York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

27 November 2019

NHS
York Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: 27 November 2019

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

TIME	MEETING	LOCATION	ATTENDEES
8.30 – 11.30	Quality Committee	General Medicine Seminar Room	Directors Non-Executive Directors
8.30 – 11.30	Resources Committee	Boardroom, Trust HQ, 2nd Floor, York Hospital	Directors Non-Executive Directors
11.00 - 11.30	Resources/Quality Committee – Items for Escalation Discussion	Boardroom, Trust HQ, 2nd Floor, York Hospital	Directors Non-Executive Directors
12.00 – 1.00	Informal Board Discussion	Boardroom, Trust HQ, 2nd Floor, York Hospital	Board of Directors
1.00 – 1.45	Corporate Trustee Committee	Boardroom, Trust HQ, 2nd Floor, York Hospital	Corporate Trustee Committee
2.00 – 5.00	**Board of Directors meeting held in public**	**Boardroom, Trust HQ, 2nd Floor, York Hospital**	**Board of Directors Members of the public**

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public) Agenda

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Apologies for absence and quorum** To receive any apologies for absence • Mike Keaney	Chair	Verbal	-	2.00 – 2.10
2.	**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest or to consider any conflicts of interest arising from this agenda.	Chair	A	07	
3.	**Minutes of the meeting held on 25 September 2019** To receive and approve the minutes from the meeting held on 25 September 2019.	Chair	B	11	
4.	**Matters arising from the minutes and any outstanding actions** To discuss any matters or actions arising from the minutes.	Chair	Verbal	-	
5.	**Staff Story** To receive the details of a staff experience.	Chief Executive	Verbal	-	2.10 – 2.25

	SUBJECT	LEAD	PAPER	PAGE	TIME
6.	**Chief Executives Update** To receive an update from the Chief Executive	Chief Executive	C	27	2.25 – 2.35
7.	**CQC Report and Action Plan** To receive a CQC report and action plan.	Chief Nurse	D	31	2.35 – 3.05
	Strategic Goal: To deliver safe and high quality patient care				
8.	**Quality and Resources Committees** Items for escalation to the Board. • 25.09.19 Minutes for information	Committee Chairs	E1 E2	121 129	3.05 – 3.15
9.	**Chief Nurse Report** To receive updates from the Chief Nurse including: • IPC Update • MCA – DoLs Update	Chief Nurse	 F F1	 143 185	3.15 – 3.25
10.	**Perinatal Mortality Review Tool Report** To receive and discuss the PMRT Report	Chief Nurse	G	189	3.25 – 3.35
	Short Break				3.35 – 3.45
11.	**Medical Director Report** To receive the Medical Director Report.	Medical Director	H	193	3.45 – 3.55

	SUBJECT	LEAD	PAPER	PAGE	TIME
12.	**Performance Report** To receive the Performance Report to include: • NHS Digital Leadership Academy – OPD transformation support	Chief Operating Officer	I	229	3.55 – 4.05
13.	**Partnership and Alliance Report** To receive the report.	Chief Operating Officer	J	243	4.05 – 4.15
14.	**Director of Estates & Facilities Report** To receive the Director of Estates and Facilities Report.	Director of Estates & Facilities/ LLP MD	K	253	4.15 – 4.25
	Strategic Goal: To ensure financial sustainability				
15.	**Finance Report & Efficiency Report** To receive an update on Finance and efficiency.	Finance Director	L L1	257 263	4.25 – 4.35
	Strategic Goal: To support an engaged, healthy and resilient workforce				
16.	**Director of Workforce Report** To receive the Workforce Report.	Director of Workforce & OD	M	275	4.35 – 4.45
	Governance				

	SUBJECT	LEAD	PAPER	PAGE	TIME
17.	**Reflections on the meeting** • Board Assurance Framework • December Board	Chair	N Verbal	293	4.45 – 4.55
18.	**Any other business**	Chair	-	-	4.55
19.	**Items for Information** • HCV Update		O	313	-

20. Time and Date of next meeting

The next meeting will be held on 29 January 2020 in the Boardroom, Trust HQ, 2nd Floor, York Hospital

Items for decision in the private meeting: -

The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to issues concerning individual people (staff or patients).

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

Register of directors' interests
November 2019

York Teaching Hospital
NHS Foundation Trust

Additions:

Changes:

Deletions:

A

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders
Ms Susan Symington (Chair)	**Non-executive Director—**Beverley Building Society **Director** - Lodge Cottages Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member—**the Court of University of York	Nil
Jennifer Adams (Non-Executive Director)	**Non-executive Director** Finance Yorkshire PLC	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse is a Consultant Anaesthetist at the Trust	Nil
Michael Keaney (Non-Executive Director)	Nil	**Chair**—YTHFM LLP	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Jenny McAleese (Non-Executive Director)	**Non-Executive Director**—York Science Park Limited **Director**—Jenny & Kevin McAleese Limited	**50% shareholder and Director**—Jenny & Kevin McAleese Limited	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Member**—Audit Committee, Joseph Rowntree Foundation	**Member of Court**—University of York	Nil
Dr Lorraine Boyd (Non-executive Director)	Nil	Equity Partner Millfield Surgery	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Lynne Mellor (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Position with BT (telecom suppliers)

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultan-cies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or com-missioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
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)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Simon Morritt (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Act as Trustee** Medi-cinema		Nil
	Other: Member of the Independent Reconfiguration Panel (Independent Committee advising the Secretary of State on contested health service re-configuration.					
Mr Andrew Bertram (Executive Director Director of Finance/ Deputy Chief Execu-tive)	Nil		Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representa-tive	Nil
Mrs Heather McNair (Chief Nurse)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr James Taylor (Medical Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultan-cies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or com-missioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mrs Wendy Scott (Chief Operating Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Brian Golding (Director of Estates and Facilities)	Nil	**Managing Director**— YTHFM LLP	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse is Director of Strategy and Planning at HEY NHS FT	Spouse is a Director at HEY NHS FT and Trus-tee of St Leonards Hos-pice
Ms Polly McMeekin (Director of Work-force & OD)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Lucy Brown (Acting Director of Communications)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Public Board Minutes – 25 September 2019

Present: **Non-executive Directors**

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

Executive Directors

Mr S Morritt	Chief Executive
Mr A Bertram	Deputy Chief Executive/Finance Director
Mrs W Scott	Chief Operating Officer
Mr J Taylor	Medical Director
Ms P McMeekin	Director of Workforce & OD

Corporate Directors

Mr B Golding	Director of Estates & Facilities/ YTHFM LLP Managing Director

In Attendance:

Trust Staff

Mrs L Provins	Foundation Trust Secretary
Mrs H Hey	Deputy Chief Nurse

Observers:	Andrew Polson	Coloplast
	Jillian Bradley	Staff
	David Watson	Member of the public
	Andrew Bennett	Staff

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

19/74 Apologies for absence

Apologies were received from Mrs L Brown (Acting Director of Communication, Mr M Keaney (Non-executive Director) and Mrs H McNair (Chief Nurse).

19/75 Declarations of interest

No further declarations of interest were raised.

19/76 Minutes of the meeting held on the 31 July 2019

The minutes of the meeting held on the 31 July 2019 were approved as a correct record.

The Board:

- **Received and approved the minutes of the Board meeting held in public on the 31 July 2019.**

19/77 Matters/actions arising from the minutes

Minute No: 19/67 – Mrs Adams noted that cleanliness in relation to catering and operating theatres would be picked up as part of the Resources Committee feedback.

Action Log:

The risk management framework review is complete

No further items were discussed.

The Board:

- **Noted the action log.**

19/78 Patient Story

Mr Morritt proposed to change the way the patient story is delivered. It was agreed that in future a patient or relative would be asked to the Board to talk through their experience, with staff members also being invited on alternate meetings to do the same.

The Board received a presentation on a patient story by Head of Nursing, Georgia Wright. Mrs Hey stated that the story was very pertinent as a number of patients had to be transferred yesterday and a more holistic approach to care was needed.

Mrs Mellor asked if any lessons could be learnt from this and whether any sort of checklist was planned. It was noted that this story would be discussed at the Senior Nurses meeting where actions would be developed.

Mrs Adams stated that this chimed with a story she had received regarding a patient from Hunmanby having an ENT appointment in York and the associated travel and time issues.

Mr Taylor stated that the patient had received good medical care, but an improved holistic approach would deliver a better patient experience.

Mrs McAleese wondered if in fact all the tests needed to be done.

The Board:

- **Received the patient story and thanked Georgia Wright for this very compelling account.**

19/79 Chief Executive Overview

The Chief Executive provided an update on the following key areas:

Listening Exercise – this is progressing and feedback will be analysed by Clever Together with opportunities to share with staff being programmed in for November. Things are already being changed that can be done quickly and more will follow.

CQC Inspection – a draft report for factual accuracy checking has been received and the Trust has sent a response back to the CQC. The Trust is broadly comfortable with the accuracy of the report, but has shared some comments on the use of resources report. The final report is expected around the 6 to 7 October and communications are being planned. The report will be worked through and an action plan drafted for the October Board.

Support to improve acute flow – The Emergency Care Intensive Support Team (ECIST) is working with the Trust on flow in the hospitals together with a number of other areas. A Co-ordinator has been provided to facilitate the work being done and comments to date are that it is very supportive and overall a positive experience. The A & E Risk Summit which was held resulted in a 3-strand action plan with 1 strand (in-hospital) being led by the Trust. Mr Morritt expressed the team's frustration around the pace of the work, although all parties are trying very hard to get some traction.

Mrs Scott stated that there had been significant pressure on the Scarborough site the day before and support was received from partners to move a significant number of patients, which was really positive and eventually left the site with 33 empty beds. This was a step change, but the Trust needed to wait to see whether the change was sustained. It was agreed that the strap line 'why not today' should be taken up.

Acute Services Review – the phase 2 draft report has been received and a workshop held with was attended by Stephen Eames the Humber Coast and Vale Lead. A partner stakeholder event will be held on the 8 October to look at the next steps. Mrs Scott stated that the Trust is already progressing some of the workstreams including urology and surgery and paediatrics and obstetrics which also have GP representation. The Board will receive a presentation at the next meeting.

Temporary Theatre at Bridlington Hospital – Mr Morritt provided the background to this which has resulted in a date for the temporary theatre at Bridlington to be removed. However, following work to look at utilisation of the theatres at Bridlington, the Trust is not going to replace the theatre as there is sufficient capacity to deliver existing work.

Mrs McAleese asked whether other theatres in the Trust were fully utilised. Mrs Scott stated that the Bridlington site has always had relatively low theatre utilisation which could be accommodated in the 2 remaining theatres and staff have been briefed on this, but a challenge will emerge if the Trust wants to grow the activity at Bridlington. Mr Taylor

stated that the orthopaedic utilisation of theatre time at Bridlington had always been very good.

ICS Accelerator Programme – Mr Morritt stated that he expected things to move quickly in relation to Humber Coast and Valle becoming an integrated care system (ICS) and the patch has been signed up to the accelerator programme. He expected a number of key staff to be involved in that programme and encouraged others to get involved. The ICS Accelerator Programme is very important indeed to the regional health economy.

The Board:

- **Received the update;**
- **Look forward to the outcome of the listening exercise;**
- **Will receive the CQC report and action plan as its next meeting.**
- **Would like to see the take up the strap line 'why not today'.**

19/80 CQC Update

This was discussed as part of the Chief Executives Overview.

19/81 Scarborough Capital Strategic Outline Business Case

Mr Golding provided an overview of the £40m capital bid for redevelopment at Scarborough. The bid is being managed by Humber Coast and Vale and was a collective £88m bid with both the Hull Trust and the North Lincs and Goole Trust. The presentation was about the organisations strategic outline business case which would normally be done before a bid is entered. It is the first part of a 3-stage approval process and it is important to receive sign off from the Treasury in the first instance. Each stage will be longer than the last.

A presentation was provided by Jo Southwell, David Thomas and Sarah Barrow.

Ms Symington thanked the team for the presentation which was very informative.

Mrs Scott challenged the need for the 3-storey build as one storey will be dormant for future use at a later date. She asked if the full £6m has to be spent whether an alternative to the dormant floor had been considered as this would give more immediate value. It was noted that if the Trust drew down less of the money then the surplus would go back into central funds, however, other options of looking at expanding the ground floor had not been looked at.

Mr Holmberg thought it unlikely that the Trust would be allowed to build capacity which would initially be empty. Mrs Southwell stated that the case alluded to the poor nightingale ward structure and there were also issues with critical care services being scattered and if these were brought together in the newly created space it would allow that space to be re-provide ward space. Mr Bertram stated that it is unlikely it would be empty space as there would be a parallel process running to be able to re-provide other services, but he agreed that a better story needed to be told around critical care and the nightingale ward provision.

Mrs Scott asked where the money would be coming from to equip the newly created space and Mr Morritt stated that nationally a multi-year capital programme was trying to be secured for the NHS.

Ms Mellor stated that the presentation was very comprehensive and asked about whether there was an opportunity to secure private funding or rent the space out to secure further funding. Mrs Southwell stated that private funding had not been considered and that if there had been more money the space would have been fitted out.

Mrs Adams asked about the £762k monies which were described at risk. Mrs Southwell stated that the next stage was the outline business case which would require this funding in relation to things such as architects. Currently, the Trust was unable to draw down against the bid, but the Trust was lobbying hard to secure early release of some of the funds. The first stage was to get the strategic outline business case approved and NHSI had committed to working with the Trust to find a solution to funding.

Mrs Adams asked if there was a cut off date for submission as she noted one of the other Trusts has already slipped in relation to timescales. It was noted that there was no cut off date, but once the joint strategic outline business case was approved the Trust could move at its own pace.

Mr Morritt was concerned that 2024 was a long time to wait for the build and he was having conversations to see if it could be pulled forward as it was a pressing issue for the Trust. The board agreed.

Mrs Adams asked if there was a plan to deal with the interim period and Mrs Southwell stated that there was a Gantt chart in the presentation.

Mr Bertram stated that he had not anticipated the consternation over creating a shell. He stated that if the shell was created as part of this business case then the space could be fitted out as part of another business case which would cost a lot less than creating a case for another new build.

Mr Holmberg was still concerned about the perception centrally around creating empty space.

Mrs Hey stated that the nightingale wards had featured on the risk register for the last 3 years and had not received any backlog maintenance so were a real issue. Mrs Southwell stated that this case was part of the plan to eliminate the nightingale wards.

Mr Bertram stated that to respond to the challenge about creating empty space a full story needed to be told in the business case around what the Trust was trying to achieve strategically, for the long-term sustainability of services for the Scarborough community.

Mrs Scott stated that this should be directly linked to the clinical strategy and that funding this was part of providing a sustainable future for the hospital at Scarborough.

Mr Morritt stated that there was a story to tell around Scarborough and the Trust's plans for providing hugely needed quality space.

Mr Bertram stated that currently no decisions were required in relation to what was provided; it was about approving the business case to go forward.

The Board approved the strategic outline business case.

The Board:

- **Fully supported the strategic outline business case;**
- **Agreed that a stronger story needed to be told in relation to the need for the extra space.**

19/82 Quality & Resources Committees – Items for escalation

Quality Committee – Dr Boyd noted that the items for escalation were:

- operational pressures,
- decontamination challenges,
- substantive staff funding and
- ECS performance.

These items will be picked up as part of individual executive briefings.

A further item for discussion was approval of the winter plan which the Quality Committee recommended to the Board. Mr Morritt stated that the Board needed to see the system winter plan and he asked for this to be brought to the next meeting. It was noted that the paper which had gone to the Quality Committee was not the same paper which had been seen at Executive Board and so the funding implications would need further scrutiny.

It was agreed that the winter plan approval should be added to the Board work programme for September next year.

Action: Internal and system winter plans to be brought to the next meeting.

Resources Committee – Mrs Adams stated that the items for escalation were:

- the month 5 finance position especially in relation to the extra staffing and the risk that the control total would not be met,
- NED concerns around waiting for the GIRFT programme to start delivering benefits,
- nurse and clinical staffing,
- the Equality and Diversity Annual Report in relation to BAME staff experiencing a higher level of bullying and harassment and the improvement in translation services,
- areas of concern regarding cleanliness in theatres and kitchens together with HPV fogging provision and the general lack of capital which could put patients at risk.

Mrs Adams noted that digital was receiving more attention, but there was concern around linkage with the Care Groups and the need for digital champions.

The Board:

- **Received the items for escalation and noted that the internal winter plan will be brought back to the next meeting for funding approval.**

19/83 Chief Nurse Report

Mrs Hey wished to highlight to the Board 3 areas which included staffing, infection control and patient experience. In relation to staffing, an acuity and dependency report had been discussed at the Quality Committee together with the usual nurse staffing paper. Discussion had been around the risks linked to agency spend; although newly recruited nurses were taking up posts now. The biggest risk was in relation to staffing 2 wards to 5 RNs on each shift which the CQC had stipulated. This was not budgeted for and the Trust had to pay high agency rates sometimes for staff who were sat waiting for patients. Mrs Hey stated that she was looking innovative ways of making this work and would provide a formal report and action plan.

Infection control was a mixed picture with the 001 C Dif outbreak now concluded and the learning being looked at with focus required on cleaning, fogging and how to decant. She highlighted that it would be a tricky winter and that the C Dif meetings would continue on a weekly basis as there was currently a high level of C Dif at York. On a positive note, the Infection Prevention Team were now up to full strength and each Care Group would have an IPC nurse aligned to their group.

The Patient Experience Steering Group (PESG) is being refreshed and the next one will be on the 23 October and Dr Boyd and 2 governors would be part of the membership. Mrs Hey stated that she was meeting with each of the care groups individually to go through patient experience and get key people engaged. Ensuring engagement form the Care Groups in this work is ongoing.

The Inpatient Survey report was discussed and it would be represented to the Board once it had gone through PESG.

Ms Mellor thanked Mrs Hey for her report, but asked what care group 6 was doing in particular, as they appeared to be doing well, and she asked if the learning was being shared? Mrs Hey stated that some of the care groups still have a backlog from being directorates but there is still commitment to the 30 day target. She stated that she would be monitoring quality and timeliness and getting tougher on holding care groups to account.

Mrs Adams stated that the inpatient survey showed a deterioration in help with feeding and she wondered if the volunteer service was being maximised. Mrs Hey stated that some of the volunteer dining companions had not been made to feel part of the team on wards so had drifted away and that the welcome was not as strong as it could have been. She has charged the team with getting this right as it was a great opportunity. The board thought this was disappointing.

The Board:

- **Noted the Chief Nurse Report especially in relation to staffing;**
- **Were pleased to note that the IPC Team were now fully staffed;**

- **Noted that the Inpatient Survey would be brought back following a discussion at PESG.**

19/84 Inpatient Survey Report

This was discussed as part of the previous item.

19/85 Medical Director Report

Mr Taylor wished to highlight from his report the positive news in relation to the National Neonatal Audit Programme (Scarborough was confirmed as outstanding for one of the audit measures) and the vascular unit at York (performed ahead of its peers on the recording of endovascular procedures).

Mr Taylor gave an overview of the operational pressures at Scarborough the previous day and that patient safety risks had been managed and there had been a fabulous response from staff and especially the nursing team. However, he acknowledged that patient experience was challenged under these circumstances and further work needed to be done.

Mr Dillon asked what caused the demand on a Tuesday? Mr Taylor stated that it was the cumulative effect from the weekend. The Trust provides a service which is more limited at the weekends than during the week, and the impact of this is significant at the Scarborough site. The clear answer to this consistent issue is to provide a full service over 7 days. Mr Taylor explained that the consultant contract did not easily allow 7 day working and that important discussions had to be with individual consultants to move ever-closer to 7 day working.

Ms McMeekin stated that job planning was complicated and that only 22 medics had not started the process, but the other 239 were awaiting sign off and it would all be concluded next month. It was also about the checks and balances to ensure the Trust was getting the most out of direct clinical care.

Mrs Adams noted that on her patient safety walkround of Chestnut Ward they had stated that nothing happens at the weekend.

Ms Symington stated that this also needed a system response.

Mrs Adams asked about the 2 priorities of same day emergency care (SDEC) and SAFER and Mrs Scott responded that these were felt to be enablers to allow the Trust to do more, but SDEC was about specialties accepting responsibility for patients and moving them out of ED. SAFER is about ensuring the flow through the hospital and would be relaunched by the Chief Nurse Team.

Mr Taylor stated that if there is no additional resource for this: any funding will need to be taken out of elective care which will have an impact.

Mrs Scott stated that full 7-day working would require a real shift in practice and culture.

Ms Mellor noted the summary of learning around patient safety walkrounds on page 210, but wondered if there could be a more regular update to ensure actions are timely. One

response today about what keeps the ward sister awake at night was about space, layout and the lack of capital: this is recognised as a real issue that will not easily be solved. Ms Symington stated that the NEDs had to be careful about slipping into operational issues in relation to walkabouts, and that there needed to be a discussion with Mrs Hoskins about how follow-up from walkabouts could be better communicated to the Board.

Action: A discussion with Mrs Hoskins around the provision of patient safety walkround action information.

The Board:

- **Noted the report and the good news about paediatrics at Scarborough and the vascular unit at York;**
- **Noted the position at Scarborough the previous day and the work which had gone into resolving the pressures.**

19/86 Performance Report

The Trust did not meet the ECS for August with performance of 81.3% Type 1 and 3 attendances are up 6% for the year to date on the same period in 18/19, with the main EDs seeing and treating an additional 5,046 patients a rise of 10%. Non-elective admissions are also up year to date by 3%. The Trust is working with NHSI and the acute board has been refreshed and Executive Board will hold the ring around delivering what the Trust has committed to deliver.

The Trust is underperforming against a number of targets. Of particular concern is waiting list backlogs in some specialities and clearly work needs to take place to address this to assess and minimise any clinical risk. Mrs Scott stated that she would like a Board discussion on the Trust position against performance targets and the likely position at year-end as the Trust is currently 7% behind on plan, 5% behind on day cases and 12% behind on OPD activity. She stressed that patients are waiting longer and that there needs to be a discussion about care group recovery plans including any associated investment if patient safety issues associated with this are identified. It was agreed to have a workshop around the waiting list position at the next Board.

Ms Symington was concerned that the comprehensive performance report was still not integrated into the meeting. The board recognise that the report represents significant work and provides great insight into performance Mr Bertram stated that he would also welcome a discussion as it should also look at how partners can play their part in any additional work required. The Trust needed to create some expectation around the role of its partners so that they also took some responsibility.

Mrs Scott also raised that the national initiative/requirement to offer choice of provider at 26 weeks would also need to be considered..

Mr Morritt stated that 3 scenarios were discussed at the August Board and any further discussion should be tied into and build on these. He suggested that this form the baseline for the October discussion.

Mrs Adams asked if the Trust was receiving more attention from Regulators and Mrs Scott responded that the Trust is currently receiving intensive support so has been given some

room. She also noted that the Trust is outperforming the national cancer 62-day standard position which is very positive.

Mr Holmberg stated that he had concerns over the 26-week patient choice standard and that it would drive inequity in the region. Mr Morritt state that all partners were having difficulties.

The Board:

- **Noted the pressures the Trust was under especially in relation to performance;**
- **Agreed that a fuller discussion on performance and finance was required at the next meeting.**

19/87 Emergency Planning Report and Annual self-assessment against core standards

Mr Chadwick, the Emergency Planning Manager joined the Board to provide an update on emergency planning. Mr Chadwick walked the Board through the submission noting items from the paper which included the self assessment of substantial compliance, notable achievements and plans for next year.

Mr Dillon asked about engagement with other partners? Mr Chadwick stated that he attended a number of engagement and partnership meetings which included the police, fire service, Councils and local residents.

Mrs Adams congratulated Mr Chadwick and the team for the work done to bring this work forward.

The Board approved the submission of the annual self assessment against core standards.

The Board:

- **Received the report and noted the huge steps forward made in this area;**
- **Approved the submission of the annual self assessment.**

19/88 Director of Estates & Facilities Report

Mr Golding stated that the Estates Team currently provides reactive HPV services and were now looking at the cost of expanding this to a proactive service. The Team is currently working with external contractors, but the provision of a proactive and reactive service with new up to date equipment would require investment and a business case was being taken to the IPC Steering Group.

In relation to cleaning standards, the Trust was not achieving the national standard in some high-risk areas such as theatres, but this was due to maintenance issues not being raised. He noted that following action 98% had been achieved last week which was the standard. In the kitchen areas it had been damage to flooring and worktops that had not been escalated and this area had also now seen a significant improvement.

Domestic staff had also been discussed at Resources due to the vacancy level; however, he explained that this was no more concerning than it had been in previous years. He stated that a number of facilities staff had been appointed which could flex between jobs if required. He noted that staffing is a continuous challenge.

Mr Golding highlighted the following for decision:

Fire Safety Policy – approved
Health & Safety Policy – approved
Annual fire safety report – acknowledged
EPAM Terms of Reference – approved to adopt

Mr Dillon was concerned about a number of items on his walkround of Chestnut Ward which required attention. Mr Golding stated that these were not acceptable and asked to be emailed with a list which he would action.

The Board:

- **Noted the report;**
- **Approved the health and safety and fire policies and acknowledged the annual fire safety report;**
- **The EPAM terms of reference were approved to adopt and the extra assurance these meetings would provide was noted.**

19/89 Director of Workforce Report

Ms McMeekin highlighted that the Trust will be employing 94.4 wte new nursing staff shortly which will take the overall vacancy rate to 10.86%, however, there is a stark difference between York and Scarborough. The recruitment programme will continue and the process to manage the pipeline is getting slicker. She highlighted that the new international nurses had all passed their OSCEs. The demand for temporary staffing had been high due to the vacancy rate and this had breached the agency cap.

In relation to medical staff, the changeover on the 7 August had seen medical vacancies increase to 9% from 7.9% in July, and again there was a difference between Scarborough and York. The Trust has welcomed 28 non training grades and the East Coast recruitment continues in relation to consultant posts.

The Equality and Diversity Report featured a number of areas from the 2018 Staff Survey, with the 2019 Staff Survey due to take place shortly and showed that staff with a BAME background were more likely to experience bullying and harassment from colleagues. She noted that there are now 39 fairness champions in place and that line management training has been taking place. Ms McMeekin also noted that all 3 categories of the 2018 survey on bullying and harassment had seen a decrease in 2018.

Mr Holmberg asked if there was any data about glass ceilings and Ms McMeekin stated that the Trust's percentage of BAME staff is above that of the local population, however this is mainly in the LLP and at lower bands.

The Board:

- **Noted the report and the comments in relation to BAME staff.**

19/90 Revalidation Report

Mr Taylor provided an overview of the report stated that the Trust's appraisal rate was 91% and the report required sign off by the Board. He noted that feedback from consultants on the benefit to patients was at 53%, but 72% felt that they benefited from the process.

The Board provided delegated authority for the Chair to sign the Designated Body Statement of Compliance once it was completed.

Ms Symington stated that she felt brilliantly delivered appraisal was vital for all staff, at all levels.

Mrs Adams asked what Mr Taylor's view was about having an allocated appraiser or being able to select one? Mr Taylor stated that he had an allocated appraiser and he noted a plan was being consulted on about having allocated appraisers. Ms McMeekin felt this would close off the route of consultants being able to say that they cannot find an appraiser.

The Board:

- **Received the report;**
- **Agreed delegated authority for the Chair to sign the report.**

19/91 Finance Report & Efficiency Report

Mr Bertram stated that the Resources Committee had spent a lot of time discussing finance so he would only provide the highlights. On page 318 of the pack the report noted that in month 5 the Trust was £700k the wrong side of its plan and therefore PSF had not been factored in, but there is an option to recover in month 6. The Trust was reporting a deficit of £5.4m against a deficit plan of £2.8m. The variance could be explained by the £700k and the PSF not being factored in. Mr Bertram stated that the Trust had not lost control of its finances, but that the system was running very hot and fragile. Pressure is down to the additional investment in staffing in July and August which was essential for patient safety and which emerged clearly from the CQC inspection. The Trust is breaching its agency cap and this is inevitably attracting the attention of NHSI. Ms McMeekin's team is working with other Trusts to share learning and good practice.

Mr Bertram stated that on a positive note, CIPs have delivered £8.7m of which £7m is recurrent. However, care group delivery is being compensated for by significant movements in the corporate position so panel meetings have been set up to hold the care groups to account. Mr Bertram stated that he is optimistic that the CIP target will be met at year end.

Mr Bertram stated that the forecast outturn position had been discussed in some detail at the Resources Committee and he noted that there was risk that if nothing was done regarding the extra system risk then the Trust would not meet its control total. This was

also being discussed at Executive Board. Mr Bertram stated that 2 key actions were in train: to firstly look to reduce discretionary expenditure and, secondly, to look at doing additional work for non-alternative contract commissioners to secure funding.

Mr Bertram noted the confusion around the winter plan discussion and he stated that he had not been sighted on the paper which was in the Quality pack as he attends Resources. He felt that there was learning that this paper also needed to go to Resources due to the financial implications. Some of the £1.8m funding is in the plan (£700k) and some actions will be difficult to deliver. He will agree the position with Mrs Scott and the Board will be updated as to the final agreed position.

Ms Symington stated that the critical issue remains recruitment: She asserted that it was important for the Board to know what the issues are and what actions are being taken.

Mrs Hey stated that the Trust is in Cohort 5 of the Retention Programme (due to our excellent retention rates) but there were still actions that may help retention in terms of the ways in which we support new starters to the trust, considering both working arrangements and also individual wellbeing.
It was noted that currently there were no winter monies available from NHSE/I, although that could change, and that there also needed to be a system response to predictable winter pressures.

Mrs Adams stated that the quality impact assessment process is tighter now and Resources have now started to receive the Efficiency Delivery Group minutes.

The Board:

- **Noted the fragility of the finance position especially in relation to the system risk:**
- **The Board asked to be kept fully informed of any changes.**

19/92 Reflections on the Meeting

BAF – Ms Symington stated that two direct points had been raised in relation to the BAF.

The first in relation to concerns that the scoring of risk 6 (staffing) was potentially too high? It was agreed that this would be reviewed by the Executive Team.

It had also been flagged that risk 1 (system finance) was a lower score than the risk on system finance on the corporate risk register? However, it was noted that the corporate risk register was about immediate operational risk and that the BAF was about strategic risk in relation to the 5 year strategy so the scores were appropriate.

Action: The Executive Team to look at the scoring of risk 6.

The scoring of risk 9 (Trust finance) was discussed as it was thought that it was a bit low, but it was agreed that it was still too early in the year to know if this should be raised, but it would be kept under review.

The Board and Committees had covered all risks during the day's discussions and any items of concern had been escalated.

The Board

- **Noted the reflections on the BAF.**

19/93 Any other Business

Primary Care Network Thanks – Dr Boyd stated that one of the vale of York Primary Care Networks, South Hambleton and Ryedale PCN (previously North Locality) is one of 4 nominees in the National Association of Primary Care awards for PCN of the year. Their nomination is largely in recognition of the significant work they have done to improve the care of their elderly and cancer populations, working in collaboration with partners. Dr Boyd stated that the PCN would like to thank the Trust for the contributions the community teams have made to support them but most specifically would like to ensure that the contribution of York Hospital Charity Fund is acknowledged and thanks extended to them via the Board.

Patient Safety Walkround (Scarborough Mortuary) – Mrs McAleese expressed her profound shock at the state of the mortuary facilities which she described as appalling and called into question the Trust's escalation systems. She noted staff were working in these conditions and that its renovation must be made a priority. Mr Bertram stated that there was a plan and he was also ashamed of the facilities and stated that staff required thanks for working in the difficult and challenging environment and for making the best of it. He stated that he will support a plan to move this forward at pace and it may be that the Charity would also be approached around the viewing facilities. Mr Bertram also noted that the mortuary had also featured on the Scarborough Capital Bid item and that this plan is also advancing. Mr Golding stated that it was also part of the very stretched capital programme.

Mrs McAleese asked if there were any other facilities which were as bad and whether these areas are the ones that should be covered in the walkrounds.

Action: Mrs Hoskins will be asked to look at the areas for patient safety walkrounds.
Action: Mortuary to be kept under review on the action list.

Mrs Mellor stated that this was the kind of thing that needed to be kept under review so that the Board could understand what action is being taken.

Research & Development Annual Report – Mrs Adams highlighted that the Resources Committee had received a really good report and that it was an example of where the Head of Research had been appointed and turned the research around in the Trust and exceeded targets.

Brexit – Mr Bertram stated that the NHS were stepping up the planning for a no deal and he wanted to reassure the Board that all obligations on the Trust were being met. In relation to the action plan previously seen by the Board all the ambers were now green. Staff and patient briefings were taking place in relation to not stockpiling and the Trust had deployed software which would allow the centre to see stocks held and move them between organisations if shortages occur.

Possible Change of Board Date – Ms Symington indicated that it was likely the Board date would be changed in October to the 6 November, however, the Board to Council of Governors meeting would still be held on the 30 October.

No further business was discussed.

The Board:

- **Received the PCN thanks and endorsed the partnership working;**
- **Noted the update and reassurance around Brexit;**
- **Noted the condition of the Scarborough Mortuary and that it should be constantly viewed as an action until conditions change.**

19/94 Date and Time of next meeting

The next public meeting of the Board will be held on 27 November 2019 in the Boardroom, Admin Block, York Hospital.

Outstanding actions from previous minutes

Minute No. and month	Action	Responsible Officer	Due date
18/69	Risk Management Framework to be reviewed following the revision of the committee structure. Reviewed at CRC – 14.3.19. Reviewed by the Quality Committee on 31.07.19	Ms Jamieson/ ~~Mrs Geary~~	Completed
19/65	Mr Jayagopal to provide an update to the Board on the plans for a new build and any difficulties being experienced due to the increase in student numbers.	Mrs Provins	Nov 19
19/66	Sustainability Report to the Board in January 2020.	Mr Golding	Jan 20
19/68	Consider in discussion with new CE, PCN presentation to board.	Ms Symington	Oct 19
19/82	Internal and system winter plans to be brought to the next meeting.	Mrs Scott	Oct 19
19/85	A discussion with Mrs Hoskins around the provision of patient safety walkround action information.	Mrs Provins	Oct 19
19/92	The Executive Team to look at the scoring of risk 6.	Ms McMeekin	Oct 19
19/93	Mrs Hoskins will be asked to look at the areas for patient safety walkrounds.	Mrs Provins	Oct 19
19/93	Mortuary to be kept under review on the action list.	Board	Until completed

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Chief Executive's Overview

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

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

Executive Summary – Key Points

The report provides updates on the following key areas:

- Our Voice Our Future
- Care Quality Commission: report and action plan
- Support to improve acute flow
- ICS Accelerator Programme
- Urology rota changes

Recommendation

For the Board to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: November 2019

1. Our Voice Our Future

In my first report to this Board I outlined my plans to carry out a Trust-wide listening exercise to hear and understand the barriers facing our staff.

I sent letters to a cross section of staff, asking them to tell me about the key things they feel prevent them from doing their work. I've also held a series of 'listen and learn' drop-in sessions.

Earlier this month the findings from this listening exercise were shared at an event for around 150 staff where the audience was invited to challenge and confirm the conclusions.

The event also saw the launch of our Trust-wide conversation, called Our Voice Our Future. Everyone has been invited to join this online conversation, where staff can share insights and ideas, and read and comment freely. The online workshop lets people join in anonymously to have their say in creating a better future for the Trust and those we care for.

There are three broad areas under discussion – fixing the basics, behaviours, and creating a new vision for the Trust.

So far over 900 people have taken part in the online workshop, and over five thousand ideas and comments have been shared.

As I have been speaking to our staff it has become clear that there are frustrations around the lack of consistency in the way we behave and how we treat each other. We will not be able to change this without talking to all our staff.

By the new year we will have a comprehensive analysis of what our staff believe is needed to fix the basics and will have validated this plan together with staff. We will continue to use these methods to ensure the voice of our colleagues really does lead to improvements.

2. Care Quality Commission: report and action plan

The report detailing the findings of the CQC's inspection of core services was published on 16 October.

The inspection took place between 18-20 June, focusing on Scarborough and Bridlington Hospitals. In addition, a use of resources assessment and a well led review were also carried out, and feed in to the overall rating.

The overall rating for the Trust remains Requires Improvement.

As I have previously briefed, 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 final report makes a number of specific recommendations, in these areas and others, and as part of the process we are required to produce an action plan in response. This plan has now been shared with the CQC and will be discussed as an agenda item later in this Board meeting.

3. Support to improve acute flow in our hospitals

In the late summer we were offered support from a number of expert teams within NHS England/NHS Improvement and the Emergency Care Intensive Support Team (ECIST) to help us to accelerate progress with the plans we have in place to improve acute flow.

As a result of conversations between ECIST and our teams, it was agreed that we would focus on two key priorities: same day emergency care (SDEC) and SAFER, as these are likely to have the greatest impact.

As part of this work, we held an 'SDEC Day' on 12 November to test our SDEC standard operating procedures and pathways for patients presenting to the Emergency Department at York Hospital.

The aim was to ensure patients who are suitable for SDEC are seen by the right team, in the right place, at the right time in order to reduce and eliminate delays for patients and improve flow throughout hospital. This is an evidence-based method, which has been shown in many other hospitals to reduce and eliminate delays for patients arriving at ED and improve flow.

Colleagues from ECIST and the Trust's improvement team were on hand to support, coach and advise staff.

There was a huge amount of enthusiasm and commitment throughout the day from staff across all Care Groups. A debrief was held at the end of the day, and it was collectively agreed to take steps to embed SDEC as business as usual across York Hospital by extending the test to a 21 day challenge. This is now underway, and a similar exercise is being planned for Scarborough Hospital.

As we enter the winter months it is vital that we continue to focus on the actions and processes that will have the most impact for our patients.

4. ICS Accelerator Programme

Humber Coast and Vale Health and Care Partnership is now a part of the ICS Accelerator Programme following the launch event in October.

An Integrated Care System (ICS) is the next step in the evolution of the Sustainability and Transformation Partnerships (STPs). The Long Term Plan committed to every STP becoming an Integrated Care System by 2020/21.

In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

A System Maturity Matrix will be used to determine whether a system is ready to become an ICS, Using the following domains:

- System leadership, partnerships and change capability
- System architecture, financial management and planning
- Integrated care models
- Track record of delivery
- Coherent and defined population

A 'thriving' ICS will be able to demonstrate robust governance, advanced progress and real system-working at all levels, across each of these components.

In order to achieve this, the following three priorities have been agreed by the partnership:

- Partnership Strategy
- Operating Arrangements
- Stakeholder Engagement

Our Chair and I attended one of the first Accelerator Programme workshops which focused on partnership working. Executive colleagues and others have been involved in further meetings and workshops as the work gathers momentum.

5. Urology rota changes

A single York-based on call service for urology was implemented on 18 November.

There will be a consultant urology presence in Scarborough between 8am and 6pm on weekdays, with consultants able to review and, if necessary, treat emergency patients within these hours.

The consultants will also continue to see inpatient referrals from other specialties, provide acute assessment clinics and deliver elective services.

Outside of these hours, some patients who require acute surgical intervention will now transfer to York Hospital or the nearest alternative emergency department.
The on call consultant urologist will be available to provide telephone advice out of hours and will advise on the safe management of the patients until they can be stabilised and transferred.

This is a temporary change to allow for a safe medical staffing model whilst we work with system partners to develop a long-term model for the acute urology service.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Care Quality Commission Summary Improvement Plan

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

At the last meeting of the Board of Directors, members received the draft CQC Summary Improvement Plan. The attached document provides the final Summary Improvement Plan which was sent to the CQC on 13 November 2019.

Members will be aware that it is a regulatory requirement to address the 'Must Do' (MD) and 'Should Do' (SD) items in the report. Each MD and SD is assigned a number and as there is some overlap and repetition in the report some actions have both MD and SD numbers.

The implementation plan delivery will be monitored through a newly established fortnightly CQC Programme Group. An update for assurance and escalation will be presented at the Quality Committee and Trust Board every month.

Executive Summary – Key Points

The June and July 2019 site visits by the Care Quality Commission (CQC) concluded with an approved report on 16 October 2019.

The Trust accepted the content of the report and the recommendations within. Whilst the Trust retained an overall Requires Improvement rating; Safety on the Scarborough site went from Requires Improvement to Inadequate.

The report identifies 26 actions the Trust Must Do and 51 actions the Trust Should Do in order to address specific concerns.

Whilst the actions identified pertain to the Scarborough and Bridlington sites only there is a need to acknowledge that many of the actions identified are relevant to address across the whole organization. Therefore, the Improvement Plan has been shared with the senior leaders in all care Groups for them to address the actions through their Care Group Governance structures; this forms part of preparing for future visits and ensuring cross care Group actions are shared.

The Improvement Plan will be updated every month and will be presented by the Chief Nurse to the Quality Committee and Trust Board every month.

Recommendation

- To note the final summary improvement plan sent to the CQC on 13 November
- To Note the review arrangements that have been established

Author: Fiona Jamieson: Deputy Director of Healthcare Governance
Director Sponsor: Heather McNair, Chief Nurse

Date: November 2019

Care Quality Commission Summary Improvement Plan

Board Assurance that CQC action is on track Key:
Delivered
On track to deliver
Some concerns – narrative disclosure
Not on track to deliver

Version Control

Version 3

12 November 2019

York Teaching Hospital NHS Foundation Trust – our improvement plan and our progress

What are we doing?

The Trust was rated as Requires Improvement following the last CQC inspection. The inspection focussed on the Trusts' east coast services and whilst most ratings stayed the same (9) or improved by one rating (2) it is noted that 'Safe' at Scarborough Hospital went down one rating to 'Inadequate'.

The CQC issued 3 requirement notices to the Trust. The 'MUST DOS' highlighted to the Trust for immediate attention are captured at the start of the Improvement Plan.

The CQC report made 77 recommendations in total, 26 of which the Trust must undertake and 51 of which the Trust should undertake. All 77 recommendations are included in our CQC Improvement Plan.

The plan is iterative and will be managed through new governance and meeting structures lead by the Chief Nurse.

The Trust Board has approved the CQC Improvement Plan which has been designed to deliver the immediate actions required as well as the longer term improvements needed. Support and engagement of our staff and our stakeholders will be fundamental to making the sustainable changes that are required for the benefit of everyone who uses our services.

A robust system of governance has been established to track and deliver the progress against the plan. The plans have been developed to match the new Care Group operational structure and thus delivery and governance will be largely owned at Care Group level. Care Group Leads have been identified to implement the plans. Care Group Leads will be supported, where identified, by Corporate Leads to ensure actions are implemented quickly and effectively and to unblock any obstacles that might prevent completion of the actions. There is Executive and Non-Executive oversight against all Care Group plans and further independent review will be provided through a clinically-led Peer Review and Audit process. Performance will be monitored through our CQC Programme Group and reported to the Quality Committee and to the Trust Board monthly. Further oversight will be provided to our stakeholders.

The improvement plan will be monitored by the CQC Programme Group on a weekly basis, with each service line being reviewed on a fortnightly basis. This document shows our plan for making these improvements and will demonstrate our progression against the plan.

The CQC Improvement Plan was signed off by the Board on 7 November 2019. The plan ensures that the format and content align to the CQC reporting domains and that there is further clarity of the intended outcomes and key performance indicators across the programme of improvement. This will assist in the process to ensure that improvement actions align with the improvement recommendations.

Who is responsible?

Our actions to address the recommendations have been agreed by the Trust Board.

Our Chief Executive, Simon Morritt, is ultimately responsible for ensuring actions in this document are implemented. Executive directors are responsible for ensuring the plan is implemented as they provide the executive leadership for quality, patient safety and workforce.

Our success in implementing the recommendations of the CQC Improvement Plan will be assessed by the Chief Inspector of Hospitals, via the regional CQC Team who we will liaise with closely.

If you have any questions about the work we are doing you may contact our Deputy Director of Healthcare Governance, Fiona Jamieson, Fiona.c.Jamieson@.york.nhs.uk

The format of this plan…

This improvement plan is set out in the same format and sequence as the CQC report with the ‘MUST DOs’ and ‘SHOULD DOs’ in the same order.

For ease of reading where a similar concern was found across 2 or more areas the plan is cross referenced to this section.

We recognise that sustainable improvement requires cultural and or behavioural changes which will take longer than our immediate action plans. We need to build a culture that empowers colleagues, that instils ownership and accountability for quality and which ensures that we deliver our promises

Target dates going up to April 2020 reflects the ambition to deliver against all our MUST DOs and SHOULD DOs; this does not mean that our work will stop in April. There will be more work to do on some actions and where we have made changes we will continue to check that the improvements have been embedded and sustained.

We have rated the actions as “green” when in the planning stage planning. This is because we believe that the plan is realistic and is on track. We recognise that as time goes on, some actions may not go to plan and if this happens they will then change to ‘amber’ which means that there are reasons to be concerned that the action will not deliver the outcome or timescale or ‘red’ if we now believe that the action is not on track to deliver. There are some actions where important aspects are not under our control and so we have used ‘amber’ to show that we have less certainty.

A MUST DO (MD) and SHOULD DO (SD) key is provided at the end of the Implementation Plan for reference

How will we communicate our progress to you?

We will provide a progress report every month, which will be monitored by the CQC Programme Group and reviewed by the Trust Board.

The progress report will be published on the Trust website in the Trust Board papers, and subsequent longer term actions may be included as part of a continuous process of improvement. Each month we will let all staff, governors and stakeholders know our progress.

We will inform all Trust staff via Staff Briefs and Staff Matters letting them know more about the inspection outcome and describing the improvement plan, where members can access the action plan and how and when we will update it.

We will present updates on progress at our scheduled Council of Governor meetings which are held in public.

We will provide updates to our stakeholders through the oversight and assurance meetings which will be held on a monthly basis.

CQC IMMEDIATE ACTIONS IMPLEMENTATION PLAN FROM THE VISIT

Issue No	Action	Lead responsibility	Key Actions	Target date	Measure or evidence of completion	Audit or ongoing assurance
IA 1	Assurance required to ensure sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed at night for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients **NB: This action links to MD2; MD3; MD4; MD11; MD 19 and MD22**	Medical Director CG2 Clinical Director	Delivery of the Hospital At Night project	31 12 2019	Hospital at Night Project Plan and Implementation Plan Medical staffing reported to CQC on weekly return Digital solution for bleep filtering and task allocation in place Junior doctor induction schedule and content to include bleep filtering and SBAR (AIRA course and links with Outreach Nurses)	
IA 2	Assurance required to ensure sufficient numbers of suitably qualified, competent, skilled and experienced registered nurses are deployed for,	Chief Nurse CG2 Head of Nursing	Coronary Care Unit and Beech Ward increased staffing to planned 5 registered nurses on each shift	Immediate and ongoing	Monitored daily with escalation and assurance as required Weekly return to CQC	A formal workforce review required in order to determine best staffing model and if needed secure

	the coronary care unit and lilac ward, on the Scarborough Hospital site, to promote safe care and treatment of patients **NB: This action links to MD4 and MD16**		Telemetry: • Standard Operating Procedure review and audit • Safe nurse staffing to monitor telemetry • Improve recording of telemetry activity Non-invasive ventilation (NIV): • NIV to be managed solely on beech ward to a maximum of	Complete and ongoing Completed and ongoing	Trust Board Nurse Staffing reports. Audit of telemetry patients undertaken and reported to Patient Safety Group – minutes from Patient Safety Group Staffing addressed. Plan for 5 registered nurses on each shift Telemetry records. Weekly return to the CQC Revised Standard Operating Procedure produced and circulated assuring management of NIV on beech ward Staffing addressed. Plan	additional funding to substantively increase the registered nurse numbers to 5 registered nurses on each shift for each ward A formal workforce review required in order to determine best staffing model and if needed secure additional funding

			2 Level 2 patients • Safe nurse staffing to manage NIV Workforce review cherry ward (AMU) on the Scarborough Hospital site	 30 11 2019	for 5 registered nurses on each shift Staff education plan for beech ward Registered nurses. Maintains over 80% of registered nurses NIV trained with competencies signed off BEST tool procured during August 2019 and data collection undertaken during October 2019 with analysis and provisional staffing plan presented 30 11 2019. (NB this work needs to link with the Scarborough site bed modelling project as the function of cherry ward may change)	to substantively increase the registered nurse numbers to 5 registered nurses on each shift for each ward Align staffing to bed modelling project and undertake 6 monthly BEST tool data capture on all emergency and acute wards and units
IA 3	Assurance required to ensure that you provide safe care and treatment across all medicine wards at the Scarborough Hospital site with particular reference to the	CG2 Clinical Director CG2 Care Group Manager	Bed reconfiguration: lilac ward assigned to medicine Revision of ward nurse staffing levels (see IA2)	Complete Complete	Lilac Ward is now a medical ward Weekly return	 Daily monitoring, escalation and

	ward environment on lilac ward, the patient mix for that ward, and to address falls	CG2 Head of Nursing	Improved observation of patients. Multi-professional staff engagement in relation to observing patients	Complete	Laminated posters displayed at each nurses station Discussion at handovers for 1 week. Week commencing 1 July 2019	assurance
			Increased Matron presence / ward leadership	Complete	Initially Matron worked on Lilac Ward 2-3 shifts per week. Increased Band 6 leadership on Lilac Ward to 3 Band 6's. Advert our for secondment for Band 7 role	Vacancy levels and recruitment / retention activities closely monitored
			Education support for staff on lilac ward: particular reference to patient falls	Undertaken and ongoing	New nursing leadership and new staff in place and being recruited to. Patient Safety Team provided additional falls prevention training records during August 2019.	Patient safety, specifically falls incidence monitoring
			All new starters and	Undertaken	Preceptorship	

			international recruits will receive the same preceptorship programme which includes training on patient safety and specifically falls prevention training.	and ongoing	programme schedule Preceptorship competency pack Evidence of attendance from medical wards at Scarborough Hospital	
IA 4	Assurance required to ensure staff on medicine wards at the Scarborough Hospital site are maintaining securely and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided **NB: This action links to MD12; MD 14; MD18; MD26; SD27; SD28 and SD42**	Medical Director Chief Nurse CG2 Head of Nursing CG3 Head of Nursing	Nursing documentation audit undertaken and results presented verbally to Nurse Management Team Meeting Newly created paperwork developed and piloted for nursing documentation. Pilot feedback considered and further revisions to paper booked required before roll out. Extraordinary Nursing Documentation	31 7 2019 31 7 2019 28 11 2019	Audit report Example paperwork and feedback from pilot Action plan from meeting	

			meeting to look at work streams and next steps			
			Immediate spot check and then schedule for monthly audit schedule for nursing documentation included as part of the Matron audits	31 7 2019	Audits and audit schedule	
			The importance and legal requirements of documentation sessions run at Scarborough Hospital during July and August 2019	31 8 2019	Education schedule and attendance	
			Confirmation that all agency staff can sign to electronic system obtained; ratification that the system was easy and well-understood and ratification that agency workers are signing into the system daily for	31 7 2019	Completed information provided by Head of Information	

			assurance			

CQC MUST DO AND SHOULD DO IMPLEMENTATION PLAN FROM REPORT

MD1	Executive Lead: Jim Taylor	The trust must ensure is has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Delivery on track RAG Rating
Trust wide			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 1.1	Undertake promotion exercise to ensure ALL staff understand the current processes for identifying learning from deaths and SIs	Deputy Director of Healthcare Governance		31 12 19	Article in Staff Matters Presentation at each Care Groups Quality Assurance Committee Presentation at Executive Board Develop presentation for medical staff induction	June 2020 undertaken Survey Monkey Audit to test that staff understand the current processes for identifying learning from deaths and SIs
MD 1.2	Develop a strategy for the identification of learning from deaths and serious incidents	Deputy Director of Healthcare Governance	Listening exercise with Care Groups. Aim to receive	31 12 19	Learning from Deaths and Serous Incidents Strategy document Sign off at Trust Quality	Learning from deaths and serious incidents minutes from Trust wide Quality Committee;

			multi-professional feedback on current process		Committee and Trust Board Evidence that the new strategy has been presented through the Care Groups Quality Assurance Committees Ongoing evidence that this is presented at appropriate groups, such as, at junior Doctor induction	Executive Board; Trust Board and Care Groups Quality Committees
MD 1.3	Undertake a multi-professional engagement exercise and in response review and revise the processes for the dissemination of learning from deaths and serious incidents	Deputy Director of Healthcare Governance	Engagement events	31 12 19	Report on what our staff think could be better about learning from deaths and serious incidents from the engagement events Revisions to current processes (to be determined)	Review document Revised processes and publications

MD2 – CG2 MD3 – CG2 MD11 – CG3 MD19 – CG5 MD22 – CG3	Executive Lead: Polly McMeekin	CG2 The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training CG2 The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department CG3 The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with Trust policy (MD11 Scar and MD22 Brid) CG5 The service must ensure that all medical staffing complete mandatory training and safeguarding training modules in accordance with trust policy	Delivery on track RAG Rating
Scarborough site CG2 CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 2.1	Implement the 'Training Passport' for staff	Director of Workforce and	Agreement of 'common	April 2021 (two year	Training Passport in place and aligned to	Improved compliance with

	employed from other NHS organisations – National Streamlining Programme	Organisational Development	standards' across STP for the 'Training Passport'	programme commenced April 2019)	Trusts 'Learning Hub'	all aspects of mandatory training
MD 2.2	For immediate improvement: • Ensure that there is adequate and accessible mandatory training sessions for staff to access	Director of Workforce and Organisational Development / Chief Nurse / Medical Director	Review of mandatory training provision to ensure the delivery meets the needs of staff (TNA) (professional input sought from CN and MD)	31 12 2019	Currently no waiting lists except for manual handling. Revised TNA applied and compliance assurance provided to Board	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly
	• Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	CG2 Clinical Director	Correspondence with each member of the medical staff Monthly monitoring of the progress through CG2 Quality Assurance Committee	30 4 2020	Compliance matches Trusts target for each element of mandatory training on 'Learning Hub'	Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly

MD 3.1	For immediate improvement: For immediate improvement: • Ensure that there is adequate and accessible multi-professional paediatric life support training sessions for staff to access • Medical and nursing staff in emergency and acute care at Scarborough Hospital should undertake paediatric life support and 80% compliance should be maintained at all times	Sandra Tucker Quinn CG2 Clinical Director and Head of Nursing	Review of paediatric life support provision to ensure the delivery meets the needs of staff Training plan for paediatric life support for current staff Rolling programme of paediatric life support to ensure improvement is sustained and embedded	31 12 2019 31 12 2019 31 3 2020	Compliance matches Trusts target (?80% of all medical staff) for paediatric life support training in acute and emergency medicine on Scarborough site	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly
MD 11.1 MD	For immediate improvement medical staff in surgery will be issued with their	CG3 Clinical Director	Correspondence with each member of the medical staff	30 4 2020	Compliance matches Trusts target for each element of mandatory training on ‘Learning	Learning Hub compliance discussed and monitored through

19.1 MD 22.1	individual compliance data and set a target date for full compliance, specifically safeguarding training modules		Monthly monitoring of the progress through CG3 Quality Assurance Committee		Hub’	CG2 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly

