York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

29 January 2020

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: 29 January 2020

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

TIME	MEETING	LOCATION	ATTENDEES
08.30 – 9.15	Private Board of Directors	Boardroom, Trust HQ, 2nd Floor, York Hospital	Board of Directors
09.30 – 12.30	**Board of Directors meeting held in public**	**Boardroom, Trust HQ, 2nd Floor, York Hospital**	**Board of Directors Members of the public**
12.45 – 13.45	Private Board of Directors Resumes	Boardroom, Trust HQ, 2nd Floor, York Hospital	Board of Directors
14.00 – 17.00	Board Development	Boardroom, Trust HQ, 2nd Floor, York Hospital	Board of Directors

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public) Agenda

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Apologies for absence and quorum** To receive any apologies for absence	Chair	Verbal		9.30 – 9.35
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 27 November 2019** To receive and approve the minutes from the meeting held on 27 November 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.	**Patient Story** To receive a presentation on Infection Control issues.	Chief Nurse	Presentation	-	9.35 – 10.00

	SUBJECT	LEAD	PAPER	PAGE	TIME
6.	**HYMS Development Update** To receive an update on progress with the HYMS development.	HYMS Clinical Dean	Presentation	-	10.00-10.15
7.	**Chief Executives Update** To receive an update from the Chief Executive	Chief Executive	C	To Follow	10.15-10.25
8.	**Integrated Care System Update** • HCV Update	Chief Executive	D	29	10.25-10.30
9.	**CQC Action Plan Monitoring Report** To monitor CQC action plan performance.	Chief Nurse	E	To Follow	10.30-10.40
	Strategic Goal: To deliver safe and high quality patient care				
10.	**Quality and Resources Committees** Items for escalation to the Board. • 27.11.19 Minutes for information • 29.01.20 Committee Logs	Committee Chairs	 F F1	 33 To Follow	10.40-11.00
	Short Break				11.00-11.10
11.	**Medical Director Report** To receive the Medical Director Report.	Medical Director	G	57	11.10-11.25

	SUBJECT	LEAD	PAPER	PAGE	TIME
12.	**Performance Report** To receive the Performance Report to include: • Winter Update	Chief Operating Officer	H	79	11.25-11.40
13.	**Partnership and Alliance Report** To receive the report.	Chief Operating Officer	I	107	11.40-11.50
	Strategic Goal: To ensure financial sustainability				
14.	**Finance Report & Efficiency Report** To receive an update on Finance and efficiency.	Finance Director	J J1	117 139	11.50-12.05
	Strategic Goal: To support an engaged, healthy and resilient workforce				
15.	**Director of Workforce Report** To receive the Workforce Report.	Director of Workforce & OD	K	151	12.05-12.20
	Governance				
16.	**Governance Documents** The Board is asked to approve the Reservation of Powers and Scheme of Delegation, Standing Orders, Standing Financial Instructions.	Chief Executive/ FT Secretary	L	173	12.20-12.25
17.	**Reflections on the meeting** • Integrated Board Report • Board Assurance Framework	Chair	Separate paper M	199	12.25-12.30

	SUBJECT	LEAD	PAPER	PAGE	TIME
18.	**Any other business** • Meeting Etiquette • New Chinese Virus Update	Chair	N	223	12.30

19. Time and Date of next meeting

The next meeting will be held on 17 March 2020 in the Boardroom, Trust HQ, 2nd Floor, York Hospital

Items for decision in the private meeting: - None

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
January 2020

York Teaching Hospital
NHS Foundation Trust

Additions:

Changes:

Deletions: **Brian Golding has dropped his Director of Estates and Facilities role.**

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)

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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

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Mrs Wendy Scott (Chief Operating Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
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 – 29 January 2020
Public Board Minutes – 27 November 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
Mrs 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
Mrs H McNair	Chief Nurse

Corporate Directors

Mr B Golding	Director of Estates & Facilities/ YTHFM LLP Managing Director
Mrs L Brown	Acting Director of Communication

In Attendance:

Trust Staff

Mrs L Provins	Foundation Trust Secretary

Observers:

Lesley Pratt	Healthwatch York
Bella Abidakun	Nurse – YTHFT
Emma Dean	Project Manager – YTHFT
David Watson	Member of the public
Sheila Miller	Ryedale Governor
Raj Purewal	Nuance Communications UK

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

19/95 Apologies for absence

Apologies were received from Mr Keaney, Non-executive Director.

19/96 Declarations of interest

No further declarations of interest were raised.

19/97 Minutes of the meeting held on the 25 September 2019

The minutes of the meeting held on the 25 September 2019 were approved as a correct record.

The Board:

- **Received and approved the minutes of the Board meeting held in public on the 25 September 2019.**

19/98 Matters/actions arising from the minutes

Action Log:

Minute No. 19/65 – Mr Jayagopal (HYMS Update) to come to the January 2020 meeting.
Minute No. 19/68 – Ms Symington to discuss PCN presentation with Mr Morritt – still to action.

No further items were discussed.

