim is now to move all non-consultant led services to an electronic referral route. Two services have already gone live across both sites, with Allied Health Professional Services aiming to go-live in September 2019 – which on its own equates to over 1,500 referrals per week being processed electronically rather than on paper.

Outpatient clinic utilisation

A report was run looking at empty outpatient appointment slots. However, due to poor booking practice and errors in outpatient templates the dataset isn't of sufficient quality to allow the team to draw clear conclusions as to what needed to be done. Close work with the Hepatology service was completed to act as a case study and a suggested programme of work and training is suggested for Care Group leads to take forward.

Expansion of text message reminders

The Trust only sends around 20% of patients attending an outpatient appointment a text reminder prior to the clinic date. Investigations in this area showed that this was because the Trust had adopted an “opt-in” approach to receiving these reminders. Work with the Trust Information Governance teams has been completed and the Trust has now amended it’s “Fair Processing Notice” on it’s website to alert patients to the fact that if they provide a mobile phone number they may receive a text reminder.

Video consultation clinics

A number of pilot specialties have been agreed in Diabetes (both sites) and with Cancer Services (both sites), with a plan to commence the service in the Autumn, following the conclusion of financial and contracting arrangements with the preferred provider. This will help reduce DNA rates and act as a significantly more convenient service for patients.

Patient Initiated Follow Up

We want to encourage patients to take more ownership of their own care and condition. The PIFU process will see selected patients not received an automatic follow up appointment, but will allow them instead to book an appointment at short notice when they feel they need it. This will mean capacity is freed up in clinic for new patients, those waiting and for other urgent patients.

Further work

Following the roll out of these initiatives, the programme will switch attention to look at Paperlite clinics, Patient Portals and the Rapid Expert Input programme.

Recommendation

To support the content and recommendations within this paper.

Author: Mark Hindmarsh – Deputy Chief Operating Officer

Director Sponsor: Wendy Scott – Chief Operating Officer

Date: July 2019



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1. Introduction and context

In 2018 in excess of 860,000 outpatient attendances took place across the Trust – making outpatients the biggest patient facing service in the organisation. The added national focus on outpatients coupled with improvements in technology mean that there is a significant opportunity to change how the Trust goes about delivering outpatient services making them more patient centric, more efficient and tailored to clinical need.

The Trust Outpatient Transformation Programme was established in February 2019 and this paper summarises the main achievements of the work to date, areas that require support and describes changes the Board will see in how outpatient services are run over the rest of this year. The work has been a collaborative effort between many areas of the Trust and CCGs, and the programme will continue to report back on other initiatives during the Autumn.

2. Removal of faxed and paper referrals

Background and drivers

In line with national policy, all consultant led first OP appointments are now sent electronically with the Trust achieving 100% compliance in April 2018. All of these referrals arrive at the Trust via the Electronic Referral System or e-RS (previously known as Choose & Book).

Focus has now moved to non-consultant led referral areas with an aim to move these areas to 100% electronic referrals too – either by reflecting them on e-RS or via direct email addresses. There is national focus on achieving a paperless NHS but another main driver is the new GP contract which states that fax machine use should be discontinued from April 2020.

Progress to date

We have undertaken an assessment of the different areas that still receive paper referrals and whether e-RS/email is more suitable for those services. The outcome of the assessment is below, which lists the specialty and/or clinic and an initial assessment of whether it's felt the service can be reflected on e-RS or email.

Rapid Access Chest Pain referrals went live electronically in May 2019 and GP practices in VoY/SR/HRW and ERCCGs are now compliant with sending referrals to this service electronically. The Acute Knee referral pathway went live in June 2019.

Next areas of focus

- Allied Health Professional Services – scoping and mobilising rollout plan with an aim of go-live date in Q3 (this equates to over 1,500 referrals per month)
- Open Access Endoscopy – scoping – timescale tbc
- Trans Ischemic Attack (mini stroke) Clinics – Go-live September 2019

Going forward, the team will continue to work through the extensive list, prioritising those areas where referrals are received from GP Practices.

Area	Clinic	Suitable for e-RS
Breast	Breast screening	No
Cardiology	Rapid Access Chest Pain	LIVE
	Heart failure Open Access Echo Service Proforma	LIVE (VoY) SR TBC



	ECG Reporting	No
Child Health	Urgent Consultant of the week Clinic	No
	Neonatal transfer to Embrace	No
Gynecology	Early Pregnancy Assessment Unit (EPAU)	No
	Termination of Pregnancy (TOP)	No
Head & Neck	Tongue Tie from Community Midwives	No
Max Fax	Temporal Artery Biopsy	No
Ophthalmology	Urgent Referral Clinic (URC)	No
	Retinal Screening	Potentially
Stroke	TIA	September 2019
T&O	Fracture Clinic	No
	Acute Knee	LIVE
Waiting List	Express re-referrals direct for surgery	No
	Open Access Endoscopy	Potentially
Other	Children's Blood Test	No
	Continence Nurse	TBC
	Paediatrics Physio	No
	Women's Unit - appliance unit	Potentially
	Pulmonary rehab	TBC
	Private Patients Unit (private refs)	No
AHP (VOY only)	Dietetics	September 2019
	Occupational Therapy	September 2019
	Speech & Language Therapy	No
	MSK service	September 2019
	Orthotics	September 2019

3. Outpatient clinic utilisation

Background and drivers

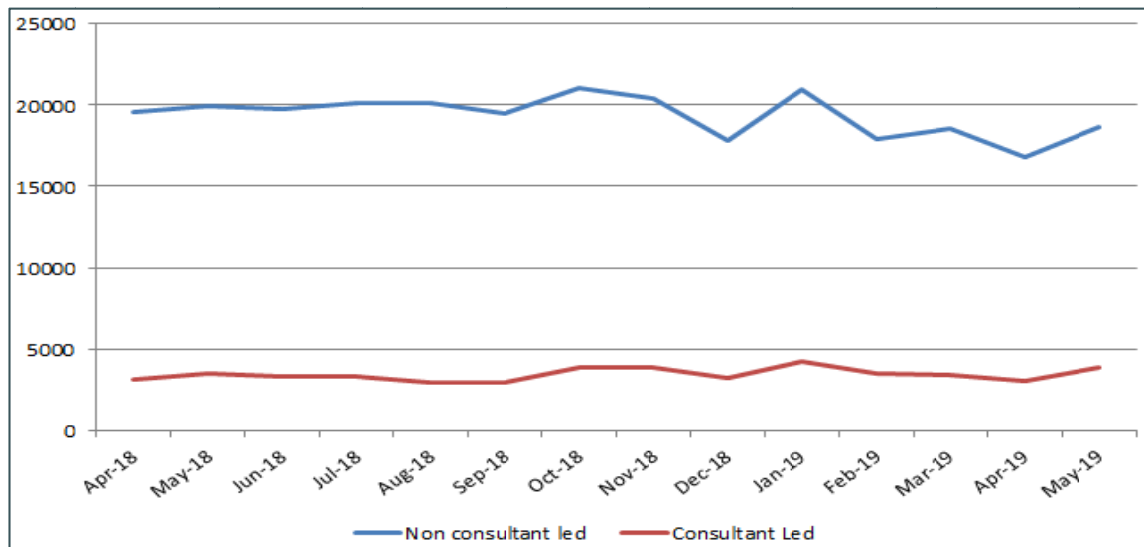
Across all areas, the Trust is constantly striving to improve the efficiency and utilisation of its services, in order to drive down patients waits and to contribute to the Trust efficiency programme. The amount of activity taking place in outpatients means that the opportunity is huge, but given and the number of locations and individuals involved in delivering outpatient services delivering real measurable improvements is challenging.

Progress to date

At the outset of the work, a simple dataset was requested showing the number of empty (unbooked) slots in outpatient clinics in the month just past. This dataset is set out below:

Chart 1. Number of empty (unbooked) slots in non-consultant led and consultant led outpatient clinics by month for all Trust sites.





The data demonstrated that there were approaching 20,000 non-consultant led empty slots per month and around 4,000 empty slots per month in all consultant led clinics. However, further analysis has demonstrated that this apparent “empty” capacity in actuality is not real, and needs to be taken in the context of:

- Thousands of patients are “overbooked” onto clinic templates
- Some appointment slots are double and triple booked
- Some templates are simply built incorrectly meaning slots are showing that never really existed
- Some templates included in the data are now obsolete and refer, in some cases, to members of staff who no longer work for the Trust.

During this time, the Trust patient access team have also revised and updated all of their Standard Operating Procedures for the booking and management of clinics. These require a formal launch and roll out.

The project team have worked extensively with the Hepatology service to rectify these issues and provide a case study and for all to use in future and helped form a actions for Care Groups to take forward.

Actions required

There are two actions required, to be taken forward by Care Group and specialty leads:

- Every outpatient template in the whole organisation should be validated and checked for accuracy so that only real available capacity is showing
- All staff who book appointments need to be properly trained against the updated Trust Standard Operating Procedures.

Support requested

The Board are requested to support the above actions so they can be taken forward with Care Group Management teams in the new Care Group structures.

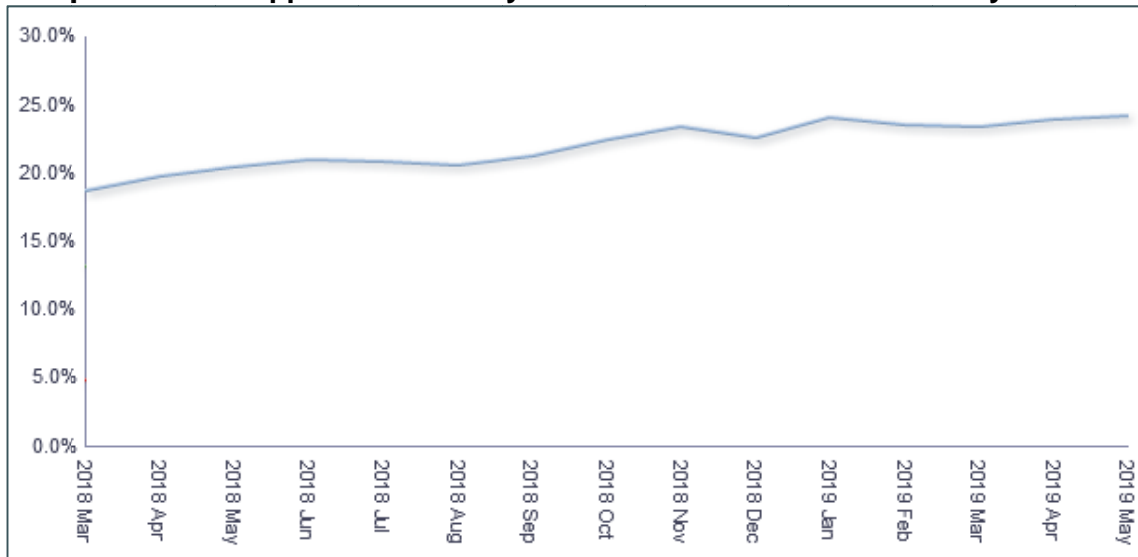
4. Expansion of text message reminders

Background

The proportion of patients with an outpatient appointment who receive a text message reminder prior to their appointment has only been increasing gradually across the Trust since the

introduction of the reminder service around 2 years ago. The most recent data set is shown below and demonstrates that around 23% of patients attending clinic received a reminder in May 2019.

Chart 2. Proportion of patients with an outpatient appointment who received a text message reminder prior to their appointment at any Trust site from March 2018 to May 2019.



Further investigation into why this number wasn't increasing more rapidly highlighted that the Trust was operating an "opt-in" system for patients into this system. Upon attendance at clinic patients were being asked if they would like to receive a text reminder in future meaning that the majority of new patients were not being sent a text and that the default position was that only patients with a follow-up appointment who had opted in were getting a reminder.

Progress to date

The Trust Information Controller and Information Governance Lead has reviewed this process in the light of the new General Data Protection Regulations (GDPR). The conclusion of this review was that we can contact people as part of delivering their care, using their mobile phone number as there is implied consent to do so when this information is initially provided.

In effect this means that the Trust can shift to operating an "opt-out" process for text message reminders. In June 2019 the Trust Information Governance Executive Group signed off a change to the Trust's Fair Processing Notice (which is available on the main [Trust website](#)) that now states:

***"Appointment reminders** - Patients who have given their mobile phone number as a contact point will receive a text message reminder for any hospital appointment that they have."*

It should be noted, that on clinical and privacy grounds patients in some specific clinics have already been excluded from receiving a text message reminder and this will remain the case.

Actions required

- Update the technical link between CPD and the text message reminder software so that any patient for whom the Trust has a mobile number and a future outpatient appointment will receive a text message
- Brief administrative staff working in all patient facing areas to continue to collect patient mobile phone numbers

Support requested

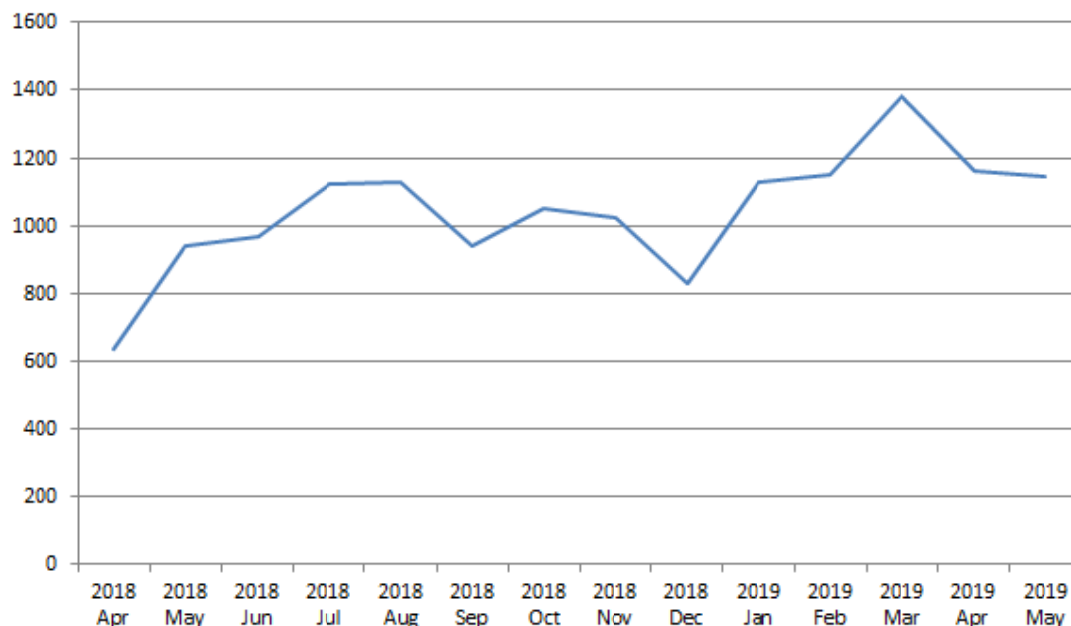
The Board is requested to support and approve the expansion of outpatient text message reminders and the updated Fair Processing Notice.

5. Video Consultation Clinics

Background

The NHS Long Term Plan has set aspirations for the NHS to reduce the number of face-to-face outpatient appointments by up to a third over the next five years. The Trust currently provide telephone and virtual clinic appointments and the most recent data set shown below demonstrates that over the past year, the Trust has steadily increased the number of non-face to face appointments to double what was recorded in April 2018.

Chart 2. Number of Non-face to face Appointments at York Trust by month from May 2018 – May 2019



In order to achieve the goal of one third reduction, the Trust has identified an opportunity to increase uptake of non-face to face appointments with the introduction of video-consultation (VC) in Diabetes and Cancer Services, across sites. The Trust already has a relationship with an organisation called Refero who could deliver this service for a pilot instance and the software they utilise also has the capability to integrate directly with CPD in the future.

Progress to Date

Responsible Clinicians have been selected in those pilot services where uptake is likely to be high and patient benefit is expected to be great. The areas will be:

- Diabetes – York Hospital
- Diabetes – Scarborough Hospital
- Cancer Services – York & Scarborough Hospital

Key requirements have been discussed with stakeholders and this has formed the baseline discussions with the potential VC provider. Locations for conducting VC from both sites have been



identified and assessed for hardware and network requirements. The booking process and governance have been drafted and available in Appendices 2. Clinical criteria is being established to ensure patient suitability for VC.

Next Steps

Detailed measurement plan to be created and involve work with the Patient Experience Team to create patient/ Clinician survey to gather feedback and measure level of improvement. Patient communication plan is to be finalised with the Communications Team, to include patient leaflet and customized virtual waiting room etc. Pending completion of above actions and securing contracts with VC provider, target go-live is w/c 12 August 2019 for Diabetes York and the other services to follow after.

Support Requested

The Board is requested to support the implementation of video-consultation and approve the process document in Appendix 1.

6. Patient Initiated Follow Up (PIFU)

Background

To support national focus in increasing uptake of alternatives to traditional face to face clinic models of care, the Trust is developing a Patient Initiated Follow-Up (PIFU) pathway. PIFU puts selected patients in control of making an appointment when they need it the most and provides them with direct access to guidance when they decide they need it. Instead of being offered regular clinic visits and routine check-ups with their consultant (e.g. at annual or 6 monthly or annual intervals), PIFU patients can make an appointment only when they need it, e.g. when experiencing a flare-up of their condition.

With the introduction of PIFU, we aim to reduce the number of unnecessary visits for selected patients and the added anxiety, travel and time they often experience when attending regular follow-ups. This reduction in visits will in turn free capacity to be used to reduce backlogs for routine patients and will open appointments for those patients that need it most. Importantly, it will also encourage patients to take more active care of their own condition and manage their own health.

Progress to Date

Due to the nature of certain rheumatoid conditions which result in often long-term FU plans, Rheumatology has been selected to trial this new pathway, across sites. CPD developments will be required to enable patient selection and identification, but also to provide a robust platform for monitoring and managing patients on the PIFU list. Pre-development diagnostic has been completed and required work estimated to take 10-15 working days plus 3 x days testing – estimated go-live w/c 02 September 2019.

Clinical criteria has been established to ensure robust patient selection and minimize risk of inappropriate pathway use. Capacity planning is to be undertaken once new Care Group appointments are complete, this will ensure required capacity is available to support PIFU pathway. Working with the Communications Team, we need to finalise the communication with Primary Care to address any anticipated impact, though this is expected to be minimal for Primary Care.

Support Requested

The Board is requested to support the expansion of our follow up pathways by the introduction of PIFU and approve the patient information leaflet Appendices 2.



7. Other areas of work in 2019

Once signed off and agreed, the policies and governance arrangements set out in this document can and should be used by areas across the Trust who want to develop outpatient services in this way too. The utility of video consultations and PIFU is wide and the pilot schemes outlined in this document form the basis for the Trust to continue to develop other areas along these lines.

Once the pilots are underway, the next areas of focus for the Trust's Outpatients programme will include:

- Paperlite Outpatient Clinics
- Development of Online Patient Portals
- Rapid Expert Input – changes to how all areas manage referrals and interact with primary care



Appendix

Video Consultation – Standard Operating Procedure

Introduction

This document has been created to support the administration of video-consultation appointments via the Refero instance.

Who will be offered Video-Consultation

Video-Consultation will be piloted in Diabetes Outpatients and Cancer Services using the Refero software. Any patient deemed clinically appropriate may be offered the opportunity to receive their follow-up consultation via video, ensuring the patient has consented. Particular attention should be paid to vulnerable patients/ patients with a safeguarding flag, see Video-Consultation Clinical Criteria for further clarification on patient selection. Options should be discussed with the patient/ family/ carers and the patient information leaflet shared, explaining their options and how to set up the video clinic.

Patient Consent

Verbal consent should be obtained and recorded on CPD. The patient's e-mail address should be recorded and verified on CPD as per E-mail verification SOP and a test Video-Consultation link sent to patient.

System Requirements

Trust Service User Requirements

The service user will require the following in order to conduct a video-consultation:

- A Trust standard PC or laptop is recommended (Trust tablet device can also be used)
- An additional monitor may be useful to allow CPD access and holding the video-consultation at the same time
- Camera and microphone if not already built into device

Patient requirements

The patient will require the following in order to conduct a video-consultation:

- A suitable device for conducting video-calls, i.e. smartphone, tablet or PC/ laptop with a webcam and microphone)
- Wi-Fi internet connection is recommended or 3G/ 4G mobile connection is sufficient
- An e-mail address for the appointment link to be sent or account created on the Refero app

Email Governance

The patient will be sent a verification e-mail when they first register for video-consultation. Responding to this e-mail will imply patient consent to conduct consultation via video. Patient e-mail address details should be stored on CPD.

Booking/ Rescheduling Video-Consultation



During the pilot, the video-consultation booking will need to be booked via both CPD and the Refero link. The video-consultation appointment should be booked into a dedicated VC slot within a standard outpatient clinic template to ensure clinic notes are prepared as per protocol for that service. Note that VC slots will be subject to standard text reminder service rules if based within a clinic that has text reminders enabled.

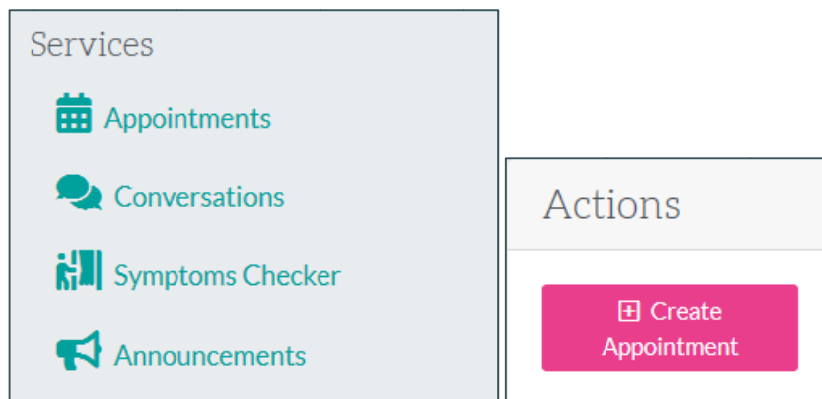
Booking VC Appointment

CPD:

- Patient identified for VC appointment via Clinician clinic outcome
- Assign relevant clinics on and book VC appointment on CPD as per usual booking process using 'VCFU' slot
- It is not necessary to send an appointment letter as the patient will receive an email appointment confirmation

Refero:

- Log-in to Refero site using receptionist log-in (speak to your supervisor if unsure of log-in details)
- Select 'Appointments' and 'Create Appointment'



- This will display the below page, complete the below details to mirror the appointment already created on CPD:
 - *Type*
 - *Reason/ Purpose*
 - *Appointment Date/ Time*
 - *Host (which Clinician to be booked with)*
 - *Attendee (Select appropriate patient)*



New Appointment

Appointment Details

<p>Type: *</p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">- Select appointment type - ▼</div>	<p>Reason/Purpose:</p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">Situation check up</div>
<p>Location</p> <div style="border: 1px solid #ccc; height: 20px; margin-bottom: 5px;"></div>	<p>Appointment Date / Time:</p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">24/06/2019 11:30 AM 📅</div>
<p>Host: *</p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">- Select appointment Host - ▼</div>	
<p>Attendee: *</p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">- Select appointment Attendee - ▼</div>	

Create

- Check all details are correct against CPD appointment and the clinic outcome and select 'Create' to confirm appointment booking
- This will send an e-mail confirmation to the patient – there is no need to send an additional appointment letter?

Cancelling/ Changing VC Appointments

CPD:

- Reschedule the VC appointment on CPD as per usual booking process, ensure the appointment is rebooked into an appropriate VC slot 'VCFU'
- Do not send an appointment letter, the patient will be sent an e-mail confirmation when booked through Refero

Refero:

- Log-in to Refero site using receptionist log-in (speak to your supervisor if unsure of log-in details)
- Select 'Appointments' to access the full list of scheduled VC appointments



Appointments

Your Appointments
 You currently have no appointments for yourself.

Surgery Appointments

Host	Attendees	When	
Dr Emmett Brown	Mr Marty McFly	Today - 11:40 (am)	

- Identify the relevant appointment to reschedule, check date/ time/ patient details and responsible Clinician before rescheduling

- Once identified, select 'Edit' →



- This will display the below booking page, edit the necessary details to mirror the rescheduled appointment created on CPD:
 - *Type*
 - *Reason/ Purpose*
 - *Appointment Date/ Time*
 - *Host (which Clinician to be booked with)*
 - *Attendee (Select appropriate patient)*

New Appointment

Appointment Details

Type: *

Reason/Purpose:

Location

Appointment Date / Time:

Host: *

Attendee: *

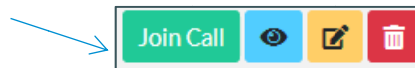
- Check all details are correct against CPD appointment and select 'Update' to confirm appointment rescheduling



- This will send an e-mail confirmation to the patient

Conducting Video-Consultation

- Clinician log-in to Refero site using individual Clinician log-in (speak to your supervisor if unsure of log-in details)
- You will be notified on Refero when a patient has checked in to the virtual waiting room and the 'Join Call' function will present next to the relevant patient



- Identify the correct patient on Refero and select 'Join Call'
- Introduce yourself, confirm the patient's identity as per usual identification procedures (i.e. name, address, DOB)
- Identify anyone else who may be with the patient and confirm who is present at the video-consultation
- Confirm the patient is in a confidential location and obtain verbal consent to continue consultation via video
- Advise the patient that their video-consultation will not be recorded and they should refrain from recording the consultation also
- Conduct video-consultation as normal

NOTE: Should you experience connectivity issues during the video-consultation that cannot be resolved, you should phone the patient and offer to continue consultation over telephone or reschedule for another VC or face-to-face appointment if necessary.

Recording the outcome of the Video-Consultation

- Record clinic outcomes on CPD as per standard face-to-face process
- At the end of the consultation, discuss the patient's preference for any follow-up appointments and ensure this is stated in CPD clinic outcome as to whether this is to be video or face-to-face
- The clinic outcome will present on the administrative worklist as usual, for the booking team to action



Feedback

Upon completing the consultation and disconnecting the video, both patient and Clinician will be prompted with a survey to gather feedback on their experience and suitability. This information will be accessed via the Patient Experience Team.

System Issues

If you experience any system issues, please contact the Service Desk:



Ex:772 5000 (External: 01904 725000)



E-Mail: service.desk@york.nhs.uk



Patient Initiated Follow-Up – Patient Information Leaflet

Rheumatology Patient-Initiated Follow-Up (PIFU)

Patient Information Leaflet

① For more information, please contact:
01904 726400



What is Patient Initiated Follow-Up (PIFU)?

Patient Initiated Follow-Up (PIFU) puts you in control of making an appointment when you need it the most and provides you with direct access to guidance when you need. The majority of patients with stable long term conditions do not require regular follow up by the hospital team and research has shown that regular visits do not help to prevent your condition returning or identify new problems.

Instead of being offered regular clinic visits and routine check-ups with your consultant, PIFU patients can make their own appointment only when they need it e.g. when you experience a flare-up of your condition – reducing the unnecessary anxiety, travel and time spent waiting for a routine follow-up.

How does it work?

Following your next clinic appointment, you will be advised by your Consultant if your condition is now suitable to have your follow-ups as patient initiated instead of the regular appointments scheduled by the hospital.

Your Consultant will have discussed the process with you and your suitability and provided you with this leaflet to consider your options. Managing your appointments in this way is optional and it is your decision.

How do I book a patient initiated follow up appointment?

The service is quick and easy to use; if you experience a flare-up, call the number on your trigger card/ this leaflet and explain to the team that you are experiencing a flare-up and you need to be seen. The team will agree a suitable appointment date/ time over the phone with you, within the next 14 working days. Please note that the operator cannot give any clinical advice.

Following your appointment, your Consultant will discuss with you to remain on Patient Initiated Follow-Up or revert to regular appointments - it's your decision again.

Please remember, it is important that you are available for your appointment. If you find you are unable to attend, please tell us in advance so we can try to give your appointment to someone else who needs it.

When should I call for a PIFU?

You should call the PIFU line if you are experiencing a flare-up of your condition and need to be seen within the next 14 working days. Your trigger card will highlight symptoms to look out for to help you decide when you need to contact us.

When not to use PIFU

If you require urgent medical advice you should contact your GP or NHS 111, or if you are really unwell, your local Emergency Department (A&E). For all other concerns, or if you are feeling unwell, your GP remains your first point of contact.



Will you still be looking after me if I do not call for a PIFU?

Yes, we will contact you to arrange a follow-up appointment if you have not contacted us after a set timescale, this will be between 1-2 years (depending on your condition). Your Consultant will agree and set this timescale during your clinic appointment depending on your condition.

If you have any concerns associated with your condition, but not a flare up, you can contact the Rheumatology Advice Line on 01904 721854.

What if I am worried and change my mind about this style of follow-up?

Some patients express concern about losing regular contact with the hospital. Everyone has different feelings when they no longer need to be seen regularly by their medical team. If you wish to go back to booking regular hospital appointments, just tell us and we will arrange this for you.

Feedback

We appreciate and encourage feedback. If you need advice or are concerned about any aspect of care or treatment, please speak to a member of staff or contact PALS on 01904 726262 or e-mail: pals@york.nhs.uk.



Care Group Governance & Assurance Arrangements for the Management of Follow Up Partial Booking Patients

Introduction

This document has been created to support the monitoring and management of Follow-Up Partial Booking (FUPB) lists, addressing those patients that have exceeded maximum wait time (Section 1) and improving long-term maintenance (Section 2).

Purpose of this document:

- To align and standardise FUPB processes across the Trust
- To reduce the number of patients on FUPB lists exceeding their allocated wait time
- Clarify the responsibilities of all parties involved with the monitoring and management of patients on a FUPB list
- Identify the support tools available
- Ensure patients are seen in a timely manner as per RTT policy and avoid delays to Follow-Up care

Support tools available:

- Signal FUPB Dashboard
- CPD Report [FUPBLIST]
- Slot-Free Report

Responsibilities:

- It is the responsibility of each Care Group to monitor FUPB lists and have an awareness of the current status of all their patients on the list
- Care Groups should be actively working to reduce the number of patients who have exceeded their allocated wait time and maintain acceptable standards on FUPB lists
- Care Groups are to establish management and administrative lead persons who are responsible for performing FUPB tasks (Outpatient Services or Independent resource) on behalf of the care group
- It is then the responsibility of that team to perform the FUPB tasks as per Outpatient Services Standard Operating Procedure (SOP)
- Where administrative support to perform FUPB task is provided by Outpatient Services, overall responsibility remains with the Care Group to monitor the FUPB lists and have an awareness of current status
- It is the responsibility of each Care Group to inform the Clinic Managers and Service Desk when a Consultant or Locum leave the Trust, so outstanding FUPB entries can be transferred accordingly
- Administrative teams should apply Outpatient Services SOP when actioning FUPB to ensure patients are safely managed through the process
- Establish clear admin time within Clinicians job plan for addressing FUPB patients that have exceeded allocated wait time
- FUPB dashboard to be accessed by Care Group Management lead on a weekly basis to identify patients who have exceeded allocated wait time

Patients Exceeding Allocated Wait Time

As a priority, Care Groups are to orchestrate a clinical review, either the responsible Consultant or nominated Clinical Lead, of patients who have exceeded maximum wait times. Individual services



within the Care Group will need to agree the overdue threshold that when reached, triggers a clinical review.

Those patients waiting in excess of 6 months of their allocated wait time should automatically receive a review, prioritising the longest waiting patient first. Remaining overdue lists should then be managed in chronological order, reviewing longest overdue patients first. This process should be overseen by the designated Care Group Management Lead for FUPB.

- Deputy Care Group Manager will add any patient safety risks, associated with overdue FUPB, to the Directorate Risk Log
- Care Groups are to address capacity issues relating to overdue FUPB lists and ensure capacity can be provided for administrative support
- Any additional capacity should be requested and provided in a timely manner as per Service Level Agreement (SLA), with clear instruction for its intended purpose

On-going Maintenance

FUPB lists should be monitored on a weekly basis to ensure they are well maintained and allow early detection of any patients that may exceed their allocated wait time.

- Administrative teams are to action the FUPB list as per the Outpatient Services Standard Operating Procedure. This process should be overseen by the responsible Care Group Manager.
- Administrative teams are to escalate any capacity issues, relating to placing patients within requested timeframe, to responsible Care Group management lead
- Care Groups are to address capacity barriers restricting the maintenance of FUPB lists and ensure capacity can be provided for administrative function
- Any additional capacity should be requested and provided in a timely manner as per Service Level Agreement (SLA), with clear instruction for its intended purpose



Responsibilities

Care Group Management Lead

- Identify responsible admin lead
- Monitor FUPB status via signal
- Ensure sufficient capacity to place FUPB
- Allocate Clinician admin time for FUPB review
- Orchestrate FUPB review for exceeded wait times
- Document patient safety risks in the Directorate Safety Log

Admin Lead

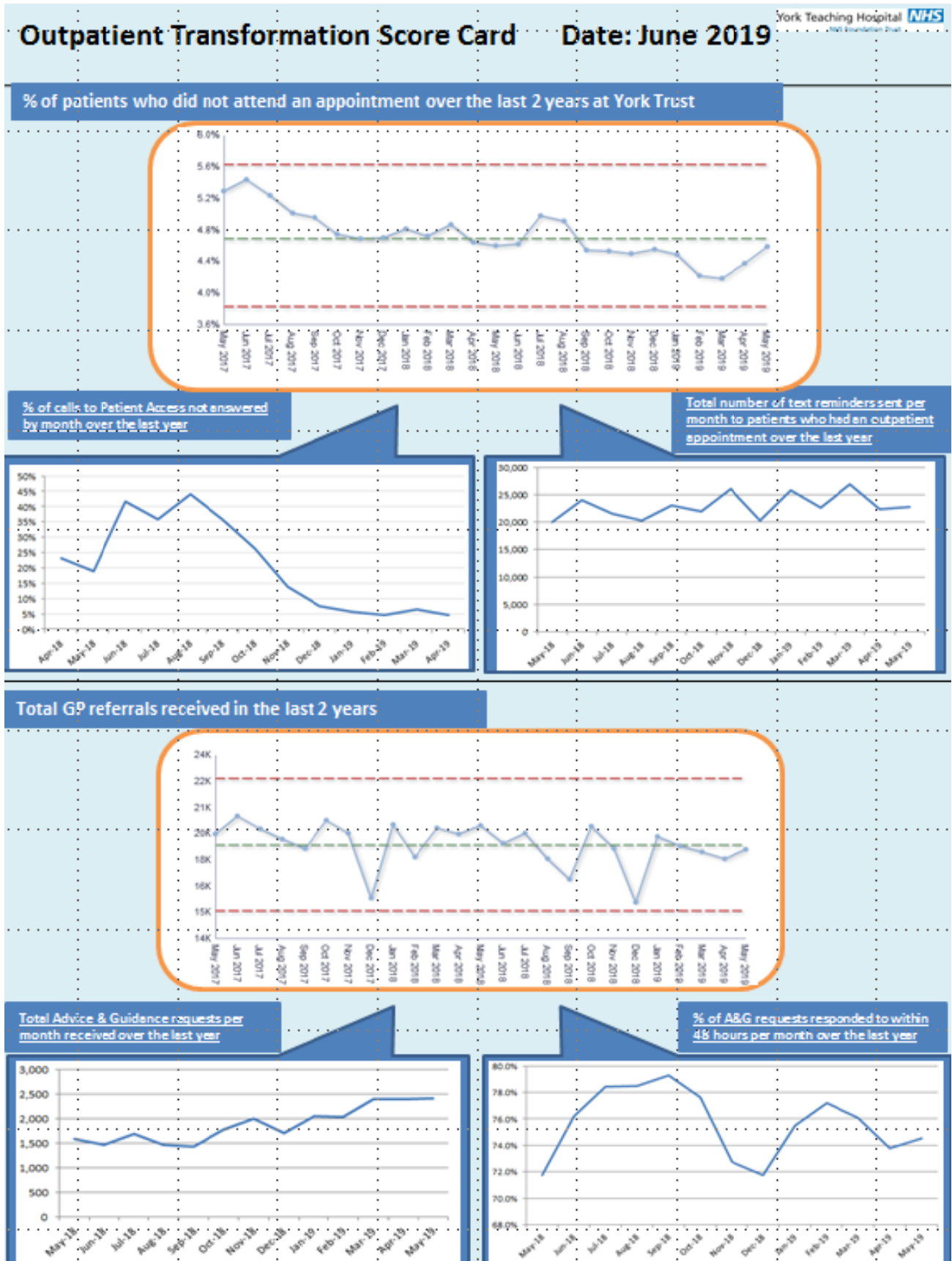
- Allocate admin time to perform FUPB
- Perform FUPB admin task
- Escalate exceeded wait times to DCGM

Responsible Clinician

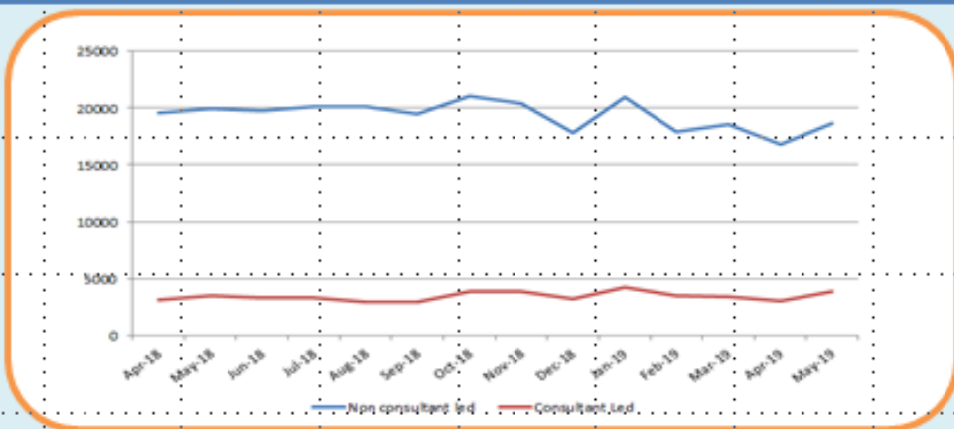
- Review FUPB exceeded wait times
- Escalate time constraints/ review issues to DCGM for logging in Directorate Safety Log



Outpatient Dashboard

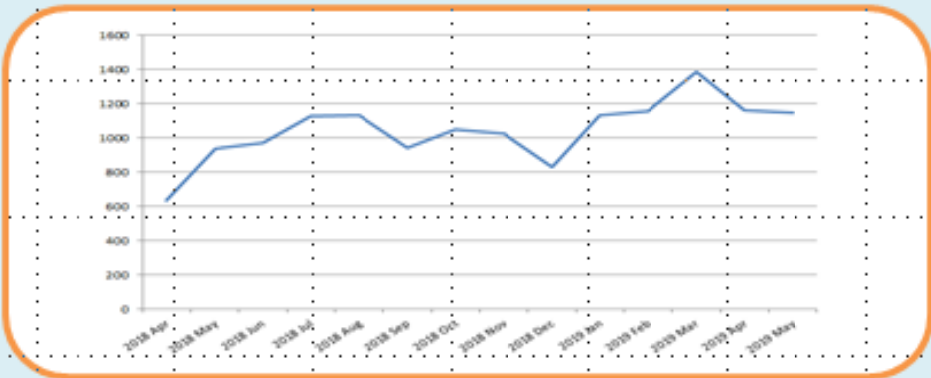


Number of empty appointment slots for all outpatient clinics at York Trust per month over the last year

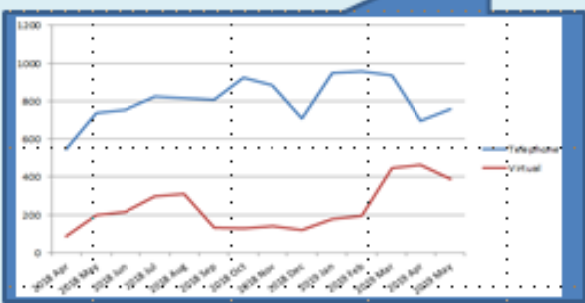


- Suggested inputs could include:
- Number of validated templates
 - Number of people trained on new booking rules
 - Number of patients receiving short notice appointment offers

Number of non-face to face appointments at York Trust by month over the last year



Split of virtual and phone appointments at York Trust by month over the last year



- Suggested inputs could include:
- Number of patients on Patient Initiated Follow Up (PIFU) list



Board of Directors – 31 July 2019

Freedom to Speak Up Guardian Bi-Annual Report January – June 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	<input checked="" type="checkbox"/>	For approval	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>		

Purpose of the Report

To update the Board of Directors on Freedom to Speak Up culture in the organisation by reviewing data, trends, themes and outcomes.