MD4	Executive Lead: Polly McMeekin	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting	Delivery on track RAG Rating
Scarborough site CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 4.1	Review the RCEM standards for staffing and undertake a gap analysis. Present findings to Trust Board	Director of Workforce and Organisational Development		31 1 2020	Trust Board presentation	Set a six monthly schedule for repeat gap analysis and risk assessments so the Trust Board understand the continued level of risk
MD 4.2	Medical recruitment plan in place and performing well	Director of Workforce and Organisational Development with CG2 Clinical Director		Complete	Vacancy level for medical staff: 9.2% on 31 10 19 Vacancy levels reported to Trust Board	Medical staffing levels monitored Vacancy level Turnover
MD 4.3	Implement the BEST nursing workforce analysis	Deputy Chief Nurse with CG2	Procure hardware	30 11 2019	Data collection, analysis and report completed and	Six monthly audit schedule for nurse

	tool and use this for the basis for workforce redesign	Head of Nursing	and software and engaged with IT to support programme Analyse data and set a 6 monthly rolling programme for data collection and analysis		presented to CG2 Quality Assurance Committee and included in Chief Nurse report for Trust Board Next steps for workforce redesign to be informed by data on other intelligence	staffing workforce using approved tool
4.4	Develop a nursing recruitment plan which includes projections and risk analysis and mitigation plan acknowledging registered nurse recruitment at Scarborough is challenging	CG2 Head of Nursing		31 1 2020	Recruitment plan with quarterly reviews and updated recruitment plans in place	Registered nurse staffing levels monitored Vacancy level Turnover
4.5	Utilising the east coast review work, undertaken by the external reviewers, the Trust will determine and approve the scope of the paediatric service at Scarborough hospital which may impact the	Chief Executive with Executive Director colleagues CG2 Clinical Director CG5 Clinical Director		30 4 2020	System wide presentation and approval of scope of paediatric services at Scarborough Hospital Fully aligned medical and nursing staffing and training plan to meet the	

	staffing levels and paediatric training level requirements				needs of children who present as an emergency or urgent case	
4.6	Immediate action to undertake a training needs gap analysis for the current substantive medical and nursing workforce, aligned to the RCEM recommendations and examine the opportunities to upskill our current staff to better meet the needs of children who present as an emergency or urgent case	Director of Workforce and Organisational Development	Training needs gap analysis undertaken and presented Internal and external training opportunities explored to deliver most appropriate training	31 1 2020	Urgent and emergency care RCEM aligned training plan and dates booked for specific training as required Staff attendance / achievement of recommended training monitored on the Learning Hub	Ongoing / rolling programme of training for nursing and medical staff who are not paediatric trained; acknowledging recruiting paediatric trained medical and nursing staff is a challenge at Scarborough hospital

MD5 – CG2 SD16 - CG3 Scar SD32 – CG5 SD38 - CG3 Brid	Executive Lead: Heather McNair	CG2 The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital CG3 The service should ensure that storage areas temperatures are monitored to demonstrate medicines are always stored in accordance with manufacturer's minimum and maximum temperature guidelines CG5 The service should ensure that daily checks on medicine fridges are carried out as per Trust policy	Delivery on track RAG Rating
Scarborough site CG2 CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 5.1	Immediate action: Lead Nurse for Medicines Management attended Scarborough Emergency Department. Reviewed compliance with safe drug storage. Provided advice and guidance to all staff and assurances that processes for safe management are in place.	CG2 Clinical Director CG2 Head of Nursing Chief Pharmacist Lead Nursing Medicines		31 7 2019	Immediate verbal assurance Controlled Drug Inspection Report Minutes from CG2 Quality Assurance Committee that audits are discussed and where needed improvement	Control drugs audits undertaken quarterly (minimum) which is reported through Pharmacy Governance – report produced

		Management			plans generated	
	In addition Lead Nurse for Medicines Management is running the preceptorship programme for all newly qualified nurses and international recruits and will deliver a section on the safe storage of medicines in all areas	Lead Nursing Medicines Management		31 12 2019	Presentation from Medicines Management Day for new starters (nursing) Competency Assessment document for new starters (nursing)	
MD 5.2	The Trusts Medicines Management Policy describes the requirements for safe storage. This section of the policy to be reproduced with 7 key messages. A laminated copy will be displayed in the clean utility / drug storage areas.	Lead Nursing Medicines Management		15 12 2019	Key messages sheet produced	Controlled Drug Inspection report
	The key messages sheet will be read out at each safety huddles for 1 week, Week commencing 11 November 2019, and signing sheet for department to be completed	CG2 Matron CG2 Head of Nursing		31 12 2019	Signature sheet to say staff have attended a safety huddle where safe storage of medicines was discussed	

	The key messages sheet will be included in local induction packs for all new starters The key messages sheet will be included in local induction packs for all new starters				Local induction pack	
MD 5.3	Matrons to undertaken quality audits and spot checks which include the safe storage of medicines	CG 2 Head of Nursing		30 11 2019	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme
MD 5.4	Chief Pharmacist has commissioned Internal Audit to undertake: Safe and Secure Handling of Medicines Audit	Chief Pharmacist Lead Nursing Medicines Management	Scope of audit approval Draft report Final report	 31 12 2019 31 1 2020	Scope of audit Schedule for audit Audit Report	Actions generated from audit will be management through the Medicines Management Group
SD 16.1 SD 38.1	Develop the current Fridge temperature monitoring Policy to include ambient temperature monitoring for all clinical areas	Chief Pharmacist		30 4 2020	Updated policy Evidence of compliance with monitoring ambient room temperatures	
SD 32.1	All wards and units in midwifery have a signing sheet for daily fridge	Head of midwifery		30 11 2019	Weekly audit reports Copies of signing sheets	

	temperature checks. The completion of this will be audited on a weekly basis by ward sister, in her absence Matron will be responsible and any lapses in compliance addressed				Evidence that compliance is discuss at CG5 governance meetings – minutes of meetings	

MD6 MD24	Executive Lead: Jim Taylor	The service must ensure that computer screens showing patient identifiable information, are not left unlocked when not in use, in its urgent and emergency care service in Scarborough hospital	Delivery on track RAG Rating
Scarborough site CG2 CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 6.1	Information Governance Training contains information about securing patient detailed guidance on computer screens. Compliance with Information Governance mandatory training to be maintained at the nationally target of 95%	CG2 Clinical Director CG2 Head of Nursing		31 12 2019	Learning Hub compliance with Information Governance Training Information Governance Training forms part of induction for all new starters Information Governance training compliance discussed at CG2 Quality Assurance meeting – meeting minutes	
MD 6.2	Information Governance Team peer reviews which provide an opportunity for immediate rectification and for staff feedback on all	Deputy Director of Healthcare Governance		30 11 2019	Schedule for peer review. Reports, actions and feedback from peer reviews.	

	information governance concerns					
MD 6.3	Matrons to undertaken quality audits and spot checks which include secure management of patient electronic and paper records	CG2 Head of Nursing CG3 Head of Nursing		30 11 2019	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme

MD7	Executive Lead: Jim Taylor	The service must ensure it takes action to improve its performance in the RCEM audit standards in its urgent and emergency care service at Scarborough Hospital	Delivery on track RAG Rating
Scarborough site CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 7.1	Undertake a gap analysis against previous RCEM audit standards and as necessary develop and action plan that delivers improved performance against the standards	Medical Director CG2 Clinical Director		31 1 2020	Paper to Trust Board	
MD 7.2	Based on the review report develop an auditable plan to improve performance against the RCEM audit standards	CG2 Clinical Director		31 3 2020	Auditable improvement plan Minutes of CG2 Quality Assurance Meetings Quarterly report to discuss RCEM audit standards at Care Group 2 Board Meeting	Achievement of RCEM audit standards are sustained and embedded in CG2 performance

MD8 – CG2 MD13 - Scar MD23 – Brid SD29 – CG5	Executive Lead: Polly McMeekin Heather McNair	CG2 The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough hospital CG3 The service must ensure all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy (MD13.1 and MD23.1 Scar and MD 23.1 and MD23.2 Brid) CG5 The service should ensure that all staff have their annual appraisals	Delivery on track RAG Rating
Scarborough site CG2 CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 8.1	Review current appraisal rate for nurses in urgent and emergency care and set a trajectory for appraisals to be undertaken to achieve 85%	CG2 Head of Nursing		29 2 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals Appraisal rates monitored through CG2 Quality Assurance Meeting and CG2 Senior Nurses Meeting– meeting minutes
MD 13.1	Review current appraisal rate for nurses in surgery and set a trajectory for	CG3 Head of Nursing		29 2 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals

MD 23.1	appraisals to be undertaken to achieve 85%					Appraisal rates monitored through CG3 Quality Assurance Committee – meeting minutes
MD 13.2 MD 23.2	Review current appraisal rate for medical staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	CG3 Clinical Director		29 2 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals Appraisal rates monitored through CG3 Quality Assurance Committee – meeting minutes
SD 29.1	Review current appraisal rate for midwives and medical staff in CG5 and set a trajectory for appraisals to be undertaken to achieve 85%	CG5 Head of Midwifery CG5 Clinical Director		29 2 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals Appraisal rates monitored through CG5 Quality Assurance Committee – meeting minutes

MD9 Scarborough site CG2	Executive Lead: Wendy Scott	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital: • The median time from arrival to treatment • The percentage of patients admitted, transferred or discharged within four hours • The monthly percentage of patients that left before being seen	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 9.1	Develop, review and deliver against the actions in the Recovery Plan	Deputy Chief Operating Officer (Acute Care) CG2 Care Group Manager	Plan developed and signed off at Trust Board Improvement trajectory achieved	31 7 2019 31 3 2020	ECS Recovery Plan and schedule for review and reporting Monthly Performance Reports presented to and discussed at Trust Board Trust Board meeting minutes	Trust Performance Reports in place and will be reviewed at Care Group and Trust Board level every month Minutes of Trust Board
MD 9.2	Engage with the offer of support from ECIST to further develop approaches to improve the	Deputy Chief Operating Officer (Acute Care)	Engagement offer from ECIST to be determined	31 7 2019	Terms of engagement and timescales presented by Chief Operating Officer to Trust Board	Progress will be monitored through the Trust Performance

	Trusts' performance as identified during the CQC visit	CG2 Care Group Manager	and key individuals to be identified to link with ECIST on a programme of work Programme of work to be determine and key objectives and actions, with leads and timescales to be presented to Trust Board	31 1 2020	Present the programme of work to Trust Board	Reports presented to Trust Board every month Progress against the programme of work, including successes, challenges and obstacles to be presented to the Trust Board (quarterly), Internal Acute Board and monitored at OPAMs (both monthly.

MD10 CG2 SD17 CG3 Scar SD39 CG3 Brid SD48 CG2 Brid	Executive Lead: Heather McNair	CG2 The service must ensure the process for the management if risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough hospital CG3 The service should continue to implement and embed the new governance structure and processes CG2 (Brid) The service should develop robust governance processes including performance dashboards, that local risks are identified, regularly reviewed and actions developed	Delivery on track RAG Rating
CG2 Scar CG2 Brid CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 10.1 SD 17.2 SD 48.1	CG2 Management Team to review, revise and deliver a Governance Management structure that meets the needs of the new Care Group	CG2 Clinical Director CG2 Care Group Manager CG2 Head of Nursing		31 12 2019	CG2 to produce a paper detailing their governance management and escalation structure Minutes of CG2 governance management meetings	

		CG3 Clinical Director CG3 Care Group Manager CG3 Head of Nursing			Risk Register Evidence of escalation to Trust Board Performance Reports	
MD 10.2 SD 17.2 SD 48.2	Executive oversight of CG2 and CG3 management of risks, issues and performance and governance will be managed through the CG2 and CG3 Care Group Boards	CG2 Clinical Director CG2 Head of Nursing CG3 Clinical Director CG3 Head of Nursing Deputy Director of Healthcare Governance		31 12 2019	Schedule of Care Group 2 Care Group Board meeting with executives Minutes of meetings CG2 Risk Register and evidence of escalation of risks to Corporate Risk Register Performance reports	

MD12 – CG3 MD14– CG3 Scar MD17 – CG2 MD26 – CG3 Brid SD27 – CG5 SD28 – CG5 SD42 – CG2 Brid	Executive Lead: Jim Taylor	CG3 The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy CG3 The service must ensure that all records are secure when unattended (MD14 Scar and MD26 Brid) CG2 The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided CG5 The service should ensure that all entries to women's records are legible CG5 The service should ensure that patients records trolleys are locked CG2 The service should make certain that staff adhere to record keeping policies and follow record keeping guidance in line with their registered professional standards	Delivery on track RAG Rating
Scarborough site Bridlington site CG3 CG2 CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 12.1	In order to alert staff to this finding during the visit: • The Medical Director will write to ALL medical colleagues detailing their responsibility to comply with the Record Keeping Standards Medical Staff – Records Management Policy • The screensaver will be refreshed during September 2019 • Staff Matters article October 2019	Medical Director Deputy Director of Patient Safety Deputy Director of Patient Safety		30 11 2019 30 9 2019 30 10 2019	Letter to ALL medical staff Screenshot of screensaver Staff Matters article	
MD 12.2 MD 18.1	Immediate action: Medical records audit to be designed and undertaken on a monthly basis with reports to CG3 and CG2 Quality	CG3 Clinical Director CG2 Clinical Director	Audit tool developed and a schedule of who and	31 12 2019	Evidence of monthly audits. Audit results presented to the CG3 and CG2 Quality assurance Committees	

	Assurance Committees. Compliance to be monitored closely at Care Group level, with evidence of associated action plans or individual performance management where necessary		when the audits are going to be undertaken produced		Evidence of improvement plans or individual performance management as necessary Evidence of improvement against audit	
MD 14.1 MD 26.1	Matrons to undertaken quality audits and spot checks which include secure management of patient electronic and paper records	CG3 Head of Nursing		30 11 2019	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme
SD 27.1	Medical and nursing staff documentation audit	Maternity Quality Assurance team		30 11 2019	Audit schedule Audit report	
SD 27.2	Audit results and compliance will be monitored and any necessary associated remedial actions taken	Maternity Quality Governance Manager		30 11 2019 monthly and ongoing	Audit reports and minutes of meetings where governance is discussed	
SD 28.1	The notes trolley in midwifery is being situated behind a lockable door	Head of Midwifery Head of Estates and Facilities		TBA	Commission for work Completion of remedial work	
MD 12 14 18	Medium / long term action: Chief Executive to examine recruiting to an executive director position	Chief Executive		30 4 2020	Executive level appointment who has lead for digital	

26	which has a specific focus on digital and who on appointments commissions a review of the Trusts' IT infrastructure and how this supports safe patient record keeping				Review commissioned of Trusts' current IT infrastructure and how this supports safe patient record keeping	

MD15	Executive Lead: Jim Taylor Polly McMeekin	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients	Delivery on track RAG Rating
Scarborough site CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 15.1	Immediate action: Where the Trust has unfilled shifts bank, agency and locums are employed. Daily monitoring is in place to ensure the safety of the wards	CG2 Care Group Director		Complete	Weekly reporting to the CQC	
MD 15.2	Review, recruitment and retention strategic approach for Scarborough site	Medical Director Director of Workforce and Organisational Development	Workforce Strategy ratified by Board June 2019. East Coast Medical Recruitment Project made substantive – Corporate	Complete	Vacancy rate monitored monthly and report to Board of Directors. Reduced rate from 21% in July 2018 to 9.8% October 2019.	Reported to Board of Directors bi-monthly (public Board)

			Directors July 2019			

MD16 Scarborough site CG2	Executive Lead: Heather McNair Polly McMeekin	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards at Scarborough Hospital site to promote safe care and treatment of patients	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 16.1	Immediate action: Where the Trust has unfilled shifts bank, agency and locums are employed. Daily monitoring is in place to ensure the safety of the wards	CG2 Head of Nursing		Complete	Weekly CQC return and letter	
MD 16.2	Immediate action: On identified wards the staffing plan was increased. The establishments will be reviewed and realigned as required to ensure safe patient care	CG2 Head of Nursing		31 1 2020	Weekly CQC return and letter	
MD 16.3	Reporting internal and external to CQC	CG2 Head of Nursing		Complete and ongoing	Nurse staffing levels are reported monthly on the	SafeCare audit is scheduled to be

		Deputy Director of Healthcare Governance			Unify return as per national standards Nurse staffing levels and vacancy levels are reported to Trust Quality Committee A letter goes to the CQC on a weekly basis as part of weekly monitoring	undertaken 21 10 2019 for two weeks. The data will be analysed and feed into workforce planning There is a plan to alter some of the wards on the Scarborough site as part of plans to sustain and grow the SDEC model. Nurse staffing workforce plans will be reviewed as part of the bed modelling exercise
MD 16.4	Review, recruitment and retention strategic approach for Scarborough site	Director of Workforce and Organisational Development	Workforce and OD Strategy ratified by Board of Directors June 2019. East Coast Medical Recruitment Project made	30 11 2019 June 2020	NHS I Retention programme project plan submitted. International nurse recruitment programme to deliver a further 48 nurses to Scarborough	Vacancy data and stability index shared with Board of Directors bi-monthly.

			substantive July 2019			

MD18	Executive Lead: Brian Golding	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients	Delivery on track RAG Rating
Scarborough site CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 18.1	A review of all substances hazardous to health to health to be undertaken to ensure only appropriate substances are stored correctly and that COSHH risk assessments are in place	Head of Safety and Security		31 12 2019	Review report COSHH assessments in date across all areas	
MD 18.2	Up to date list of COSHH leads for all areas to be provided and reported through CG1 Quality Assurance Meeting Appropriate training or training updates to be delivered to COSHH Leads	CG2 Head of Nursing Head of Safety and Security		30 11 2019 31 12 2019	Up to date list of COSHH assessors COSHH training records	
18.3	COSHH Leads to provide local training and ensure staff in each department	CG2 COSHH Leads		31 3 2020	Learning Hub compliance with CG2 basic Health and Safety mandatory	

	understand their roles and responsibilities associated with the management of hazardous substances				training Evidence of local COSHH training initiatives	

MD20 – TW Scar MD25 – TW Brid SD15 – CG3 Scar SD20 – TW Scar SD21 – TW SD50 – TW SD51 - TW	Executive Lead: Wendy Scott	TW The service must ensure the backlogs and overdue appointments in the trust is addressed and improved CG3 The service should ensure that they continue their work to improve patient access and flow to reduce referral to treatment times and patient cancellations TW The service should ensure the services assess risk in patients waiting beyond the recommended appointment dates	Delivery on track RAG Rating
Scarborough site Bridlington site Trust wide Outpatients CG3		TW The service should consider ways to reduce the number of cancelled clinics in outpatients	

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 20.1 MD 25.1 SD	Delivery of the Outpatients Transformation Programme	CG6 Manager	Introduce: -Rapid expert opinion -Patient Initiated Follow Up in Rheumatology	31 12 2020 30 9 2019	Programme Plan Highlight Reports Enhanced management of Follow up partial booking	Evidence of SOP development and integration

15.1 SD 21.1			-Video Consultation Diabetes & Cancer -2 way text reminders for all Outpatient appointment & follow up	30 9 2019 30 6 2020		
MD 20.2 MD 25.2 SD 15.2	An RTT Recovery Plan is being updated to clearly state the projections for service delivery and backlog reduction	Chief Operating Officer Care Group Managers All Care Groups	RTT backlog to be reduced to 28,880 (78% performance delivery)	30 3 2020 and ongoing	Updated RTT Recovery Plan Presentation / minutes of Trust Board meeting which reference monthly RTT performance	Weekly Performance Meetings with all Care Groups Weekly Performance Overview Documents at Care Group and Trust level
SD 15.3	Reducing patient cancellations	CG3 Manager	30% reduction in same day cancellations	Q1 20/21 Oct 19	**IP Cancellations** Develop Day Unit Recovery area on Scarborough hospital site General Surgery rota changes have moved cancer colorectal resections to York to alleviate bed pressures and long Length of stay at Scarborough Hospital	Day Unit area operational

					site	
SD 20.1	Risk assessment of patients waiting beyond recommended appointment dates	Clinical Directors All Care Groups	Reduce longest follow up partial booking waiters	31 January 2020	Risk assessment process tested and delivered reduced longest waiters. Risk assessment processes embedded in Ophthalmology and Gastro Further risk assessment processes being undertaken as required at Care Group level Reported in monthly Clinical Governance meetings as part of the standard template Very long waits added to Care Group risk registers and discussed through governance meetings	Governance meetings Risk Registers

MD21 - Scar MD26 - Brid	Executive Lead: Wendy Scott	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Delivery on track RAG Rating
Scarborough site Bridlington site Trust wide Outpatients			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 21.1	Supporting Performance Delivery Paper presented to Trust Board which provided a detailed recovery plan for any specialty or cancer site that was not achieving RTT and cancer waiting times	Chief Operating Officer Care Group Managers		31 7 2019 Complete	Trust Board minutes	
MD 21.2	Progress against the Performance Delivery Paper is monitored at Trust Board .	Chief Operating Officer	On going	November 2019 Monthly and ongoing	Update report on progress to be presented at Executive Board in November 2019 Progress against	Performance

					recovery provided by monthly Performance Reports Trust Board minutes	recovery assurance is monitored across a number of system meetings: Trust performance framework. Care Group Boards. System Performance Meeting. Weekly performance meetings are held with Care Groups to tackle issues arising from recovery plans in the moment.

SD1	Executive Lead: Polly McMeekin	The Trust should formalise written guidance for the fulfilment of the requirement of the Fit and proper Persons test (FPPT) for Directors	Delivery on track RAG Rating
Trust wide Corporate			Delivered

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 1.1	Guidance drafted to be presented and approved at Trust Board	Lynda Provins	Procedure drafted August 2019 Discussed with Chair August 2019 Presented to Corporate Directors August 2019	27 8 2019 approved by Corporate Directors	Guidance document	Yearly board report in April

SD2	Executive Lead: Wendy Scott	The trust should develop a sustainable clinical strategy at pace building on the outcomes of the east coast acute services review and ensure it dovetails with the care group plans	Delivery on track RAG Rating
Trust wide Corporate			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 2.1	Determine nature and scope of Clinical Strategy Completion of Clinical Strategy document	Wendy Scott	Executive Board – Workshop to develop this. Sign off by Executive Board and Board of Directors	January 2020 March 2020	• Workshop setup • Notes, outcomes and actions from Workshop published Completed Document approved by Executive Board and Board of Directors	Use of document as reference tool in future Board of Directors, Executive Board and Care Group Performance Review Meetings.

SD3	Executive Lead: Simon Morritt	The trust should ensure there is a clear accountability framework setting out the governance arrangements for the care group structure	Delivery on track RAG Rating
Trust wide Corporate			Delivered

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 3.1	Develop a Care Group Governance and Performance Framework	Lynda Provins	Trust Board – July 2019	Complete	Care Group Governance and Performance Framework	Monitoring through Care Group EPAMs in place. Schedule for EPAMs for each Care Group. EPAM Action Logs

SD4	Executive Lead: Wendy Scott Simon Morritt	The trust should continue its work to improve reporting of performance information to enable easier oversight and governance and continue its work to improve digital systems and processes	Delivery on track RAG Rating
Trust wide Corporate			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 4.1	Chief Executive to examine recruiting to an executive director position which has a specific focus on digital and performance reporting and who on appointment undertakes a review of reporting systems and develops a Digital Strategy which encompasses performance reporting infrastructure	Simon Morritt		30 4 2020	Successful appointment Digital review Digital Strategy	
4.2	Immediate action: New Care Group Dashboard have been developed on gone 'live'	Head of Information		Completed	Care Group Dashboards	

SD5	Executive Lead: Simon Morritt	The trust should continue to review the Board members skills and prioritise its planned board development activities	Delivery on track RAG Rating
Trust wide Corporate			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 5.1	Introduction of a Board Development Programme 2020/2021	Lynda Provins		TBA	Development Programme Schedule of Board Development days Attendance at and reflections from Board Development days	

SD6 CG2	Executive Lead: Brian Golding	The service should consider having a designated ligature free room in its urgent and emergency care service at Scarborough hospital for patients suffering from mental illnesses	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 6.1	Immediate action: Whilst all rooms are observed at all times and the risk for injury from ligature is low an immediate action has been made to identify a room for high risk patients. This will be used as part of routine business and patients at high risk will be moved to this room as soon as it is available to further minimise any risk of injury from self harm	CG2 Head of Nursing Head of Estates and Facilities		31 12 2019	Consultation room 1 or 2 will adapted to care for high risk patients Completion of work and communication with staff about use of the room	
SD 6.2	A designed ligature free room will be part of the planning for the new build Emergency Department at	CG2 Head of Nursing Head of Capital	See attached project programme (subject to	Ongoing See also attached project programme	Specific sections of minutes when detailed planning commences	• Minutes of project Board and Project

	Scarborough Hospital	Planning	regular review and update)  Acrobat Document	(previous column)		Team meetings • Project Programme • Approved SOC, OBC, FBC business cases • Approved designs and specifications (FBC-stage) • Construction procurement

SD7	Executive Lead: Brian Golding	The service should consider having a designated Paediatric area within the first assessment and majors areas of its urgent and emergency care service at Scarborough hospital	Delivery on track RAG Rating
CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 7.1	Immediate action: Department review to examine whether improvements such as wall art or a screened area can be created. If feasible remedial work to be undertaken	CG2 Care Group Manager Head of Estates and Facilities	Report with departmental review and options	31 12 2019 29 2 2019	Report New designated area for paediatrics	
SD 7.2	A designed area for the management of paediatrics will be part of the planning for the new build Emergency Department at Scarborough Hospital	CG2 Care Group Manager Head of Capital Planning	See attached project programme (subject to regular review and update) Acrobat Document	Ongoing See also attached programme (previous column)	Specific sections of minutes when detailed planning commences	• Minutes of project Board and Project Team meetings • Project Programme • Approved SOC, OBC, FBC business cases • Approved designs and

						specifications (FBC-stage) Construction procurement

SD8 CG2 SD12 CG3 – Scar SD35 CG3 - Brid	Executive Lead: Brian Golding Heather McNair	CG2 The service should ensure all equipment is cleaned and labelled to indicate when it was last cleaned in its urgent and emergency care service at Scarborough hospital CG3 The service should ensure there is consistent use of labelling to show when equipment has been cleaned	Delivery on track RAG Rating
CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 8.1 SD 12.1 SD 35.1	The Trust made a conscious decision to stop using labels to indicate that equipment was clean Staff at each local induction will be taught about what equipment is on each unit and how to clean it	CG2 Head of Nursing CG3 Head of Nursing		Immediate and ongoing at induction	When questioned staff can describe the equipment on their unit and when and how this should be cleaned Copy of IPC audits Minutes of CG2 Quality Assurance Meetings	The IPC Team undertake ‘Back to Basics’ spot audits where equipment cleaning is checked. The results are fed back to the appropriate CG for assurance / action

SD9 – CG2 SD14 – CG3 Scar SD37 – CG3 Brid	Executive Lead: Polly McMeekin	CG2 The service should ensure an embedded system of clinical supervision is in place in its urgent and emergency care service at Scarborough hospital CG3 The service should ensure that they can demonstrate nursing staff receive regular, formal clinical supervision, in accordance with professional guidelines and trust policy	Delivery on track RAG Rating
CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 9.1	Medical; Midwifery and Allied Healthcare Professionals have Clinical Supervision in place. Policies in place Develop at Clinical Supervision Policy / Strategy for nursing	Deputy Director of Healthcare Governance Deputy Chief Nurse		Complete 31 1 2020	Policies Policy	Staff feedback / staff survey Staff feedback / staff survey

SD10	Executive Lead: Wendy Scott	The service should ensure it continues to look at new ways of working to improve patient flow from its urgent and emergency care service at Scarborough hospital	Delivery on track RAG Rating
CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 10.1	Develop SDEC Model Create appropriate space to support delivery of SDEC Model Review and revise staffing model to effectively deliver SDEC, ensuring the correct level of medical and nursing leadership has oversight of how the SDEC Model is developed and governed	CG2 Clinical Director CG2 Head of Nursing		30 4 2020	Improved ECS	
10.2	Review and revise the delivery of SAFER • SAFER engagement event with staff • Consider small scale project	CG2 Head of Nursing CG2 Clinical Director		29 2 2020	'SAFER' model is well-understood and active on all wards across the site Improvement in ECS	

	creating and exemplar ward and then a programme to roll out SAFER more effectively					

SD11 SD44	Executive Lead: Heather McNair	CG2 The service should ensure it improves the availability of written information available in other languages and formats for patients using its urgent and emergency care services CG2 Brid The service should have a range of tools available to assess patients where their communication may be impaired	Delivery on track RAG Rating
CG2 – Scar CG2 – Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
11.1	Identify most frequently issued leaflets to be translated into most frequently used languages	Lead for Patient Equality and Diversity / CG2 Head of Nursing	Most commonly requested leaflets in emergency and urgent care to be translated into the most frequently requested language translations.	30 11 2019	Leaflets accessible in most commonly requested languages and available within the department	

11.2 44.1	Improve staff awareness and approach to Accessible Information compliance	Lead for Patient Equality and Diversity	Posters advertising communication needs to be displayed	30 11 2019	Visible posters available throughout the emergency and urgent care department	
		CG2 Clinical Director/ CG2 Head of Nursing	Staff to undertake e-learning on Accessible Information standard	31 12 2019	All staff have undertaken Accessible Information standard	
		CG2 Clinical Director/ CG2 Head of Nursing	Staff to undertake e-learning on updating patient communication needs on CPD	31 12 2019	All staff know how to add or maintain patient communication needs on CPD	
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Develop arrangements for information to be available in easy read format	31 1 2020	Library of easy read leaflets available to be printed when required.	
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Patient Leaflets to be available in MP3/audio format	31 1 2020	Library of MP3/audio recordings of leaflets available to be played/emailed to patients by staff when required.	

		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Staff awareness of how to book interpreter and translation services	31 12 2019	Staff are confident in knowing how to make interpreter bookings and knowing how to request translation of documents.	
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Staff to be made aware how to access leaflets electronically and how to make into large print.	31 12 2019	Staff are confident in knowing how to access leaflets held electronically and produced in the patients chosen large print format	

SD13 CG3 – Scar SD36 CG3 - Brid	Executive Lead: Heather McNair	The service should ensure quality dashboard information is displayed in public areas	Delivery on track RAG Rating
CG3 Trust wide			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
13.1	Perfect Ward providers visit to hospital to present their app	Deputy Chief Nurse		Completed	Presentation	
13.2	Business Case to be written and presented to panel to seek funding for Perfect Ward App and delivery of quality data that can be displayed on a dashboard	Deputy Chief Nurse		31 1 2020	Business case panel Corporate Directors Action Log	

SD18 – CG2 SD19 – CG6 Scar OPD SD31 – CG5 SD49 – CG6 Brid OPD	Executive Lead: Heather McNair	CG2 The service should ensure that resuscitation trollies are checked in accordance with the trust's policy and action is taken and improvement monitored when this is found not to be so CG6 The service should ensure the resuscitation trolley is checked consistently and as required CG5 The service should ensure that daily checks on the resuscitation trolley are completed as per Trust Policy	Delivery on track RAG Rating
CG2 CG5 CG6			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
18.1	Matrons to undertaken quality audits and spot checks which include the resuscitation trollies	CG 2 Head of Nursing CG5 Head of Midwifery CG6 Head of Nursing		30 11 2019	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme

SD22	Executive Lead: Heather McNair	The service should ensure clear cleaning guidance of the cuffs is in place when fabric blood pressure cuffs are used	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
22.1	Standard Operating Procedure developed and distributed	Community Midwifery Manager		31 10 2019	Standard Operating Procedure	
22.2	3 months post implementation of the Standard Operating Procedure audit of compliance. Audit report to be presented to CG5 Quality Assurance Committee	Community Midwifery Manager		31 1 2020	Audit report Minutes of CG5 Quality Assurance Meeting	

SD23	Executive Lead: Heather McNair	The service should obtain advice from the infection prevention and control team about the use and storage of non-packaged cotton wool balls	Delivery on track RAG Rating
CG5			Delivered

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
23.1	Infection prevention and control team advice is for small single use packs. The service has moved to using only small single use packs of cotton wool balls	Head of Midwifery		Complete	Only single use small packs of cotton wool balls in use	

SD24	Executive Lead: Heather McNair	The service should ensure that community equipment which requires calibration has this completed as per maintenance schedule	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
24.1	Review medical engineering register of equipment to ensure this correlates with what the service holds	Community Midwifery Manager		Completed	Review document	
24.2	To ensure no outstanding equipment for calibration check with all individual community staff members From 2020 all staff to check this as part of annual appraisal	Community Team leaders Community Team leaders		31 12 2019 31 1 2020	Minutes of meeting where individual community staff members asked to undertake check Annual appraisal records	
24.3	Annual audit against medical engineering register	Community Team Leaders		31 12 2020	Audit report against medical engineering register	

SD25	Executive Lead: Heather McNair	The service should ensure that the staff responsible for cleaning the pool are shown the correct cleaning procedure / guideline for this piece of equipment	Delivery on track RAG Rating
CG5			Delivered

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
25.1	Guideline on pool cleaning produced	Labour Ward Manager		Complete	Guideline	
25.2	Healthcare Assistant training packaged developed and delivered	Labour ward Manager		Complete	Training records	
25.3	Record of pool cleaning put in place	Labour Ward Manager		Complete	Pool Cleaning Record	

SD26	Executive Lead: Heather McNair	The service should ensure single use equipment is within its expiry date	Delivery on track RAG Rating
CG5			Delivered

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
26.1	Deliver a process for ensuring single use equipment is within expiry date	Head of Midwifery		Complete	Process description Minutes of the meeting where compliance discussed	

SD30	Executive Lead: Heather McNair	The service should audit MEOWS so that they are assured the system is being used effectively	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
30.1	Information Team have been requested to develop the IT system to enable the team to audit MEOWS	Head of Information		Complete	Mechanism to audit MEOWS electronically in place	
30.2	MEOWS audit	Head of Midwifery		28 2 2020	Audit schedule Audit results Minutes of governance meeting where audit results and associated actions are discussed	

SD33	Executive Lead: Heather McNair	The service should ensure that all patient group direction paperwork has authorisation signatures against those staff names who are able to administer patient group directions	Delivery on track RAG Rating
CG5			Delivered

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
33.1	New process established where all new starters are required when approved as competent to sign the PGD paperwork	Head of Midwifery		Complete	New process described Signatures all up to date on paperwork	
33.2	Compliance oversight and regular reviews	Labour Ward Manager		Complete	Compliance reviews at CG5 Quality Assurance Meeting	

SD34	Executive Lead: Brian Golding	The service should ensure that Entonox gas is removed from the atmosphere in Labour ward and monthly monitoring put in place to ensure that unsafe levels of Entonox gas are not in the atmosphere	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
34.1	Testing undertaken and all levels are within normal limits	Head of Health and Safety		Complete	Testing results	
34.2	Re-testing of levels schedule in place to provide further assurance that the results are consistently within normal limits	Head of Health and Safety		31 1 2020	2nd set of testing results	

SD40 SD46	Executive Lead: Heather McNair	CG3 The service should investigate and respond to complaints in accordance with trust policy CG2 The service should take action to improve complaints response times to bring them in line with their complaints policy	Delivery on track RAG Rating
CG3 Brid CG2 Brid TW			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
40.1 46.1 TW	Deliver complaints letter writing training to new managers and matrons	Lead for Patient Experience	Training undertaken September 2019	Completed	List of people who attended complaints letter writing training and course details  Letter writing training course atten  Writing-to-customers -course-V2.pdf	Monthly OPAM and EPAM reports highlight breaches and areas for improvement ~ escalated to care group managers
40.2 46.2 TW	Complaints Management Policy review and revision	Lead of Patient Experience	Survey of staff to understand their concerns	30 12 2019	Revised Complaints Management Policy	Monthly and quarterly Board reports highlight good practice and areas of concern.

			Listening exercise with care group management to inform review			In-house complaints management training will be delivered in Q4 once policy has been ratified
40.3 46.3	Complaints management in accordance with Trust policy	CG3 Head of Nursing CG2 Head of Nursing		31 1 2020	Good compliance with timeliness Action log from CG3 OPAM CG3 Patient Experience dashboard	

SD41	Executive Lead: Heather McNair	The service should replace or repair broken equipment in a timely manner and [ensure] safety equipment is available to meet the needs of the patient	Delivery on track RAG Rating
CG2 Brid TW			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
41.1	Ensure each ward unit and department manager or team leader understands the process for reporting broken equipment and how to escalate if the correct equipment is not available for their patients	CG2 Head of Nursing Deputy Chief Nurse		31 12 2019 31 1 2020	Communication with senior nurses at Bridlington Hospital Staff Matters article	

SD43	Executive Lead: Heather McNair	The service should complete mental capacity assessments on patients in a timely way where there is any doubt a patient is able to make an informed decision about their care and treatment. Assessment and outcomes should be documented in care records	Delivery on track RAG Rating
CG2 Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
43.1	Quarterly audit, with analysis report and action planning	Nicola Cowley		Ongoing quarterly	Quarterly reporting and action plan completion.	Part of Safeguarding Adults Audit programme Exception reporting to individual care groups and the Safeguarding Adults Governance Group/
43.2	Targeted monthly training compliance review	Nicola Cowley		Ongoing monthly	Improved training compliance	Exception reporting to individual care groups and the Safeguarding Adults Governance Group
43.3	Ongoing work with IT Development group to	Lisa Haigh	The electronic	January 2020	Electronic evidence of capacity consideration	Audit of system to be discussed.

	embed mental capacity assessment and related documents electronically		system will act as a prompt to consider capacity throughout patient journey		required under the Mental capacity Act.	Progress will be monitored by the Safeguarding Adults Governance Group.

SD45	Executive Lead: Wendy Scott	The service should work towards reducing length of stay for non-elective patients	Delivery on track RAG Rating
CG2 Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 45.1	A comprehensive piece of transformation work as to how Johnson Ward functions as a rehab ward with some palliative care beds is due to commence November/December 2019. This project will focus on the workforce model (People), refresh the processes that underpin how Johnson Ward functions (SAFER) and how Johnson Ward fits with the various community and local authority offers that are in	CG2 Care Group Manager CG2 Head of Nursing	Project scope and Project plan in place. Confirmation of patient criteria for transfer onto Johnson Ward Revised workforce model	30 November 2019 30 November 2019 31 March 2020	LOS data for patients on Johnson Ward LOS data monitored at CG2 Quality Assurance Committees – minutes of meetings	Trust Performance Reports in place and will be reviewed at Care Group and Trust Board level every month Minutes of Trust Board

	place.					

SD47	Executive Lead: Heather McNair	The service should consider developing documented admission criteria for the ward	Delivery on track RAG Rating
CG2 Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
47.1	Develop an admissions criteria for Johnson ward at Bridlington hospital site	CG2 Head of Nursing AHP Lead for Professional Standards		31 12 2019	Admission criteria document	

KEY TO MUST DOS AND SHOULD DOS	
MD/SD	
MD1	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation.
MD2	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.
MD3	The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department.
MD4	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting.
MD5	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.
MD6	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.
MD7	The service must ensure it takes action to improve its performance in the RCEM standards in its urgent and emergency care service at Scarborough hospital.
MD8	The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough hospital.
MD9	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital.
MD10	The service must ensure the processes for the management of risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough hospital.
MD11	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.
MD12	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.
MD13	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.
MD14	The service must ensure that all records are secure when unattended.
MD15	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.

MD16	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.
MD17	The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
MD18	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.
MD19	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.
MD20	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved.
MD21	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
MD22	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.
MD23	The service must ensure that all medical staff receive annual performance appraisals, in accordance with professional standards and trust policy.
MD24	The service must ensure that electronic records are secure (screens locked) when unattended.
MD25	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved.
MD26	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
SD1	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
SD2	The trust should develop a sustainable clinical strategy at pace building on the outcomes of the east coast acute services review and ensure it dovetails with the care group plans.
SD3	The trust should ensure there is a clear accountability framework setting out the governance arrangements for the care group structure.
SD4	The trust should continue its work to improve its reporting of performance information to enable easier oversight and governance and continue its work to improve its digital systems and processes.
SD5	The trust should continue its review of the Board members skills and prioritise its planned board development activities.
SD6	The service should consider having a designated ligature free room in its urgent and emergency care service at Scarborough hospital for patients suffering from mental health illnesses.
SD7	The service should consider having a designated paediatric area within the first assessment and major's areas of its urgent and emergency care service at Scarborough hospital.

SD8	The service should ensure all equipment is cleaned and labelled to indicate when it was last cleaned in its urgent and emergency care service at Scarborough hospital.
SD9	The service should ensure an embedded system of clinical supervision is in place in its urgent and emergency care service at Scarborough hospital.
SD10	The service should ensure it continue to look at new ways of working to improve patient flow from its urgent and emergency care service at Scarborough hospital.
SD11	The service should ensure it improves the availability of written information available in other languages and formats for patients using its urgent and emergency care service at Scarborough hospital.
SD12	The service should ensure there is consistent use of labelling to show when equipment has been cleaned.
SD13	The service should ensure quality dashboard information is displayed in public areas.
SD14	The service should ensure that they can demonstrate nursing staff receive regular, formal clinical supervision, in accordance with professional guidelines and trust policy.
SD15	The service should ensure that they continue their work to improve patient access and flow to reduce referral to treatment times and patient cancellation rates.
SD16	The service should ensure that storage areas temperatures are monitored to demonstrate medicines are always stored in accordance with manufacturer's minimum and maximum temperature guidelines.
SD17	The service should continue to implement and embed the new governance structure and processes.
SD18	The service should ensure that resuscitation trollies are checked in accordance with the trust's policy and action is taken and improvement monitored when this is found not to be so.
SD19	The service should ensure the resuscitation trolley is checked consistently and as required.
SD20	The service should ensure the services assess risk in patients waiting beyond the recommended appointment dates.
SD21	The service should consider ways to reduce the number of cancelled clinics in outpatients.
SD22	The service should ensure clear cleaning guidance of the cuffs is in place when fabric blood pressure cuffs are used.
SD23	The service should obtain advice from the infection prevention team about the use and storage of non-packaged cotton wool balls.
SD24	The service should ensure that community equipment which requires calibration has this completed as per maintenance schedule.
SD25	The service should ensure that staff responsible for cleaning of the pool are shown the correct cleaning procedure/guidelines for this piece of equipment.
SD26	The service should ensure single use equipment is within its expiry date.
SD27	The service should ensure that all entries to women's records are legible.
SD28	The service should ensure that patient's records trolleys are locked.
SD29	The service should ensure that all staff have their annual appraisals.

SD30	The service should audit MEOWS so that they are assured the system is being using effectively.
SD31	The service should ensure that daily checks on the resuscitation trolley are completed as per Trust policy.
SD32	The service should ensure that daily checks on medicine fridges are carried out as per Trust policy.
SD33	The service should ensure that all patient group direction paperwork has authorisation signatures against those staff names who are able to administer patient group direction medicines.
SD34	The service should ensure that Entonox gas is removed from the atmosphere in Labour ward and monthly monitoring put in place to ensure that unsafe levels of Entonox gas are not in the atmosphere.
SD35	The service should ensure labelling is used to show when equipment has been cleaned.
SD36	The service should display quality dashboard information in public areas.
SD37	The service should ensure that they can demonstrate nursing staff receive regular, formal clinical supervision, in accordance with professional guidelines and trust policy.
SD38	The service should ensure that storage areas temperatures are monitored to demonstrate medicines are always stored safely in accordance with manufacturer's minimum and maximum temperature guidelines.
SD39	The service should continue to implement and embed the new governance structure and processes.
SD40	The service should investigate and respond to complaints in accordance with trust policy.
SD41	The service should replace or repair broken equipment in a timely manner and safety equipment is available to meet the needs of the patients.
SD42	The service should make certain that staff adhere to record keeping policies and follow record keeping guidance in line with their registered professional standards.
SD43	The service should complete mental capacity assessments on patients in a timely way where there is any doubt a patient is able to make an informed decision about their care and treatment. Assessments and outcomes should be documented in care records.
SD44	The service should have a range of tools available to assess patients where their communication may be impaired.
SD45	The service should work towards reducing length of stay for non-elective patients.
SD46	The service should take action to improve complaints response times to bring them in line with their complaints policy.
SD47	The service should consider developing documented admission criteria for the ward.
SD48	The service should develop robust governance processes including performance dashboards, that local risks are identified, regularly reviewed and actions developed.
SD49	The service should ensure the resuscitation trolley is checked consistently and as required.
SD50	The service should ensure the services assess risk in patients waiting beyond the recommended appointment dates.
SD51	The service should consider ways to reduce the number of cancelled clinics in outpatients.

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Quality Committee – 25 September 2019

Attendance: Lorraine Boyd (LB) (Chair), James Taylor (JT), Helen Hey (HH), Fiona Jamieson (FJ), Wendy Scott (WS), Rebecca Hoskins (RH), Jenny McAleese (JM), Nicky Slater (NS), Helen Hey (HH), Heather McNair (HM), Steve Holmberg (SH), Sharon Jones (SJ), Lynda Provins (LP), Melanie Liley (ML)

1. Apologies for Absence (1 minute)

No apologies.
The meeting was declared quorate.

Observing

Gill Bradley
Michala Little

2. Declaration of Interests (1 minute)

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

3. Minutes for the meeting held on 31 July 2019 (4 minutes)

The minutes were accepted as a true and accurate record.

4. Matters arising from the minutes and any outstanding actions (5 minutes)

4.1 SH enquired after the data quality that was currently showing that Scarborough had a higher than expected mortality and was reassured that changes to data input should be reflected in the SHMI within 6 months.

4.2 LB requested an update on Clinical Harm Reviews. HM confirmed this related to the learning in respect to 12 hour trolley waits and risks of patient harm, for example, falls and pressure ulcers and missed medication. RH advised that the 48 hour breach report needs to be changed to allow for better assessment of potential harm.

Action: RH to update at the next meeting

4.3 LB asked if any feedback had been received yet from CQC on the sepsis outlier alert. JT confirmed there had not and he is not expecting anything further on this now and assumes CQC are satisfied.

4.4 The committee reviewed the action log with the following marked as complete:

Date of Meeting	Action	Owner	Due Date	Comments
25/5/19	Update on review of Clinical Effectiveness & Patient Safety Group	BH	25/9/19	Update received 31.7.19
31/7/19	Provide additional assurance around basic hygiene to next meeting	HM	Sept 19	Updated committee 26/9/19
27/3/19	Short narrative or expected completion date to be included in Target Completion date column. MD12 Good Governance	FJ	25/5/19	Complete
31/7/19	NS to investigate & amend anomalies in C-diff data	NS	Sept 19	Complete
31/7/19	WS to discuss recovery plans with Finance Director & report back	WS	Sept 19	Complete
31/7/19	Review variation in falls data in May and report back	RH	Sept 19	Complete
31/7/19	Inspect Scarborough Mortuary	HM & JM	Sept 19	Attended 25/9/19 Complete
31/7/19	Review how extreme risks will be reviewed monthly, as this Committee meets bi-monthly.	FJ &LP	Sept 19	Complete
31/7/19	Training for NEDs to be added to risk management framework.	FJ	Sept 19	Complete
31/7/19	Provide progress update on 14 hour consultant review at next meeting	JT	Sept 19	Complete
31/7/19	Investigate & review corporate risks with the Executive Team	FJ	Sept 19	Complete
31/7/19	Consider effective use of Quality Committee	LB & HM	Sept 19	Complete
31/7/19	Ensure MRSA screening added to Care Group agendas	HM	Sept 19	Done – Will be picked up through governance meetings
31/7/19	Ascertain who is the Safeguarding NED	LP	Sept 19	HM and SH to meet w/c 30/9

4.4 HM has asked for the action plan to be arranged by due date and to remove completed actions going forward.

5. Escalated Items

No items at this time

6. Board report (5 minutes)
BAF 1, 3

It was agreed that this item should be taken at the end of the meeting to enable items relating to the board report not already discussed in the meeting to be raised.

There were no further items raised.

7. Chief Nurse Report (45 minutes)
BAF 1, 2, 3, 4, 5, 6, 7, 8

7.1 HH updated the committee regarding hand hygiene. There has been a weekly audit on the wards since April which shows compliance is improving. Tom Jacques and IPC conduct spot checks for data collection assurance. There will be an investigation into the wards which score 100% and wards which achieve the lowest compliance.

A Nursing dashboard is currently in development which NS and BH will start to build in the next few weeks. Much of the data needs to be manually extracted so resource has been identified to support this until an interface can be developed.

7.2 The Unify return has not kept pace until this month. The inclusion of Band 4 and HP has expanded the table and so HH has included a link to the document in the report in place of the table. It was noted that the link will not work on the current laptops when outside the trust, this will have an impact on Non-Executives' ability to access the information.

Action: Check when Non-executives will have access to the new laptops to allow them access to Trust IT servers. LB

7.3 The Trust continues to report weekly to the CQC on Scarborough wards staffing levels. CQC have recently requested more detail on NIV patients. HM assured the committee that the Trust has the ability to move RN's between wards to fill in any gaps and matrons are undertaking daily review of agency staffing levels. JM noted that Beech and Lilac wards appeared to be overstaffed, HM advised that staffing levels were increased at the request of the CQC. HH is preparing a proposal for 'on call' RN's to be available when needed; this will negate the need to 'overstaff' the wards and reduce the financial burden.
The need to consider how substantive resource can be found to sustain safer staffing levels in the context of current financial challenges was acknowledged and discussed. Further triangulation between skill mix support to RGN vacancies and safety and performance is needed to support decision making.

Action - It was resolved that this should be part of a wider discussion with Resource Committee.

7.4 HH brought some good news; there has been an increase in recruitment. Going forward reporting will be presented by care groups, including all nurses. LB asked if this would enable more flexible skill mixing and use of using resource. This should be helpful to some extent, although flexible use of Specialist Nurses remains a challenge. Scarborough continues to see the use of high cost agency nurses as it has been a challenge to recruit. One suggestion to combat the shortfall would be to use Specialist nurses over winter. The possibility of apportioning 1 day per week of specialist nurse time to attend wards / provide 'hot clinics' was discussed. The Committee welcomed the news of the new recruits and also the increased focus on retention of existing staff.

Action: options for more flexible use of specialist nurses to be explored HM.

7.5 The Committee received and discussed the Acuity Audit Report. Limited assurance was reported as a result of data limitations meaning the position reflected may be inaccurate. The ongoing work to improve data collection, standardisation and relevance is noted and improvement anticipated.

7.6 The Inpatient Survey Report was received and discussed. It was considered to be a little unambitious and in need of reinvigoration. The 'Hello My Name Is' relaunch will be deferred and reconsidered once the Chief Executive has concluded the listening exercise. Patient Experience Group will be relaunched, with the first meeting to be held on 23rd October to discuss Terms of Reference; members will include representatives from each Care Group. LB will be the Non-Executive representative in this group.

Action: Non-executive, frontline staff to be included in the members list
Action: Steering Group to report back November 19.

7.7 The decontamination challenges were discussed and noted and the need to prioritise a long term solution in support of patient safety acknowledged.

Full recruitment to the IPC team was noted and welcomed

Action: Wider discussion with Resource Committee
Action: Board to be made aware of IPC challenges

7.8 The Falls Sensor look back exercise, providing a good example of quality improvement and culture change being embedded across the organisation was received and noted.

7.9 The CQC quarterly report was discussed.

8. Medical Director Report (24 minutes)
BAF 1, 2, 5, 8

8.1 JT highlighted an error on Page 104; there was one case where a written apology was not evidenced instead of two.

8.2 JT relayed findings of outstanding improvement by Scarborough Hospital in NNAP Audit between 2016 and 2018, which the Committee commended. Also the Trust performed well in all vascular activity.

8.3 Tariq Hoth is supporting an Wendy Scott with working on patient flow. The NHSI team are assisting with same day emergency care and SAFER compliance. Dr. Baz is attending

York Hospital ED 1 day a week to help with improvements. Ed Smith is making progress on plans regards to rotas, timetables, patient flow which will be presented to Exec board.

8.4 14 hour consultant review has shown an improvement over the last three months. Donald Richardson is working on realigning and improving job plans across the medical workforce – work in progress. The Committee welcomed the improvement and look forward to further updates and consolidation.

8.5 The SI and Incident Themes Report was received and discussed. Key themes from SI's were radiology and diagnosis reporting which triangulates with staffing challenges and performance pressures, both appropriately represented on the Risk Registers
HM raised medication errors as a concern and what input the Chief Pharmacist has in the investigation and learning process from this. It was felt that more use might be made of this resource.

8.6 The Duty of Candour 6 monthly report was received.

8.7 The patient safety Group and Clinical Effectiveness Group Minutes were received

Action: Board to be made of operational pressures, risks and mitigating actions by Medical Director.

9. Performance Report (39 minutes)
BAF 1, 2, 3, 4, 9, 10

9.1 The Performance Report was received and key performance standards were discussed. WS confirmed the discussions that have taken place in relation to 'skin' services and the use of dermatoscopic photographs to assess whether the patient requires further assessment/treatment. In the last 6 months the Trust has managed over 14,000 advice and guidance requests from GPs and the Trust has seen a reduction on GP referrals. Its unclear whether there is a direct correlation between the two.. Of increasing concern is the capacity required to undertake this activity.. A full assessment of the use of advice and guidance is being undertaken along with an assessment of the resource implications.. WS planned to discuss to discuss emergency care performance in detail at the public Board meeting.

Action: Emergency care performance for attention of Board by Chief Operating Officer

9.2 The Trust Winter Plan was received and discussed.. The schemes identified are predicated on the costs associated with funding agency posts. Some elements of the plan have rolled over from last year and are now funded as business as usual. Additional schemes have been identified and will require additional funding. It was noted that a significant element of the winter funding relates to additional medical and nursing staff. There is an assumption that there will be slippage as not all shifts will be filled.. The need for an integrated system response is a key requirement and this remains a risk to delivery at the present time As the system plan has not yet been finalized. It's unclear at this stage what additional capacity the system is going to provide. The Trust plan assumes the use of ward 29 at York as the winter ward; this will impact on the ability to deliver the orthopaedic backlog. It was noted that this is behind trajectory and this may adversely reflect on performance. The risks and mitigations within the plan were noted, as was the need to carefully manage expectations The Quality Committee approved the paper. Questions

were raised regarding the impact of pension tax on medical staff and the uptake of extra shift, it is understood that advice is being given on an individual basis.