Executive Summary – Key Points

The overall number of concerns is decreasing however, patient safety concerns are increasing. Includes examples of good speaking up culture and where this needs improving.

Recommendation

1. Note the increase in patient safety concerns being raised.
2. Approve that all staff that have undergone the line manager training use their reflective diaries as part of their appraisal to demonstrate positive behaviours and compassionate leadership.

Author: Lisa Smith, Freedom to Speak up Guardian

Director Sponsor: Mike Proctor, Chief Executive

Date: June 2019

1. Introduction and Background

This is the bi-annual report to the Board to update on national and regional information regarding the 'Freedom to Speak Up' agenda and to provide data and information on the Trust's speaking up culture, drawing comparisons from the previous six months data.

2. Detail of Report and Assurance

2.1 National picture

The National Guardian's Office (NGO) has just completed its latest case review at Brighton and Sussex University Hospitals Trust. All the recommendations from case reviews are discussed at the Fairness Champion Steering Group meetings as a standing agenda item.

The NGO has been recruiting seven 'Regional Liaison Leads' to develop the freedom to speak up agenda in primary care and learn from the experience in hospital Trusts.

The Trust Freedom to Speak Up Guardian (FTSUG) attended the 'Pan Sector' meeting in June which was hosted in London by ACAS; the meeting focused on 'non-disclosure agreements' and lessons from other sectors.

The NGO publishes quarterly data on speaking up information from 227 hospital Trusts across England.

Trust (Q2 2018/19) compared to some Q2 national data:

	Anonymous cases	NGO Category Elements of Bullying / Behaviours	Patient Safety/Quality	Doctors Speaking Up
Trust data	1 case	57% <i>(this includes all elements of behaviour/relationships concerns as well as bullying and harassment)</i>	24%	19%
National data	15%	39%	27%	8%

This is a shift from the previous 6 months where 77% of concerns were related to elements of bullying/behaviour and only 13% accounted for patient safety concerns.



2.2 Regionally

The Trust FTSUG was invited to be on the interview panel along with the CEO and a Director for the appointment of a FTSUG for Yorkshire Ambulance Service.

Yorkshire and Humber FTSUG network continues to meet every two months which the Trust FTSUG attends and also continues to support a number of peers in neighbouring Trusts via the 'buddy' system.

2.3 Locally making a difference

2.3.1 Example of a freedom to speak up case

A senior clinician contacted the FTSUG via email on 11/04/19 to raise concerns regarding the Electronic Prescribing and Medicines Administration (ePMA) which involved concerns about lack of staff engagement, poor communication and potential patient safety risks which had been previously raised via the line management structure but no action taken to address them.

Date	Description
11/04/19	FTSUG replied to the staff member asking for further details
14/04/19	Copies of previous correspondence regarding concerns shared with FTSUG
17/04/19	FTSUG and staff member met to discuss next steps
18/04/19	FTSUG sent email to senior management team outlining staff concerns
18/04/19	Response from manager with explanation of current action
19/04/19	FTSUG shared response with staff member
23/04/19	Staff member response was they felt this still wasn't being taken seriously or addressed appropriately
10/05/19	FTSUG escalated to senior manager
13/05/19	FTSUG and senior management team met to discuss and agree an action plan, which included a much more open and transparent communication and a positive way to engage with staff to listen to concerns over ePMA
14/05/19	Plan shared with staff member response
04/07/19	Staff member emailed FTSUG: <i>"Thought you might like some positive feedback following the concern I raised about epma and communication as a new newsletter for epma has been sent round today so it looks like they have listened. Thanks again for your help and support with this issue."</i>



2.3.2 Fairness Champions

The Fairness Champion Steering Group has reviewed and updated the Terms of Reference for both the Steering Group and the Fairness Champion role.

A further eleven Fairness Champions were recruited in 2018; four have now left the Trust. This means there are now 37 Fairness Champions who have been through induction and 3 more have been interviewed and are awaiting induction. Additionally we have an advance 'waiting list' of several individuals who wish to be considered should we run a future recruitment campaign.

In February, we launched our Fairness Champion experience survey – issued after each request for support – which we hoped would help tackle the issue of under reporting. Two have been returned to date. We have also instigated 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.

In the last six months there have been 16 requests for support (or 'cases') recorded of which six are currently open. These cases are NOT included in the FTSUG quarterly return to the NGO.

The most prevalent themes are bullying / harassment issues followed by sickness absence, stress and management behaviours.

Theme	%
Bullying / Harassment	42.86%
Sickness absence	14.29%
Stress	14.29%
Management behaviours	14.29%
Policies, procedures and processes	7.14%
HR issues	7.14%
Total	100%

- At 36% of all cases, the staff group most frequently requesting support is 'Administrative and Clerical' followed by Estates & Ancillary at 29%
- Thirteen have been referred to the Freedom to Speak Up Guardian from Fairness Champions
- Only five cases have been requests for Fairness Champion support at a formal meeting
- The average amount of time spent on each contact is 39.75 minutes
- The FTSU G has referred 5 cases to the fairness champions.



2.3.3 Education and training

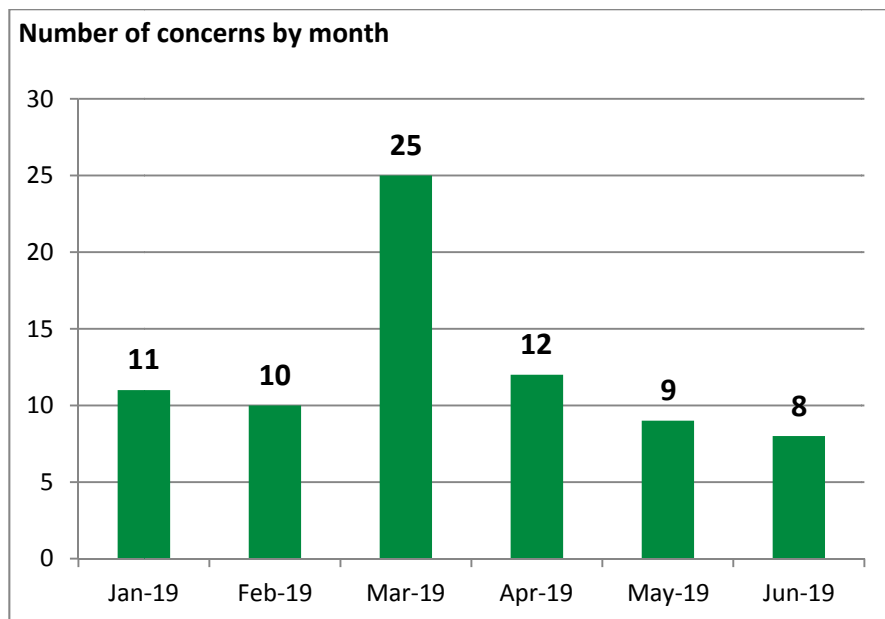
The plan for new management training course which focuses on how to challenge inappropriate behaviours and create an open and supportive culture is for this to be cascaded out in bespoke sessions for care group staff throughout 2019. Feedback from the course remains extremely positive and behaviour change is being evaluated through reflective diaries which could be used in staff appraisals to help monitor the impact of the training.

2.3.3 Schwartz Rounds

“Schwartz Rounds” were introduced into the organisation in 2016/17. The FTSUG is an active member of the steering committee, and to mark Speak Up month, in October we delivered the Round “When I spoke up” which was then later featured in the national bulletin from the NGO.

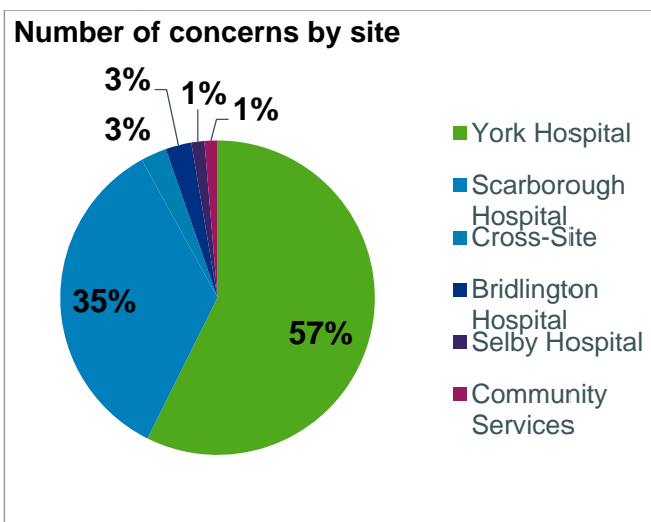
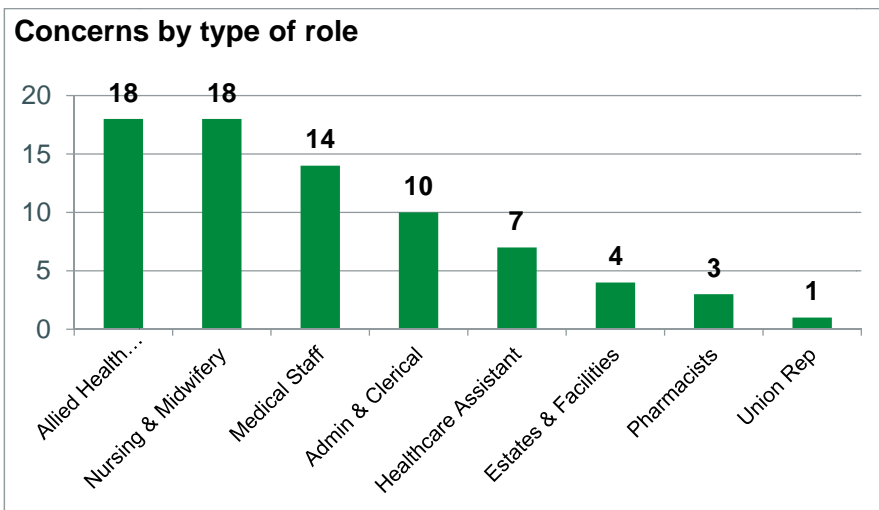
2.4 Concerns

The total amount of concerns raised during the last 6 months was 75, meaning the average monthly contacts with the FTSUG were 12.5 per month compared to 19 per month for the previous 6 months.



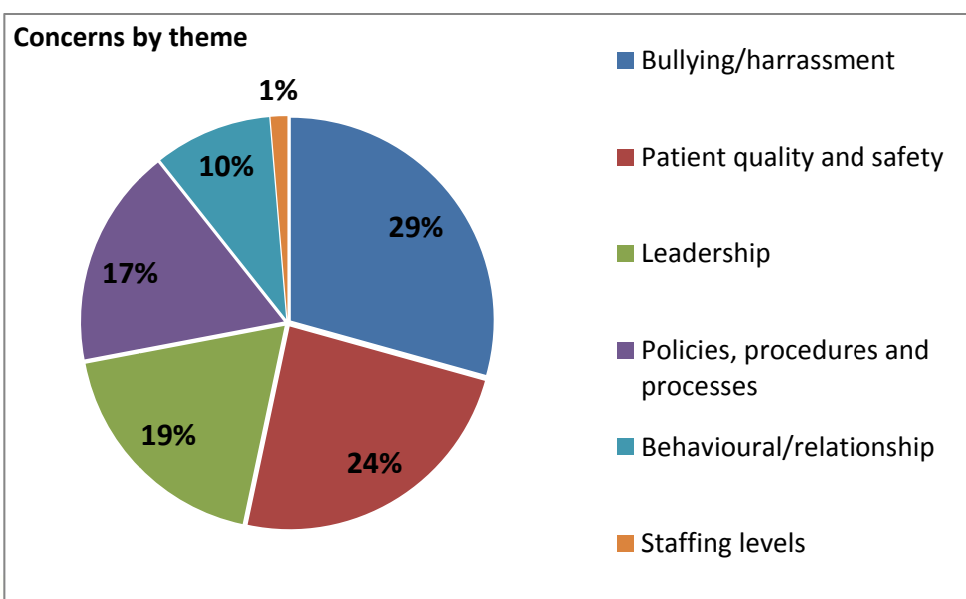
In March, listening exercises were held with Radiology staff which accounted for 10 staff and also with Special Care Baby Unit in Scarborough which accounted for 6 staff. This accounts for the high numbers in March. As per NGO guidance these have to be recorded as individual speak ups to ensure consistent approach to reporting and to gain individual feedback on the experience of speaking up which will be different for each member of staff.

The number of doctors raising concerns remains high compared to national data which is a positive impact of the dual role of the FTSUG and the trust Guardian of Safe Working.

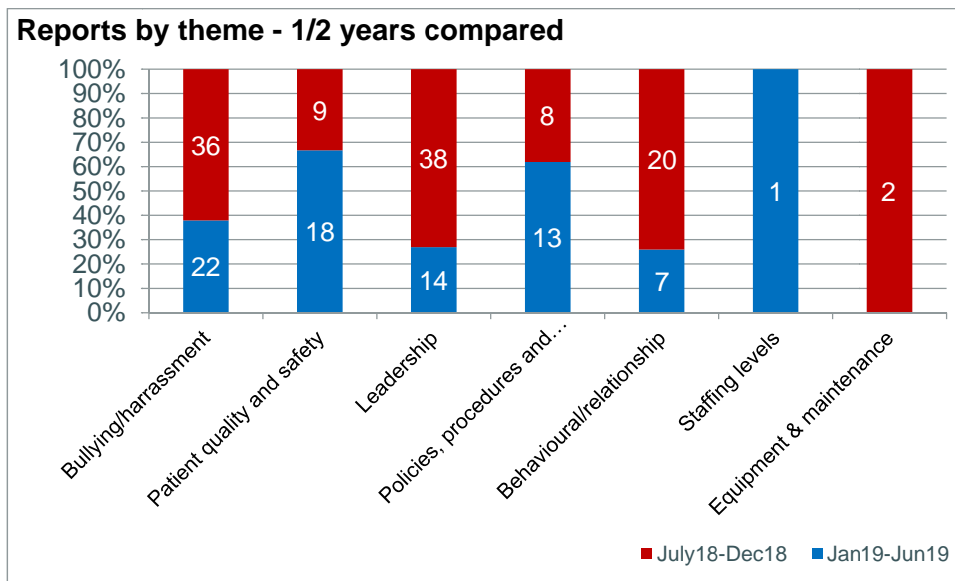


2.5 Themes

Although the overall number of concerns has gone down, the number of patient safety and staffing issues being raised has risen significantly, especially at Scarborough Hospital.



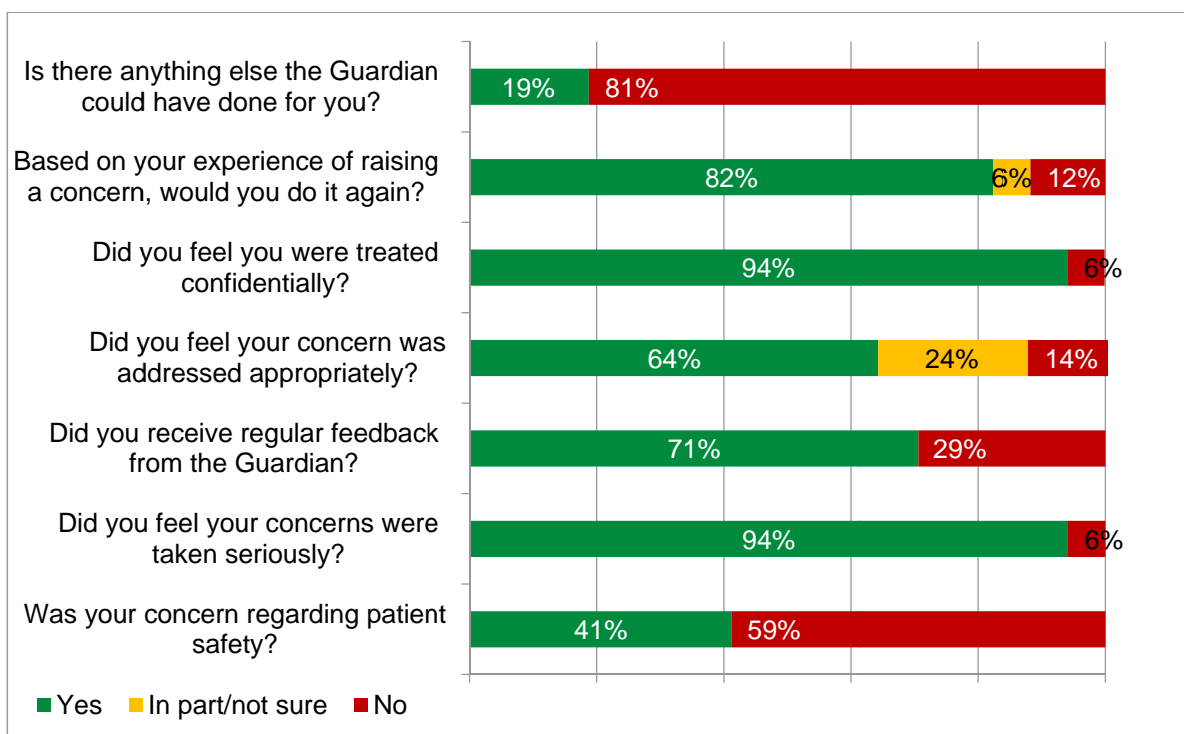
To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.



2.6 Feedback

Each staff member raising a concern is sent a feedback questionnaire once the FTSUG has ‘closed’ the concern. This is done via an anonymous on line survey which has limitations in reaching all Trust staff, and response rates are low. The chart below is for ALL feedback received.

Consideration needs to be given on how to gain feedback on the harder to reach staff groups who speak up who have limited access to computers at work.



- 94% say their concern was taken seriously
- 82% say based on their experience they would speak up again
- 64% say they feel their concern has been appropriately addressed by the FTSUG
- 94% say they were treated confidentially
- 71% say they have not received any unfair treatment since speaking up.

However, there is still work to be done around staff feeling safe to speak up when comments such as the one below are received in the feedback survey:

“Care should be taken when reporting concerns onto the management. A senior nurse in XX was phoned by a matron late one Saturday night and berated for comments made to the Guardian. It seems the management are telling the Matrons exactly what has been said and by whom, this has led to staff not feeling safe reporting concerns.”

3. Conclusion

The Trust FTSUG continues to be busy in comparison to similar size Trusts across the country, although the numbers in the last 6 months have reduced, there has been an increase in the number of patient safety concerns. Whilst some good progress is being made in some cases to address concerns and make positive changes, there are other examples (as given in this report) where a speaking up culture is not embraced and staff are fearful to speak up.

4. Recommendations

The Board of Directors are asked to:

1. Note the increase in patient safety concerns being raised.
2. Approve that all staff that have undergone the line manager training use their reflective diaries as part of their appraisal to demonstrate positive behaviours and compassionate leadership.



Board of Directors – 31 July 2019 Guardian of Safe Working Q1 Report: April – June 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	<input checked="" type="checkbox"/>	For approval	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>		

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 is required to report to the Board on a quarterly basis. The role aims to provide the Trust with assurance over the safe working of junior doctors and to alert the Board to any areas of concern

Recommendation

The Board of Directors are asked to:

Note the changes to the GoSW role and Junior Doctors' Forum (JDF) as a result of the agreed new deal as part of the 2016 TCS for doctors and dentists in training including the appointment of a Champion of Flexible Working.

Author: Lisa Smith, Guardian of Safe Working

Director Sponsor: Mike Proctor, Chief Executive

Date: July 2019

1. Introduction and Background

This is the Q1 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 April - June 2019 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

2.1 Junior Doctors' Forum

Since the introduction of the new contract for doctors and dentists in training 2016, the BMA has been in dispute with NHS employers over some of the terms and conditions. This dispute has now been resolved with BMA members voting for changes under a 'new deal' which was agreed in July 2019. The changes are widespread and involve changes to payment and training as well as changes to safe working.

Under the new deal, the GoSW has been given significantly more authority to intervene in safety matters and disputes over rotas and annual leave, along with the JDF being given additional responsibilities. There are now additional conditions around safe working that will constitute a breach and the financial penalties for breaching safe working have also increased.

Many of the changes to improve safe working and rest have already been adopted by this Trust through the work we have been doing via the JDF. This includes our early implementation of the 'good rostering guidance' which is now contractually required of all Trusts.

- **Junior Doctors Award Ceremony**

The first junior doctors award ceremony took place on 17 May. The event was well received and successful. Planning is already underway by member of the JDF to make it bigger, better and more inclusive next year.

The BMA will be writing an article about the event in their national journal 'The Doctor'.

- **Rest Facilities**

The Trust will be receiving a share of the national funds to improve rest facilities for junior doctors (around £30k). The JDF is currently canvassing the views of our junior doctors on how to make best use of the funds, one option being explored is to provide sleeping pods on each hospital site.

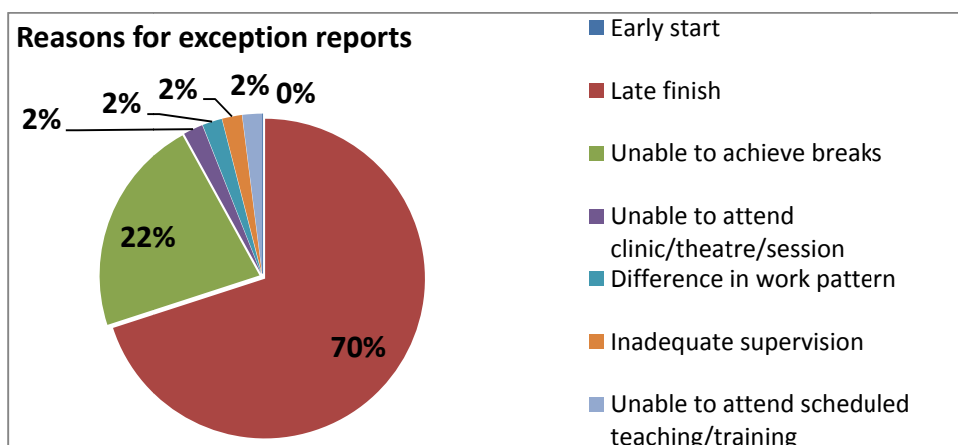
- **GoSW Annual Appraisal**

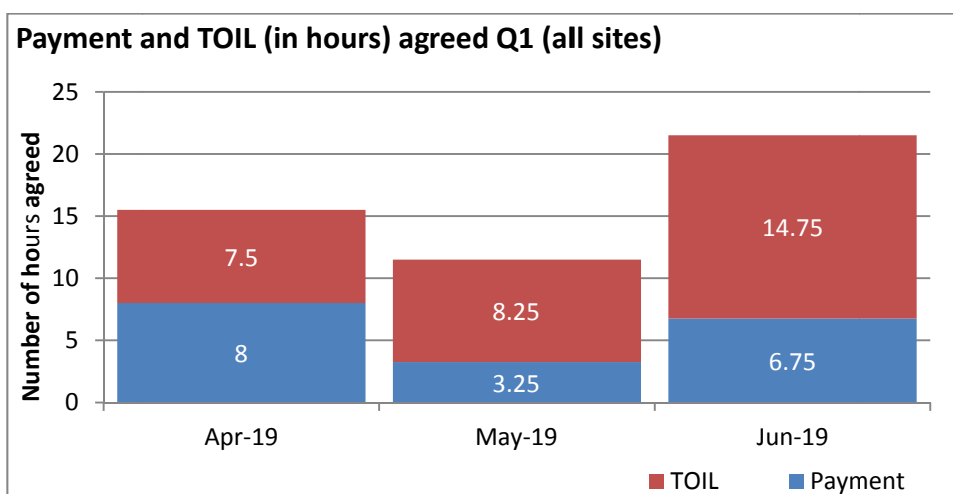
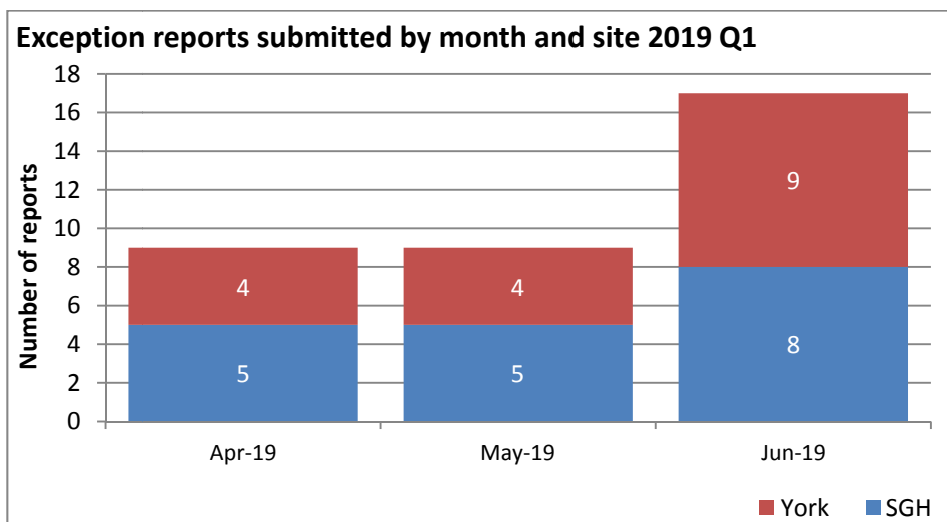
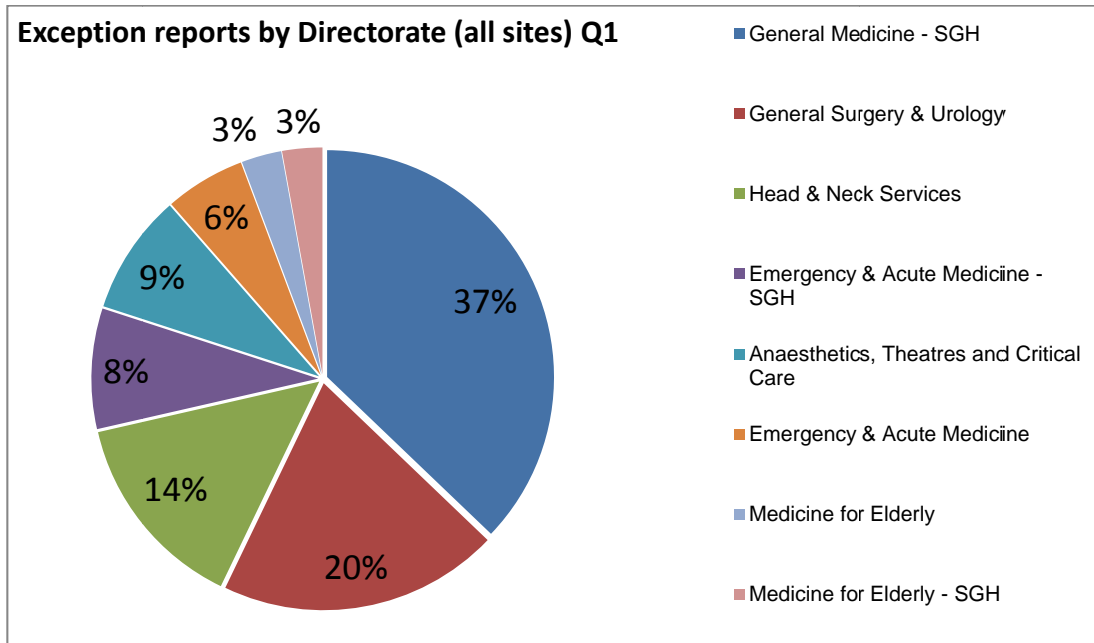
Around this time each year the GoSW is required to obtain feedback from junior doctors and team members on performance and the role. This is currently a live survey which closes on 28 July 2019 and will be reported to the Board in Q2.

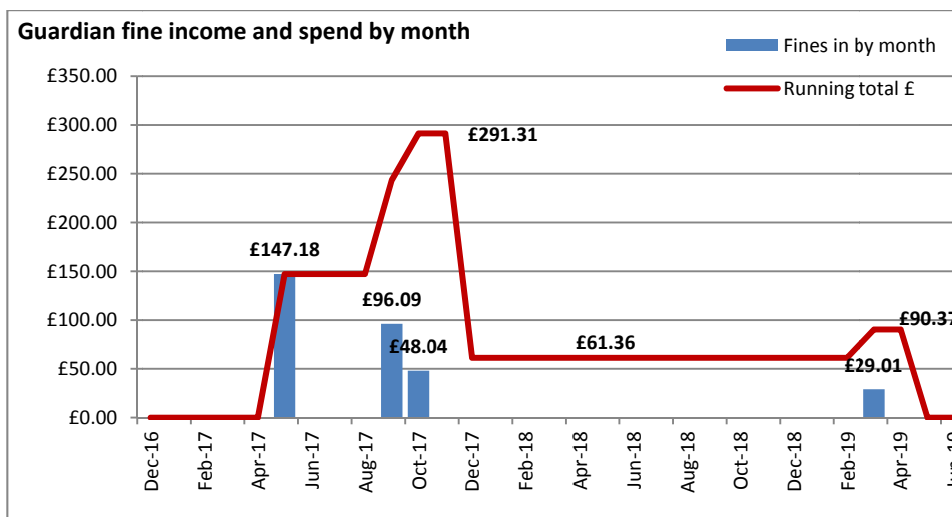
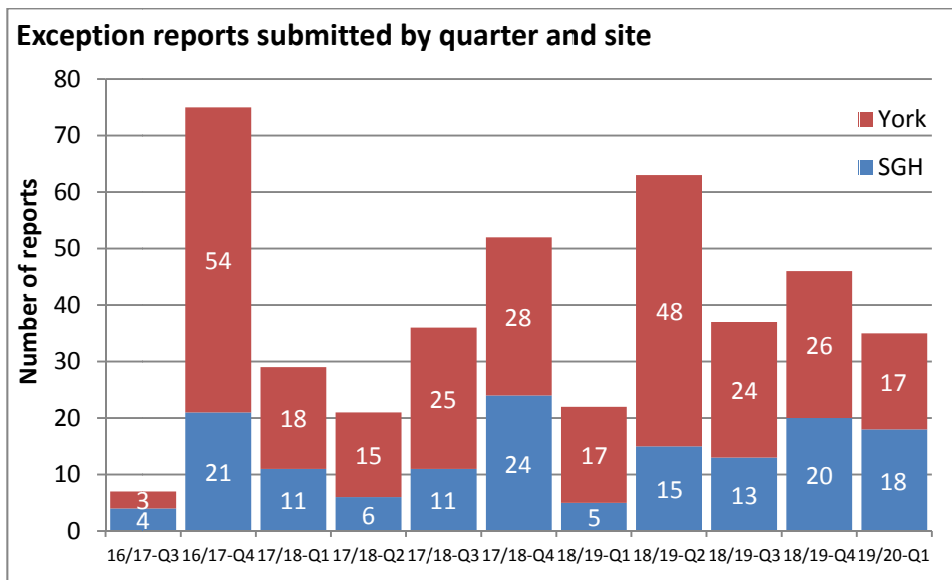
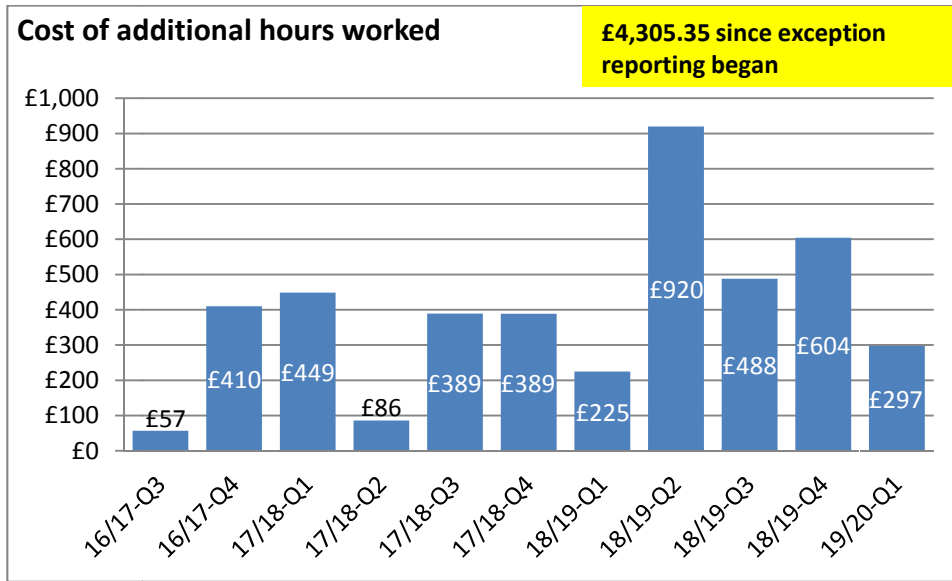
2.2 Exception reporting and guardian fines

- The 35 reports in Q1 came from 17 doctors. ‘Perceived staff shortage’ was most frequently recorded as the reason with the second (equal) highest reasons being ‘unavoidable delay’ (such as deteriorating patient at time due to leave) and ‘unreasonable workload’
- There have been no guardian fines levied for Q1 and the balance is now zero as the £90 previous balance was used towards the Junior Doctor Awards
- 82.86% (29) of exception reports were closed within 14 days
- 14.29% (5) were closed by the clinical supervisor, 57.14% (20) by the educational supervisor and the remaining 28.57% (10) by either the GoSW or the Director of Medical Education
- 37.14% (13) have resulted in payment to the junior doctor for additional hours worked (total of 18 hours claimed with a value of £118.46)
- 60% (21) have resulted in TOIL being approved (total of 16.25 hours claimed)
- 2.86% (1) had no impact on TOIL or additional hours (invalid claim made for traveling time)
- 94.28% (33) were for issues relating to Hours & Rest, and 5.72% (2) were for issues relating to both Hours & Rest *and* Education.

The following charts detail the number of exception reports received from each site and the reasons for them along with details of guardian fine spending and cost to the Trust in terms of additional hours worked.







2.3 Positive outcomes from Exception Reports

- Improved process for the Medical Education Centres to notify the rota team of fixed exam dates (to help further minimise risk of doctors applying for study leave without sufficient notice)
- A report from a junior doctor in Scarborough raised serious concerns about extreme bed pressure over a weekend and a very complex patient. This was escalated to the Deputy Medical Director who met with the junior to offer support and thanked him for raising the issues. He confirmed the main interventions to address the concerns are all the things already being addressed and include:
 - Early senior review, not endless wait for junior clerking
 - Consultant attribution of patients being simplified and individuals held to account against that system
 - Improved bed availability on base wards
 - Improved rota design to maximise numbers and support out of hours.

2.4 Summary of Rota Gaps

	Covered by trainee	Covered by Trust Grade	Vacant
York	90.4%	3.2%	6.4% (Q4 6.32%)
Scarborough	80.9%	7.8%	11.3 % (Q4 9.23%)

3. Next steps

To establish a multi- professional working group to develop a priority action plan for implementation of the revised contract for doctors and dentists in training.

4. Detailed recommendation

The Board of Directors are asked to:

- Note the changes to the GoSW role and JDF as a result of the agreed new deal as part of the 2016 TCS for doctors and dentists in training including the appointment of a Champion of Flexible Working.





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	12 ↑	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	16 ↑	1
Patient Care	4. Failure to maintain and develop the Trust's estate	25	16 ↑	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	20 ↑	1
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	16	12 ↑	2
Workforce	8. Failure to ensure there is engaged leadership and strong, effective succession planning systems in place	16	12 ↑	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
Finance	12. Failure to achieve the System's financial plan – new risk	25	16	6

Board of Directors – 31 July 2019

Medical Director's 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 | <input checked="" type="checkbox"/> |
| For discussion | <input checked="" type="checkbox"/> |
| For assurance | <input type="checkbox"/> |
| For approval | <input type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Purpose of report

This report provides an update from the Medical Director on salient issues aligned to the Patient Safety Strategy.

Executive Summary -Key Points

Seven Day Services Clinical Standards

Early Detection & Treatment – May 2019 saw successful implementation of NEWS2 and the 4AT assessment. Further work is required to ensure level of consciousness and confusion is recorded.

Learning from Death – The Trust received a letter from NHS Blood and Transplant outlining how the Trust contributed to the UK's success, as well as ways to maximise donation opportunities. From 12 consented donors, the Trust facilitated 11 actual solid organ donors resulting in 27 patients receiving a transplant during the time period.

Recommendation

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

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

Director sponsor: Mr. James Taylor, Medical Director

Date: July 2019

1. Introduction and Background

The Medical Director's report will now report against key areas of work identified within the Patient Safety Strategy.

Early Detection & Treatment.

Areas of Frequent Harm.

Learning from Death

Infection Prevention & Control

Consistency of Care

2. Key areas of work

2.1 Early Detection and Treatment

2.1.1 NEWS2 and 4AT Assessment

May 2019 saw the implementation of NEWS 2 and the 4AT assessment. Early feedback from staff is positive, with additional support being offered to staff as required. At the time of reporting, there has been no impact noted by Critical Outreach Teams, although further work is required to ensure level of consciousness and confusion is recorded in the revised observations.

2.2 Learning from Death

2.2.1 Taking Organ Transplantation to 2020: Trust Performance – 2018/19

2018/19 was another record year for organ donation in the UK with 1600 patients donating organs following their death. The Trust received a letter in May 2019 from NHS Blood and Transplant outlining how the Trust contributed to the UK's success, as well as highlighting ways to maximise donation opportunities.

From 12 consented donors, York Teaching Hospital NHS Foundation Trust facilitated 11 actual solid organ donors resulting in 27 patients receiving a transplant during the time period. This is in comparison to 2017/18 when our Trust facilitated 11 actual solid organ donors from 15 consented donors.

When compared with national data, during the time period the Trust was:

- Exceptional for the referral of potential organ donors
- Exceptional for Specialist Nurse presence when approaching families to discuss organ donation
- Your Trust referred 50 patients to NHSBT's Organ Donation Services Team; 39 met the referral criteria and were included in the UK Potential Donor Audit. There were no additional audited patients that were not referred.



- A Specialist Nurse was present for 18 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- Thank you for missing no opportunities to follow best practice out of 57 during the time period. This compares with 5 (6%) out of 82 in 2017/18.

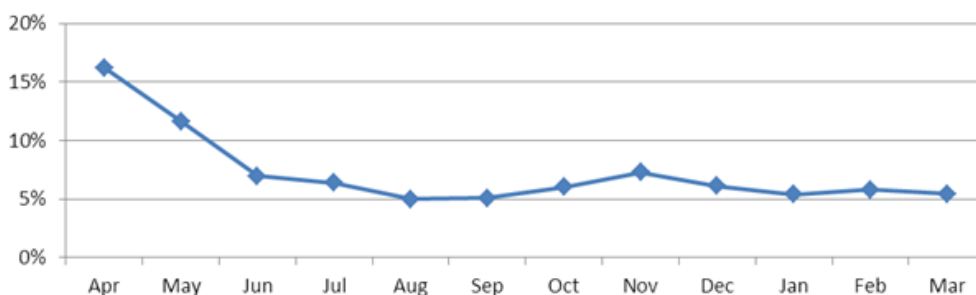
A copy of the letter is available in Appendix A.

2.3 Infection Prevention and Control

2.3.1 Antimicrobial prescribing data

Previous reporting against the CQUIN for 2018/19 was focused on achieving a percentage reduction in the total volume of antimicrobial prescribing, plus a percentage reduction in the prescribing of carbapenems. For the total volume we have actually had an increase in prescribing. This is likely to be due to the lack of reviewing, following the implementation of EPMA. There is work planned on EPMA to address this during the next 6 months. For the carbapenems and pip tazo there is a percentage decrease in usage however the trajectory is that this decrease is getting smaller and will eventually become an increase. In the meanwhile there are education sessions arranged and some screen savers to promote awareness.