Action: The Quality Committee resolved to take the following recommendations to the Public Board :-

a] approval of the required investment in the Winter Plan in the interest of patient safety
b] approval of the short term changes to ward functions recommended I the Winter Plan
c] approval of the delivery schemes as planned
d] approval of the proposed communication plan

9.3 CQUIN Report was received and noted to be largely on track.

10. 19-20 Quality Priorities Report (5 minutes)

Qualities Priorities Report was received and discussed. Progress was noted and no significant concerns raised. HM requested a RAG rating to be added to the progress report to provide a visual indicator of the progress, link to QI and to tie the work back to Patient Experience. It was agreed that an additional meeting should be convened in Jan 2020 to begin to identify potential Quality Priorities for next year

Action: LP arrange a meeting with interested parties Jan 2020

11. Board Assurance Framework – Corporate Risk Register (5 minutes)

LP will be meeting with the Chief executive on 14th October to discuss the BAF following amendments made by the executive team. SH highlighted the risk score of some items on the BAF appear too high. BAF 6 in particular was highlighted as an example with a score of 20 which has been unchanged for some time. It was questioned whether the many mitigations undertaken have been fully factored in and there was some discussion on what a realistic expectation in this domain would be.

12. Reflections on the meeting (2 minutes)

HM asked for the following to be added to the agenda for discussion

Audit Committee DOLs paper
Learning from deaths – medical examiner roles
Medicines Management

13. Any other business (1 minute)

A request was made for larger meeting rooms for both York and Scarborough meetings going forward as the current space is inadequate.

Action: LP to change locations

Next meeting of the Quality Committee: 27 November 2019, General Medicine Seminar Room, York Hospital

Action Log

Date of Meeting	Agenda Item	Action	Owner	Due Date	Comments
31/7/19	6	FJ to lead improving performance on Duty of Candour.	FJ	Nov 19	
31/7/19	8.1	HM committed to producing a report on acuity & harm for November meeting.	HM	Nov 19	Update received 25/9/19
31/7/19	8.1	Provide more assurance around outputs & triangulation with numbers.	HM	Nov 19	
31/7/19	8.2	Consider assurance process in relation to patient movements & IPC	HM	Nov 19	
31/7/19	8.3	Review complaint response times	HM	Nov 19	
25/9/19	4.2	12 hour breach review work.	RH	Nov 19	
25/9/19	7.4	Explore options for more flexible use of specialist nurses	HM	Nov 19	
25/9/19	7.5	Update Acuity Audit	HM	Nov 19	
25/9/19	7.6	Progress update from PEG relaunch	HM	Nov 19	
25/9/19	8.4	Progress report on 14 hour consultant review	JT	Nov 19	
25/9/19	10	Additional meeting to consider potential 2020/21 Quality Priorities	LP	Jan 20	

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Resources Committee – 25 September 2019

Attendance: Jennie Adams (JA) (Chair), Lynne Mellor (LM), Jim Dillon (JD), Andrew Bertram (AB), Brian Golding (BG), Graham Lamb (GL), Adrian Shakeshaft (AS), Kevin Beatson (KB), Steven Kitching (SK), Polly McMeekin (PM), Lynda Provins (LP) (for items 1-7 only), Lydia Harris (LH) (for item 13 only), Tracy Astley (TA) (minute taker)

Apologies for Absence: Mike Keaney (MK)

1. Welcome

JA welcomed everyone and declared the meeting as quorate.

JA informed the committee that the agenda would be rotated to allow Executive's to have an equal share of airtime.

2. Declaration of Interests

There was no new declaration of interests.

3. Minutes of the meeting held on 31 July 2019

The minutes of the meeting held on 31 July 2019 were approved as an accurate record subject to the following amendment: -

p.18 items considered for escalation to the 'May' Board should read the 'July' Board.

4. Matter arising from the minutes and action log

The following matters arising not recorded in the Action Log were discussed:

Sustainability – it was confirmed that the BoD were very happy to endorse the work of the Green Champions. It was noted that 39 had been recruited and a further push to recruit more was ongoing.

Digital - it was noted that a push to recruit Digital Champions in the Care Groups was ongoing. Jim Taylor was very keen on the idea. KB advised that they had identified one for AHP this week. A discussion took place around the remit of the digital champions. AS advised that there was a long way to go yet and that these individuals should not be "hobbyists" but have allocated time in their job plans to drive this agenda forward. JA commented that she would continue to highlight this unfinished business at Board level.

CIP delivery within the Care Groups – it was noted that this would be discussed further in the efficiency section of the meeting.

Patchwork App – PM explained it had been a pilot and was proving very helpful as a way to fill gaps in medical rotas. The challenge was the cost at £9k per year as this did not stack up with the back-office savings that were required. Sam Mason, Finance Manager, will be helping to develop a more sophisticated business case to reflect the full benefits.

LP asked if there were any other apps. PM replied that there was, but they wanted to create their own bank of staff. She was looking at extending Patchwork across the STP in order to negotiate a cheaper license. AB added that he did not want anyone making a decision about Patchwork based on cost alone as the money was there to support it and this was an opportunity for the Trust to be a flagship for new technology.

LLP Supervisor Recruitment – BG advised a new Head of Facilities Management had been appointed and will take up post next week. As part of their work programme there were a whole series of actions in place including a visit to Northumbria to see what they were doing. Whilst there is no short term movement an improvement should be seen within the next 12 months.

Low levels of statutory and mandatory training in medical workforce – PM reported an 85% compliance trust wide. To present it at Board level this will be broken down into Care Group and Staff Group to highlight areas of low and high uptake. She advised that they were into 6 months of a 2-year programme to streamline the process.

Action Log:

Highlight new limited assurance audits to the Committee – this was ongoing.

Bring backlog maintenance schedule and risk assessment to next meeting – completed via separate meeting on 11th October. JA was becoming more concerned about the growing list of repairs and replacements that were a feature of the Board papers this month – including HPV machinery, pagers at SGH and ventilation system at York theatres.

Action: JA to provide Committee with assurance on backlog maintenance to November meeting following the October meeting.

Bring Digital Strategy to next meeting – Carry over action to November.

Pick up missing information in the BAF – LP advised that 4 out of 6 risks did have changes to their actions. Actions may change for the other 2 after a review. Completed.

Raise with FJ the issue of the CN & COO registers not being up to date – LP confirmed this has been completed.

Discuss issues raised with the BAF & CRR with the Quality Committee at their meeting – LP confirmed that has been completed.

Add milestones into their reports and the Digital Strategy – AS/KB confirmed that the milestones have been added. Completed.

Add EDG minutes to the Resources Committee work programme for each meeting – LP confirmed this had been added. Completed.

Add the Occupational Health report to the Resources Committee work programme annually – LP confirmed this had been added. Completed.

Further assurance requested by the BoD around actions to address hygiene scores in catering and operating theatres – BG confirmed that he had given additional information is his report to the Committee. Completed.

Provide a more detailed assurance to next committee meeting on actions taken in regard to PLACE – BG confirmed that this was covered in his report to the Committee. Completed.

5. Board Assurance Framework (BAF) – Corporate Risk Register (CRR)

Board Assurance Framework (BAF)

LP informed that the BAF was reviewed quarterly. She had met with some of the Executives. Risk 5 for SNS had been reviewed and the score changed. She was discussing with people about reviewing Residual and Target scores. She confirmed the document was a lot more dynamic than it used to be.

AS/KP spoke about the altered risk on SNS around failure to maintain and transform services to ensure sustainability. The committee felt lack of capital was hindering progress and asked how this could be addressed in the assurance column. A question was asked if they had explored all options to obtain funds including STP capital. They confirmed that they do explore all options.

LM asked if they would need as much capital as they move to a more 'software as a service' model on the cloud. KB replied that historically several licenses were purchased to allow people usage of software. If they moved more into licensing then in theory it should start reducing capital costs and increase flexibility, although operating expenditure would increase.

AB gave an overview of how a managed service contract was working in Labs and stated that it was another way of extending their capital programme. LM added that one financial benefit was that they did not need ownership of the infrastructure.

Referring to the BAF, JA commented that she liked to see where it had changed. LP informed that she would also be tracking changes on the next version.

Corporate Risk Register (CRR)

LP confirmed that the CRR had been updated and review dates amended which Fiona Jamieson had submitted in the Committee pack of papers. AB confirmed that Fiona had updated the CRR.

LP reminded the Committee to highlight any changes to the CRR/BAF they wish to raise as discussions take place during the meeting.

PM highlighted that a risk had been added around care hours per patient per day. Staff were not using their tablets in real time. They were working with IT to resolve this issue.

JA referred to AB and highlighted that one risk that was similar was scored as 16 on the BAF but scored 25 on the CRR. Was this a slightly different issue? AB replied that the BAF and CRR were two different documents, one was short term and operational and the other strategic looking at long term circumstances. Therefore, risk scores could be different.

BG advised that he was going to change the risk on fire alarm systems at YH and SGH as the work at YH was complete and SGH will be completed in a few months.

6. Escalated items

Audit Committee

Managing Annual Leave - JA highlighted an issue in the Counter Fraud Report to Audit Committee around managing annual leave as there were instances where staff had taken too much. Counter Fraud felt that monitoring annual leave by managers was a bit hit and miss. She asked PM if there may be a problem.

PM replied that she had not received any evidence that this was a problem. She stated that it was a challenge to monitor annual leave of medical staff when they were not working on Trust site but were delivering Trust services.

AB advised that they do rely on the recording of annual leave at individual level and do not have a corporate team doing this.

PM stated that with the e-Rostering roll out this will diminish the issue. She has asked the Workforce Leads to establish that there were processes, checks and balances in place regarding annual leave and that it was being taken fairly.

Internal Audit Report in Finance – JA highlighted the good example where a manager (AB) worked with his team to complete the actions recommended by Internal Audit to turn a limited assurance into a high assurance. AB confirmed that once he had spoken to his team and stipulated the importance of completing the recommended actions these were carried out within a week.

No further items were discussed.

7. Board Report

PM wanted to highlight the change in reporting turnover. JA asked as they get more data could previous years be shown. PM confirmed this will be done.

JA picked out the c-diff spike at SGH and asked about the Estates team response. BG informed that he was producing a business case to (1) strengthen the team that provided in-house HPV fogging, and (2) to request a small capital element of £10k to buy 3 new pieces of equipment to replace the ones that were coming to the end of life. They would then look at how they could deliver a proactive service on a rolling basis. The business case will be seen by the Infection Prevention Steering Group.

The committee did not have anything further to raise which wouldn't be picked up in the Executive's reports.

8. Director of Estates & Facilities Report

BAF Risks – 4,6 and 11

Review of Corporate Risks

BG advised that there were currently 3 corporate risks within E&F. Two were held by the Trust and the third by YTHFM relating to the obsolete fire alarm systems at both York and Scarborough Hospitals. The York project was nearing completion and was now live and considered appropriate to de-escalate the risk from the CRR for York. The Scarborough project was ongoing and will remain on the CRR for the next few months.

EPAM – Terms of Reference

BG gave an overview of the LLP partnership with the Trust as set out in the MSA. One of the requirements was to establish EPAMs where executive officers of the Trust meet with YTHFM senior management. To this end, he has drawn up a draft TOR which has been agreed in the Management Group, agreed with the Corporate Directors and would like this committee to recommend to the BoD that it be formally adopted.

BG commented on his dual role as the Managing Director of the LLP and as Director of E&F on an honorary contract. The suggestion now was that these two roles were separated and that commencement of EPAMs would become the break point. Simon Morritt was in agreement with this.

JA commented that her only concern was the small number of members at 3 for the meeting to be quorate and wondered if this was too small. BG replied that given the range of topics there would be many more attending.

JA asked where the minutes would be presented. BG replied that the BoD would have two routes to the business of the LLP (1) the management group and the NED who will report into the Board, (2) at the EPAM meeting where either the CE or FD would attend and then report to either Resources or Quality Committee which will link to the Board.

BG advised that a meeting had been arranged with Sue Symington to discuss separation of duties.

The Committee noted the EPAM TOR and agreed to recommend its adoption to the BoD.

Health & Safety Annual Report

BG confirmed this was for the entire organisation, Trust and the LLP, and included the Annual Fire Safety Report and the Annual Fire Safety Statement. He asked that the Committee recommend to the BoD that they be adopted. He confirmed that the Trust was fire safety compliant, replacing the fire alarms and progressing with the Fire Safety Strategy.

JA commented that at the last meeting there was concern around PLACE results and hygiene. An extra paper had been submitted around what was being done and it was disappointing to note that there had been very little improvement in standards in Theatres even with the additional surveillance. She also commented that the Theatre Cleaning Performance Action Plan had no timelines or accountability.

BG replied that at the last point on the 25 August the cleanliness monitoring score for YH was 95%. He was pleased to report that last week's result was 98% and it will be continually monitored. He explained that they were consistently failing on the same items. Upon examination it was revealed that the problem was not a domestic issue, but environment related such as skirting boards coming loose. JA challenged that the assessment was on cleanliness rather than structural issues and the actions were all cleaning related.

LM asked for the deadlines and the responsible owners to be added to the action plan.

JA referred to the catering hygiene audits and asked for clarification on how to interpret the scores. BG was not sure but said he would find out. She noted that the scores appear to be worsening for SGH/BH and Q2 information was missing for YTH. The Committee requested further clarification on catering cleaning standards and on actions taken to date and planned.

It was also noted that the snapshot KPI PLACE and TAPE audit figures did not really help to illustrate how the Trust was doing over time. Trend data would be more helpful.

Attention to Board: Cleaning concerns.

Action: Provide committee update on progress with HPV equipment business case in November.

Sustainable Development Report

BG explained that there was a 12 month programme set up on raising awareness on sustainable development across the Trust. WRM is now looking to deliver 10 programmes of work that will see reductions in carbon emissions and utilities cost. The savings should be more than the consultancy fee.

JA was concerned about the oil pollution into the river Ouse originating from Trust premises and asked if this was being dealt with. BG explained that they have had some buildup of oil over a number of years in the sumps and they were working with the Environment Agency to rectify the situation.

LM was pleased to hear about the progress regarding teleconferencing and hoped that the Trust would become increasingly ambitious in targets for reducing unnecessary travel. BG gave an update on how the trial was progressing with the aim of replacing at least one journey per week over a 13 week period. He informed the committee that he was encouraging the LLP senior managers to use this facility to reduce travelling. Progress within the Trust was a little slower; it was a cultural change which people needed to embrace. AS informed that IT was providing training and that people were teleconferencing more than once per week.

JA mentioned the procurement of the Trust's food and Internal Audit findings that we are not fulfilling our target to source food locally. BG agreed that food should be bought in Yorkshire but this must be balanced against cost.

Action: BG to add the deadlines and the responsible owners to the Theatre Cleaning Performance Action Plan.

Action: BG to clarify catering hygiene audit results for next meeting, and action plan.

Attention to the Board: Approve the EPAM TOR.
Attention to the Board: Endorse the Statement of Fire Safety for completion by the Director of E&F and the Chief Executive.

9. Director of Workforce Report

BAF Risks: 6,7 and 8

Vacancy rates

PM stated that p.147/8/9 gave a breakdown of the vacancy position across all clinical staff groups and it was the first time they had done it for AHPs, Scientists and Technical groups at the request of the CQC.

The medical vacancy rate currently stood at 9%. They were reporting 7.9% in July. Some deterioration in August was expected because of the junior doctor rotation. Work continues and since July more non-training grade medical staff have commenced in post across Scarborough and York Hospitals.

Agency usage continued to be closely monitored because of the cap issues. An escalation process was recently approved with the emphasis on the Care Groups taking ownership.

Retention Programme

The Trust were participating in Cohort 5 of the NHSI/E retention programme with the aim to reduce turnover by 2%. PM explained that this will be more challenging to achieve than for previous cohorts who started from a higher baseline. Helen Hey was the Clinical Lead for the Trust. The programme will consist of workshops on new initiatives although many of the initiatives from NHSI/E had already been implemented by the Trust.

JD queried why PM had set the target at 2% if it was hard to achieve. PM replied that it was necessary to set the target at 2% to get on the programme. She advised that they were pulling together an action plan which will flow from the initiatives that come out of the workshops.

Apprenticeships

There were 219 apprentices in the Trust with a further 19 in the LLP and the scheme was progressing well. PM explained that there were two targets that the Trust had to meet (1) the Apprenticeship Levy (2) the Public Sector target, which measured the number of new starters the Trust must have each financial year. She explained that with the Public Sector target there were no consequences, but it did highlight what apprenticeships to concentrate on.

Sickness Absence

JA noted that from the annual comparison sickness had increased from last year. PM replied that she was confident some of that had come from the uncertainty that restructuring brings. In addition, the vacancy rates across the Trust also challenges the

workforce. JA commented that a lot of the sickness was stress, anxiety, depression related and asked if it was related to the care groups and what was causing so much anxiety. PM replied that it was really a management restructure which caused anxiety amongst that group. JA commented that now the Care Groups were established staff might be a little more relaxed.

Flu Campaign

PM advised that the Trust was well on with this. This year they were encouraging peer vaccinators across the organisation with 55 identified to date. The challenge was the risk appetite because there was quite a lot of training involved and she was speaking to Jim Taylor and Heather McNair to ascertain whether all the training was needed.

Leadership Development

PM explained that they were receiving help from NHS Elect. The Trust pay an annual fee for being a member but most of the training was being delivered by the ODIL team. Those that have taken part so far have been the Care Group Directors and Care Group Managers. The next cohort will be the Heads of Nursing, AHP Leads and Care Group Workforce Leads during October and November.

Limited Assurance Audit – compliance with WTD

PM commented that there were 4 recommendations.

1. WTD Guidance – the contractual wording has been reviewed and circulated via Staff Bulletin.

2. Declaring secondary employment as part of the appraisal process – PM had pushed back on this as she felt an appraisal was not the appropriate place to discuss this issue. A reminder will be circulated to staff via Staff Bulletin and the managers will be asked to discuss with staff.

3. WTD requirement on Patchwork app – PM stated that Patchwork will gather this information but for those who have declined going on Patchwork the payroll form had been strengthened.

4. Reporting of WTD breaches – PM informed that they were looking at how to capture this for staff who were not on e-Rostering.

Equality and Diversity Annual Report

PM advised it was an annual report split into two sections. Section 1 was written by Heather McNair about patients, and section 2 was about the workforce. The report essentially provides key statistics against the objectives set out and shows progress to date.

PM was really pleased to report that the Trust had retained their Disability Confident Employer status.

PM stated that accessibility standards remained an issue. They were working with Estates & Facilities on signage, and have commissioned DA Languages for interpretation and translation services.

JA stated that it was quite a hefty report and asked if there could be an executive summary to pick out key issues next time – and for similar reports to the Committee. PM advised they were looking at revising it for next year as there were other aspects that they were now required to report on.

JA noted the report on bullying and harassment and highlighted this was something they needed to monitor.

Action: PM to feed BAME issue into action plans.

Attention to the Board: Pressures on agency spend.
Attention to the Board: E&D - concerns with accessibility and bullying towards BAME staff.

10. Finance Report

BAF Risks: 9,10 and 12

GL informed the committee that at month 5 it was reporting a £700k shortfall on the pre-PSF control total. He explained that the NHSE&I control total reconciliation process took place at the end of each quarter so there was still an opportunity to recover the Q2 position and secure the full Q2 PSF and FRF funding.

In Q1 the Trust was reporting a deficit of £5.4m against a plan of £2.8m, thus reporting a £2.6m adverse variance to plan. At this stage the Trust was not including PSF and FRF of £1.8m (value not added for months 4 and 5).

Regarding income GL reported that the Trust was around £1.8m off track, almost entirely related to PSF shortfall. Activity levels in outpatients and elective/day case work remained down on plan affecting income levels for those contracts still agreed on a PbR basis, but other income was ahead of plan.
Expenditure was reported as £800k adverse variance to the expenditure plan. This related to an increase in pay expenditure with some compensation in other expenditure areas. Areas of concern included agency spend on nursing and medical staff at SGH, an action taken as a result of the CQC discussion on staffing levels. If spend continues at the current rate, it is likely that the Trust will be in breach of its annual agency expenditure cap of £15m by some £5m.

With regard to forecast outturn, GL reported on a number of different scenarios and stated that it was unlikely the Trust will deliver the control total for 2019/20 without taking additional recovery action.

JA commented that the situation was concerning especially around agency spend which was having a significant adverse impact on finance.

PM advised that in the Workforce report starters will only now be counted where the start date is within the next 3 months. She gave an overview of recent recruitment including the 104 nurses due to start within the next 6 months from international recruitment.

PM advised that discussions had taken place with the Chief Nurse Team to continue with Thornberry agency until the end of October. They will continue with the blanket bookings with other agencies for the next 8 weeks. The increase in the establishment requested by the CQC on the SGH site has increased shift requests to around 600 a month across the Trust. It had been necessary to go out to external agencies.

JA asked if any improvement was forthcoming. AB replied that they had built in the situation with Thornberry for the September position until mid-October and then will look at it on a weekly basis. He added these were all actions that had been used in the past.

AB spoke about undertaking a Q2 mini year end close down and how adjustments would be made to secure the six month target financial position – and with it, the PSF. He spoke about the agreement through the Care Groups to postpone recruitment to back office functions/managerial posts but was concerned that 6/7 weeks into the new Care Group structure the Trust was telling everyone not to spend.

AB assured the committee that they had not lost control of the finances. There was a specific issue that the Trust had to respond to that had caused pressure which will not be temporary and needs to be offset.

LM asked if the CQC had any ideas or provided any assistance. AB replied that the Chief Nurse Team and FJ meet with the CQC on a regular basis and that they do provide help informally.

A discussion took place around increasing income and AB informed that one of the efficiency workstreams was around overseas visitors accessing the health service. Through this, the Trust had grown income from this source this year by 50% and intended to extend it.

JA enquired about the progress of the GIRFT project and when it might start to deliver measurable benefits. AB replied that it had been going for a couple of years now and he had high hopes that it will deliver soon.

SLR Report – the Committee received the report and noted its contents. No comments were made.

Action: AB to provide update on GIRFT projects to November meeting.

Attention to the Board: Missing the control total without significant further actions – highlighting agency spend pressure and moves to offset this.

11. Efficiency Report

SK informed that at month 5 £8.7m had been delivered against an annual target of £17.1m. Risks remained on delivery, especially in the Care Groups as only £400k had come from them. Care Group Efficiency Panels have been arranged and the Care Group committee structure has been replicated from the corporate structure. JA commented that it was quite clear from the data provided where the challenges were and where savings had come from.

JD asked if the NHS National Framework could help. AB informed that NHSI run an operational productivity team who the Trust were in constant contact with. They come in on a regular basis. In addition, there was Model Hospital data that they upload online that gave an overview of where the Trust stands nationally.

JD asked if there was some focus to get together to discuss issues. AB informed that they had benchmark data which will point out where the Trust was an outlier and they were conducting a detailed piece of work on costs so they had the answers when Model Hospital asked those questions. Some of the Trust's challenges were unique and they needed to explain some variations in these terms.

JA stated that the deteriorating financial position was obviously something that needed to be discussed at Board level.

SK informed that with regard to QIA they were going to review a large number of CIPs this month. JT and HM have had an oversight of all schemes.

JD asked whether Brexit would affect the supply of drugs. AB replied that there was a No-deal Brexit Group within the Trust. The Trust cannot stockpile drugs or supplies. Nationally key drugs were being stockpiled. At a local level the Trust had software that informed national and regional teams what drugs the Trust held. A clear message had been relayed to patients not to stockpile medicines.

LM asked if the issues regarding Brexit should be recorded in the BAF. AB advised that there were checklists which they were following to minimise the risks. He was wary of putting Brexit on the BAF in case it gave the impression of unpreparedness to external parties such as the press.

JA asked AB to ensure the risk scores on the finance part of the BAF and CRR were accurately reflecting the new financial outlook.

Action: AB to review the risk scores on the finance part of the BAF and CRR in light of financial deterioration in month 5.

12. Digital Report

BAF Risk: 5

AS/KB gave succinct points of the report:-

- The draft Digital Strategy had been completed and had been sent to key people for comments.
- Windows 10 was continuing to be rolled out and the ATP installation will begin October.
- GP Connect has progressed and the Trust was now awaiting certification through NHS Digital which should take around 3 months. They were now on the pathway to link with GP Connect to obtain patient information on allergies, medication and summary of care record.

LM asked what the efficiency potential was around GP Connect. KB replied that from an administrative point of view it was hard to predict what the improvements will be. SK/AS were in discussions about this.

JA enquired about the Community Mobile Worker Project and asked if there was funding for this. AS replied that there was funding in place. LM queried what needed to be done to make the roll out go faster than the predicted 4 months. KS replied that they had to do it step by step due to resources. There was only a small training team and it needed to be rolled out in groups so the staff could be supported properly.

Action: Submit Digital Strategy to next meeting of committee.

Attention to Board: Linking of GP Connectivity Programme to the Efficiency Programme.

13. Research & Development Annual Report

LH reported that it had been a really good year. The main metric measure was the number of patients on clinical trials which stood at 4940 against a target of 3800.

Along with HYMS they had developed their first Academic Unit in Perioperative Medicine and have submitted a £2.5m grant to the National Institute for Health which sadly has just recently been declined. She was awaiting a detailed feedback on their decision.

A restructuring has also taken place in the key support roles to streamline processes and two strategic staff appointments have been made (Lead Research Nurse and Grant Development Officer) to assist the Head of R&D in achieving outstanding activities in the strategy in the coming year. Two Clinical Leads for Research have also been recruited to set the strategic direction and develop their new research strategy.

With regard to developing the AHP research agenda LH reported that she had 30 AHPs waiting to do research.

LH informed that funding was being changed next year. Instead of it being based on the number of patients on a trial it was going to be the number of trials being run. This could have adverse consequences for research income.

JA commented that she really enjoyed reading the report. It was an excellent performance this year in terms of patient involvement and recruitment into key roles.

LM commented that it was a fantastic report and congratulated LH. She thought it was such an important area for the Trust given that it was a teaching hospital.

A discussion took place around PAs being given to doctors/consultants specifically for research. LH said it was something that they were discussing with various senior staff as it was crucial to encourage doctors/consultants to take part in research. PM confirmed that this was being looked at and was establishing who really had a passion for research and would then concentrate their PAs on research.

Attention to the Board: Progress of R&D.

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

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

- Workforce update - pressures on agency spend. Two more months of constant pressure and then should ease.
- Finance update – Trust will miss control total without significant action.
- E&D report – concerns with accessibility and BAME bullying/harassment.
- Research report – Progress of R&D.
- H&S report - Cleaning concerns for theatres and catering.
- Sustainability – start of 12-month delivery programme.
- Digital update – GP connectivity programme. Still not seeing level of digital leadership in Care Groups that is required.

15. Time and date of next meeting

The next meeting will be held on 27 November 2019 in the Boardroom, 2nd Floor at York Hospital.

Action Log

Meeting Date	Action	Owner	Due Date
29.05.19	Highlight new limited assurance audits in their report to the Committee.	Executives	Ongoing
25.09.19	Add deadlines and responsible owners to the Theatre Cleaning Performance Action Plan.	BG	Nov'19
25.09.19	Clarify catering hygiene audit results for next meeting, and action plan.	BG	Nov'19
25.09.19	Review the risk scores on the finance part of the BAF & CRR.	AB	Nov'19
25.09.19	Produce final draft of Digital enabling strategy for next meeting.	KB/AS	Nov '19
25.10.19	Provide update on GIRFT projects to November meeting.	AB	Nov 19
25.10.19	Provide update on HPV equipment business case progress.	BG	Nov 19
25.10.19	Provide Committee with assurance on backlog maintenance following October meeting.	JA	Nov 19
25.10.19	Consider appropriate actions following E&D report – BAME bullying issue.	PM	Nov 19

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Infection Prevention and Control (Q2- 2019/20)

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

This report is a legislative and regulatory requirement. The Trust continues to acknowledge its responsibility to provide safe and effective Infection Prevention & Control (IPC) practice. The primary aim of IPC practice is to reduce harm from avoidable infections that occur either, as a direct result of an intervention, or from contact with the healthcare environment. This report summarises performance against our statutory obligations and provides assurance by describing the interventions and processes employed to reduce the Healthcare Associated Infections (HCAI) across the Trust.

Executive Summary – Key Points

This report covers the period 01 July – 30 September 2019.

The IPC Team has experienced a challenging second quarter of 2019-20.

The previously reported outbreak of Clostridium Difficile (C-diff) at the Scarborough site continued to dominate activity in Q2. The outbreak concluded in on 17 September 2019. Background rates of C-diff infection remain high across the Trust. A full outbreak report is included at Annex A.

The IPC Team is also monitoring an ongoing outbreak of MRSA colonisation of babies in the York SCBU. There were no reported cases in Q2, but more recently, in early November, there has been a single case identified. This sample will be sent to the reference laboratory for genetic typing. A case review of over 90 babies has been conducted during Q2 to try to

identify the source. PHE have led this process with assistance from the IPC Team. They have suggested that further work is needed to conclude the study.

The York and Scarborough Norovirus Escalation Policy has now been completed and is being trialed in draft form. The aim of the document is to invoke a rapid response to outbreaks of Viral Gastroenteritis from across all system partners.

The IPC Team is now fully recruited with 0% RN vacancy. A full summary of the IPC staffing position is included in the main body of this document.

Author: Tom Jacques, Lead Nurse Infection Prevention & Control

Contributory Authors: Dr. Damian Mawer, Deputy Director of Infection Prevention & Control and Consultant Microbiologist

Director Sponsor: Heather McNair, Chief Nurse and Director of Infection Prevention & Control

Date: November 2019

1. Clostridium difficile outbreak, Scarborough hospital and community sites:

The outbreak of *C. difficile* infection (CDI) that affected Scarborough Hospital was finally brought under control and declared over on 17 September 2019. The first case was on 25 February 2019. There were 29 cases in total of CDI confirmed to have been caused by the outbreak strain (ce001) of the bacterium. A number of wards saw clusters of cases (Holly, Oak and Lilac wards at Scarborough, Johnson ward at Bridlington), but many of the patients have had stays on multiple wards. The outbreak and its management attracted scrutiny from PHE, the local CCGs, NHSI and NHSE.

A full summary report from the outbreak is at Annex A. Actions that have not been completed represent unresolved risks for the Trust.

The lack of a decant facility at Scarborough sits on the Corporate Risk Register. At the time of writing it has been agreed that Colin Weatherill and Tom Jacques will write a business case for the new HPV service, using the papers on staffing enhancements produced by the LLP.

2. York & Scarborough Norovirus Escalation Plan

During the Norovirus outbreak earlier this year, it was identified that the system response to 9 wards being closed at York Hospital was poor. This was compounded not having an established system for communication across the system.

In response to this, the York and Scarborough Norovirus escalation plan has been developed and is attached at Annex B.

It is based on a series of action cards that describe how to react to a low, medium and high level outbreak of norovirus that will help absorb the burden across the primary, secondary and social care sectors.

Although in draft format, the Trust will trial this plan this year and make adjustments with our partners as necessary.

3. IPC Governance in the Care Group Structure

A draft copy of the new IPC governance structure is attached at Annex C. This structure is yet to have formal ratification at TIPSG, but it is hoped that it will improve upon the previous structure and put IPC at the centre of the Care Groups core business.

The IPC team has already liaised with all CG management teams and attended the Quality Committee for CG 1&2. It is at these meeting where IPC everyday business can be discussed and issues can be addressed quickly and decisively.

4. Hydrogen Peroxide Vapour Decontamination (HPV)

There are various elements to setting up the required HPV service discussed in Q1 DIPC report.

- Procurement of HPV monitoring system
- Staffing enhancements to enable the system to work
- 2 separate Business Cases (Proactive & Reactive)
- Equipment procurement to be included in the reactive business case.

Tom Jacques is now coordinating these pieces of work. It is envisaged that the business cases will go to the Business case Panel on 23 Dec 2019.

5. Ward Refurbishment Programme

The Director of Estates and facilities confirmed at TIPSG on 29 July 2019 that there would be no funding available for ward refurbishment work in this financial year. This is the second concurrent year that the Trust has not refurbished a ward / dept. This is concerning as the estate is deteriorating. If we are to sustain clean, safe environments in which to care for our patients, the Trust must agree a strategic and sustainable programme of ward refurbishments.

6. IPC On-Call

Earlier this year, Corporate Directors approved a paper recommending that the IPC On-call service be changed to weekends only. The recommendation was made after comparisons were made with our regional neighbours and after careful examination of the existing service and its effectiveness. Ultimately, York Trust was an outlier in terms of the service and it was felt that the organisation had developed a ‘learned dependency’ on the service. It was felt that staff on duty and on site were capable decision makers. Extra training and support was given to bed managers to support them in IPC decision making.

This system change was enacted on 1 November 2019 and will be assessed on 1 December 2019 and then again 1 April 2020. At the time of writing, no early problems have been identified.

7. CQC Report & IPC

The draft CQC report did not identify anything to the IPC team that we did not already know about. We have concluded there are 7 IPC related observations in the table below. All are ‘Should Do’ rather than ‘Must Do.’

Perhaps the most notable observation is that many of the IPC risks had been on the Corporate Risk Register for a significant amount of time and they were not being progressed. They were clear that this was an organisational responsibility rather an IPC team responsibility.

Many of the minor observations have already been corrected.

	Area	CQC Observation	Action Required
1	Well Led	Some of the risks such as infection prevention and control and workforce had been significant risks for a long time without any movement or improvement	Maintain the RR to ensure that all risks are current correctly scored and escalated where necessary. Lead IPC Nurse to continue to flag risks to appropriate Trust executive and regularly brief CN / DIPC
2	Maternity	The service should obtain advice from the infection prevention team about the use and storage of non-packaged cotton wool balls.	IPCT to liaise with CG5 Quality Committee establish current practise. Smaller disposable prepacked cotton wool packs advised.
3	Maternity	The service should ensure clear cleaning guidance of the cuffs is in place when fabric blood pressure cuffs are used	IPCT to observe practise and remediate training as necessary. Formally record training.
4	Maternity	Staff were not aware of the correct procedure and products to use when cleaning the birthing pool; potentially putting women and babies at risk if not cleaned properly between use	IPCT to work on development of SOP with CG5 and LLP (facilities)
5	Maternity	Community staff did not clean blood pressure cuffs between uses and non-packaged cotton wool balls were being used.	See above actions
6	Emergency / Urgent	The service should ensure all equipment is cleaned and labelled to indicate when it was last cleaned in its urgent and Emergency care service at Scarborough hospital.	IPCT to work with Scarborough ED. Consistent approach to cleaning of equipment and labelling. Labels not advised by the IPCT.
7	Surgery	There was an inconsistent approach to the use of 'I am clean' labels to show when it was last cleaned	IPCT to discuss at CG3 Quality Committee and visit surgical areas on Scarborough site. IPCT to undertake 'Back to Basics' spot audits where equipment cleaning is checked and the results fed back to the CG

8. Training

The IPC team have met with staff of the University of Coventry (Scarborough Campus) in Q2. We have been keen to foster a close relationship with the university to help shape and influence IPC training activity to those that may become future staff. The IPC team have the same meeting scheduled for December with York University.

The team is also reviewing how mandatory training is undertaken by substantive and bank staff. A proposal to re-shape IPC mandatory training will be sent to Corporate Directors in Q3.

9. Arjo – Huntleigh 8000X Bed Upgrade

During the outbreak of CDI at Scarborough Hospital, it was identified that an upgrade to the current fleet of hospital beds was required. The upgrade is designed to stop the build-up of organic matter in the cot-sides of the bed.

406 beds required the upgrade. To date, 80 beds have had the upgrade applied. The IPC team is working with the LLP to expedite this process.

10. Patient Movement Document

In response to an SI earlier in the year, a document designed to limit the number of moves made by a patient around the organisation is attached at Annex D. This document has huge benefits from IPC perspective where the principle of minimal movement is paramount.

The document has received approval and is being trialled at Scarborough Hospital site. A review of its effectiveness will be conducted 6 months after roll-out.

11. IPC Staffing

RN Vacancy within the IPC Team is currently 0%

Due to the lack of trained IPN applicants, it has been necessary to recruit non-IPC trained nurses. Nurses that have been recruited all have a specific interest in IPC and are experienced RN's in their respective areas (ICU, ED & Endoscopy).

These staff will have a thorough induction to the IPC Department as well as working through the Infection Prevention Society competency framework before assuming independent responsibilities. It is envisaged that this will take 6-9 months to complete.

The current IPC Team (as of Nov 2019) consists:

Post (Base)	Hours	Name	Comments
DIPC		Heather McNair	Chief Nurse
DDIPC		Damian Mawer	IPC Doctor / Cons Micro

Cross-site

Post (Base)	Hours	Name	Comments
Lead Nurse (8B)	1WTE	Tom Jacques	

Scarborough Hospital

Post (Site)	Hours	Name	Comments
IPC Nurse (B7 SGH)	1 WTE	Andy Whitfield	
IPC Nurse (B6 SGH)	1 WTE	Amanda Smith	
IPC Nurse (B6 SGH)	0.4 WTE	Alison Wright	
Secretary (B3 SGH)	1 WTE	Stephen Brady	

York Hospital

Post (Base)	Hours	Name	Comments
IPC Nurse (B7 YH)	1 WTE	Anne Tateson	
IPC Nurse (B6 YH)	1 WTE	Lynn Stokes	Acting B7 @ SGH
IPC Nurse (B6 YH)	1 WTE	Stuart Cowley	
A & S Nurse (B5 YH)	0.8 WTE	Rachel McHale	
A & S Nurse (B5 YH)	0.2 WTE	Jane Balderson	
AP (B4 YH)	1 WTE	Nick Mitchell	
Data Entry (B3 YH)	1 WTE	Gillian Leonard	

Out of Hospital Units

Post (Base)	Hours	Name	Comments
IPC Nurse (B7 OOH)	1 WTE	Annette Williams	

The Infection Prevention nursing team work alongside the Consultant Microbiologists/ Infection Prevention doctor team
Katrina Blackmore (Decontamination / Water Safety)
Dave Hamilton (Microbiology Clinical Lead)
Barry Neish (Water Safety Group)
Neil Todd (Antimicrobial lead/ Ventilation)

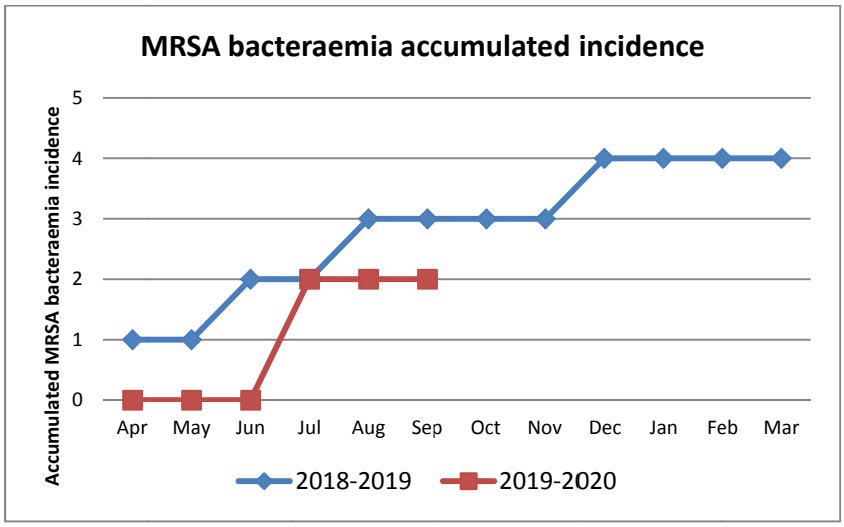
Mandatory Reporting of Healthcare Associated Infections (HCAI)

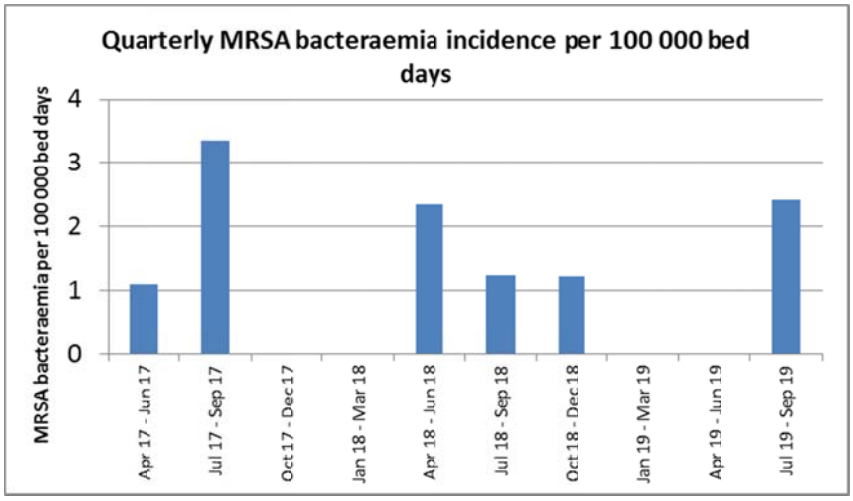
In 2018-19, it was mandatory for trusts to report MRSA, MSSA and E. coli bloodstream infections (bacteremia), and *C. difficile* toxin cases, to Public Health England.

In 2019-20, reporting of other Gram-negative bloodstream infections will also be mandatory, although the Trust has been reporting these voluntarily since April 2017.

Methicillin Resistant *Staphylococcus Aureus* (MRSA)

The trust has had 2 cases of MRSA bacteremia this quarter. This is down from 3 cases at the same point in the last financial year.



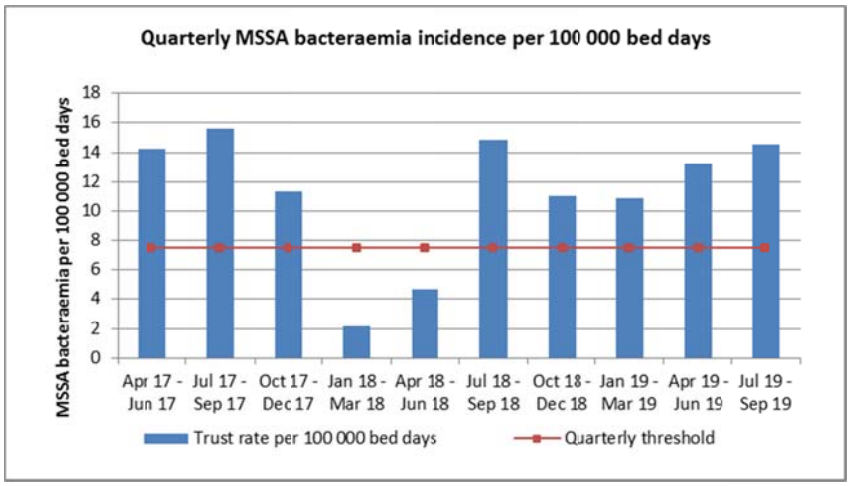


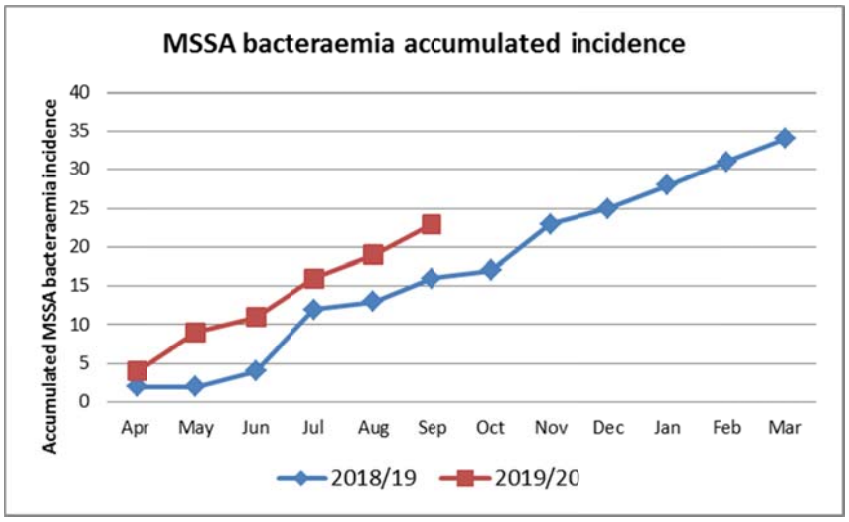
Methicillin Susceptible Staphylococcus Aureus (MSSA)

MSSA bacteremia rates are higher than in the first quarter of 2018/19, with a total 11 cases against an annual threshold of 30.

Total MSSA quarter two 2018/19 = 12 – total Q1+2 = 16
Total MSSA quarter two 2019/20 = 12 – total Q1+2 = 23

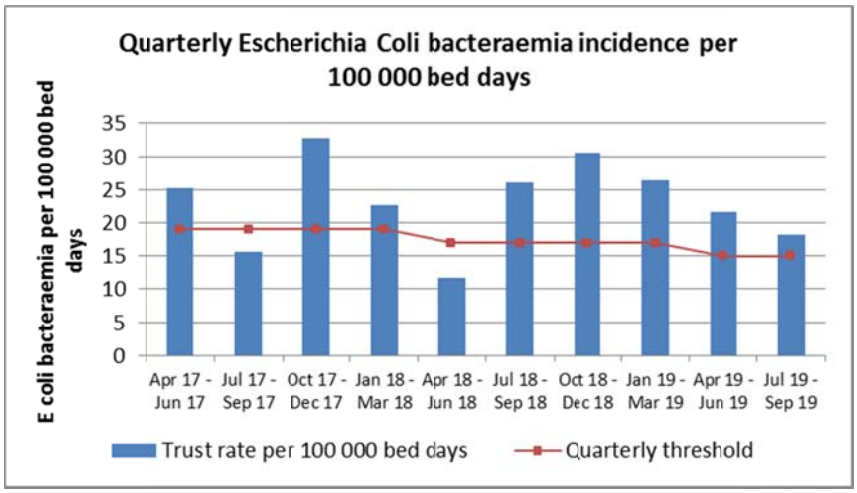
The Staphylococcus Aureus Bacteremia Reduction Group is to be re-invigorated in Q3 as its work had stalled due to staff movement. Dr Mawer will lead this group.

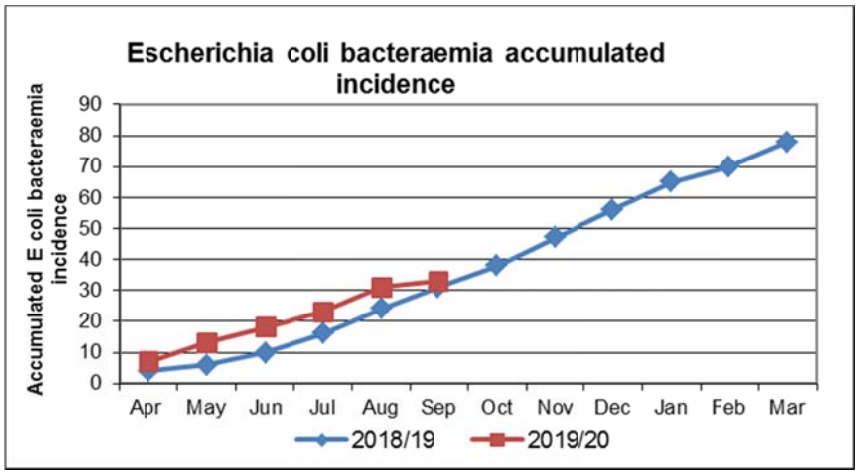




Escherichia coli bacteremia

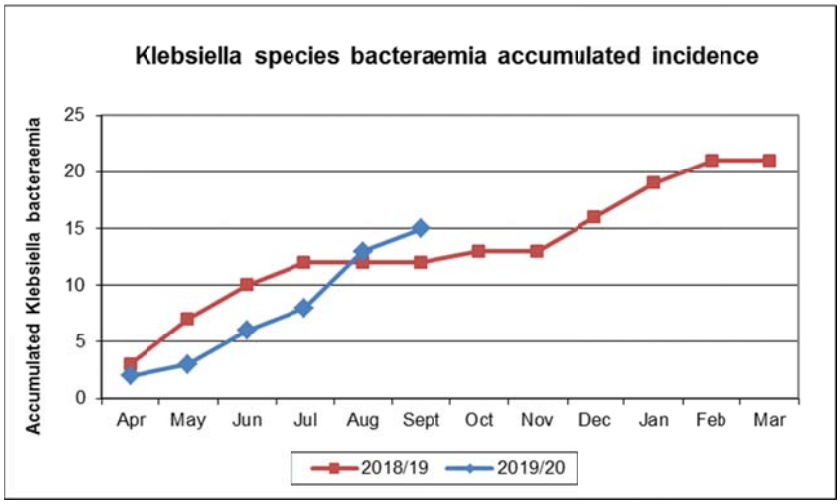
There is a 50% reduction target for healthcare associated *E. coli* bacteremia across the healthcare economy between 2017 - 2021, set as a CCG Quality Premium. The data presented are for cases defined as ‘hospital onset’.



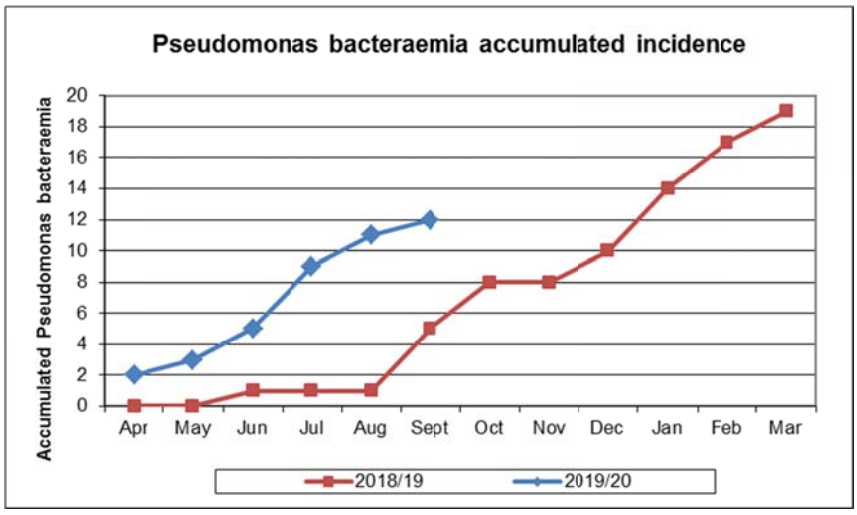


The IPC team is working with the CCG Infection Prevention leads to consider ways of introducing wider health economy solutions where recurring problems are identified.

Klebsiella species bacteraemia

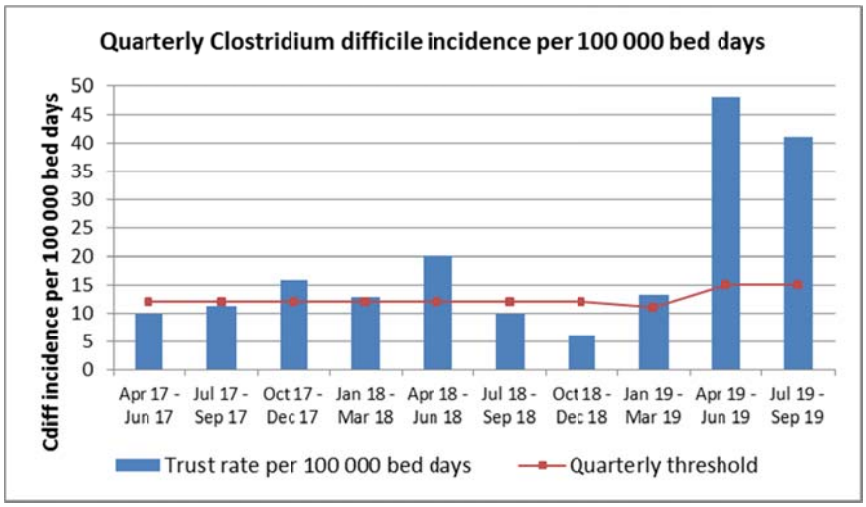


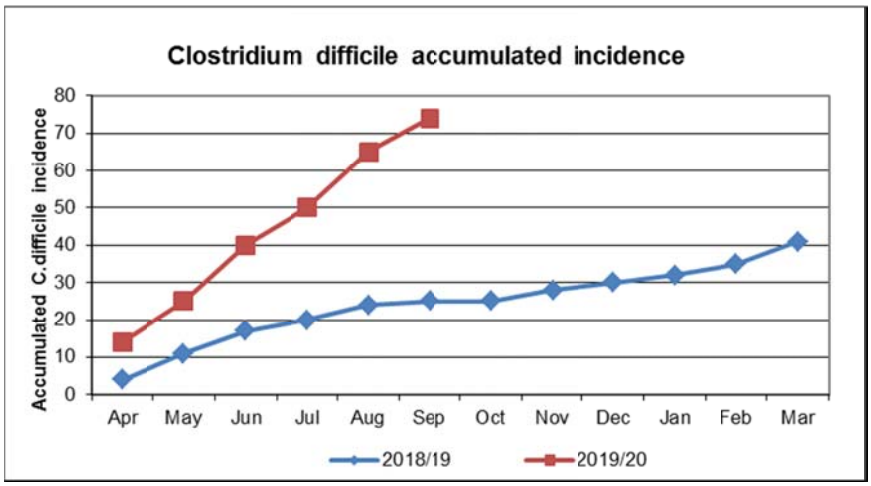
Pseudomonas aeruginosa bacteraemia



Clostridium Difficile

The trust threshold for 2019/20 is 61 cases of hospital acquired *C. difficile*. Incidence in Q2 following the outbreak at Scarborough Hospital, the Trust saw a big spike in the number of cases. This puts the trajectory well above where we should be for this point in the year. The Trust continues to attract attention from outside agencies because of the high CDI rate. Even with the 29 cases linked to the outbreak at Scarborough Hospital taken away from the figures, the Trust remains significantly over trajectory for this organism. This is the same at both acute sites. The risks described in the CDI Action Plan are felt to be significantly hampering efforts to control this organism.





Audit & Surveillance

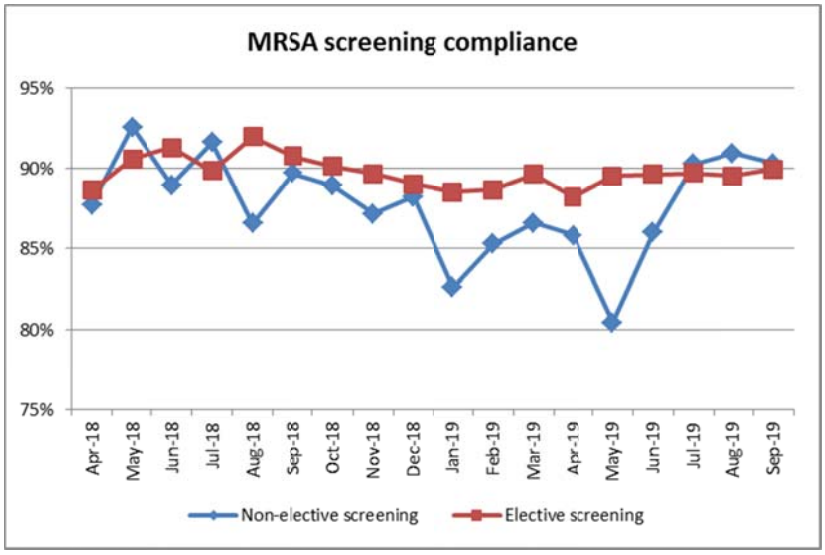
Carbapenemase Producing Enterobacteriaceae (CPE)

There were no Trust attributed cases of CPE identified in Q2 2019/20.