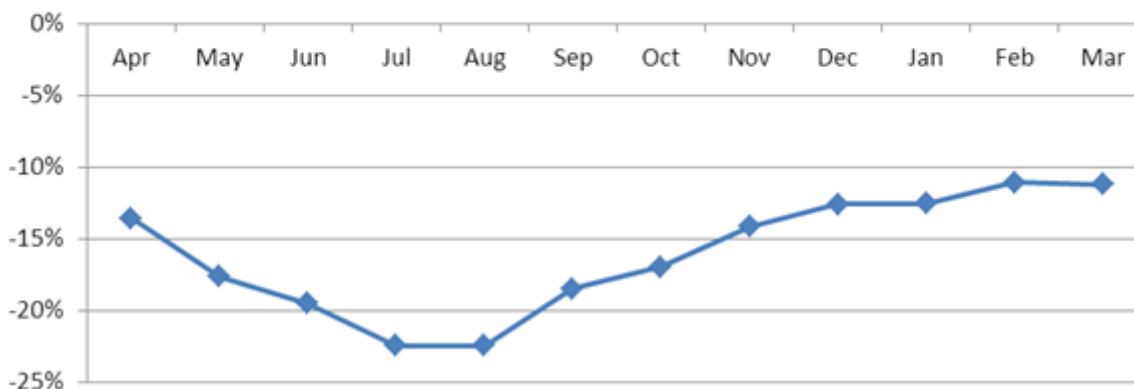
Month by Month % change (cumulative) in Trust wide antimicrobial total consumption (expressed as DDD/1000 admissions (inc day cases) comparing April 2017 to March 2018 with April 2018 to March 2019



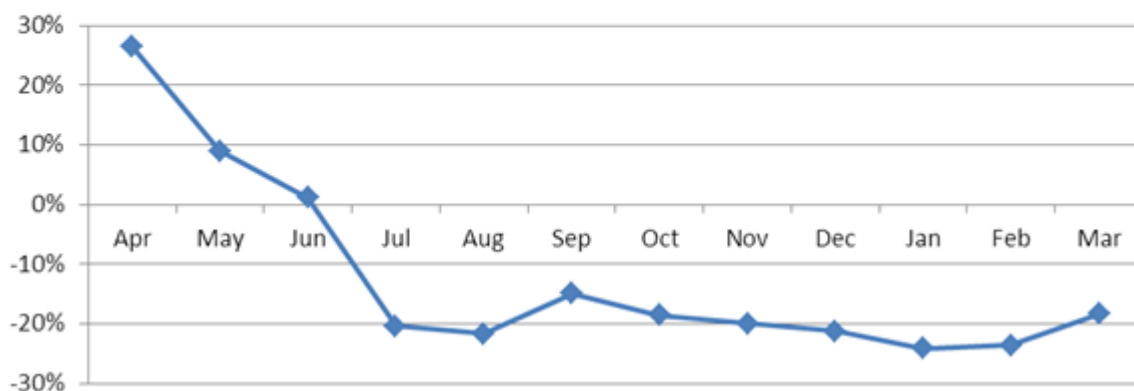
The percentage difference in the total volume of antimicrobials between the financial year 17/18 and 18/19 remains positive despite the introduction of ARK and promoting the noting of the start date on EPMA. Efforts continue to reduce the volume of antimicrobials by review of the antimicrobials treatment poster and promoting timely review of antimicrobials to ensure that no patient receives any more antimicrobials than they actually need. Antimicrobials such as Pip Tazo and Carbapenems are reviewed on a daily basis by the antimicrobial team.



Month by Month % change (cumulative) in Trust wide piperacillin/tazobactam consumption
 (expressed as DDD/1000 admissions (inc day cases)
 comparing April 2017 to March 2018 with April 2018 to March 2019



Month by Month % change (cumulative) in Trust wide Carbapenem consumption
 (expressed as DDD/1000 admissions (inc day cases)
 comparing April 2017 to March 2018 with April 2018 to March 2019



2.4 Consistency of Care

2.4.1 Patient Safety Walkrounds

There were 11 patient safety walkrounds during May and June across Scarborough, York and Community. The walkrounds were hosted by the Patient Safety Team, Non-Executive Directors and Governors. Themes identified included speed of IT systems causing ‘work arounds’ for staff, successful implementation of NEWS2, the use of safety huddles and learning from incidents. Good infection prevention and control measures were observed, although the wearing of lanyards by clinical staff was identified. It was also highlighted that when patients are transferred between the hospitals and peripheral sites, patients are discharged in CPD, then re-admitted rather than managed as an intra hospital transfers.



2.4.2 Patient Safety Group

The minutes of the Patient Safety Group meeting on 21 May 2019 are available in Appendix B.

2.4.3 Clinical Effectiveness Group

There has been no Clinical Effectiveness meeting since January 2019

2.4.4 Patient Safety Week

Patient Safety Week was held across the York Teaching Hospitals NHS Foundation Trust 20th May to 26th May 2019. This coincided with the launch of the Trust Patient Safety Strategy and was used to encourage involvement from staff, patients and visitors. The slogan for the week was Patient Safety is Everyone's Business.

Throughout the week the Patient Safety team had stands at York and Scarborough Hospitals providing some information about the work ongoing and raising the profile of the team members. This was boosted each day by stands organised by specialist teams such as Infection Prevention and Control, Tissue Viability, Pharmacy, Incident Reporting and Allied Healthcare Professionals. Stands were visited by staff, patients and visitors to the organisation.

Staff were invited to attend presentations about Sepsis, Human Factors, Quality Improvement methodology, Learning from Deaths and Safeguarding. Guest Speaker, Professor Rebecca Lawton from the National Institute for Health Research (NIHR) spoke about Patient Safety Research at the frontline and encouraged staff to think about any research that could be done in their own workplace.

The week was used as an opportunity to increase the presence of the Patient Safety Team on the wards during walkrounds and to engage non-clinical teams, such as the Porters and Catering. Each of the Community Inpatient Units and Bridlington Hospital were visited by a member of the Patient Safety Team and information packs/ booklets provided. Feedback about the week has been very positive with several people have enquired about being involved in Patient Safety Improvement projects.

3 Recommendation

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



May 2019

Dear Mr Proctor and Mr Taylor,

2018/19 was another record year for organ donation in the UK with 1600 patients donating organs following their death. Every donation is a reflection of the altruism of the patient and their family and testament to the care and professionalism of colleagues across the NHS who facilitate this complex and lifesaving process. I would like to take this opportunity to thank you and your colleagues within your organisation for their dedication and commitment in achieving this number of organ donors, without which it would not have been possible.

This letter explains how your Trust contributed to the UK's success, as well as highlighting ways to maximise donation opportunities. Colleagues in England may also find the activity data provided helpful for Care Quality Commission (CQC) inspections. With the passing of Max and Keira's Law on the 15th March 2019, resulting in the introduction of deemed consent in Spring 2020, we hope donation numbers will continue to increase and the lifesaving gift of organ donation will benefit many more lives.

Taking Organ Transplantation to 2020: Trust Performance - 2018/19

From 12 consented donors, York Teaching Hospital NHS Foundation Trust facilitated 11 actual solid organ donors resulting in 27 patients receiving a transplant during the time period. This is in comparison to 2017/18 when your Trust facilitated 11 actual solid organ donors from 15 consented donors.

Quality of care in organ donation - 2018/19

When compared with national data, during the time period your Trust was:

- Exceptional for the referral of potential organ donors
- Exceptional for Specialist Nurse presence when approaching families to discuss organ donation
- Your Trust referred 50 patients to NHSBT's Organ Donation Services Team; 39 met the referral criteria and were included in the UK Potential Donor Audit. There were no additional audited patients that were not referred.
- A Specialist Nurse was present for 18 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- Thank you for missing no opportunities to follow best practice out of 57 during the time period. This compares with 5 (6%) out of 82 in 2017/18.

For various reasons it may not always be possible to follow best practice; if there was an occasion when best practice was not followed your Organ Donation Committee Chair or Clinical Lead for Organ Donation will be able to explain the circumstances. For further information on best practice in organ donation see NICE Clinical Guidance 135.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and performance data at the Board with support from your Organ Donation Committee Chair and Clinical Lead for Organ Donation.

Why it matters

In 2018/19, 296 people benefited from a solid organ transplant in Yorkshire And The Humber. However, 40 people died on the transplant waiting list during this time and 467 people were still waiting as of the 31 March 2019.

Thank you for your ongoing support for organ donation and transplantation.

Yours sincerely,



Anthony Clarkson
Director of Organ Donation and Transplantation
NHS Blood and Transplant



MINUTES

Title:	Patient Safety Group
Date:	Tuesday 21 st May 2019
Time:	08:00 – 09:30
Location:	Ophthalmology Seminar Room, York Hospital with VC to Orchard Room, Scarborough Hospital
Chairing:	Rebecca Hoskins (RH)
Attendees:	Rebecca Hoskins (RH), Elizabeth Ross (ER), Chris Foster (CF), Jonathan Thow (JCT), Helen Holdsworth (HH), Helen Noble (HN), Fiona Jamieson (FJ), Ru Rupsinghe (RR), Jan Godwin (JG), Donald Richardson (DR), Gemma Williams (GW), Vicky Mulvan-Tuohy (VM)
Apologies:	Jim Taylor (JT), Ed Smith (ES), Neil Todd (NT),

No	Item/Discussion	Lead for actions
1.	Apologies	
	RH welcomed everyone to the meeting and gave apologies as above.	
2.	Notes from the meeting held on 19th March 2019 and Matters Arising	
	<p>The minutes from the 19th March 2019 meeting were agreed as an accurate record.</p> <p>EPMA – the scheduled downtime in April went well, another downtime took place last week.</p> <p>The actions on the action log have been listed by priority order however this work has been paused due to the launch of NEWS2. The top priority work is; antibiotic ordering, pharmacy reviews, as this will mitigate other issues, allergies to be made more visible and work on patients being discharged and returning as an inpatient; being able to review the patient record.</p> <p>Just Culture – a working group has been formed to look at the just culture part of the patient safety strategy..</p> <p>NEWS2 – launched today at 7am, all patients NEWS scores will disappear which means all patients on the ward require a new set of observations to be inputted for the NEWS2 score to be visible.</p> <p>CQUIN – RH informed the group CQUIN have been agreed with the CCG they are;</p> <ul style="list-style-type: none"> • Falls – falls risk assessment for all patients over 65 who have an admission of 48 hours or more. • Same day service in ED – look at AF, PE and Pneumonia • Antimicrobial prescribing • Flu vaccination for staff – trajectory is higher this year • Stroke 6 month review <p>SCBU - MRSA and environment upgrade required – ER highlighted there have been no further cases however the environment is still a high risk.</p>	

	<p>SHMI – Scarborough SHMI rate has reduced; SJCR methodology has been applied to case note reviews to identify any learning. .</p> <p>Post take – 7 day services audit is underway with the time to post take review not consistently achieved within 14 hours and the plan is that if a junior doctor is recording the PTC on behalf of the consultant they must select consultant from the drop down list. RH asked for this to be escalated to board as part of the 7 day self-assessment.</p>	
3.	<p>SI Trends and Learning (Standing Item)</p>	
	<p>During the past 12 months there have been 161 SI's declared with a change in balance compared to previous trends.</p> <p>40 of the 161 SI's were stood down, the remaining SI's were in the following categories:</p> <ul style="list-style-type: none"> • 93 x clinical • 38 x pressure ulcers • 30 x falls <p>FJ informed the group the approach to SI's has changed, wards / departments are sometimes expected to carry out a 72 hour report following a serious incident to enable better decision making and determine whether it should be declared an SI. It is expected with the introduction of the 72 hour report the number of SI's declared will reduce and this will mean fewer will be de-logged.</p> <p>The revised national SI framework is likely to be published in November. It is proposed that this will mean fewer SI's declared however the investigation period will be longer, to allow thorough review and engagement with patients and families ER informed the group the HSIB reporting period is 6 months. 1 case was declared in December 2018 and the Trust is waiting for the final report.</p> <p>Since January 2019 there has been 27, 72 hour trolley waits, this is the biggest area of growth in SI's.</p> <p>2 never events have been presented at the SI meeting.</p> <ol style="list-style-type: none"> 1. Dermatology – mole removed. The issue with this case was how the patient was referred to the service. Key learning is; the department need to enhance the SOP and to stop consultants referring patients directly. 2. Wrong site, stent – process issues, radiographer did not know which side and the theatre staff were not familiar with their surroundings. <p>There has been a growth in delayed diagnosis and treatment in Radiology and Ophthalmology.</p> <p>Ophthalmology have an action plan in place to improve and manage their back log of patients however this could take up to 3 years to see all of the patients. Once the Community Stadium build is completed some of this work will move there.</p> <p>Radiology has issues with some mis-diagnosis and delay with the cancer pathway and reporting. A paper has been written and will be presented at Quality Committee this month.</p> <p>Discussions are taking place to look into how SI's will be managed in the care groups and how the learning will be shared. FJ and RH are working</p>	

	with the Care Group management teams.	
4.	Clinical Guidelines (Standing Item)	
	<p>There are 1211 clinical guidelines of which 75 are out of date (6%), the number outstanding keep reducing each month.</p> <p>There are 179 corporate guidelines of which 23 are out of date (12%). The majority of the outstanding guidelines sit with HR, they have reduced from 35 to 16. The delay for some is due to needing staff side representation. The group were informed that a number of the outstanding guidelines will be captured in the recruitment policy which is due to be updated late summer, CF is asking if the outstanding guidelines can have an extension to bring them in-line with the recruitment policy update.</p> <p>There was a discussion regarding guidelines that the Trust may not have, and how we could sign post colleagues to external resources. It was agreed that if Clinicians do not inform anyone that guidelines are not available, there will be no plans to address this gap. RR suggested she could link with the speciality leads and look into what external guidelines are required, RH asked for a meeting with CF, RR and GW to look into a task and finish group for guidelines.</p>	RH, CF, RR, GW to meet re: external guidelines and a task and finish group
5.	Calculating the risk score for mortality	
	DR informed the group CARS has been put on hold due to the work for NEWS2. When this work is completed, the score will be displayed on the whiteboard and named individuals will be able to look into the information further and see all the variables that make up the score.	
6.	Making data count	
	RH informed the group there is making data count guidance from NHSI and this will be distributed to staff during Patient Safety Week.	
7.	E-Consent	
	<p>E-consent - DR informed the group a meeting has been scheduled with the company to look at the development of e-consent and if it will work across the whole Trust or within specific areas. The Trust would like e-consent to be used for all Trust procedures.</p> <p>Consent – RH informed the group the Trust has been offered a free 6 month trial period and is obtaining quotes to identify what the cost of using the Royal College of Surgeons leaflets would be going forwards. RH is meeting with colleagues to explore how this may support the consent process.</p>	
8.	Items to escalate to the Board of Directors (Standing Item)	
	<p>The group agreed the following items need to be escalated to the Board of Directors:</p> <ul style="list-style-type: none"> • Post take review within 14 hours not been met • Entonox levels at Scarborough 	

<p>9.</p>	<p>Sub Group Action Logs</p> <p>Papers circulated with the agenda:</p> <ul style="list-style-type: none"> • Alcohol Steering Group • Blood Transfusion Group • Clinical Ethics Committee • Deteriorating Patient Group • Diabetes Inpatient Review Group • Falls Steering Group • Junior Doctors Improvement Group • Medicines Management Group • Mortality Steering Group • Obstetrics and Gynaecology – Scarborough • Obstetrics and Gynaecology – York • Pressure Ulcer Steering Group • VTE Committee <p>For information:</p> <ul style="list-style-type: none"> • Safeguarding Governance Group – to follow 	
	<p>RH commented on the high number of sub group reports submitted for today's meeting – good return rate.</p> <p>Junior Doctor Safety Improvement Group RR informed the group there is work ongoing to assess Junior Doctors clinical skills when they join the Trust, the aim is to tackle poor compliance with ANTT. For this to work there needs to be multiple sessions held during August, the rota team are happy to allocate junior doctors to each session however the issue is getting the right number of facilitators, the Clinical Skills Team are covering a number of sessions but there needs to be more facilitators for this to work. RH and RR to meet outside of this meeting to discuss further.</p> <p>Medicines Management Group There is an ongoing issue with patients own drugs been left in the bedside lockers, a business case has been approved but there is no funding available. This means there is a risk regarding the safe management of patients own medications and patients are unable to self-medicate.</p> <p>HH believes this issue has been added to the corporate risk register, FJ advised it is not on the corporate risk register therefore DR asked that bedside lockers are added to the corporate risk register because nearly 50% of lockers are broken and patients bring in their own medication which is now been stored in the drug trollies where there is not the space. HH agreed to check that lockers on are the medicines management risk register.</p> <p>A group has been set up to look at issues on discharge and patients drugs, this will be led by Clare O'Brien, Lead Nurse Patient Safety.</p> <p>Mortality Steering Group RH asked DP to send her the Directorates and Clinical Lead for those that are not submitting their quarterly report.</p>	<p>RH and RR to discuss facilitators for the sessions.</p> <p>HH to check on the medicines management risk register and add to the corporate risk register</p> <p>DP to send the list of outstanding Quarterly reports to RH.</p>

	<p>Obstetrics and Gynaecology Clinical Governance Group – Scarborough</p> <p>Entonox levels on the Labour Ward at Scarborough are still above recommended levels and are on the risk register. The high levels are a risk to staff, visitors and women. Midwives who are pregnant have been given the option for rotation on to Hawthorn Ward.</p> <p>The high levels have been brought up at the Trust Health and Safety Meeting, Colin Weatherill has carried out a risk assessment but not got a solution and Occupational Health have advised staff should wear a mask rather than a mouth piece, ventilation should be in the rooms and midwives should leave the room regularly.</p> <p>The group discussed the Entonox levels need to be escalated to the Board because the real risk cannot be mitigated; at York the air flow works well however due to the fabric of the building at Scarborough it is not been ventilated out.</p> <p>RH asked JR to carry out a library search on Entonox and the impact to staff.</p>	<p>RH to escalate to Board.</p> <p>JR to do a search on Entonox and the impact to staff.</p>
10.	Any Other Business	
	<p>Deconditioning – one year ago there was a deconditioning project led by the Therapists; the plan is to re-launch this once the new Chief Nurse joins the Trust. This will link with SAFER.</p>	
Next Meeting		
Date & Time:	Tuesday 16 th July 2019, 08:00 – 09:30	
Location:	VC – Board Room (York) & Orchard Room (Scarborough)	

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Performance and Activity Report

June 2019 performance

Produced July 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

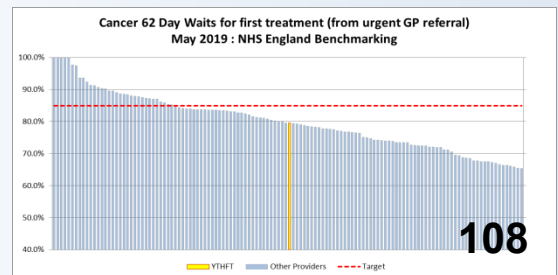
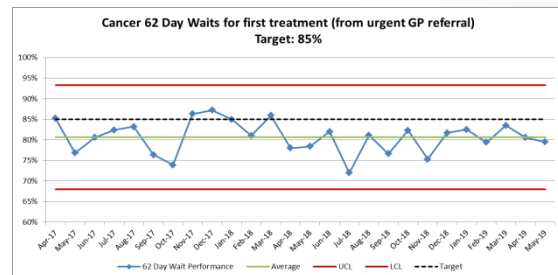
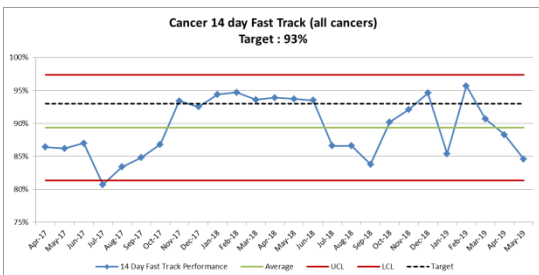
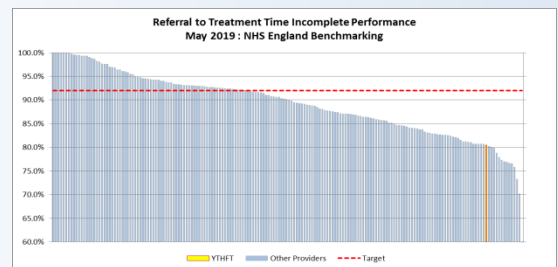
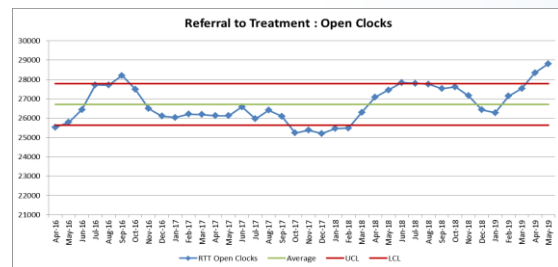
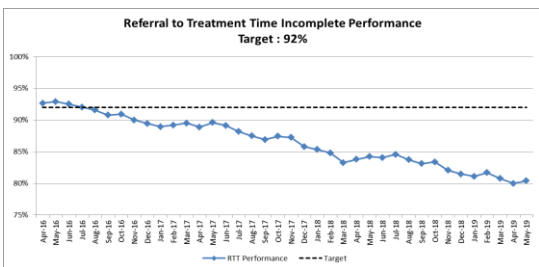
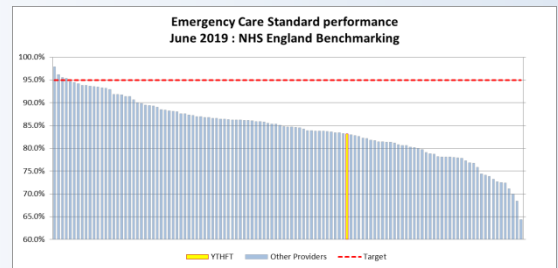
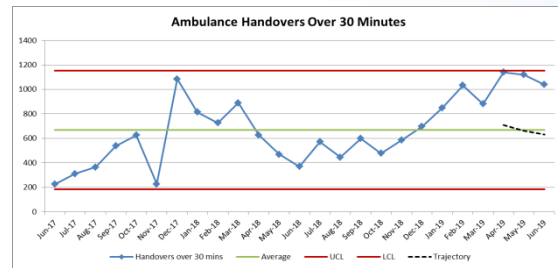
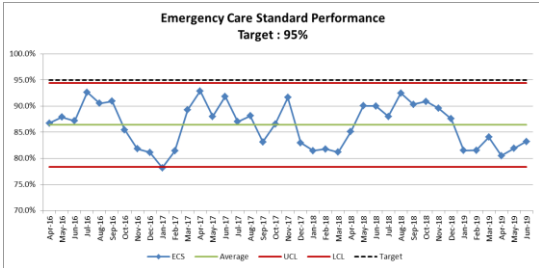
Key Performance Indicators – Trust level

Operational Performance: Key Targets

Emergency Care Standard Performance
Ambulance handovers waiting 15-29 minutes
Ambulance handovers waiting 30-59 minutes
Ambulance handovers waiting >60 minutes
RTT Incomplete Pathways
RTT Open Clocks
RTT 52+ Week Waiters
Cancer 2 week (all cancers)
Cancer 2 week (breast symptoms)
Cancer 31 day wait from diagnosis to first treatment
Cancer 31 day wait for second or subsequent treatment - surgery
Cancer 31 day wait for second or subsequent treatment - drug treatments
Cancer 62 Day Waits for first treatment (from urgent GP referral)
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)

Target	Sparkline / Previous Month
95%	▲
0	▼
0	▼
0	▲
92%	▼
26303	▼
0	▲
93%	▼
93%	▲
96%	▲
94%	▲
98%	▶
85%	▼
90%	▼

Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
90.0%	88.0%	92.5%	90.3%	90.9%	89.6%	87.6%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%
765	785	766	883	891	840	1083	935	892	915	956	1072	978
260	355	342	360	345	389	463	470	556	484	593	671	587
110	216	104	238	132	197	233	380	477	397	548	449	453
84.1%	84.5%	83.7%	83.1%	83.4%	82.0%	81.5%	81.1%	81.7%	80.8%	80.0%	80.4%	78.3%
27842	27796	27756	27525	27616	27164	26433	26278	27144	27536	28344	28809	28723
9	0	0	1	1	1	0	0	0	3	0	0	3
93.5%	86.6%	86.6%	83.8%	90.2%	92.1%	94.6%	85.4%	95.7%	90.7%	88.3%	84.6%	-
93.6%	94.7%	97.4%	99.0%	100.0%	93.3%	92.8%	93.4%	93.2%	90.7%	79.6%	91.4%	-
98.9%	98.4%	99.2%	97.6%	98.6%	98.4%	96.8%	96.4%	98.7%	96.9%	96.7%	98.3%	-
100.0%	97.6%	94.3%	92.9%	96.9%	93.2%	95.0%	90.5%	92.3%	97.4%	94.3%	95.1%	-
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
82.0%	72.0%	81.1%	76.6%	82.3%	75.3%	81.7%	82.5%	79.4%	83.5%	80.6%	79.5%	-
96.5%	91.3%	93.0%	87.7%	93.6%	92.9%	88.6%	90.6%	89.1%	92.7%	100.0%	92.1%	-



Assurance Framework
Responsive

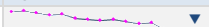





Performance Summary by Month: Constitutional and Operational Monitoring – Trust level

	Target	Sparkline / Previous Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Operational Performance: Unplanned Care															
Emergency Care Attendances			17242	18903	18215	17073	16960	16191	16571	16575	15500	17489	18055	18270	18256
Emergency Care Breaches			1722	2266	1366	1650	1545	1686	2059	3069	2863	2791	3525	3310	3067
Emergency Care Standard Performance	95%		90.0%	88.0%	92.5%	90.3%	90.9%	89.6%	87.6%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%
ED Conversion Rate: Proportion of ED attendances subsequently admitted			38%	37%	38%	38%	38%	39%	41%	38%	38%	36%	36%	37%	38%
ED Total number of patients waiting over 8 hours in the departments			159	260	110	212	216	242	324	904	802	687	1007	855	695
ED 12 hour trolley waits	0		0	0	0	0	0	0	0	16	8	28	24	26	2
ED: % of attendees assessed within 15 minutes of arrival			63%	62%	70%	61%	65%	63%	63%	62%	59%	63%	58%	59%	57%
ED: % of attendees seen by doctor within 60 minutes of arrival			40%	41%	50%	42%	45%	49%	50%	43%	40%	38%	37%	37%	41%
Ambulance handovers waiting 15-29 minutes			765	785	766	883	891	840	1083	935	892	915	956	1072	978
Ambulance handovers waiting 15-29 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	846	829	812	795
Ambulance handovers waiting 30-59 minutes			260	355	342	360	345	389	463	470	556	484	593	671	587
Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	380	365	350	335
Ambulance handovers waiting >60 minutes			110	216	104	238	132	197	233	380	477	397	548	449	453
Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	330	297	281	264
Non Elective Admissions (excl Paediatrics & Maternity)			4599	4834	4723	4577	4643	4563	4713	4524	4029	4580	4585	4766	4761
Non Elective Admissions - Paediatrics			638	665	535	689	862	1042	942	921	865	891	766	749	710
Delayed Transfers of Care - Acute Hospitals			1020	1071	1336	1180	1251	1059	1212	1093	1067	1178	1456	1520	1491
Delayed Transfers of Care - Community Hospitals			262	307	301	381	357	358	337	385	295	377	277	303	371
Patients with LOS 0 Days (Elective & Non-Elective)			1448	1571	1476	1431	1447	1368	1375	1421	1278	1362	1266	1348	1554
Ward Transfers - Non clinical transfers after 10pm	100		71	73	38	76	83	85	85	100	71	94	87	87	76
Emergency readmissions within 30 days			822	914	831	857	837	861	875	852	739	871	875	-	-
Stranded Patients at End of Month - York, Scarborough and Bridlington			366	385	369	379	403	363	368	439	386	442	422	406	397
Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington			342	347	325	371	398	374	376	431	433	409	405	399	373
Super Stranded Patients at End of Month - York, Scarborough and Bridlington			118	125	118	132	159	132	116	153	130	153	138	143	135
Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington			113	115	115	125	142	147	129	151	166	143	147	134	141
Operational Performance: Planned Care															
Outpatients: All Referral Types			19324	20164	18624	17806	20686	19613	16888	19856	19315	18908	18595	19338	18805
Outpatients: GP Referrals			9899	10522	9703	9207	10760	10195	8624	10038	10416	9801	9534	9726	9429
Outpatients: Consultant to Consultant Referrals			2140	2252	1973	1929	2413	2254	1961	2537	2221	2251	2177	2337	2205
Outpatients: Other Referrals			7285	7390	6948	6670	7513	7164	6303	7281	6678	6856	6884	7275	7171
Outpatients: 1st Attendances			9588	9700	9051	8468	10249	10157	8059	9868	9005	9312	8603	9209	9232
Outpatients: Follow Up Attendances			16736	17100	15635	15546	17736	17533	14446	18028	15417	16441	15036	16375	15102
Outpatients: 1st to FU Ratio			1.75	1.76	1.73	1.84	1.73	1.73	1.79	1.83	1.71	1.77	1.75	1.78	1.64
Outpatients: DNA rates			5.9%	6.5%	6.4%	6.1%	6.0%	5.8%	6.4%	6.1%	5.7%	5.5%	5.9%	6.1%	5.9%
Outpatients: Cancelled Clinics with less than 14 days notice	180		145	184	173	160	180	163	162	206	193	209	180	179	198
Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons			885	945	1070	884	941	865	802	1039	997	1168	1142	1068	1047
Diagnostics: Patients waiting <6 weeks from referral to test	99%		96.3%	95.6%	93.5%	94.9%	96.2%	93.9%	91.1%	90.6%	92.9%	93.0%	87.5%	86.4%	88.9%
Elective Admissions			752	736	612	575	766	718	602	614	554	687	652	682	722
Day Case Admissions			6049	6094	6117	5714	6595	6287	5344	6621	5868	6082	5849	6075	5886
Cancelled Operations within 48 hours - Bed shortages			7	10	4	34	68	12	33	22	10	17	32	66	59
Cancelled Operations within 48 hours - Non clinical reasons			89	98	96	106	137	131	91	114	90	141	130	147	194
Theatres: Utilisation of planned sessions			92%	92%	93%	91%	90%	93%	88%	86%	87%	90%	92%	86%	89%
Theatres: number of sessions held			636	608	553	555	674	661	523	586	506	576	576	601	599
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)			61	74	63	76	79	66	66	53	89	108	99	43	83

Assurance Framework
Responsive

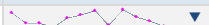



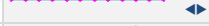

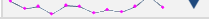
Performance Summary by Month – Trust level continued

18 Weeks Referral To Treatment
Incomplete Pathways
Waits over 52 weeks for incomplete pathways
Waits over 36 weeks for incomplete pathways
Total Admitted and Non Admitted waiters
Number of patients on Admitted Backlog (18+ weeks)
Number of patients on Non Admitted Backlog (18+ weeks)

Target	Sparkline / Previous Month
92%	
0	
0	
26303	
	
	









Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
84.1%	84.5%	83.7%	83.1%	83.4%	82.0%	81.5%	81.1%	81.7%	80.8%	80.0%	80.4%	78.3%
9	0	0	1	1	1	0	0	0	3	0	0	3
438	390	369	298	361	355	431	497	530	606	669	632	660
27425	27796	27756	27525	27616	27164	26433	26278	27144	27536	28344	28809	28723
2330	2273	2272	2245	2219	2299	2352	2463	2470	2738	2850	2877	2847
2041	2023	2245	2401	2369	2578	2550	2500	2505	2556	2825	2769	3391

Cancer (one month behind due to national reporting timetable)
Cancer 2 week (all cancers)
Cancer 2 week (breast symptoms)
Cancer 31 day wait from diagnosis to first treatment
Cancer 31 day wait for second or subsequent treatment - surgery
Cancer 31 day wait for second or subsequent treatment - drug treatments
Cancer 62 Day Waits for first treatment (from urgent GP referral)
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)

Target	Sparkline / Previous Month
93%	
93%	
96%	
94%	
98%	
85%	
90%	

Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
93.5%	86.6%	86.6%	83.8%	90.2%	92.1%	94.6%	85.4%	95.7%	90.7%	88.3%	84.6%	-
93.6%	94.7%	97.4%	99.0%	100.0%	93.3%	92.8%	93.4%	93.2%	90.7%	79.6%	91.4%	-
98.9%	98.4%	99.2%	97.6%	98.6%	98.4%	96.8%	96.4%	98.7%	96.9%	96.7%	98.3%	-
100.0%	97.6%	94.3%	92.9%	96.9%	93.2%	95.0%	90.5%	92.3%	97.4%	94.3%	95.1%	-
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
82.0%	72.0%	81.1%	76.6%	82.3%	75.3%	81.7%	82.5%	79.4%	83.5%	80.6%	79.5%	-
96.5%	91.3%	93.0%	87.7%	93.6%	92.9%	88.6%	90.6%	89.1%	92.7%	100.0%	92.1%	-

Variation and Assurance symbols key:

KEY	TILE	DESCRIPTION	CATEGORY	DEFINITION
1		= HIGH Special Cause : Note/Investigation	VARIATION	Last 3 Months above the average
2		= LOW Special Cause : Note/Investigation	VARIATION	Last 3 Months below the average
3		= HIGH Special Cause : Concern	VARIATION	Last 6 Months above the average
4		= LOW Special Cause : Concern	VARIATION	Last 6 Months below the average
5		= Common Cause	VARIATION	None of the above
6		= Consistently Hit Target	ASSURANCE	Last 3 Months above target
7		= Consistently Fail Target	ASSURANCE	Last 3 Months below target
8		= Inconsistent Against Target	ASSURANCE	None of the above

Operational Context

The Trust did not meet the Emergency Care Standard (ECS) planned trajectory of 87% for June 2019, with performance of 83.2%. After seeing significant improvement over the previous eight months, the last six months have been below the rolling four-year average of 86.4%. The Trust performed below the national position for June (86.4%). Unplanned care continues to be challenging, Type 1 and 3 attendances are up 6% for Quarter 1 on the same period in 2018/19. In total an extra 1,966 patients have attended the main EDs, UCCs and MIUs compared to quarter 1 2018, with the main EDs (Type 1) seeing and treating an additional 3,247 patients; a rise of 11%.

Two twelve-hour trolley breaches were reported in June 2019, both at Scarborough Hospital. These breaches have been reported to NHS Improvement as required and were due to capacity constraints in ED and a lack of capacity within the inpatient bed base.

Ambulance arrivals continue to increase, with 10 of the last 11 months above the two-year average. The continued increase in demand during June combined with continuing high bed occupancy on both Scarborough and York sites contributed to 1,040 ambulances being delayed by over 30 mins, above the improvement trajectory of 599 submitted to NHSE&I. The increase in ambulance arrivals has, after seeing relatively stable performance in the first two-thirds of 2018/19, seen 7 consecutive months where the number of ambulances being delayed by over 30 mins has been above the two-year average. In line with other ED providers, the Trust are reporting ambulance handover numbers weekly to NHS Improvement. The Trust is working with the ECIST Ambulance Paramedic Lead on both sites. Following a diagnostic exercise undertaken jointly with the ED team that took place in March at York and May at Scarborough, a programme of work that builds on best practice from other areas has been agreed and is in progress.

The Trust has in line with previous months seen an increase in bed pressures, with both Scarborough and York Hospitals experiencing bed occupancy of above 90% at midnight for all but two days in the entire month. The Delayed Transfers of Care (DToC) position decreased in June. Delayed transfers have been affected by a lack of care home capacity and a shortage in the availability of packages of home care. The Trust is actively working to mitigate the pressures from increased demand through the Complex Discharge multi-agency group.

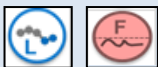
Targeted actions

- Refreshed ECS action plans for both sites submitted to NHSE&I with specified discharge levelling targets, non-admitted breach targets, golden patients and a target for the number of patients transferred to discharge lounge by midday.
- ECS Task force on each site meeting weekly led by Deputy Medical Director and Chief Operating Officer.
- Senior consultant moved from York ED to Scarborough ED to bolster senior decision making. Deputy Medical Director has also moved to Scarborough to support patient flow work.
- Discussions regarding establishing Scarborough and York 'System Summit' are ongoing.
- Submission made to NHSE&I for £1.92m capital project to co-locate facilities for same day emergency care / CDU with ED at York.
- The Trust is working with the ECIST Ambulance Lead on both sites. A programme of work that builds on best practice from other areas is in progress.
- SDEC task force has been created in Scarborough led by Dr Phil Jones.
- Time out session with York ED, Care of the Elderly, Acute and General Medicine clinicians to review assessment floor/functions. APIC function is being relaunched after initial pilot and evaluation.

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 June 2019 was 87%.

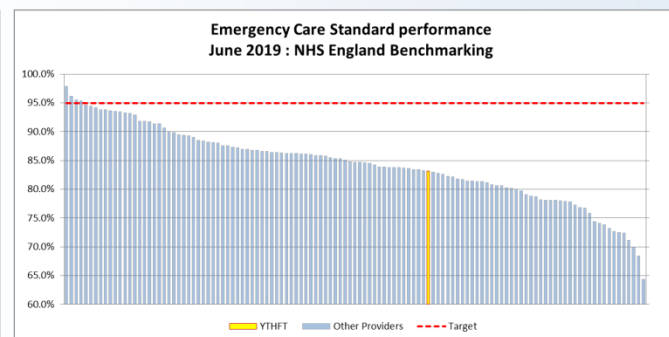
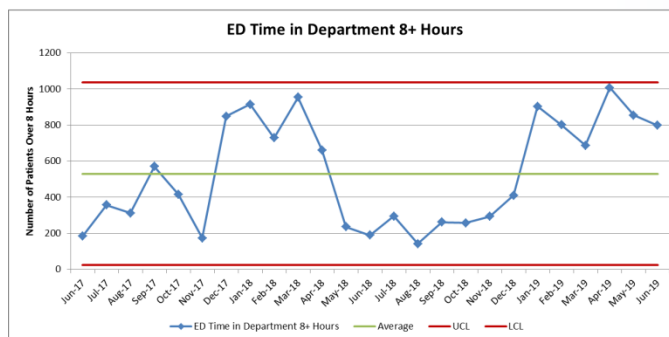
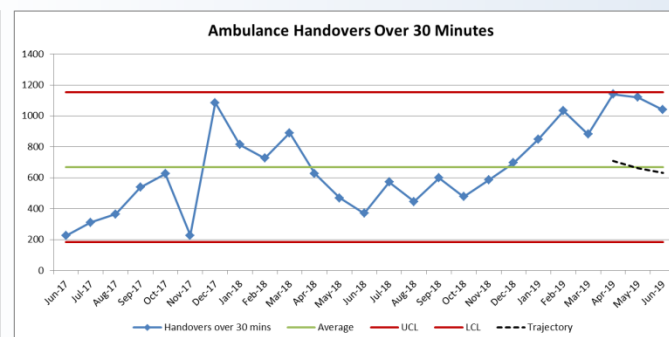
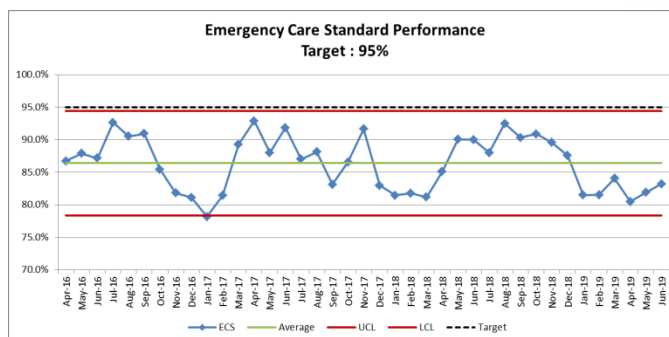
Consequence of
under-achievement

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

Performance Update:

- The Trust achieved 82.3% in June 2019 against the planned trajectory of 87%.
- Type 1 and 3 attendances are up 6% for Quarter 1 on the same period in 2018/19. In total an extra 1,966 patients have attended the main EDs, UCCs and MIUs compared to quarter 2018, with the main EDs (Type 1) seeing and treating an additional 3,247 patients; a rise of 11%.
- The number of patients waiting over 8 hours had showed improvement in 2018/19, with eight months below the four-year average. However in June 2019 there were 799 patients who waited over 8 hours, the sixth consecutive month above the four-year average. There were 2 twelve hour trolley waits reported on the Scarborough site.
- Ambulance arrivals have, after seeing relatively stable performance in the first two-thirds of 2018/19, seen 7 consecutive months where the number of ambulances being delayed by over 30 mins has been above the two-year average.