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

MRSA screening

There has been a notable recent increase in compliance of non-elective MRSA screening in recent months and is now back above 90%.



ANNEX A

Outbreak report: *Clostridium difficile* infection Scarborough & Bridlington 2019

Location:
Scarborough hospital (principally Holly, Oak, Lilac, Ann Wright and Beech wards).
Bridlington hospital (Johnson ward).
Malton hospital (Fitzwilliam ward).

Date of start of investigation:
First case 25/2/19.
Period of increased incidence (PII) meeting on Holly ward 21/3/19.
PII meeting on Johnson ward 12/4/19.
First major outbreak meeting 26/4/19.

Date outbreak closed:
14/9/19, twenty-eight days after the last case of the outbreak strain (PHE agreed definition).

Synopsis:
Ribotyping 001 outbreak
This synopsis is largely based on an epidemiological report of the outbreak written by Lara Utsi, PHE.
The outbreak involved 29 confirmed cases of *Clostridium difficile* infection (CDI) ribotype 001 identified in patients admitted to Scarborough General Hospital (SGH) between 25 February 2019 and 17 August 2019 (Figure 1). The number of cases identified per month peaked in April (8 cases) and May (7 cases) but dropped to one in June. There was a resurgence of cases later in the summer with 4 cases identified in July and 3 in August. Isolates from 15 cases (52%) were found to be toxin positive.
Twenty-four cases were first identified from specimens taken while admitted to hospital for over 48 hours (hospital-onset). Four cases had community onset (with specimens taken in the community or within 48 hours of admission) but had been admitted to the NHS acute trust in the four weeks before onset. Eight cases were normally resident in care homes, two of whom were resident in the same care home.
Eleven cases are known to have died, seven of which died within 30 days of their earliest positive specimen dates. The 30-day all-cause fatality rate for this outbreak was 24%.
All cases had been admitted to SGH prior to specimen collection, with identification as a case occurring at a maximum of 39 days after discharge. There were seven wards on which two or more cases had contemporaneous overnight admissions in the four weeks prior to CDI in at least one case (SGH – Holly, Ann Wright, Lilac, Oak, Beech; Bridlington – Johnson; Malton - Fitzwilliam). Admissions periods to these are summarised in Figure 2.
No single ward can account for all cases, with between 7% and 48% of cases having had overnight admission to each of the above wards prior to identification as a case (Table 1). This indicates that transmission of the outbreak strain occurred in multiple locations. There were five cases with admission to just one ward prior to identification as a case (Holly, n=3; Lilac, n=1; Ann Wright, n=1). All three cases identified in August had been admitted to Oak ward for >12 days prior to specimen collection.

Data on secondary care antibiotic prescribing were available for 22 cases. The following figures do not include any antibiotics prescribed in primary care. 95% of cases (n=21) had been prescribed at least one antibiotic while admitted to hospital in the six weeks before earliest specimen onset. 20 of these cases had received at least one broad-spectrum antibiotic over this period. Cases had taken antibiotics on a median of 6 days in the six weeks before identification as a case (range 0 to 25 days). Eighteen cases had received prescriptions for two or more antibacterial groups in this period (median: 3, range: 0 to 5 antibacterial family groups).

Non-ribotype 001 cases

In addition to the cases described above there were 22 patients with non-ribotype 001 CDI during the outbreak period. Isolates from 18 cases (82%) were found to be toxin positive. Six cases are known to have died, five within 30 days of their earliest positive specimen dates. The 30-day all-cause fatality rate in this group was 9%.

Five ribotypes were identified in two or more cases: 002 (three cases), 005 (four cases), 014 (two cases), 081 (two cases) and 220 (two cases). Two of the patients with 002 have overlapping admissions on Oak ward; the third case was admitted within a week of the second being discharged from there. None of the other cases with the same ribotypes had overlapping ward admissions.

Key issues identified and actions taken:

Theme	Finding	Action(s)	Completed (Y/N – if no current status indicated)
Stool sampling	Trust's stool sampling flowchart not displayed on wards. Staff unaware of the flowchart and how to use it.	Flowchart displayed in sluice on every ward. Education and awareness-raising provided by IPC team.	Y
	Sampling delayed when patient presenting with diarrhoea (in 3 cases delay was >48hr leading to the cases being attributed to the trust).	Managers of admission units asked to reinforce to staff the importance of sending samples as soon as possible from patients admitted with diarrhoea.	Y
Equipment decontamination	Lack of clarity around responsibility for cleaning toilet seat raises.	Clarification provided that this is the responsibility of domestic staff.	Y
	Difficulty cleaning ArjoHuntleigh 8000 bed frames (particularly rails).	Fault of the bed design. ArjoHuntleigh fitting cleanable covers to bed rails.	N – program of bed rail cover placement ongoing
	Dirty commodes with no evidence of an audit process for commode cleaning on some wards.	Feedback to ward managers. Spot-checks put in place. Commode cleanliness are one element of the new IPC "Back to Basics" ward audits.	Y Audits commenced October 2019
Hand hygiene	Evidence of poor hand hygiene practice amongst all staff groups.	Hand hygiene awareness and training days provided by IPC and CCG nurses. Hand hygiene part of "IPC must do" messages sent out via Staff Bulletin and screen savers.	Y Y
	Lack of regular hand hygiene audits on most wards.	Weekly audits reintroduced on all wards, with results fed back to matrons, ward managers and Deputy Chief Nurse. Audits most successful when initially undertaken by a "mystery shopper".	Y
Ward cleaning	Lack of domestic staff leading to delays in terminal cleaning of side rooms.	Recent figures showed that the Trust was down a substantial amount of cleaning hours per week on all sites. Job ads are currently out, and the	N – LLP actively recruiting cleaning staff

		LLP is endeavoring to recruit further cleaning staff to try and cover this shortfall.	
	Synbiotix system was not flagging all areas of cleaning.	IPC Lead met with Compliance Lead, Synbiotix system now changed to include all areas.	Y
HPV decontamination	Existing Bioquell HPV machines no longer providing high level disinfection.	Estates reviewing current market options for replacement of machines.	N – LLP seeking further information on the microbiological efficacy of the systems on the market
	Current staffing of HPV service insufficient for requirements of reactive and proactive service.	Estates producing an options appraisal for staff costs to meet requirement for a 24/7, year-round reactive and proactive service.	Y
Decant facility	Lack of decant facility in Scarborough. Deep cleaning and HPV undertaken on a bay-by-bay basis, risking re-contamination of clean areas. This issue continues to be on the Corporate Risk Register.	Ward configuration plan from CG2 that will release Ann Wright as a decant space. Will allow bay decants from other wards, but no more than that.	N – SDEC capacity to be enhanced before Ann Wright can be closed. Will remain open as a ward over winter 2019-20. Risk has been escalated to the DIPC
Patient transfers	Patients experiencing multiple ward moves during admission, increasing infection risk and generating a poor patient experience.	Patient transfer document produced and has been trialled. Aims to limit ward transfers to maximum of two (unless clinically indicated).	N – outcome of trial awaited.
Antibiotic prescribing	Inappropriate use of piperacillin-tazobactam (mostly related to management of ‘severe’ sepsis).	Sepsis Steering Group asked (through Dr Todd) to address this issue.	Y
	Prolonged antibiotic courses.	ARK antibiotic stewardship programme being introduced across hospital.	N – ARK rolled out across Medicine, Orthopaedics and Elderly Care 30/9/19. Surgical wards to follow by end of 2019

Unresolved risks:
Actions that have not been completed represent unresolved risks. They are identified in the table above. The lack of a decant facility at Scarborough sits on the Corporate Risk Register. At the time of writing it has been agreed that Colin Weatherill and Tom Jacques will write a business case for the new HPV service, using the papers on new equipment and staffing enhancements produced by the LLP.

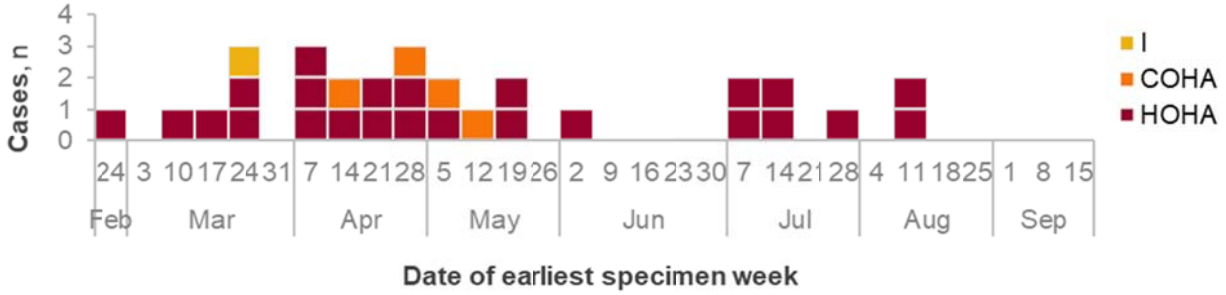
Completed by:
Dr Damian Mawer
Deputy Director for Infection Control & Infection Control Doctor
Tom Jacques
Lead Nurse for Infection Control

Date:
October 2019

Figures and tables:

Figure 1: Earliest specimen dates of CDI cases by case definition onset category, toxin positivity and ribotype, n=29
COHA = Community-onset Healthcare Associated; HOHA = Hospital-onset Healthcare Associated; I = Indeterminate

Case definition onset category



Toxin positivity

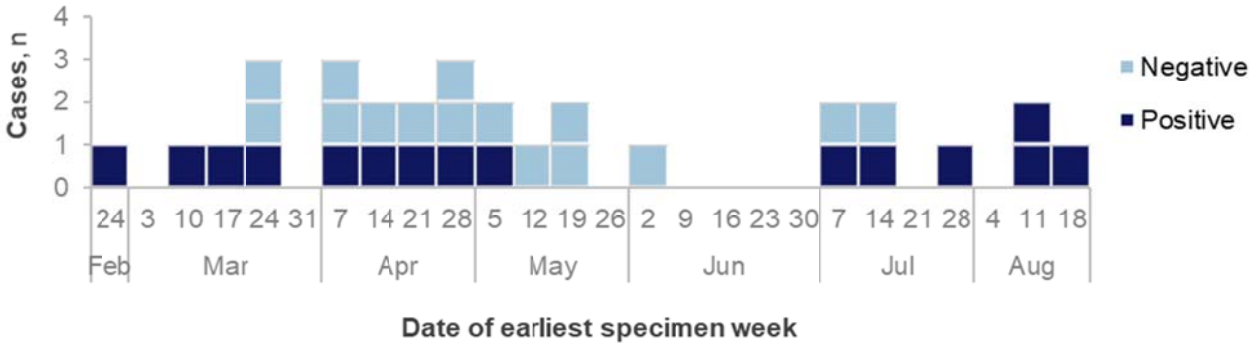


Figure 2: Admission, specimen dates and dates of death for outbreak-associated cases, n=29

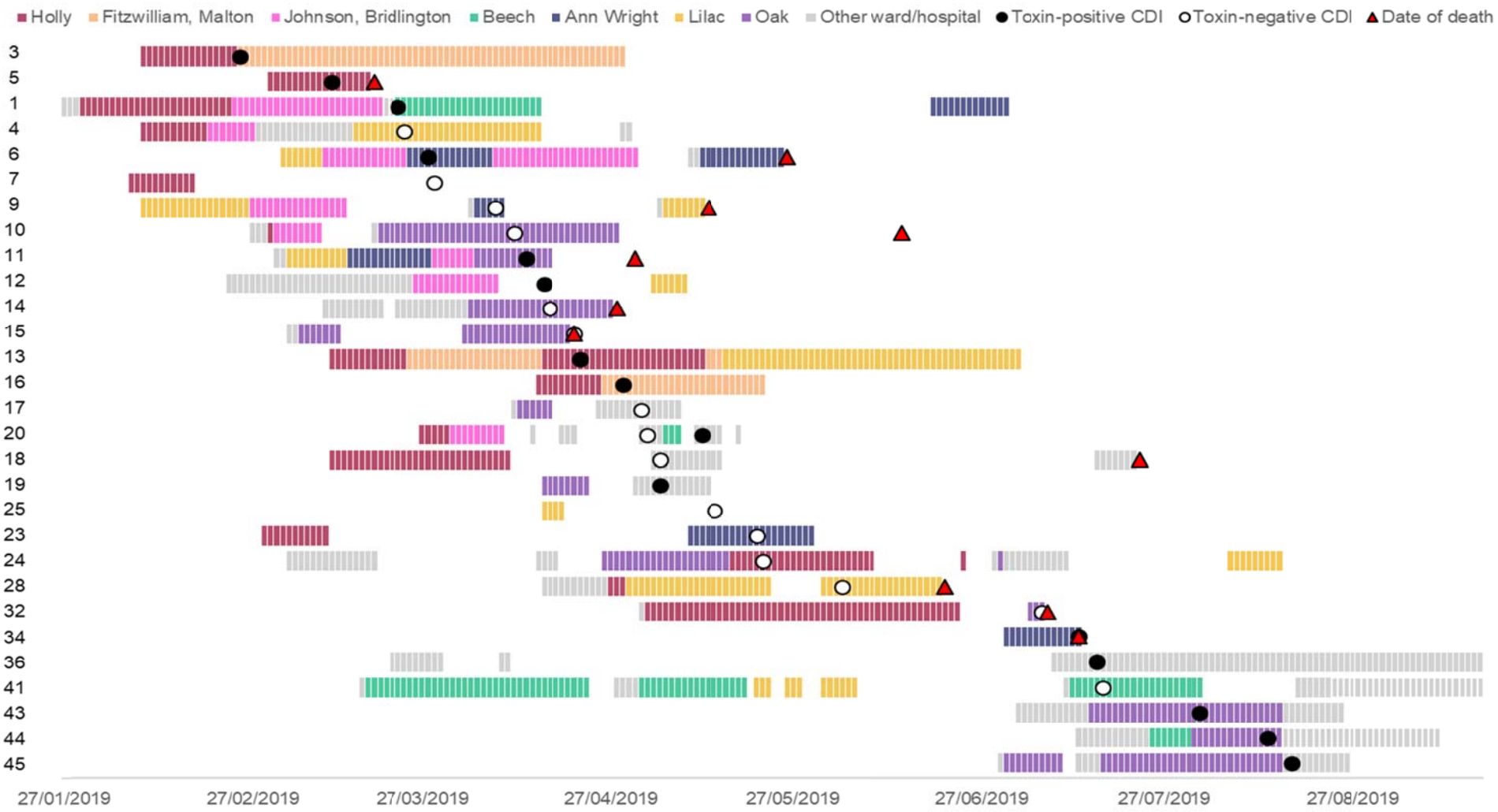


Table 1: Overnight admissions to hospital wards prior to identification as a case

	Cases admitted to each ward for at least one night prior to identification	
	Number exposed	% exposed
Scarborough		
Holly	14	*48*
Oak	11	*38*
Lilac	7	*24*
Ann Wright	5	*17*
Beech	3	*10*
Bridlington		
Johnson	8	*28*
Malton		
Fitzwilliam	2	*7*

ANNEX B

York & Scarborough Health and Social Care Norovirus Outbreak Escalation Plan

Version	2
Effective Date:	3/10/2019
Last review Date	3/10/2019
Next Review Date	
Organisations present:	VoY CCG SRCCG YFT

Introduction

Outbreaks of infections or communicable disease can occur at any time and cause much discomfort and inconvenience for patients and staff. They may threaten the operational function of the health and social care system.

Not all incidents involving infection or communicable disease will require a response involving the whole of the health and social care community, and many incidents may be managed through normal working practices without the need for activating this escalation plan or a formal Outbreak Control Team.

Scope

This escalation plan is aimed at supporting the health and social care system in the management and control of an outbreak of infection.

Outbreak

An outbreak of infection is the occurrence of two or more linked cases of the same illness (e.g. on the same ward, care home or unit etc.), or a greater than expected rate of infection compared with the usual background rate for the particular population and period. An outbreak will vary according to the infection strain and/or disease, size and type of population exposed and time and place of occurrence.

Outbreaks for the purpose of this escalation plan will be classified under the following categories:

Low level outbreak –

1. **An outbreak affecting relatively few patients/residents and staff.**
2. **Symptoms are minor and the cases are restricted to one ward or care home or unit within a care facility at most.**
3. **There might be some disruption to the ward/ home activity but the problem can be contained with no major impact on service delivery.**

For example in the case of viral gastroenteritis: 1 ward/community unit or care home closed with vomiting and/or diarrhoea.

In addition the daily system call will inform the escalation to the next outbreak level taking into account the impact on service delivery across health and social care.

Medium level outbreak

1. **Can be an outbreak involving up to two wards with patients and staff with the same clinical signs.**

2. **Can be an outbreak involving up to 4 care homes within a CCG area.**
3. **There may be some disruption to ward/home activity with some impact on service delivery.**

For example in the case of viral gastroenteritis this may include a combination of wards/community units and care homes.
In addition the daily system call will inform the escalation/ de-escalation to the next outbreak level taking into account the impact on service delivery across health and social care.

High level outbreak –

Defined by any or all of the following:

1. **Occurs on a large scale involving significant numbers of patients/ residents and or staff in a number of hospital wards, community units and care homes.**
2. **affects more than four wards / related community sites and more than 4 care homes**
3. **Symptoms will vary according to the causative organism, but severe symptoms in a smaller number of clinical areas / patients caused by highly pathogenic organisms would also class as a high level outbreak.**
4. **Major disruption to ward, community units and care home activity and patient flow and has a significant impact on service delivery across the health and social care economy.**

For example in the case of viral gastroenteritis: more than 2 related clinical areas (e.g. wards at one hospital site and related community units) plus more than 4 care homes closed within a CCG area closed with vomiting and/or diarrhoea.

In addition the daily system call will inform the de-escalation to the next outbreak level taking into account the impact on service delivery across health and social care

Recognition and declaration of an outbreak

Effective control depends on early recognition of an outbreak and timely intervention. Outbreaks identified within an organisation needs to be communicated out to the Health and Social care community to allow an appropriate system wide response.

Please see appendix one Template email for notification of outbreaks within health care.

Care home closures due to outbreaks are circulated by Public Health England following the notification by the individual home.

Each organisation/care facility is responsible for following their internal outbreak policy to manage the outbreak.

System Wide Management

Please refer to the action cards appendix 2 -4 for the system response to the applicable level of outbreak.

Roles and Responsibilities

YHFT and Representative Role and Responsibilities	
Role: NHS provider organisations may be required to support the response to a communicable disease control incident or outbreak, or may be directly affected by it. If a representative is required, the Director, or deputy Director, of Infection Prevention and Control will represent the organisation on the OCT and will ensure information is cascaded appropriately within the Trust.	
Responsibilities:	
1	Implement actions and measures detailed in the YFT Major outbreak plan, where the outbreak related specifically to YFT sites in order to minimise impacts.
2	Collaborate with multi-agency partners, including Public Health England and the Local Authority, to facilitate a combined response where required.
3	Activate the escalation and business continuity plans as appropriate to manage increases in demand and risk of disruption to usual services.
4	Request additional assistance from commissioners where required, as is appropriate and in line with national guidance.

YHFT and HFT as Community Services provider and Representative Role and Responsibilities	
Role: NHS provider organisations may be required to support the response to a communicable disease control incident or outbreak, or may be directly affected by it. If a representative from YHFT and HFT is required, the Director of Children's and Community Services, Director of Mental Health Services or the Deputy Director of Nursing and Standards will represent the organisation on the OCT and will ensure information is cascaded appropriately within the Trust.	
Responsibilities:	
1	Collaborate with multi-agency partners, including Public Health England and the Local Authority to facilitate a coordinated response.
2	Activate business continuity plans as required to manage increases in demand and risk of disruption to usual services.
3	If the outbreak requires a YHFT& HFT response or directly affects YHFT& HFT, a Trust Director will follow the YHFT and HFT outbreak policy.
4	Request additional assistance from commissioners where required, as is appropriate and in line with national guidance.
5	Support delivery of mass vaccination or mass treatment if it is required in a range of settings e.g. in the community, schools.
6	Provide infection prevention and control nurse support where requested.

Vale of York & Scarborough Ryedale Clinical Commissioning Groups Role and Responsibilities	
Role: As a commissioner, the CCG will would have the responsibility for ensuring that commissioned services deliver an appropriate clinical response to any incident that threatens the Public's Health. The CCG will not normally be represented directly at the incident/outbreak control team but will work closely with the NHS England Area Team to discharge responsibilities as required.	
Responsibilities:	
1	Ensure its staff and commissioned services adhere to any requirements to notify/ report to Public Health England communicable diseases and any other chemical and environmental incidents in line with nationally or locally agreed guidelines.
2	Ensure capacity to mobilise resources to deal with a large public health incident e.g. mass treatment is available from providers.
3	Ensure that provision for the mobilisation of NHS resources is included in all appropriate contracts.
4	Provide resources and funding to carry out mass treatment as directed by NHS England.
5	Support the NHS England area team in mobilising the providers of NHS-funded healthcare.
6	Authorise additional assistance as required by a local provider of NHS-funded care following the activation of Major Incident arrangements, including communicable disease incidents or outbreaks with impacts on the provision of the service.
7	Authorise variations to contractual obligations where necessary to respond to communicable disease outbreaks and incidents not covered by Major Incident clauses.

NHS England and Representative Role and Responsibilities	
Role: The role of NHS England as a direct commissioner is to take responsibility for ensuring that contracted providers deliver an appropriate clinical response to any incident that threatens the Public's Health. Representation may be required from the NHS England Area Team where the nature of the incident/outbreak requires the mobilisation of NHS-funded providers of healthcare in the implementation of agreed public health control measures.	
Responsibilities:	
1	Ensure that provision for the mobilisation of NHS resources is included in all appropriate contracts.
2	Coordinate the NHS response and mobilisation of NHS-funded services
3	Assure the capability of the NHS response to the incident or outbreak.

4	Ensure capacity to mobilise resources to deal with a large public health incident e.g. mass chemoprophylaxis or immunisation, is available from providers as per local mass treatment plans.
5	Ensure that its staff and commissioned services adhere to any requirements to notify/ report to PHE communicable diseases and environmental incidents in line with national or locally agreed guidelines.
6	Support the response where a mass treatment response is required, where necessary mobilising NHS resources as per local mass treatment plans.
7	Authorise additional assistance as required by a local provider of NHS-funded care following the activation of Major Incident arrangements, including communicable disease incidents or outbreaks with impacts on the provision of the service.
8	Authorise variations to contractual obligations where necessary to respond to communicable disease outbreaks and incidents not covered by Major Incident clauses.
9	Advise the incident/ outbreak control team on the available capabilities and the feasibility of an agreed response.
10	Working with NHS clinical commissioning group representatives as required to effectively mobilise resources.
11	Provide an overview of the impact of the response on normal service provision and business continuity, along with the capacity and capability of the NHS to deliver a response.

Template email for outbreak update

Dear colleague

Infection Prevention & Control Team

Ward / Bay Closure Update
Date

Ward and Bay closures Trust								
Date Closed	**Ward**	**Hospital**	**Bay/s**	**Reason Closed**	**Date of Next IPN Review**	**Number of Patients affected**	**Number of Staff affected**	**Date of Opening**

Regards

Low Level Outbreak System Response			
Triggers	**Actions**	**By Whom**	**Response**
A single ward/ care home or units is reporting patients/ residents and or staff with symptoms	Raise awareness within Secondary Care/ community units to ensure all patients admitted with D&V are isolated or cohorted on admission. Restrict to admissions affected by. Can still admit to rest of ward. No transfers out from ward to other wards or hospitals except for urgent clinical need (e.g. ITU). Transfer of patients to Nursing Homes to be discussed with IP&C team	YFT, HFT	IPC teams to raise awareness and follow internal outbreak policy. Information to be cascaded to admission areas All patients that present a risk of norovirus (e.g. present with symptoms of diarrhoea and/or vomiting or have been in contact with others with D&V within the previous 72 hrs) are admitted directly to a single side room and **ISOLATED**. Communication teams to produce posters and place at entrances to hospital/wards. IPC Team to inform relevant operational staff. Staff to utilise systems partners Viral Gastroenteritis System Partners Guidance (Appendix 5)
	Raise awareness within care homes to ensure all patients are isolated were possible	CIPN	Send out communication to care homes to inform regarding isolation of patients and communication of infection status if admission to an inpatient area is required (inter healthcare transfer form).

	Raise awareness across the system of the current outbreak status	YFT, HFT Care Homes Public Health England	To complete daily outbreak alerts using template email to agreed distribution list Monday to Friday. To inform Public Health England of outbreak. Ensure outbreak status is displayed within the home. To send out daily outbreak update across the system
	Raise awareness with the general public of the signs and symptoms and self-care advice.	Trust & CCG Communication Teams	To ensure a co-ordinated message is delivered across the CCG areas. Agreed messages to be sent out across communication networks.

Medium Level Outbreak System Response			
Triggers	**Actions**	**By Whom**	**Response**
Up to 2 wards or a number of bays / 4 care homes or units are reporting patients/residents and or staff with symptoms with some disruption to service delivery. (In addition to low level response)	Convene Outbreak meetings and establish actions to reduce impact on bed capacity: Provide information on current situation: • **IP&C details of closed ward (s)** • **Trust wide & community bed state**	YFT,HFT	Liaise with PHE/CCDC and Directorate Managers, CCG lead and liaise with Community IP&C Team. Include information on Trust public website regarding ward restrictions. Daily update on wards restrictions on intranet and IP&C webpage. Communicate outbreak status to YAS
	Support discharge to care homes	CIPN	Provide advice in line with the partners in care document (Appendix 5)
	Raise awareness across the system of the current outbreak status	YFT, HFT Care Homes Public Health England	To complete daily outbreak alerts using template email to agreed distribution list. To inform Public Health England of outbreak. Ensure posters are in place to inform visitors of outbreak status. To send out daily outbreak update across the system
	Admissions to the Trust retained for patients who need acute care for whom use of other healthcare facilities or admission avoidance is clinically inappropriate.	Trust & CCG Communication Teams	Cascade information to GPs and out of hour's service, to facilitate admission avoidance where clinically appropriate.

	Raise public awareness of outbreak to reduce unnecessary visitors to the Trust on next working day.		Issue public message reminding symptomatic visitors to avoid visiting. To include symptom and self-care reminder

High Level Outbreak System Response			
Triggers	**Actions**	**By Whom**	**Response**
Affects more than 4 wards /related community sites/more than 4 care homes or units are reporting patients/residents and or staff with symptoms with significant impact on service delivery. (In addition to medium level response)	Convene daily meetings and establish actions to reduce impact on bed capacity: Provide information on current situation: • **IP&C details of closed ward (s)** • **Trust wide & community bed state** Restricted Visiting to be initiated	YFT,HFT	Liaise with HPE/CCDC and Directorate Managers, CCG lead, YAS and liaise with Community IP&C Team. Include information on Trust public website regarding ward restrictions. Production and placement of Restricted Visiting posters at entrances to hospital and wards Daily update on wards restrictions on intranet and IP&C webpage.
	Support discharge to care homes	CIPN	Provide advice in line with the partners in care document (Appendix 5)
	Raise awareness across the system of the current outbreak status	YFT, HFT Care Homes Public Health	To complete daily outbreak alerts using template email to agreed distribution list. To inform Public Health England of outbreak. To send out daily outbreak update across the

		England	system Instigate system wide approach to capacity issues via outbreak management group.
	Admissions to the Trust retained for patients who need acute care for whom use of other healthcare facilities or admission avoidance is clinically inappropriate. Raise public awareness of outbreak to reduce unnecessary visitors to the Trust on next working day.	Trust & CCG Communication Teams	Cascade information to GPs and out of hour's service, to facilitate admission avoidance where clinically appropriate. Issue public message reminding symptomatic visitors to avoid visiting. To include symptom and self-care reminder

System Partner's document

*System partner logos to be added as guidance shared with each organisation

Viral Gastroenteritis
Systems Partners Guidance

Version Control

Version	Release date
9.1	09/04/2018

Guideline	Effective Discharge of patients from wards/ inpatient areas which have had an outbreak of Viral Gastroenteritis (Including Norovirus)
Version Control	Version 0.9
System Partners	Hull and East Yorkshire Hospitals NHS Trust Humber Teaching Foundation NHS Trust City Health Care Partnership CIC Yorkshire Ambulance Service NHS Trust East Riding of Yorkshire Council Hull City Council NHS East Riding of Yorkshire CCG NHS Hull CCG NHS Vale of York CCG NHS Scarborough & Ryedale CCG Public Health England Thames Ambulance Service Limited Yormed Ambulance Service York Teaching Hospital NHS Foundation Trust City of York Council
Background	It has been recognised that there is no consistent approach between system partners on the discharge of patients that have been exposed to Viral Gastroenteritis (including Norovirus) within a ward/inpatient area. This document is a guideline in order for the system to adopt an agreed position on discharge of these

	patients.
Viral Gastroenteritis (including Norovirus) description	**Viral Gastroenteritis (including Norovirus)** This is a viral infection which causes diarrhoea and vomiting. It affects semi closed communities such as hospitals. Immunity is short-lived and therefore a high proportion of those exposed to infection develop symptoms. In healthy people these are relatively short-lived and mild. Transmission is by person-to-person infection, contaminated surfaces and contaminated food and drink.
Principles of agreement	For a patient that is medically fit for discharge, it is recommended that the following principles should be adopted by all system partners and Acute trusts: • Any patient on a ward/inpatient area affected by Viral Gastroenteritis (including Norovirus) going to their own home without additional services can be discharged as soon as they are thought to be medically fit even if they are still symptomatic. • Patients who are on a ward/inpatient area where there are closed bays due to infection but who are not in a closed bay can be discharged to their own home, intermediate care, community/ mental health inpatient service or to a nursing or residential home. • Patients in closed bays/inpatient area, who are not symptomatic because they have resolving symptoms (i.e.48hrs symptom free), can be discharged to their own home either with or without services, intermediate care, community/ mental health inpatient service or to a nursing or residential home. • Patients in closed bays/inpatient area who have not been symptomatic and are due to be discharged to a nursing or residential home should be assessed on an individual patient basis*. In general, discharge should not occur until the bay has been reopened, however discussion can be

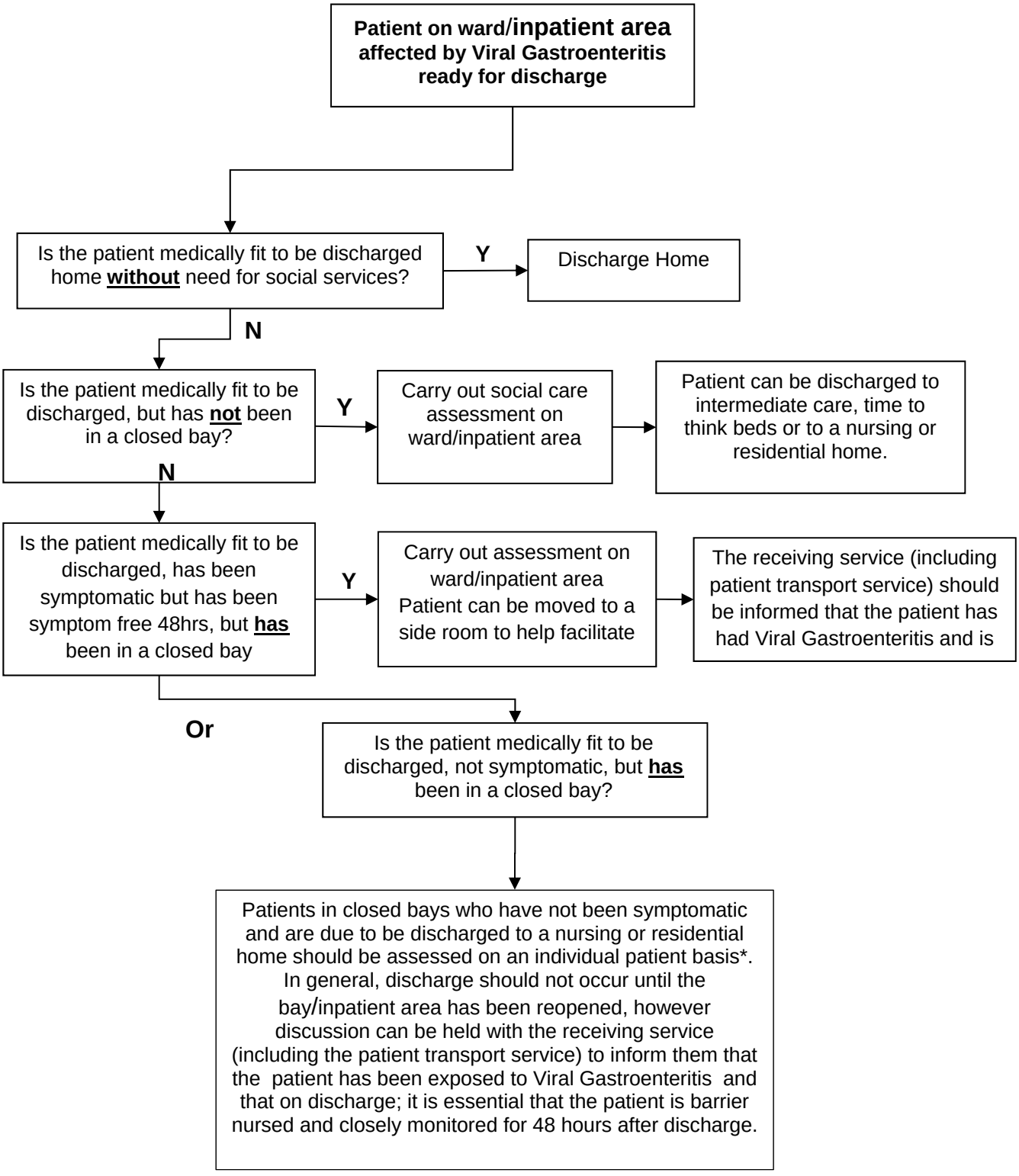
	held with the receiving service to inform that the patient has been exposed to Viral Gastroenteritis (including Norovirus) and that on discharge; it is essential that the patient is barrier nursed and closely monitored for 48 hours after discharge.
Staff undertaking assessments on closed wards (Allied Healthcare Professionals and Social Care Staff)	In principle as long as appropriate precautions are taken the assessment for discharge process should continue. • Patients who are on a ward/inpatient area where there are closed bays but who are not in a closed bay. Staff can continue to assess the patient and the patient can continue to attend other areas for rehabilitation/ investigation. • Patients in closed bays/inpatient area, who are not symptomatic because they have resolving symptoms (i.e.48hrs symptom free). If facilities allow these patients can be taken to a non-affected area of the ward/inpatient area and staff can continue to assess the patient. • Patients in closed bays/inpatient area who have not been symptomatic should be assessed on an individual patient basis.
Effective from	1st April 2018
Date	9th February 2018
Review Date	31st March 2019
Contact for this guidance	Jo Raper jo.raper@nhs.net

***Assessment on an Individual Patient Basis**
This assessment should be undertaken in conjunction with the Infection Prevention & Control team, receiving service and Public Health England. This is to ensure the receiving service is able to prevent the spread of infection. The default will remain not to discharge unless safe discharge arrangements can clearly be described and this will not be on every occasion.

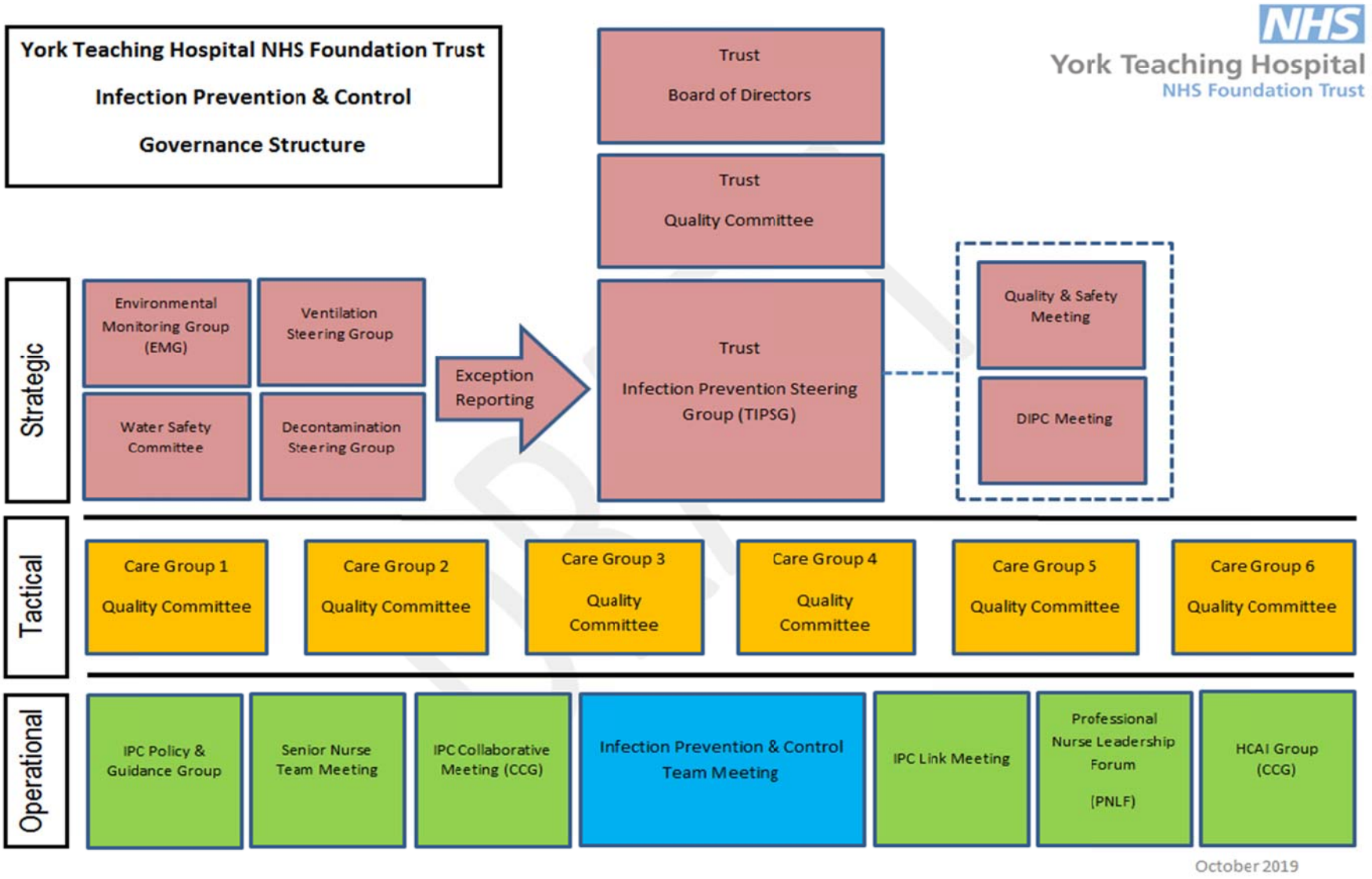
Closed Care Homes /Acute, / Community, Mental Health inpatient areas

Where a care home/ inpatient area has been closed due to infection since the patient's admission the patient should not be discharged back to the area until it is reopened.

Patient Discharge for a ward affected by Viral Gastroenteritis (including Norovirus)


Patient on ward/inpatient area affected by Viral Gastroenteritis ready for discharge
Is the patient medically fit to be discharged home without need for social services?
Y
Discharge Home
N
Is the patient medically fit to be discharged, but has not been in a closed bay?
Y
Carry out social care assessment on ward/inpatient area
Patient can be discharged to intermediate care, time to think beds or to a nursing or residential home.
N
Is the patient medically fit to be discharged, has been symptomatic but has been symptom free 48hrs, but has been in a closed bay
Y
Carry out assessment on ward/inpatient area Patient can be moved to a side room to help facilitate
The receiving service (including patient transport service) should be informed that the patient has had Viral Gastroenteritis and is
Or
Is the patient medically fit to be discharged, not symptomatic, but has been in a closed bay?
Patients in closed bays who have not been symptomatic and are due to be discharged to a nursing or residential home should be assessed on an individual patient basis*. In general, discharge should not occur until the bay/inpatient area has been reopened, however discussion can be held with the receiving service (including the patient transport service) to inform them that the patient has been exposed to Viral Gastroenteritis and that on discharge; it is essential that the patient is barrier nursed and closely monitored for 48 hours after discharge.

NB Please ensure you inform the patient transfer service if the patient is potentially infectious


York Teaching Hospital NHS Foundation Trust
Infection Prevention & Control
Governance Structure
NHS
York Teaching Hospital
NHS Foundation Trust
Trust
Board of Directors
Trust
Quality Committee
Strategic
Environmental Monitoring Group (EMG)
Ventilation Steering Group
Water Safety Committee
Decontamination Steering Group
Exception Reporting
Trust
Infection Prevention Steering Group (TIPSG)
Quality & Safety Meeting
DIPC Meeting
Tactical
Care Group 1
Quality Committee
Care Group 2
Quality Committee
Care Group 3
Quality Committee
Care Group 4
Quality Committee
Care Group 5
Quality Committee
Care Group 6
Quality Committee
Operational
IPC Policy & Guidance Group
Senior Nurse Team Meeting
IPC Collaborative Meeting (CCG)
Infection Prevention & Control Team Meeting
IPC Link Meeting
Professional Nurse Leadership Forum
(PNLF)
HCAI Group (CCG)
October 2019

ANNEX D

Addressograph

NHS
York Teaching Hospital
NHS Foundation Trust

Decision to Admit: **Transfer/ward move from AMU/Cherry - *please tick***
Other Direct Admission area - *please state ward/area*

(Pilot) Version 2 - 09.10.19

Date & Time: ……

Transferring to appropriate clinical/speciality area? **YES / NO**

- **Any infection risk? YES/NO** (if yes please document in patient notes)

4AT SCORE

Transfer/Move Two: Please carefully consider this move before initiating

Date & Time: ……..

4AT SCORE

- **Reason for Transfer:**

  Downstream ward transfer □
  Outlying ward □
  Create Capacity □

- **Clinical exceptions :**
  Speciality area required □
  Critical care/Infection area required □
  (DATIX not required)

Transfer/Move Three: Please carefully consider this move before initiating and complete DATIX/WEB N……..

4AT

Date & Time: ……..

- **Reason for Transfer:**

  Downstream ward transfer □
  Outlying ward □
  Create Capacity □
  (Complete DATIX to Matron)

- **Clinical exceptions :**
  Speciality area required □
  Critical care/Infection area required □
  (DATIX not required)

Transfer/Move Four: Please avoid not fitting clinical requirements
DATIX/WEB N……..

Date & Time: ……..

4AT SCORE

Reason for Transfer: General Ward Transfer □ Outlying ward □ Create Capacity □
(Complete DATIX to Matron and document in medical notes rationale)

Clinical exceptions: Speciality area required □ Critical care/Infection area required □
(DATIX not required)

Rationale for introduction

- **Patients being moved bed areas/wards during a single in-patient stay is associated with a higher risk of falls, increased risk of confusion/hospital acquired delirium extended length of stay, complaints regarding adequate communication, risk of infection/spread of infection and poor patient experience.**
- **There is also an associated cost attached to moving patients impacting on the workload of our clinical and facilities staff.**

Infection Prevention

- **Before moving a patient, check CPD for Infection alerts.**
- **Do not move patients from wards experiencing an outbreak.**
- **Seek advice from the IPC Team if you are unsure of the patient's infection status.**

Frailty/Dementia

- **Any patient who has a diagnosis of Dementia, Confusion, on the Frailty pathway or at risk of Hospital Acquired Delirium should only ever be moved between the hours of 22.00 and 08.00 hrs, in a clinical exception or if no other patient is able to be moved (exception AMU)**
- **They should also never be moved unless deemed necessary under clinical exception. For example transfer to ICU, Surgical/Medical, Stroke or Coronary Care Unit.**

Clinical Exceptions

- **This would be a transfer to a specialist area, rehabilitation on Stroke Unit, Johnson Ward (rehabilitation, DTOC or Palliative care bed) or discharge of care to Malton or Whitby Hospital.**

ANY FURTHER WARD MOVES WILL NEED TO BE DISCUSSED FIRST WITH MATRON OR FLOW PRACTITIONER – DATIX TO BE COMPLETED AND RATIONALE DOCUMENTED IN NOTES.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Deprivation of Libery Safeguards in the Trust and next steps - Liberty Protection Scheme

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☐ **to support an engaged, healthy and resilient workforce**
☐ **to ensure financial sustainability**

Recommendation

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

Purpose of the Report

This report provides an overview of the Trust's management of Deprivation of Liberty Applications and the impact of the Mental Capacity Act (amendment) Bill.

Executive Summary – Key Points

- The remit of the Safeguarding Adults Team and their role
- Deprivation of Liberty Applications – a brief overview of the Trust's position and any identified risks
- Liberty Protection Scheme and the impact for the Trust.

Recommendation

The Board is asked to note the contents of this report as:

- Assurance of the management of the current Deprivation of Liberty applications
- And to note the potential impact of the Liberty Protection Scheme both strategically and operationally.

Author: Nicola Cowley

Director Sponsor: Heather McNair, Chief Nurse

Date: September 2019

1. Introduction and Background

The Trust's Safeguarding Adults Team provides safeguarding adults advice, support and administration for staff that suspect, know of or observe abuse of adults.

It also provides support and advice strategically and operationally to staff for the Mental Capacity Act, Prevent, Deprivation of Liberty Safeguards (DoLS), the PREVENT duty and caring for patients with Learning Disabilities.

The Named Nurse for Safeguarding Adults is responsible for ensuring senior level awareness in respect of the national, regional and local context.

One of the most important changes in 2018 was substantial reform and parliamentary time given for the Deprivation of Liberty Safeguards (DoLs) legislation.

This report outlines current operational processes and how the above will impact on our service.

2. Detail of Report and Assurance

2.1 Current Position

The Mental Capacity Act provides a legal framework to deliver care to patients lacking capacity to make specific decisions. In 2005, Deprivation of Liberty Safeguards were introduced (DOLS). The purpose of DOLS is to provide statutory safeguards that will render lawful any care delivered which may constitute a deprivation of liberty in our hospital.

In practice this means that where a patient lacks capacity, is subject to continuous supervision and control AND the person is not free to leave (Supreme Court 19/03/2014) the Trust is required to make an application to deliver care.

A deprivation of liberty application is in no way a negative. Making an application is assurance that staff delivering care are:

a) Acknowledging that a patient lacks capacity,
b) Recognising that a specific care delivery will/may deprive a patient of their liberty and
c) We (the Trust) are therefore legally authorised to deliver care which may deprive a patient of their liberty.

Examples of a Deprivation of Liberty could include the use of mittens, a nasal bridle or enhanced supervision (list not exhaustive).

Across the Trust there will be areas where there will be a "high expectation" of applications (such as older people's care). DOLS activity in these areas is monitored quarterly to ensure continued compliance and where gaps are identified targeted support is offered.

Once an application is made by a ward the Trust is authorised to deprive a patient of their liberty to deliver care for up to 14 days. Beyond 14 days must be authorised by the local authority.

The DoLs process continues to be impeded by the backlog of referrals requiring assessment once they reach the Local Authority. Both NYCC and CYC DoLS team have report delayed responses to applications.

This impacts the Trust's obligation to notify the CQC of approvals/cancellations of applications. The Trust CQC representative was informed of this challenge and has reported that it is a well-recognised national issue and noted to be beyond the Trust's control. However, due to the continued high demand the local authorities are unable to fulfil their assigned duties in respect of DoLS assessments

This situation is cited on the Safeguarding Adults Risk register.

2.2 Mental Capacity (Amendment) Bill

The Mental Capacity (Amendment) Bill was introduced in July 2018 and seeks to replace the current system known as 'Deprivation of Liberty Safeguards' (DoLS).

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

The reforms seek to:
•introduce a simpler process
•be less burdensome on people, carers, families and local authorities
•allow the NHS, rather than local authorities, to make decisions about their patients, allowing a more efficient and clearly accountable process.

Currently the local authority are the supervisory body for Deprivation of Liberty Applications, this means they are responsible for approving standard applications. Under LPS Supervisory Bodies are replaced with Responsible Bodies

If a patient is receiving care in hospital then the Trust will be the Responsible Body.

It is proposed that Trusts appoint "Hospital Managers" who will be responsible for assessment and authorisation; This involves:

- Authorisation conditions being applied
- Consultation with key people
- IMCA appointment where necessary
- Pre –authorisation review – replaces Best Interest Assessor roles
- Preparation of Draft authorisation record
- Authorisation and review

Authorisations can last for up to 12 months
A Code of Practice is expected at the end of the year with implementation anticipated in April 2020.

3. Next Steps

The Trust will need to identify who, within the organisation, will conduct assessments, which professionals will be responsible for monitoring and conducting reviews and how the Trust will demonstrate compliance with the CQC regulation.

Added to this would be:

Strategic and operational briefings
Training
Policy development/amendment and awareness raising

NHS England is party to the national Mental Capacity Act (MCA) Implementation Board and the Head of Safeguarding at NHS England has convened monthly working groups with system leaders to discuss the amendments within the Bill in readiness for legislative change. Locally the local authority Task and Finish group is available to partner agencies to ensure a consistent approach and will charged with developing the practicalities of embedding the new scheme.

Finally, it is essential that there is national commitment from all professional bodies to support implementation which in turn is cascaded through these bodies to support awareness.

The team will continue to update on this important change.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Perinatal Mortality Review Tool (PMRT) report Jan-Mar 2019

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☐ **to support an engaged, healthy and resilient workforce**
☐ **to ensure financial sustainability**

Recommendation

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

Purpose of the Report

To update the Board on learning from reviews using the PMRT

Executive Summary – Key Points

There is a national requirement for all cases of stillbirth and early neonatal death to have a multidisciplinary review using a standardized tool. This report is providing assurance to Trust board of compliance with this requirement and to inform the board of learning from cases.

Recommendation

For information only

Author: Sara Collier-Hield, Quality and Safety Matron. Maternity

Director Sponsor: Heather McNair, Chief Nurse

Date: 24 October 2019

1. Introduction and Background

The use of the National Perinatal Mortality Review Tool commenced January 2018 and has been embedded within the MDT Perinatal Mortality and Morbidity meetings at both York and Scarborough sites within York Teaching Hospitals NHS Foundation Trust.

A log is kept locally to ensure we meet the time frames outlined in the CNST standard below:

a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.
b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.
c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.
d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.

2. Detail of Report and Assurance

This report gives detail of all cases reviewed in quarter two of year 2019/20 and associated learning completed.

2.1 PMRT case detail

1.

Reason for PMRT: Intrapartum Stillbirth (Twin 1)
Date of death: 19.3.19
Gestation: 27 weeks 5 days
Maternal age: 34 years
Postmortem: No
Parents informed of review: Yes
PMRT draft report: 3.7.19

2.

Reason for PMRT: Intrapartum Stillbirth (Twin 2)
Date of death: 19.3.19
Gestation: 27 weeks 5 days
Maternal age: 34
Postmortem: No
Parents informed of review: Yes
PMRT draft report: 3.7.19

The mother booked her care at James Cook Hospital in Middlesborough. She was allocated as high risk in view of multiple pregnancy and IVF pregnancy. She had a low lying placenta on Twin 1.

The mother was on holiday at a caravan park when she had a significant ante-partum haemorrhage and was admitted to Scarborough General Hospital by ambulance. Care was given over a number of hours and then a plan was made to deliver the twins in view of the excessive maternal vaginal blood loss. The plan was to deliver by Caesarean section. Once in theatre, strong urges to push were felt and the mother was examined and found to be in labour. Spontaneous vaginal delivery occurred of twin one followed by twin two ten minutes later.

Attempts were made to resuscitate both the babies. There was an appropriate senior team in place to lead resuscitation of both babies, with Consultant presence. Resuscitation attempts lasted 18 minutes for twin 1 and 17 minutes for twin 2.
Whilst a post-mortem was not performed placental histology was carried out
Following the review and taking into account the information from the placental histology and other investigations the cause of death of twin 1 was determined to be: APH/ placental abruption/placenta praevia- Severe hypoxic ischaemia. The cause of death for twin 2 was determined to be: APH/ placental abruption - Severe hypoxic ischaemia.

Despite not having the results of a post-mortem the review panel are very confident about the cause of death. The review group identified care issues which they considered were likely to have made a difference to the outcome for the babies.

This case has also been a Trust Serious Investigation (SI). The SI report states there were two opportunities to deliver the babies earlier than they were. The PMRT review group feel there were 'issues which they considered were likely to have made a difference to the outcome for the baby' but there were 'no issues with care identified for the mother following confirmation of the death of her babies'.
Any future pregnancies would be considered high risk and would be managed through Consultant led care.

3.

Reason for PMRT: Late fetal loss at 23 weeks gestation
Date of death: 25.4.19
Gestation: 23
Maternal age: 37
Postmortem: Yes
Parents informed of review: Yes
PMRT completed report: 25.7.19

The mother was assessed as high risk at booking in view of BMI being raised (BMI 42). The root cause of the baby's death, after all the investigations, was marginal placental abruption. This was found on the placenta pathology. There were no issues found with the care provided in the antenatal period. If the mother was to consider a future pregnancy, she should endeavour to reduce her pre pregnancy weight. Serial scans would be offered from 24 weeks gestation and a consideration of whether aspirin should be taken during the pregnancy.

3. Next Steps

On-going PMRT cases in the review process:

Site	Date of death	Reason PMRT required
York	15.7.19	Term antenatal stillbirth, unbooked pregnancy
Scarborough	28.7.19	36 week antenatal stillbirth, booked at another Trust
Scarborough	6.10.19	36 week antenatal stillbirth

These cases will be included in future reports once reviews are fully completed.

4. Detailed Recommendation

The service will continue to review all cases and implement required changes from learning. A quarterly report will continue to be produced and submitted for Trust Board information, in compliance with requirements for Clinical Negligence Scheme for Trusts (CNST) criterion 1 section D.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 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	☒
For discussion	☒
For assurance	☐
For approval	☐
A regulatory requirement	☐

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 Standards

This is a follow up self-assessment; the previous return was submitted in June 2019. Following the previous submission, a standard operating procedure and dashboard of outstanding reviews was developed via a task and finish group, led by the Patient Safety Team on behalf of the Medical Director, and involving Care Group Directors. In addition, work continues to assess job plans in line with senior review.

The data captured in this report is from an audit undertaken during the period of the 21 – 28 October 2019, including all acute admissions. This was a different methodology to the last audit which included a sample of 116 patients; therefore it is not possible to use the previous data as a comparator.

The data was extracted from CPD using either Post Take Complete or Consultant Reviewed Awaiting Post Take being selected.

Results were as follows:
Standard 2 – non compliant
Standard 5 – compliant

Standard 6 – compliant
Standard 8 – compliant

The data was shared with Care Group Directors and Care Group Managers for validation purposes, along with the full 10 Clinical Standards for information and comment, specific to their service, in relation to performance and any planned improvements.

Recommendation

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

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

Director sponsor: Mr. James Taylor, Medical Director

Date: November 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.