Performance:



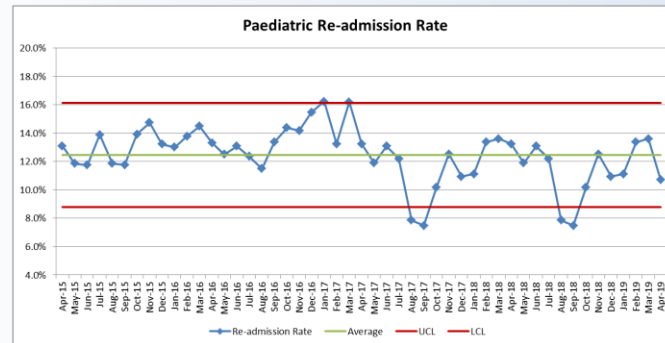
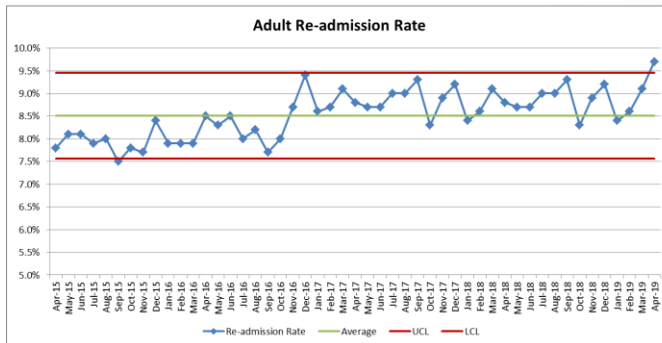
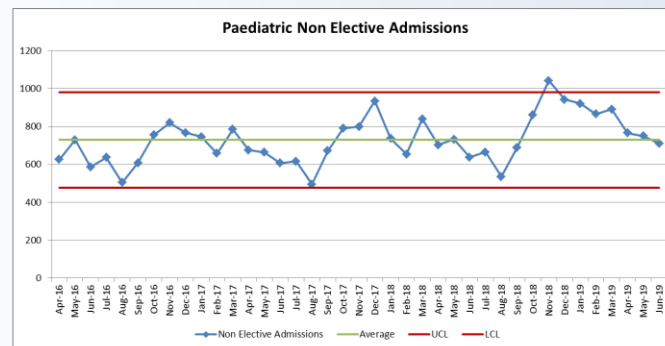
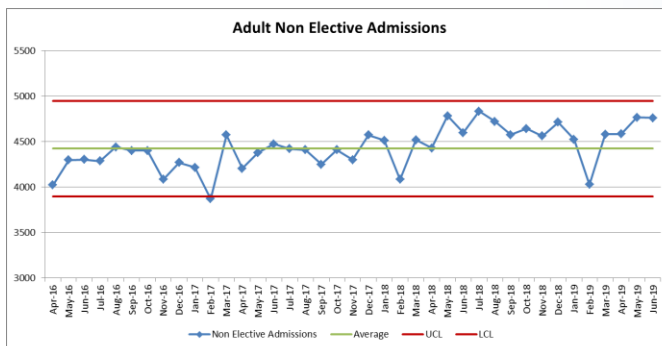
Assurance Framework
Responsive

Unplanned Care

Performance Update:

- The number of non-elective admissions in quarter 1 increased by 2% in 2019/20 compared to 2018-19 (+300). For twelve of the past sixteen months adult admissions have been above the four year average. Paediatric admissions continue to be high although June was below the four year average for the first time in 9 months.
- The adult readmission rate rose in April and continues to be above the four year average and is being investigated by the Trust’s analytics team. Paediatric readmissions fell below the four year average for the third time in five months.
- The Trust has in line with previous years seen an increase in bed pressures, with both Scarborough and York Hospitals experiencing bed occupancy of above 90% at midnight for all but two days during the entire month.
- The number of stranded patients at month end decreased in June, with the average daily number of beds occupied by a stranded patient showing a small reduction compared to May.
- The number of beds occupied by super-stranded patients (patients who stay more than 21 days) decreased compared to May, however there was a small increase in the average daily number of beds occupied by a super-stranded patients compared to May.

Performance:



Cancer Waiting Times

(Reported a month in arrears)

Operational Context

Overall, the Trust achieved 84.6% against the 14 day Fast Track referral from GP target in May. National performance for May was 90.8%.

The Trust continues to experience high numbers of Cancer Fast Track (FT) referrals, with an 8% increase in FT referrals in quarter 1 2019-20 compared to 2018-19. Due to this continued rise in referrals, the Trust is undertaking more cancer activity which is impacting on the capacity available for routine outpatient appointments, negatively affecting the Trust's RTT incomplete total waiting list position.

Performance against the 62 day target from referral to treatment decreased slightly from April to May (80.6% to 79.5%) and remains below the 85% national target. National performance for May was 77.5% with the Trust ranked 63rd out of 134 provider (85% target). May was the third lowest month on record for England as a whole and the 6th consecutive month that the Trust has outperformed the national position.

The Trust's performance equated to 132 accountable patients treated in May, with 27 accountable breaches. These were spread across a range of tumour pathways, with the highest number of breaches seen in Colorectal and Urological cancers. Of the reported patient breaches, 60% relate to delays for medical reasons, delays to diagnostic tests or treatment plans/lack of capacity, 28% relate to complex or inconclusive diagnostics and 12% were due to patient unavailability.

With the exception of the 14 day Symptomatic Breast standard, all other cancer waiting time targets were met in May.

Progress towards the April 2020 target to diagnose patients within 28 days continues (target percentage yet to be set), with performance of 61.9% in May; this target is currently being shadow reported. National comparative data is set not currently available.

Targeted actions

- Recovery plans being developed for Cancer – any tumour sites not achieving the 14 day and/or 62 day standards.
- Weekly Monday AM meeting established between Chief Operating Officer and Directorate Managers to implement “senior plan for every patient” above 28 days. The aim is to remove 7-14 day marginal delays in order to prevent further 62 day breaches in the future.
- New weekly ‘Cancer Wall’ meeting being setup and trialled.
- A revised criterion for prostate diagnosis has been agreed internally, reducing the number of patients who will require an MRI. This will ensure that those who do require an MRI will receive it sooner.
- Pathways have been reviewed for all the major tumour groups and work is ongoing to embed the timed pathways.
- Collaborative work with primary care and commissioners is ongoing to support referral processes.
- Continued engagement in regional Cancer Alliances and with the STP on increasing capacity.
- Review of cancer governance arrangements ongoing following a visit to James Cook Hospital.

Assurance Framework
Responsive

14 Day Fast Track – Cancer Waiting Times

Standard(s):



Fast Track referrals for suspected cancer should be seen within 14 days.

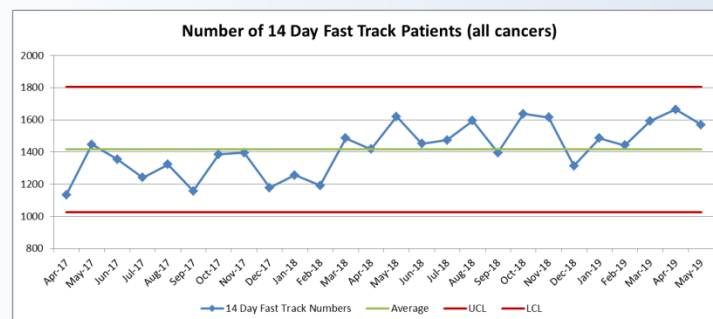
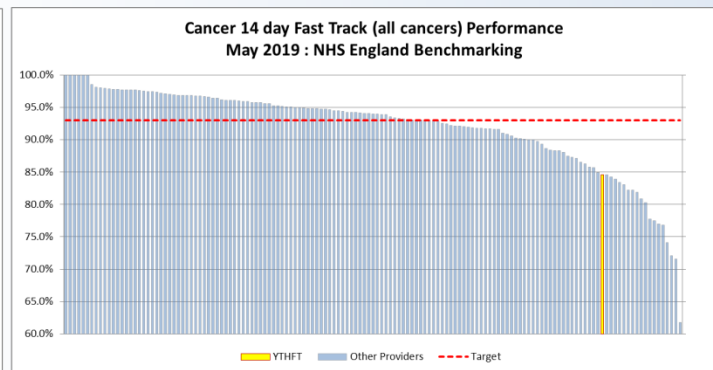
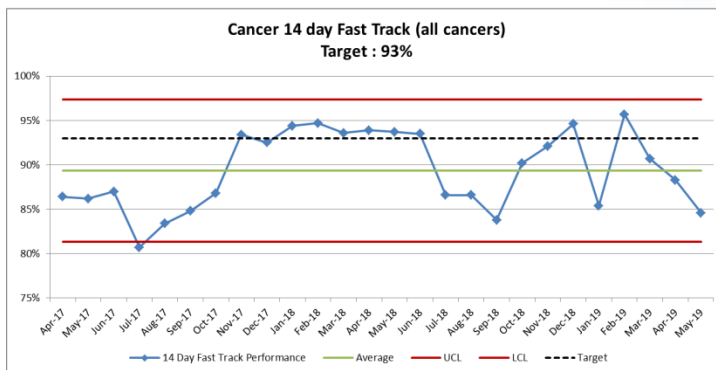
Consequence of
under-achievement:

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

Performance Update:

- Overall, the Trust achieved 84.6% against the 93% target in May 2019. The 93% target was met for Breast, Gynaecological, Haematology, Upper GI and Urological.
- We are continuing to experience high demand in relation to cancer fast track referrals, with an 8% increase in referrals seen in quarter 1 2019/20 compared to 2018/19.

Performance:



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 an urgent GP or dental referral.

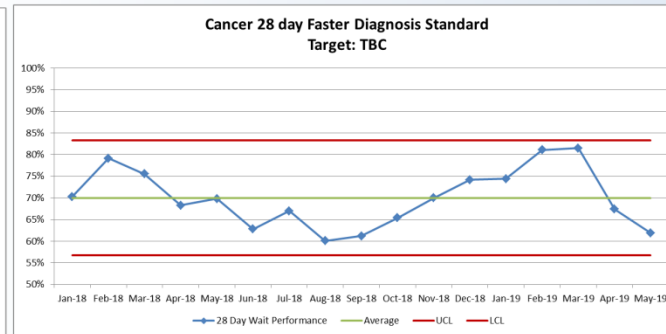
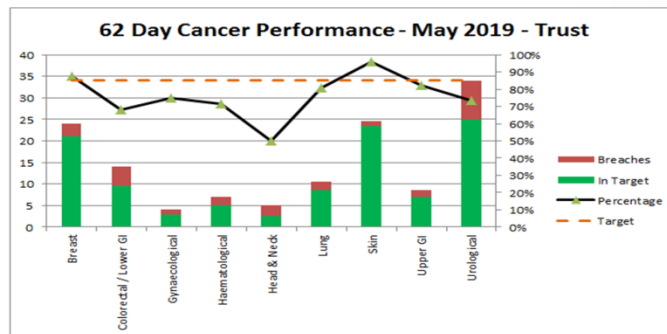
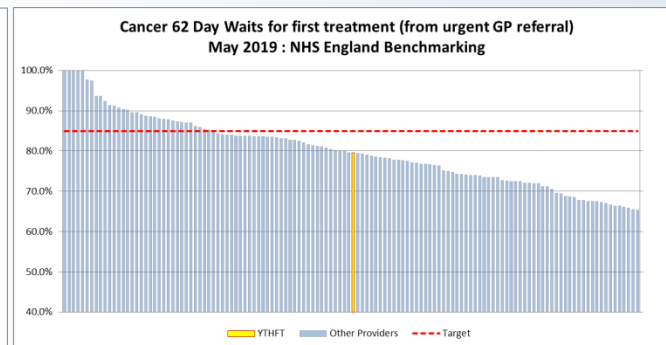
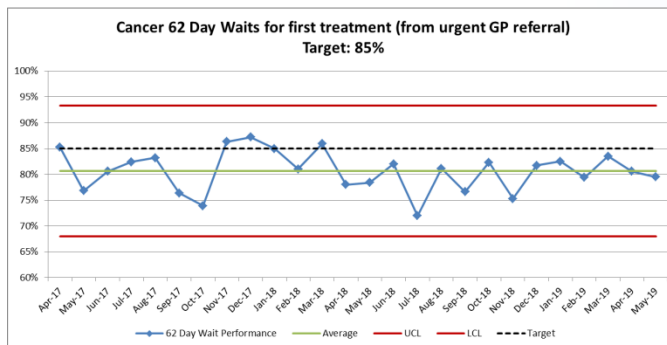
Consequence of
under-achievement:

Patient experience, clinical outcomes and potential impact on timely access to treatment.

Performance Update:

- Performance against the 62 day target from referral to treatment decreased slightly from April to May (80.6% to 79.5%) and remains below the 85% national target. National performance for May was 77.5%. The Trust's performance equated to 132 accountable patients treated in May, with 27 accountable breaches. These were spread across a range of tumour pathways, with the highest number of breaches seen in Colorectal and Urological cancers.
- Of the reported patient breaches, 60% relate to delays for medical reasons, delays to diagnostic tests or treatment plans/lack of capacity, 28% relate to complex or inconclusive diagnostics and 12% were due to patient unavailability.

Performance:



Operational Context

The Trust has seen a 0.3% decrease in the total incomplete RTT waiting list (TWL) at the end of June, falling to 28,723. This is ahead of the trajectory of 29,722 submitted to NHSE&I.

GP Referrals received by the Trust in June were below the four year average for the fourth consecutive month, the number received YTD is a 6% reduction on those received in quarter 1 2018-19. Non-cancer GP referrals are down 8% at the end of quarter 1 compared to Q1 2018-19.

The Trust YTD is 2% behind the planned activity levels for elective inpatients, 5% behind plan on day cases and has not delivered the planned level of outpatient appointments; follow ups in particular are down 11%. General Surgery and Cardiology are particularly down against plan and therefore have seen large numerical rises in TWL compared to the end of March 2019, analysis is being undertaken by the Trust's Information Team to understand the disparity in TWL, referral and activity changes across specialities.

The Trust's RTT position for June was 78.3%, below the 80.0% trajectory that was submitted to NHSE&I. The backlog of patients waiting more than 18 weeks increased by 10%, primarily on the non-admitted pathway. The impact of cost reduction schemes across the local healthcare system on the RTT TWL and performance are currently being modelled.

The number of long wait patients (those waiting more than 36 weeks) increased by 28 at the end of June. Long waiting patients are across multiple specialities, with weekly monitoring in place by the Corporate Operations Planning and Performance team.

There were 3 patients waiting over 52 weeks at the end of June; 2 in Urology and 1 in Ophthalmology. The 2 urology patients declined dates in June and were both treated on the 2nd July. The Ophthalmology patient had a date of the 24th June but was cancelled due to a more urgent patient. The patient subsequently made themselves unavailable until the 15th July. The patient has a booked date for the 15th July.

In March 2019 the Trust completed a project with the North of England Commissioning Support team (NECS). NECS conducted a diagnostic analysis on the Trust's TWL and provided a report to NHSE&I that gave assurance that the Trust has "appropriate validation, training and SOPs in place" for RTT and is "in control of the RTT TWL".

The Trust has seen an improvement against the national 6 weeks diagnostic target in June, with performance of 88.9% (up from 86.4% in May), against the standard of 99%. National performance for May was 95.9%, the worst performance since February 2008. Pressures remain in endoscopy, Echo CT, Non-Obstetric Ultrasound and MRI. Echo-cardiographs have been affected by staff shortages and the service is reviewing actions to mitigate pressures. Action plans for all modalities not achieving the standard are being refreshed and regularly monitored with directorates.

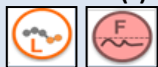
Targeted actions

- Recovery plans being developed for RTT/TWL – any specialties above the March 2018 waiting list position and/or significantly off plan for 2019/20.
- Ongoing implementation of the programme structure and metrics for the core planned care transformation programmes covering theatre productivity, outpatients productivity, refer for expert opinion and radiology recovery.
- Ongoing monitoring of all patients waiting over 40 weeks to ensure all actions are taken to ensure patients have a plan to avoid a 52 week breach.

Assurance Framework
Responsive

18 Weeks Referral to Treatment

Standard(s):



The total incomplete RTT waiting list must have less than 26,303 open clocks by March 2020. The Trust must not have any 52 week breaches in 2019-20.

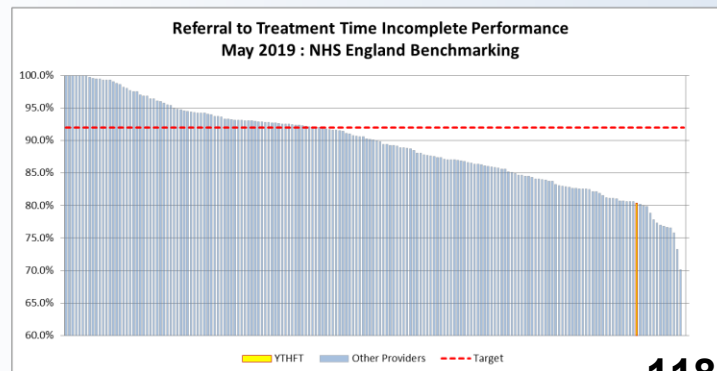
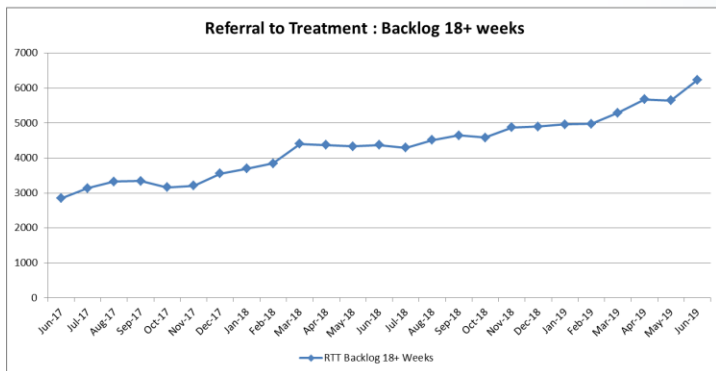
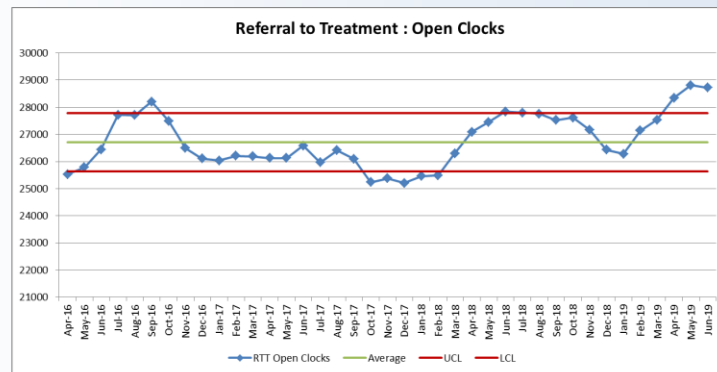
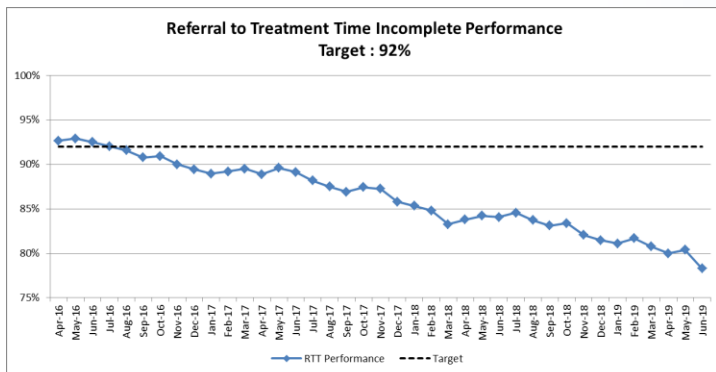
Consequence of under-achievement:

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

Performance Update:

- The total number of patients on an RTT incomplete pathway was 28,723 at the end of June, this is ahead of the trajectory of 29,722 submitted to NHSE&I.
- The Trust achieved 78.3% RTT at the end of June, below the 80.0% trajectory submitted to NHSE&I.
- The Trust 'Did Not Attend/Was Not Brought' (DNA) rate decreased to 5.9% in June, the 10th consecutive month below the two-year average. Work is ongoing to move the Trust from a 1-way text reminder service to a 2-way opt-out service.

Performance:



Assurance Framework Responsive

Diagnostic Test Waiting Times

Standard(s):



Ensure at least 99% of patients wait no more than 6 weeks for a diagnostic test.

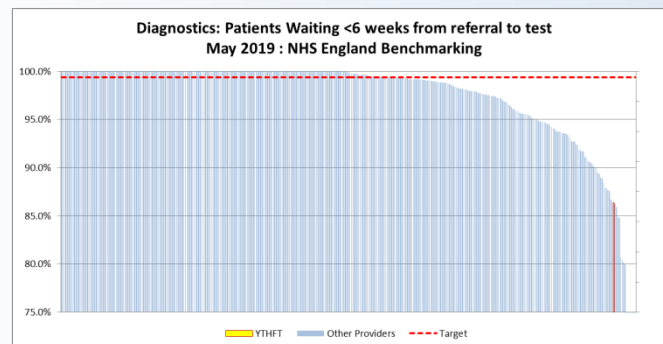
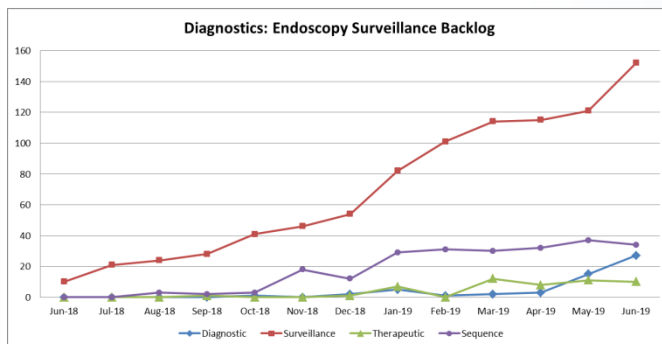
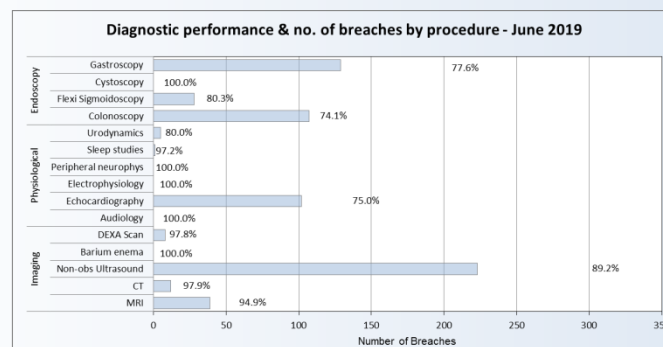
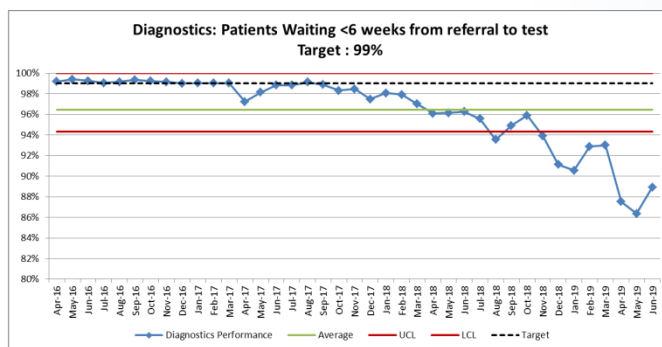
Consequence of under-achievement:

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

Performance Update:

The Trust has seen an improvement against the national 6 weeks diagnostic target in June, with performance of 88.9% (up from 86.4% in May), against the standard of 99%. Pressures remain in endoscopy, Echo CT, Non-Obstetric Ultrasound and MRI. Echo-cardiographs have been affected by staff shortages and the service is reviewing actions to mitigate pressures. Action plans for all modalities not achieving the standard are being refreshed and regularly monitored with directorates.

Performance:



Assurance Framework
Responsive

Commissioning for Quality and Innovation (CQUIN): 2019-20

CQUIN Name & Description	Executive Lead	Operational Lead	Quarter 1 RAG & Risks	Quarter 2 RAG & Risks	Quarter 3 RAG & Risks	Quarter 4 RAG & Risks
CCG1a: Antimicrobial Resistance; Urinary Tract Infections	James Taylor	Rachel Davidson	Amber Discussions ongoing with COG to agree local arrangement to deliver QJ project			
CCG1b: Antimicrobial Resistance; Colorectal Surgery	James Taylor	Michael Lim	Green			
CCG2: Uptake of Flu Vaccinations Improving the uptake of flu vaccinations for frontline clinical staff within Providers to 80%.	Polly McMeekin	Karen O'Connell and Sarah Tostevin	Amber Due to performance in 2018/19			
CCG7: Three high impact actions to prevent Hospital Falls	Helen Hey	Rebecca Hoskins	Amber Baseline and improvement trajectory to be agreed as part of Q1 evidence			
CCG9: Six Month Reviews for Stroke Survivors	Wendy Scott	Jamie Todd	Green			
CCG11: Same Day Emergency Care; Pulmonary Embolus, Tachycardia with Atrial Fibrillation and Community Acquired Pneumonia	Wendy Scott	David Thomas and Jamie Todd	Amber Exclusion criteria, baseline and improvement trajectory to be agreed			
PSS3: Cystic Fibrosis Supporting Self-Management	Wendy Scott	Karen Cowley	Green			

Board of Directors – 31 July 2019

Director of Estates and Facilities Report – July 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	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>		

Purpose of the Report

The purpose of this report is to provide monthly updates and assurance to the Board of Directors via the Resources Committee relating to the corporate responsibilities of the Estates and Facilities Directorate.

Executive Summary – Key Points

The Director of Estates and Facilities Report provides the Resources Committee with an overview of the key responsibilities of the Estates and Facilities Directorate and highlights any prevalent themes.

Recommendation

The Resources Committee is asked to note the updates and assurance provided.

Author and Director Sponsor: Brian Golding, Director of Estates and Facilities

Date: July 2019

1. Director's Overview

I am on annual leave and so will not be attending this meeting. Dave Biggins will attend to answer questions on the compliance report, Jane Money will brief the Committee on the planned sustainable development engagement project and Andrew Bennett will attend as deputy Managing Director of YTHFM.

I am conscious that we have agreed to engage the Committee in the backlog maintenance prioritisation process and Andrew Bennett, who leads on capital planning, will be able to explain how we intend to do this.

2. YTHFM Band 1 to Band 2 Transition

A further letter was issued to all existing Band 1 members of staff on 27 June reminding them that the opportunity to transition to Band 2 is still available. Responses have been requested by 12 August. A Frequently Asked Questions and Answers document was enclosed with the letter and Andy Betts will be delivering a number of extraordinary briefing sessions during week commencing 22 July to answer any further questions and hopefully alleviate any concerns.

3. Health, Safety and Security

The monthly Health and Safety report for the Trust and LLP is attached at Appendix 1.

At the time of this report, there have been no reportable accidents recorded for this month.

The Trust's Health and Safety Non-Clinical Risk Group met on 24 June; the Group wishes to highlight the following items to the Resources Committee for information:

- The Group has received an overview in relation to statutory mandatory training and will be reviewing food safety elements of essential skills training following recent listeria announcements linked to sandwiches within Hospital environments.
- A detailed report will be presented in due course in relation to the self-assessment audit results; there are concerns regarding the integrity of the responses and the position will be reviewed. Membership of the Group will be reviewed in line with this workstream and address whether a health and safety lead is required within each Care Group.
- A briefing note is being prepared in order to provide key information and raise awareness of how to keep our corridors safe and clear of clutter

Summary Note: Committee members are asked to note the contents of this report and the update from the Trust's Health and Safety Non-Clinical Risk Group.

Estates and Facilities Compliance

The June report from the Trust's Estates and Facilities Compliance Unit is attached at Appendix 2. This report will be presented to the LLP Management Group and the LLP Operational Management Group.

All policies and procedures are now in final draft, with only a handful awaiting formal endorsement by the approving groups and committees.

YTHFM senior managers are now focussed on recovering the Premises Assurance Model safety domain scores, back to the 2018 level, and are targeting elimination of any 'red' scores.

4. Sustainability Update

The Committee will remember that the Trust's next significant project in this area involved the appointment of an external consultancy to work with us to raise awareness of environmental issues across the Trust.

The Sustainability Engagement project is now being launched and work is commencing in line with the mobilisation period of the project. An update report is attached at Appendix 3, which Jane Money, the Trust's Head of Sustainable Development will explain.

The Trust's Travel and Transport Group met on 17 May 2019 and the minutes of this meeting are enclosed for information at Appendix 4.

Summary Note: Committee members are asked to note the contents of this report and the minutes of the latest Travel and Transport Group meeting.

5. Space Management

The Trust's Space Management Group met on 23 April 2019 and the minutes of this meeting are enclosed for information at Appendix 5.

6. Detailed Recommendation

The Resources Committee is asked to note the updates and assurance provided.



APPENDIX 1

Health and Safety Non-Clinical Risk Summary Report – June 2019

1. Introduction

This report relates to June 2019 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. June Summary

Opened Employee and Public Liability Claims

Trust Claims

At the time of the production of May's report information relating to claims had not been submitted. In May 2019, 2 claims were logged against the Trust; these are summarised below:

YHT/S/19/037 - Employers liability - During a carefully planned admission of a patient who required additional assistance and had carers present, the claimant was physically assaulted by the patient sustaining a bite wound to her right hand.

YHT/S/19/039 - Public liability - Alleged claimant was transferring from a hospital wheelchair to a car seat in the car park when a wheel came off and moved sideways tipping them to the floor causing concussion and laceration injury to the head.

In June 2019, 3 claims were logged against the Trust and these are summarised below:

YHT/S/19/047 – Employers liability – It is alleged that a staff member was injured due to a patient pulling them as the patient was seated. This caused MSK injuries. The claimant alleges that the patient required 2 staff to mobilise the patient.

YHT/Y/091 – Employers liability – It is alleged that a staff member was assaulted by a patient on Ward 17.

YHT/Y/19/107 – Employers liability – It is alleged that a staff member injured their back when lifting a patient.

LLP Claims

In June 2019, no claims were logged against the LLP.

Reported Non-Clinical Serious Incidents

In June 2019, no non-clinical serious incidents were reported.

Reported - Non-clinical Risk Safety Alerts.

In June 2019, there were no new non-clinical safety alerts reported to the Trust/LLP.











Health and Safety Performance Monitoring - Summary of June

Review of Datix-reported incidents for June identifies several key themes which are highlighted below:

- Reported staff incidents were down (12%); this was due to less incidents resulting in an injury and less general staff issues being reported for the month.
- Reported security issues were down (16%). As reported in May, this continuing downwards trend is across all sub categories.
- As in May, E&F Facilities reported incidents were significantly higher (63.3%) than the average monthly reports; this was due to the addition of a category relating to blockage of sluice being added to Datix in May. For June, 29 Datix reports were recorded for blocked sluice and macerators causing drainage systems problems. For the sub-category a more representative comparison would be between May (35) and June which shows a decrease of 17%.
- Reports of fire alarm activations and fire management issues were down (66.7%) on the monthly average. This was due to a fall in reports of activations from use of aerosols and contractors working on site and activating the fire alarm system.
- Reported E&F health and safety incidents were down (28.5%) on the monthly average with a decrease in reported identified dangerous occurrences.

For each reporting category under E&F non-clinical incidents on Datix (Trust HES and YTHFM) categories, Table 1 below shows the percentage change against the monthly average and a summary below shows the long term trend review of incidents in all categories.

The reporting categories and the associated number of incidents reported are detailed in Table 1 shown below. There has been no change in the level of incidents within the E&F Contact With category. An increase in incidents is indicated by a red upwards arrow for ease of reference; a decrease in incidents is indicated by a green downwards arrow.

Incident Type	Jun-19	Ave Record Month	% Var Month
E&F Contact With	0	0	 0%
Slips, Trips and Falls (Pt & Others)	257	246	 4.35%
Staff Incidents	73	83	 -12%
Security	21	25	 -16%
E&F Equipment Issues	28	25	 10.7%
E&F Facilities	44	16	 63.6%
E&F Fire	2	6	 -66.7%
E&F H&S	5	7	 -28.5%
Cumulative Total Month	430	409	 4.9%
Total Datix	1282	1286	 -0.31%

For June 2019, the Trust (SHE) and YTHFM LLP functions were responsible for leading on investigations into 50 incidents on Datix equating to 3.90% of the total number of incidents reported on Datix. The combined Trust (SHE) and YTHFM LLP functions reported 30 incidents on Datix, equating to 2.34% of the total number of incidents reported on Datix for all Directorates.

Long Term Trend Monitoring for Incident Type Category Q1 2019/20

Listed below is the summary of Q1 (April – June 2019) reported incident by category Trust/LLP split.

Combined sites	Quarter	19/20 Q1											
	Month	April			May			June			Summary Q1		
	Incident Category	Trust	LLP	Total	Trust	LLP	Total	Trust	LLP	Total	Trust	LLP	Total
E&F Contact With	Various	0	0	0	0	0	0	0	0	0	0	0	0
E&F Facilities	Building Issues	4	2	6	0	5	5	2	6	8	6	13	19
E&F Facilities	Sluice Blockages	1	0	1	34	0	34	29	0	29	64	0	64
E&F Facilities	Catering Issues	1	0	1	34	0	35	29	0	29	64	0	65
E&F Facilities	Cleaning Issues	0	2	2	0	0	0	0	0	0	0	2	2
E&F Facilities	Interpretation issues	1	0	1	0	1	1	0	2	2	1	3	4
E&F Facilities	Clinical waste	0	0	0	0	0	0	0	0	0	0	0	0
E&F Facilities	Switch board	0	0	0	0	0	0	1	1	2	1	1	2
E&F Facilities	Porters issues	1	0	1	1	0	1	0	1	1	2	1	3
E&F Facilities	Transport issues (v.tube)	1	2	3	0	2	2	0	1	1	1	5	6
E&F Facilities	Transport issues (vans)	0	0	0	0	0	0	0	0	0	0	0	0
E&F Fire	Fire alarm activation	0	2	2	1	0	1	1	0	1	2	2	4
E&F Fire	Fire safety management	7	4	11	4	4	8	1	0	1	12	8	20
E&F H&S	Dangerous occurrence	1	0	1	0	0	0	0	1	1	1	1	2
E&F H&S	Medical Gas	4	2	6	5	3	8	0	4	4	9	9	18
E&F H&S	Road Traffic Collision	0	0	0	0	1	1	1	0	1	1	1	2
E&F Equip	Reusable equipment	0	1	1	0	0	0	0	0	0	0	1	1
E&F Equip (inc Mediquip)	Single use equipment	19	3	22	8	2	10	18	2	20	45	7	52
STF	Slips Trips Falls (Pt & Others)	4	0	4	7	1	8	14	0	14	25	1	26
Staff Incidents	Contact with	197	1	198	262	0	262	257	0	257	716	1	717
Staff Incidents	Injury	1	0	1	1	0	1	1	1	2	3	1	4
Staff Incidents	Manual handling	18	4	22	32	2	34	25	3	28	75	9	84
Staff Incidents	Staff issues	1	0	1	5	0	5	7	0	7	13	0	13
Staff Incidents	Slips trips falls	33	3	36	23	1	24	16	2	18	72	6	78
Staff Incidents	V&A (staff)	5	0	5	2	1	3	3	0	3	10	1	11
Staff Incidents	Work related ill health	20	0	20	23	0	23	15	0	15	58	0	58
Security	V&A	0	0	0	0	0	0	0	0	0	0	0	0
Security	Security Issue	5	3	8	5	3	8	4	6	10	14	12	26
Security	Theft	2	5	7	6	3	9	3	8	11	11	16	27
Security	Drug / Alcohol Issue	1	1	2	0	2	2	2	0	2	3	3	6

Reporting under Reporting of Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) Q1 Summary

For June 2019, no RIDDOR accidents were reported on Datix.

RIDDOR is monitored on a weekly basis. For Q1, there have been 3 RIDDOR incidents reported; 1 incident at York Hospital, 1 at Scarborough Hospital and 1 at Malton Hospital.

All 3 incidents were classified as slips, trips or falls with no one common cause, details are summarised below for information:

- A staff member trying to recover an item from a 750 litre waste bin and falling against the bin;
- A staff member catching their foot in a bed sheet and;
- A slip on water splashed from a hand wash basin.

All of these reported incidents for the whole YTH group relate to YTHFM staff.

Patient Advice and Liaison Service (PALS) Data Q1

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

Q1 non-clinical and environmental (EFM) PALS are summarised below:

	Apr 2019	May 2019	Jun 2019	Jul 2019	Total
Concern	0	0	1	0	1
Compliment	1	0	0	0	1
Enquiry	2	3	4	3	12
Comment	3	5	3	2	13
Total	6	8	8	5	27

The general themes from the reported categories are detailed below:

- 1 comment, 1 enquiry and 1 concern were raised in relation to the attitude of the parking attendant in the blue badge parking area at York Hospital. Both have been addressed by the Security and Car Parking managers.
- The enquiries related to car parking charges, the safety of toilet door mechanisms with the Emergency Department at York Hospital and the positioning of signage at the main entrance to York Hospital. All enquiries have now been responded to.
- A concern was raised in relation to the knowledge of the staff on the Outpatients when questioned regarding the anti-coagulant clinic. This was incorrectly allocated to Estates and Facilities however the concern has now been addressed and no further action is required.
- A concern was raised by a visitor after they tripped at the main entrance of York Hospital. This has been addressed and Legal team have been advised.

3. External Authorities

There were no reported H&S/non-clinical interventions from external authorities for the month of June 2019. A CQC inspection is currently ongoing across the Trust. As at the date of this report, there has been no indication of any specific H&S/non-clinical issues being identified.

4. Conclusion

This report highlights the performance of health, safety and non-clinical risk in the Trust (SHE) and YTHFM LLP for June 2019 and a summary of Quarter 1, forming part of the ongoing oversight of the Trust's governance arrangements.