Infection Prevention & Control

Consistency of Care

2. Key areas of work

2.1 Areas of frequent harm

2.1.1 ED long waits & 12 hour breaches

In response to the increasing number of patients experiencing long waits in ED, a stakeholder meeting has taken place to review the level of care delivered to this group of patients and the 72 hour report that is completed for each 12 hour breach.

The group has agreed a number of actions and progress against these will be reported to Quality Committee in due course.

2.2 Consistency of Care

2.2.1 Patient Safety Walk rounds

There were 8 Patent Safety Walk rounds during September and October attended by members of the Patient Safety team, Governors, Non-Executive Directors and the Trust Chair. Those areas visited were Chestnut, Duke of Kent, Maple, Mortuary SH, Stroke, White Cross Court, Ward 26 and the new endoscopy unit.

Summary of learning includes:

Staffing – More support for staff when dealing with aggressive patients, consideration to be given to the risks and mitigations for bank HCAs to perform observations. Lack of availability of nurse uniforms. Some of these are Trust wide issues and are under discussion.

Environment – Issues in relation to the environment and facilities were highlighted in six out of the eight areas visited, areas of concern have been escalated to the facilities and states department to ensure these are captured on the capital programme. These included: outdated call bell systems; general layout of some areas with inappropriate flooring; and lighting for patients at risk of falls. Concerns were raised from White Cross Court in relation to a lack of a security system making staff feel vulnerable out of hours with this being a nurse led unit and away from the main hospital site.

Refurbishment of the Scarborough mortuary is on the capital plan with a business case in development for a temporary store. Quotes are being requested for improvement of the viewing area and relatives room through charitable funds and this is to remain a priority on the board agenda and will be closely monitored.

Stroke unit were keen to develop an area to reflect rehabilitation, it was suggested funding be sought from the charitable funds committee. The area felt calm, clean and organised and it was felt that patient experience was good.
Both Maple and Ward 26 felt calm and tidy, Maple being spacious and clean with good storage facilities which can pose a challenge for a lot of areas.

With the implementation of Care groups, feedback will be provided to the care group managers in relation to the risks, findings and recommendations from the Patient Safety walk rounds. The care group managers will provide actions and assurance and an update on actions will be presented to Quality Committee.

2.2.2 Patient Safety Group

The minutes of the Patient Safety Group meeting in September are available in Appendix A.

2.2.3 Seven Day Services (7DS)

This is a follow up self-assessment; the previous return was submitted in June 2019. Following the previous submission, a standard operating procedure and dashboard of outstanding reviews was developed via a task and finish group, led by the patient safety team on behalf of the Medical Director, and involving Care Group Directors. In addition, work continues to assess job plans in line with senior review.

The data captured in this report is from an audit undertaken during the period of the 21 – 28 October 2019, including all acute admissions. This was a different methodology to the last audit which included a sample of 116 patients; therefore it is not possible to use the previous data as a comparator.

The data was extracted from CPD using either Post Take Complete or Consultant Reviewed Awaiting Post Take being selected.

Results were as follows:
Standard 2 – non compliant
Standard 5 – compliant
Standard 6 – compliant
Standard 8 – compliant

The data was shared with Care Group Directors and Care Group Managers for validation purposes, along with the full 10 Clinical Standards for information and comment, specific to their service, in relation to performance and any planned improvements.

The full report is available in Appendix B and C.

2.2.4 National Ophthalmology Database Audit

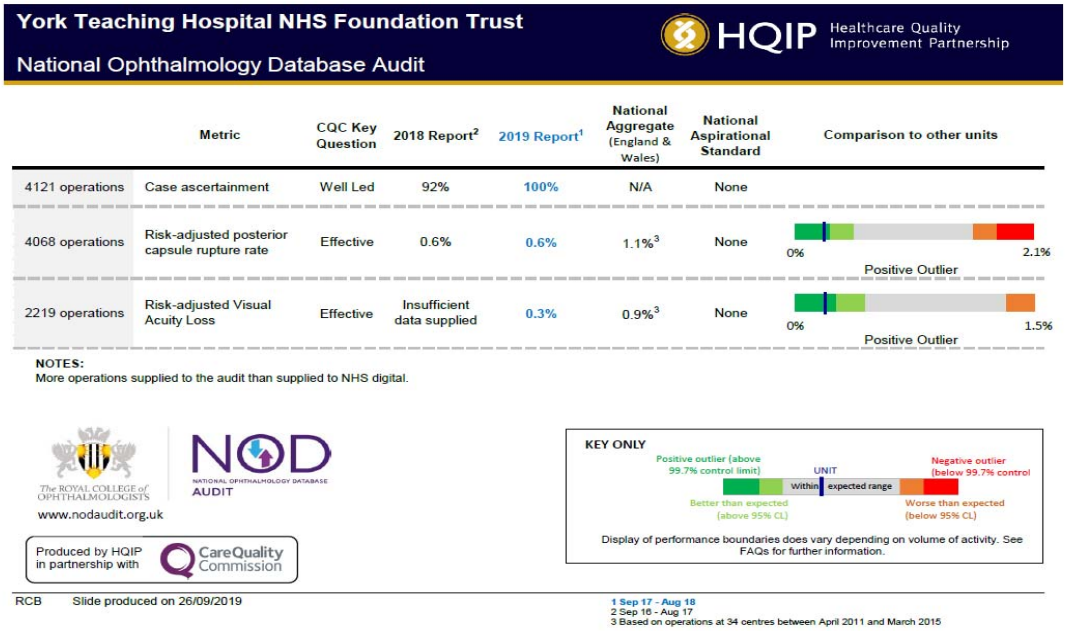
Cataract surgery remains the most frequently undertaken NHS surgical procedure with approximately 414,000 cataract operations undertaken in England and 20,000 in Wales during 2017-2018.

The current report documents prospectively collected cataract surgery data and reports results for named NHS centres. These include operations performed and recorded by all surgeons of all grades within centres.

Two primary indicators of surgical quality are audited. These are, firstly, a complication that happens during surgery when the capsule that holds the lens is broken (the index surgical intraoperative complication of significant breach of the lens-zonule barrier through rupture of the posterior lens capsule or vitreous prolapse or both, abbreviated as PCR), and secondly Visual Acuity (VA) Loss (doubling or worse of the visual angle) related to surgery. These outcomes are presented as risk adjusted rates for centres, supported by relevant contextual information including surgical volumes, data completeness, case complexity, access to surgery and deprivation.

Included in this third prospective report are operations undertaken between 1 September 2017 and 31 August 2018.

The results for the Trust are presented below.



York Teaching Hospital NHS Foundation Trust

National Ophthalmology Database Audit

HQIP Healthcare Quality Improvement Partnership

	Metric	CQC Key Question	2018 Report[2]	2019 Report[1]	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other units
4121 operations	Case ascertainment	Well Led	92%	100%	N/A	None	
4068 operations	Risk-adjusted posterior capsule rupture rate	Effective	0.6%	0.6%	1.1%[3]	None	0% 2.1% Positive Outlier
2219 operations	Risk-adjusted Visual Acuity Loss	Effective	Insufficient data supplied	0.3%	0.9%[3]	None	0% 1.5% Positive Outlier

NOTES:
More operations supplied to the audit than supplied to NHS digital.

The Royal College of Ophthalmologists
NOD National Ophthalmology Database Audit
www.nodaudit.org.uk

Produced by HQIP in partnership with CareQuality Commission

KEY ONLY
Positive outlier (above 99.7% control limit) | UNIT | Negative outlier (below 99.7% control)
Within expected range
Better than expected (above 95% CL) | Worse than expected (below 95% CL)
Display of performance boundaries does vary depending on volume of activity. See FAQs for further information.

RCB Slide produced on 26/09/2019

1 Sep 17 - Aug 18
2 Sep 16 - Aug 17
3 Based on operations at 34 centres between April 2011 and March 2015

The full report can be found at:
https://www.hqip.org.uk/wp-content/uploads/2019/09/Ref-110-NOD-Audit-Annual-Report-2019-FINAL.pdf

2.2.5 Medication Safety Strategy update

The use of medicines is the most common type of healthcare intervention. Most medicines are used safely and effectively, but sometimes errors occur that can lead to harm to patients. By identifying areas of particular risk, NHS organizations and healthcare professionals can take action to significantly improve the safety of patients receiving and taking medicines.

The Trust's Medication Safety Strategy was updated in November 2017 and aims to improve medication safety across 5 themes:-

1. Improving reporting and learning from medication incidents
2. Reducing harm from high risk medicines
3. Ensuring support for safe and secure use of medicines
4. Learning from and contributing to the national medication safety agenda
5. Creating a culture of medication safety within the trust, encompassing the entire multidisciplinary team, and patients

An action plan for 2019 was developed, based on the above strategy, which is owned by the Medication Safety Group and monitored by the Medicines Management Group.

The full report is available in Appendix D.

2.2.6 Lead Healthcare Scientist

The Healthcare Science (HCS) Workforce provides the scientific backbone of NHS and Public Health services, working across Laboratory Sciences, Physiological Sciences, Bioinformatics, Medical Physics and Clinical Engineering. This 50,000 strong workforce underpins 80% of diagnoses and makes a direct contribution to patient care.

Professor Sue Hill, Chief Scientific Officer and her team wrote to all Medical Directors in 2016 highlighting the importance of local Healthcare Science leadership in pushing forward the Long Term Plan and developing professional capability and capacity to deliver whole system change.

The Healthcare Science workforce in York NHS Foundation Trust has developed both local and regional networks in order to move forward cohesively on important changes such as education and training, new ways of working and scientific innovations, but we lack the strategic leadership a nominated Organisational Lead Scientist (OLS) would give both feeding into the national network of HCS leads, and driving change initiatives at board level.

The HCS network group recommends the appointment of an Organisational Lead Scientist aligned to the Medical Director, to ensure safe and effective scientific operational delivery, and ensuring the priorities of the Long Term Plan and the more recent Interim NHS People Plan are delivered.

A paper outlining the proposed benefits of this role is available in Appendix E.

2.3 Learning from death

2.3.1 Medical Examiner Role

The purpose of the Medical Examiners Service is:-

1. To assist the treating medical team (TMT) to complete an accurate medical certificate of cause of death (MCCD).
2. Ensure prompt and accurate Coroner's referral where needed.
3. To ensure carers have the opportunity to comment on the care provided.
4. To ensure carers have clear information about the MCCD and what it means.
5. Identify any governance concerns or opportunities for quality improvement.
6. To uncover any criminal activities.
7. Public Health surveillance to detect any recurrent themes in mortality locally.

There will need to be a number of Medical Examiners (MEs) covering the York and Scarborough sites but there also needs to be a system for other small sites. The Royal College of Pathologists has run a number of pilot sites around the country and their experience indicates a need for 10 PAs of medical time per 3000 deaths, but this includes support of Medical Examiner's Officers (MEOs) and does not factor in multiple sites.

Scrutiny of medical notes is estimated to take a mean of 15 minutes each. MEOs can undertake some duties of the ME by careful delegation and will be particularly useful in ensuring the most efficient use of medical staff time.

For a summary of the implementation plans for the ME service, please see Appendix F.

3. Recommendation

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

APPENDIX A

York Teaching Hospital NHS Foundation Trust

MINUTES

Title:	**Patient Safety Group**
Date:	Tuesday 17th September 2019
Time:	08:00 – 09:30
Location:	Ophthalmology Seminar Room, York Hospital with VC to Cedar Room, Scarborough Hospital
Chairing:	Becky Hoskins (BH)
Attendees:	Vicky Mulvana-Tuohy (VM), Donald Richardson (DR), Helen Holdsworth (HH), Ed Smith (ES), Fiona Jamieson (FJ), Chris Foster (CF), Jonathan Thow (JTH)
Apologies:	Neil Todd, Helen Noble

No	Item/Discussion	Lead for actions
1.	**Apologies**	
	BH welcomed everyone to the meeting and gave apologies as above.	
2.	**Notes from the meeting held on 16th July 2019 and Matters Arising**	
	The minutes from the 16th July 2019 meeting were agreed as an accurate record. **SI research programme** – FJ informed the group WL is completing a PHD on root cause analysis in investigation. **Fall sensor look back report** – BH has sought the view of the new Chief Nurse Heather McNair asking for her opinion on fall sensors, waiting for a reply. **Calculating the risk score for mortality** – DR informed the group this system is currently been tested and will then be turned on behind the scenes to gather a months' worth of data by colleagues on AMB and Critical Care. **Central Alert System Policy** – FJ informed the group she is adding a paragraph informing staff which areas need to feed back to.	
3.	**SI Trends and Learning (Standing Item)**	
	During the past 12 months there have been 169 SI's declared. The 169 SI's were for the following categories: • 22 x falls • 32 x pressure ulcers • 115 x clinical of which 38 were due to 12 hour trolley waits The themes recognised from the SI's are; • Delays in reporting • Capacity issues • Missed diagnosis	

	• Suboptimal care • Deteriorating patient Items of learning identified are: • Lung cancer pathway – work ongoing • Communication • Staff do not feel empowered to seek help when escalating; this has been identified through a number of SI's. BH informed the group the Trust are waiting for feedback were the focus needs to be following the interviews with Judith Dyson. Never events have been occurring on local procedures outside of theatres for example in Dermatology. Not all patients have a senior review within 14hours, this is been addressed through the seven day service group. There is an SOP been developed working with the Care Group Directors. Going forwards there is going to be a dashboard showing the number of patients that require a senior review There was a discussion regarding patients in Scarborough waiting 5-6 hours to be assessed which is a risk and one that is getting worse over time. Yesterday there were a couple of sepsis cases which were delayed. There was a conversation regarding how the Trust measure improvements following SI's. FJ suggested going forwards each Care Group are asked to look at positive outcomes from their SI's. BH suggested a review of the SI action plans over the past 6 months to identify big system changes. There was also a discussion that the Trust should be more pragmatic regarding the number of recommendations to ensure they are delivered in a timely manner, it was suggested 3 recommendations per case.	
4.	**Clinical Guidelines (Standing Item)**	
	There are 1230 clinical guidelines of which 6% are out of date. There are 179 corporate guidelines of which 9% are out of date. CF informed the group there is an issue regarding the HR Corporate Documents that are out of date due to the number of routes they need to be approved by, this has been escalated to the Director of HR, no response yet received. HR have been offered an extended deadline and going forwards it has been agreed they will receive one year's notice that the document is due to be reviewed to give them the opportunity to get it approved through all the routes. There was a discussion that within each Care Group the Clinicians need to agree what clinical documents they need and take ownership of them. CF stated the RR carried out an analysis of the gap in clinical documents it was agreed BH, RR and CF will meet to discuss this further.	**BH to organise a meeting to discuss the clinical document gaps.**
5.	**Telemetry Activity Audit**	
	The telemetry activity audit is a request following the CQC visit and is been carried out on CCU at Scarborough Hospital, the CQC raised concerns over staffing levels. The Trust must report weekly to the CQC the audit results and staffing levels.	

	FJ clarified Cherry, CCU (SGH), Lilac and Beech must send to her each week; the number of patients on telemetry daily, the machine they are on and the log number of the machine and they must also send the number of patients on NIV and non NIV level 2 patients, the ward they are on, bed number and appropriate log number. Currently Beech Ward are trying to cohort NIV patients in one bay however due to bed occupancy this is not been achieved. There was a discussion that telemetry is driven by the lack of bed space on CCU which is the culture and NIV is a clinical risk.	
6.	**Hoverjacks**	
	BH informed the group there are no hoverjacks on site at Bridlington Hospital since there hoverjack was sent to be fixed. The hoverjack was decommissioned and has never been replaced. Work is ongoing to replace hoverjacks across the Trust – document attached.  SBAR Hoverjacks...docx	
7.	**Patient Information Leaflets – EIDO trial**	
	EIDO Healthcare is an online library of patient information leaflets which the Trust has signed up to a free trial to access the leaflets. An email will be circulated to colleagues informing them of this library of leaflets and how to access them. Susan Manktelow will help support the process and monitor the usage. BH explained the licence is costly to buy, 120 titles would cost £20,000 per year.	
8.	**LOCSSIPs**	
	There was nothing to update.	
9.	**ANTT & VIP Scores**	
	There is a focus to train all Junior Doctors of grade F2 and above on ANTT however this has been challenging due to doctors rotations. There have been discussions regarding holding simulation training but the Clinical Skills Team do not have the capacity to facilitate this. BH explained we are now looking into how the Clinical Educators could be involved. It has been identified there is a gap in staffs knowledge of VIP scoring, the company is providing visuals aids to help improve this.	
10.	**Items to escalate to Board of Directors (Standing Item)**	
	It was agreed JT will escalate the following items to the Board of Directors; • SI trends and learning • NIV at Scarborough – not able to comply with regulations due to the lack of capacity and beds.	
11.	**Sub Group Action Logs** **Papers circulated with the agenda** • **Alcohol Steering Group**	

	• **Blood Transfusion Group** • **Clinical Ethics Group** • **Deteriorating Patient Group** • **Falls CQUIN** • **Falls Steering Group** • **Medicines Management Group** • **Mortality Steering Group** • **Pressure Ulcer Steering Group** • **Safeguarding Adults Governance Group** **For Information:** • **Deconditioning Group –** will recommence in October 2019. • **Scarborough Obstetrics and Gynaecological Governance Group –** No update since the July meeting, next meeting on Tuesday 17th September.	
	Deconditioning Group There was a trip to Nottingham to look into how they categorise their level of harms. The deconditioning group need to look into linking SAFER into the deconditioning training. **Medicines Management Group** Funding has still not been found to purchase patient's own drug lockers, the Chief Pharmacist is going to escalate the significant risk to patient safety to the Chief Executive.	
12.	**Any Other Business**	
	There were no items to discuss under any other business.	

Next Meeting	
Date & Time:	Tuesday 19th November 2019, 08:00 – 09:30
Location:	VC – Ophthalmology Seminar Room (York) & Cedar Room (Scarborough)

APPENDIX B

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
7 Day Services-Self Assessment

Trust Strategic Goals:

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

Recommendation

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

Purpose of report

This paper is to provide a self-assessment of the Trusts performance against 7 day services standards

Executive Summary - Key Points

This report provides a self-assessment of the 4 key Clinical standards as defined by NHSI. It provides a brief overview of performance against a number of other standards. Ongoing audit of 7 day service standards is required bi- annually.

Recommendation

Quality Committee is asked to note this self-assessment

Author: Mrs. Helen Noble, Head of Patient Safety

Director sponsor: Mr. James Taylor, Medical Director

Date: November 2019

1. Introduction and Background

This is a follow up self-assessment; the previous return was submitted in June 2019. Following the previous submission, a standard operating procedure and dashboard of outstanding reviews was developed via a task and finish group, led by the patient safety team on behalf of the Medical Director, and involving Care Group Directors. In addition, work continues to assess job plans in line with senior review.

2. 7 Day Services Self-Assessment

The data captured in this report is from an audit undertaken during the period of the 21 – 28 October 2019, including all acute admissions. This was a different methodology to the last audit which included a sample of 116 patients; therefore it is not possible to use the previous data as a comparator.

The data was extracted from CPD using either *Post Take Complete* or *Consultant Reviewed Awaiting Post Take* being selected.

The data was shared with Care Group Directors and Care Group Managers for validation purposes, along with the full 10 Clinical Standards for information and comment, specific to their service, in relation to performance and any planned improvements.

2.1 Clinical Standard 2

All acute admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, within 6 hours wherever possible, but at the latest within 14 hours from the time of admission to hospital.

The following compliance rates for Post take/Senior review within 14 hours on both sites were as follows:

Trust weekday	72.4%
Trust weekend	60.1%
OVERALL	69.5%
Care Group 1	
Weekday	83.3%
Weekend	64.8%
OVERALL	77.9%
Care Group 2	
Weekday	64.9%
Weekend	50.0%

OVERALL	61.7%
Care Group 3	
Weekday	66.2%
Weekend	53.6%
OVERALL	63.9%
Care Group 4	
Weekday	71.4%
Weekend	NA
OVERALL	71.4%
Care Group 5	
Weekday	78.7%
Weekend	28.6%
OVERALL	73.5%
Care Group 6	
Weekday	48.2%
Weekend	76.2%
OVERALL	59.1%

2.2 Clinical Standard 5

Hospital in patients must have scheduled seven day access to diagnostic services, typically ultrasound, computerized tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant directed diagnostic tests and completed reporting will be available seven days a week:
Within 1 hour for critical patients
Within 12 hours for urgent patients
Within 24 hours for non-urgent patients

- Radiology-York site has scheduled seven day access for x-ray plain film, CT and Ultrasound for inpatients. Whilst Scarborough site has seven day access for both x - ray plain films and CT. Neither site currently provides seven day access for MRI. However there is network agreement with Hull for out of hours critical patients e.g. suspected Cauda Equine. Whilst access is available across seven days, this does not necessarily mean there is always sufficient capacity.

- Between the hours 9.00 – 17.00 Monday to Friday, there is a dedicated Duty Radiologist scheduled for cross site provision. In addition, between these hours there are scheduled sessions for Consultant Radiologists to report both CT and MRI inpatient scans across both sites. Between 17.00 and 9.00, Radiologist cover is

provided on an on call basis, either by an in house Radiologist, or by a third party outsourcing company.

- Microbiology- Main service gap is failure to incubate blood cultures bottles within 4 hours of them being taken overnight. Clinical advice is available 24/7 on a category A on-call rota.

- Echocardiography-There is a 9-5 service Monday – Friday provided by the cardio-respiratory department, at all other times patients requiring urgent echocardiography are seen by the on call consultant cardiologist.

- Endoscopy/ ERCP services and more importantly the management of biliary sepsis is being discussed at length in Surgery including availability of Upper GI specialist surgeons at both sites, transfer issues, and increased ERCP capacity). Saturday/Sunday - Critical acute bleed patients at Scarborough are transferred to York (formal networked arrangement) after discussion between the referring doctor and the on call York Gastroenterologist. This means there is provision for critical patients over the weekend however there is currently no provision of inpatient endoscopy for Urgent/Routine patients. An audit of inpatient referrals is being undertaken and the results of the audit will help shape where improvement can be made with the wait times for inpatients requiring an endoscopy procedure.

2.3 Clinical Standard 6

Hospital in patients must have 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols.

- Access to Interventional Radiology is available 24/7. Out of “normal hours” this is provided on an on call basis at York site only, with patients being transferred from Scarborough to York if deemed appropriate.

- Critical, Urgent and Routine patients have access to endoscopy within the recommended timescales. Routine inpatient referrals into endoscopy are triaged and scheduled according to clinical urgency. Where appropriate they are referred for their test as an outpatient instead.

- The endoscopy service is available to critical inpatients 24 hours a day, 7 days a week via an out of hours on call service. Saturday/Sunday - Critical acute bleed patients at Scarborough are transferred to York (formal networked arrangement) after discussion between the referring doctor and the on call York Gastroenterologist. This

means there is provision for critical patients over the weekend however there is currently no provision of inpatient endoscopy for Urgent/Routine patients.

- Renal replacement therapy-Dialysis is offered 24 hours a day, 7 days a week on the York site. Patients requiring dialysis in Scarborough are transferred where appropriate or in some cases stabilised with hemofiltration on ICU prior to transfer.

2.4 Clinical Standard 8

All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The following data was captured during the week of the audit by the Patient Safety team who visited high dependency areas. Patients were identified and confirmed as needing daily / twice daily review by nursing staff.

Trust

Weekday once daily reviews	94%
Weekend once daily reviews	100%
Weekday twice daily reviews	94%
Weekend twice daily review	91%

Care Group 1

Weekday once daily reviews	94%
Weekend once daily reviews	100%
Weekday twice daily reviews	50%
Weekend twice daily review	100%

Care Group 2

Weekday once daily reviews	100%
Weekend once daily reviews	N/A
Weekday twice daily reviews	80%
Weekend twice daily review	0% (1 patient)

Care Group 3

Weekday once daily reviews	100%

Weekend once daily reviews	100%
Weekday twice daily reviews	95%
Weekend twice daily review	100%

3. Next Steps

This self-assessment will be submitted to NHSI for external publication.

Care group directors are required to:

- Agree improvement trajectories with directorate teams
- Establish mechanisms at directorate level to monitor compliance with standard 2 and establish escalation processes if the standard is not being met
- Establish robust assurance processes to ensure compliance and improvement as part of care group governance
- Ensure workforce requirements meet the expectations of delivery of 7 day services

4. Recommendations

Quality Committee is asked to note this self-assessment

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Organisationally the compliance rate for consultant review within 14 hours of admission as recorded in the core patient database was 72.4% during the week and 60.1% on a weekend. .There is variation in performance between care groups. Care group 1-weekday 83.3%,weekend 64.8% Care group 2-weekday 64.9%,weekend 50% Care group 3 -weekday 66.2%,weekend 53.6% Care group 4-weekday 71.4%,weekend N/A Care group 5 -weekday 78.7%,weekend 28.6% Care group 6 -weekday 48.2%,weekend 76.2%	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
	Overall compliance across the 7days from all diagnostic services.	Echocardiography	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available off site via formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Overall compliance across the 7 days from all key consultant directed interventions.	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients deemed high dependency receive a daily review by a consultant at which time a clear pathway of care is agreed.Those requiring twice daily review are often seen by a Senior Registrar following an agreed pathway of care. If the situation arises whereby the patient deteriorates or requires further intervention,a consultant is available 24 hours a day ,7 days a week. Compliance with this standard is: Trust-weekday once daily review 94%,weekend once daily review 100% Trust-weekday twice daily review 94%,weekend twice daily review 91%	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Clinical Standard 1- 89% of respondents to the National inpatient survey felt that they were treated with respect and dignity whilst they were an inpatient. Clinical Standard 3-MDT Review.A review of SAFER principles is being established. Currently undertaking a scoping exercise to determine the provision of consultant led ward rounds across all inpatient areas. Clinical Standard 4-Shift handovers. Handover amongst doctors varies between specialities and across sites due to the differences in out-of-hours cover. In York and Scarborough out-of-hours cover for all General Medical and Elderly Medicine wards are provided by one team who are also responsible for acute admissions. There is a designated time and place for handover between the 'on-call' team. There is currently no electronic medical handover although this is being addressed as part of a large scale review into out-of-hours care. Nursing handover is generated electronically with all wards having at least twice daily handover. Clinical Standard 7-Mental Health Services.York ED has 24/7 Mental health liaison service in situ .Mental health services in Scarborough are only provided by Liaison Psychiatry 5 days a week, approx. 9-5. Clinical Standard 9-Transfer to Community,Primary and Social care.Community hospitals provide a range of healthcare facilities and resources based in the community and designed to meet the needs of local people. District nursing teams, Community response teams have access to GPs, in hours through the GP practice of the patient and out of hours for advice and support through the local provider vocare. Transfers happen 24/7 and the trust has a contract with transport services for this . Clinical Standard 10-Quality Improvement.The Trust approach to QI is to continually develop capability and capacity across all disciplines at all levels. The leaders of improvement programme is underway with cohort 1.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Full compliance for the urgent clinical network services across 7 days.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

APPENDIX D

York Teaching Hospital NHS Foundation Trust

Board of Directors – 27 November 2019
Medication Safety Strategy Update

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

To update the Committee with progress with the Trusts Medication Safety Strategy

Executive Summary – Key Points

This report provides the Committee with an update on progress with the Medication Safety Action Plan, which is based on the Trust's Medication Safety Strategy, and provides details for planned work during the next Quarter

Recommendation

The Committee is asked to note the contents of the report, be assured of progress with the Medication Safety Action Plan and to continue to support the work of the Medication Safety Team.

Author: Helen Holdsworth, Deputy Chief Pharmacist/Medication Safety Officer

Director Sponsor: Mr. James Taylor, Medical Director

Date: November 2019

1. Introduction and Background

The use of medicines is the most common type of healthcare intervention. Most medicines are used safely and effectively, but sometimes errors occur that can lead to harm to patients. By identifying areas of particular risk, NHS organizations and healthcare professionals can take action to significantly improve the safety of patients receiving and taking medicines.

The Trust's Medication Safety Strategy was updated in November 2017 and aims to improve medication safety across 5 themes:-

1. Improving reporting and learning from medication incidents
2. Reducing harm from high risk medicines
3. Ensuring support for safe and secure use of medicines
4. Learning from and contributing to the national medication safety agenda
5. Creating a culture of medication safety within the trust, encompassing the entire multidisciplinary team, and patients

An action plan for 2019 was developed, based on the above strategy, which is owned by the Medication Safety Group and monitored by the Medicines Management Group.

2. Quarter 1 & 2 update

Progress against the action plan for Quarter 1 and 2 is detailed below.

2.1 Improving reporting and learning from medication incidents

- Established a process to review and share learning from pharmacy medicines reconciliation and clinical validation errors. A clinical error group meets monthly and there is feedback of learning for Pharmacists and Medicines Management Technicians.

- Work continues on the use of SPC charts to identify priorities for learning from and reducing harm from medication incidents. Our initial findings were presented at the Microsystems Coaching Academy conference in Sheffield and at the regional Medication Safety Officers meeting.

2.2 Reducing harm from high risk medicines and processes

- <u>Demonstrating on going compliance with old NPSA/NHSI alerts.</u>
  We have developed an action plan and prioritized the 69 alerts. The initial phase has focused on the 5 alerts associated with never events. We have identified areas of non-compliance and have developed audit and training strategies. Work on the priority 2 alerts has been put on hold whilst an audit tool is developed.

- A tool to prompt medication review in patients at risk of falls has been developed and piloted on Holly ward and Ward 35. Whilst the tool is beneficial, the challenge is in encouraging medical staff to use it. When pharmacy staff were present on the ward round over 95% of medicines were reviewed with 50% of these either been stopped or the dose been reviewed. However when pharmacy staff are not present the tool is either not used, or not all the medication is documented as reviewed.

- A survey of junior doctors about prescribing and monitoring of Gentamicin has raised concerns about their knowledge and skills in this area. Additional training sessions have occurred at and the results fed back to the antimicrobial stewardship team to be incorporated in future training.

- Following an SI/Never event where Oramorph was administered via the intravenous route a task and finish group has been set up to review equipment available and training for oral and EnFit syringes.

2.3 Ensuring support for safe and secure use of medicines

- A training strategy has been developed to provide assurance that all staff are aware of the 5 NPSA alerts associated with never events. Work to develop training resources has commenced.

- A new prescription and monitoring form for Iloprost has been approved, supporting staff when prescribing and administering this drug.

- Commissioned an internal audit report on the safe and secure handling of medicines within the Trust

2.4 Learning from and contributing to the national medication safety agenda

- There have been 2 meetings of the Yorkshire and Humber MSO network (chaired by York's MSO) This has allowed for learning to be shared amongst Trusts. A regional approach to the WHO Medication Safety Challenge has been discussed. Regional medication safety bulletins are been developed with the launch of yellow card reporting planned for November.

2.5 Creating a culture of medication safety within the trust, encompassing the entire multidisciplinary team, and patients

- The MSO has been invited to attend the Trust SI group.

- Medication Safety/Governance reports are been developed and piloted within Care Group 2, these focus on incidents, SIs, medicines shortages, PGDS,

complaints and claims. If successful these will be rolled out to the other Care Groups.

3. Next Steps

The Medication safety strategy is due for review and will be updated to take into consideration new national initiatives including WHO Medication Safety Challenge technical reports, HSIB reports and the new national Patient Safety Strategy.

Planned activities for Quarter 3 are detailed below:-

Improving reporting and learning from medication incidents

- Continue the work with SPC charts to identify and focus on areas for improvement projects.

Reducing harm from high risk medicines and processes

- Following the approval of the business case for Pharm Outcomes, a system to facilitate transfer of information to community pharmacies on discharge, we will work with IT to integrate Pharm Outcomes with our IT systems and develop guidance for pharmacy staff as to when and how to use Pharm Outcomes.

- Explore further options to prompt medication review in patients at risk of falls to support the falls CQUIN.

Ensuring support for safe and secure use of medicines

- Develop training resources to ensure staff are aware of their responsibilities with regard to medication related never events and consider ways to promote these.

- Act on any recommendations from the internal audit report on safe and secure handling of medicines

- Take action on recommendations from the CQC report relating to medicines use, mainly management of Patient Group Directions and temperature monitoring of medicines storage area

- Support improvements to EPMA to enable prioritization of patients on high risk medicines

Learning from and contributing to the national medication safety agenda

- Participate in yellow card awareness week, 25th to 29th November. Planned activities include stands in reception to promote awareness amongst patients and

stands outside the canteen and ward visits to raise awareness between medical and nursing staff.

Creating a culture of medication safety within the trust, encompassing the entire multidisciplinary team, and patients

- Roll out the Medication Safety/Governance reports to the other Care Groups.
- Explore the possibility of replicating the Medication Safety Technician role in Pharmacy at York Hospital.

4. Detailed Recommendation

The Committee is asked to note the contents of the report, be assured of progress with the Medication Safety Action Plan and to continue to support the work of the Medication Safety Team.

APPENDIX E

York Teaching Hospital NHS Foundation Trust

Board of Directors – 27 November 2019
Healthcare Science Report

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

To highlight the benefit of an Organisational Lead Scientist (OLS) and seek support to appoint an OLS for the Trust

Executive Summary – Key Points

- The Chief Scientific Officer (CSO) is working on embedding a national leadership infrastructure of Organisational Lead Scientists across every provider Trusts in England. There is currently 72% coverage. In order to ensure integration across STPs and ICSs, to embed clinical leadership capability and capacity across the system 100% coverage is encouraged
- The OLS are senior scientists who represent all healthcare science (HCS) specialisms within the organisation they provide leadership, input, advice and expertise into regions, STPs and emerging ICSs and impact on service model development particularly within primary and community care
- The Trust's HCS network seeks support from the Medical Director to appoint an OLS, either as a shared role, or individual.

Recommendation

The HCS network group recommends the appointment of an Organisational Lead Scientist aligned to the Medical Director, to ensure safe and effective scientific operational delivery, and ensuring the priorities of the Long Term Plan and the more recent Interim NHS People Plan are delivered.

Author: Joanne Horrocks (on behalf of HCS network group)

Director Sponsor: James Taylor, Medical Director

Date: November 2019

1. Introduction and Background

The Healthcare Science (HCS) Workforce provides the scientific backbone of NHS and Public Health services, working across Laboratory Sciences, Physiological Sciences, Bioinformatics, Medical Physics and Clinical Engineering. This 50,000 strong workforce underpins 80% of diagnoses and makes a direct contribution to patient care.

Professor Sue Hill, Chief Scientific Officer and her team wrote to all Medical Directors in 2016 highlighting the importance of local Healthcare Science leadership in pushing forward the Long Term Plan and developing professional capability and capacity to deliver whole system change.

The Healthcare Science workforce in York NHS Foundation Trust has developed both local and regional networks in order to move forward cohesively on important changes such as education and training, new ways of working and scientific innovations, but we lack the strategic leadership a nominated Organisational Lead Scientist (OLS) would give both feeding into the national network of HCS leads, and driving change initiatives at board level.

2. Detail of Report and Assurance

Healthcare Science representatives from each strand of HCS (i.e. Life Sciences, Physical Sciences and Physiological Sciences) meet up on a quarterly basis to discuss and address local and regional issues within Healthcare science

Feedback from a regional network meeting has highlighted the work of the Shelford group of Healthcare Scientists (from best performing hospitals), and lead by Angela Douglas, Deputy CSO. The Shelford group would like to engage with all Trust Lead HCS. Currently York has no OLS so is excluded from contributing to national initiatives. Angela Douglas is very keen to support Trusts to appoint a Lead Scientist and has shared a document highlighting the benefits of this role (attached – appendix 1)

The local network has discussed how the recent change in the Trust management structure from directorates to care groups may give an opportunity to revisit the possibility of appointing a Lead Scientist– either as a shared role, or individual.

3. Next Steps

If the Medical Director is supportive appointing an OLS, the HCS network group would be able to work with him to facilitate appointing to this role.

4. Detailed Recommendation

The HCS network group recommends the appointment of an Organisational Lead Scientist aligned to the Medical Director, to ensure safe and effective scientific operational delivery, and ensuring the priorities of the Long Term Plan and the more recent Interim NHS People Plan are delivered.

Appendix 1 Benefits of Organisational Lead Scientists

The Opportunity and Challenge

Healthcare scientists and the clinical services they lead encompass over fifty areas of scientific and clinical expertise covering 150 service areas of pathology and laboratory science inclusive of genomics and embryology, physiological sciences, computer science and bioinformatics, medical physics and clinical engineering. The workforce undertakes over a billion diagnostic and scientific investigations, interventions and analyses a year, inclusive of blood tests, cardiac, respiratory and hearing testing and ensuring the planning and safety of multimodality imaging and radiotherapy through to specialist interventions including whole genome sequencing, proton beam and CAR-T therapy. The results of which impact 3 in 4 clinical decisions in the patient journey. This is a digitally enabled, technologically driven, agile workforce that operates at the limits of innovative science bringing the highest levels of scientific and technological knowledge and skill to improve quality and safety, save lives and improve health outcomes. Currently most services are based in secondary care organisations with limited direct provision in primary and community care.

To ensure the priorities of the LTP, and that we are continuing to expand the frontiers of medical science and innovation, introducing new treatment possibilities that a modern health service should rightly be providing (for example, new cell and gene therapies and genomics), which would enable

- disease risk to be assessed sooner
- screening for disease to happen before symptoms occur
- health or environmental threats to be identified before infection spreads
- the use of more preventive and less invasive treatment options
- timely decisions to be made on admittance or discharge from hospital
- health interventions to be assessed earlier to minimise or stop disease progress
- the selection of appropriate treatments that reduce patient risk and increase effectiveness
- patient prognosis and treatment managed to be better understood
- the integration of data at a population level for better planning

Strong leadership through the appointment of Organisational Lead Scientists aligned to the Medical Directors will be needed, to ensure safe and effective scientific operational delivery, introduction of new models of multiprofessional care and personalised treatments based on genomic and other diagnostic and clinical data, reducing inequalities and enabling equity of access and high quality accredited services including for point of care testing

Policy and Regulatory Requirement

Over the lifetime of the LTP there are a multiplicity of regulatory and policy requirements that will drive the Healthcare Science function - some of which are still emerging - inclusive of:

MHRA Medical Devices and other regulatory requirements related to Genomics and Diagnostic – this will impact on the operation of laboratories as well as the application of data analytics and algorithms as well as on the use of cutting edge next generation diagnostics such as genomics.
Radiation protection legislative and regulatory requirements - with Medical Physicists having responsibility for radiation safety both within hospitals and across populations and reporting to relevant authorities and agencies.
NICE Diagnostic and clinical guidelines - the former specifically require systematic implementation.
NHS E Innovation scorecard and AAR recommendations – which feature POCT and other diagnostics.
UKAS accreditation for pathology, physiology, medical physics and engineering services the evidence informing CQC service regulation, under the key enquiry of 'well led' and the links to UK NEQAS schemes providing quality information.
EU Exit preparations and shortage escalation/resilience - for laboratories, scientific services and other diagnostics
UK Genomics healthcare strategy – this will be developed in 2019 and will incorporate SofS ambition to generate 5 million genomic analyses over the next 5 years (500,000 WGS will come from NHS as signalled in LTP and significant

other NHS non WGS testing)
NHS E Genomics Implementation Plan to deliver the NHS Genomic Medicine Services and the LTP commitments involving a variety of scientific services
Life Sciences Industry Strategy and commitments to deliver digital pathology, AI and machine learning, cancer genomics (WGS) and the accelerating earlier disease detection collaborative aimed at 5 million analyses using emerging technology all of which require scientific service alignment and involvement
NHS I Operational Productivity and Improvement Plans – specifically pathology and imaging networks as well as scientific service leadership within the GIRFT and improvement programmes
UK AMR Action Plan – specifically focused on the CSO SRO/leadership of AMR diagnostics and for implementation across the NHS
Cross government Hearing Action Plan –CSO is the SRO for implementation across the regions and the oversight of the regional contracts
Strategy for Home Oxygen services in England and Wales – CSO is SRO for implementation across the regions
Cancer, Diabetes, Cardiovascular, Respiratory, Stroke, Maternity and Neonatal health and Mental Health clinical policy and strategy– all require scientific services for delivery of LTP commitments
Prevention strategy – particularly associated with for example implementation of polygenic risk scores or of other programmes with PHE
Digital Health Plans – particularly related to integration of genomic, pathology and other diagnostic data and involving HRD UK, NHS X, NHS D and other different bodies
Research and Innovation Plans – supporting the commitments outlined in the LTP

In line with NHS England's and NHS Improvement's operating model, and reflecting the central team arrangements, leadership of these commitments and duties would be best placed with a lead healthcare scientist with the support of the central Healthcare Science network.

Aligning aspects of the function

The national CSO team has a small number of specialist scientific advisors which will be aligned with regions as relevant. Currently there is a gap in the line of sight for leadership for operational delivery, improvement and innovation from the CSO national team through to provider organisations where Lead Healthcare Scientists do not exist. Where they do exist, this provides the ability to influence or inform across NHS provider organisations.

The CSO Plan is to align regional appointments with Organisational Lead Scientists to better improve demand and supply modelling for healthcare science disciplines. Where Organisational Lead scientists work in networks to support their Organisations, working with other Organisational Lead Scientists across the regions. This regional network will also align scientific leadership within for example Pathology and Genomic Laboratory Hub networks to the regions. However, the success of such alignment would be dependent on the coordination and appointment of Organisational Lead Scientists in every Provider Organisation, to maximise inputs and impacts in a similar way to the functioning of the Regional Medical Directors and Local Medical Directors.

There would be further opportunities to, for example, facilitating the move from an ad hoc input into cancer alliances from the critical scientific services that support cancer pathways, into more systematic and line of sight leadership.

Through such networks the Office of the CSO can ensure science and evidence drives service transformation of Healthcare Science services, through regional delivery, supported by an expert corporate team, focussed on clinical and evidence based improvements in science. The CSO Team is working on embedding a national leadership infrastructure of Organisational Lead Scientists across every provider Trusts in England. There is currently 72% coverage. In order to ensure integration across STPs and ICSs, to embed clinical leadership capability and capacity across the system we would like to encourage 100% coverage. If your organisation does not currently have a Lead Scientist, we are recommending that one is appointed. This will ensure expert scientific leadership and advice from and into the CSO team and across a wider system.

Current infrastructure

The OLS are senior scientists who represent all healthcare science specialisms within the organisation they provide leadership, input, advice and expertise into regions, STPs and emerging ICSs and impact on service model development particularly within primary and community care. There has also been successful input of Lead Healthcare Scientists into Clinical Senates advising on service reconfiguration.

Key relationships within the regional structure

There are key relationships with

- Medical Directors to drive multiprofessional leadership, new models of care especially in ICSs and within PCNs, with NHS E/I networks to drive operational efficiency and with the improvement teams
- Specialised commissioning hubs related to of a range of services where diagnostics and scientific services are part of the end to end patient pathway inclusive of genomic laboratory hubs, specialist cardiovascular services, cochlear implant and BAHA services, cancer services – radiotherapy, SIHMDs services highly specialised services etc
- Screening services
- Cancer alliances
- Medicines optimisation committees (with the increasing relationship between medicines and genomic/phenotypic data)
- Safety and surveillance committees – particularly in relation to AMR and Home Oxygen
- Emergency preparedness and resilience planning
- NHS D infrastructure and digital data hubs/LICREs
- PHE infrastructure in relation to infection
- HEE Regional directors

This outlines the many benefits Organisational Lead Scientists can have across a system and to their own Organisation.

Should you require any further information please do not hesitate to contact the office of the CSO at NHS England and Improvement.

CSO, England (NHS ENGLAND & NHS IMPROVEMENT - X24) - england.cso@nhs.net

APPENDIX F

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November- 2019
Medical Examiner Service - York and Scarborough

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

Inform Quality Committee members on the plans for implementation of the ME role

Executive Summary – Key Points

The purpose of the Medical Examiners Service is:-

1. To assist the treating medical team (TMT) to complete an accurate medical certificate of cause of death (MCCD).
2. Ensure prompt and accurate Coroner's referral where needed.
3. To ensure carers have the opportunity to comment on the care provided.
4. To ensure carers have clear information about the MCCD and what it means.
5. Identify any governance concerns or opportunities for quality improvement.
6. To uncover any criminal activities.
7. Public Health surveillance to detect any recurrent themes in mortality locally.

There will need to be a number of Medical Examiners (MEs) covering the York and Scarborough sites but there also needs to be a system for other small sites. The Royal College of Pathologists has run a number of pilot sites around the country and their experience indicates a need for 10 PAs of medical time per 3000 deaths but this includes support of Medical Examiner's Officers (MEOs) and does not factor in multiple sites.

Scrutiny of medical notes is estimated to take a mean of 15 minutes each. MEOs can undertake some duties of the ME by careful delegation and will be particularly useful in ensuring the most efficient use of medical staff time.
A reasonable starting point would be 3 MEs in York with 5 PAs allocated and 2 MEs with 2.5 PAs in Scarborough. Cover for leave and sickness may be problematic.

The Doctors need to have completed the 26 ME Learning for Health training core modules (8-9 hours) and attend a tutorial session. Over a longer period the subsequent 61 modules need to be completed.

The Doctors should be at least five years post qualification and have good clinical experience. They need to have the ME role incorporated into their job plan ie are able to be released from other duties or agree increased PA time.

Recommendation

Quality Committee members are asked to note the plans for implementation of the ME role.

Author: Peter Wanklyn, Lead Medical Examiner

Director Sponsor: Mr. James Taylor, Medical Director

Date: October 2019

1. Introduction and Background

This service will operate five days a week on the York and Scarborough sites and there needs to be on call availability 7 days a week for certain categories of patients whose, for instance, religious beliefs necessitate burial within 24 hours. The Registrar in York has confirmed that out of hours requests for body disposal are very rare so the 7 day availability will be low intensity and probably provided by the Lead ME.

2. The purpose of the Medical Examiners Service is:-

1. To assist the treating medical team (TMT) to complete an accurate medical certificate of cause of death (MCCD).
2. Ensure prompt and accurate Coroner's referral where needed.
3. To ensure carers have the opportunity to comment on the care provided.
4. To ensure carers have clear information about the MCCD and what it means.
5. Identify any governance concerns or opportunities for quality improvement.
6. To uncover any criminal activities.
7. Public Health surveillance to detect any recurrent themes in mortality locally.

2.1 Process

Current Trust procedures and paperwork will be replaced by new documentation and an augmented database.

The ME work is likely to be most efficiently organised for an afternoon period which allows time for TMT to discuss the MCCD and attend the bereavement office. The summary of death certification form will be completed by the attending Doctor.

The ME office will be in the bereavement department and should have uninterrupted access to a Trust PC and a quiet area to communicate sensitive information. They should have time to review the medical notes and CPD then complete form ME-1 together with the ME database.

They will discuss the case with the TMT and agree the MCCD or that a referral to the Coroner's office is required.

If an MCCD is being issued, the ME will contact the bereaved next of kin by phone or in person if they are present in bereavement. The ME will inform them of the cause of death and ensure that they understand it fully. Any questions will also be answered fully.

The ME will assess whether further Trust investigation is needed eg Serious Incident or SJCR. If an SJCR is required they will inform the Patient Safety team who will arrange for it to be completed by the relevant Directorate.

Once this service is fully established, the initial mortality reviews by each Consultant will no longer be necessary and will cease. In addition, the current practice of routine SJCR for every Inquest into an inpatient death will cease. The ME can decide if individual cases need an SJCR. Finally, the Lead Medical Examiner will attend the Quality and Safety

meeting so other staff will no longer need to review deaths for the meeting. This will provide rapid feedback to the Medical Director about any new themes, patterns or concerns.

2.2 Personnel

There will need to be a number of Medical Examiners (MEs) covering the York and Scarborough sites but there also needs to be a system for other small sites. The Royal College of Pathologists has run a number of pilot sites around the country and their experience indicates a need for 10 PAs of medical time per 3000 deaths but this includes support of Medical Examiner's Officers (MEOs) and does not factor in multiple sites.

Scrutiny of medical notes is estimated to take a mean of 15 minutes each. MEOs can undertake some duties of the ME by careful delegation and will be particularly useful in ensuring the most efficient use of medical staff time.

A reasonable starting point would be 3 MEs in York with 5 PAs allocated and 2 MEs with 2.5 PAs in Scarborough. Cover for leave and sickness may be problematic.

The Doctors need to have completed the 26 ME Learning for Health training core modules (8-9 hours) and attend a tutorial session. Over a longer period the subsequent 61 modules need to be completed.

https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_32&programmeId=32

The Doctors should be at least five years post qualification and have good clinical experience. They need to have the ME role incorporated into their job plan ie are able to be released from other duties or agree increased PA time. A Lead ME has been appointed to deliver the service and cover 3/5 York weekday

Requirements for the Service in the non-statutory phase

- Up to 10 PAs of senior medical time need to be provided and funded.
- Working environment: need a dedicated office in York and Scarborough with PC and sufficient privacy to discuss confidential information with bereaved families.
- Development of a database for all cases. This may be developed nationally but the current Trust bereavement service database can be modified for initial use.
- ME officers role is to be developed. This may prove to be particularly valuable at SGH and other sites. It will allow the use of ME time most efficiently so reducing the cost of the service and the impact on clinical duties.
- Adequate quality assurance and feedback from the Registrar, Coroner and users. The Lead ME will be responsible for gathering feedback and service improvement. This will involve providing updates, advice and training for all MEs.
- We also need a dedicated email address for the Medical Examiner's Office, both in York and Scarborough.

- Release of senior medical staff from already full job plans
- Volume of work – particularly on a Monday. This needs to be scoped to determine PAs required and distribution through the week.
- Across the Trust there are > 2000 deaths per year but there are very different Bereavement Services and mortuary set ups between the two main sites
- The ME service will increase the number of SJCRs requested. The National pilot site experience suggests around 10% of deaths need an SJCR. Some Directorates currently struggle to deliver current number of reviews.

3. Next Steps

The ME Service is independent from the Trust and is accountable to the Regional ME (Graham Cooper) and national ME (Alan Fletcher).

More information is available at:

https://www.rcpath.org/profession/medical-examiners.html

4. Detailed Recommendation

Quality Committee members are asked to note the plans for implementation of the ME role.