5. Recommendation

The Resources Committee 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: 11 July 2019

FM Contract (YTHFM)

Monthly FM Compliance Report

Month	June 2019
David Biggins	Head of FM Compliance & Performance
(Quarter) /Year	(1) 2019/2020
Version	1.0

Facilities Management Key Performance Indicator Dashboard- Month 3 - June 2019

Metric Description	KPI	York Site	SGH Site	Brid Site	Selby Site	Malton Site	Shift	Live KPIS
Policies & Procedures identified on the Policy and Procedure Register are approved and within review dates	100%	88%	88%	88%	88%	88%		5
TAPE Assessment								
All sites are achieving KPI against the Trust Assessment of Patient Environment (TAPE)	80%	84.85	84.85	95.46%	92.42%	87.88%		5
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%	8.00%	7.20%	7.60%	7.60%	8.00%		5
YTHFM is demonstrating less than 20% amber or red ratings against NHS Premises Assurance Model; Safety and Patient experience Domains	<20%	19.1%	39.60%	41.70%	42.90%	53.10%		5
PLACE Assessment								
Cleanliness Domain	98%	95.20%	92.90%	96.80%	100%	85.80%		5
Food Domain	78%	78.80%	81.30%	70.10%	83.80%	79.20%		5
Condition, Appearance & Maintenance Domain	85%	85.60%	86.60%	87.10%	98.40%	87.80%		5
Dementia Domain	78%	58.90%	58.70%	52.40%	78.00%	63.10%		5
Disability Domain	67%	67.10%	68.20%	50.20%	78.40%	66.70%		5
Environment & Equipment								
Catering Hygiene surveillance	29	24	27	28	28	28		5
Grounds & Gardens Surveillance	92%	75.00%	56.25%	43.75%	87.50%	81.25%		5
Medical Equipment Surveillance	90%	89.50%	94.00%	93.00%	96.50%	97.50%		5
Cleanliness Technical Audits								
Very High Risk Areas (av)	>98%	96.44	97.95	97.03	97.97			4
High Risk Areas (av)	>95%	88.53	93.83	97.74	91.54	90.85		5
Significant Risk Areas (av)	>85%	80.78	91.22	93.75	91.36			5
	KPIs Met	21	3	4	4	8	3	
	KPIs Partially Met	33	7	8	7	7	5	
	KPIs Not met	17	5	3	4	0	5	
	KPIs measured in period	71	15	15	15	15	13	

Green	KPI ratings within a range that indicates operational arrangements are effective and generally being met	29.50
Amber	KPI Ratings within a range that indicates some elements of good practice but also elements that require moderate improvement	46.60
Red	KPI ratings within a range that indicates weak operational controls and significant improvement required	23.90

Master KPI Summary - All Sites							
2019-2020		Apr-19	%	May-19	%	Jun-19	%
Green	KPI ratings within a range that indicates operational arrangements are effective and generally being met		36.50		34.70		29.50
Amber	KPI Ratings within a range that indicates some elements of good practice but also elements that require moderate improvement		34.70		43.10		46.60
Red	KPI ratings within a range that indicates weak operational controls and significant improvement required		28.80		22.20		23.90

1. Policy and Procedure Compliance- Directorate

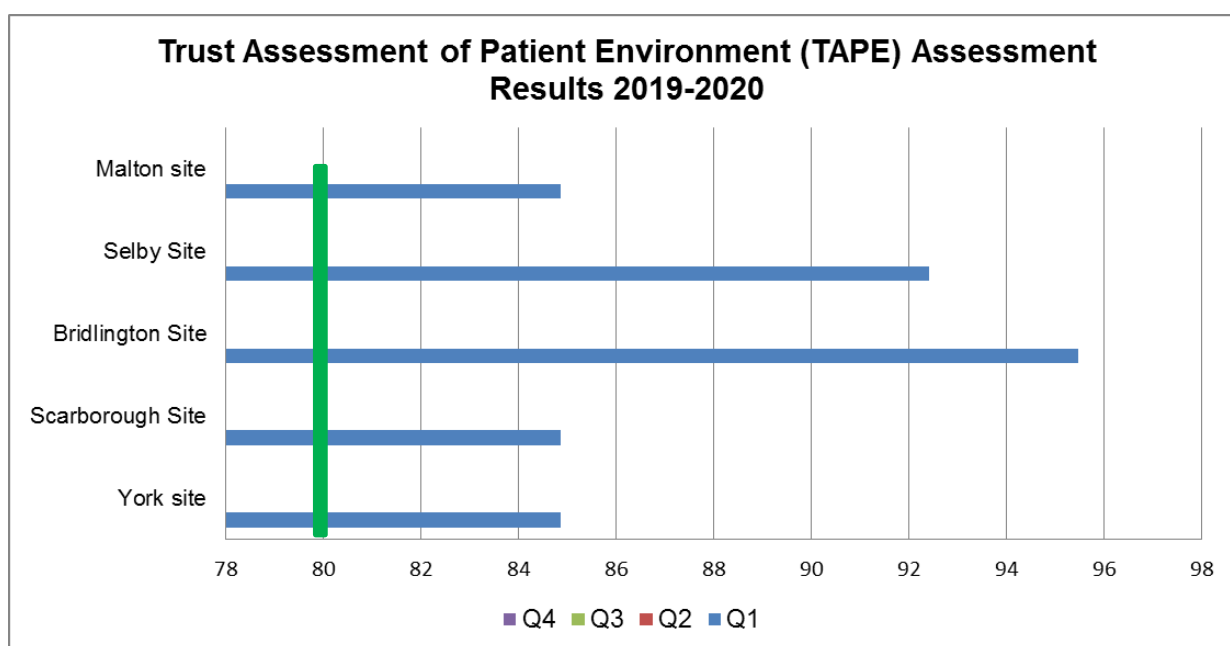
Estates & Facilities Directorate Policies & Procedure Register							
	Title	Format	Current Status	Policy in date or outstanding	Next Review Date	Authors	Approving Group/Committee
1	Asbestos Management	Policy	Approved		Nov-20	K Needham	Health & Safety Committee
2	Asset Management & Maintenance	Procedure	Approved		TBC	J Dickinson	Premises Assurance Group
3	Environmental Cleaning Policy	Policy	Approved		Oct-19	A Betts	Trust Infection Prevention Group
4	Health & Safety Policy	Policy	Approved		Apr-20	C Weatherill & K Needham	Health, Safety & Non Clinical Risk Group
5	Catering	Procedure	Approved		TBC	S Mollier	Site Facilities Management Group
6	Medical Gas Pipeline services management Policy	Policy	Approved		Oct-19	D Moon	Medical Gas Committee
7	Safety procedure; Natural Gas & LPG	Procedure	Approved		Nov-21	J Dickinson	Health & Safety Committee**
8	Water Safety & Legionella	Policy	Approved		Mar-22	D Moon	Water Safety Group
9	Electrical Safety	Plan	Approved		Feb-18	P Johnson	Electrical Safety Group
10	LOLER/Lifts	Procedure	Approved		Jan-22	J Dickinson	Health & Safety Committee
11	Ventilation & Air Conditioning	Procedure	Approved		Dec-19	J Dickinson	Ventilation Steering Group
12	Pressure Systems	Procedure	Approved	not published	TBC	J Dickinson	Health & Safety Committee**
13	Decontamination	Policy	Approved		Jun-21	D Biggins	Decontamination Steering Group
14	Fire Safety Management	Policy	Approved		Jan-21	M Lee & K Hudson	Health & Safety 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	not published	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		May-22	L David	Site Facilities Management Group
21	Portering	Procedure	Approved	not published	Jul-18	J Louth/H Stelmach	Site Facilities Management Group
22	Heatwave	Plan	Approved		Mar-19	C Weatherill.	Health & Safety Committee
23	Capital Projects Policy	Policy	None		TBC	A Bennett	CPEG
24	Inclusive built environment policy	Policy	Approved		Mar-21	D Biggins.	Health, Safety & Non Clinical Risk Group
25	Control of substances hazardous to health	Policy	Approved		Jul-20	K Needham	Health & Safety Committee

2. Decontamination of Reusable Medical Devices- Site

Decontamination of Reusable Medical Devices- Audit Dashboard				Reviewed: 28th January 2019								
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-18	Aug-19		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-19	Jan-20		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	1	1	12	15	Outpatients-SGH							
Cardio Unit -York	0	1	14	15	Cardio Unit -York							
Cardio Unit- SGH	2	1	12	15	Cardio Unit- SGH							
	3	16	442									

Trust Assessment of Patient Environment (TAPE) - Site

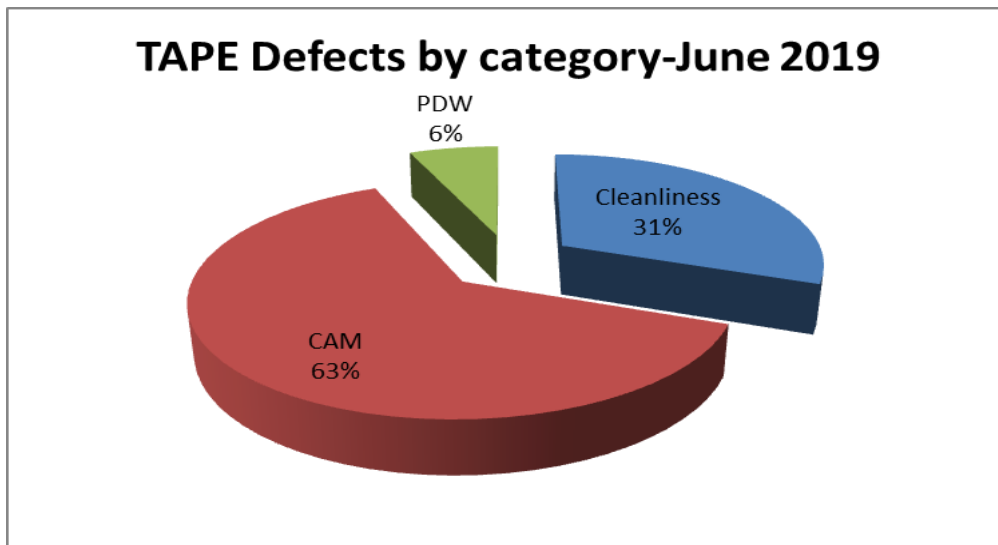
The Quarter 1 results for 2019/2020 are shown below with all sites where TAPE Assessment takes place now meeting and exceeding the key performance indicator and notably a reduction in defects of 66% against this time last year however some of this defect reduction will be due to the access assessment no longer being part of the TAPE Process.



There are currently over 60 Defects recorded on the TAPE 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 1-2019/2020 is shown below and shows that issues relating condition, appearance and maintenance of our estate came up over 60% of the defects identified.



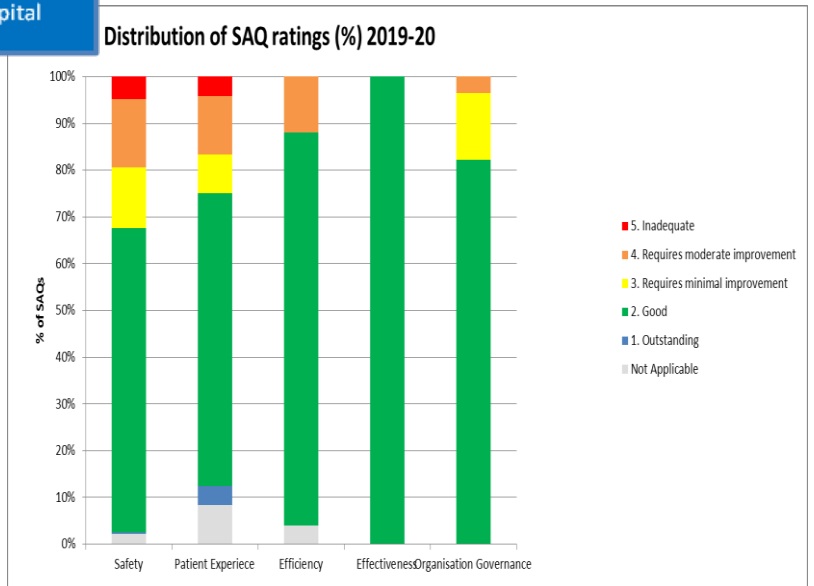
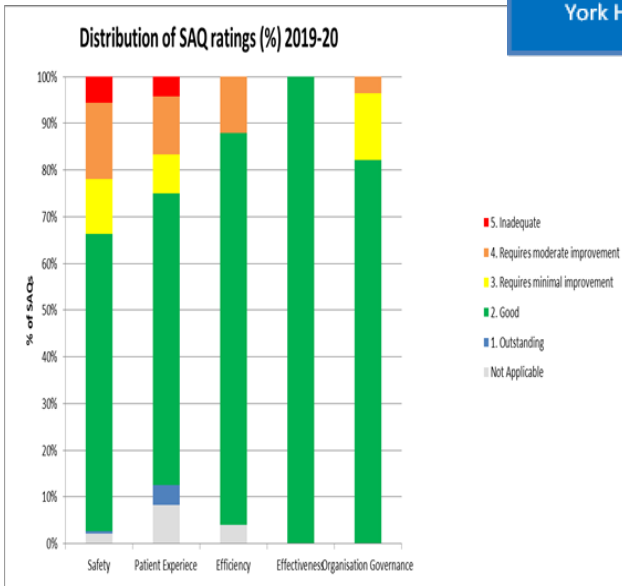
Full details of current TAPE Defects are provided at Appendix 1

NHS Premises Assurance Model Position

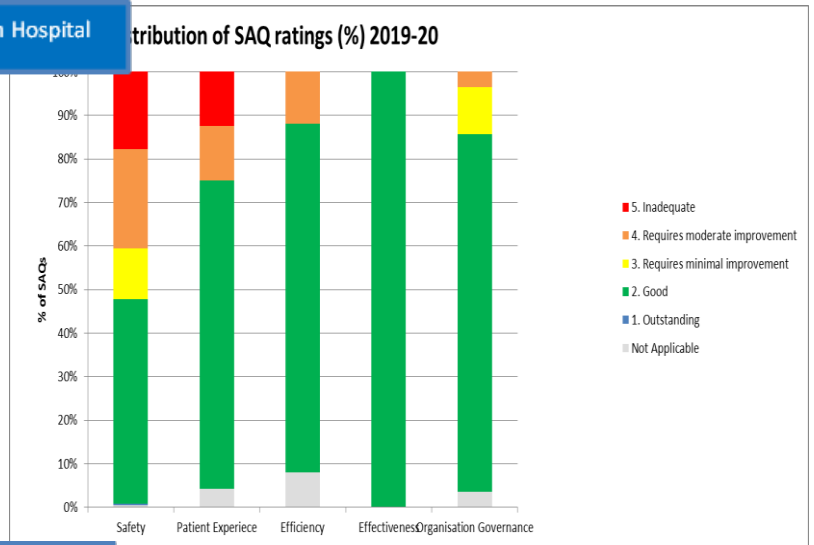
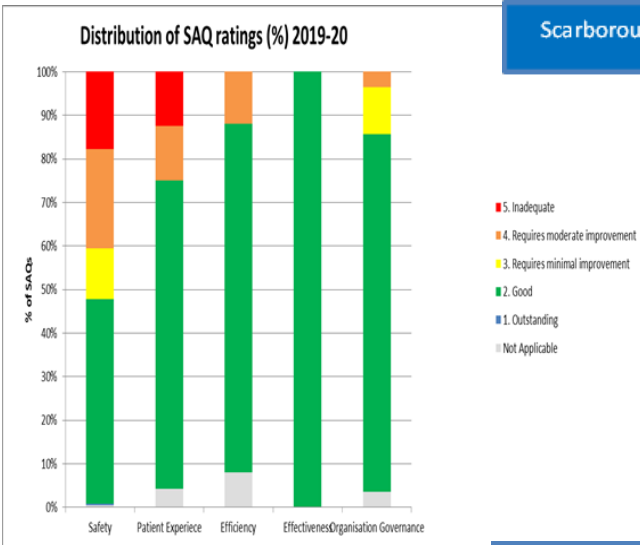
May 2019

June 2019

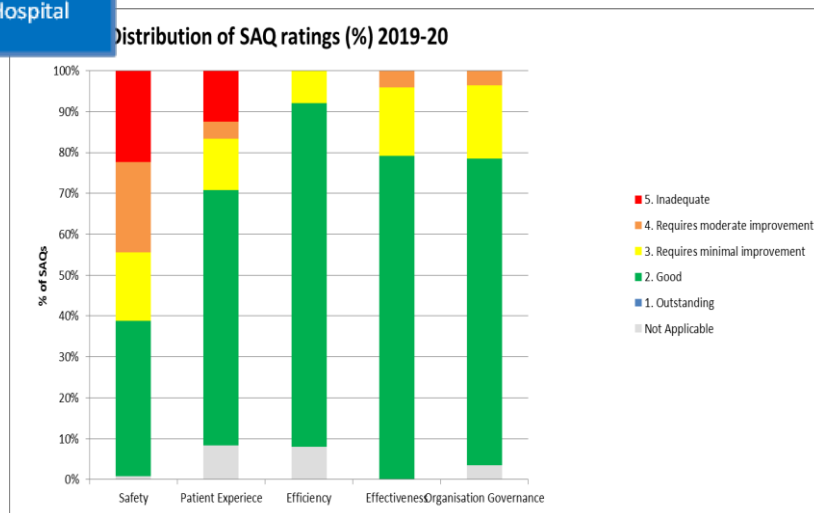
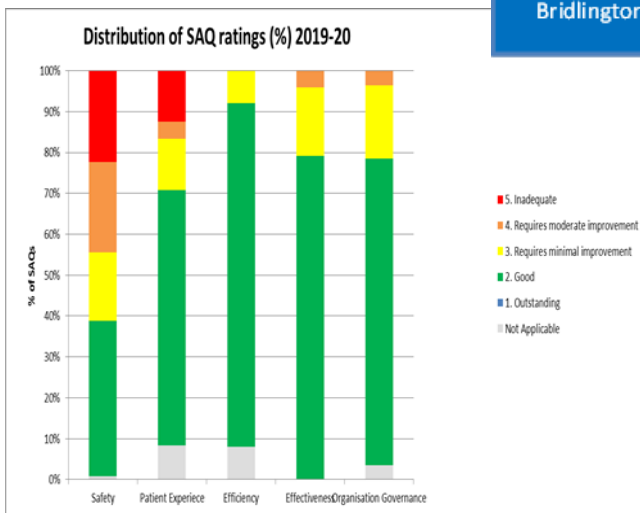
York Hospital



Scarborough Hospital



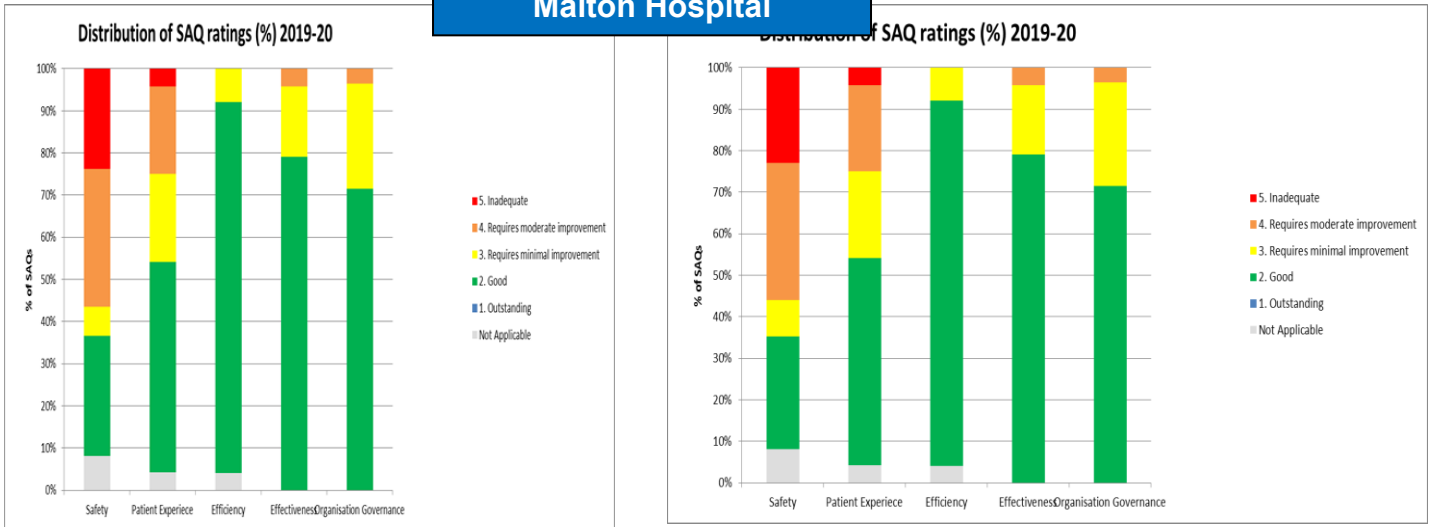
Bridlington Hospital



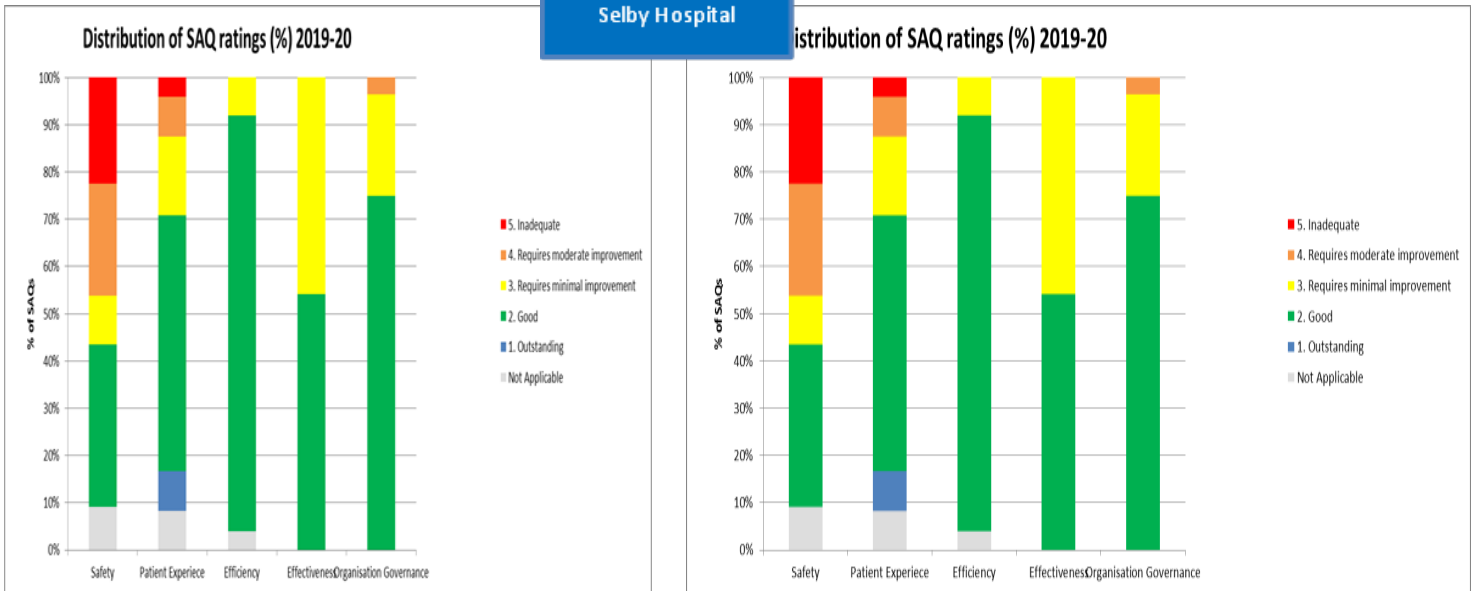
May 2019

June 2019

Malton Hospital



Selby Hospital



NHS Premises Assurance model has improved against last month's report although the transparency of evidence to support compliance decisions remains an issue with much of the supporting evidence not available to view.

This issue was raised during a recent internal audit and it is understood from the Action Plan, a copy of the relevant section is shown over the page. It should be noted that the deadline for this improved visibility of live data has now expired.

Excerpt from Audit Y1947 Action Plan

Finding	Risk	Recommendation	Priority	Management Response	Responsible Officer	Target Date
Audits A schedule of 'unannounced' compliance audits against SAQ guidance by the AHEF and his team have not been formally established and carried out.	Failure to comply with statutory legislation leading to legal action and/or financial penalties.	1. Management should formally schedule and carry out 'unannounced' compliance audits to identify areas of weakness and potential further training.	Moderate	We will be carrying out audits to a schedule to cover all functions at all sites. The aim is to have a functional system that is visible to everyone with live data.	John Dickinson/ Malcom Gresty	1 June 2019

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

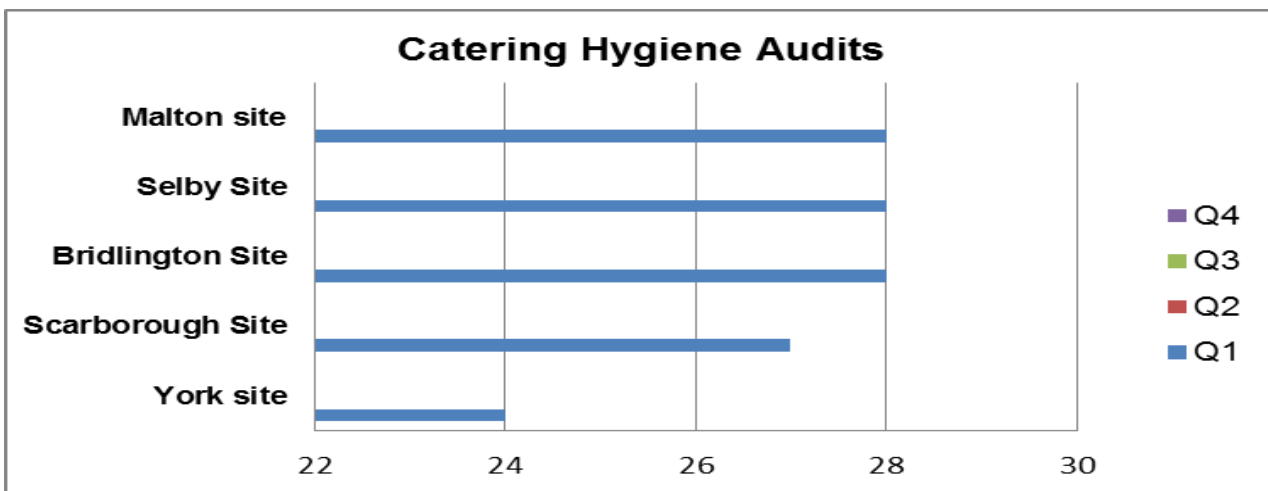
	CLN Score %	Food Score %	PDW Score %	Condition Score %	DEM Score %	DIS Score %
RCB55 YORK HOSPITAL	95.27%	78.84%	76.41%	85.66%	58.98%	67.21%
RCBCA SCARBOROUGH HOSPITAL	92.98%	81.36%	70.94%	86.67%	58.74%	68.71%
RCBNH BRIDLINGTON HOSPITAL	96.87%	70.12%	77.11%	87.10%	52.45%	50.20%
RCB05 ST MONICAS HOSPITAL	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 position than previous year

Catering Hygiene Audits

Quarter 1 catering Hygiene audits for main food production units and kitchens are shown below. The audit scores at the York food production unit are of a particular concern. This is now the 3rd quarter running at which the York site scores have been rated as inadequate and it is recommended that Facilities Managers plan actions to improve compliance in this area as a priority.

Compliance Rating	Q1
York site	24
Scarborough Site	27
Bridlington Site	28
Selby Site	28
Malton site	28

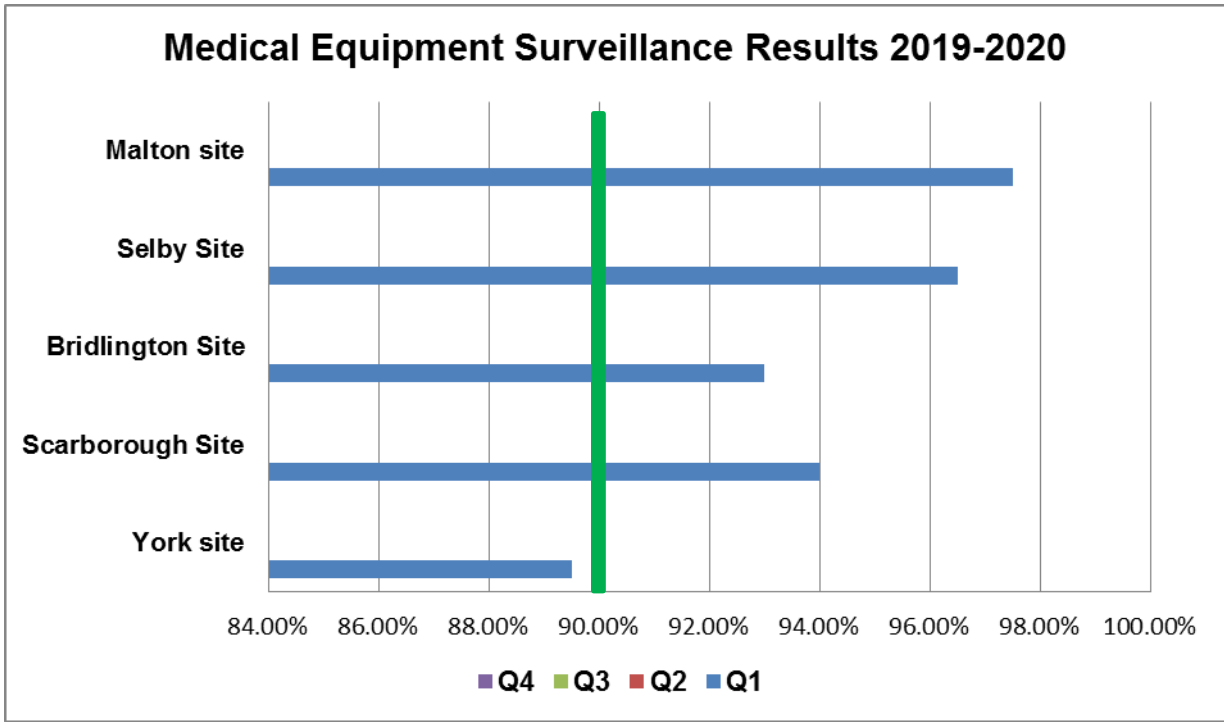


Medical Equipment Surveillance Results

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.

All sites at Quarter 1 are meeting the key performance indicators with the exception of the York site which is less than 1% outside of the KPI of 90%.



Cleanliness monitoring results

The KPI master dashboard at Page 2 indicates that as an average over the latest 4 week period there have been no inadequate ratings within any cleaning risk categories across the organisation however there is room for improvement to move the from amber rating to green in the “very high risk” and “high risk” category areas.

The tables below show the average results for operating theatres at the 3 main sites for June 2019.

York Hospital- Operating Theatres

Audit Type	Hospitals	Areas	DATE OF WEEK COMMENCING			
Facilities	YH	Theatres				
FUNCTIONAL AREA	ZONE	RISK LEVEL	1	2	3	4
			02/06/19	09/06/19	16/06/19	23/06/19
Theatres - Patient Areas	Theatres	Very High	94.97	94.73	93.08	98.01
Day Theatres	Theatres	Very High	98.52	98.21	97.13	99.02
Eye Theatres	Theatres	Very High	100	99.70	99.32	99.66
Key Performance Indicator			98	98	98	98

Scarborough Hospital- Operating Theatres

Audit Type	Hospitals	Areas	DATE OF WEEK COMMENCING			
Facilities	SGH	Theatres				
FUNCTIONAL AREA	ZONE	RISK LEVEL	1	2	3	4
			02/06/19	09/06/19	16/06/19	23/06/19
Main Theatres	Theatres	Very High	99.63	99.4	98.87	98.27
Key Performance Indicator			98	98	98	98

Bridlington Hospital- Operating Theatres

Audit Type	Hospitals	Areas	DATE OF WEEK COMMENCING	
Facilities	BDH	Theatres		
FUNCTIONAL AREA	ZONE	RISK LEVEL	1	3
			02/06/19	16/06/19
Main Theatres	Theatres	Very High	97.83	98.84
Vanguard	Theatres	Very High	97.13	99.93
Shepherds Daycase Theatre	Theatres	Very High	97.70	96.50
Key Performance Indicator			98	98

Inclusive built environment/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).

Access audit reports are being prepared following each audit and disseminated to Estates, facilities and site managers for information and any necessary planning of improvements or reasonable adjustments as required. An additional 5 audits have been completed since the last monthly report in May 2019.

A risk register of the top 50 accessibility improvements has been created and shared with the wider Estates and Facilities and Capital planning teams.

APPENDIX 1 TAPE DEFECT REGISTER

23/04/2019	SGH	2	Some welds missing from flooring	McMillan Unit	Corridors and approaches			CAM
23/04/2019	SGH	2	Areas of rubber skirting coming away from wall	McMillan Unit	Corridors and approaches			CAM
23/04/2019	SGH	2	Some flooring upstands coming away from wall particularly in corners	McMillan Unit	Corridors and approaches			CAM
23/04/2019	SGH	2	Marks and damage to wall paint surfaces	McMillan Unit	Corridors and approaches			CAM
23/04/2019	SGH	3	Staining to floor surfaces	McMillan Unit	Toilets and Bathrooms			CAM
23/04/2019	SGH	3	Build up of dust to high and low surfaces	McMillan Unit	Toilets and Bathrooms			CL
23/04/2019	SGH	3	Stains on surface of WCs	McMillan Unit	Toilets and Bathrooms			CAM
23/04/2019	SGH	4	Some holes in wall surfaces not filled	McMillan Unit	Toilets and Bathrooms			CAM
23/04/2019	SGH	3	Light pulls dirty and broken	McMillan Unit	Toilets and Bathrooms			CAM
23/04/2019	SGH	4	Trim damaged and coming away on sink unit	McMillan Unit	Toilets and Bathrooms			CAM
23/04/2019	SGH	4	Paint surface damaged under hand drier	McMillan Unit	Toilets and Bathrooms			CAM
23/04/2019	SGH	8	Build up of dust on large proportion of high areas throughout department	McMillan Unit	Department			CL
23/04/2019	SGH	23	Floor surfaces stained	Main Reception	Toilets and Bathrooms			CAM
23/04/2019	SGH	23	Hand rails dusty	Main Reception	General Reception area			CL
23/04/2019	SGH	23	Dirt build up around floor joints and welds	Main Reception	General Reception area			CL
23/04/2019	SGH	23	Build up of dust and cobwebs in some ceiling vents	Main Reception	General Reception area			CL
23/04/2019	SGH	33	Plastic ceiling tiles missing	Corridor	2nd floor new side			CAM
23/04/2019	SGH	33	Areas of damaged floor surface taped and worn	Corridor	2nd floor new side			CAM
23/04/2019	SGH	33	Areas of damaged floor screed	Corridor	2nd floor new side			CAM
23/04/2019	SGH	33	A number of bumper boards damaged and loose	Corridor	2nd floor new side			CAM
23/04/2019	SGH	33	Seals around expansion joints in floor broken	Corridor	2nd floor new side			CAM
23/04/2019	SGH	33	Plaster damaged on corners of walls	Corridor	2nd floor new side			CAM
23/04/2019	SGH	60	No lockable storage on the ward for patients	Cherry Ward	All patient bedded areas			CAM
23/04/2019	SGH	48	Build up of dust on large proportion of high areas.	Cherry Ward	General department			CL
23/04/2019	SGH	46	Debris in cutlery storage, floor needs scrubbing, vents dusty and hand wash sink dirty and build up around tap spouts	Cherry Ward	Kitchen			CL
23/04/2019	SGH	42	High proportion of marks on walls	Cherry Ward	Corridors and approaches			CAM
23/04/2019	SGH	42	Marks on wall laminate both on surface and underneath	Cherry Ward	Corridors and approaches			CAM
08/05/2019	BRID	24	2 x soft chairs in entrance stained in poor condition.	Main Reception	General Reception Area			CAM
08/05/2019	BRID	24	1 x light diffuser missing and 2 x light diffusers broken.	Main Reception	General Reception Area			CAM
08/05/2019	BRID	24	Trim missing off entrance doors vision panel, also general damage.	Main Reception	General Reception Area			CAM
08/05/2019	BRID	24	Build up of dust in uplighters.	Main Reception	General Reception Area			CL
08/05/2019	BRID	24	Build up of dust on roof structure above entrance doors.	Main Reception	General Reception Area			CL
08/05/2019	BRID	24	Tape on floor around internal drain cover.	Main Reception	Male Toilet			CAM
08/05/2019	BRID	24	Unfilled holes in wall adjacent to sink.	Main Reception	Male Toilet			CAM
08/05/2019	BRID	24	Paint missing off wall adjacent to sink.	Main Reception	Male Toilet			CAM
08/05/2019	BRID	24	Water damage to flooring under sink.	Main Reception	Male Toilet			CAM
08/05/2019	BRID	24	Rust and dirt build up around base of toilet.	Main Reception	Male Toilet			CAM
08/05/2019	BRID	24	Build up of scale in waste water preventer	Main Reception	Male Toilet			CAM
08/05/2019	BRID	24	Rust on floor covering from rusty bin base.	Main Reception	Female Toilet			CAM
08/05/2019	BRID	24	Toilet door stop loose.	Main Reception	Female Toilet			CAM
08/05/2019	BRID	24	Damage to wall surfaces.	Main Reception	Female Toilet			CAM
08/05/2019	BRID	60	No lockable storage on the ward for patients	Lloyd Ward	General Department			PDW
08/05/2019	BRID	59	No privacy curtains in bathrooms, bath is visible when door is open.	Lloyd Ward	General Department			PDW
14/05/2019	Selby	5	No Cleaning Schedules publically displayed in the department.	Radiology	General Department			CL
14/05/2019	Selby	20	Non patient and visitor area (store) unattended and insecure.	Radiology	General Department			CAM
14/05/2019	Selby	20	Non patient and visitor area (store) unattended and insecure.	Radiology	General Department			CAM
14/05/2019	Selby	34	Excessive amount of dust and debris in lift door channels.	Passenger Lift	Lift A			CL
14/05/2019	Selby	39	Build up of dust on top of wall lights.	Stair Case	Stair case A			CL
14/05/2019	Selby	39	Build up of dust on window cills.	Stair Case	Stair case A			CL
14/05/2019	Selby	39	Exposed areas of building adhesive on inside edge of stair risers/treads.	Stair Case	Stair case A			CAM
14/05/2019	Selby	52	Underside of commode dirty.	IPU Ward	Room 4			CL
14/05/2019	Selby	52	Underside of commode dirty.	IPU Ward	Room 5			CL
14/05/2019	Selby	52	Build up of dust on base of blood pressure monitor.	IPU Ward	Ward			CL
18/06/2019	York	5	No publicly displayed cleaning schedule	Renal	Not applicable			CL
18/06/2019	York	6	Renal Kitchen - Floors, sockets & high dusting	Renal	Kitchen			CL
18/06/2019	York	27	Purell dispenser empty outside ADU	AMU reception	Not applicable			CAM
18/06/2019	York	34	Lift - lift grooves, starting, floor	Junction 5 lift bay	AL5			CAM
18/06/2019	York	42	Flooring needs repair, scuffs and damage to walls, veneer on nurses station damage	Ward 22	Corridor			CAM
18/06/2019	York	46	Tops of cupboards very dusty, fly screen dusty, build up around edges of floor, food service trolley very dusty on rear and dirty around base of trolley, interior of fridge needs cleaning.	Ward 22	Kitchen			CL
18/06/2019	York	56	Floor needs repair. Damage to walls needs repair.	Ward 22	Sluice			CAM
18/06/2019	York	59	No privacy curtain in ward shower.	Ward 22	shower			PDW
18/06/2019	York	60	Patients have no access to lockable storage	Ward 22	All bedded areas			PDW

Sustainability Update - Sustainability Engagement on Cost and Carbon Reduction Project

Background

Corporate Directors approved the business case last year for a carbon and cost reduction programme which aims to integrate sustainability throughout the whole organisation.

The project is expected to save circa £100k per annum net after the newly created post salaries have been deducted. The Resources Committee report in March advised that there had been some delays caused by the recruitment process, but the project now has the full complement of agreed staff and work started on 3rd June with Consultants WRM to begin to mobilise the project.

Project Update

During the last month, a range of data sets have been provided to Consultants WRM to collate an up to date and accurate baseline. The data collation and mobilisation period will last until September when the various sub-projects will be launched.

WRM provided a briefing in June with key stakeholders within the Estates and Facilities teams setting out the timescales for mobilisation and giving a brief overview of each sub-project area from the following:

- **BMS Strategy, Optimisation and Training**
 - A BMS Technician has now been recruited and following a discussion with the consultants, has started work collating information in readiness for the strategy delivery part of this project.
- **Sub-Metering (Pilot)**
 - Pilot of sub-metering will be implemented in one or two areas/departments once a suitable area(s) has (have) been identified.
- **Energy Team & Energy Kaizens**
 - Formation of an energy team will be arranged to deliver focused improvement with energy kaizens. This will follow on from the work of the BMS strategy monitoring.
- **Energy Reduction Working Group**
 - A group will be established to meet monthly to discuss energy consuming assets and to plan course of action for improvements in efficiency.
 - WRM have arranged to meet the Energy Manager to develop this work for the September launch.
- **Teleconferencing Development (Trial)**
 - Discussions have begun about the teleconferencing options available across the Trust and initially 25 appropriate Senior Managers who currently drive between York and Scarborough at least once a week will be asked to take part in a trial which is anticipated to start in September.
- **Unions Engagement**

- WRM will prepare a briefing for engagement with Unions to advance sustainability agenda and discuss the project work.
- **Energy/Sustainability Awareness & Behaviour Change**
 - It is proposed that at least four staff energy and sustainability awareness campaigns will be established over the coming year from September. These campaigns will target areas of energy and environmental wastage, and improve patient experience.
 - The four campaigns will be promoted through recruited “champions” across the organisation.
 - The newly appointed Environmental Awareness Officer will be provided with best practice examples and templates for these campaigns.
- **Green Champions & Sustainability Awards**
 - The Environmental Awareness Officer is developing the work with WRM to recruit Green Champions who will support the sustainability work.
 - The Resources Committee is asked to endorse this work by requesting that Senior Managers across the Trust support (where possible) the attendance of Green Champion volunteers at regular meetings (to be held every 2-3 months) for one hour over lunch time. In addition, permission is requested for a small amount of time each month, wherever possible, so that the Green Champions can find out about current practices within their own work area and be an advocate for change which promotes more effective use of resources. This may include setting a good example; undertaking mini audits and surveys; and putting up posters, labels and stickers provided by the Environmental Awareness Officer (in conjunction with Energy, Waste and Travel colleagues) to reduce energy waste, improve recycling and support active travel and reduce single occupancy car journeys.
- **Material Re-use**
 - Discussions have begun with the Head of Procurement about the participation in material re-use initiatives using software called WARP-IT (for furniture and other materials/equipment re-use) which can improve Trust wide opportunities with improvements in monitoring.

Conclusion

A great deal of work is now in the process of beginning so that this project can officially launch the majority of the sub-project areas in September. This briefing seeks the support of the Resources Committee, the Board of Directors and Trust senior managers to embed these new ways of working throughout the organisation by endorsing the Green Champion recruitment and their project support work.

Recommendation

1. That the Resources Committee endorse the recruitment of Green Champions across the Trust and request that Senior Managers permit (where possible) the attendance of Green Champion volunteers at regular meetings (to be held every 2-3 months) for one hour over lunch time. In addition, permission is given for a small amount of time each month, wherever possible, so that the Green Champions can find out about current practices within their own work area and be an advocate for changes which promote more effective use of resources.

Prepared by
Jane Money
Head of Sustainability
Ext 6498

July 2019

APPENDIX 4

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST

Minutes of the Joint Travel and Transport Group Meeting held on Friday 17th
May 2019 at 10.00am in Ophthalmology Seminar Room (YH)

Present:	Brian Golding (Chair)	Director of Estates & Facilities, YTHFM
	Janet Mason	Head of Security / Car Parking
	Darren Miller	Security CP Manager
	Storm Baines	Enterprise
	Chris Pearson	Governor / North Yorkshire County Council
	Sheila Miller	Governor
	Robert Peacock	North Yorkshire Healthwatch
	Kenneth Gill	Ryedale Community Transport
	Kim Last	Local Negotiating Committee (Staffside Rep)
	Jane Money	Sustainability
	Dan Braidley	Trust Travel Planning Consultant
	Christian Malcolm	Transport Administrator
	Jane Money	Head of Sustainability
	Nathan Smith	Senior Buyer
	Don Mackenzie	Energy Manager
Apologies:	Karen Woodward	York Wheels
	Wendy Vaughan	Medical Secretary, Diabetes Centre
	Kenneth Gill	Ryedale Community Transport
	Kat Pickles	Transportation Business Officer, East Riding
	Simon Old	Consultant Side Rep
	Leslie Pratt	Healthwatch York
	Franco Villani	Staff Side Rep
	Phil Bland	Deputy Transport Manager
	Teena Wiseman	Staff Benefits
	Anne Penny	Staff Side Rep

1	<p>Apologies</p> <p>Attendee introductions made. Apologies for absence were received. JMas noted that Sarah Brown from HR would like to the join the group. CM to add to attendee list.</p>	CM
2	<p>Minutes of the Previous Meeting and Matters Arising</p> <p>The minutes of the meeting held on 20 November 2017 were agreed as a true and accurate record, with the following corrections taken note of:</p> <ul style="list-style-type: none"> P5, Community Travel – 3rd line, amend ‘deferred’ to ‘referred’ on 3rd line, with regards to free patient transport being referred to RCT <p>CM to make corrections and reissue. <i>Update: Correction completed.</i></p> <p><i>Community Travel</i> SM confirmed that the issue around the referred patients from YAS has calmed down in Malton, although problems still persist. There is greater pressure around patient transport at Scarborough and Bridlington however. RCT are attempting to encourage both sites to adopt a system where patients travelling to York only pay for the fuel costs.</p>	

<p>3.</p>	<p>Personal Travel Plan</p> <p>DB was not able to attend meeting, but has provided a set of notes with his updates, which was circulated around the group prior to the meeting. BG provided DBs travel plan updates.</p> <p>Travel plan has been approved and full and shortened versions are now available online on Staff Room and the Trust's website.</p> <p>Key aims of the plan were highlighted, which DB will be working on:</p> <ul style="list-style-type: none"> • Increase healthy and active travel • Reduce Pollution and congestion • Reduce single occupancy car journeys • Ensure there is fair and adequate provision • Contribute to sustainability agenda <p>BG drew attention to the aim of reducing pollution and congestion in particular, emphasising its importance in relation to the related health risks. The topic is now being dealt with NHS-wide and is being targeted specifically in its 5 year plan.</p> <p>Targets with measurable outcomes have also been identified. SM stated that from a Governor's perspective it was great to see a report with specific dates and times associated with the targets, as they are few and far between.</p> <p>A discussion was initiated by DMac on the measuring of pollution related targets and the extent to which this impact will cover. BG pointed out that even if the hospital CO2 levels are fine, that doesn't mean we aren't contributing to the issue on a citywide level, with Gillygate near York Hospital highlighted as a chief example. It's not just areas around hospitals though that need to target the problem. BG had seen a report of the dangerous levels of air quality outside of schools in Manchester, where the pupils as an action were approaching drivers with their vehicles idling and asking them to turn off their engines while making pick-ups and collections. SM pointed out that modern cars now have start/stop technology which will help over time. SB confirmed that all Enterprise pool cars have this technology included and that it is becoming the standard way forward across the board.</p> <p>JMas and DB will look at the travel plan targets and ascertain the actions we can take as Trust and with the local community to address pollution levels.</p>	<p>JMas & DB</p>
<p>4.</p>	<p>Staff, Patient & Visitors for York, Scarborough and Bridlington</p> <p><i>Staff Benefits</i></p> <p>Helen Hardwick had produced a brief report in TW's absence for the group, which BG read out, covering:</p> <ul style="list-style-type: none"> • Bus ticket sales for the previous financial year • Bus tickets are no longer sold in the Staff Benefits shop as First York have removed the facility, replaced by their app as a means for purchasing tickets. Some issues were experienced by staff without smart phones. First York have provided cards that can be used for payment to the Trust for these staff affected in this way. There is normally a charge associated with these cards, but we have been given them at no cost. • Staff Benefits have re-negotiated the same rate discounted rate for staff with 	

First York, which is subsidised by the car parking budget. JMas has taken on responsibility for making these payments to First York.

- **BG asked JMas and TW to see if we can promote this further.**

**JM &
TW**

JMas noted that there was the possibility of being able to negotiate a greater discount, however there is some data that needs to be collated and reviewed first.

Park & Ride / Car Parking

DB's notes had been circulated around the group in advance and the group reviewed these in the meeting.

P&R has officially started. BG stated that the P&R has been supported by the hospital charity who contributed £200,000 into funding this initiative. Most of the takings from the P&R (there are some ticket exceptions) will go back into the charity itself, so by using the service, staff and patients bus fares are feeding back into the NHS to support healthcare further, rather than providing First York with additional profit. This is a big additional incentive that many people may not have picked up on and is something that we should look to promote further. JMas and DB to look at promoting this service from this positive angle, perhaps incorporating a good news story from both a staff and patient perspective.

Figures for the first week of the P&R were available in DBs report. BG thought that these were a good start to the service's introduction. BG used the P&R on its second day and was chatting to a couple on the bus who were delighted with the service and the route it was taking and we wanting to tell their friends.

SB asked what kind of volumes of passengers will be needed to sustain the service, though not at this point as its only just been introduced. JMas has the original business case with those figures, but not to hand.

BG commented on how First York are flexible in running this service. They will monitor usage and demand, adjusting the services accordingly and put on additional buses if demand increases at peak times.

SB Queried if the Car park volumes had decreased since the introduction of the service. DMill said there were some periods where volumes were lower, but others where there were vehicles queuing. JMas also noted that the weather influences car usage too, with better weather impacting car park volumes too as people opt to walk more – this makes it difficult to measure how much of the lower volume periods are due to the new P&R or the weather at this point in time.

BG highlighted that the P&R service is an important step as it feeds into are targets relating to pollution and there will be further losses of car park spaces due to the building of the Vascular Imaging Unit (VIU) this year. The new VIU unit will allow the Theatres Recovery area to expand in the hospital, which is comparative to other hospitals in the region has some of poorest conditions. During the construction of the VUI, 150 car park spaces will be lost and when the VUI is completed we will get 100 of those spaces back. The P&R has the capacity to support this overall reduction in spaces, but it will need to be promoted.

JMas said the car parking permit review is ongoing, which will also help tackle the reduction in spaces, but it is a very emotive issue. As part of the process though, the P&R will be suggested as an alternative. York is the main pressure point in terms of car parking, which is why there is a focus on this site in particular for now. An outline

of what is being prepared for the car parking review and this should be presented to the group to the Travel & Transport, Corporate and Governors to review.

CP commented on the fact that the shared council car park at Selby is often full. JMas has been speaking to the police who are reviewing their access and where they're going to be based, so there's a possibility that some of the pressure there may be alleviated. EP noted that the pool cars currently based in the Estates compound may move to this main Selby car park as there are issues with accessing them out of hours. JMas confirmed that they had actually been moved over already. SB asked if there were any bays marked out for them to reserve those places for the pool cars. JMas said there weren't yet as it isn't a car park owned by the Trust so we can't mark these up independently.

CP also noted that some of the signage for the multi-storey car park charges seems to have disappeared. DMill said that it sounded like part of the signage has dropped off. DMill to ask Andy Hamer to repair it.

DMill

SM raised the issue of the car parking at Malton being full. BG suggested that we could remove the yellow lines where people are parking anyway because of the full capacity. Since that area is constantly being taken up by vehicles, we might as well legitimise the parking there.

DMill highlighted that SGH is full, but manageable, though the summer may bring increased pressures. JMas highlighted that there are increased complaints from residents about staff parking outside of their houses.

SB asked if rapid chargers for electric vehicles are still being considered. BG confirmed that we have agreed with the council to support their scheme. **JMas said that she will need to review with JMon and Paul Johnson on the possible locations to implement.**

**JMas,
JMon,
PJ**

Cycling

BG advised that Scarborough bridge has been opened, despite there being construction works ongoing around it. The bridge vastly improves the travelling time from the train station to the hospital for pedestrians and cyclists, so this is great news overall. LP said that while it is open, at the moment though it is only until 22:30 and no-one was aware it would be closed after this time until people tried to use it. This restriction may need addressing, though it was unclear at this time if it is temporary until the construction works around it are completed.

Also in relation to transport from the train station, DMill asked that as we are subsidising buses, can we subsidise train journeys also, particularly if the route from the station to the hospital is now easier. BG said that we will be moving onto this and would like staff tickets to be available for business travel between York and Scarborough stations, since the Trust pays for business travel journeys anyway. When required, staff could then go in and simply collect a pre-bought ticket for their journey. **BG asked JMas and DMill to look into establishing this process.**

**JMas &
DMill**

DMill asked SB if Enterprise were or could be based at SGH station to support staff reaching Scarborough Hospital, as an alternative to buses. SB said that he had already started looking into this as a potential option recently, but wasn't quite at a position to raise it at the meeting. Essentially though, Enterprise don't currently have any vehicles on site there, but they may be able to invest in placing some there on a pay-by-use basis, which our staff could then potentially use. Hopefully he will have an

update on this for the next meeting.

BG read DBs updates on the Travel Event at Ellerbys on 25 March 2019.

JMas commented that the issue of a lack of changing and showering facilities for cyclists has been raised again. BG had handed the issue over to capital planning, but JMas is now engaging with them to push on this for a result again.

D Mill noted that Scarborough could do with a review of the cycle storage provision available. D Mill to discuss with DB on his return.

**D Mill &
DB**

Taxis

BG informed the group that JMas is now looking at taxi usage across the Trust, gathering data and seeing if we can centralise it. JMas said she's taken on responsibility for taxis and the Transport department (which D Mill is helping to manage). Once she has more data, JMas will review this with D Mill and PB to see if there are any beneficial adjustments that could be made or initiatives explored that would support the travel plan. For example, would it be possible to have regular transportation scheduled between sites that staff could utilise? At this point though, its early days.

Pool, Hire and CO2 Reports

SB gave a presentation of the pool car achievements in the last year, including:

- Over 1,000 members of the scheme, a 30% increase on membership from the previous year
- 562,000 miles have been travelled in the last year, taken out of the grey fleet which is in excess of 2 million miles.
- There were over 1,000 journeys per month between the pool and hire cars
- CO2 reductions have been contributed to the grey fleet on all of these journeys from newer vehicles with regular service checks.
- Reduction of single occupancy pool car journeys, with over 2,900 passengers car sharing over the year
- A £72,000 saving has been made for the Trust in direct mileage alone, plus additional savings of £162,000. Overall, the pool car scheme has generated estimated savings between £230,000 – £250,000.
- 2/3 of the pool car fleet have been upgraded since its inception, including improved features (stop/start technology, bluetooth etc.) which will hopefully encourage further uptake with the scheme.

SM asked if BG could present this to the board of governors at their next meeting.

BG

SB stated that through his work connections amongst the local community, he knows the council are very impressed with the ongoing work here at the Trust. Of all the NHS schemes that Enterprise support, this is by far the best one in the north of England, particularly because of the way that BG and the T&T group have supported and pushed for this.

D Mill suggested the possibility of having 2 pool cars that couldn't be pre-booked ahead of time like the others, but would be made available for any last minute, urgent bookings. Often the pool cars pre-booked a long time in advance making it difficult to arrange transport for these last minute circumstances. SB agreed that while it would be beneficial, it would have to be carefully balanced with a financial commitment that

	<p>is both ambitious and cautious to run effectively.</p> <p>EP confirmed that wasted journeys are being targeted still and JMas has been writing to repeat offenders personally.</p> <p>SM commented on how she's happy with the increase in the pool car usage at Malton, while JMas noted that they are now looking into the feasibility of adding another pool car there.</p> <p><i>Car Sharing</i> Our contract with Liftshare coming up for renewal again, though we are not thrilled with the value of service that they bring compared to the costs they charge. We do not, however, have the resources internally to manage car sharing ourselves. JMas and DB need to work on the approach to car sharing and also place some further emphasis on promoting the scheme again.</p> <p><i>Community Travel</i> SM confirmed Ryedale Community Transport (RCT) were very busy, although KG is coping for now. They've also had their 30th anniversary celebration which went well.</p> <p>JMas said a complaint had been received by an Easingwold community driver, who she has since met up with. The drivers currently hold blue badges, however, these are likely to be removed. JMas has confirmed that we will give them the same blue badge provision with us, even if they lose their actual blue badges.</p> <p><i>Air Pollution</i> JMon highlighted that the issue of air pollution is now being tackled by the overall NHS plan, although there will need to be a big collaborative effort with communities to make the impact needed. The One Planet York scheme has already been engaging with the local community for some time now on sustainability issues, so there's already some good foundations in place here.</p>	<p>JMas & DB</p>
<p>6</p>	<p>PALS</p> <p>BG noted there were 8 travel related incidents in the PALS report. BG has read through these and all were based around the issue of parking and customer expectations and there wasn't anything of particular concern. 8 complaints over a 3 month period is a low figure and more than acceptable.</p>	
<p>7</p>	<p>Any Other Business</p> <p>KP is currently working with the Smile Foundation, CCG and YAS. The recent tightening of the YAS criteria has been causing issues. Looking at the possibility using vehicles in 'dead' times (e.g. after school drop-offs) to transport patients – this is in very early days of discussion, however, there be an update at the next meeting.</p> <p>BG highlighted that there isn't an ambulance service representative in the T&T group. KP has a contact that we could potentially approach to invite along. BG & JMas to look at engaging with them once details are provided.</p>	<p>KP, BG & JMas</p>
<p>8.</p>	<p>Items for highlighting to Sustainable Development Group</p> <ul style="list-style-type: none"> • Opening of Scarborough Bridge • Pool car fleet annual report 	

	<ul style="list-style-type: none">• Park & Ride	
	<p>Next Meetings</p> <p>Friday 16 Aug 2019, at 10.00 – 12.00 Friday 15 Nov 2019, at 10.00 – 12.00</p> <p>All in the Ophthalmology Seminar Room (YH)</p>	

DRAFT MINUTES

Title:	Space Management Group
Date:	23 rd April 2019
Time:	9.00am – 11.00am
Location:	Capital Team Meeting Room, Ground Floor, Capital Projects Building

Chair:	Tony Burns	Property Asset Manager (TB)
Attendees:	Brian Golding	Director of Estates and Facilities (BG)
	Andrew Bennett	Head of Capital Projects (AB)
	Jo Southwell	Strategic Capital Planning Manager (JS)
	Tom Jacques	Lead Nurse, Infection Prevention (TJ)
In attendance:	N/A	
Apologies:	Steve Bennison	Finance Manager (SB)
	Mark Hindmarsh	Head of Operational Strategy (MH)
	Adam Copley	Finance Manager, SLR & Costings (AC)

Item	Action
1. <u>Apologies for Absence</u> See above.	
2. <u>Minutes from the last Meeting</u> The minutes of the meeting held on the 29 th January 2019 were approved.	
3. <u>Action Log</u> The Actions generated from the meeting on the 29 th January 2019 were discussed. (See new Action Log dated 23 rd April 2019)	
4. <u>Space Requests</u> The Group went through the Un-Met Accommodation Needs Spreadsheet and discussed the Requests under Major, Large & Medium Headings. The significant points were..... <u>Scarborough Hospital – Modula Building – Private Patients</u> Moving out in 4 to 6 weeks' time. <u>Scarborough Hospital – Modula Building – Patient Access Team</u> Business Case to be produced. <u>Scarborough Hospital – Modula Building – Mental Health Team</u> Difficult to resolve at present. Tenant, TEWVFT.	

Item		Action
	<p><u>Scarborough Hospital – Occupational Health – Requires Relocation</u> Difficult to resolve at present. Possibly Vacant Space in Springhill House.</p> <p><u>York Hospital – Cystic Fibrosis – Requires Relocation</u> Difficult to resolve at present. Possible move to Endoscopy</p> <p><u>York Hospital – Specialist Nurses Office Overcrowded</u> Firstly, a De-Clutter is required. Tom Jacques to speak to Helen Hay regards this.</p> <p><u>Malton Hospital – Union Office</u> Discussed by the Group and agreed that the Union Rep should approach Polly McMeekin in HR regards further Union Office Space. TB to pass this on.</p> <p><u>Bed Storage</u> Discussed by the Group and given the lack of Space agreed that for the time being the Beds are continued to be stored at Bridlington Hospital.</p> <p><u>External Requests</u> Discussed that length by the Group and decided that these should go to Mark Hindmarsh to consider. Tony Burns to forward to Mark Hindmarsh.</p>	<p>TJ</p> <p>TB</p> <p>TB</p>
4a.	<p><u>Draft Space Request Process/Proforma</u></p> <p>AB presented a Draft Space Request Process/Proforma and the Group discussed it. They agreed that the introduction of this Form would help with Space Requests, including an emphasis on the requester looking at what actions they can do in the first instance. It was suggested that the Form included Clinical v Non-Clinical Space and that it made reference to the Business Case Form for New Starters. AB said he would process the Form through proper channels.</p>	AB
5.	<p><u>Review of Property Schedule</u></p> <p><u>Tribune House</u> Lease expires on 31st Dec 19 and renewal arrangements need to start.</p> <p><u>Clifton Park Chapel</u> Re-start negotiations on the Lease. Check Folder recently found for evidence of who paid for the Refurbishment. BG pointed out the uncertainty of the MSK/Orthopaedics future at the Site.</p> <p><u>Amy Johnson Way – Rental of Space to CCG</u> AB pointed out that the CCG are looking to extend their occupation of the Mezzanine. He will discuss this Nicky Slater, Head of Patient Services and Patient Access.</p>	<p>TB</p> <p>TB</p> <p>AB</p>
5a.	<p><u>NHS Property Services Issues</u></p> <p><u>Invoices Email Address</u> Issues with the email address suggested by Finance were discussed. AB was concerned that the address was an individual in Finance who may have left. TB will check on this.</p> <p><u>Unpaid 18/19 FM and Service Charge Invoices</u></p>	TB

Item		Action												
	<p>TB explained that he would be meeting with the NHSPS Facilities Services Manager on the 26th April 19 to get an explanation on why a large number of the Invoices are considerably higher than the previous year.</p> <p><u>Upcoming 19/20 Arrangements</u> TB stated that he will place POs once he receives the Charging Schedules.</p>	<p>TB</p> <p>TB</p>												
5b.	<p><u>YTHFT/YTHFM Property Arrangements</u></p> <p>AB explained that further work was being done to clarify the relationship between the Trust and the LLP regards Leases and Licences.</p>													
6.	<p><u>Space Utilisation Initiatives</u></p> <p>Nothing for this Meeting.</p>													
7.	<p><u>Estates Strategy</u></p> <p>Nothing for this Meeting.</p>													
8.	<p><u>Feedback from BCP/HR Recruitment</u></p> <p>No Report from HR regards the New Positions requiring Workstations.</p>													
9.	<p><u>Carter Report</u></p> <p>TB reported on the figures.</p> <table border="0" data-bbox="245 1171 1230 1305"> <tr> <td>Non Clinical Space:</td> <td>23.15%</td> <td>Satisfactory</td> </tr> <tr> <td>Vacant Space:</td> <td>2.80%</td> <td>Not Satisfactory. Should be <2.50%</td> </tr> <tr> <td>Underused Space:</td> <td>0.00%</td> <td>Satisfactory</td> </tr> <tr> <td>Cost of Space:</td> <td>£248.68</td> <td>Satisfactory</td> </tr> </table>	Non Clinical Space:	23.15%	Satisfactory	Vacant Space:	2.80%	Not Satisfactory. Should be <2.50%	Underused Space:	0.00%	Satisfactory	Cost of Space:	£248.68	Satisfactory	
Non Clinical Space:	23.15%	Satisfactory												
Vacant Space:	2.80%	Not Satisfactory. Should be <2.50%												
Underused Space:	0.00%	Satisfactory												
Cost of Space:	£248.68	Satisfactory												
10.	<p><u>Review of Group Membership</u></p> <p>AB suggested a review of the Membership and will discuss with TB.</p>	<p>AB/TB</p>												
11.	<p><u>Any Other Business</u></p> <p>AB pointed out that he has the Trust's Surplus Land List.</p>													
12.	<p><u>Date, Time and Location of Next Meeting</u></p> <p>8th Aug 2019, 9.00am to 11.00am in Capital Meeting Room & WebEx</p>													

Board of Directors – 31 July 2019

Workforce Report – July 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	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input type="checkbox"/>		

Purpose of the Report

To provide the Board with key workforce metrics (up to June 2019), and an overview of work being undertaken to address workforce challenges.

Executive Summary – Key Points

- There continue to be improvements in the monthly sickness absence rates for both the Trust and the LLP with absence rates in May 2019 of 3.67% and 6.21% respectively.
- Temporary nurse staffing demand in June 2019 equated to 497.31 FTE and although this was almost 12% higher than demand in the same month of 2018, the overall fill rate of almost 79% was the highest rate achieved in the last 12 months.
- The Trust has been selected to participate in phase 1 of the roll out of the NHS Leadership Academy’s Organisation Talent Management Diagnostic Tool and Toolkit. This, alongside the Trust’s move to a Care Group structure will provide opportunities to review, assess and rate the Trust’s talent management maturity
- The Clinical Undergraduate and Work Based Learning team have been working with Coventry University Scarborough to agree plans to increase student nurse numbers on the East Coast from 27 to 120 over three years.

Recommendation

The Board is asked to note and discuss the content and findings within the report.

Author: Polly McMeekin, Director of Workforce and Organisational Development

Director Sponsor: Polly McMeekin, Director of Workforce and Organisational Development

Date: July 2019

1. Introduction and Background

July's Workforce Report details a number of key workforce metrics, with commentary around the Trust's current sickness absence levels, and the current levels of temporary medical and nurse staffing utilisation within the Trust.

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

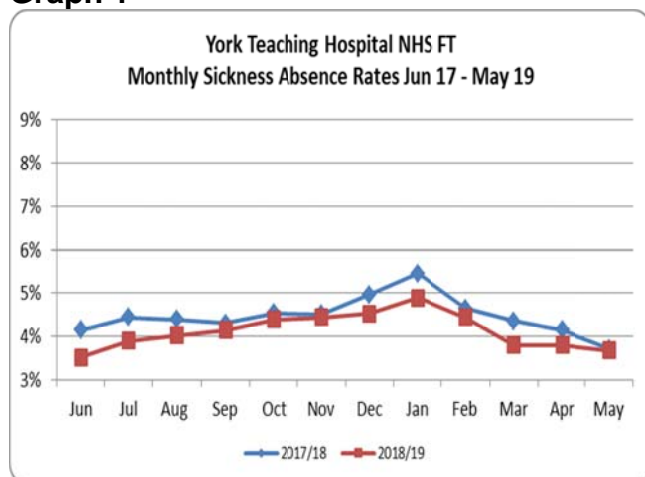
Graphs 1 and 2 show monthly sickness absence rates for the period from June 2017 to the end of May 2019. Sickness information for York Teaching Hospital Facilities Management (YTHFM) is reported separately to the rest of the Trust (and benchmarked against the Estates and Facilities directorate absence rate figures prior to the transfer).

The monthly absence rate in May 2019 for the Trust was 3.67%; this was the fourth month in a row where absence has been lower than in the previous month. This was also lower than the absence rate in the same month of the previous year.

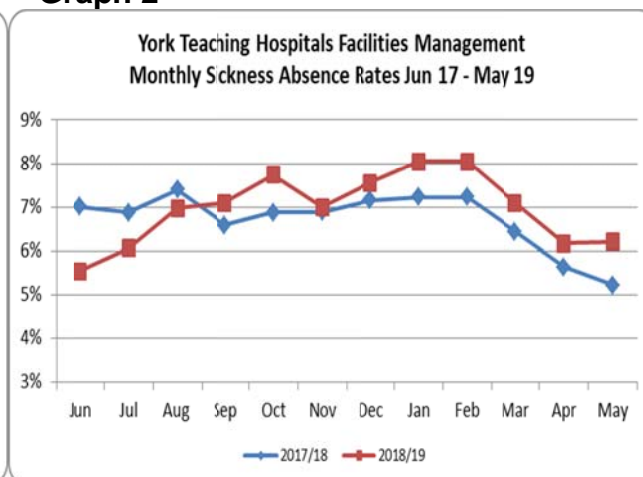
The monthly sickness absence rate for YTHFM in May 2019 was 6.21% this was the third month in a row where absence has been lower than in the previous month, although it was higher than the rate in May 2018 (5.22%).

Graphs 1 and 2 – Monthly Sickness Absence Rates

Graph 1



Graph 2



Source: Electronic Staff Record

Sickness Absence Reasons

The top three reasons for sickness absence in the year ending May 2019 for the Trust and YTH Facilities Management, based on both days lost (as FTE) and numbers of episodes are shown in table 1 below:

Table 1 – Sickness Absence Reasons - Year to May 2019

York Teaching Hospital NHS FT	
Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 23% of all absence days lost	Gastrointestinal – 23.43% of all absence episodes
MSK problems, inc. Back problems – 15.5% of all absence days lost	Cold, Cough, Flu – 19.95% of all absence episodes
Gastrointestinal – 9.2% of all absence days lost	Headache/Migraine – 8.27%
YTHFM	
Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 26.8% of all absence days lost	Gastrointestinal – 22.51% of all absence episodes
MSK problems, inc. Back problems – 20.8% of all absence days lost	Cold, cough, flu – 15.67% of all absence episodes
Gastrointestinal – 5.7% of all absence days lost	Anxiety/stress/depression – 7.5% of all absence episodes

In the year to May 2019, anxiety / stress / depression and MSK problems were the main causes of sickness absence in both organisations (days lost). Seasonal sickness reasons such as gastrointestinal problems and cold, coughs and influenza proportionately formed the majority of the number of episodes of sickness absence.

2.2 Temporary Staffing

Temporary Medical Staffing

113.75 FTE Medical & Dental roles were covered in May by a combination of bank (39%) and agency workers (61%).

We are continuing to work with Patchwork, the provider of our medical bank management software to improve the availability of management information relating to our medical temporary staffing usage.

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of 478 FTE staff per month. Demand detailed here is those shifts which have been requested to be filled by the temporary staffing team. Demand in June 2019 equated to 497.31 FTE. Although this was a slight reduction in demand from the previous month it was almost 12% higher than demand in the same month of 2018.

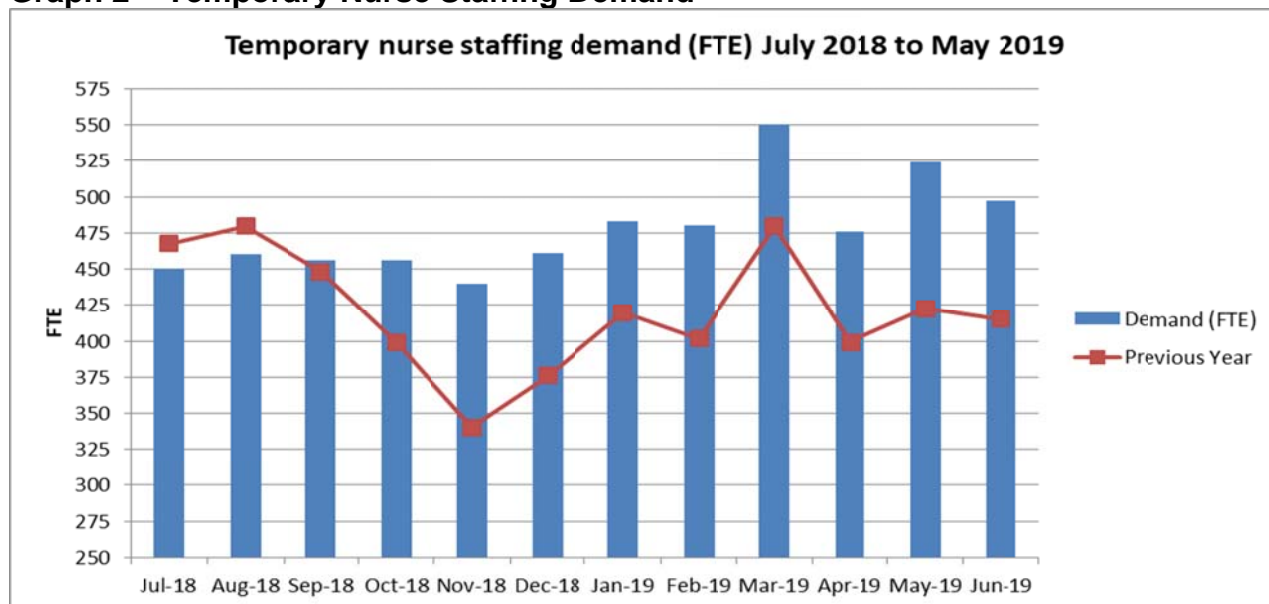
Nursing vacancy rates continue to impact demand for temporary staffing and this is expected to continue at least until the newly qualified nurses start with the Trust in the Autumn.

Filling temporary staffing demand in recent weeks and months has been particularly challenging on the Scarborough site, where the vacancy rate is especially high. An incentive (an uplift of 15% to the basic bank rate) has been offered to bank workers for working shifts in the adult inpatient wards, ED and SCBU on the Scarborough site throughout July. However, this has not resulted in increased uptake of bank shifts. To mitigate this, the Trust has expanded its agency usage over the last three months (see Graph 3 below). Beyond the immediate term, the Workforce, Learning and Chief Nurse teams are reviewing the experience of student nurses on our Bank with a view to increasing levels of take-up for Health Care Assistant shifts.

In the coming months, the number of nurses in our employment should also increase in line with the autumn university out-turn, and the progress of the Trust’s international recruitment activities. The Trust expects 72 newly qualified nurses to join the Trust in the next 3-months, while 50 nurses are expected to arrive from countries including the Philippines, India, United Arab Emirates and Nigeria before the end of the calendar year.

Graph 2 shows the pattern of demand over the last 12 months compared to the previous 12 months. The increase in demand over this time is reflective of high registered nurse vacancy rates.

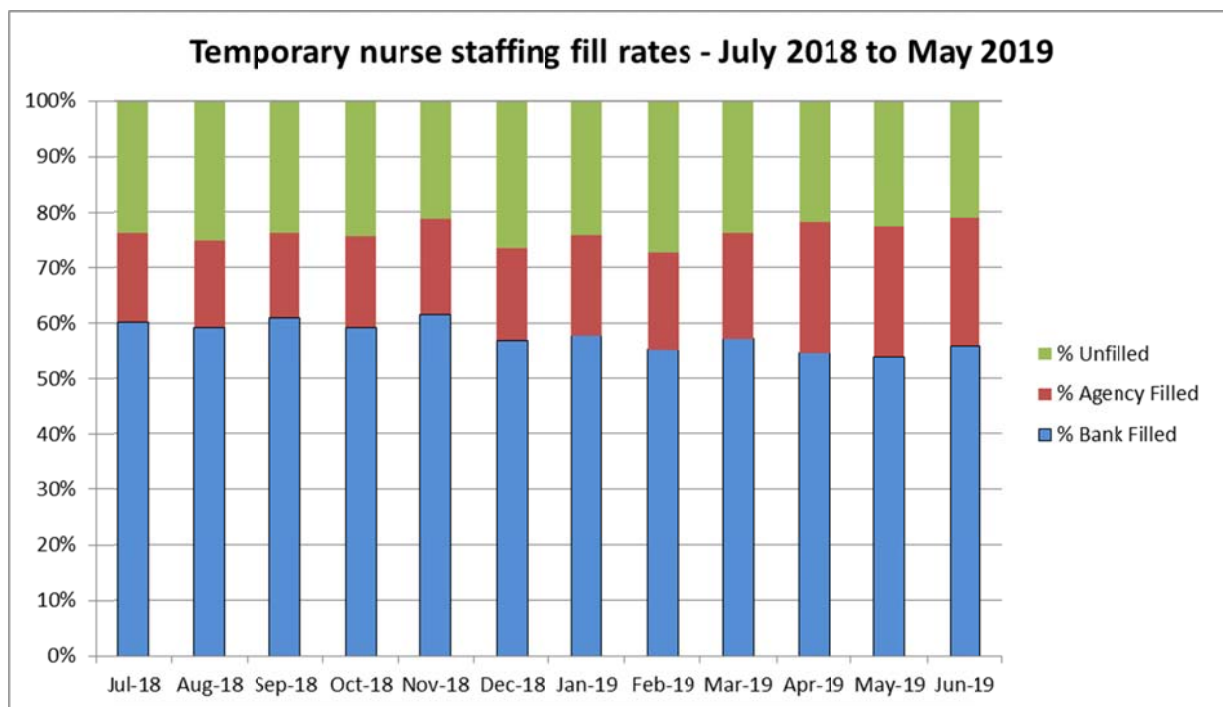
Graph 2 – Temporary Nurse Staffing Demand



Source: BankStaff

Graph 3 shows the proportion of all shifts requested that were either filled by bank, agency or were unfilled. Overall, 56.02% of shift requests in June 2019 were filled by bank staff. The agency fill rate was 22.96%. The proportion of shifts that remained unfilled in June was 21.97%, this was the lowest unfilled shift rate in the last 12 months.

Graph 3 – Temporary Nurse Staffing Fill Rates



Source: BankStaff

2.3 Medical Vacancies

As at June, the Trust is reporting an overall medical vacancy position (headcount) of 7.9%, which was a reduction from a position of 9.7% in April which was presented in this report in May. The vacancy position in York is currently 6.7% whilst in Scarborough, it is 10.8%.

It is anticipated that the position may regress a little in August when there will be a peak in movement during Junior Doctors’ Changeover; however, this will also coincide with some promising interviews/discussions planned on the East Coast in regard to the following positions:

- Locum Consultant Anaesthetist
- Locum Consultant in Elderly
- Specialty Doctor in ED

Appendix one shows a detailed breakdown of the medical vacancy position by site and directorate.

2.4 Talent Management

The talent management agenda has been refreshed within the Workforce and OD strategy for 2019/2024 to ensure that the Trust has a workforce that is fit for purpose.

The Trust has been selected to participate in phase 1 of the roll out of the NHS Leadership Academy’s Organisation Talent Management Diagnostic Tool and Toolkit. This, alongside the Trust’s move to a Care Group structure will provide opportunities to review, assess and rate the Trust’s talent management maturity. The Diagnostics allows for information to be

collected to inform the maturity rating prior to submission via a digital tool. A report will then be produced digitally that will provide the organisation with a comprehensive set of responses to guide next steps including signposting to national resources and relevant guidance to support implementation.

In addition to this the Trust is part of a regional Talent Management Community of Practice which provides the forum to share and receive updates on the talent management agenda in Yorkshire and Humber.

2.5 Corporate Learning and Development

Increasing student nurse numbers

To assist with the work in reducing nurse vacancy rates, the Clinical Undergraduate & Work Based Learning Development Lead and the Practice Education Team Lead have been working with Coventry University Scarborough (CUS) to agree an increase in student nurse numbers for the Trust's East Coast services. The intention is to provide a continual stream of nurse students graduating at Scarborough that will support Trust's recruitment plans for the future.

An agreement has been established between the Trust and CUS to support an additional 8 students onto the programme for this year (September 2019). This has increased the available places on the East Coast from 27 to 35 this year and an additional increase of 5 places next year that will grow the cohort intake each year to 40 students. This means a gradual increase from 27 to 120 nurse students on the East Coast over three years.

Statutory and Mandatory training compliance

Appendix two details statutory and mandatory compliance as at 1st July 2019. Each program is RAG rated and an indication of any improvement or deterioration in compliance rates compared to the previous month. For groups other than junior doctors, more than 70% of the 44 programs are currently RAG rated green (compliance in above 85%) and only two are currently rated red (compliance below 50%). Compliance is typically lower for junior doctors, we would expect this to improve as a result of the regional streamlining project that the organisation is taking part in.

Scarborough Hospital's annual Young Persons' Programme (YPP)

The Scarborough Young Person's Programme ran from 3-7 June, giving 24 local pupils from a number of schools the chance to sample some of the many careers on offer and learn more about life in a busy acute hospital. The week included a packed programme based on a mock-up of an emergency department which included decision making exercises, practical training sessions, behind the scenes tours of departments, meeting junior doctors, pharmacy, estates management and much more. A number of clinical staff support this in their own time and without this input it would not be possible to run the programme.