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Performance and Activity Report

October 2019 performance

Produced November 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

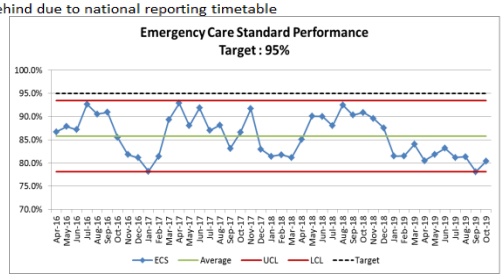
To ensure financial stability

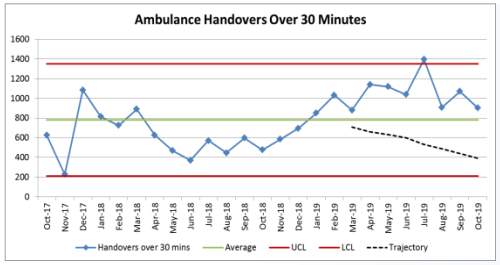
Assurance Framework Responsive

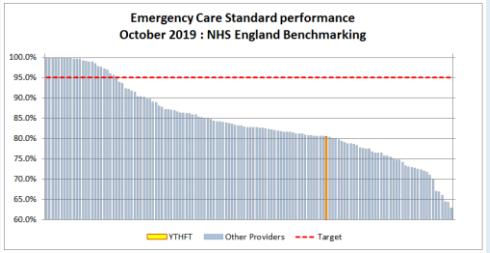
Key Performance Indicators – Trust level

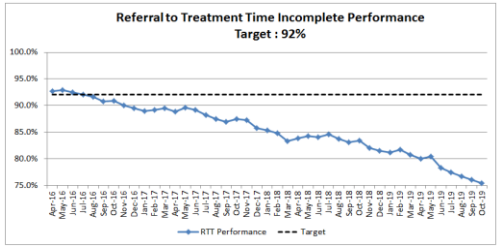
Operational Performance: Key Targets	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Emergency Care Standard Performance	95%	90.9%	89.6%	87.6%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%
Ambulance handovers waiting 15-29 minutes	0	891	840	1083	935	892	915	956	1072	978	988	983	969	1112
Ambulance handovers waiting 30-59 minutes	0	345	389	463	470	556	484	593	671	587	723	547	605	571
Ambulance handovers waiting >60 minutes	0	132	197	233	380	477	397	548	449	453	673	362	466	332
Stranded Patients at End of Month - York, Scarborough and Bridlington		403	363	368	439	386	442	422	406	397	394	409	397	363
Super Stranded Patients at End of Month - York, Scarborough and Bridlington		159	132	116	153	130	153	138	143	135	140	148	136	125
Diagnostics: Patients waiting <6 weeks from referral to test	99%	96.2%	93.9%	91.1%	90.6%	92.9%	93.0%	87.5%	86.4%	88.9%	87.5%	81.7%	82.4%	83.3%
RTT Incomplete Pathways	92%	83.4%	82.0%	81.5%	81.1%	81.7%	80.8%	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%
RTT Total Waiting List (RTT TWL)	26,303	27,616	27,164	26,433	26,278	27,144	27,536	28,344	28,809	28,724	28,394	29,252	29,771	29,442
RTT 52+ Week Waiters	0	1	1	0	0	0	3	0	0	3	0	1	1	0
Cancer 2 week (all cancers)	93%	90.2%	92.1%	94.6%	85.4%	95.7%	90.7%	88.3%	84.6%	81.5%	85.9%	89.9%	90.9%	-
Cancer 2 week (breast symptoms)	93%	100.0%	93.3%	92.8%	93.4%	93.2%	90.7%	79.6%	91.4%	93.8%	95.2%	97.1%	98.1%	-
Cancer 31 day wait from diagnosis to first treatment	96%	98.6%	98.4%	96.8%	96.4%	98.7%	96.9%	96.7%	98.3%	98.8%	99.1%	99.5%	97.5%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	96.9%	93.2%	95.0%	90.5%	92.3%	97.4%	94.3%	95.1%	96.9%	93.8%	84.4%	100.0%	-
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	82.3%	75.3%	81.7%	82.5%	79.4%	83.5%	80.6%	79.5%	85.0%	79.5%	80.7%	79.4%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	93.6%	92.9%	88.6%	90.6%	89.1%	92.7%	100.0%	92.1%	100.0%	100.0%	90.6%	100.0%	-

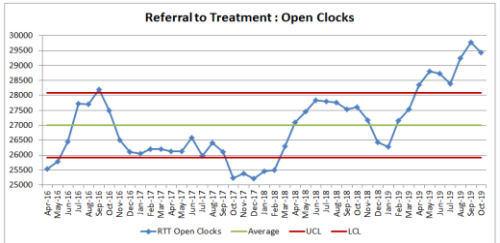
note: cancer one month behind due to national reporting timetable

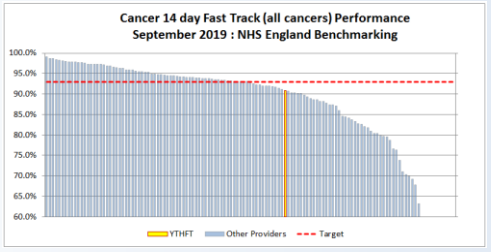


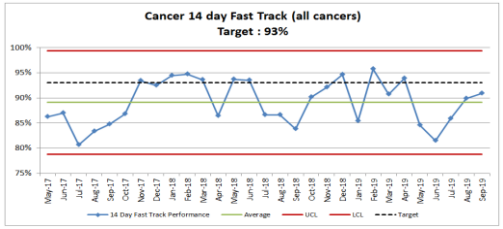


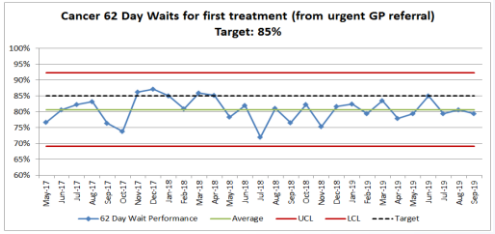


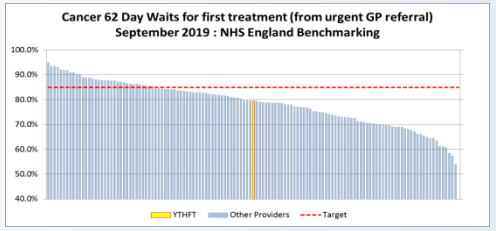












Assurance Framework Responsive

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

Operational Performance: Unplanned Care	Target	Sparkline / Previous Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Emergency Care Attendances		▲	16960	16191	16571	16575	15500	17489	18055	18270	18256	20101	19683	18486	18800
Emergency Care Breaches		▼	1545	1686	2059	3069	2863	2791	3525	3310	3067	3785	3671	4043	3689
Emergency Care Standard Performance	95%	▲	90.9%	89.6%	87.6%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%
ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	38%	39%	41%	38%	38%	36%	36%	37%	38%	38%	38%	37%	30%
ED Total number of patients waiting over 8 hours in the departments		▼	216	242	324	904	802	687	1,007	972	799	1,029	912	1,275	817
ED 12 hour trolley waits	0	▼	0	0	0	16	8	28	24	26	2	1	7	32	16
ED: % of attendees assessed within 15 minutes of arrival		◀▶	65%	63%	63%	62%	59%	63%	58%	59%	59%	53%	55%	54%	54%
ED: % of attendees seen by doctor within 60 minutes of arrival		◀▶	45%	49%	50%	43%	40%	38%	37%	37%	36%	34%	33%	32%	32%
ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▼	4.1%	3.8%	2.9%	3.0%	3.1%	3.2%	3.7%	4.0%	4.4%	4.8%	4.4%	4.6%	4.1%
Ambulance handovers waiting 15-29 minutes		▲	891	840	1083	935	892	915	956	1072	978	988	983	969	1112
Ambulance handovers waiting 15-29 minutes - improvement trajectory			-	-	-	-	-	846	829	812	795	778	761	744	727
Ambulance handovers waiting 30-59 minutes		▼	345	389	463	470	556	484	593	671	587	723	547	605	571
Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	380	365	350	335	319	304	289	274
Ambulance handovers waiting >60 minutes		▼	132	197	233	380	477	397	548	449	453	673	362	466	332
Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	330	297	281	264	215	182	149	116
Non Elective Admissions (excl Paediatrics & Maternity)		▲	4643	4563	4713	4524	4029	4580	4585	4766	4761	5069	4873	4553	5145
Non Elective Admissions - Paediatrics		▲	862	1042	942	921	865	891	745	729	711	808	658	790	945
Delayed Transfers of Care - Acute Hospitals		▼	1251	1059	1212	1093	1067	1178	1456	1529	1486	1346	1325	1355	1215
Delayed Transfers of Care - Community Hospitals		▲	357	358	337	385	295	377	277	303	352	235	333	335	342
Patients with LOS 0 Days (Elective & Non-Elective)		▲	1447	1368	1375	1421	1278	1362	1241	1386	1550	1609	1471	1364	1665
Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	1072	1032	1085	1151	991	1097	1102	1157	1076	1241	1115	1139	991
Ward Transfers - Non clinical transfers after 10pm	100	▲	83	85	85	100	71	94	87	87	76	87	72	89	104
Emergency readmissions within 30 days		▼	837	861	875	851	741	876	924	907	935	1014	930	-	-
Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	403	363	368	439	386	442	422	406	397	394	409	397	363
Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▼	398	374	376	431	433	409	405	399	373	390	384	380	361
Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	159	132	116	153	130	153	138	143	135	140	148	136	125
Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▼	142	147	129	151	166	143	147	134	141	138	134	138	129

Operational Performance: Planned Care	Target	Sparkline / Previous Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Outpatients: All Referral Types		▲	20686	19613	16888	19856	19315	18908	18595	19338	19011	20082	18035	18432	19715
Outpatients: GP Referrals		▲	10760	10195	8624	10038	10416	9801	9534	9726	9487	9914	9289	9383	9941
Outpatients: Consultant to Consultant Referrals		▲	2413	2254	1961	2537	2221	2251	2177	2337	2225	2311	2027	2169	2299
Outpatients: Other Referrals		▲	7513	7164	6303	7281	6678	6856	6884	7275	7299	7857	6671	6880	7475
Outpatients: 1st Attendances		▲	10249	10157	8059	9868	9005	9312	8603	9209	9211	9884	8308	8758	9894
Outpatients: Follow Up Attendances		▲	17736	17533	14446	18028	15417	16441	15036	16375	15104	16824	14116	14921	17156
Outpatients: 1st to FU Ratio		▲	2	2	2	2	2	2	2	2	2	2	2	2	2
Outpatients: DNA rates		▼	6.0%	5.8%	6.4%	6.1%	5.7%	5.5%	5.9%	6.1%	5.9%	6.3%	6.0%	6.0%	5.9%
Outpatients: Cancelled Clinics with less than 14 days notice	180	▲	180	163	162	206	193	209	180	179	198	243	240	232	270
Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	437	580	620	837	803	979	993	945	883	987	1214	1316	1474
Diagnostics: Patients waiting <6 weeks from referral to test	99%	▲	96.2%	93.9%	91.1%	90.6%	92.9%	93.0%	87.5%	86.4%	88.9%	81.7%	81.7%	82.4%	83.3%
Elective Admissions		▲	766	718	602	614	554	687	652	682	722	690	579	683	757
Day Case Admissions		▲	6595	6287	5344	6621	5868	6082	5849	6075	5886	6243	5907	6139	6692
Cancelled Operations within 48 hours - Bed shortages		▼	68	12	33	22	10	17	32	66	59	32	13	60	26
Cancelled Operations within 48 hours - Non clinical reasons		▼	137	131	91	114	90	141	130	147	194	229	85	173	148
Theatres: Utilisation of planned sessions		▲	90%	93%	88%	86%	87%	90%	92%	86%	89%	89%	91%	91%	95%
Theatres: number of sessions held		▲	674	661	523	586	506	576	576	602	609	712	501	588	640
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		▲	79	66	66	53	89	108	99	43	83	104	92	48	66

Assurance Framework Responsive

Performance Summary by Month – Trust level continued

18 Weeks Referral To Treatment	Target	Sparkline / Previous Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Incomplete Pathways	92%	▼	83.4%	82.0%	81.5%	81.1%	81.7%	80.8%	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%
Waits over 52 weeks for incomplete pathways	0	▼	1	1	0	0	0	3	0	0	3	0	1	1	0
Waits over 26 weeks for incomplete pathways	0	▼	1795	1762	1943	2192	2066	2220	2468	2657	2558	2735	3239	3595	3508
Waits over 36 weeks for incomplete pathways	0	▲	361	355	431	497	530	606	669	632	660	632	868	887	1076
RTT Total Waiting List (RTT TWL)	26,303	▼	27616	27164	26433	26278	27144	27536	28344	28809	28724	28394	29252	29771	29442
Number of patients on Admitted Backlog (18+ weeks)		▲	2219	2299	2352	2463	2470	2738	2850	2877	2847	3338	3543	3639	3686
Number of patients on Non Admitted Backlog (18+ weeks)		▲	2369	2578	2550	2500	2505	2556	2825	2769	3391	3079	3283	3445	3554

Cancer (one month behind due to national reporting timetable)	Target	Sparkline / Previous Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Cancer 2 week (all cancers)	93%	▲	90.2%	92.1%	94.6%	85.4%	95.7%	90.7%	88.3%	84.6%	81.3%	85.9%	89.9%	90.9%	-
Cancer 2 week (breast symptoms)	93%	▲	100.0%	93.3%	92.8%	93.4%	93.2%	90.7%	79.6%	91.4%	93.8%	95.2%	97.1%	98.1%	-
Cancer 31 day wait from diagnosis to first treatment	96%	▼	98.6%	98.4%	96.8%	96.4%	98.7%	96.9%	96.7%	98.3%	98.8%	99.1%	99.5%	97.5%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	▲	96.9%	93.2%	95.0%	90.5%	92.3%	97.4%	94.3%	95.1%	96.9%	93.8%	84.4%	100.0%	-
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	◀▶	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▼	82.3%	75.3%	81.7%	82.5%	79.4%	83.5%	80.6%	79.5%	85.0%	79.5%	80.7%	79.4%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	▲	93.6%	92.9%	88.6%	90.6%	89.1%	92.7%	100.0%	92.1%	100.0%	100.0%	90.6%	100.0%	-

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

Assurance Framework Responsive | **Emergency Care Standard and Unplanned Care**

Operational Context

The Trust did not meet the Emergency Care Standard (ECS) planned trajectory of 90% for October 2019, with performance of 80.4%. The last ten months have been below the rolling four-year average of 85.8%. The Trust performed below the national position for September (83.6%), the worst performance nationally since the standard was introduced in 2004.

The Trust ECS 'footprint' performance which includes a third of the activity at Whitby MIU was 80.7%.

Unplanned care continues to be challenging, with type 1, 2 and 3 attendances up 7% for the year to date on the same period in 2018/19. In total an extra 8,870 patients have attended the main EDs, UCCs and MIUs compared to the same period last year, with the main EDs (type 1) seeing and treating an additional 6,029 patients; a rise of 9%.

Sixteen twelve-hour trolley breaches were reported in October 2019 at Scarborough Hospital. The breaches were reported to NHS England and NHS Improvement as required and were due to capacity constraints in ED and a lack of capacity within the inpatient bed base.

High levels of Ambulance arrivals continue to impact the two main EDs, with the last seven months above the two-year average, the 4,512 ambulance arrivals in October was the third highest in the last two years. The continued demand during October contributed to 903 ambulances being delayed by over 30 minutes, above the improvement trajectory of 390 submitted to NHS England and NHS Improvement. The increase in ambulance arrivals has seen ten 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 England and 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 is agreed and is in progress.

The Trust continues to experience bed pressures, with Scarborough Hospital experiencing bed occupancy of above 90% at midnight on all but one day during the month. York Hospital had above 90% bed occupancy for 19 days.

The acute Delayed Transfers of Care (DToC) position in October was the lowest this financial year but remained above target, this is a continuation of a fluctuating and unpredictable position over the last thirteen months. 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

- An internal Acute Board, chaired by the Trust CEO meets monthly, where key actions, issues and progress against improvement plans are discussed.
- The Trust and wider York and Scarborough system has been identified as needing support in order to address performance challenges, resulting in the Emergency Care Intensive Support Team (ECIST) working alongside Care Group teams to observe, advise and facilitate change.
- Focused work underway to help 'unlock' the acute pathway, reduce overcrowding in ED and promote better flow through the hospitals – SDEC and SAFER.
- SAFER to be relaunched and reframed as a safety tool, sponsored by the Medical Director and Chief Nurse.
- A review of the integrated discharge approach on the acute floor is underway to bring together DLT, Social Workers, CRT, RATS and the therapists to better support the acute teams with discharges.
- A significant number of patients appear to be admitted with low level mental health needs. ECIST will support a mental health mini-MADE event and the outcomes of this will be shared with partners to generate discussion about next steps.
- The Winter plan 19/20 for YFT & system partners incorporates; (1) high impact schemes embedded from 18/19, (2) Winter Pressure Grant schemes & (3) the additional system & locality specific actions mobilised across both sites by Chief Officers following the ECS Risk Summit. These are captured in a single system workplan held by the A&E Delivery Board & System Resilience Group, with ECIST supporting all in-hospital actions. For YTHFT these include: communication plans and learning from stakeholder engagement; increased bed capacity; increased decision making capacity; and temporary changes to the function of some wards.

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 October 2019 was 90%.

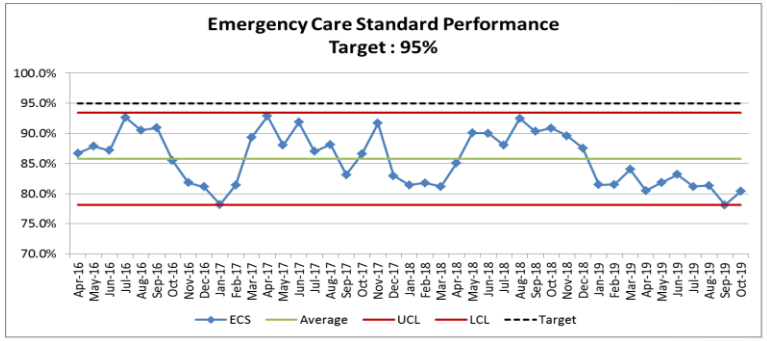
Consequence of under-achievement

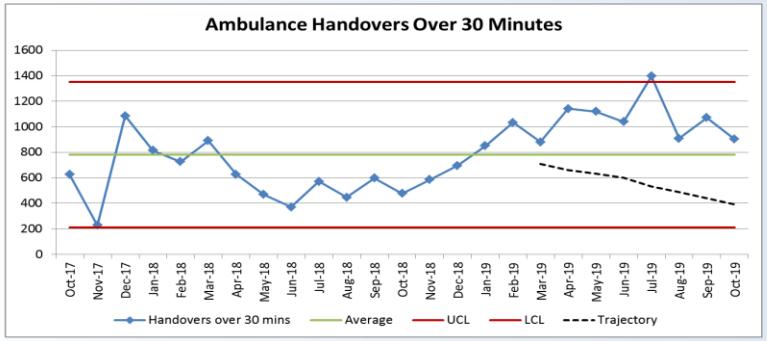
Patient experience, clinical outcomes, timely access to treatment, regulatory action and loss of the Provider Sustainability Fund (Access Element).

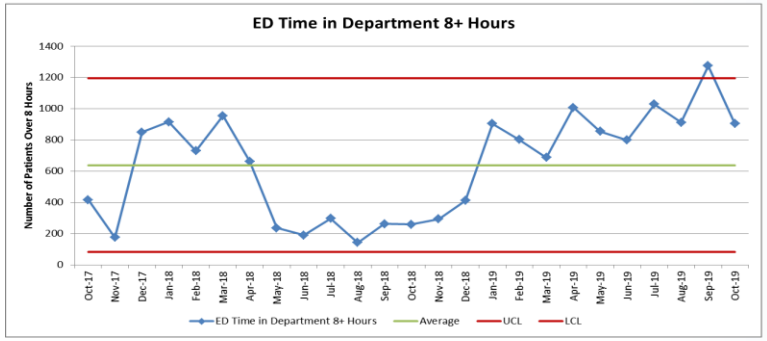
Performance Update:

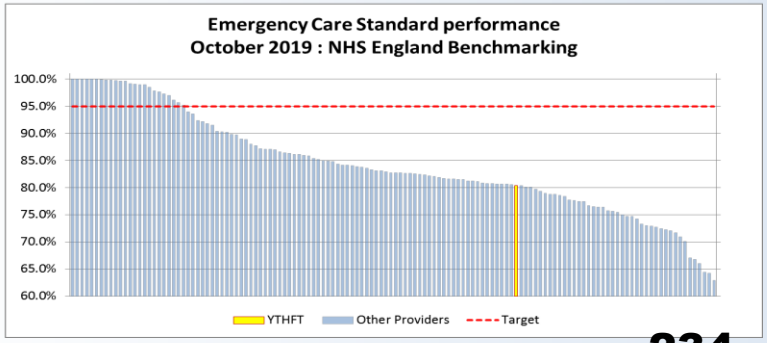
- The Trust achieved 80.4% in October 2019 against the planned trajectory of 90%.
- For the year to date on the same period in 2018/19. In total an extra 8,870 patients have attended the main EDs, UCCs and MIUs compared to the same period last year, with the main EDs (type 1) seeing and treating an additional 6,029 patients; a rise of 9%.
- The number of patients waiting over 8 hours remains high, in October 2019 there were 817 patients who waited over 8 hours, the tenth consecutive month above the four-year average.
- There were sixteen twelve hour trolley waits reported on the Scarborough site.
- Ambulance arrivals have seen ten 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

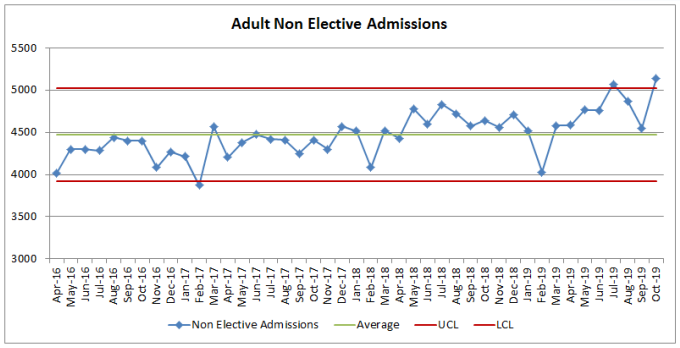
Performance Update:

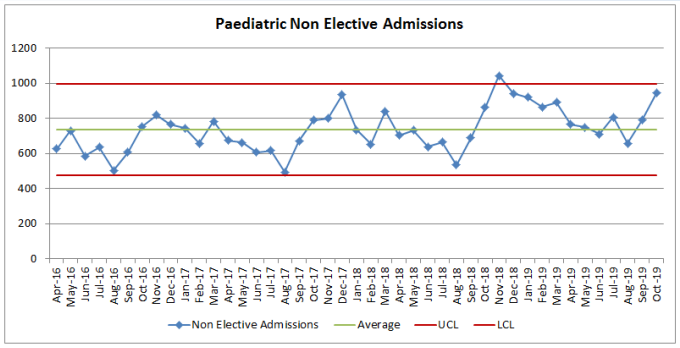
- The number of adult non-elective admissions for the year to date has increased by 4% YTD in 2019/20 compared to 2018-19 (+1,165). For sixteen of the past seventeen months adult admissions have been above the four year average. Paediatric non-elective admissions have been above the four year average for ten of the past twelve months and are 12% up YTD compared to 2018/19.

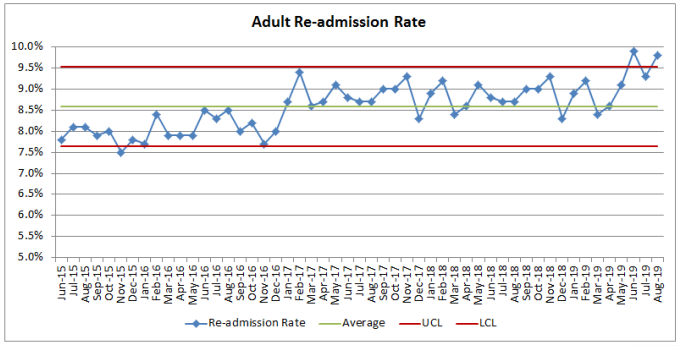
- The adult readmission rate continues to be above the four year average, analysis by the Trust's analytics team identified that there is an issue with the merging of two patient spells on CPD if it has been identified that a patient has been discharged in error. This can occur if a patient has been discharged prior to completion of an electronic discharge notice (EDN) or following the transfer of a patient from ward or one hospital site to another, when this should be recorded as a single patient spell. The Trust's Development Team are working to understand what changes need to be made to CPD to facilitate more accurate patient pathways. Paediatric readmissions fell markedly in August.

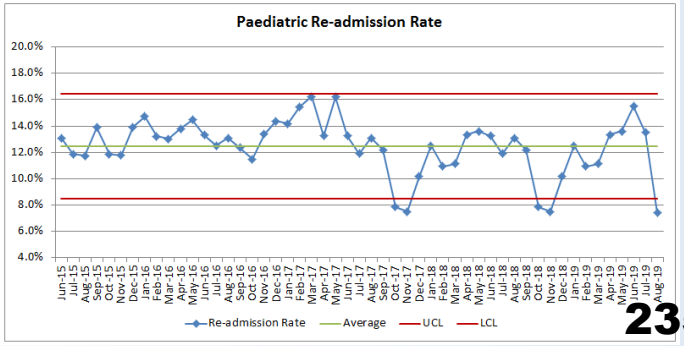
- In October the number of stranded patients at month end decreased with the number of beds occupied by super-stranded patients (patients who stay more than 21 days) at month end also decreasing.

Performance:









Assurance Framework Responsive

Cancer Waiting Times

(Reported a month in arrears)

Operational Context

Overall, the Trust achieved 90.9% against the 14 day Fast Track referral from GP standard in September. National performance for September was 90.1%, the second consecutive month the Trust has outperformed the national position).

The Trust continues to experience high numbers of Cancer Fast Track (FT) referrals, with a 7% increase in FT referrals received in quarters 1 and 2 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 was 79.4% in September, five of the last six months have seen between 79% and 81% performance. National performance for September was 76.9% and this was the 10th consecutive month that the Trust has outperformed the national position. The Trust's performance equated to 124 accountable patients treated in September, with 25.5 accountable breaches (35 patients). The breaches 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, 6% relate to delays for medical reasons, 54% due to delays to diagnostic tests or treatment plans/lack of capacity, 31% relate to complex or inconclusive diagnostics and 9% due to patient delay.

Progress towards the April 2020 target to diagnose patients within 28 days continues, with performance of 59.4% in September. Performance is currently being shadow reported as a national target percentage has yet to be set.

Targeted actions

- Recovery plans have been developed for any tumour sites not achieving the 14 day and/or 62 day standards. Progress against these plans is being monitored with care groups on a weekly basis.
- Weekly 'Cancer Wall' meeting implemented with scrutiny of every diagnosed cancer patient without a treatment plan, to reduce unnecessary delays and mitigate risk. Patients on a 62 day pathway without a diagnosis are also reviewed and plans agreed where required.
- 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.
- Developing a Rapid Diagnostic Centre (RDC) for patients with vague symptoms and Upper GI referrals.
- NHSI Elect facilitating a rapid improvement project to reduce delays in Head and Neck pathway.
- Focussed project on 28 day referral to diagnosis, overseen by Cancer Delivery Group which is a subset of Cancer Board.

Assurance Framework Responsive

14 Day Fast Track – Cancer Waiting Times

Standard(s):

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

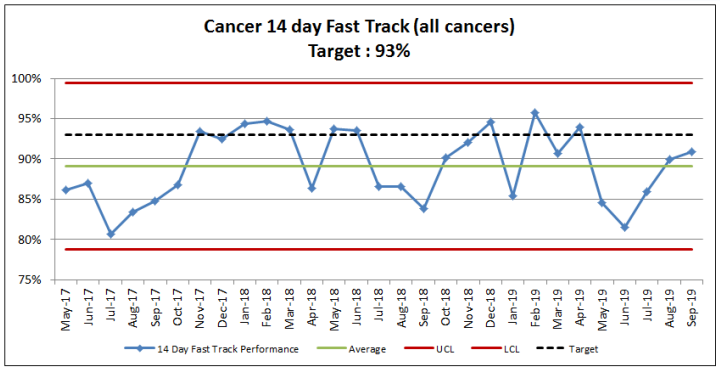
Consequence of under-achievement:

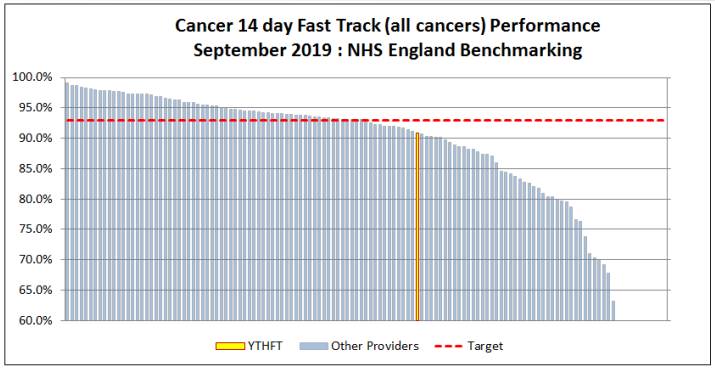
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

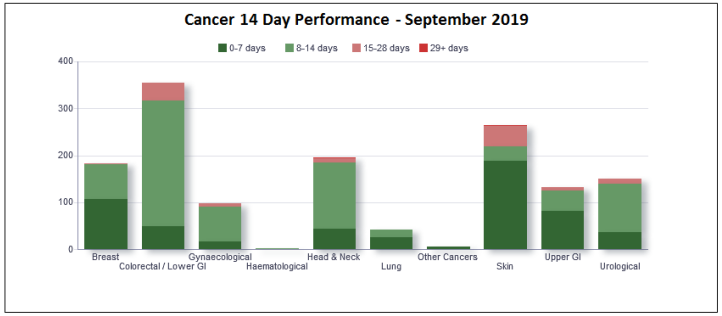
Performance Update:

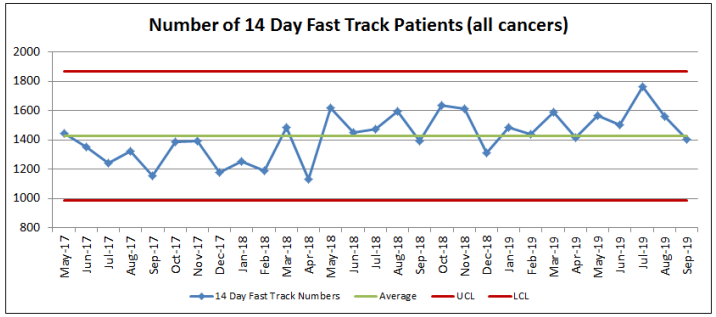
- Overall, the Trust achieved 90.9% against the 14 day Fast Track referral from GP standard in September. The 93% target was met for Breast, Haematology, Head & Neck, Lung and Upper GI.
- The Trust continues to experience high numbers of Cancer Fast Track (FT) referrals, with a 7% increase in FT referrals received in quarters 1 and 2 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.

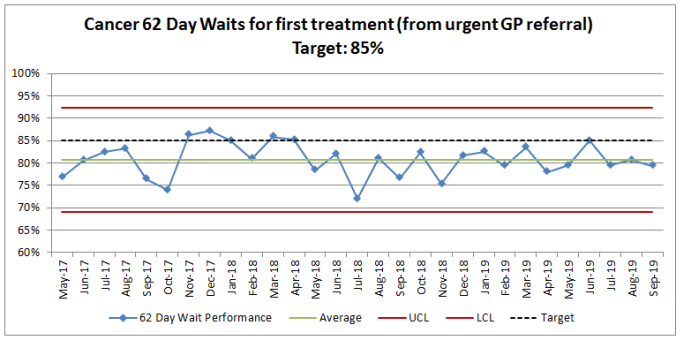
Consequence of under-achievement:

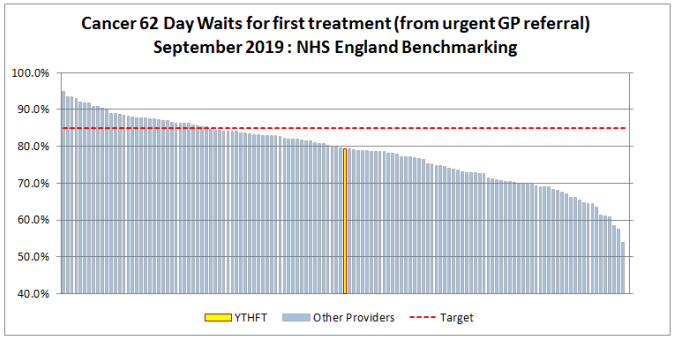
Patient experience, clinical outcomes and potential impact on timely access to treatment.

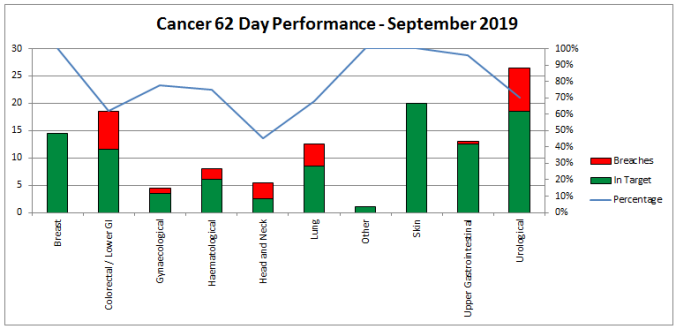
Performance Update:

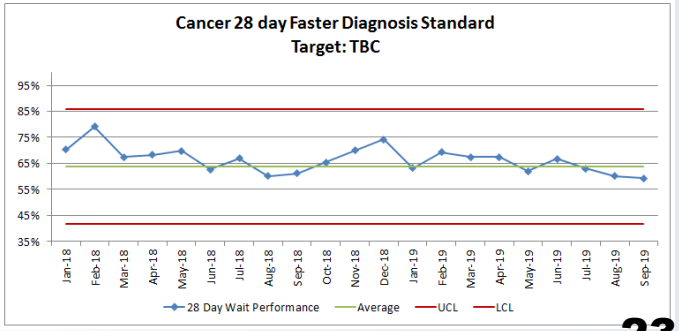
- Performance against the 62 day target from referral to treatment was 79.4% in September.
- The Trust's performance equated to 124 accountable patients treated in September, with 25.5 accountable breaches (35 patients). The breaches were spread across a range of tumour pathways, with the highest number of breaches seen in Colorectal and Urological cancers.
- Of the reported patient breaches, 6% relate to delays for medical reasons, 54% due to delays to diagnostic tests or treatment plans/lack of capacity, 31% relate to complex or inconclusive diagnostics and 9% due to patient delay.

Performance:









Assurance Framework Responsive

Planned Care

Operational Context

The total incomplete Referral to Treatment (RTT) waiting list (TWL) stood at 29,442 at the end of October, down 329 clocks on the end of September position. This is below the trajectory of 31,846 submitted to NHS England and NHS Improvement but above the target to have below 26,303 open clocks (March 2018 position) by the end of March 2020.

GP referrals received by the Trust in October were below the four year average for the eighth consecutive month, the number received for the year to date is a 3.6% reduction on those received in the same period in 2018-19.

The Trust's RTT position for October was 75.4%, below the 80.0% trajectory that was submitted to NHS England and NHS Improvement. The backlog of patients waiting more than 18 weeks increased by 2%.

The NHS Long Term Plan set out a requirement for the implementation and local delivery of alternative provider choice at 26 weeks for patients on an incomplete RTT pathway. National implementation following pilot schemes is due for roll-out in 2020-21, the Trust along with Commissioners are in dialogue with NHS England and NHS Improvement as to system requirements with published guidance awaited. At the end of October there were 3,508 patients waiting 26 weeks or over; a reduction of 87 on the end of September position.

The number of long wait patients (those waiting more than 36 weeks) increased by 189 at the end of October. Long waiting patients are across multiple specialities and performance is being monitored with care groups on a weekly basis. There were no patients waiting over 52 weeks at the end of October.

The Trust has seen an improvement against the national 6 weeks diagnostic target in October, with performance of 83.3% against the standard of 99%. National performance for September was 96.2%. At a Trust level, pressures remain in Endoscopy, Echo CT and Non-Obstetric Ultrasound. Recovery plans have been created for all modalities not achieving the 99% standard and progress against these is being monitored with Care Groups on a weekly basis. The Endoscopy position was impacted by a sustained increase in fast track demand on the service causing routine patients to be displaced to prioritise these clinically urgent patients. The opening of the Trust's new Endoscopy Unit at York on the 17th of October is expected to lead to a significant improvement in performance against the diagnostic target. The Trust is working with the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services with a full day site meeting booked for the 19th of November.

Targeted actions

- Recovery plans have been developed for RTT/TWL for all specialties above the March 2018 waiting list position and/or where specialties are significantly off plan for 2019/20. Progress against these plans is being monitored with care groups on a weekly basis.
- Ongoing implementation of the programme structure and metrics for the core planned care transformation programmes covering theatre productivity, outpatients productivity, Refer for Expert Input (REI) 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 52 week breaches.
- New Endoscopy Unit at York opened on the 17th October.
- Ongoing work with commissioners to reduce referral demand.
- Targeted Consultant validation of all patients waiting 15+ weeks without any future booked activity due to commence on 25th November.
- Care Group Efficiency Reviews held to challenge recovery plans and utilisation of outpatient and theatre capacity. These are chaired by the Chief Executive, with the Chief Operating Officer and Director of Finance.
- Support from the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services. Initial conversations already started and full day site meeting booked for 19th November.

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.

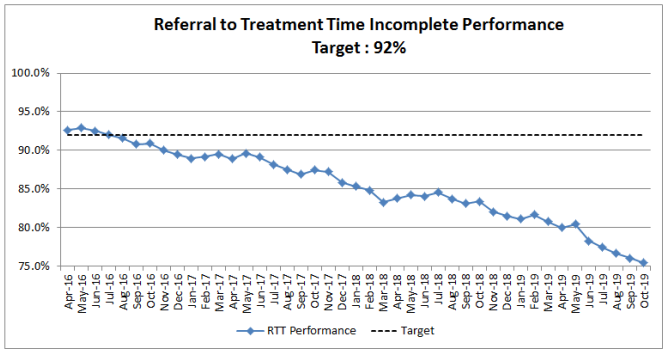
Consequence of under-achievement:

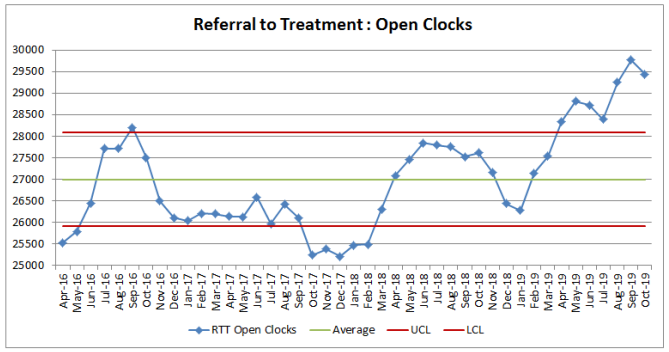
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

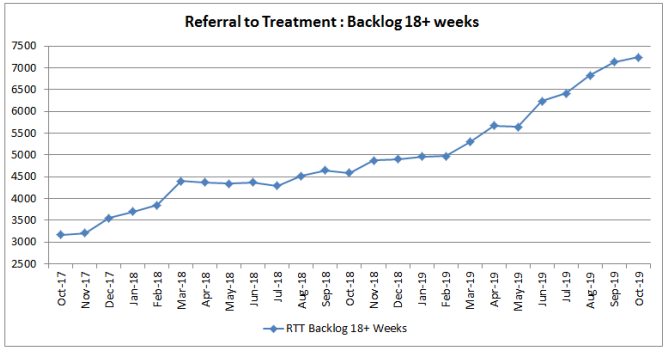
Performance Update:

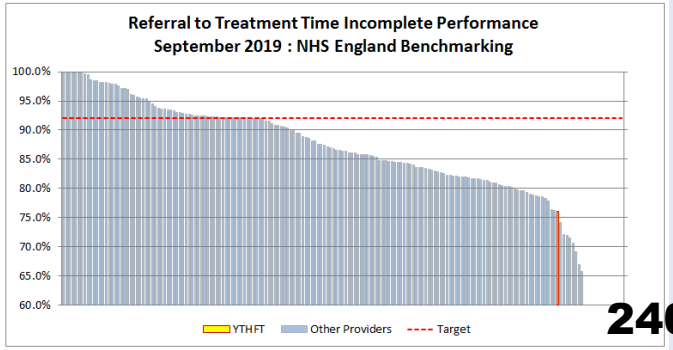
- The total incomplete Referral to Treatment (RTT) waiting list (TWL) stood at 29,442 at the end of October, down 329 clocks on the end of September position. This is above the target to have below 26,303 open clocks (March 2018 position) by the end of March 2020.
- The Trust achieved 75.4% RTT at the end of October, below the 80.0% trajectory submitted to NHS England and NHS Improvement.
- Although the Trust's 'Did Not Attend/Was Not Brought' (DNA) rate fell slightly to 5.9% in October, performance has now remained below the two-year average for nine consecutive months. Work is ongoing to move the Trust from a 1-way text reminder service to a 2-way opt-out service to further reduce DNA rates.

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.

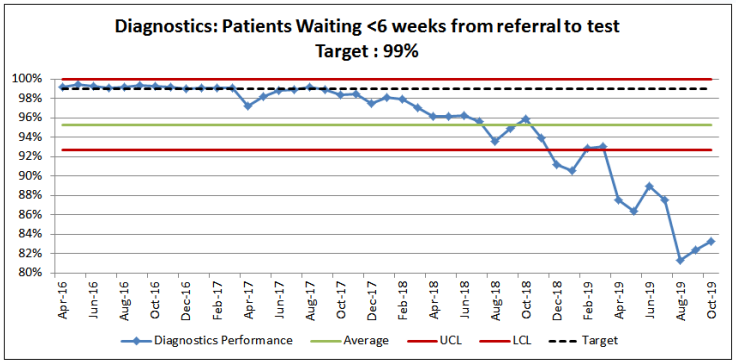
Consequence of under-achievement:

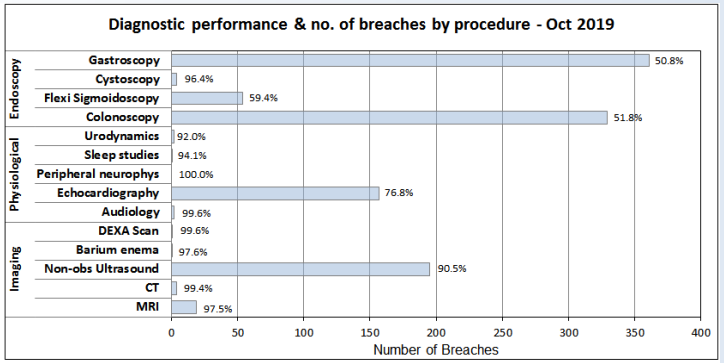
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

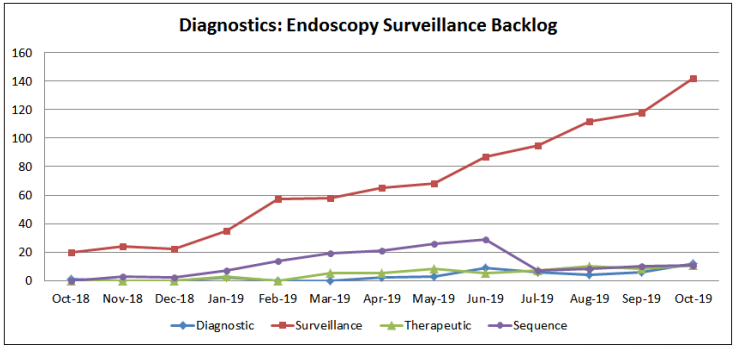
Performance Update:

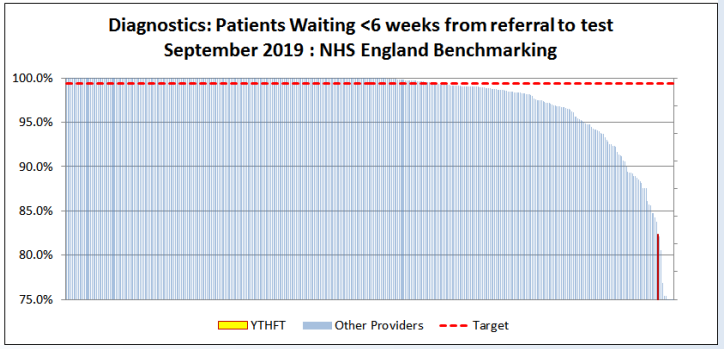
- The Trust has seen an improvement against the national 6 weeks diagnostic target in October, with performance of 83.3% against the standard of 99%.
- At a Trust level, pressures remain in endoscopy, Echo CT and Non-Obstetric Ultrasound. Recovery plans have been created for all modalities not achieving the 99% standard and progress against these is being monitored with Care Groups on a weekly basis.

Performance:









Assurance Framework Responsive

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

CQUIN Name & Description	Executive Lead	Operational Lead	Quarter 1 Outcome	Quarter 2 Outcome	Quarter 3 RAG & Risks	Quarter 4 RAG & Risks
CCG1a: Antimicrobial Resistance; Urinary Tract Infections	James Taylor	Rachel Davidson	**Achieved**	**Achieved**	**Green Project on track**	
CCG1b: Antimicrobial Resistance; Colorectal Surgery	James Taylor	Michael Lim	**Achieved**	**Achieved**	**Green Project on track**	
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	**N/a Annual plan**		**Amber Due to performance in 2018/19**	
CCG7: Three high impact actions to prevent Hospital Falls	Heather McNair	Rebecca Hoskins	**Achieved**	**Achieved**	**Green Project on track**	
CCG9: Six Month Reviews for Stroke Survivors	Wendy Scott	Gemma Ellison	**Achieved**	**Achieved**	**Green Project on track**	
CCG11: Same Day Emergency Care; Pulmonary Embolus, Tachycardia with Atrial Fibrillation and Community Acquired Pneumonia	Wendy Scott	David Thomas and Gemma Ellison	**Achieved**	**Achieved**	**Green Project on track**	
PSS3: Cystic Fibrosis Supporting Self-Management	Wendy Scott	Eleanor King	**Achieved**	**Achieved**	**Green Project on track**	

Board of Directors – 27 November 2019
Humber Coast and Vale Health and Care Partnership and Hull and Harrogate Alliances Update

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

The report is a regular update of progress and developments for the Board of Directors on the work programme relating to the Humber Coast and Vale Health and Care Partnership and Harrogate and Hull Alliances.

The intention of the report is to provide the Board with further information in relation to the work being undertaken and to provide an opportunity for discussion, debate and feedback.

Executive Summary – Key Points

Key points to note include:

- the progression of the Scarborough Acute Services Review and the completion of Stage Two work
- the development of the Strategic Outline Case for the Scarborough Emergency Department development to facilitate release of allocated capital funding
- preparatory work in connection with the implementation of the Radiology Reporting Hub
- the provisional allocation of £280k over two years to York Teaching Hospital NHS Foundation Trust for a Rapid Diagnostic Centre
- the development of revised care pathways for the Medical Oncology service

Recommendation

The Board of Directors is asked to the note the contents of this paper.

Author: Neil Wilson, Head of Partnerships and Alliances

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: November 2019

1. Introduction and Background

This report provides an update of progress and developments in relation to the work that the Trust is undertaking within the Humber Coast and Vale Health and Care Partnership and with Hull University Teaching Hospitals NHS Trust and Harrogate and District NHS Foundation Trust.

The intention of the report is to provide the Board with further information in relation to the work being undertaken and to provide an opportunity for discussion, debate and feedback.

2. Humber Coast and Vale Health and Care Partnership (HCV)

a) Local Health and Care Plans

Work is ongoing within the designated localities of the Partnership in relation to the development of plans and priorities. These in turn support the development of the HCV response to the NHS Long Term Plan.

Key priorities include:-

- Improving patient outcomes
- A radical shift to self-care and prevention
- Sustainable acute care
- Stabilising the care market
- Shifting to “digital” technology
- Transforming care to respond to learning disabilities and autism

A System Transformation Board covering the York and Scarborough Localities has been established and meets monthly.

Governance arrangements are being reviewed to ensure that there is a multi agency approach to agreeing and taking forward local priorities.

The Scarborough Acute Services Review is part of the approach to ensure that services at Scarborough Hospital are configured in a way that ensures they are clinically sustainable.

The Review has to date been overseen by a Review Steering Group and involves a number of partners from Scarborough and Ryedale, Vale of York and East Riding CCG’s, York Teaching Hospital NHS FT (YTHFT) and the Humber Coast and Vale Health and Care Partnership. There is also representation from NHS Improvement (NHSI).

The Review has progressed through Stage One including the first and second phases (a diagnostic assessment involving a detailed appraisal of existing clinical services and prioritisation of key sustainability issues). The third phase (an evaluation of clinical models to address identified issues which contain proposals for future service delivery) has also been also completed.

Clinical Reference Group meetings involving senior clinicians and managers from the Trust, local GPs, Yorkshire Ambulance Service (YAS) and HUTHT have been held to discuss the emerging clinical models.

A public facing summary document of the outputs from Stage One was issued in March 2019.

Stage Two of the Review process commenced in April 2019 and was completed in September 2019.

The work involves more detailed financial analysis of the impact on activity and workforce terms of the implementation of the clinical models and in-depth discussions have been held with the respective clinical teams.

A further strand of work focusing on development of a potential vision, plan and implementation programme for integrated out of hospital care is also being progressed.

Discussions have commenced involving the North Yorkshire CCG Director of Strategy and Integration and representatives from Humber Teaching NHS Foundation Trust (the local community services provider) and Social Services around alignment of the North Yorkshire vision for an integrated care model with similar local developments being progressed in the Scarborough locality.

b) Humber Coast and Vale Health and Care Partnership Wide Initiatives

The Partnership has established three Strategic Boards covering key stakeholder priorities. These are:-

- **Capital and Estates** (reviewing whole system and Trust priorities including the progression of capital bids). The Scarborough ED scheme was prioritised as the top item and confirmation of full financial support (£40m) was received in December 2018.Work is currently underway on the imminent submission of a Strategic Outline Case to enable the release of funding for the Scheme. Further guidance is awaited on future capital bidding opportunities for schemes across the Partnership.

- **Digital Technology** (the Strategic Digital Board is chaired by Chris Long, Chief Executive, Hull University Teaching Hospitals NHS Trust). System wide and Acute Trust digital technology and innovation priorities have been identified for funding support from the Health System Led Investment (HSLI) Fund.

  A key System wide initiative is a project on clinical records sharing with a particular focus on technology to support transfers of care and YTHFT initiatives including improvement of hospital flow, endoscopy imaging, mobile working for community teams and an integrated Laboratory Information Management System (with Hull University Teaching Hospitals NHS Trust).

These will be developed with supporting business cases pending confirmation of final funding (the YTHFT initiatives amount to approximately £3m over the course of the current and next financial years).

- **Workforce** (chaired by Rob Walsh, North East Lincolnshire Council and CCG Chief Executive).

A Diagnostic Services Strategic Board has been established to consider current and predicted capacity and demand issues.

The following priorities have been agreed:-

- Development of an assurance framework which will set out the main risks within diagnostics and mitigations.

- This will in turn support development of funding priorities, workforce strategy and discussions about the future direction of travel (as advised by the experts in working groups reviewing Radiology, Pathology and Endoscopy services).

- Determination of strategic priorities for replacement of existing equipment and placement of future equipment.

With respect to acute service collaboration, a Humber Coast and Vale Hospital Partnership Board comprising Chief Executives and Executive Directors of the three acute provider organisations in the HCV area is overseeing the following areas of work:-

- The reformed Elective Care Delivery Board and Group (involving acute providers and CCG's) which is reviewing opportunities for clinical and non-clinical service transformation to improve quality and encourage efficient practice.

- The Operational Delivery Network (encompassing Complex Rehabilitation and Cardiology as well as the more established Major Trauma and Critical Care groups) which is reviewing care pathways and performance/outcomes as well as sharing best practice.

- Assessment of the implications of specialised service guidance and reviews.

Key highlight areas being progressed include:-

a) Orthopaedics

- Sharing of best practice in relation to the development and operation of fracture and other subspecialised clinics.

- A review of thresholds and MSK triage arrangements to ensure consistency of content and application.

- Review of 'Right Care Right Time' and 'Getting it Right First Time' benchmarking data across providers and localities.

- Specialist revision protocols and kit procurement processes are being scrutinised to ensure standardisation and opportunities for cost improvements in relation to collaborative equipment purchase are being explored.

b) Orthodontics/Maxillofacial Surgery

- The development of a draft orthodontic network plan is being progressed for potential implementation in 2020.

- The implications of a potential North Yorkshire and Humber Oral Surgical Referral Management system (based on the current West Yorkshire model) are being worked through for potential implementation next year.

c) Ophthalmology

- York has adopted the Hull model of virtual clinics for Glaucoma follow up patients.

- Clinical workshops are planned to review the development and application of common service specification standards.

d) End of Life Care

- A standardised approach to pathways is being explored and used of shared documentation is being progressed.

e) Urology

- There is continued progress on the development of a tripartite urological service network following clinician/management network event (areas include a patch wide stones service and more widespread use of the lithotripsy service in Hull).

f) ENT

- A number of meetings of a network group of lead clinicians and managers across the three Acute Trusts have been held and the group are developing a work programme sharing best practice and reviewing care pathways.

g) Cardiology

- The Operational Delivery Network meeting involving the three Acute Trusts, CCG's and Primary Care representatives in the Humber Coast and Vale patch has been established.

- A number of initiatives are being progressed including a review of workforce in the Trusts, sharing of planned service and capital developments, common patient level data, CVD prevention and detection and a model for Community Cardiology services.

h) Radiology

- A capacity and demand analysis plan for diagnostics has been finalised involving a wide group of clinical and managerial representatives across the HCV patch.

- The plan was considered at the HCV Partnership Executive Group meeting and the capacity and recruitment gaps highlighted. A patch wide Diagnostic Group (with Executive Director Leadership) to oversee and co-ordinate a concerted planning and delivery approach to this area. The Group has met on three occasions (see above).

- Utilising centrally awarded transformation monies a radiology reporting hub involving the three acute trusts (led by YTHFT) which will identify and share reporting capacity and reduce outsourcing costs is being developed. Following a formal tendering exercise, a formal award of contract with the Intelerad company as a partner organisation delivering the system has recently been made.

- Preparatory work on the new system is being undertaken prior to the commencement of trials in selected pathway areas within the next few months.

- Discussions are progressing in relation to a financial model for staff collaborative reporting and plans are underway to recruit a Programme Manager (using allocated transformation monies) to oversee the development.

- Positive discussions have been held with the Yorkshire Imaging Collaborative (covering the West Yorkshire Acute Trusts) who will shortly be purchasing a similar solution and there has been agreement to develop common reporting standards and protocols.

  Notification was given to potential suppliers through the recently issued tender documentation guidance that the procurements are part of an aligned process. It is envisaged that this will ensure competitive pricing from suppliers and interconnectivity between the two systems.

i) Rapid Diagnostic Centre Pathway Development

Funding has been made available through the Humber Coast and Vale Cancer Alliance to set up Rapid Diagnostic Centres (RDC) for patients with serious non-specific (SNSS) symptoms and to explore ways to expand the remit of RDCs to improve cancer diagnostic provision for other patient cohorts.

Trust Radiology clinicians and managers along with primary care colleagues in the York/Scarborough area have expressed an interest in developing a purpose designed

pathway to meet this guidance. There is capacity to manage the change and potential to benefit a greater number of patients.

The vision is that in time RDCs will offer:

- A single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer
- A personalised, accurate and timely diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally

A key element of the pathway is the use of filter function tests to determine suitability for the RDC pathway.

A provisional allocation of £280k over a two year period has been allocated to the York/Scarborough area for this purpose (with potential for further funding to be made available in subsequent years to support continued roll out).and a working group is being established to progress this development.

j) Pathology

- In response to an NHSI networking request and following approval from the Hospital Partnership Board, a Hull/York Pathology Collaborative Board has been established with appropriate clinical and managerial involvement. A work programme has been drawn up covering key service and capital priorities.
- To help progress the work programme, a full scale review of the Laboratory Services across the two organisations has been undertaken which is helping to inform the production of a Network Outline Business Case which will be finalised shortly.
- The confirmation of provisional funding for the Laboratory Information Management System across the two Trusts from the national Provider Digitalisation Fund (see above) is a key milestone that will help progress the overall development of the Network.

k) Pharmacy

- A co–ordinated response to regional collaborative work (e.g. regional store, supply chain procurement, aseptic review, TPN rationalisation) is being worked through by the Partnership Chief Pharmacist group.
- A link has been made with collaborative commissioning work on self-care and home care provision and prescription/medication review.

l) Procurement

- The three acute provider Heads of Procurement have identified common clinical product savings.

- All Trusts have been formally accredited to Level 1 of Standards of Procurement.

- Procurement support for the radiology reporting hub and orthopaedic collaboration has been provided (see above).

3. Clinical Alliance with Harrogate and District NHSFT

The Clinical Alliance Board meetings are held on a quarterly basis and it has been agreed that in future the meeting time will be extended and the Chief Executives, Chief Operating Officers, Directors of Finance and Medical Directors of the respective organisations are all in attendance.

YTHFT is also a partner in the West Yorkshire Acute Trust collaborative (West Yorkshire Association of Acute Trusts - WYAAT) which is developing areas for partnership working and shared learning.

Discussions have been held with the WYAAT Programme Director to share respective clinical alliance work plans. Regular follow up meetings are planned.

Specific highlighted areas of current collaborative activity with HDFT are as follows:-

a. Joint Breast Screening/Symptomatic Service Capital Scheme

Discussions are taking place about the shared use of a potential new facility on the Harrogate Hospital site for the first stage screening/symptomatic service(YTHFT currently provides the Breast Screening service to Harrogate patients).

This would involve joint Trust support for overall capital costs.

b. Review of Medical Oncology Service

This is being undertaken to encompass the Trust service delivered in partnership with HDFT and HUTHT, in the light of ongoing staffing and service pressures. Inter - service meetings with colleagues from these two Trusts and LTHT are being held to progress the review.

A short term collaborative solution to address particular staffing pressures in the Breast Medical Oncology service has been worked up and implemented for Scarborough and Harrogate patients.

This involves support from Leeds clinicians to Harrogate (where YTHFT runs clinics) and the pooling of clinical expertise from the York clinicians in York itself. Scarborough patients

are continuing to receive Chemotherapy services locally but travel to York for their outpatient care.

A group of clinicians and managers from YTHFT and HUTHT have been reviewing care pathways for the full range of oncology tumour sites as part of the development of a longer term sustainable model across all aspects of the Medical Oncology service.

This includes medium to longer term arrangements for Breast Medical Oncology provision for Scarborough and Harrogate patients.

4. Detailed Recommendation

The Board of Directors is asked to note the contents of this paper.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Director of Estates and Facilities Report

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☐ **to ensure financial sustainability**

Recommendation

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

Purpose of the Report

This report summarizes the issues discussed at the resources committee and provides an update on the Scarborough mortuary replacement.

Executive Summary – Key Points

This will be the last report in this format as the post of Director of Estates and Facilities will be dis-established at the end of this month as the formal contract management arrangements for YTHFM LLP come into force.
The responsibilities of the post are being transferred to other Executive portfolios.

Recommendations

The Board is asked to note the new arrangements for assurance relating to Estates and Facilities.