Student feedback after the event confirmed that they found the week interesting, informative and compelling, and many agreed they would like to work in the NHS having been on the programme. Some will consider apprenticeships as an option. The YPP

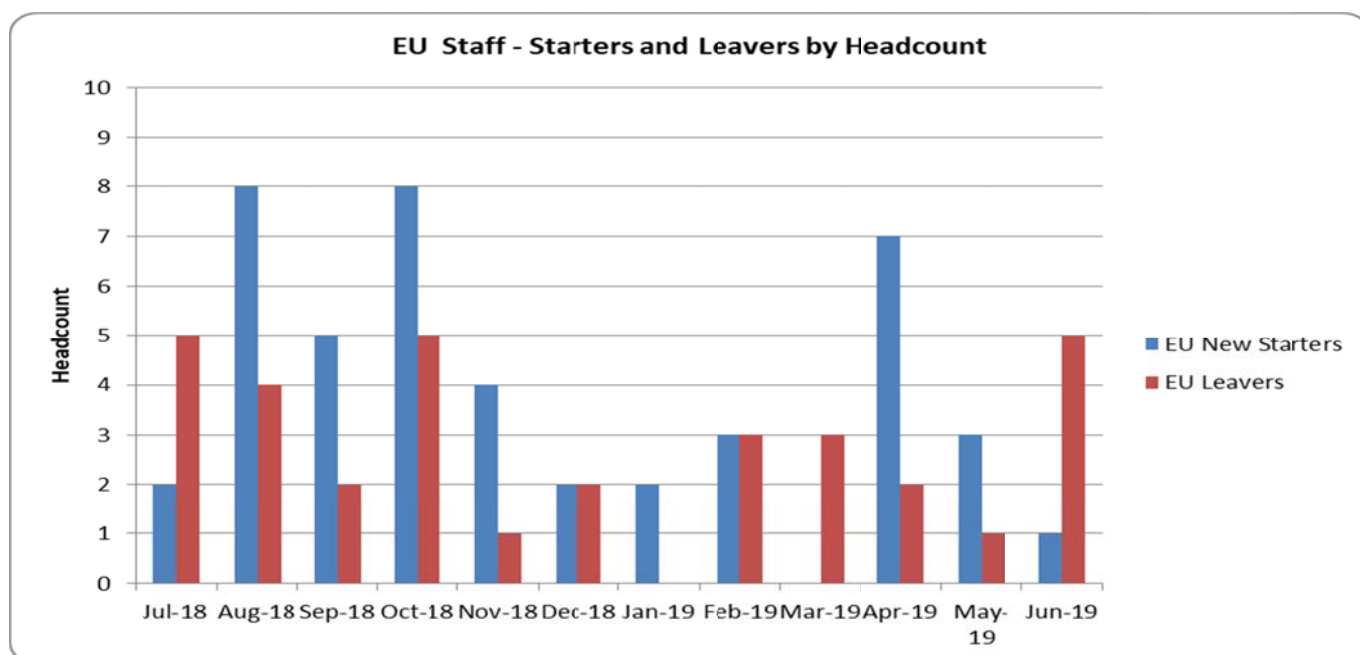
forms part of a work-stream looking at how we can encourage younger people to choose healthcare as a first career. The scheme has been piloted in Scarborough in order to get the right combination of activities and following evaluation will be rolled out in York next year. Other aspects of this work include involvement in the Scarborough Tech Academy for Health and Social care, career pathway development with Humber Coast and Vale networks and development of NHS Ambassador roles to support schools with student preparation for the world of work.

2.6 EU Workforce and Brexit

The Department of Health has directed organisations to prepare for a No Deal Brexit. Part of this direction involves development of an action plan which includes monitoring the impact of Brexit on workforce numbers.

As at 30 June 2019, records showed 339 EU nationals employed by the Trust. In the year to June a total of 32 staff from within the EU joined the organisation while 28 staff left over the same time period. The turnover rate of EU staff (based on headcount) between 1st July 2018 and 30th June 2019 was 9%.

Graph 5 – EU Staff Starters and Leavers



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	18	2	0	1	5.6%	6	2	0	3	-16.7%	10	1	0	1	0.0%						34	5	0	5	0.0%
Acute & Emergency (CG2)	30	11	0	3	26.7%	17	5	0	0	29.4%	49	10	4	12	4.1%	16	0	0	0	0.0%	112	26	4	15	13.4%
Child Health	12	4	0	0	33.3%	1	0	0	0	0.0%	8	0	0	0	0.0%	4	0	0	0	0.0%	25	4	0	0	16.0%
General Medicine																9	1	0	1	0.0%	9	1	0	1	0.0%
General Surgery & Urology	8	1	1	0	25.0%	5	1	0	1	0.0%	8	3	0	2	12.5%	9	0	0	0	0.0%	30	5	1	3	10.0%
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	1	0.0%	2	0	0	0	0.0%	22	2	0	1	4.5%
Ophthalmology	4	2	0	1	25.0%	3	2	0	0	66.7%	1	0	0	0	0.0%						8	4	0	1	37.5%
Radiology	6	3	0	0	50.0%																6	3	0	0	50.0%
Specialist Medicine	3	0	0	0	0.0%	2	0	0	0	0.0%	2	0	0	0	0.0%	1	0	0	0	0.0%	8	0	0	0	0.0%
Trauma & Orthopaedics	8	0	0	0	0.0%	5	0	0	0	0.0%	5	1	0	0	20.0%	2	0	0	0	0.0%	20	1	0	0	5.0%
Total	97	23	1	5	19.6%	45	11	0	4	15.6%	92	16	4	16	4.3%	44	1	0	1	0.0%	278	51	5	26	10.8%

York

York																									
Specialty	Consultant					Middle Grades					Training Grades (inc Trust Grades)					Foundation Grades					Total				
	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %
Anaesthetics	51	2	2	2	3.9%	9	1	2	1	22.2%	20	3	0	2	5.0%	4	0	0	0	0.0%	84	6	4	5	6.0%
Child Health	18	0	1	0	5.6%	1	0	0	0	0.0%	17	0	0	0	0.0%	4	1	0	1	0.0%	40	1	1	1	2.5%
Elderly Medicine	15	3	0	0	20.0%	2	0	0	0	0.0%	20	0	0	0	0.0%	8	0	0	0	0.0%	45	3	0	0	6.7%
Emergency & Acute	19	1	0	1	0.0%	7	2	0	0	28.6%	21	3	0	0	14.3%	6	0	0	0	0.0%	53	6	0	1	9.4%
General Medicine	38	5	0	1	10.5%	10	1	1	0	20.0%	26	1	0	0	3.8%	25	0	0	0	0.0%	99	7	1	1	7.1%
General Surgery & Urology	37	5	0	5	0.0%	12	2	1	1	16.7%	15	1	0	1	0.0%	13	0	0	0	0.0%	77	8	1	7	2.6%
Head & Neck	20	0	0	0	0.0%	11	1	0	2	-9.1%	14	1	0	1	0.0%	0	0	0	0		45	2	0	3	-2.2%
Laboratory Medicine	13	2	0	0	15.4%	2	0	0	0	0.0%	5	3	0	1	40.0%	1	0	0	0	0.0%	21	5	0	1	19.0%
Obstetrics & Gynaecology	12	1	0	0	8.3%	2	0	0	0	0.0%	9	3	0	0	33.3%	2	0	0	0	0.0%	25	4	0	0	16.0%
Ophthalmology	20	3	0	2	5.0%	6	2	0	2	0.0%	6	1	0	1	0.0%	0	0	0	0		32	6	0	5	3.1%
Radiology	25	2	0	2	0.0%	1	1	0	0	100.0%	7	1	0	0	14.3%	0	0	0	0		33	4	0	2	6.1%
Sexual Health	2	0	0	0	0.0%	7	1	0	0	14.3%	2	1	0	0	50.0%	0	0	0	0		11	2	0	0	18.2%
Specialist Medicine	35	1	2	1	5.7%	5	2	0	0	40.0%	14	3	0	0	21.4%	2	0	0	0	0.0%	56	6	2	1	12.5%
Trauma & Orthopaedics	13	0	0	0	0.0%	8	0	2	1	12.5%	9	4	0	3	11.1%	3	0	0	0	0.0%	33	4	2	4	6.1%
Total	318	25	5	14	5.0%	83	13	6	7	14.5%	185	25	0	9	8.6%	68	1	0	1	0.0%	654	64	11	31	6.7%

Net vacancy % = (Vacancies + Leavers Pending - Starters Pending) / Establishment

Leavers = currently serving notice

Starters = accepted appointment, now pending start date

932	115	16	57	7.9%
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Appendix 2 Statutory and Mandatory training compliance

Stat Mand Compliance Report -1st July 2019 (Junior Doctors removed)

Core training

Certification	Number of staff who require this training	Number of staff currently compliant	Last month's Compliance percentage	This month's Compliance percentage	Status (month on month)
Adult DNACPR	518	435	83%	84%	↑
Adult Life Support	5758	4873	84%	85%	↑
Conflict Resolution	9198	7934	86%	86%	=
Fire Safety Awareness (High Risk)	3490	2777	81%	80%	↓
Fire Safety Awareness (Low Risk)	5714	5144	91%	90%	↓
Health & Safety inc. Risk Management	9198	8423	92%	92%	=
Infection Prevention and Control (ANTT-Practical)	2641	1800	66%	68%	↑
Infection Prevention and Control (ANTT-Theory)	3309	2838	85%	86%	↑
Infection Prevention and Control Level 1	3848	3593	92%	93%	↑
Infection Prevention and Control Level 2	5350	4544	86%	85%	↓
Information Governance	9204	8349	91%	91%	=
Manual Handling Practical	7233	5315	73%	74%	↑
Manual Handling Practical (6 yearly)	1964	1742	88%	89%	↑
Manual Handling Theory	9198	8147	88%	89%	↑
Paediatric DNA CPR	30	16	53%	53%	=
Paediatric Life Support	512	440	86%	86%	=
Prevent Awareness	5515	4901	88%	89%	↑
Prevent Level 3	3683	2800	73%	76%	↑
Safeguarding Adults Awareness	3531	3255	91%	92%	↑
Safeguarding Adults Level 1	1991	1621	82%	81%	↓
Safeguarding Adults Level 2	3683	3183	87%	86%	↓
Safeguarding Children Level 1	3341	3071	91%	92%	↑
Safeguarding Children Level 2	5153	4279	83%	83%	=
Safeguarding Children Level 3 Core Modules	318	249	78%	78%	=
Safeguarding Children Level 3 Specialist Modules	387	330	86%	85%	↓
Total:	104767	90059	86%	86%	=

	≥ 85%
	≥ 50% and < 85%
	< 50%

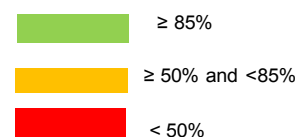
Essential skills

Program	Number of staff who require this training	Number of staff currently compliant	Last month's Compliance percentage	This month's Compliance percentage	Status (month on month)
Blood Safety	4391	3816	87%	87%	=
Care of the Adult Patient with Diabetes Initial & Updates	2212	1647	72%	75%	↑
Dementia Awareness	5231	4812	92%	92%	=
Dementia Higher Level	402	365	91%	91%	=
End of Life Care (Medical Staff) Initial & Updates	439	205	35%	47%	↑
End of Life Care (Non-Medical Staff) Initial & Updates	3452	1354	31%	39%	↑
Female Genital Mutilation (FGM)	464	450	97%	97%	=
Food Hygiene Awareness	4259	3947	93%	93%	=
Immunisations & Vaccinations	248	212	85%	86%	↑
Learning Disabilities Awareness	5676	5310	94%	94%	=
Medical Devices Awareness (Medical Staff)	564	509	89%	90%	↑
Medical Devices Awareness (Non-Medical Staff)	5039	4737	94%	94%	=
Medical Gas Safety	4981	4555	92%	91%	↓
Medicines Management	2535	2444	96%	96%	=
Non-Medical Consent	635	613	97%	97%	=
Nutrition	3383	3061	90%	91%	↑
Patient Safety	5057	4516	90%	89%	↓
Pressure Ulcer Prevention	4434	4094	93%	92%	↓
Sepsis Awareness	3485	3017	87%	87%	=
Total	56887	49664	87%	87%	=

Junior Doctors - Stat Mand Compliance Report - 1st July 2019

Core Training

Certification	Number of staff who require this training	Number of staff currently compliant	Last month's Compliance percentage	This month's Compliance percentage	Status (month on month)
Adult DNACPR	342	221	64%	65%	↑
Adult Life Support	351	226	63%	64%	↑
Conflict Resolution	353	152	42%	43%	↑
Fire Safety Awareness (High Risk)	320	292	92%	91%	↓
Fire Safety Awareness (Low Risk)	33	28	83%	85%	↑
Health & Safety inc. Risk Management	353	238	67%	67%	=
Infection Prevention and Control (ANTT - Practical)	348	91	26%	26%	=
Infection Prevention and Control (ANTT-Theory)	348	225	64%	65%	↑
Infection Prevention and Control Level 1	5	4	100%	80%	↓
Infection Prevention and Control Level 2	348	245	70%	70%	=
Information Governance	353	251	71%	71%	=
Manual Handling Practical	353	36	10%	10%	=
Manual Handling Theory	353	226	63%	64%	↑
Paediatric DNA CPR	15	1	7%	7%	=
Paediatric Life Support	59	20	34%	34%	=
Prevent Awareness	5	4	100%	80%	↓
Prevent Level 3	348	121	34%	35%	↑
Safeguarding Adults Level 1	5	3	75%	60%	↓
Safeguarding Adults Level 2	348	197	56%	57%	↑
Safeguarding Children Level 1	5	3	75%	60%	↓
Safeguarding Children Level 2	287	199	70%	69%	↓
Safeguarding Children Level 3 Core Modules	38	13	33%	34%	↑
Safeguarding Children Level 3 Specialist Modules	23	8	35%	35%	=
Total:	4993	2804	56%	56%	=



Essential Skills

Program	Number of staff who require this training	Number of staff currently compliant	Last month's Compliance percentage	This month's Compliance percentage	Status (month on month)
Blood Safety	345	235	68%	68%	=
Dementia Awareness	300	197	65%	66%	↑
Dementia Higher Level	75	54	71%	72%	↑
End of Life Care (Medical Staff) Initial & Update	305	43	12%	14%	↑
Female Genital Mutilation (FGM)	70	43	58%	61%	↑
Learning Disabilities Awareness	348	246	70%	71%	↑
Med Devices Awareness (Medical Staff)	350	246	70%	70%	=
Sepsis Awareness	331	243	73%	73%	=
Total	2124	1307	61%	62%	↑



Board of Directors – 31 July 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	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>		

Purpose of the Report

The purpose of this report is to advise the Board of Directors of the financial position for month 3 (quarter 1) of the 2019/20 financial year.

Executive Summary – Key Points

The income and expenditure position for month 3 (quarter 1) of the 2019/20 financial year confirms the Trust has met its pre-PSF control total. It is therefore appropriate to apply PSF and FRF to the month 3 position.

Recommendation

The Board of Directors is asked to note the report.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: July 2019

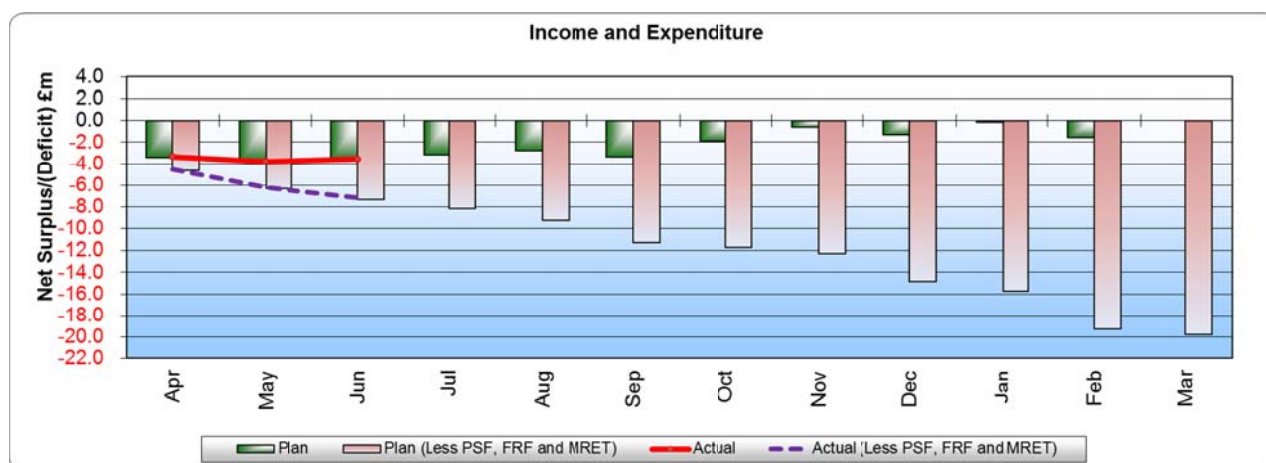
1. Year to date Summary Financial Position

The income and expenditure position for month 3 (quarter 1) of the 2019/20 financial year confirms the Trust has met its pre-PSF control total. It is therefore appropriate to apply PSF and FRF to the month 3 position.

Before the application of any sustainability or financial recovery funding the Trust had planned for a £7.4m deficit position. The actual reported position is a deficit of £7.2m with the Trust reporting a £0.2m favourable variance against the pre-PSF control total.

After applying PSF and FRF the Trust is reporting a planned deficit of £3.8m and an actual deficit of £3.6m, thus reporting a positive £0.2m variance to plan.

The chart below summarises the pre and post PSF plan for the year alongside the actual performance for quarter 1.



2. Summary Financial Commentary

Income is showing an under recovery against plan of £0.8m for the first three months of the financial year. This position has been materially influenced by a lower than plan spend (and therefore income level) from specialised commissioner funded excluded from drugs tariff. This has a neutral impact on the overall position as both income and expenditure are impacted. Activity levels in outpatients and elective/day case work appear to be down on plan for non-AIC commissioners, with a corresponding reduction in income levels. This position is being investigated. This position is, in the main, compensated by non-NHS clinical income positive variances and additional to plan education and training income and R&D income.

Expenditure is reported overall as £1.0m better than plan, with a small £0.1m underspend against pay provisions and an underspend of £1.0m against excluded from tariff drugs and devices. There is spend pressure from drugs included in tariff and from clinical supplies and services but this is being compensated by an underspend on other general costs.

Notwithstanding the pay underspend, agency expenditure has started the year with an immediate pressure breaching the NHSI set cap of £3.8m with a year to date spend value of £4.8m. Notable pressure this month is evident in continued medical agency costs with a

significant peak in nursing agency costs. Clearly this position is reflective of the current vacancy pressure and staffing difficulties across many of the Trust's wards and departments.

In terms of the Trust's efficiency programme, month 3 delivery has been positive with £5.6m delivered against the 2019/20 plan of £17.1m. Encouragingly this remains almost all having been removed recurrently. Actual delivery for the first quarter of the financial year has almost exactly matched the profile of the delivery and is therefore not causing any pressure on the overall financial position.

3. Supplementary Actions

At this stage there are no supplementary actions required by the Board of Directors. Key actions in place continue to be:

- Expenditure discipline and control
- Efficiency programme delivery
- QIPP system cost recovery delivery through the STB
- Cash flow management
- The second iteration of a medium term system financial plan is now being worked on in partnership with our local commissioners. At the time of writing this report the national medium term financial planning guidance has been delayed several weeks. The first draft of our local plan is being prepared using local assumptions and will be shared, as timetabled, with the Board this month.

Finance Risks:

- The Board should be aware that delivery of system cost reduction through QIPP is essential for the system going forward. The Board will be updated on the latest contract position and cost reduction work.
- Control over our expenditure position remains a key risk. Expenditure discipline remains at an enhanced level, whilst recognising key patient safety considerations.
- Pressure on our agency position is causing this to run ahead of the NHSI cap (Trust plan).

4. Recommendation

The Board of Directors is asked to note the positive first quarter income and expenditure position for the Trust in relation to delivery of control total.



Board of Directors – 31 July 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	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input type="checkbox"/>		

Purpose of the Report

To update the Board of Directors on the delivery of the Trust's Efficiency Programme.

Executive Summary – Key Points

The 2019/20 target of £17.1m is 100% planned (90% Low Risk and 10% Medium Risk). Full year delivery as at June 2019 is £5.6m.

The key risks to the programme are:

2019/20 - recurrent delivery £4.7m.

2020/21 - planning gap of £1.2m plus high risk plans of £4.1m.

Recommendation

The Board of Directors is asked to note the June 2019 CIP position.

Author: Wendy Pollard, Deputy Head of Resource Management

Director Sponsor: Andrew Bertram, Finance Director

Date: July 2019

Briefing note for the Board of Directors meeting 31 July 2019

1. Summary reported position for June 2019

1.1 Current position – highlights

Delivery – Full year Delivery is £5.6m as at June 2019 which is (33%) and has improved in month by £1.1m. This position compares to a delivery position of £7.3m in June 2018.

Part year delivery is **£-0.3m** behind the profiled plan submitted to NHSI.

In year planning – At June 2019 the target of £17.1m is 100% planned (Low Risk £15.4m and Medium Risk £1.7m).

Four year planning – Four year planning shows a gap of £12.7m, of which £1.2m falls in 20/21 and £11.5m in the following two years.

Recurrent vs. Non recurrent – Of the £5.6m full year delivery, £4.7m has been delivered recurrently which is 27% of the overall target for 2019/20, an improvement of £0.6m in month. Recurrent delivery is **£-0.6m** behind the same position in June 2018.

1.2 Overview

2019/20 and 2020/21 Planning

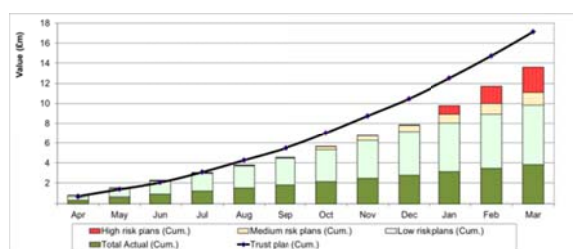
2019/20 Planning

In response to the regional team request for a full low risk CIP plan by the end of Q1 we can confirm we are now fully planned with 90% low risk and 10% medium risk plans to the value of £17.1m.

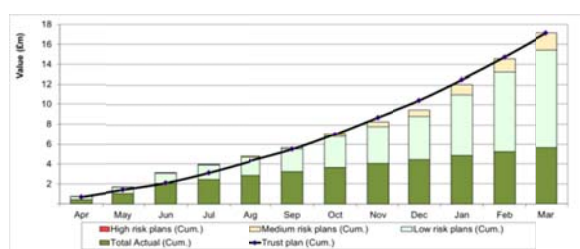
Significant work has been carried out to remove the £3.5m planning gap and £1.4m high risk plans. Medium risk plans have also reduced over the 3 month period from £3.1m to £1.7m and we continue to work on converting the medium risk plans to low risk. All Carter categories have seen an increase in plans with a higher proportion added to Workforce (£1.7m) and Corporate and Admin (£1.5m). Work continues with Care Groups to ensure we have deliverable low risk plans.

The two graphs below summarise the in year delivery and planning position at the end of April and end of June. The June position (July Board report) shows 100% planned at low and medium risk.

In Year Delivery and Plans - May 2019 Board Report



In Year Delivery and Plans - July 2019 Board Report



2020/21 Planning

The current CIP target for 2020/21 is £8.2m and assumes that we have no carry forward from 2019/20. The planning gap for 2020/21 is £1.2m plus an additional £4.1m high risk plans. Of these high risk plans £2.1m sits within Workforce across Medical and Nursing and the main schemes are Theatre Productivity, VIU Productivity and Child Health.

We do need to ensure that the distinction is made between what is CIP and 'System' savings to avoid any 'double count'. Please see **Appendix 1** - Matrix of Transformation Schemes Efficiency Categorisation.

The CET will be working with Care Groups over the coming months to review High risk plans and bridge the planning gap to ensure we are fully planned for 20/21 prior to the annual plan submission.

CIP Planning Risk 2020/21 – Table 1 below summarises the current planning position for 2020/21.

Table 1:

Planning Risk	20/21 £'m
Gap	1.2
High	4.1
Medium	1.0
Low	1.9
TOTAL	8.2

Delivery Performance

While delivery is broadly on plan we have seen a slip in month of £0.1m to £0.3m behind planned position. As indicated in May 7 Directorates had 'nil returns for the first two months, this now sits at 9 Directorates with a 'nil' return for two consecutive months (see **Appendix 2 – Directorate Performance**). As agreed at last month's EDG letters are to be issued from the Chief Executive's Office to each of these Directorates to address non delivery.

Transactional schemes

Transactional scheme Plans of £14.7m represent 86% of the overall Efficiency Target. Full year Delivery is £3.9m as at June 2019 of which £3m is recurrent.

Transformational schemes

Transformational scheme Plans of £2.4m represent 14% of the overall Efficiency Target. Full year Delivery is £1.7m as at June 2019 of which £1.7m is recurrent.

Please refer to **Appendix 3** – Summary of Schemes by Category.

Model Hospital/GIRFT/Use of Resources

Work continues with NHSI Operational Productivity in terms of Trust CIP and System plans using the 'opportunity' presented in the Model Hospital with particular focus on Back Office and Admin. At a meeting this week it was agreed that information shared at System

level by NHSI should be updated and re-presented to reflect the changes to Trust CIP Plans and recurrent delivery. We are working closely with our regulator on this.

An update on Get It Right First Time (GIRFT) will be provided next month after the GIRFT Programme Board has taken place. There is a regional Stroke GIRFT meeting taking place in Hull in July with attendees from across the STP.

The Trust's Use of Resources Assessment has taken place and we have provided supplementary information for final assessment. This assessment forms a part of the overall CQC Report.

Quality Impact Assessment (QIA)

Quality Impact Assessments (QIA) are carried out following the Trust's Risk Management Framework.

There are 261 Schemes in total at the end of June 2019 and these are categorized into the following risks:

High Risk Schemes	0
Moderate Risk schemes	16
Low Risk Schemes	110
To be assessed	135

There are 135 schemes to be self-assessed and reminders have been issued to expedite these returns.

Moderate Risk schemes to be discussed at EDG in July 2019 (**Appendix 4 – Moderate Risk QIA**).

Appendix 1 - Transformation Scheme - Efficiency Categorisation

Transformation Scheme	Cash Releasing Efficiency (CIP)	Efficiency Credit (CIP)	QIPP	Source of Funding	System Savings
Planned Care					
Outpatients	✓	✓			
Rapid Expert Input	✓	✓			
Ophthalmology		✓			
Theatre without Drama	✓	✓			
Cardiology		✓		✓	✓
T&O	✓				
Endoscopy	✓	✓			✓
Unplanned Care					
York Urgent and Emergency Care		✓			
Complex Discharge Programme		✓			
Hospital Out of Hours					
Scarborough Single Improvement Programme	✓	✓			
Diagnostics					
Radiology	✓	✓			
Cancer					
Dermatology					
Community					
Community Mobile Working	✓	✓			

APPENDIX 2 - DIRECTORATE PERFORMANCE

DIRECTORATE	FYE Carried forward	April Achieved	May Achieved	June Achieved	Total
AHP	£13,833	£13,833	£0	£353,489	£367,322
Chief Exec		£0	£79,569	£39,763	£119,332
Chief Nurse Team		£0	£0	£48,000	£48,000
Child Health	£9,701	£13,217	£5,875	£119,531	£138,623
Community	£17,999	£19,091	£0		£19,091
ED Scarborough	£24,208	£28,498	£0		£28,498
ED York	£26,022	£30,552	£0	£58,983	£89,535
Estates and Facilities	£380,360	£380,360	£0		£380,360
Finance	£21,303	£21,303	£56,297	£86,598	£164,198
General Medicine Scarborough	£53,697	£55,341	£0		£55,341
General Medicine York	£294,728	£300,224	£0	£67,460	£367,684
GS&U	£142,690	£146,944	£0	£9,797	£156,741
Head and Neck	£3,859	£6,343	£0	£15,000	£21,343
HR	£892	£10,592	£36,000	£20,000	£66,592
Lab Medicine	£78,204	£78,204	£0		£78,204
LOD&R		£20,000	£21,500	£16,000	£57,500
Medical Governance	£3,195	£3,195	£0		£3,195
Medicine for the Elderly Scarborough	£3,718	£6,664	£0		£6,664
Medicine for the Elderly York	£15,234	-£17,224	£0	£18,790	£1,566
Ophthalmology	£17,750	£18,614	£2,016	£53,000	£73,630
Ops Management	£282	£282	£0		£282
Orthopaedics	£30,363	£236,201	£162,000	£154,205	£552,406
Pharmacy	£248,591	£338,869	£0		£338,869
Radiology	£73,812	£82,812	£114,896	£49,998	£247,706
Sexual Health	£18	£8,018	£18,400	£21,096	£47,514
SNS		£0	£0	£50,000	£50,000
Specialist Medicine	£775,437	£791,643	£1,317	£16,940	£809,900
TACC	£35,402	£61,292	£181,858	-£122,681	£120,469
Womens Health	£11,073	£12,807	£0	£2,122	£14,929
DIRECTORATE TOTAL	£2,282,371	£2,667,675	£679,728	£1,078,091	£4,425,494

RESERVE	£0	£1,174,713	-£29,050	£62,092	£1,207,755
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TOTAL	£2,282,371	£3,842,388	£650,678		£5,633,249
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Appendix 3 - 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	£14.7	£ 3.9	£ 3.0	£ 0.9	£ 1.5	£ 1.6
Transformational	£ 2.4	£ 1.7	£ 1.7	£ 0.0	£ 0.5	£ 0.4
Total Programme	£17.1	£ 5.6	£ 4.7	£ 0.9	£ 2	£ 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	£ 0.2	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
Outpatients	£ -	£ -	£ -	£ -	£	£ -
ADM	£ 0.8	£ 0.4	£ 0.4	£ 0.0	£ 0.2	£ 0.1
Pharmacy	£ 1.3	£ 1.3	£ 1.3	£ 0.0	£ 0.3	£ 0.3
Paperlite	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ -	£ 0.0
Printer Strategy	£ 0.1	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
Total Transformational Schemes	£ 2.4	£ 1.7	£ 1.7	£ 0.0	£ 0.5	£ 0.4

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)	£ 2.0	£ 0.2	£ 0.2	£ 0.0	£ 0.1	£ 0.0
Carter W/force (Nursing)	£ 1.4	£ 0.1	£ 0.1	£ 0.0	£ 0.1	£ 0.0
Carter W/force (AHP)	£ 0.2	£ 0.4	£ 0.4	£ 0.0	£ 0.0	£ 0.1
Carter W/force (Other)	£ 1.8	£ 0.3	£ 0.0	£ 0.3	£ 0.4	£ 0.3
Carter Procurement	£ 3.2	£ 1.6	£ 1.5	£ 0.1	£ 0.7	£ 0.5
Carter Hospital Medicine & Pharmacy	£ 2.0	£ 1.6	£ 1.6	£ 0.0	£ 0.4	£ 0.4
Carter Corporate & Admin	£ 0.5	£ 0.6	£ 0.1	£ 0.5	£ 0.1	£ 0.5
Carter Estates & Facilities	£ 1.0	£ 0.4	£ 0.4	£ 0.0	£ 0.2	£ 0.1
Carter Imaging	£ 0.5	£ 0.2	£ 0.2	£ 0.0	£ 0.1	£ 0.1
Carter Pathology	£ 0.6	£ 0.1	£ 0.1	£ 0.0	£ 0.0	£ 0.0
Other Savings Plans/Unidentified	£ 3.9	£ 0.1	£ 0.1	£ 0.0	£ 0.0	£ 0.0
Total Programme by Carter Category	£17.1	£ 5.6	£ 4.7	£ 0.9	£ 2.1	£ 2.0

It should be noted that Transformational Schemes will also be included in the Carter Categories.

APPENDIX 4

MODERATE RISK QIA - CIP SCHEMES JULY 2019

Item	Directorate	Scheme Ref	Scheme Name	Description of risk	Potential Clinical Impact	Impact on Service	Possible mitigation	Date Assessed	Probability / likelihood	Consequence/ Severity	Risk Rating	Risk Acceptability	RESPOND
1	Child Health	CIP1920-034	INCREASED ACTIVITY FROM OTHER TRUSTS	Financial	Increase in clinical activity	Increase in clinical activity	monitor clinical activity and impact to service	06/06/2019	2	2	4	Moderate Risk	
2	Child Health	CIP1920-036	SCBU YORK SKILL MIX REVIEW	Financial	Option appraisal as per RCPC invited review March 2019	Option appraisal as per RCPC invited review March 2019	Option appraisal as per RCPC invited review March 2019	06/06/2019	2	2	4	Moderate Risk	
3	Child Health	CIP1920-037	TEWV REGIONAL EATING DISORDER CENTRE (YORK CONSULTANT RESOURCE)	Financial	new service	consultant capacity	consultant capacity	06/06/2019	2	2	4	Moderate Risk	
4	Out of Hospital	CIP1920-067	DISTRICT NURSES SKILL MIX REVIEW	Skill mix based on erroneous activity data.	Capacity not meeting demand and patients receiving reduced care	Potential increased sickness and R&R issues.	Workforce Transformation Project	02/07/2019	3	2	6	Moderate Risk	
5	Pathology	CIP1920-053	HISTOLOGY (B7 PRACTITIONERS TAKING ON CONSULTANT WORK SPA'S)	Risk that Practitioners are unable to cover enough work	delayed results	delayed results		19/06/2019	2	2	4	Moderate Risk	
6	Pathology	CIPPATH102	CONVERT 1.00 WTE B6 TO 1.00 WTE B5 WITH REMAINDER TO CIP - HISTO	Potential dilution of skill mix by replacing qualified staff with trainees	delayed results	delayed results		19/06/2019	2	2	4	Moderate Risk	
7	Pathology	CIPPATH185	SKILL MIX - CONVERT 2 X 1.00 WTE B6 TO 2 X 1.00 WTE B4 WITH REMAINDER TO CIP	Potential dilution of skill mix by replacing qualified staff with trainees	delayed results	delayed results	Stepwise changes to ensure service is not compromised	19/06/2019	2	2	4	Moderate Risk	
8	Radiology	CIP1920-048	SONOGRAPHERS DOING FNA'S	Potential risk of substandard service and reduction in patient experience	Potential clinical impact if provision of service is substandard	None	Agreed training and competency programme in place. Audit of outcomes to be embedded.	11.06.19	2	2	4	Moderate Risk	
9	Radiology	CIP1920-180	ADDITIONAL ACTIVITY ABSORBED BY RADIOLOGY	Potential risk of reduction in access performance and increased waiting times	Potential impact on outcomes if patients wait longer than appropriate	Decreased performance against 6 week standard	Performance metrics reviewed monthly and mitigating actions agreed and completed. Demand management is a workstream on improvement programme which mitigate increase in appropriate demand.	11.06.19	3	2	6	Moderate Risk	
10	Radiology	CIP1920-186	BRIDLINGTON RADIOLOGY ON-CALL SAVINGS	Potential risk of reduced experience if patients who attend out of hours at Brid and need imaging. They will need to wait until following day or attend SGH	No expected clinical impact as only undertake x-ray out of hours and currently on call Radiographers only called in between once or twice a fortnight	No service impact	Discussed and agreed with provider of MIU. Currently demand is extremely low and any significant imaging already streamed to SGH when necessary. This plan puts more robust daytime weekend provision	11.06.19	2	2	4	Moderate Risk	

Respond to Risk:

Seek - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*

Accept - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).

Avoid - this strategy usually requires the withdrawal from the activity that gives rise to the risk.

Transfer - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer arrangement.*

Modify - this strategy involves specific controls designed to change the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust.

Board of Directors – 31 July 2019 Digital Report – July 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	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>		

Purpose of the Report

The purpose of this report is to provide update and assurance to the Board of Directors via the Resources Committee relating to the work and responsibilities of the Systems and Network Directorate.

Executive Summary – Key Points

The Digital Report provides the Resources Committee with an overview of the key responsibilities of the Systems and Network Services Directorate and highlights any areas of concern or themes.

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

- Digital maturity
- LHCRE
- Key Project Updates
- Doctor survey feedback

Recommendation

The Resources Committee is asked to note and discuss the content within the report.

Author: Kevin Beatson, Head of Systems Development & Adrian Shakeshaft, Head of IT Infrastructure

Director Sponsor: Mike Proctor, Chief Executive

Date: July 2019

1. Introduction and Background

This report contains updates on a number of key pieces of work that Systems and Network Services (SNS) are engaged in, as well as details of other significant items that the Committee requires sight of, such as risk and results of recent audits.

The following appendix has also been included;

1. Paperless Strategy proposal

2. Digital Strategy

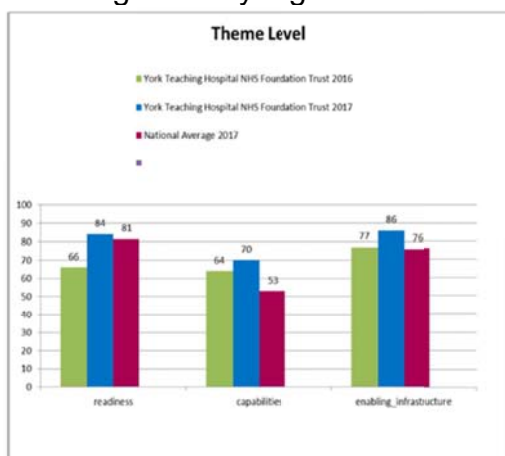
A high level Digital Strategy is currently in the process of being created and will be complete by the end of September. The Strategy will describe how Digital will support the Trust's Strategy and describe the Trust's Digital Journey. Our Strategic aim is to make digital technology a key component of all Trust transformation, ensuring digital is a part of every clinical pathway and contributes to the care and safety of our patients.

3. Digital Maturity Assessment

The Digital Maturity Assessment from 2107/18 has finally been made public. This gives an overall score of 80, putting us 57th out of 232.

In our STP footprint Hull scored 75, making them 85th and NLAG scored 53.3 making them 220th

It is of note that it was a self-assessment but we are one of the few that were externally audited by Deloitte following this assessment. It is also a broad brush approach to maturity taking a particular viewpoint of what constitutes digital maturity in a healthcare environment. Obviously, a lot of trusts will have improved since then – we certainly would score significantly higher due to EPMA roll out.



Reference: <https://www.hsj.co.uk/technology-and-innovation/second-digital-maturity-index-scores-in-full/7025408.article>

We are currently engaged with Himss (Healthcare Information and Management Systems Society) to perform an assessment of our digital maturity. They will use their 9 stage model (0-7) to benchmark our maturity and provide a gap analysis which will inform our planning.

Ref <https://www.himss.eu/healthcare-providers/emram>

4. Engagement

4.1 LHCRE

YTHFT are on the second wave of engagements of LHCRE, which now has the Yorkshire and Humber Care Record (YHCR). The initial project initiation meeting with the YHCR team has taken place. We are fully engaged with the program, having been represented on the System of Systems technical architects board since its inception. Currently we are developing use cases along with other organisations that are in wave 2. System developments will be taking place over the next three to four months. Emphasis will be on Emergency Care and Cancer Care (this is the basis of the funding that the region secured) The project will provide access to elements of our patient record to partners and vice versa. We are currently working with NYCC to explore the potential of opening up NYCC Care Plans to our CPD users within the Trust.

Further information on YHCR: <https://yhcr.org/>

4.2 CYC Digital Interoperability Working Group

We are actively engaged with City of York Council through our membership of the Digital Interoperability Working Group. A project has been initiated to look at how we can utilise digital solutions to improve the ability of all teams involved in an individual's assessment, discharge and care planning to share relevant information in a secure and timely way, to improve the management and care of patients; specifically around the complex discharge pathways. The LHCRE/YHCR work is expected to support this project in addition to building on existing systems in place at CYC and YTHFT. For example, social care workers can already access CPD to review and add to the note of inpatients waiting for discharge.

4.3 SNS Survey of Doctors

We have recently closed a survey that we targeted to all doctors working in the Trust. We had 251 respondents. The survey addressed a variety of topics and provided the opportunity to give feedback.