Author: Brian Golding, Director of Estates and Facilities/LLP MD
Director Sponsor: Brian Golding, Director of Estates and Facilities/LLP MD

Date: November 2019

1. Overview

Since YTHFM went live I have been carrying out the dual roles of Managing Director of YTHFM and Director of Estates and Facilities for YTHFT. Whilst this has provided continuity and stability during the transitional phase it was always recognised that this would be a time limited arrangement as there is a potential conflict of interest in this arrangement.

Following approval of terms of reference by both the Resources Committee and the Board of Directors YTHFT has now established management arrangements for the Master Services Agreement with YTHFM, and formal monthly Executive Performance Assurance Meetings will commence form the end of November 2019. On commencement of the EPAM it has been agreed that I will relinquish the Director of Estates and Facilities role. My residual corporate responsibilities will be divided as follows:

- YTHFM contract management, (including compliance) – Director of Finance
- Trust-wide Health and Safety – Chief Nurse
- Sustainable Development - leadership to be procured from YTHFM.

This will, therefore, be the final report in this format.

The Board is asked to note the new arrangements for assurance relating to Estates and Facilities.

2. Review of Corporate Risks

Following discussion at the September meeting of the Resources Committee, the risks associated with the replacement of the fire alarm systems at both the York and Scarborough sites have been de-escalated and no longer feature on the corporate risk register. The system at York is in the final commissioning phase and the Scarborough system is substantially complete. It should be remembered that these projects were delivered by the In House team, saving the Trust over £200k in management contractor fees.

The two remaining corporate risks relate to limited access to capital to develop the Estate strategically and to keep on top of backlog maintenance. These risks are worsening as capital constraints get ever tighter.

A separate meeting of the Resources Committee took place last month at which the processes for prioritising investment were discussed. A comprehensive condition survey has been completed for all sites, and the estates team are now merging their existing asset management plans into this overarching document. From next year all maintenance plans will be prioritised based on the level of risk identified in the condition survey.

3. Scarborough Mortuary

Since the discussion at the Board in September, following on from the site walk-round, the Capital Programme Executive Group have met and discussed the poor condition of the mortuary facilities on the Scarborough site.

Funding has been identified and procurement commenced for the immediate provision of a replacement body store.

The infrastructure element of the Scarborough strategic capital includes the replacement of the Scarborough mortuary. The Strategic Outline Case for the overall Scarborough investment has now been submitted, and we await approval from the centre. We understand that early draw down against the funds may be possible once the SOC is approved. In these circumstances we will be making a case to bring the mortuary element of the project as far forward as possible.

Meanwhile the Bereavement team are bidding for some minor works funding to allow them to make some cosmetic and practical improvements in the existing environment.

4. Health and Safety

The Resources committee discussed the monthly Health and safety report.
There were no RIDDOR reportable incidents, (incidents that we are obliges to report to HSE) this month in the trust.

5. Cleaning performance

The Resources Committee received assurance around the action plans relating to the previous concerns around performance in the main theatres and kitchens at York hospital.

6. Annual PLACE inspection

The annual PLACE inspections were completed during September and October this year. The results will be published nationally in January 2020.
On behalf of the Trust I'd like to express thanks to the volunteers who participated in the inspections.

7. Succession planning

As the Board will know I am planning to retire from the NHS at the end of March 2020. YTHFM LLP have started the recruitment process for a replacement Managing Director.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Finance Report

Trust Strategic Goals:

☐ **to deliver safe and high quality patient care as part of an integrated system**
☐ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

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

Purpose of the Report

The purpose of this report is to advise the Executive Board of the financial position for month 7 of the 2019/20 financial year.

Executive Summary – Key Points

The income and expenditure position for month 7 of the 2019/20 financial year confirms the Trust has not met its pre-PSF control total. It is therefore not appropriate to apply PSF and FRF to the month 7 position. The usual reconciliation process applies at the end of the quarter and so recovery of this position is possible.

For the period April to October the Trust's pre-PSF control total was a deficit of £11.8m. This position has not been achieved with the pre-PSF income and expenditure position being a deficit of £12.3m, resulting in an adverse variance to plan of £0.5m. After applying PSF for the months where this has been secured the Trust is reporting a deficit of £3.2m against a planned deficit of £1.9m, therefore reporting an adverse variance to plan of £1.3m.

Recommendation

The Board of Directors is asked to note the income and expenditure position for the Trust in relation to delivery of control total and to support continuing with the enhanced expenditure scrutiny and cost reduction measures to maintain forecast outturn against plan.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: November 2019

1. Year to date Summary Financial Position

The income and expenditure position for month 7 of the 2019/20 financial year confirms the Trust has not met its pre-PSF control total. It is therefore not appropriate to apply PSF and FRF to the month 7 position. The usual reconciliation process applies at the end of the quarter and so recovery of this position is possible.

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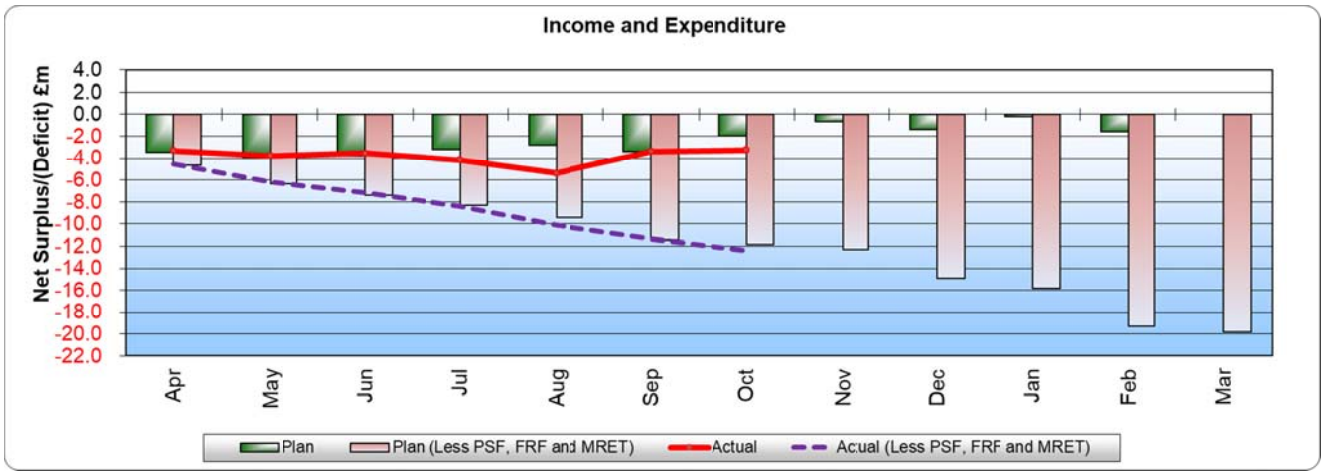
The Trust is continuing the trend of fluctuations around the control total position, reflective of the fragility and stretch of the current financial position. Sustainability Funding linked to the second half of the year is at significant risk. For information 35% of Sustainability Funding is linked to financial performance in the first half of the year and 65% is linked to financial performance in the second half.

The chart below summarises the pre and post PSF plan for the year alongside the actual performance for the year to date.



2. Summary Financial Commentary

NHS Clinical Income remains behind plan by £1.0m and relates to continued underperformance against activity plans. This position is more than compensated for by non-NHS clinical income positive variances, additional to plan education and training income and R&D income and other miscellaneous income sources. Income all sources is reported with a £0.2m favourable variance to plan.

There is a notable movement between last month and this month where, due to the fact that the pre-PSF control total has not been met, we have been unable to assume achievement of sustainability funding in month 7. This has caused an immediate £0.8m negative income variance.

The operational expenditure variance to plan has continued to deteriorate from a reported adverse variance last month of £1.4m to an adverse variance at month 7 of £2.0m. The most significant area of deterioration has been with other non-pay expenditure where the operational overspend has deteriorated from a slight underspend to a £1.5m overspend. Some compensation has been reported in other expenditure lines and, notably, the pay position has improved in month.

The overspend in Other Costs has been driven in-month by outsourcing endoscopy at £160k and the Trust has also incurred an additional charge associated with the management charge for Lloyds Pharmacy of £167k, relating to additional activity going through the unit. The improvement in the pay position has been partly due to a re-categorisation of £0.2m from pay to non-pay linked to the RMO at Bridlington. There are numerous other smaller value pressures in this category.

Notwithstanding this improvement in pay expenditure, medical and nursing expenditure remain the significantly overspending areas.

Notable reductions are evident in all categories of agency expenditure this month. The detailed finance report shows that nurse agency expenditure, whilst having reduced in month, is currently running at almost twice the planned and NHSI cap figure.

Notwithstanding the vacancy position in terms of medical and nursing staffing the Trust continues to materially breach its agency expenditure cap. Spend is now £12.0m against a year-to-date cap level of £8.9m. The Trust is currently £3.1m ahead of its cap set by NHSI. A simple extrapolation suggests the annual cap of £15m will be breached by some £5m, with total expenditure set to exceed £20m. Close monitoring and continued improvement action are necessary during the second half of the financial year.

In terms of the Trust's efficiency programme, in-month delivery for October has moved delivery to £11.0m of the £17.1m target. Recurrent delivery stands at £7.9m. Continued focus and energy is required to ensure delivery of the programme.

Given the extensive and detailed financial plan agreed this year, and the known provisions created for agreed cost pressures, it would be reasonable to assume that we should be starting to see a positive variance appear against our planned deficit. This is further supported by the decisions taken to not implement some of the activity funding on the back of supporting the wider system position. This saving has not been given up to the system yet and so this will place further pressure on our position when this happens.

The most material pressure on our position is that associated with additional nursing as a result of the CQC's intervention. This amounts to £1.0m year to date, and whilst this is approved spend this has not been provided for in our financial plan and represents an in-year cost pressure.

There are also a significant number of other material pressures that are building. These pressures are all unfunded, all unplanned, all without business case approval and as a result are placing at risk our sustainability funding. In order of materiality; the gap in our Histopathology workforce is resulting in a net pressure of £238k from external reporting and the same position is applicable within Radiology where the cost pressure from outsourced reporting, net of all provisions, stands at £230k. The RMO arrangement at

Bridlington is exceeding approved budgetary levels by £147k as a result of difficulties with the supplier providing the service. A further unplanned and unknown pressure has also emerged from the mobile MRI facility at the Scarborough site. This was originally commissioned for the duration of the MRI replacement scheme at Scarborough with the mobile rental costs capitalised as part of the scheme. However, the mobile has continued on site and subsequent costs of £141k now need to be charged to our revenue position. And finally, an analysis of the self-rostered Emergency Department consultants at the York site has identified frequent rostering above the agreed and funded 8:8:5 rota; this has incurred unplanned and unapproved costs of £76k to date.

This list accounts for material expenditure commitments made without planning or approval totaling £832k so far this financial year. In addition to this is the additional nursing staff linked to the CQC intervention of circa £1m year to date.

3. Forecast Outturn

There are no further updates to provide to the forecast outturn. Our plan remains to meet our control total albeit there is significant associated risk linked particularly to the unplanned cost pressures on the Trust. The intention of the cost control measures is to counter these pressures and the intention to push the CIP target further is to provide additional financial cover.

4. Supplementary Actions

Expenditure control action has been fully implemented across the Care Groups and Corporate Directorates. The Board is asked to continue to support and endorse the additional actions in support of delivery of the financial control total position. Specifically:

- Expenditure discipline and control has been increased. This includes the cessation or temporary delay of non-essential expenditure, requisition scrutiny for essential items only, temporary restrictions to non-essential training and development costs and enhanced vacancy control scrutiny of non-clinical posts particularly.
- Efficiency programme delivery action has been re-focused through a series of CIP Panel Meetings with the Corporate Team
- Additional focus is continuing on the QIPP system cost recovery delivery through the System Delivery Board
- Additional income recovery plans are being compiled by each of the Care Groups for non-AC contracted commissioners
- And numerous other measures have been communicated for action.

5. Recommendation

The Board of Directors is asked to note the income and expenditure position for the Trust in relation to delivery of control total and to support continuing with the enhanced expenditure scrutiny and cost reduction measures to maintain forecast outturn against plan.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Efficiency Programme Update

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

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 October 2019 is £11.0m.

The key risks to the programme are:

2019/20 - recurrent delivery £7.9M.
2020/21 - planning gap of £8.8m plus high risk plans of £4.5m.
2021-24 - planning gap of £29m

Recommendation

The Board of Directors is asked to note the October 2019 CIP position.

Author: Wendy Pollard, Deputy Head of Resource Management

Director Sponsor: Andrew Bertram, Finance Director

Date: November 2019

Briefing note for the Board of Directors meeting 27 November 2019

1. Summary reported position for October 2019

1.1 Current position – highlights

Delivery – Full year Delivery is £11.0m as at October 2019 which is (64%) of the target and has improved in month by £1.7m. This position compares to a delivery position of £14.8m in October 2018.

Part year delivery is £0.5m ahead of the profiled plan submitted to NHSI.

In year planning – At October 2019 the target of £17.1m is 100% planned (Low Risk £15.6m and Medium Risk £1.5m).

Five year planning – Five year planning (20/21 – 24/25) shows a gap of £37.5m.

Recurrent vs. Non recurrent – Of the £11.0m full year delivery, £7.9m has been delivered recurrently which is 46% of the overall target for 2019/20, an improvement of £0.8m in month. Recurrent delivery at October 2018 was £8.4m.

Risk **– Appendix 1 – Risk Scores** provides an overview of the Risk associated with the Efficiency Programme. This is viewed over a 4 year period and takes into consideration in-year and 4 year planning, in year delivery and recurrent delivery and governance risk.

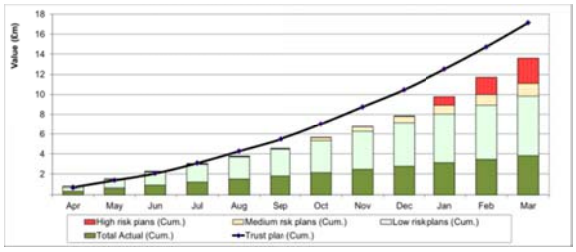
1.2 Overview

Planning

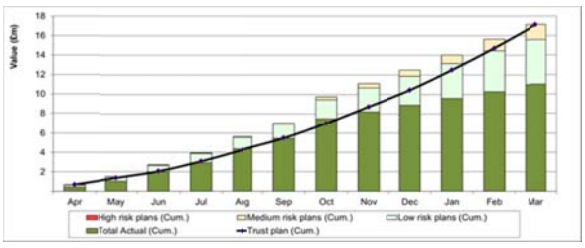
In Year Planning - 2019/20

The two graphs below summarise the in-year delivery and planning position at the end of April and end of August. The October position (November Board report) shows 100% planned at low and medium risk. Medium risk plans remain at £1.5m, 10% of the Programme.

In Year Delivery and Plans - May 2019 Board Report



In Year Delivery and Plans – November 2019 Board Report



Planning - 2020/21 to 2023/24

Table 1 below summarises the current planning position of the CIP Programme for the 4 years from 2020/21 to 2023/24. This assumes an element of carry forward for each year.

Table 1 - CIP Programme 4 Years to 2023/24

York Teaching Hospital NHS Foundation Trust
Cost Improvement Programme 4 Years

	2020/21	2021/22	2022/23	2023/24
	£'000	£'000	£'000	£'000
Financial plan	9,647	10,150	8,278	8,923
Initial non recurrent to recurrent carry forward	6,361	6,004	6,219	5,623
Total target	**16,008**	**16,153**	**14,496**	**14,547**
Identified with high achievability				
Low risk				
Low risk	**3,302**	**1,775**	**895**	**878**
Medium risk	**1,042**	**326**	**1,121**	**833**
High risk	**3,143**	**1,590**	**56**	**0**
Grand Total	**7,487**	**3,691**	**2,072**	**1,711**
Shortfall against Target	**-8,521**	**-12,462**	**-12,424**	**-12,836**

The CET will be working with Care Groups over the coming months to review Moderate and High risk plans and bridge the planning gap to ensure we are fully planned for 2020/21 prior to the annual plan submission. Opportunities identified in the Model Hospital, including GIRFT, will inform these discussions.

Schemes from the Workforce, Procurement and Back Office work plans will incorporated into the planning position over the coming weeks.

Delivery Performance

Delivery across Care Groups has been poor for two consecutive months impacting on overall performance. Finance Managers are working with their respective Care Groups to ensure that performance improves for Month 8, see **Appendix 2 – Care Group and Directorate Performance**.

Transactional schemes

Transactional scheme Plans of £13.8m represent 81% of the overall Efficiency Target. Full year Delivery is £9.3m as at October 2019 of which £6.2m is recurrent.

Transformational schemes

Transformational scheme Plans of £3.3m represent 19% of the overall Efficiency Target. Full year Delivery is £1.7m as at October 2019 of which £1.7m is recurrent. There has been no movement in delivery of Transformational Schemes in October.

Please refer to **Appendix 3** – **Summary of Schemes by Category**.

Get It Right First Time (GIRFT)

Please refer to **Appendix 4 – GIRFT Highlight Report** for an update on the GIRFT Programme.

NHSI Support

Recovery Plans have been submitted to NHSI at the end of October for the Back Office function, Workforce and Procurement. Plans continue to be refined.

NHSI continue to support us on the efficiency agenda and will be holding a Rapid Improvement Event on Recruitment in early December.

Governance and Assurance

Quality Impact Assessment (QIA)

Quality Impact Assessments (QIA) are carried out following the Trust's Risk Management Framework.

There are 315 Schemes in total at the end of October 2019 and these are categorized into the following risks:

Extreme Risk Schemes	1
High Risk Schemes	0
Moderate Risk schemes	6
Low Risk Schemes	134
To be assessed	174

Extreme Risk Scheme
Orthopaedics – Plaster Technician lack of capacity; increased demand on service.

Moderate Risk Schemes
Please refer to **Appendix 5 – QIA** for detail of schemes.

The Extreme and Moderate risk plans have been reviewed with JT (Medical Director) and further clarification is being sought from the Care Groups.

Risk

As indicated in the report the main Risks presenting are:

- Planning
- Delivery (recurrent and non recurrent)
- Focus

To reduce the above risks the following following strategy is in place:

- Engagement and discussion with newly formed Care Groups.
- Re-establish CIP Workshops.
- Identify and explore opportunities presented in Model Hospital, SLR and GIRFT.
- Adopt a methodical approach to reviewing Model Hospital using Planning Guidelines by Carter Category.

RISK SCORES - OCTOBER 2019 - APPENDIX 1

Care Group	Yr1 Target	4Yr Target	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Overall Financial Risk		Governance Risk	
	(£000)	(£000)	%	Risk	%	Risk	%	Risk	%	Risk	Total Score		% Assessed	
CG1. Acute, Emergency and Elderly York	2,622	8,084	58%	HIGH	36%	HIGH	30%	MEDIUM	47%	HIGH	11	HIGH	29%	HIGH
CG2. Acute, Emergency and Elderly Scarborough	2,107	4,992	26%	HIGH	17%	HIGH	7%	HIGH	46%	HIGH	12	HIGH	32%	HIGH
CG3. Surgery	3,611	9,853	81%	HIGH	32%	HIGH	20%	HIGH	40%	HIGH	12	HIGH	9%	HIGH
CG4. Cancer and Support Services	3,176	8,139	49%	HIGH	28%	HIGH	25%	HIGH	58%	HIGH	12	HIGH	74%	MEDIUM
CG5. Family Health	2,180	5,243	44%	HIGH	24%	HIGH	9%	HIGH	26%	HIGH	12	HIGH	41%	HIGH
CG6. Specialised Medicine	3,095	8,165	115%	LOW	52%	HIGH	39%	HIGH	69%	HIGH	10	HIGH	83%	LOW
Corporate Functions														
Chief Nurse Team	275	441	66%	HIGH	17%	HIGH	0%	HIGH	41%	HIGH	12	HIGH	33%	HIGH
Chairman and CEO	165	316	143%	LOW	143%	LOW	0%	HIGH	74%	HIGH	8	MEDIUM	0%	HIGH
SNS	215	431	27%	HIGH	27%	HIGH	17%	HIGH	17%	HIGH	12	HIGH	67%	MEDIUM
Ops Management	928	2,221	27%	HIGH	27%	HIGH	17%	HIGH	17%	HIGH	12	HIGH	0%	HIGH
Medical Governance	1,149	2,560	6%	HIGH	6%	HIGH	6%	HIGH	3%	HIGH	12	HIGH	0%	HIGH
Finance	1,211	3,240	206%	LOW	179%	LOW	93%	LOW	87%	HIGH	6	LOW	62%	MEDIUM
Workforce and Organisational Development	54	98	231%	LOW	69%	MEDIUM	2%	HIGH	213%	LOW	7	MEDIUM	0%	HIGH
Estates and Facilities	294	704	193%	LOW	64%	MEDIUM	64%	LOW	114%	LOW	5	LOW	0%	HIGH
TRUST SCORE	**0**	**0**	**100%**	HIGH	**64%**	LOW	**46%**	LOW	**73%**	HIGH	**8**	MEDIUM	45%	HIGH

Appendix 2 - Directorate Delivery Performance **Sum of Total 2019/20**

		September			October			In Month Delivery		
Care Group	**Directorate**	**R**	**NR**	**Total**	**R**	**NR**	**Total**	**R**	**NR**	**Total**
1. Acute, Emergency and Elderly Medicine (York)	Community	19910	0	19910	19910	0	19910	0	0	0
	ED York	121413	0	121413	121413	0	121413	0	0	0
	General Medicine York	473304	156347	629651	475304	165679	640983	2000	9332	11332
	Medicine for the Elderly York	160737	0	160737	160737	0	160737	0	0	0
1. Acute, Emergency and Elderly Medicine (York) Total		**775,364.00**	**156,347.00**	**931,711.00**	**777,364.00**	**165,679.00**	**943,043.00**	**2,000.00**	**9,332.00**	**11,332.00**
2. Acute, Emergency and Elderly Medicine (Scarborough)		137557	163940	301497	137575	216440	354015	18	52500	52518
2. Acute, Emergency and Elderly Medicine (Scarborough) Total		**137,557.00**	**163,940.00**	**301,497.00**	**137,575.00**	**216,440.00**	**354,015.00**	**18.00**	**52,500.00**	**52,518.00**
3. Surgery	GS&U	191465	79582	271047	243053	96381	339434	51588	16799	68387
	Head and Neck	141441	35612	177053	142517	35612	178129	1076	0	1076
	TACC	323946	304868	628814	350308	304868	655176	26362	0	26362
3. Surgery Total		**656,852.00**	**420,062.00**	**1,076,914.00**	**735,878.00**	**436,861.00**	**1,172,739.00**	**79,026.00**	**16,799.00**	**95,825.00**
4. Cancer and Support Services	Cancer	8684	10000	18684	8684	10000	18684	0	0	0
	Endoscopy	1166	0	1166	1166	0	1166	0	0	0
	Lab Medicine	202787	42142	244929	202787	42142	244929	0	0	0
	Pharmacy	364512	0	364512	364512	0	364512	0	0	0
	Radiology	201717	69998	271715	202195	69998	272193	478	0	478
4. Cancer and Support Services Total		**778,866.00**	**122,140.00**	**901,006.00**	**779,344.00**	**122,140.00**	**901,484.00**	**478.00**	**-**	**478.00**
5. Family Health	Child Health	171911	178315	350226	173081	178315	351396	1170	0	1170
	Sexual Health	6114	119842	125956	6114	119842	125956	0	0	0
	Womens Health	15347	37266	52613	16011	37266	53277	664	0	664
5. Family Health Total		**193,372.00**	**335,423.00**	**528,795.00**	**195,206.00**	**335,423.00**	**530,629.00**	**1,834.00**	**-**	**1,834.00**
6. Specialised Medicine	Ophthalmology	20637	43000	63637	20637	43000	63637	0	0	0
	Orthopaedics	279721	49000	328721	282417	49000	331417	2696	0	2696
	Specialist Medicine	915289	52603	967892	903817	302427	1206244	-11472	249824	238352
6. Specialised Medicine Total		**1,215,647.00**	**144,603.00**	**1,360,250.00**	**1,206,871.00**	**394,427.00**	**1,601,298.00**	**- 8,776.00**	**249,824.00**	**241,048.00**
7. Corporate Functions	Chief Exec	208	234180	234388	208	272420	272628	0	38240	38240
	Chief Nurse Team	0	48000	48000	0	48000	48000	0	0	0
	CIP Reserve	2662243	108347	2770590	3356447	610206	3966653	694204	501859	1196063
	Estates and Facilities	383967	0	383967	413137	0	413137	29170	0	29170
	Finance	268742	227971	496713	272960	255779	528739	4218	27808	32026
	Medical Governance	3195	0	3195	3195	3966	7161	0	3966	3966
	Ops Management	26931	18672	45603	30543	7668	38211	3612	-11004	-7392
	SNS	0	50000	50000	17115	50000	67115	17115	0	17115
	Workforce & organisational development	3449	148700	152149	3473	148700	152173	24	0	24
7. Corporate Functions Total		**3,348,735.00**	**835,870.00**	**4,184,605.00**	**4,097,078.00**	**1,396,739.00**	**5,493,817.00**	**748,343.00**	**560,869.00**	**1,309,212.00**
Grand Total		**7,106,393.00**	**2,178,385.00**	**9,284,778.00**	**7,929,316.00**	**3,067,709.00**	**10,997,025.00**	**822,923.00**	**889,324.00**	**1,712,247.00**

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	£13.8	£ 9.3	£ 6.2	£ 3.1	£ 5.7	£ 6.5
Transformational	£ 3.3	£ 1.7	£ 1.7	£ 0.0	£ 1.4	£ 1.0
Total Programme	**£17.1**	**£ 11.0**	**£ 7.9**	**£ 3.1**	**£ 7.0**	**£ 7.5**

Table 2: Transformational Scheme Summary

Transformational Scheme	Annual Plan £'m	Full Year Delivery £'m	Full Year Recurrent Delivery £'m	Full Year Non Recurrent Delivery £'m	NHSI Plan YTD £'m	Total Delivery YTD £'m
Theatre Productivity	£ 0.8	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
Outpatients	£ -	£ -	£ -	£ -	£	£ -
ADM	£ 0.8	£ 0.4	£ 0.4	£ 0.0	£ 0.5	£ 0.2
Pharmacy	£ 1.3	£ 1.3	£ 1.3	£ 0.0	£ 0.8	£ 0.8
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
Scarborough Single Improvement Programme	£ 0.1	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
Ophthalmology	£ 0.1	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
District Nursing	£ 0.2	£ 0.0	£ 0.0	£ 0.0	£ 0.1	£ 0.0
Total Transformational Schemes	**£ 3.3**	**£ 1.7**	**£ 1.7**	**£ 0.0**	**£ 1.4**	**£ 1.0**

Table 3: Efficiency Programme by Carter Category						
Carter Category	**NHSI Annual Plan £'m**	**Full Year Delivery £'m**	**Full Year Recurrent Delivery £'m**	**Full Year Non Recurrent Delivery £'m**	**NHSI Plan YTD £'m**	**Total Delivery YTD £'m**
Carter W/force (Medical)	£ 2.0	£ 0.6	£ 0.6	£ 0.0	£ 0.2	£ 0.5
Carter W/force (Nursing)	£ 1.4	£ 0.7	£ 0.7	£ 0.0	£ 0.4	£ 0.7
Carter W/force (AHP)	£ 0.2	£ 0.4	£ 0.3	£ 0.1	£ 0.1	£ 0.3
Carter W/force (Other)	£ 1.8	£ 1.1	£ 0.0	£ 1.1	£ 0.9	£ 0.9
Carter Procurement	£ 3.2	£ 2.8	£ 1.9	£ 0.9	£ 1.6	£ 1.8
Carter Hospital Medicine & Pharmacy	£ 2.0	£ 1.7	£ 1.7	£ 0.0	£ 0.9	£ 1.0
Carter Corporate & Admin	£ 0.5	£ 2.5	£ 1.7	£ 0.8	£ 0.2	£ 1.6
Carter Estates & Facilities	£ 1.0	£ 0.4	£ 0.4	£ 0.0	£ 0.5	£ 0.3
Carter Imaging	£ 0.5	£ 0.3	£ 0.2	£ 0.1	£ 0.3	£ 0.2
Carter Pathology	£ 0.6	£ 0.2	£ 0.2	£ 0.0	£ 0.2	£ 0.1
Other Savings Plans/Unidentified	£ 3.9	£ 0.4	£ 0.2	£ 0.2	£ 1.6	£ 0.2
Total Programme by Carter Category	**£17.1**	**£ 11.0**	**£ 7.9**	**£ 3.1**	**£ 7.0**	**£ 7.5**

It should be noted that Transformational Schemes will also be included in the Carter Categories.

Appendix 4

York Teaching Hospital
NHS Foundation Trust

Highlight Report

GIRFT Assurance Board Update at 28th October 2019

This report provides a brief update of work completed since the last assurance board on the 30th July 2019.

Progress Update at 28th October 2019

New Appointments to GIRFT Team

Following the last board meeting, Richard Khafagy (Associate Medical Director) has now been appointed as Senior Clinical GIRFT lead and will be supported by the GIRFT Programme Lead (Michael Davison) and GIRFT administration support assistant (Roz Clarke) in supporting Care groups to deliver the GIRFT programme of work.

Shared Learning

The main focus this quarter has been to develop a common understanding as to how to deliver an effective process to support shared learning across the Trust. The intention would be to bring together lessons learned from a variety of information sources into a single system. Early discussions have highlighted that the 'Learning Hub' may provide an accessible solution that can act as a single repository for our shared learning. This work will continue and further updates will be provided in due course.

NHS Litigation Review

The Legal team have been working with NHS Resolution to validate open claims and identify specialties that maybe outliers in terms of legal costs. Early work indicated that a number of claims had been incorrectly assigned to specialties and skewing the outlier information provided by the GIRFT team. Work continues on ensuring all claims are correctly assigned before assessing which specialties are outliers.
In addition, Richard Khafagy has reviewed a number of open claims across different specialties to establish if there are any themes emerging – this work is continuing.

Regular Review Meetings with Medical Director

Richard Khafagy and Michael Davison are now meeting monthly with the Medical Director to provide regular progress updates and assurance outside of the monthly board meetings.

GIRFT Dashboard & Review Meetings

A summary dashboard has been created that will focus attention on:

- Highlight key activities within the department
- National standards compliance
- Locally agreed actions following review meetings
- Litigation costs and Harm reviews
- Shared learnings

We continue to schedule review meetings (Respiratory and Renal) and are aware that review meetings with Endocrinology, Diabetes and Anaesthetics are to be scheduled.

GIRFT Activity Highlights: 1st August to 31st October

Date	Activity	Next Steps
1st Aug	Prototype dashboard designed for capturing agreed outputs from GIRFT review meetings	Develop into final product
1st Aug	Litigation claims review commences with support from NHS resolution. There are in excess of 450 open claims that need to be reviewed.	Initial review highlights claims have been assigned to incorrect specialties – reassign to correct specialties and look for common themes.
6th Aug	Confirmation provided in writing to GIRFT team that we are working towards the 5 point plan for reviewing our current legal claims.	1. Claim coded correctly to specialties. WIP 2. Review outlier specialties. 3. Review claims in outliers. 4. Triangulate claims to other harm data sources 5. Share learnings
18th Aug	AMD reviews active General Surgery claims to identify common themes.	Continue to review open claims to identify trends. WIP
23rd Aug	Rheumatology Deep Dive meeting scheduled	10th December 2019
Sept		
13th Sept	Review meeting with Care Group 3 – Intensive care	Actions agreed and dashboard completed
19th Sept	ED data set validated with GIRFT national team	Await dates for deep dive reviews
20th Sept	GIRFT request best practice report from our diabetes service	Submit report – the best practice studies will be included in the national report.
25th Sept	Lung Cancer data submission completed	Await feedback from national GIRFT team
25th Sept	Review meetings scheduled for Renal and Respiratory Medicine Respiratory Review – 12th Nov 2019 Renal Review – 10th Dec 2019	Schedule pre-meetings to sense check challenges faced by departments and assess actions that can be taken immediately.
Oct		
10th Oct	GIRFT request best practice report for our low non-surgical infection rates in Breast Surgery	Submit report – the best practice studies will be included in the national report.
18th Oct	Meeting with Respiratory service to review patient activity recording process and identify improvements.	Identify department needs and engage with SNS to agree

		CPD updates
28th Oct	GIRFT Assurance Board	
29th Oct	Meeting with Learning Hub manager to assess how to use the Hub to provide a 'Shared Learning' platform	Complete mini feasibility study and create prototype subject to outcome of feasibility study.
Nov		
12th Nov	Internal Respiratory Review Meeting	Document agreed follow on actions
Dec		
2nd Dec	External GIRFT review meeting: Acute & General Medicine	Respond to Observation report recommendations once received.

Appendix 5

2019/20 Directorate QIA Assessment

Care Group	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	Value £'000	
CG 1	Community	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	95	
CG 2	General Medicine Scarborough	CIP1920-192	INCREASE VF TO 7.5% ACROSS AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	Risk that the service will not be adequately resourced	Pateints will be de-conditioning and increased length of say	Increased LOS and failed discharges/ Readmittances	Reversal of CIP if the Turnover does not reach 7.5% in this area	30/09/2019	2	3	6	Moderate Risk	162	
CG 4	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	9	
CG 5	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	40	3 yrs
CG 5	Child Health	CIP1920-036	SCBU YORK SKILL MIX REVIEW	Financial	Option appraisal as per RCPCH invited review March 2019	Option appraisal as per RCPCH invited review March 2019	Option appraisal as per RCPCH invited review March 2019	06/06/2019	2	2	4	Moderate Risk	6	
CG 5	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	8	
CG 6	Orthopaedics	CIP1920-144	NHSI OPERATIONAL PRODUCTIVITY - ORTHOPAEDICS (3.3 INCREASE CAPACITY FOR HAND AND UPPER LIMB SURGERY AT YORK)	Increased demand on plastering	Lack of capacity, potential high cost locum required.	Lack of capacity, potential high cost locum required.	Recruitment of plaster technician. Restriction of service development & provision.	01/10/2019	5	3	15	Extreme Risk	31	
												TOTAL	351	

Corporate Efficiency Team Sign Off (Please return with electronic signature):	
Name:	
Signature	
Assistant Medical Director Sign Off (Please return with electronic signature):	
Name:	
Signature	
Assistant Chief Nurse Sign Off (Please return with electronic signature):	
Name:	
Signature	

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 November 2019
Workforce Report – November 2019

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

To provide the Board with key workforce metrics (up to October 2019 where available); and an overview of work being undertaken to address workforce challenges.

Executive Summary – Key Points

- More than a hundred new nurses have commenced employment with the Trust during the last two months comprising 92 new graduates and 22 international nurses. This, together with other programmes of work, has helped to shrink the Trust's vacancy position going into the winter period.
- The Trust is making strong progress with eJob Planning for Medical and Dental staff and is on course to achieve the NHS Improvement Level of Attainment requirements for job planning in this staff group by March 2021.
- Current workforce campaigns: the NHS Staff Survey response rate was 35.55% on 8th November; 44% of frontline healthcare workers in the Trust have received the 'flu vaccine (up to 8th November 2019).
- A refreshed report on Statutory and Mandatory training shows that compliance within the Medical and Dental staff group remains challenging across all six Care Groups.
- The Trust is taking steps to become a Carer Friendly employer, and hopes to have its work accredited by the York Carers Centre in the new calendar year.

Recommendation

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

Author: Will Thornton, Head of Resourcing

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

Date: November 2019

1. Introduction and Background

November's Workforce Report sets out the current position for vacancies, medical and dental job planning, sickness absence, temporary staffing utilisation and statutory and mandatory training. There is additional coverage of ongoing initiatives designed to improve and support organisational culture.

2. Vacancies

Appendices one, two and three show the detail of vacancies within: the nursing and midwifery workforce (including unregistered workforce); registered medical and dental workforce; and other registered workforce.

Nursing recruitment update

Over the autumn, the Trust has welcomed 92 newly-qualified nurses to Staff Nurse roles across medical and surgical specialties in York (65) and Scarborough (27) Hospitals. 55 nurses arrived from University of York, while 14 joined after graduating from University of Hull. The nurses are currently following the Trust's preceptorship programme which will support them to take their first steps as registrants.

Source: Twitter

The Trust's nursing workforce has been further bolstered by 22 new starters from overseas in October and November (6 in Scarborough and 16 in York). The latest recruits bring the number of arrivals via the international nurse recruitment programme to 49 across York and Scarborough since the end of May 2019 (12 in Scarborough and 37 in York).

Of the 49 international nurses, 23 have been supported by the Workforce Development and Chief Nurse Teams to sit their NMC's Objective Structured Clinical Examination (OSCE). 20 of the nurses achieved a pass, and have either already been, or are in the process of being licenced to practice in the UK.

At present, 67 further arrivals are planned in 2020 (51 in Scarborough and 16 in York). Scoping work is currently being undertaken to develop a proposal to increase this number; however, the overall vacancy position for registered nurses and midwives has improved significantly since May 2019 (when it reached 17.46%). As at the end of October the rate was 11.66%.

Medical vacancies

The Trust is now reporting a medical vacancy figure below 10% on each of its main hospital sites. The level of improvement on the East Coast is such that there are only seven vacancies outside of Consultant and SAS Grades which the Trust is now seeking to fill.

There have been 81 new starters across all medical grades during the last 3-months (which includes September and October changeover). At Consultant level, the Trust has welcomed four new Upper GI Surgeons (including one Locum Consultant), three Anaesthetists and two Gastroenterologists in York. During the same period, a new Locum Consultant Anaesthetist has been appointed in Scarborough, along with five Specialty Doctors (two in Emergency Medicine, two in General Surgery and one in Anaesthetics).

Other vacancies

Appendix 3 shows the detail of vacancies within other staff groups. This does not include pending starters. Of note, the overall vacancy position for Allied Health Professionals has improved significantly during 2019 from 7.71% at the end of January to 4.93% at the end of October.

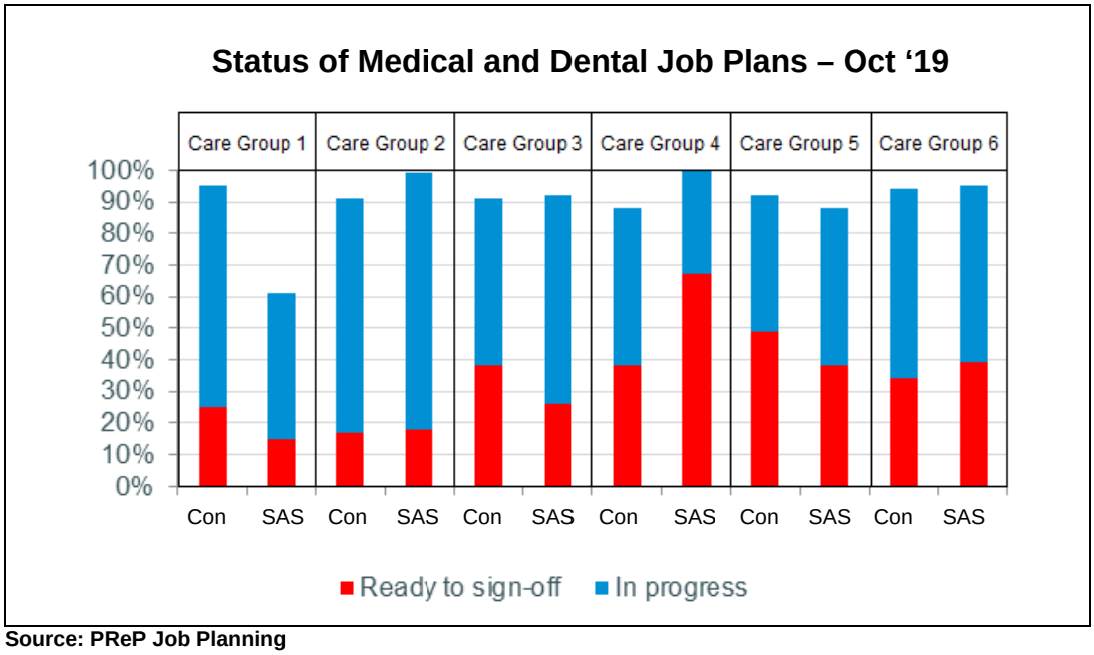
3. Job Planning

The Trust is working towards NHS Improvement's Levels of Attainment for E-Rostering and E-Job Planning. The guidance sets out standards to modernise the management of clinical workforce capacity, with a target of 90% utilisation of both systems by clinical staff, to be achieved by March 2021.

Over the past year, the Trust has concentrated its effort towards these targets on implementing E-Job Planning for the Medical and Dental Workforce. The 2019-20 Job Planning cycle was extended to allow for the implementation of the PReP Job Planning system. As of October 2019, the system was being utilised by 94% of the Trust's Consultants and SAS Doctors. The majority of their job plans are now either awaiting sign-off or close to final submission. The cycle will conclude with a panel meeting with each specialty in November and December, using a 'confirm and challenge' format. A breakdown of the current status of Job Plans broken down by Care Group and Grade can be found in Chart 1 (below).

In parallel with this work, the Trust is piloting the system with a small group of Allied Health Professionals. Initial feedback from the pilot indicates that it has been well-received. A more formal evaluation will help to inform the Trust's plans to introduce the system to other clinical groups, specifically: non-ward based nurses (e.g. Specialist Nurses); Pharmacists; Scientists; and the wider Allied Health Professional group.

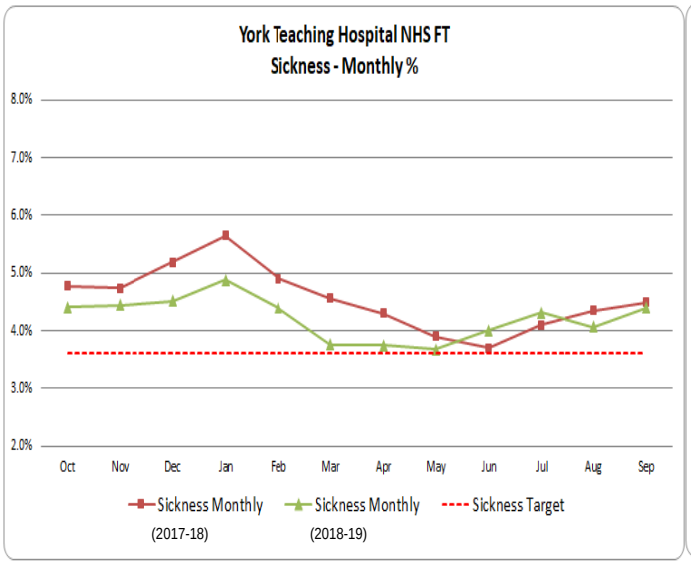
Chart 1

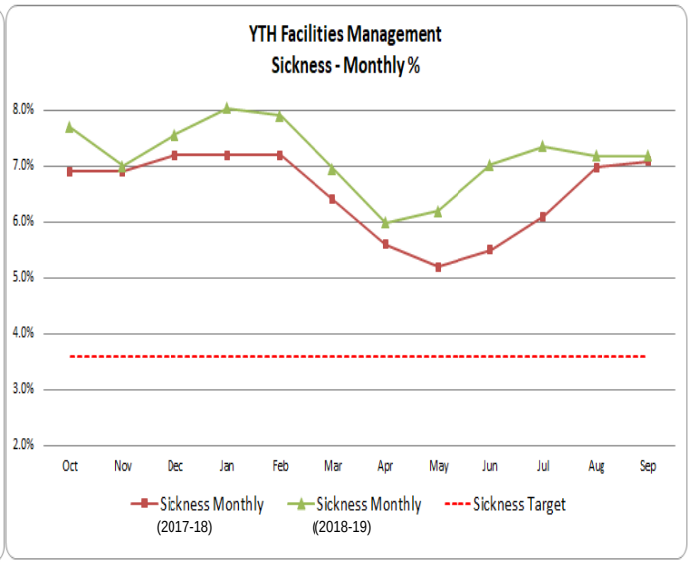


Source: PReP Job Planning

4. Sickness Absence

Charts 2 and 3 – Monthly Sickness Absence Rates





Source: Electronic Staff Record

Charts 2 and 3 show monthly sickness absence rates for the Trust and York Teaching Hospital Facilities Management (YTHFM), covering the period October 2017 to September 2019.

The monthly absence rate in the Trust in September was 4.39%; which is marginally below the rate at the same point in the previous year. The most recent national data (from June 2019) showed that the Trust's monthly sickness absence rate was, at that point, 0.07% higher than the median in our peer group.

YTHFM continue to report a higher rate of absence. In September 2019, this was 7.18%. YTHFM also continue to see a higher proportion of long-term sickness absence (75% of all time being lost to long-term absences) compared with the Trust (61%).

'Flu Campaign

The Trust is making strong progress with its 2019-20 'Flu Campaign. Thanks to the efforts of the Occupational Health Team in the super clinics and peer vaccinators on wards, 44% of the Trust's frontline staff received the vaccination by the end of the first week in November. During this period, one peer vaccinator (Sister on the Ambulatory Care Unit and Acute Assessment Unit) was able to give out more than 253 'flu jabs, underlining the importance of making the vaccination easily accessible to busy staff.

The super clinics will continue to operate until the last week of November. The Trust is working towards NHS England & Improvement's target for 80% of frontline staff to receive the vaccination before the end of the campaign in February 2020. In 2018-19, 71% of this group received the vaccination.

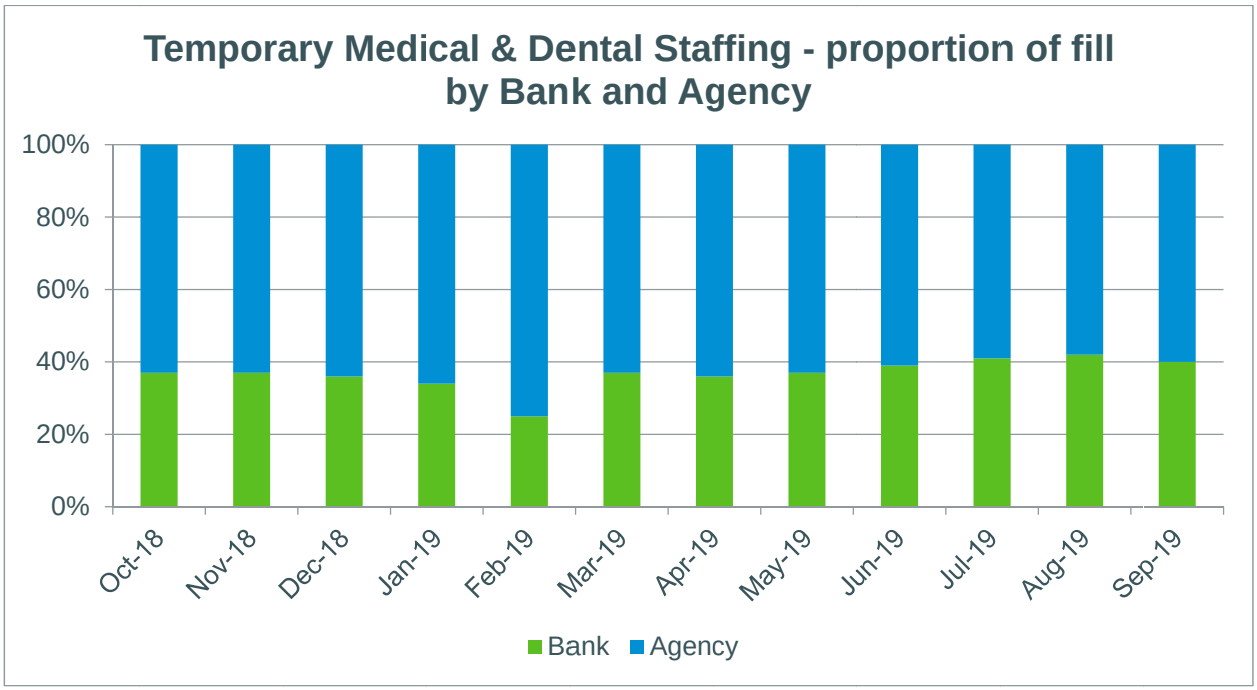
5. Temporary Staffing

Temporary Medical Staffing

During October, 116.46 FTE Medical & Dental roles were covered by a combination of bank (43%) and agency workers (57%).

The Trust trialled the Patchwork system for filling medical locum requests in the period March to August 2019. As Chart 4 indicates, the organisation saw a sustained improvement in Bank fill-rates during this time. The trial has been extended for a further three-month period. This will allow the Trust to develop a Business Case for retaining the system for deployment across all specialties and grades. The use of the system has reduced reliance on locums at training grade level; and the next step is to increase bank bookings at Consultant and SAS level. The overall target is to increase Bank fill-rates to 50% by the end of 2020.

Chart 4 – Temporary Medical Staffing Fill Rates



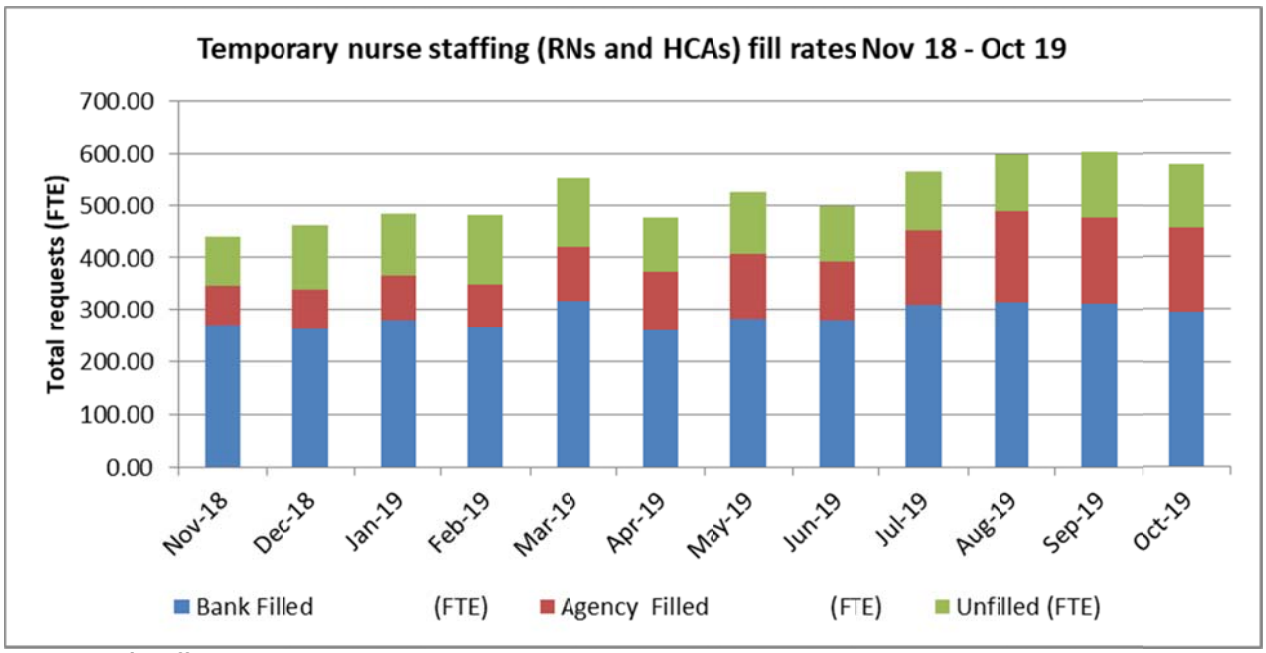
Source: Medical Rostering Records

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) across the Trust continues to be high. The number of shifts requested in October equated to 579 FTE. This is a significant increase from the number of requests received in the same month in 2018 (456 FTE). Reasons include a higher level of sickness amongst registered staff (4.52% vs 4.31%), a higher real-time vacancy level at Scarborough Hospital (when new starters who are due to commence within 3-months are set aside, 141.71 FTE positions were vacant in August 2019 vs 103.96 FTE in August 2018) and increases to staffing following the inspection by the Care Quality Commission.

Chart 5 shows the number of all shifts requested that were either filled by bank, agency or were unfilled. Overall, 50.70% of shift requests in October 2019 were filled by bank staff. The agency fill rate was 27.99%. In order to sustain a strong bank fill-rate, the Trust plans to offer an incentivised rate of pay to bank staff during the period December 2019 – March 2020. This will represent a 15% increase for substantive staff working on the bank; and 10% for bank-only workers.

Chart 5 – Temporary Nurse Staffing Fill Rates



Source: BankStaff

6. Statutory and Mandatory Training Update

Corporate Induction compliance in September was 94%, while compliance with Statutory and Mandatory Training was 83%.

The Trust's priority is to improve compliance within the Medical and Dental staff group. This was identified as an issue in the Safe and Well Led domains of the CQC's recent report, and is underlined by the Care Group compliance 'heat-map' in Appendix 4. Measures to address this include new reporting to improve non-compliance visibility, empowering trainers to be able to tackle gaps in training records directly with staff and the Humber Coast and Vale Streamlining Programme.

7. Risk Assessment Following Trauma Training

To support staff resilience the Trust has developed and piloted the Risk Assessment Following Trauma (RAFT) programme. A similar concept is already well-established within the military. It is a package which incorporates the principles of education, risk assessment and mentoring into an intervention designed to manage the impact of serious work related incidents on staff.

The programme is peer-led and helps identify where someone might be struggling with their mental wellbeing. If an issue is identified, the person is then signposted to access appropriate support 'in the moment' (or as near as possible to the event). This is a structured and evidence-based method of providing post-incident support. Crucially, it is highly accessible to staff working in pressurised clinical environments, and affords them time to review and reflect on their experiences in a supportive environment.

The Trust's programme is in its infancy, but has been tested with two pilot courses in December 2018 and January 2019, one on each main hospital site. These have trained

31 members of staff as RAFT Support Workers, and produced detailed feedback to guide further refinement. Over 100 employees have accessed the programme for support to date.

The aspiration is to embed the programme as an additional tool to complement the Trust's existing support for staff mental wellbeing. The Trust also plans for this work to provide the basis for a formal research project in the future.

8. Culture and Engagement

Just Culture

In October, the Trust ran its first Just Culture training session for Workforce and Trade Union colleagues, specifically focusing on employee relations procedures. Application of the Just Culture framework for employee relations matters has already seen a significant reduction in the number of formal disciplinary cases in the Trust, for example in March 2019 the team were dealing with 10 live disciplinary cases, whilst in November 2019 this had fallen to only two live cases. The Trust is continuing to work with managers to develop a just and learning culture, where the focus is on learning from adverse events to improve patient care. Further training sessions will take place across the Trust's hospitals in 2020.

Our Voice Our Future

The programme of Chief Executive-hosted Listen and Learn Sessions has now completed. The output from these sessions, combined with feedback from the initial listening exercise with a cross-section of 650 'influential staff' created more than 1,000 ideas and suggestions for consideration. The analysis of these ideas, completed by the Trust's Employee Engagement Partner Clever Together, has identified a number of areas where staff and teams experience barriers that stop them from working to their full potential. The findings were shared at the Our Voice Our Future Summit which took place on 14 November in Malton and was attended by more than 130 staff from across the Trust. As well as being a chance to share these findings, the event helped test and develop a number of key conclusions from the programme.