Highlights

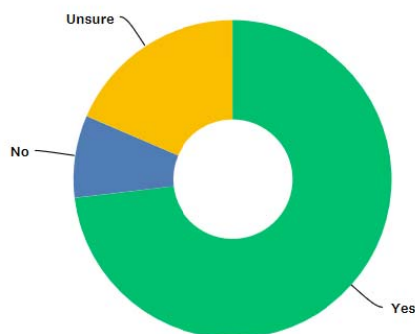
Overall we had just under a 30% response rate. 40% of our consultants responded.

Mobility & PC Access

One area we were particularly interested in is the attitude to our doctors in relation to mobile devices;

Mobile phones should be used for clinical applications

Answered: 227 Skipped: 24



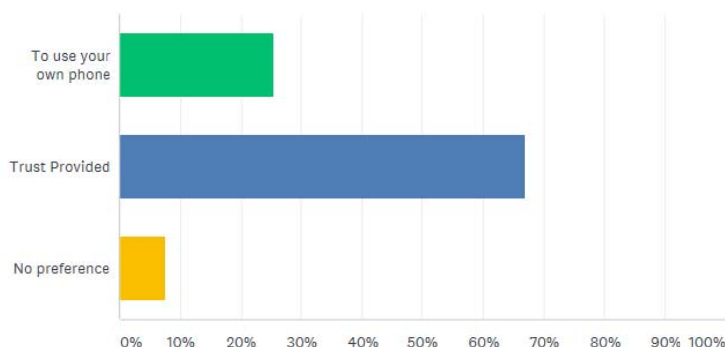
ANSWER CHOICES	RESPONSES	
Yes	73.13%	166
No	8.37%	19
Unsure	18.50%	42
TOTAL		227

Amongst junior grades this rose to 82%

In relation to who's phone, the perceived wisdom is that people want to use their own devices. We asked;

If you were to use your own smartphone to access a Trust system, the Trust would need to install management software on your phone to control the software and assure security. Bearing this in mind, would your preference be

Answered: 227 Skipped: 24



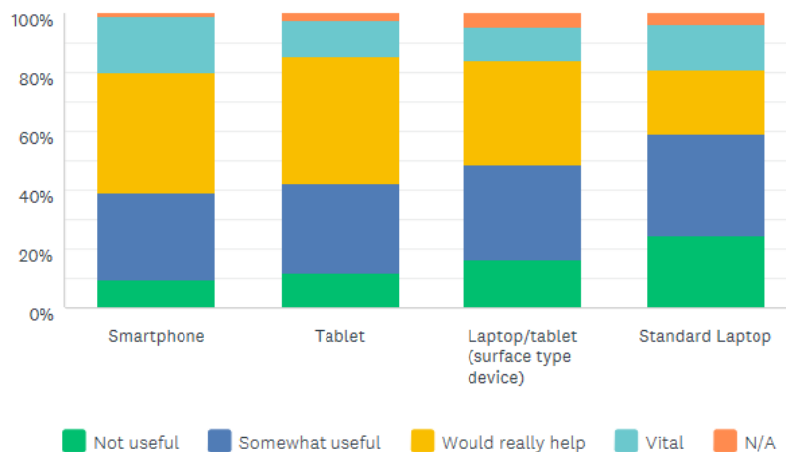
ANSWER CHOICES	RESPONSES	
To use your own phone	25.55%	58
Trust Provided	66.96%	152
No preference	7.49%	17
TOTAL		227

As well as phones, we were interested in attitudes to mobile devices in general.



How useful would the following devices be to support your work

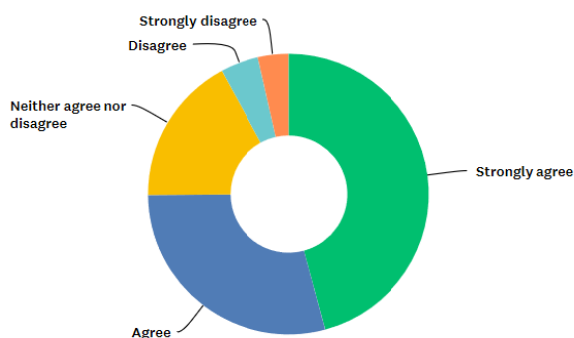
Answered: 227 Skipped: 24



Concentrating specifically on access to clinical records;

Having access to Patient Records using mobile devices would help me in my work

Answered: 227 Skipped: 24



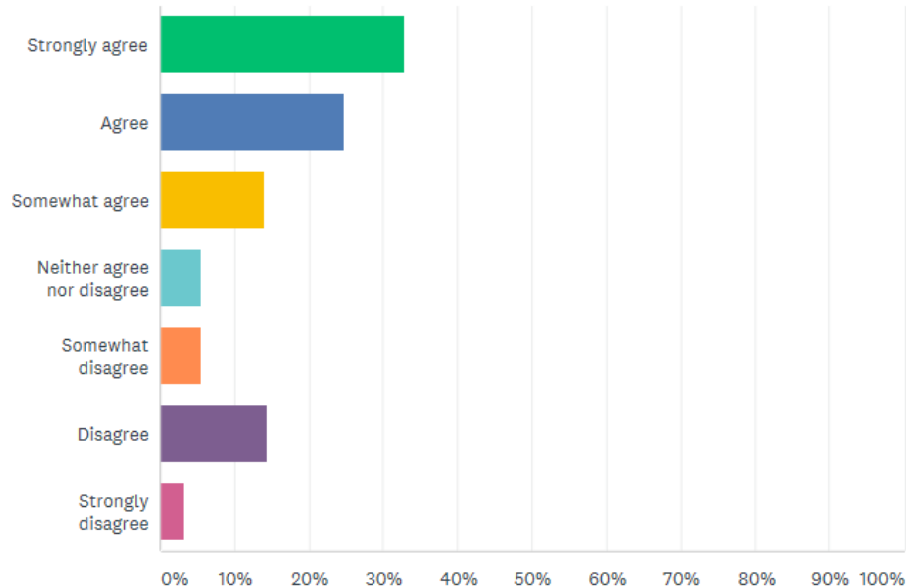
This is 75% of doctors agreeing or strongly agreeing that mobile access would help them in their work.

We asked for respondents to tell us what functionality they wanted on phones. Many highlighted the obvious drawback of screen size, There were some very specific requests, but the recurrent themes were CPD, email, access to reference information, tasks and handover, alerts and diagnostic results and general communications.

We asked about access to hardware and software. Although we have a relatively high number of devices on each ward there are undoubtedly times when they are all in use. We have wall mounted PC's, laptops on trolleys and desktop PC's. Providing additional devices in most clinical locations is constrained by the physical environment as well as cost.

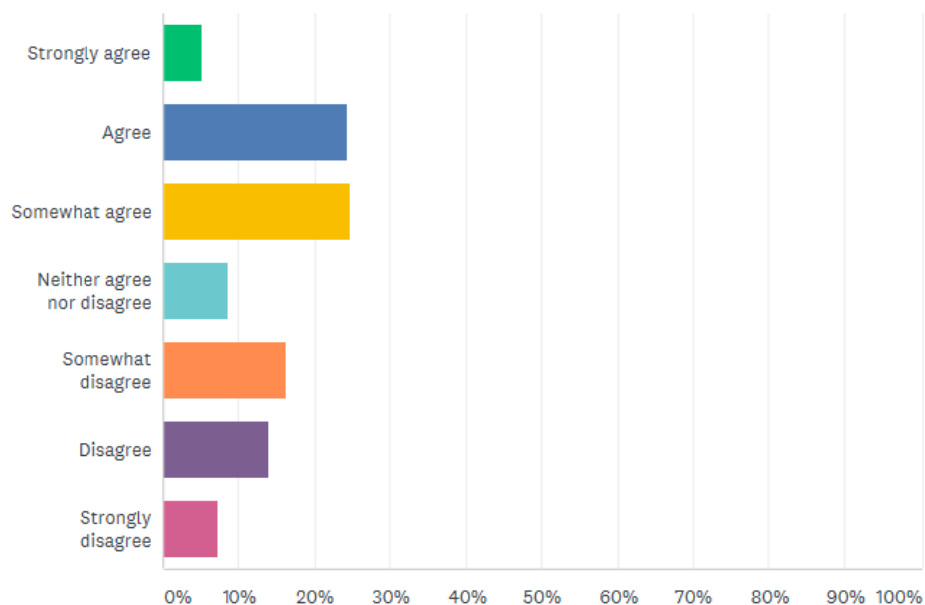
I regularly have difficulty accessing PC's during my working shift

Answered: 222 Skipped: 29



I can easily access the software I need in order to do my job

Answered: 222 Skipped: 29



Our Response

We believe that the problem of access to PC's and software cannot be solved by increasing the numbers of the current PC estate. Furthermore, the mode of interaction with devices is frequent, but often short in duration. This leads to wasted time and frustration. Whilst a recent small scale observational audit by Dr. William Lea and final year Medical

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Students showed that this is less than anecdotally reported (an average of 1.11 minutes to locate a PC and log on), it is still time we could release to care.

We are currently extending CPD functionality to provide bleep filtering and task management on Mobile Phones. These devices will be issued to doctors as their personally held devices (i.e. not shared), but will be trust devices managed by the Trust. The project is specifically at supporting out of hours activity. Assuming it is successful we will plan to extend this to all doctors. We have already engaged with some doctors as part of this project in order to agree the scope of phase 1. That engagement, along with the detailed responses from this survey will be used to guide the development of further capabilities to meet the more general requirements.

Our strategy for clinical applications running on mobile phones will be to provide devices. At this stage we do not intend to support a “Bring Your Own Device” environment. We ask that the board support this approach.

We are supporting the use of the “forward” app as a tactical approach to replacing the widespread use of WhatsApp.

We are currently piloting the use of a tablet friendly version of CPD on the wards. This work is a combination of getting the right devices and ensuring the software is fit for purpose.

We currently have an ongoing trial of laptop/tablet (surface type product) by Breast Surgeons. These are running windows 10, have exceptionally fast logon/logoff times and can be used mobile, or in conjunction with a monitor and docking station. These can work anywhere across the network and would be “owned” by the consultant. Assuming the trial is successful we will need to develop a business case. In most cases this would free up the current office desktop.

An audit of the use of current ward based devices is being planned to ensure we are making the best use of our existing hardware.

We will be presenting further analysis of the survey to the Board in future reports.

5. Recent Advances and Significant Changes

Always On VPN (Virtual Private Network)

We have started the deployment of an “always on” VPN system. This means that users will be able to access the trust network directly from a laptop without having to use a token and logon on to VPN and then use terminal server. As long as the user has an internet connection, the result is that the laptop acts just as if you are on Trust premises. Outlook, personal drives, CPD and the Trust intranet and other applications can all be accessed. For community workers this means they can use SystmOne on their laptops which have inbuilt SIM cards.

Forward App

WhatsApp has become widely used in many hospitals, including our own. The forward app is a replacement for WhatsApp that meets the relevant Information Governance and

security requirements and is supported by the NHS nationally. It is secure to communicate about patients and is designed to support that. Our renal team has switched over from WhatsApp to forward. Initial indications are positive. We are in discussions with the company around how we might work together on this initiative.

Endoscopy Reporting System

Major updates have been implemented to the endoscopy reporting system within CPD. These changes were to support the requirements of the National Endoscopy Database (NED) and required to ensure we meet JAG requirements.

Reference: <https://ned.jets.nhs.uk/KPI/>

Virtual Fracture Clinic

Changes have been made to CPD to support the running of virtual fracture clinics. At the time of writing this has led to a 20% reduction in face to face appointments amongst that cohort of patients.

Cancer Treatment Summary

Creation of new functionality to enable production of a letter electronically once the patient has completed their cancer treatment. This letter includes information about the cancer, how it was treated and also symptoms to look out for which may indicate that the cancer has returned. In addition this letter is able to be transmitted to the GP. This functionality will replace a manual process of creating the letter, freeing up Nursing time and making it less prone to error.

Cloud Based Shared Care Record for Cystic Fibrosis

To support the Cystic Fibrosis service, which is a cross organizational service with HUTH, we have implemented a shared care summary record. This is a cloud based “internet first” project that can be accessed by authorized users from anywhere. This is very much a quick tactical approach to support the clinicians in their delivery of care. It does not currently have any interfaces with CPD or Lorenzo at Hull.

Mobile Emergency Department Dashboards

We have delivered a prototype ED dashboard that runs on a mobile phone. Unlike general clinical applications and other trust systems, this does not need to be on a Trust device. Any smartphone will suffice for an authorized user.

The application is designed to provide high level information around the current state of our hospitals. It shows the OPEL status, numbers of patients in ED and how long they have been there, bed occupancy by ward and gender. The information is real time.

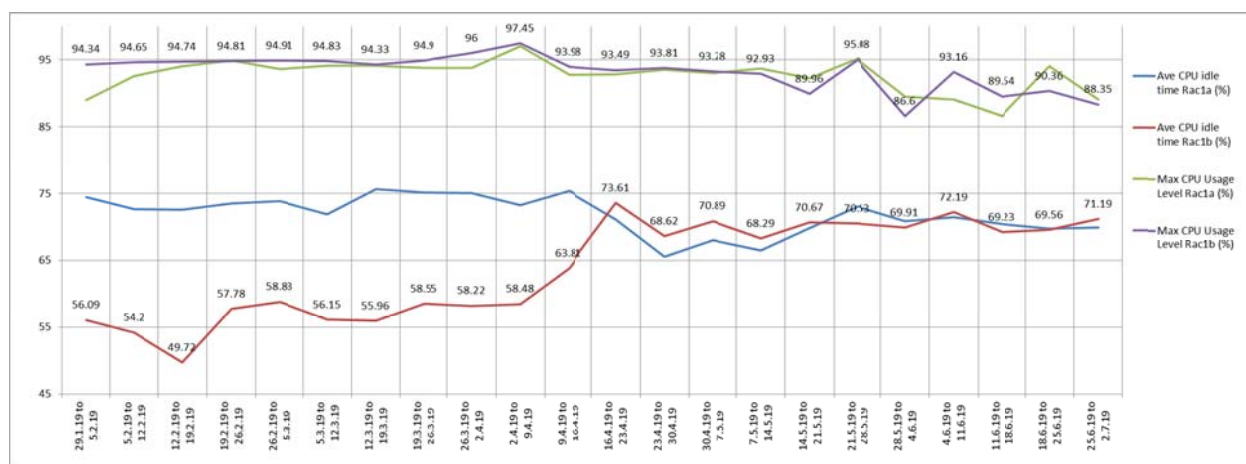
Currently this only works on our network, but ongoing work to our infrastructure will allow this to be used across the internet, making it very useful to directors and managers, particularly when on call.

CPD Performance

During November 2018 we experienced some severe performance issues on our CPD application following the expansion of EPMA to Scarborough. These were particularly severe in the electronic prescribing system. On one occasion this indirectly led to an outage of the system. The problem was unusual as the performance degradation did not align with what was expected as our general load increased. Following this we initiated

several strands of work to improve the situation. As well as initiating code reviews and doing some performance tuning we implemented a major upgrade of our APEX system (this is the Oracle development product that we use to develop much of our system). The combined effort of the upgrade and various tuning improvements has seen a measurable improvement in performance, both from a user interface and database perspective. Opening EPMA for example is 2 to 3 times faster than it was a year ago.

In relation to the underlying servers, the graph below shows how the CPU load has improved and stabilised across the two nodes of the server,



Sexual Health

As part of their new contact Sexual Health Services have to send communications to GP’s electronically, using national standards. The third party supplied system (Telecare) they currently use is not capable of doing this. The service is still currently using Telecare, but is now using CPD for clinical letters that do get transmitted direct to GP. These are currently hidden from other CPD users.

The long term plan for Systems within Sexual Health is being developed.

Service Line Reporting (SLR) & National Cost Collection (NCC)

We have been working with the Finance Department supporting this annual mandatory cost collection return that all providers of NHS healthcare are required to complete and submit to NHS Improvement.

The National Cost Collection encompasses the Reference Cost submission and the newly-mandated Patient Level Costing submission.

This is a highly automated process based on the current automated Secondary Use Serviced (SUS) submissions extracts (IP, OP and ED). Using data from SUS provides the all the benefits resulting from the strict data collection process that SUS enforce: extremely low numbers of DQ errors, full compliance with all the Data Dictionary standards and coding accuracy. It also has the added benefit of allowing these datasets to be cross referenced with existing internal and external reports and data submissions.

6. Key Projects in Progress (Updates)

Moving Business Intelligence to the Cloud

Our Oracle cloud instance has been initiated and we are in the process of migrating current on-premises functionality to the new service. Initiation of the service was

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completed as planned although the configuration of the secure link to our data warehouse was delayed due to configuration issues that the supplier needed to resolve.

New version of Signal

Signal, our reporting repository is being replaced by a completely new version. The new signal will be much more modern looking and well organized in relation to its content. It is being written to be responsive and so will perform well on tablets. It will expose dashboards and reports that are hosted by our cloud based business intelligence system.

Windows 10

The piloting of Windows10 is progressing well, with various system improvements being implemented following the initial deployments. One important benefit is logon speed. On relatively new devices logon times are in the order of 10-20 seconds. Even on the oldest PCs that we have (that are capable of running windows10) we anticipate very significant improvements.

Printer Strategy Update

The project has been running for six months,
The system reduces waste by;

- Allowing users to delete unwanted jobs before they're printed
- Automatically purging print jobs that haven't been collected within 72 hours
- Forcing single-sided print jobs to duplex
- Forcing colour documents to print as mono if user doesn't have colour rights

The most recent quarter shows the following savings were achieved:-

- Over 84000 pages deleted by users (rather than printing them)
- Over 110000 pages deleted by the system
- 111,500 sheets of paper saved

In terms of environmental impact;

- 16,295 litres of water saved
- 4,447 kg of CO2

We no longer have printed documents sitting on printers waiting to be collected which is a reduction in the risk of an information governance breach.

Patient Initiated Follow Up

Work is progressing on CPD changes to support the introduction of Patient Initiated Follow Up (PIFU) this will allow suitable patients to have control over when they have a follow up appointment. Rather than giving them a set appointment, say in 3, 6 or 12 months, they will be allowed to contact the service if they feel the need; for example if they have a flare-up. This will reduce unnecessary face to face appointments and improve the service to the patient, moving to an intervention based on need rather than predetermined schedule. Changes to CPD will support this initiative and provide a safety net so that we don't "lose" patients. The pilot will be in Rheumatology.

Maternity Services Dataset submission (MSDS)

MSDS is a patient-level data set that captures key information at each stage of the maternity care pathway which is recorded on CPD. It includes mother's demographics, booking appointments, admissions and re-admissions, screening tests, labour and delivery along with baby's demographics, admissions, diagnoses and screening tests.

We are developing an automated way of producing the MSDS based on the existing Business Intelligence reports available to the Maternity Dept. This will ensure consistency of approach between internal and external reports whilst reducing DQ challenges and improving the speed, accuracy and efficiency with which these reports are generated.

7. A comparison of Skype and Webex

At present the Trust pays an annual subscription of just over £20,000 to enable the use of Cisco Webex for anyone that needs it.

Skype for Business (which comes as part of the Microsoft Office 365 suite of applications) is widely used and understood by users familiar with Microsoft tools. Skype performs broadly the same functions as Cisco Webex however due to the Trust's current, converged voice video and data infrastructure, Webex should be utilised as the preferred collaboration tool of choice, given those currently available to us.

Webex offers the most functionality and interoperability with the Trust's existing video and telephony platforms, and can be integrated with existing workflows and meeting schedules to enable ease of access.

It is difficult to compare like for like prices at present due to the Microsoft licensing models available however there is an ongoing project to explore all options around the use of Office 365 due to the current version of Microsoft Office in use in the Trust going end of support in 2020.

8. Audit Reports

There have been no further audit reports since the last meeting.

9. Update on SNS Risk Register

Corporate risk SNS 55 relating to the Lab medicine system data has moved a step closer to elimination now that the operating system on the servers has been successfully upgraded. A call has been logged with IBM to progress the next steps.

Risk ref SNS 39 relating to a failure of the bleep system has increased in score due to a recent fault on the Scarborough system. Due to the age of the system the maintainers cannot provide 24 x 7 cover and it is a priority on the SNS capital spend to replace the system as soon as possible as well as implementing more robust contingency measures.



10. Detailed Recommendation

The Resources Committee is asked to note the updates and assurances.



APPENDIX 1

Paperless Strategy

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	<input checked="" type="checkbox"/>	For approval	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input type="checkbox"/>		

Purpose of the Report

1. To appraise the Board of our intentions in relation to the paperless agenda
2. To ask the Board to give support of the approach which will in turn provide support for subsequent plans and business cases

Executive Summary – Key Points

Paperless working will be achieved by supporting staff with the appropriate equipment, developments and support to be able to manage patients safely and efficiently without the requirement for paper case notes. The reduction of case notes will not only support the digital strategy but also reduce the huge burden of storage space and case note retrieval.

The priority will be in the Outpatient Clinic services where we will be able to prove the concept and increase confidence and support any concerns and then roll out to Inpatients. This strategy will, in the main, be delivered by adapting our existing systems but is heavily dependent on staff behaviours as well as IT capability. It will also require improved digital leadership in each of the implementation areas.

Recommendation

The board are asked to support this strategy.

Author: Kevin Beatson, Head of Systems Development

Director Sponsor: Mike Proctor, Chief Executive

Date: July 2019

1. Introduction and Background

1.1 Assumption

This paper takes as a “given” the requirement to implement a paperless or paperlight system within the Trust. Our goal is to provide a universally accessible, reliable and comprehensive electronic patient record with associated workflows to those involved in the care, management and administration of patients.

For the purpose of this report the major benefits of electronic systems are accepted.

This report does not address the cost implications (either costs of implementing or the potential cost savings) of moving to paperlight or provide detailed description of the various projects that will be required, or are in progress.

1.2 Strategic Alignment

The paperlight strategy aligns to the trust strategic goals;

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

A fully integrated digital system is essential to support safe and effective patient care and is a pre-requisite to effectively supporting the goals of the wider healthcare community. Integrated care systems, across the STP area and wider community, rely heavily on the existence of underlying integrated digital systems.

- To ensure financial stability

Whilst there are resource implications in delivering digital systems, the adoption of digital technologies have real value implications; supporting innovative approaches to delivery of care, reduction in administrative burdens, therefore releasing time and money for direct patient care etc.

This proposed strategy will support the Strategic Themes of;

- Making best use of every pound
- Working collaboratively in our partnerships and alliances
- Delivering clinically sustainable services for our patients

1.3 Current Situation

Following a decision by the Executive Board, CPD has been the primary patient record used by the Trust for many years. Although the paper case notes hold some information that is not on CPD, eg inpatient notes and outpatient continuation sheets, the majority of recent letters, discharge notifications and diagnostic results are not held in them and the reliance is already on CPD. This current situation is far from ideal and therefore we must work towards the electronic record being the repository for the entire patient record.

CPD has a document viewer and a summary of the data can be seen which means that we are in a fortunate position that we do not need to procure a patient portal/aggregator type product to pull together data from multiple systems as we only have this one clinical system. This will support the plans to transition to a paperless environment.

The maturity of CPD means that we already have a very comprehensive electronic record and already have many clinics that operate without the support of the paper case notes. E.g. Diabetes and Urology One Stop Clinic. We are also aware anecdotally that many patients are seen without any reference whatsoever to the paper case note by the clinicians.

1.4 Paperless v. Paperlight

In a true paperless environment all data is captured directly onto computer systems. Everything is recorded digitally at point of care, intervention or decision point. Whilst this might be perceived as a valid goal, in many cases it is not achievable in a short timeframe.

Full digitisation is complex, difficult and time consuming to successfully implement. Paper forms can be designed and implemented in a very short time to meet immediate demands. Whilst there are approaches to successfully deal with this it has to be accepted that in the short to medium term there will be some paper. **It is therefore proposed that our initial transitional goal is paper-light.**

In a Paper-light environment permanent physical casenotes will not be used. It will be accepted that some paper artefacts will be created or updated as part of the process of care; these documents will not be stored but scanned onto CPD.

2. Detail of Report and Assurance

2.1 Summary of Proposal

Our Proposal is to work towards the implementation of a complete paperless system but to adopt a paper-light approach in the first instance, as a tactic to expedite the implementation and to realise benefits more rapidly.

Case notes will be phased out by not extracting them from storage except by specific request and new case notes will no longer be created. Any paper forms or documentation relating to patients will be scanned into the electronic record by the Scanning team.

The proposal is to start with the Outpatient Clinics prior to extending to Inpatient Services. The rationale behind this is that it will be easier to implement in this area and to prove the concept and from a Health records perspective, the majority of effort of pulling and distributing case notes is for Outpatients. Freeing up this resource will allow staff to scan the appropriate paperwork into the electronic record and better support the roll out into Inpatients.



2.2 Workflow

Implementing paperless working is more than simply digitising patient records. Paper is used to support workflows. In most cases we already use CPD to manage workflows electronically, for example biochemistry requesting, clinic letter management and inpatient referrals across Specialties.

Paper workflows do still exist and fall into two broad categories; firstly, those where we do have capabilities but these have not been fully exploited (e.g. some radiology and pathology order requesting). In these cases we must work with the various stakeholders to remove barriers and ensure compliance.

The second category is where we do not yet have the full capability, for example outpatient consultant to consultant referrals or the communication within clinic between nurses and doctors. In most cases the end result is recorded electronically, but we have paper flows within the process. This leads to two problems;

- We have a process we can't fully monitor or control
- We need a physical casenote to "carry" the document

We have a sophisticated workflow capability within CPD and have full control and capability to make the necessary changes to our existing systems to implement full electronic workflows.

We ask that the board support the broad objective;

All workflows within our healthcare environment should be electronically recorded and managed. At no point should the provision of care rely solely on a paper document transferring responsibility or information relating to a patient from one party to another.

2.3 Scanning

A common approach to scanning is to use electronic document management (EDM) solutions to implement scanning, often using batch processing. This is a sensible approach in the following circumstances;

- The environment has a lot of disconnected systems
- High volumes of documents need scanning
- There are no existing workflow solutions

These are relatively high cost solutions requiring significant investment in time and money. All paperwork needs changing to include barcodes and then the scanned documents need presenting to the users – in our case we'd need to get them back into CPD so they could be seen within the entire record.

Many organisations have implemented systems or services that scan historical casenotes. This is a very expensive approach and the resultant digitised record is difficult to navigate. It is not a viable approach for us considering that CPD is already considered the primary record.

We have been scanning or loading documents directly into CPD for several years. This is done at the point of use directly into the patient record in the correct context with the appropriate “tagging” of documents so they appear correctly categorised within the CPD document viewer.

The advantages to this approach (as opposed to a batch scanning/electronic document management system) are;

- Low cost; we don't need large layout of capital for new systems or high volume batch scanners.
- We don't need to implement specialist stationary or bar codes
- Existing proven software, low training burden
- Scanning directly onto CPD and validated at time of scanning

On this basis, and being mindful that paperlight and scanning is a step towards a fully paperless system, we are proposing that we continue and expand the scanning of documents directly into CPD.

2.4 Outpatients & Medical Day Case

Individual requirements for implementation will vary to some extent as specialties have their own specific challenges and workflows. In general, the principle will be that casenotes will not be created for new referrals. The default position will be to not pull casenotes for clinics. During implementation individual clinics can be flagged as paperlight to allow us to support a phased roll out. It will still be possible to flag individual patients for casenote retrieval. As much activity as possible is to be recorded directly on CPD. Any paper created during the attendance such as nursing documentation or doctors' continuation sheets will be scanned onto CPD immediately after the attendance. System changes will be made to support the necessary flows of information between all events on a pathway and between staff on the day of clinic. Numerous system improvements have already been implemented (and are ongoing) in preparation for the move to paperlight clinics.

Some clinics, for example diabetes and the Urology one stop clinic already work in this way.

2.5 Endoscopy

Our endoscopy service is already digitally mature and it is expected that Endoscopy will be fully digital once the Endoscopy Imaging project is fully commissioned. All changes to systems for digital workflows have been completed and are ready to deploy. We plan to scan in nursing documentation until this is also fully digitised.

2.6 Inpatients

Casenotes would not be pulled by default. Physical casenotes will not be created for new patients. Old casenotes could still be requested from health records if needed. We are not proposing to digitise old casenotes.



Each patient would have a temporary folder/file for the duration of their inpatient spell. This is an approach that is adopted by many hospitals, including Global Digital Exemplars (GDE). This would hold any paper artefacts that have not yet been digitised. Post discharge, the contents of the file would be manually scanned into the patient record. The file/folder would be re-used. As the system matures the aim would be to make this approach redundant.

Day case surgery documentation is already scanned onto CPD.

2.7 Community Services

Community Nursing, AHP's and Palliative care use SystmOne and will move to paperless working. This is an active project and is being supported by the deployment of over 500 laptops with full system connectivity using our new VPN and associated infrastructure.

3. Constraints and Concerns

3.1 Order Requesting and paper referrals

Currently most pathology and radiology in outpatients along with some referral documentation are still managed on paper. These documents require pre-printed patient labels. It is proposed that we do not implement work-arounds for the creation, storage and distribution of patient labels.

The recommendation is that we implement electronic requesting in all instances in outpatient clinics. This not only meets our requirement of having fully electronic workflows but removes a major impediment to the removal of the physical casenote.

3.2 Workflow

The physical casenote is used to convey information and instructions passing between staff at various points during a patient pathway for example;

- Between referral vetting and first appointment
- Between nursing teams and the Doctor in clinic
- Between the appointment and subsequent follow ups
- Between wards and admin teams

All these workflows need to be electronic. Capability within CPD has already been implemented to address some of these. Further changes will need to be implemented.

3.3 Consent forms

Consent forms will need to be digital. We are currently investigating options using third party software. As an interim solution they will need scanning. The lifecycle of a consent form may span more than one attendance. In advance of a fully electronic system a local temporary storage solution may be required.

3.4 Electronic Patient Record Functionality

We must ensure that the performance of systems is as good as it can possibly be in order to support clinicians delivering care. We are making further enhancements to the record viewer based on feedback from users. Engagement with staff is ongoing and the resulting changes will result in a better user experience. The move to paperlight and paperless will require engagement with staff on a service by service basis and undoubtedly lead to requirements for further changes. In some cases this may require procurement of and interfacing with third party packages. We will need to develop an approach to the creation of freehand drawings for some specialties.

3.5 Electronic Forms and Documentation

As described in this paper, it is not necessary to digitise every pro-forma in order to achieve paperlight working. The recommendation is to implement a paperlight environment whilst working on a digitisation strategy. To this end we are exploring options to enable the rapid creation of electronic forms.

Many notes are written on paper and stored in the casenote, particularly during inpatient spells. All notes will need to be written directly onto the electronic record, generally CPD or SystemOne. The notes entry system in CPD will be enhanced to make this more effective. This will end current duplication of effort and improve the quality of patient records. Pathway documentation in particular contains a lot of redundant or duplicated data.

A strategy and specific detailed plans will be developed for supporting inpatient activity.

3.6 Slow Logons and Adequate Access to Devices

To support paperlight and paperless working we must continue to improve our technical capabilities to ensure systems are fit for purpose and do not become a barrier to the provision of quality care or erode the support of this strategy. This requires;

- Investment in PC Hardware to ensure an aging PC population doesn't adversely impact users
- Ensuring we have the existing devices in the right locations with the correct configuration
- Mobility; appropriate mobile devices suitable for the task at hand
- Virtual Desktop Environments or other mechanisms to allow fast logons and user switching
- Deployment of Windows 10

3.7 Business Continuity

Our existing infrastructure and the CPD system already has a high level of redundancy, backups and Disaster Recovery (DR) capabilities. Currently for a catastrophic failure of CPD, it would take between 30 and 45 minutes. The current platform is due to be refreshed within the next 12 months, as part of this upgrade we will be presenting plans that will reduce the time to recovery.

Disaster planning should always involve explicit plans for Business Continuity. Expenditure on technical solutions for business continuity support depends upon appetite for risk and availability of resource. Having considered options, we are developing a plan to stream a sub-set of CPD to a cloud hosted service. This would provide read only access during the period that the live service was being restored.

This approach would require investment. A business case and options appraisal will be developed.

3.8 User Engagement and Capacity

Moving to a paper free or even a paper.-light Trust is not an IT Project. Although enhancements to IT systems will be required and there will be supporting IT developments and projects, fundamentally this is a comprehensive adaptive and change process program of work and will need the appropriate project management and project support.

Most importantly we will need the user community themselves to drive this forward and to support the process. Notwithstanding the constraints and concerns currently, the workforce is generally positive towards digital working and can see the benefits and efficiencies from electronic records and systems. Identified champions or leads for each area would need to drive this forward and have capacity and ownership to support this work with strong communication plans across the Trust to ensure that staff are fully supported and are engaged with the process.

4. Next Steps

The work to implement Paperlight working in outpatients is ongoing as part of the Outpatients Transformation stream of work. On the assumption that this paper is supported by the board we recommend that;

1. A multi-disciplinary Project Team is created to lead the implementation of the move to paperless working.
2. The digital workforce is expanded to provide leadership in each care group inclusive of each MDT group



Humber, Coast and Vale Health and Care Partnership

Update Report

June 2019

The following report highlights recent work of the Humber, Coast and Vale Health and Care Partnership across some of our key priority areas. It also provides an overview of the issues and topics discussed at the June Partnership Executive Group meeting.

A full list of our priorities and further information about the work of the Partnership can be found on our website at www.humbercoastandvale.org.uk.

Executive Group Overview

Welcome to our new Independent Chair

The Executive Group welcomed the Partnership's newly appointed Independent Chair, Professor Stephen Eames CBE. Having taken up the role in early June, Stephen is now working alongside the Partnership Lead Andrew Burnell (CEO of City Healthcare Partnership CIC), with a particular focus on helping the Partnership move forward towards its goal of becoming an Integrated Care System (ICS) before 2021.

The Executive Group welcomed the additional support and recognition that Stephen's appointment as Independent Chair brings to the Partnership. Stephen reiterated how much he is looking forward to building on the many achievements of the Partnership and working with us as we continue to improve health and care across Humber, Coast and Vale.

Feedback from Partnership Focus Meeting with NHS England/Improvement

On 13th May, our Partnership Lead and Partnership Director attended a focus meeting with the Regional Director for NHS England/Improvement and other senior leaders to provide an update on progress of the Partnership over the past six months and discuss next steps for development. The feedback from that meeting was discussed at the Partnership Executive Group and can be summarised as follows.

In terms of leadership and governance, the Partnership is continuing to make good progress and is no longer considered "challenged". The Partnership should seek to achieve ICS status by April 2020.

The Partnership faces a number of key strategic challenges. In this context, a number of key expectations were discussed in the focus meeting:

- The focus on collaborative work at neighbourhood and place level should be maintained;
- Maximum benefit needs to be secured from investment of Wave 4 capital;
- Proposals for the future of acute hospital services need to be developed through the acute reviews over the coming months;



- The Partnership's financial strategy is sound but needs to be implemented;
- The system approach to planning that has been adopted for 2019/20 should be maintained;
- Material improvement in financial and service performance will be required in 2019/20.

In addition, the Partnership's support requirements were discussed. The need for additional capacity to support key programmes of work and the development of the system towards ICS status have been recognised and, where possible, these will be addressed through the ongoing staff alignment process that is currently being undertaken by NHS England/Improvement.

Partnership Event Feedback

Over 100 people from across Humber, Coast and Vale came together for the Partnership System Leaders Event on 11th June on the outskirts of York making this our biggest Partnership Event yet. There was a high level of energy and excitement in the room and many colleagues have provided positive feedback about how much they enjoyed the event, in particular, learning about some of the collaborative work that is taking place across the Partnership. The event started with a welcome from our Executive Lead, Andrew Burnell, and Independent Chair, Stephen Eames. Participants then heard from Healthwatch about their engagement work with members of the public on the NHS Long-Term Plan, which will help to shape our Partnership Long-Term Plan and ensure the views and perspectives of local people are at the heart of our developing plan. Over the course of the afternoon, colleagues took part in a series of discussions based around the Partnership's collaborative programmes. The comments and ideas raised in each of these discussions will help to inform the Partnership's Long-Term Plan, which will be developed over the coming months.

Partnership Long Term Plan – Next Steps

The Partnership Long Term Plan is currently under development. This month the Partnership published its [Engagement Mapping Report](#), which provides a summary of the key themes and issues arising from engagement and involvement work that has been undertaken by partner organisations over the past 18 months. The report will be used to inform the work of the collaborative programmes as they develop their plans over the coming months. This will be complimented by the feedback report that is being produced by local Healthwatch following their engagement with thousands of local residents across Humber, Coast and Vale on the NHS Long Term Plan.

The next steps in developing the Partnership Long Term Plan, will build on the success of the Partnership Event on 11th June. This will involve hosting similar events in each sub-system (North and North East Lincolnshire; York/North Yorkshire and Hull/East Riding) over the summer months. In addition, a clinical engagement event will take place in September for clinicians from all disciplines and backgrounds (including primary and secondary care physicians; nurses; therapists and other allied health professionals).

These events will be a key element of our Long Term Plan engagement programme and will help to ensure all stakeholders are given an opportunity to attend and shape the Partnership's Long Term Plan. Details of all the events and how to register to attend are [on our website](#).

Primary Care Strategy

The Partnership was required to produce a Primary Care Strategy to be submitted to NHS England/Improvement by 30th June 2019. The strategy was widely circulated amongst partners and was also discussed at the recent Partnership Event. The draft strategy is a high-level document which sets out key aspirations and goals for developing primary care across the Partnership and will form the basis of the primary care element of the Partnership Long-term Plan. Local primary care strategies and plans will continue to be developed in each of our places/CCG areas. You can read the draft strategy [on our website](#).

In addition, partners within primary care have been working to support the development of Primary Care Networks (PCNs) across Humber, Coast and Vale. Humber, Coast and Vale was one of the first regions nationally to report all GP practices had formed Primary Care Networks, ahead of the national deadline (15th May 2019). There are now 29 confirmed Primary Care Networks across the Partnership, all of which have appointed an Accountable Clinical Director. These new networks will play an important role in supporting transformation and bringing together out of hospital services in each of our localities.

System Finance – York/Scarborough

A brief update on the York/Scarborough system financial position was provided to the Executive Group meeting. As has been reported previously, there are significant financial challenges within the local system that all partners are working together to address. A number of meetings have taken place over the last four months, involving local partners and regulators (NHS England/Improvement) in relation to agreeing a system control total and long-term financial recovery plan. Work will continue with all partners to agree a way forward in line with the broader work to produce a Partnership Long-term Plan.

Partnership Oversight and Assurance

With a wide range of collaborative programmes now established and a shared ambition to achieve ICS status now agreed, there is a recognition amongst partners that oversight and assurance arrangements for the Partnership should now be reviewed. A high-level paper was discussed at the June Executive Group meeting, which set out some principles for mutual accountability and a proposed approach for system oversight and assurance for the Partnership. The aim would be to put arrangements in place that best enable the collaborative programmes to deliver agreed objectives and outcomes and the Partnership as a whole to deliver on its priorities. This would involve oversight of progress and performance at organisational, place, sub-system and full Partnership level.

Proposals will be developed over the coming weeks to be discussed at a future Executive Group meeting.

Acute Services Reviews

A brief update on the two acute services reviews being undertaken by the Partnership was provided. Both programmes have recently appointed new management leads and are continuing to engage with clinicians and a range of stakeholders to develop proposals for the future of acute hospital services across our Partnership. The latest updates from the programmes can be found [on our website](#).

Other News from the Partnership

Stakeholder Engagement Events – Partnership Long Term Plan

To support and inform the development of the Partnership Long Term Plan, the Partnership is holding three Stakeholder Engagement Events across the Humber, Coast and Vale area over the coming months. The engagement events are open to anyone who has an interest in the future of health and care in the Humber, Coast and Vale area.

They will be of particular interest to:

- Voluntary and community sector organisations
- Governors and members of local NHS organisations
- Staff, including staff-side representatives
- Patient Participation Group (PPG) members
- Local Councillors and other community leaders

The events are free to attend but it is essential to [register your attendance](#) as places are limited.