The next phase of this work involves the launch of an online workshop to allow staff to comment on key themes from the feedback and help determine the Trust's priorities in addressing them. This will provide the Trust with a comprehensive analysis of what staff believe is needed to fix the basics and what is needed for the organisation to achieve its ambition to become an outstanding Trust. The plan is for work to begin in January to start using these insights to take action where it is required.

Staff Survey

At 7th November, the 2019 Staff Survey response rate was 35.55%. Clever Together report that the response rate is well-spread across Care Groups, staff groups and sites; and that they already have a sufficient number of replies to reach conclusions that would be statistically valid. The Survey closes at the end of this month, after which quantitative information will be shared with the Trust. This will help to complement the rich information already generated by the Our Voice Our Future programme.

9. Carer Friendly Employer

As part of its drive to become a more flexible, supportive employer, the Trust has held discussions with the York Carers Centre (YCC) about how it can do more to support staff who have caring responsibilities outside of work. YCC is an independent charity, principally funded by City of York Council and Vale of York Clinical Commissioning Group to support carers across three groupings: young carers (5-18); young adults (18-25) and adults.

Statistics place the number of people in the workforce who are caring for someone older, disabled or seriously ill at one in nine workers (Employers for Carers). Amongst carers, one in six people give up work or reduce their hours to care. Many of these employees are at the peak of their careers, which creates a significant risk for the retention of skilled, experienced workers.

Initial discussions have focussed on seven areas where the Trust can become more effective:

1. Raising carer awareness and ensuring line managers can identify carers through training.
2. Developing and maintaining carer friendly HR management and policies.
3. Recognising that carers within the workforce may need support to balance work and caring successfully.
4. Signposting carers to appropriate information and support.
5. Showing a positive and enabling attitude to employees and job applicants who are carers.
6. Providing opportunities for carers to be involved in organisational development, ensuring their voices are heard.
7. Supporting carers to recognise their physical and emotional health needs in order to support well-being.

The Trust has developed a high-level improvement plan against these seven points and is in the process of applying to the Centre to be recognised as a Carer Friendly Employer. The accreditation would represent an important first step in raising awareness about the Trust's support for staff who are carers, and precipitate a number of further activities to help ensure they receive consistent support.

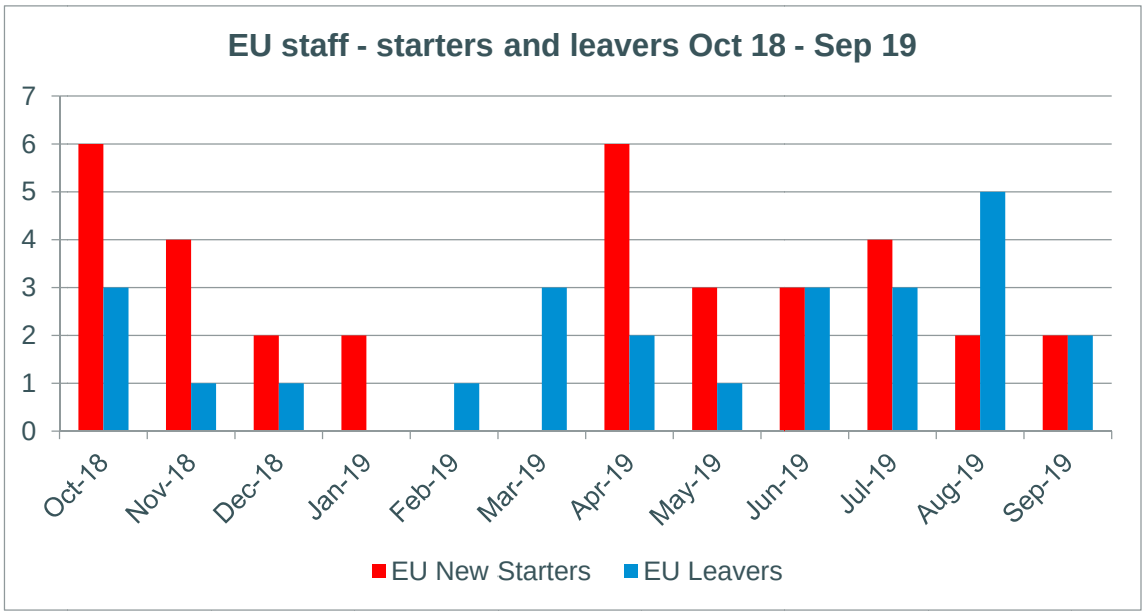
10. EU Workforce and Brexit

Throughout October and November, the Trust has stepped-up its efforts to support EU staff to apply to the UK Government's EU Settlement Scheme. Amongst other rights, the scheme enables EU citizens to secure the right to work in the UK beyond the transition period following Brexit (currently either 31 December 2020 or 30 June 2021 dependent on whether the UK leaves with a deal). The Trust have made Android phones with the 'EU Exit: ID document check app' available for staff to make their applications, and also arranged drop-in sessions with York Citizens' Advice Bureau.

As at 30 September 2019, 251 EU nationals were employed by the Trust on permanent or fixed term contracts. In the year to September 2019 a total of 34 staff from within the EU

joined the organisation while 25 staff left over the same time period. The turnover rate of permanent EU staff (based on headcount) between 1 October 2018 and 30 September 2019 was 9.96%.

Chart 6 – EU Staff Starters and Leavers



11. Detailed Recommendation

The Board of Directors is asked to read the report and discuss.

Appendix 1 – Nursing and midwifery vacancy position to end of October 2019

Nurse Midwifery and Care Staff – Staffing Data - October 2019

Trust wide

	Budgeted Establishment			Staff in post			Starters in next 3 month			Net Vacancy					
										WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Trust wide	2128.37	95.19	1022.94	1829.3	131.67	950.44	51	0	22	248.07	-36.48	50.5	11.66%	-38.32%	4.94%

York

	Budgeted Establishment			Staff in post			Starters in next 3 month			Net Vacancy					
										WTE			%		
	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3
York	1488.45	75.43	680.94	1324.99	98.24	628.38	34	0	17	129.46	-22.81	35.56	8.70%	-30.24%	5.22%

Scarborough and Bridlington

	Budgeted Establishment			Staff in post			Starters in next 3 month			Net Vacancy					
										WTE			%		
	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3
Scarborough &	639.92	19.76	342	504.31	33.43	322.06	17	0	5	118.61	-13.67	14.94	18.54%	-69.18%	4.37%

*NB. In consultation with the Chief Nurse Team, the numerator and denominator have changed from previous iterations of the report so that Specialist Nurses and nurses in Band 8a roles are also included.

Appendix 2 – Registered medical and dental vacancy position November 2019

Scarborough

Directorate	Consultant					SAS 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 %
Care Group 2	**25**	**7**	**0**	**2**	**20.0%**	**18**	**3**	**0**	**3**	**0.0%**	**71**	**7**	**0**	**1**	**8.5%**	**25**	**1**	**0**	**0**	**4.0%**	**139**	**18**	**0**	**6**	**8.6%**
Elderly Medicine	7	1		0	**14.3%**	6	1	0	1	**0.0%**	11	1	0	0	**9.1%**	3	0			**0.0%**	27	3	0	1	**7.4%**
Emergency & Acute Medici	7	2	0	1	**14.3%**	8	2	0	2	**0.0%**	23	3	0	0	**13.0%**	3	1		0	**33.3%**	41	8	0	3	**12.2%**
General Medicine	11	4		1	**27.3%**	4	0		0	**0.0%**	37	3	0	1	**5.4%**	19	0	0	0	**0.0%**	71	7	0	2	**7.0%**
Care Group 3	**24**	**2**	**2**	**1**	**12.5%**	**10**	**0**	**1**	**0**	**10.0%**	**17**	**2**	**0**	**2**	**0.0%**	**12**	**0**			**0.0%**	**63**	**4**	**3**	**3**	**6.3%**
General Surgery & Urology	5	0	1		**20.0%**	3	0	1		**33.3%**	8	2	0	2	**0.0%**	9	0			**0.0%**	25	2	2	2	**8.0%**
Head & Neck	1	0			**0.0%**	2	0			**0.0%**						1	0			**0.0%**	4	0	0	0	**0.0%**
Theatres, Anaesthetics & C	18	2	1	1	**11.1%**	5	0		0	**0.0%**	9	0		0	**0.0%**	2	0			**0.0%**	34	2	1	1	**5.9%**
Care Group 4	**6**	**3**			**50.0%**																**6**	**3**	**0**	**0**	**50.0%**
Radiology	6	3			**50.0%**																6	3	0	0	**50.0%**
Care Group 5	**21**	**4**	**0**		**19.0%**	**5**	**0**	**0**	**0**	**0.0%**	**15**	**1**	**0**	**0**	**6.7%**	**6**	**0**			**0.0%**	**47**	**5**	**0**	**0**	**10.6%**
Child Health	13	4	0		**30.8%**	1	0			**0.0%**	8	1	0	0	**12.5%**	4	0			**0.0%**	26	5	0	0	**19.2%**
Obstetrics & Gynaecology	8	0			**0.0%**	4	0	0	0	**0.0%**	7	0		0	**0.0%**	2	0			**0.0%**	21	0	0	0	**0.0%**
Care Group 6	**16**	**1**	**1**	**0**	**12.5%**	**10**	**3**		**0**	**30.0%**	**9**	**1**		**0**	**11.1%**	**2**	**0**			**0.0%**	**37**	**5**	**1**	**0**	**16.2%**
Ophthalmology	3	0		0	**0.0%**	3	2		0	**66.7%**	1	0			**0.0%**						7	2	0	0	**28.6%**
Specialist Medicine	6	1		0	**16.7%**	2	0			**0.0%**	2	0		0	**0.0%**						10	1	0	0	**10.0%**
Trauma & Orthopaedics	7	0	1		**14.3%**	5	1			**20.0%**	6	1		0	**16.7%**	2	0			**0.0%**	20	2	1	0	**15.0%**
Total	**92**	**17**	**3**	**3**	**18.5%**	**43**	**6**	**1**	**3**	**9.3%**	**112**	**11**	**0**	**3**	**7.1%**	**45**	**1**	**0**	**0**	**2.2%**	**292**	**35**	**4**	**9**	**10.3%**

York

Directorate	Consultant					SAS 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 %
Care Group 1	70	8	3	2	**12.9%**	16	4			**25.0%**	72	7	0	0	**9.7%**	38	1		0	**2.6%**	196	20	3	2	**10.7%**
Community						1	0			**0.0%**	1	0			**0.0%**				0		2	0	0	0	**0.0%**
Elderly Medicine	15	3	0		**20.0%**	2	0			**0.0%**	20	0		0	**0.0%**	7	0		0	**0.0%**	44	3	0	0	**6.8%**
Emergency & Acute Medicine	18	2	1	1	**11.1%**	6	3			**50.0%**	20	3		0	**15.0%**	7	0		0	**0.0%**	51	8	1	1	**15.7%**
General Medicine	37	3	2	1	**10.8%**	7	1			**14.3%**	31	4	0	0	**12.9%**	24	1		0	**4.2%**	99	9	2	1	**10.1%**
Care Group 3	108	3	1	1	**2.8%**	31.7	2.3	3	1	**13.6%**	55	2		0	**3.6%**	15	0		0	**0.0%**	209.7	7.3	4	2	**4.4%**
General Surgery & Urology	38	0			**0.0%**	12	1	3	1	**25.0%**	17	1			**5.9%**	12	0		0	**0.0%**	79	2	3	1	**5.1%**
Head & Neck	20	1		0	**5.0%**	12	1		0	**8.3%**	15	1		0	**6.7%**	0	0		0		47	3	0	0	**6.4%**
Theatres, Anaesthetics & CC	50	2	1	1	**4.0%**	7.7	0.3	0		**3.9%**	23	0		0	**0.0%**	3	0		0	**0.0%**	83.7	2.3	1	1	**2.7%**
Care Group 4	51.6	4	1	2	**5.8%**	3	2	0		**66.7%**	16	2		0	**12.5%**	3	0		0	**0.0%**	73.6	8	1	2	**9.5%**
Cancer Support	12	0		0	**0.0%**	2	1			**50.0%**	5	2		0	**40.0%**	2	0		0	**0.0%**	21	3	0	0	**14.3%**
Laboratory Medicine	14.6	2	1	0	**20.5%**						5	0		0	**0.0%**	1	0		0	**0.0%**	20.6	2	1	0	**14.6%**
Radiology	25	2	0	2	**0.0%**	1	1	0		**100.0%**	6	0			**0.0%**				0		32	3	0	2	**3.1%**
Care Group 5	32	2	1	0	**9.4%**	11	3	0		**27.3%**	32	2		0	**6.3%**	8	0		0	**0.0%**	83	7	1	0	**9.6%**
Child Health	18	1	1	0	**11.1%**	1	0			**0.0%**	17	0		0	**0.0%**	4	0		0	**0.0%**	40	1	1	0	**5.0%**
Obstetrics & Gynaecology	12	1	0		**8.3%**	3	2	0		**66.7%**	12	1			**8.3%**	2	0		0	**0.0%**	29	4	0	0	**13.8%**
Sexual Health	2	0			**0.0%**	7	1			**14.3%**	3	1			**33.3%**	2	0		0	**0.0%**	14	2	0	0	**14.3%**
Care Group 6	62	5	2	3	**6.5%**	18	3	3	2	**22.2%**	27	1	0	0	**3.7%**	3	1		0	**33.3%**	110	10	5	5	**9.1%**
Ophthalmology	20	2	2	2	**10.0%**	6	0		0	**0.0%**	6	0		0	**0.0%**				0		32	2	2	2	**6.3%**
Specialist Medicine	29	3	0	1	**6.9%**	6	3	1	2	**33.3%**	12	0	0	0	**0.0%**				0		47	6	1	3	**8.5%**
Trauma & Orthopaedics	13	0			**0.0%**	6	0	2	0	**33.3%**	9	1		0	**11.1%**	3	1		0	**33.3%**	31	2	2	0	**12.9%**
Total	**324**	**22**	**8**	**8**	**6.8%**	**79.7**	**14**	**6**	**3**	**21.7%**	**202**	**14**	**0**	**0**	**6.9%**	**67**	**2**	**0**	**0**	**3.0%**	**672**	**52**	**14**	**11**	**8.2%**

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

Leavers = currently serving notice

Starters = accepted appointment, now pending start date

964	**87**	**18**	**20**

Appendix 3 – Other registered staff - vacancy position to end of September 2019

	Establishment	Staff in post	Vacancies
Registered AHPs;			
Radiographers	169.32	157.68	11.64
Physiotherapists	168.50	164.54	3.96
Speech and Language Therapists	40.60	38.94	1.66
Dietetics	30.51	23.82	6.69
Occupational Therapists	82.96	80.45	2.51
AHP Total	**491.89**	**465.43**	**26.46**
Registered Scientific & Technical			
Pharmacists (includes Technicians)	156.82	136.06	20.76
ODPs	87.10	86.57	0.53
Scientific & Technical Total	**243.92**	**222.63**	**21.29**
***Registered Healthcare Scientists**	**161.26**	**167.11**	**-5.85**

*Measurement amended from first iteration of the Board report in September 2019 to encompass a wider group.

Appendix 4 – Statutory and Mandatory Training compliance by Care Group to end of September 2019

Monthly Care Group Compliance by Staff Group	Adult DNA CPR	Adult Life Support	Conflict Resolution	Fire Safety Awareness (High Risk)	Fire Safety Awareness (Low Risk)	Health and Safety inc. Risk Management	Infection Prevention and Control (ANTT - Practical)	Infection Prevention and Control (ANTT - Theory)	Infection Prevention and Control L1	Infection Prevention and Control L2	Information Governance	Manual Handling Practical	Manual Handling practical (6 yearly)	Manual Handling Theory	Paediatric DNA CPR	Paediatric Life Support	PREVENT Awareness	PREVENT Level 3	Safeguarding Adults Awareness	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Safeguarding Children L3 (Core Staff)	Safeguarding Children L3 (Specialist Staff)
CG1 Acute Emergency and Elderly Medicine-York																									
Add Prof Scientific and Technic	92%	42%	100%	100%		100%	42%	100%		83%	100%	58%		100%				75%			83%		80%	100%	67%
Additional Clinical Services		90%	89%	85%	86%	92%	49%	63%	97%	90%	92%	83%	50%	87%		78%	92%	56%	88%	92%	68%	75%	87%	56%	
Administrative and Clerical		90%	87%		86%	93%			90%		93%		81%	87%		100%	94%		90%			90%	50%		
Allied Health Professionals		86%	83%	100%	93%	98%		93%		89%	96%	88%	78%	89%				90%			86%	100%	87%		
Healthcare Scientists		89%	89%		89%	94%			94%		94%	89%		94%		89%	94%		94%				94%		
Medical and Dental	62%	70%	53%	83%	83%	60%	31%	59%		59%	60%	31%		63%		49%		50%			56%	100%	55%	62%	50%
Nursing and Midwifery Registered	100%	91%	89%	86%	87%	93%	77%	90%		89%	94%	80%		93%		92%		90%			90%	100%	92%	68%	100%
Students		100%	100%		100%	100%	100%	100%		100%	100%	0%		100%				100%			100%		0%		
CG2 Acute Emergency and Elderly Medicine-Scarb																									
Additional Clinical Services		93%	90%	88%	83%	93%	40%	54%	92%	93%	95%	83%		94%		76%	97%	50%		98%	56%	100%	93%	100%	
Administrative and Clerical		100%	94%		86%	95%			97%		96%		90%	93%			97%		96%			93%	83%		
Allied Health Professionals		95%	86%		98%	100%				93%	98%	76%		95%				98%			95%	100%	94%		
Estates and Ancillary		100%	88%		88%	100%			100%		88%	100%		100%			100%		100%				88%		
Healthcare Scientists		100%	86%		100%	100%			100%		100%	14%		100%		100%	100%		100%				100%		
Medical and Dental	54%	60%	39%	83%	80%	58%	27%	57%		48%	52%	23%		50%		38%		37%			50%		58%	29%	
Nursing and Midwifery Registered	100%	92%	91%	94%	90%	96%	77%	94%		93%	96%	74%		94%		89%		90%			93%		92%	75%	
CG3 Surgery																									
Add Prof Scientific and Technic		96%	86%	81%	83%	96%	63%	90%	100%	84%	94%	75%	100%	94%		57%	100%	87%	100%		87%	100%	88%		
Additional Clinical Services		88%	92%	79%	94%	91%	60%	83%	97%	85%	93%	86%		88%		91%	93%	42%	98%	89%	58%	96%	84%		
Administrative and Clerical		100%	95%		90%	97%			96%		97%	100%	90%	95%			96%		95%	100%		95%	73%		
Allied Health Professionals		100%	75%		100%	100%				100%	92%	92%		100%				92%			100%		100%		
Estates and Ancillary			87%		93%	87%			93%		100%	93%		80%			87%		87%			83%	67%		
Healthcare Scientists		90%	94%		90%	94%			94%		90%	74%		94%			100%		94%				90%		
Medical and Dental	66%	71%	53%	82%	73%	66%	28%	68%		63%	67%	39%		62%				52%			60%		63%	0%	0%
Nursing and Midwifery Registered		94%	90%	86%	84%	94%	80%	90%		88%	93%	77%		93%		76%		88%		100%	89%	100%	92%		

Monthly Care Group Compliance by Staff Group	Adult DNA CPR	Adult Life Support	Conflict Resolution	Fire Safety Awareness (High Risk)	Fire Safety Awareness (Low Risk)	Health and Safety inc. Risk Management	Infection Prevention and Control (ANTT - Practical)	Infection Prevention and Control (ANTT - Theory)	Infection Prevention and Control L1	Infection Prevention and Control L2	Information Governance	Manual Handling Practical	Manual Handling practical (6 yearly)	Manual Handling Theory	Paediatric DNA CPR	Paediatric Life Support	PREVENT Awareness	PREVENT Level 3	Safeguarding Adults Awareness	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Safeguarding Children L3 (Core Staff)	Safeguarding Children L3 (Specialist Staff)
CG4 Cancer and Support Services																									
Add Prof Scientific and Technic		100%	95%		92%	97%		100%	97%	100%	97%	87%		95%			98%	93%	95%	100%	89%	88%	93%		
Additional Clinical Services		94%	90%	93%	89%	96%	60%	90%	91%	96%	94%	79%		90%			91%	80%	90%	92%	80%	88%	91%		
Administrative and Clerical		100%	97%		93%	98%			97%		96%		93%	97%			100%		95%			97%	77%		
Allied Health Professionals		93%	89%	94%	91%	96%		90%	100%	90%	96%	81%	100%	95%			100%	87%	100%	100%	89%	100%	94%		
Estates and Ancillary			100%		0%	100%			100%		100%	100%		0%			100%		100%			0%			
Healthcare Scientists			97%		96%	98%			96%		93%	93%	100%	93%			99%		96%			97%			
Medical and Dental	83%	87%	83%	81%	72%	73%	0%	87%	71%	72%	76%	46%		78%			82%	80%		71%	78%	59%	78%		
Nursing and Midwifery Registered	100%	95%	94%	100%	93%	95%	80%	95%		94%	96%	83%		94%			100%	92%		100%	92%	100%	94%		
CG5 Family Health & Sexual Health																									
Add Prof Scientific and Technic			100%		100%	100%			100%		100%	100%		100%			100%		100%						100%
Additional Clinical Services		94%	86%	80%	89%	90%	46%	75%	100%	91%	94%	78%	100%	92%		84%	97%	57%		96%	71%		94%	81%	100%
Administrative and Clerical		100%	93%		90%	98%			97%		97%		93%	96%			99%		95%			97%	100%	100%	
Allied Health Professionals		97%	95%	95%	100%	98%				100%	100%	92%	100%	97%		98%	100%	98%		100%	93%		100%	100%	92%
Estates and Ancillary			100%		100%	0%			100%		100%	100%		100%			100%		100%				100%		
Medical and Dental	65%	74%	55%	85%	81%	72%	34%	69%		62%	66%	31%		62%	40%	44%		57%			63%		58%	58%	46%
Nursing and Midwifery Registered		93%	86%	85%	89%	93%	67%	90%		90%	93%	79%		92%		87%		92%			90%		100%	83%	81%
CG6 Specialised Medicine & Outpatients Services																									
Add Prof Scientific and Technic		84%	92%		83%	91%			94%		97%	80%	94%	91%			94%	100%	89%	83%	100%	100%	88%		100%
Additional Clinical Services		96%	96%	100%	92%	97%	71%	100%	96%	96%	97%	87%		96%			99%	100%		96%	100%	83%	98%		
Administrative and Clerical		50%	93%		89%	94%			94%		94%	96%	89%	92%			94%		94%			93%	100%		
Allied Health Professionals		96%	88%		90%	97%		50%		93%	93%	85%		88%				88%			93%		91%		
Estates and Ancillary			100%		100%	100%			100%		100%	100%		100%			100%		100%				100%		
Healthcare Scientists		100%	100%		88%	100%			100%		100%	100%		100%			100%		100%				100%		
Medical and Dental	70%	72%	66%	83%	88%	76%	20%	70%		73%	75%	51%		73%				63%			68%		72%		
Nursing and Midwifery Registered	100%	92%	94%	100%	93%	98%	74%	93%		96%	98%	81%		94%				92%			94%		88%	100%	

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York Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

Board Assurance Framework – At a glance

Strategic Goals

- **To deliver safe and high quality patient care as part of an integrated system**
- **To support an engaged, healthy and resilient workforce**
- **To ensure financial stability**

Goal	Strategic Risks	Original Risk Score	Residual Risk Score	Target Risk Score
Patient Care	1. Failure to maintain and improve patient safety and quality of care	**16**	**12 ↔**	**6↑**
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 ↔**	**9↑**
Patient Care	5. Failure to develop, maintain/replace and secure IT systems impacting on security, functionality and clinical care	**20**	**12 ↑**	**6**
Workforce	6. Failure to ensure the Trust has the required number of staff with the right skills in the right location	**25**	**12 ↓**	**9↑**
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	**16**	**16 ↑**	**6↑**
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	**25**	**16**	**6**

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Board Assurance Framework

BAF definition adopted by the Governance, Assurance & Risk Network (GARNet): 'the key source of information that links the strategic objectives to risk and assurance'.

Introduction

All Trusts are required to prepare public statements to confirm that they have done their reasonable best to maintain a sound system of internal control to manage the risks to achieving their objectives. This is achieved by the Chief Executive providing a signed Annual Governance Statement, which covers the risk management and review processes within the Trust. The evidence to back up this Statement is supported by the Board Assurance Framework.

The Trust's Board Assurance Framework is based upon the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Board of Directors to resolve issues or concerns and to improve control mechanisms.

The risk scoring matrix (appendix 1) is part of the Trust's Risk Management Framework and will be used to score risks.
Risk Appetite (appendix 2) is part of the Trust's Risk Management Framework

Strategic Goals	**The planned objectives which an organisation strives to achieve**
Principal Risks	**The key risks the organisation perceives to achieving its strategic goals**
Key Controls	**The controls or systems in place to assist in addressing the risk**
Assurances on Controls	**Sources of information (usually documented) which service to assure the Board that the controls are having an impact, are effective and comprehensive**
Gaps in Controls	**Where we are failing to put control/systems in place**
Gaps in Assurance	**Where we are failing to gain evidence that our control systems, on which we place reliance are effective**
Risk Appetite	**The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives – appendix 2: Trust Risk Appetite.**

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (1) Failure to maintain and improve patient safety and quality of care **CRR Ref**: MD 2a&b, 3, 4, 5, 6a&b, 7, 8, 10 – CN 2, 7, 8, 17, 20, 22, 23, 24 – COO 2, 3, 6, 7, 8, 17, 18, 19, 20 – HR 1a&b, 4, 15 – CE 4 – DE1, 2 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Quality) **Director Lead:** Medical Director, Chief Nurse, Chief Operating Officer	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure including o Assigned Director Portfolios, Structures & Teams o Ward to board nursing structures & teams o Patient Experience Steering Group o Safeguarding Children & Adults Teams & Internal & External Structures o Health & Safety Systems & Groups o Infection Prevention & Control meeting structures - Strategies, Policies & Procedures o Nursing and Midwifery Strategy, Patient Experience Strategy, Sign up to Safety Campaign pledges and Patient Safety Strategy. o Risk Management Framework o Performance Management Framework - Systems &Monitoring o Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities o CQUINs & contract monitoring o Recording of escalation systems NEWS etc o Medicines Management/EPMA implementation o National Surveys o NICE, NSF and Clinical Audit o Capital Programme o Maternity CNST o Performance reporting and accountability/ performance reviews/ performance dashboards	- External inspections including CQC Reports - Internal Audit Programme - CQC and Choices website feedback - SHMI - National Survey Action Plans, Friends & Family Test - Premises Assurance Model, PLACE/TAPE Reports - Patient Experience Work Plan & Quarterly Reports - Quarterly Pressure Ulcer & Falls Reports - Mortality Reports – Learning from Deaths - IPC Quarterly Report & Annual Report - Patient Safety, Quality, Workforce, Finance and Performance Report to Board/Committees - Annual Complaints Report to Board - Quality Report - Patient Safety Walk Rounds - NICE, NSF and Clinical Audits/Effectiveness Reports - Safeguarding Children & Adult Reports to Board - Maternity Reports - Staffing Reports - Learning Hub Data - Health & Safety Reporting - 7 day audit – 7 day task & finish group & plan - Integrated Board Report - COO led monthly operational performance meetings with each Care Group	- Implementation of 7 day working systems and controls - Jnr Drs Contract (National) - 2003 Consultants Contract does not facilitate 7 day working(National) - Mortality Reporting - Staffing Vacancies (CQC Report following unannounced visits) - Infection Rates - Limited capital - Under performance against key national targets and standards - Safeguarding – specifically Adult MCA/DoLS Actions (Identify plans to address gaps) - Mortality – Team to support Medical Examiner (Apr 20) - Staffing – East Coast Review looking at sustainability - Infection Control - Capital Programme in respect of backlog maintenance (reviewed at Resources) (Oct 19) - Care Group improvement

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- Statutory and mandatory training – trained professional staff - A number of local adaptations in relation to 7 day working - Lead medical examiner role introduced	- CEO led efficiency meetings with each Care Group - QIA of each efficiency scheme signed off by MD and Chief Nurse. - Medical Examiner appointed - Local ownership of MCA/DoLS – matrons audit carried out	programmes & performance recovery plans developed by each Care Group (Nov 19) - CQC Unannounced visit action plan (monthly monitoring at Board) - MCA/DoLS action plans/reaudit (Nov 19) - CQC Action Plan going to Board (Nov 19)

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (2) Failure to maintain and transform services to ensure sustainability **CRR Ref**: MD 8, 10 – CE 3, 4, 5a&b, 8 – COO 3, 6, 7, 8, 17, 18, 19, 20 – DE1, 2 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Quality) **Director Lead:** Chief Operating Officer	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 3 Severity= 4 Score: 12	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee & Governance Structure o Directors Portfolios – Transformation Lead o Business case management system o System Transformation Board o Care Group Structure implemented - Strategies Policies & Procedures o Development of Trust Strategy and supporting strategies o Development of Care Group Service Plans and associated Business Cases - Partnership working o HCV HCP engagement o ECIST Support o McKinsey Engagement o Partnerships & Alliances o Health & Wellbeing Board & Place Based Boards	- Reports from E & Y – McKinsey Reports - HCV HCP Reports/Papers - External Review - Scarborough - Peer Review - External Benchmarking of systems and pathways - Executive Board Papers - Care Group Pathway Redesign - Performance data - Partnership & Alliance Reports	- Stakeholder Session being held to agree next steps (Nov 2019) - Acute Service Review – Scarborough – Phase 2 concluded Oct 2019 - Programme of work agreed with NHSI & Stakeholders (commenced May 2019) **Actions** (Identify plans to address gaps) - Developed specs and tendered for a partner to support the review - McKinsey appointed and commenced the phase 2 review in May 2019 – concluded in Oct 19 - Acute services review phase 2 steering group established with multi stakeholder representation - 2 Clinical reference groups undertaken to date which include hospital clinicians & GPs. - Finance Group established - Comms Group established - Presentation to Trust Board and Stakeholders following completion of the second phase (31.07.19) – planned for Nov 19

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Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (3) Failure to meet national standards **CRR Ref**: COO 2, 3, 6, 7, 8, 17, 18, 19, 20 – CE 8 – MD 6a&b, 7, 8, 10 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Quality) **Director Lead:** Chief Operating Officer, Chief Nurse, Medical Director	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee Structure/Governance o Corporate Performance Team o Integrated Acute & Planned Care Board (York & SGH) o Care Group Structure implemented - Partnership Working o Ernst & Young Diagnostic Work o ECIST engagement o YAS engagement o Health & Care Resilience Board o HCV HCP Cancer Alliance Board o Complex Discharge Working Group o System Planned Care Steering Group - Strategies, Policies & Procedures o Trust Strategy, Clinical Strategy and Care Group Strategies o Policies & Procedures/Standard Operating Procedures o Performance Recovery Initiatives o Winter Planning/System Resilience/Winter Plan o Trust Operational Plan - Training & Development	- E & Y Reports - External Benchmarking of systems and pathways - Internal Audit Programme - Performance Reports - Operational Performance Recovery Plan - Winter Plan/System Resilience Plan - SAFER Local Delivery Plan - Planned Care Transformation Plan - Validation - Operational Plan - Learning Hub Data	- Continued challenges around achieving the ECS on a sustainable basis - Need to develop primary care and community services – East Coast Review – to include a system plan for out of hospital services. - Recruitment **Actions** (Identify plans to address gaps) - East Coast Review Phase 2 (31.07.19) – presentation to Board (Nov 19) - HCV HCP capital bid for SGH – business case development and submission - Recruitment - Initiatives linked to strategic staffing risk - Single integrated improvement plans being developed with regular monitoring via PAMs (from 1.8.19 onwards) - Daily reporting of ECS performance & ED breach analysis – identification of learning or areas for improvement (new format from Jul 19) – continues to be refined with support from ECIST) - Development of an ECS recovery plan for both sites – which continues to be refined with weekly monitoring by COO - Performance recovery plans developed for under performing areas (Jul 19 Board Subcommittee) – refresh & forecast to Board (Nov 19) - Ambulance handover action plan developed –

		improvement trajectory agreed with NHSI – monthly improvement trajectories monitored at Board sub committee

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (4) Failure to maintain and develop the Trust's estate **CRR Ref**: DE 1, 2 – CN 8, 17, 20, 23 – MD 7 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Director of Estates and Facilities	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structures o Estates Operational Management Structures o Health & Safety Systems & Groups o Capital Programme Executive Group o HCV HCP Capital Group Representation o SLAs between Trust and LLP o LLP Committees/Governance Structure - Strategies, Policies & Procedures o Capital Programme o Estates Strategy o PLACE/TAPE Programme o Compliance Report Schedule o HCV Estates Strategy	- Compliance with P21+ and DH approved process for specific capital schemes - Condition Surveys - HCV HCP Capital Group Reports & Minutes - Internal Audit Programme - NHS Premises Assurance Model - Capital Programme Reports - PLACE/TAPE Reports - PLACE Report to Council of Governors - Sustainable Development Reports - Health & Safety and Fire Reports - Capital Programme Executive Group Reports - Monthly Facilities Management Report - Board/Committee Reports - Health & Safety Reports - First Party Audit Process - EPAM terms of reference	- Contract management arrangements – structure in place (premeet Sept – 1st meeting Oct) - Lack of capital - **Actions** (Identify plans to address gaps) - Condition Survey finalised -link to capital programme (Aug 19) (Resource Committee meeting being organised for Oct 19. - MSA (Apr 19) (+200 day review) - Lack of capital put on CRR following Board discussion – management of programme through CPEG - Management Group – Executive Perf ToRs to Board (Sept 19) (Pre-Oct 19) (Commence Nov 19) - Business Case – computer aided facilities management system (Jul 19) – approved now being implemented – goes live (Jan 20)

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (5) Failure to develop, maintain/replace and secure digital systems impacting on security, functionality and clinical care **CRR Ref**: SNS 1, 55, 74 **Lead Committee:** Board (last formal review – Apr 19)(Resources Sept 19) **Director Lead:** Chief Executive	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 3 Severity= 2 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Systems & Networks Team - governance structure o Senior Management team meetings o Project Management Group o Technical Steering Group o Security Focus Group o Change Board o Information Governance Executive Group o Named SIRO and Caldicott Guardian o Attendance at Operational meetings o Capital Programme Executive Group - Systems o Capital Programme o Risk management o On-call Service o Internal monitoring/alerting systems o Third Party Monitoring o Ongoing User Awareness Programme - External o DSP Toolkit o NHS Digital Cyber Security Support Model o Third party support & maintenance contracts - Strategies, Policies & Procedures o Digital Strategy o Information Security Management System - Training and induction of staff	- External & Internal Audit Reports - Resources Committee and Board Reports - Board NHSI Declaration – Data Security & Protection Requirements - Learning Hub Data - DSP Toolkit Compliance - Cyber Incident Handling Process - Disaster recovery plans - SNS Information Asset Register - Risk Register - Cyber Security Assessment & Action Plan - SUS Data Quality - Development Programme – infrastructure, information & clinical systems - Digital maturity assessment - Benchmarking data - User engagement and feedback - Incident Management reporting	- Continued challenges around end user experience - Lack of capital - Digital readiness (NHS Long Term Plan) - Lack of explicitly Named CIO - No Digital representation at Board level (CIO / CCIO) - Lack of CCIO available capacity - There are no nominated Digital leads in Care Groups and across the entire MDT structure - A structured programme of user engagement **Actions** (Identify plans to address gaps) - An end user experience strategy to be created as part of Digital Strategy update (Ongoing, review Dec 2019) - Lack of capital put on CRR, managed via CPEG - Resources Committee to oversee digital - Building a Digital Ready Workforce engagement ongoing (review Oct 2019) - Board lead for digital under discussion (Oct 2019) - Digital maturity to be scored via EMR Adoption Model (EMRAM) (Nov 2019) - User feedback to be gained via a number of methods; surveys, email, roadshows, user training (ongoing, review Dec 2019) - Cyber Essentials+ by June 2021

Strategic Goal: To support an engaged, healthy and resilient workforce **Principal Risk**: (6) Failure to ensure the Trust has the required number of staff with the right skills in the right location **CRR Ref**: HR 1a&b, 4, 15 – CN 2, 24 - MD 2a&b, 8 – CE3, 4, 5a&b **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Director of Workforce and OD	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure - Strategies, Policies & Procedures o Supportive polices and processes o Workforce & OD Strategy - Processes & Systems o HCV HCP Workforce Strategy o Workforce redesign including ACPs, Nurse Practitioners, Nursing Associates and Physicians Associates o Bank Management and Governance o Appraisal processes – Job Plans o Apprenticeship Programme o Overseas Recruitment o Employer Brand including Partnership with FE/HE providers o Volunteering Programme o HYMS Expansion - Statutory and Mandatory Training o Development Opportunities ie: Leadership o Mentoring, Coaching/Mediation & training o Learning Management System development o Post & Undergraduate Medical Education o Medical library	- Staff Survey/Staff FFT - National Apprenticeship standards - ROA reporting to HEE - Internal audit programme - National accreditation schemes - Annual quality assurance visits from HEE/HYMS - Library quality standards - Programmes designed and evaluated by HEI and NHS Elect - National Leadership Academy assurance - SSW/FTSUG Monitoring Reports - Turnover analysis (quantitative and qualitative) - Board & Committee reports covering turnover, vacancy rates, stat & mand take up, sickness absence data - Portfolios of learning evidence available - Staffing reports - E-rostering Data/CHPPD Data - Learning Hub Data including training course material - Exit Questionnaire Data - NHSI maintaining workforce safeguards - QIA for new nurse roles	- Work/life balance expectations of the future workforce - Brexit/ Immigration Policy - Public Sector pay restraint - Removal of nurse bursary - NMC – minimum language standard - Age Profile - National changes to standards, applications & implementation of new policies. - Effective utilisation of E Rostering Tool - Implementation of electronic job planning - HEE Policy/FE/HE varied uptake Pension Tax Implications Actions (Identify plans to address gaps) - Workforce redesign in partnership with FE/HE (Sept 20) - Staff Survey Action Plan in place & being implemented (Jan 20) - Health & Wellbeing Initiatives being implemented (Sept 20) - Workforce Plan (Oct 19) - Apprenticeship Steering Group Outputs (Apr 20) - Implementation of e-Job Planning (Nov 19) - Continue to develop Bank (Apr 20 - HCV HCP Workforce Action Plan (Oct 19) - Salary Flexibility (Oct 19) - East Coast medical recruitment project (Jan 20)

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		- Recruitment Initiatives (Mar 20)

Strategic Goal: To support an engaged, healthy and resilient workforce **Principal Risk**: (7) Failure to ensure a healthy engaged and resilient workforce **CRR Ref**: HR 1a&b, 2, 4, 15, 16 – CE8 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Director of Workforce & OD	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 2 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure o Occupational Health Service/EAP o Junior Doctor Forum o LNC/JNCC - Strategies, Policies & Procedures o Supportive polices and processes o Workforce & OD Strategy - Processes & Systems o Star Awards/Celebration of Achievement o Recruitment and Retention Processes o Workforce redesign including ACPs, Nurse Practitioners, Nursing Associates and Physicians Associates o Appraisal processes – Job Plans o Schwartz Rounds & RAFT o HYMS expansion o LIVEX - Statutory and Mandatory Training o Development Opportunities including Leadership o Mentoring, Coaching/Mediation & training	- Staff Friends and Family Test - Sickness absence analysis, Turnover analysis (quantitative and qualitative) - Board & Committee reports covering turnover, vacancy rates, stat & mand take up and appraisal rates - E-rostering Data/Flexible working data - Health & Wellbeing Data - Learning Hub Data - Staff Survey - Health Assured Data - RAFT evaluation - FTSU/SWG monitoring data - Staff Benefits Programme - Fairness Champions	Work/life balance expectations of the future workforce Shift patterns and impact on Health & Wellbeing and HEE national policy Insufficient training places Consultant contract negotiations Pension Tax Implications **Actions** (Identify plans to address gaps) Staff survey action plan in place & being implemented (Jan 20) Implementation of RAFT (Nov19) Implementation of Health & Well being Strategy (Dec 19) Workforce Plan implementation (Oct 19) Flu Vaccinations (Feb 20) Safer Working Group Feedback initiatives (continuous) Line Manager Competency Training (Oct 20)

Strategic Goal: To support an engaged, healthy and resilient workforce **Principal Risk**: (8) Failure to ensure there is engaged leadership and strong, effective succession planning **CRR Ref**: CE3, 8 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Chief Executive	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure o Remuneration Committee o Nomination & Remuneration Committee - Strategies, Policies & Procedures o Workforce & OD Strategy o Gender Pay Analysis o WRES/WDES o HCV HCP workforce plan - Statutory & Mandatory Training o Training and Development including various leadership courses - Processes & Systems o Facilities Career Pathway development o Appraisal Processes	- Succession Planning Papers - Directors Portfolios - Team Structures - Learning Hub Data - Board/Committee HR Reports - Internal Leadership Programmes - Internal Managerial Programmes - Revalidation data - AIC Contract Monitoring across system	HEE National Policy Pension Tax Implications Board gaps Actions (Identify plans to address gaps) Humber, Coast & Vale Leadership being implemented NY & York System Leadership Group being implemented Progression and evaluation of internal leadership courses (Apr 20) Board development – Programme being drafted (Dec 19) SM 100 days incorporating the Clever together work and CQC Report (Dec 19)

Strategic Goal: To ensure financial stability **Principal Risk**: (9) Failure to achieve the Trust's financial plan **CRR Ref**: DOF 1, 3, 4, 8, 9, 11 – COO 2, 8 – DE1, 2 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Finance Director	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 3 Severity= 4 Score: 12	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure o Annual Planning Cycle and Business Planning Process o SFIs, Scheme of Delegation, Policies and Procedures o Efficiency Delivery Group and implementation of recommendations o Contract Management Group o Collective Board Ownership o Legally binding contracts o External and Internal Audit Services o PMM meetings - Partnership Working o Shared Risk Contract o HCV HCP and Partnership working ie: Contractual MOU o Local patch wide engagement through the System Delivery Board (SDB) o Medium Term Financial Plan for the system - Processes & Systems o Care Group CIP Delivery Plans o Sound financial systems, cost controls and monitoring o Capital Programme o Control Total Agreement (multi-year)	- External and Internal Audit Programmes - NHSI Reporting - External Audit - Value for money review - NHSI Use of Resources Review - Monthly Accounts & Reports - Operational Plan - Business Cases and benefits monitoring - Committee Papers including Audit and Resources Committee - Capital Programme Reports and monitoring - Medium Term Financial Planning - East Coast Review	- Continued recruitment difficulties placing financial pressure from agency and locum replacement staff resulting in pressure against the Trust's agency cap. - Failure to deliver system wide QIPP with Commissioners placing financial pressure on the system partners and the Trust through the shared risk contract. - System affordability issues in relation to delivery of constitutional standards **Actions** (Identify plans to address gaps) - Multiple Recruitment initiatives listed on strategic risk 6. - Development and refinement of a system wide medium term financial recovery plan with deliverable QIPP requirements by the SDB (final submission Nov 19) - Continual review of constitutional standard delivery with system partners and regulators.

Revised BAF approved in Aug 18 – current version 0.16 (Nov 19)

Strategic Goal: To ensure financial stability **Principal Risk**: (10) Failure to develop and maintain engagement with partners **CRR Ref**: CE3 – DOF 4, 11 – COO 2, 3, 6 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Chief Operating Officer	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 2 Score: 4

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Partnership Working o York/Harrogate Alliance o HCV HCP Executive Group and subsidiary working groups o HCV HCP Place Based Boards o HCV HCP Cancer Alliance Board and subsidiary working groups o York Primary Care Home Steering Group and subsidiary working groups o HCV HCP Hospital Partnership Group o SGH Acute Service Review Steering Group o Health & Wellbeing Board o East Coast Strategic Review Group o Systems Transformation Board o OHC Services Strategy o HCV HCP Strategy & Place Based Plans o Complex Discharge Steering Group - Strategies, Policies & Procedures o Refreshed Trust & Clinical Strategies	- CQC System Report - Agendas, minutes and papers of the various HCV HCP and partnership groups - HCV Executive Group – CEO attendance - Hull/York Partnership Board - Harrogate/York Partnership meetings - Quarterly System Finance Meetings - OHC Services Reports - NHSI Action Plan	- Place Based Plans - System governance arrangements that describe approach to delivery of the system transformation programme **Actions** (Identify plans to address gaps) - Development of system plan - Proposal that sets out future 'system' governance, currently being developed by system partners - Clinical reference group (sponsored by Trust MD & CCGs Clinical Chairs)

Strategic Goal: To ensure financial stability **Principal Risk**: (11) Failure to develop a trust wide environmental sustainability agenda **CRR Ref**: DOF 1, 3, 4, 8, 9, 11 – HR 1a&b, 4 – DE1, 2 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Director of Estates and Facilities (reviewed Oct 2018)	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 2 Severity= 2 Score: 4	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)

- Trust Committee/Governance Structure
  - Trust Sustainable Development Management Group
  o Board Commitment
  - Travel and Transport Group
  - Head of Sustainability
- Processes & Systems
  o Good Corporate Citizen/ Sustainability Development Assessment Tool
  o Sustainable Development Unit Template (measures Carbon footprint)
  - Sustainability Champions
  - Consultancy Contract Phase 1 and 2
  - 12 month sustainable awareness development programme
- Partnership Working
	- Sustainable Development Management Plan
	- Sustainable Development Reports/Papers
	- Transport Group Reports/papers
	- Compliance with NICE
	- Sustainability Annual Report
	- Trust Annual Report Sustainability Section including extn. assessment against report content
	- Carbon Savings figures
	- Savings Cost Benefit Analysis
	- Travel Plan
	- Benchmarking using SD Assessment Tool
		- Engagement of staff
		- Raised awareness when procuring
		- Energy Management Group – Business Case being drafted
		- National Clinical Waste Provision Issue
		
		Actions
		
		(Identify plans to address gaps)
		
		- Sustainable Development Management Action Plan (Oct 19)
		- Sustainable Development Assessment Tool Action Plan (Apr 20)
		- Clinical Waste – NHSI to monitor contract – interim contract with Leeds signed – awaiting further developments (Jan 20)

Strategic Goal: To ensure financial stability **Principal Risk**: (12) Failure to achieve the system's financial plan **CRR Ref**: DOF 1, 3, 4, 8, 9, 11 – COO 2, 8 – CE3 **Lead Committee:** Board (last formal review – Jul19)(Sept 19 – Resources) **Director Lead:** Finance Director	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure o Annual Planning Cycle and Business Planning Process o SFIs, Scheme of Delegation, Policies and Procedures o Efficiency Delivery Group and implementation of recommendations o Contract Management Group o Collective Board Ownership o Legally binding contracts o External and Internal Audit Services o PMM meetings - Partnership Working o Shared Risk Contract o HCV HCP and Partnership working ie: Contractual MOU o Local patch wide engagement through the System Delivery Board (SDB) o Medium Term Financial Plan for the system - Processes & Systems o Care Group CIP Delivery Plans o Sound financial systems, cost controls and monitoring o Capital Programme o Control Total Agreement (multi-year)	- NHSI&E Reporting - Quarterly System Finance Meetings - Monthly Accounts & Reports - Operational Plan - Medium Term Financial Planning - East Coast Review	- Failure to deliver system wide QIPP with Commissioners placing financial pressure on the system partners and the Trust through the shared risk contract. - System affordability issues in relation to delivery of constitutional standards - Pressure on non-York FT CCG contract expenditure - Operational pressures for the Trust **Actions** (Identify plans to address gaps) - Continual review of constitutional standard delivery with system partners and regulators. - Development and refinement of the system wide medium term financial plan (Nov 19) - Engagement of financial turnaround delivery capacity in addition to core system teams from Q2.

Revised BAF approved in Aug 18 – current version 0.16 (Nov 19)

Appendix 1: Calculating Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring.

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Severity - Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood - Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios - In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the risk score is determined it is the highest l risk score that must be referred to on the risk register**.

Appendix 2 - Risk Appetite Statement (Risk Management Framework - Appendix 4)

1. Quality & Safety - Delivering high quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an on-going commitment to being a learning organisation. The trust has a risk adverse (Low) appetite to risk which compromises the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.

2. Patient Centred Care - This Trust has made a commitment to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services. The trust is risk adverse (Low) to enabling care without validating and verifying what outcomes are possible and desirable with all stakeholders.

3. Partnerships - This trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the trust's current and future services. The trust has a risk seeking (High) appetite for developing these partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.

4. Financial Stability - The Trust is committed to fulfilling its mandated responsibilities in terms of managing public funds for the purpose for which they were intended. This places tight controls around income and expenditure whilst at the same time ensuring public funds are used for evidence based purpose. The Trust is averse (Low risk appetite) to committing non evidence based expenditure without its agreed control limits.

5. Recovery - As a Trust we look beyond clinical recovery through facilitating recovery and promoting social inclusion by measuring the effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the person and their family. The trust is risk adverse (Low) to recovery that does not provide high levels of compliance with service user outcome measures.

6. Improvement and Innovation - Innovation is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The trust has a risk tolerant (Moderate) appetite to risk where benefits, improvement and value for money are demonstrated.

7. Leadership & Talent - The trust is committed to developing its leadership and talent through its Organisational Development and Workforce strategy. The trust is committed to investment in developing leaders and nurturing talent through programmes of change and transformation. The trust has a tolerant (Moderate) appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.

8. Operational Delivery of Services -The Trust is committed through its embedded strategy, governance and performance management frameworks to deliver the activity for which it has been commissioned. The Trust has an adverse (Low) appetite for failing to deliver the requirements outlined and agreed in commissioner contracts.

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Humber, Coast and Vale Health and Care Partnership

Update Report

September 2019

The following report provides an overview of the issues and topics discussed at the September meeting of the Humber, Coast and Vale Health and Care Partnership Executive Group. It also highlights recent work of the Partnership across some of our key priority areas.

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

Independent Chair's Report

The Independent Chair's report included an update on preparations for EU Exit and broader issues of winter planning and system resilience. NHS England/Improvement's lead for EU Exit, Dr Keith Willetts, will be visiting Immingham to discuss EU Exit preparations and meet with local system leaders in early October 2019.

In addition, the development of the Partnership towards Integrated Care System (ICS) status was an important item of discussion. Partners continue to emphasise the importance of collaboration at place and sub-system level, with collaboration being undertaken at scale where it makes sense to do so. This approach and commitment to subsidiarity will continue to underpin the work of the Humber, Coast and Vale Partnership over the coming months and years. The ICS Accelerator Programme will enable the Partnership to further review and refine these principles and agree a Partnership operating model that would continue to deliver for Humber, Coast and Vale. All partners agreed that the strong relationships that had been established with local government leaders should be maintained and strengthened through our ICS development process.

Partnership Executive Lead's Report

The Partnership Executive Lead's report included an update on the Accelerator Programme. The Accelerator Programme is an intensive programme of hands-on support structured around core components of system development as set out in the ICS maturity matrix. This work will be taking place over the next three months to support the Partnership towards gaining ICS status and will focus on priority areas identified by local system leaders. Leads for the four priority workstreams were confirmed as follows:

- Partnership Strategy – Andrew Burnell
- Operating Arrangements – Jane Lewington
- Stakeholder Engagement – Andrew Phillips
- Population Health Management – Steve Pintus

In addition, the Executive Group discussed the need to put in place effective oversight and assurance arrangements for the Partnership to ensure the Partnership's programmes are delivering the outcomes they expect to effectively as well as maintaining an overview of performance across the whole system. There are existing oversight arrangements within each of our six places and across sub-systems, for example A&E Delivery Boards, which are looking at quality and performance issues. However, in accordance with the principle of mutual accountability, it was agreed that there should be a role for the Partnership Executive Group to provide an oversight and assurance role across the whole system to complement the work of local boards.

Partnership Long Term Plan

The Partnership is continuing to work towards producing the Partnership Long Term Plan. The Plan has been produced through an inclusive process involving internal and external stakeholders in a range of workshops, planning meetings and discussions. Finance, performance and workforce assumptions have been agreed by partners working together at sub-system level and brought together to support the overall plan. In addition, partners have worked together through the Partnership's collaborative programmes and in each of the six places to produce the content for the strategic narrative.

The Executive Group reviewed the assumptions in relation to the activity that we expect to undertake, the workforce that will be required to deliver care and the impact on finance and performance across the system. The Executive Group agreed that ensuring local ownership of the plan and maintaining a focus on outcomes should be prioritised. The first draft of the Partnership Long Term Plan will be submitted to NHS England/Improvement on 27th September 2019 with the final version due to be submitted on 15th November 2019. Further information about the Plan and the process to develop it is **on our website**.

Commissioning Review Update

Across Humber, Coast and Vale, health and care services are commissioned by a range of local commissioners (NHS Clinical Commissioning Groups as well as Local Authorities) and national bodies (e.g. NHS England, Public Health England). In line with the policy direction set out in the NHS Long Term Plan, commissioners across the Partnership are reviewing existing commissioning arrangements with a view to identifying opportunities to collaborate and improve outcomes for local people.

A high-level update on the work to review commissioning arrangements was provided at the Executive Group meeting. It was reported to the Executive Group that the current Accountable Officer of East Riding of Yorkshire CCG, Jane Hawkard, is leaving the organisation at the end of October 2019 to take up a new role. In light of the continuing review of commissioning arrangements, partners have agreed that an interim arrangement should be put in place whereby there will be a single accountable officer for Hull, East Riding of Yorkshire and North Lincolnshire CCGs. Emma Latimer will take up this role from 1st November 2019. The commissioning review

will continue and further discussions will take place regarding the future development of commissioning in the Humber and York/North Yorkshire areas.

Digital Update

Earlier this year, the Strategic Digital Board commissioned work to produce a digital strategy for the Partnership. An extensive engagement exercise with internal and external stakeholders was undertaken to identify key principles and ambitions for digital and digitally-enabled health and care transformation within Humber, Coast and Vale. In July 2019, a draft digital strategy was presented to the Strategic Digital Board, which sets out the key principles, strategic direction and priorities that the Partnership should address to support digital transformation. The draft strategy is available **on the Partnership website** and partners are encouraged to review the document and provide feedback via the Partnership Office.

An update was also provided on the Health System Led Investment Fund (HSLI). Through the fund, the Partnership secured £2.3m investment for providers in 2018/19 for improvements to digital technology. A further £2.2m (2019/20) and £5.2m (2020/21) was expected to be available, however, the availability of this funding and the process for accessing it is still not confirmed. Following a prioritisation exercise, supported by the two sub-regional boards and representatives from provider organisations, the Strategic Digital Board has agreed a prioritised schedule of investments for 2019/20 and 2020/21, subject to funding.