The Board:

- **Noted the action log and went through each item.**

19/99 Staff Story

Emma Dean, International Nurse Project Manager and Bella Abidakun, a Band 5 Nurse on G1 joined the Board. Ms Abidakun provided the Board with a perspective on what it was like to join the Trust following the international recruitment process.

Ms Abidakun stated that the process had been satisfactory and that she had decided to come to York as it was described as the best city to live in, in 2018! She had also looked at the package on offer which was very good in comparison to some of the others. She noted that preparation for exams was good, but there was a problem with having to continually move training rooms, which cut into training time.

Ms Abidakun stated that the support from the Project Team was good, but she had understood that she would be working in a supernumerary role on the ward in the first instance and this had been very hit-and-miss. It had been difficult to ask questions as some staff accepted the international nurses and some did not and some of the staff treated her as bank staff. Her view was that at the end of the day everyone was there to benefit the patients and communication needed improving.

Ms Symington thanked her for her honest and open account. Ms McMeekin stated that the issue with moving training rooms had been addressed following the feedback received. Mrs McNair apologised openly to Ms Abidakun and stated that the Trust had real lessons to learn and she reassured the board that she had already picked up on some of the issues and discussed them with her senior team. She stressed that this should be a two way learning process, with staff at the Trust also learning from the international recruits.

The Board:

- **Received the staff story and thanked Ms Abidakun for providing a very honest and helpful account of her first few months with the Trust.**

19/100 Chief Executive Overview

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

General Election – Mr Morritt noted that the Trust were still in the purdah period.

Our voice, Our Future Update – Mr Morritt stated that the summit had been held in Malton on the 14 November and following this an on line workshop had been launched and staff were being encouraged to engage. The on line platform would close on the 12 December and a plan would be drafted for the New Year which would identify how matter raised would be progressed.

CQC Action Plan – Mr Morritt noted that this was on the agenda and the Trust was still on weekly monitoring and there was concern that the Trust had not been hitting the full rotas expected by the CQC for 3 weeks.

Support to improve acute flow – Mrs Scott noted that a perfect 'Same Day Emergency Care' (SDEC) day had been held in both York and Scarborough in order to stress test pathways and feedback gathered would inform the project plan. The plan will be owned by the Care Groups With oversight from the Trust Acute Board Chaired by the CEO.

Integrated Care System (ICS) – Mr Morritt stated that Humber, Coast and Vale needed to become an ICS by April 2020 and that meant intensive work by the senior teams involved.

Urology – the cross-site out of hours rota had gone live on the 18 November across the two hospitals.

Ms Symington stated that she had committed to having an ICS item at every Board meeting.

The Board:

- **Received the update;**
- **Fully supported the Our Voice, Our Future work and looked forward to receiving further updates.**

19/101 CQC Report and Action Plan

Mrs McNair stated that the response to the CQC Report had been submitted on time. The action plan included all the must and should do elements and was being monitored by her team fortnightly. The actions were also being looked at to see which were transferrable to the York site. The proposal was to monitor the action plan by exception at the Quality Committee and then escalate to the Board. Mrs McNair also stressed that that the actions would need to be sustained so this would also be monitored and there are some actions that will require organisational buy in.

Mrs McNair stated that the Trust is still on weekly monitoring by the CQC. She noted that medical staffing remained good, as did Lilac Ward staffing, but the respiratory and cardio area staffing was more challenging. . Shifts are not being picked up even by the most expensive agency; however, she stated that these shortfalls had not caused harm to patients. Mrs McNair stated that the CQC are “nervous” as the Trust is now going into winter and these areas will get busier. An action open to the CQC is to mandate the Trust to close beds. NHSI have facilitated a wider system meeting to discuss what to do should this happen, as a system response would be required: despite the Trust’s best efforts staffing in these areas was not improving.

Mrs McAleese asked if the immediate actions could be removed as these had been done.

Mrs McNair stated that her challenge would be that there were some very stretching targets involved, but she stated that it was important that the Trust stretched itself and if it was unable to meet actions then it should be able to explain why.

Ms Symington asked about recruitment. It was noted that the vacancy rate had been as high as 50% in some areas which was improving and further recruitment is planned, but the winter period is of concern. Ms McMeekin stated that there are another 51 nurses recruited for Scarborough in 2020 and another business case for further recruitment is being drafted. However, Mrs Scott also pointed out that there will be further nurses who will leave. The work with Coventry University would also provide nurses, but this would only improve the position in later years. Ms McMeekin stated that it was about treating staff well so that they stay and it was sad that staff did not realise that their behaviours affected the position.

Ms McMeekin stated that she had recently received feedback as to the influencing factors for employment from university nursing students. The feedback included; a nice environment, being paid at band 5 whilst waiting for a PIN number and other small things like having a locker to put personal effects whilst on shift. She stated that there was a 35% uptake from students at York University and this should be the main pipeline into the Trust, but was not currently. What was clear when talking to students was that they knew all about ‘the Leeds Way’. Ms Symington stated that there was obviously some work to do, but it should be clear that creating a friendly workplace which welcomed all newcomers was the responsibility of every single member of staff in the trust.
Mrs Adams stated that the report was a good format, but she was a little confused by the colours. Mrs McNair explained that the CQC had asked the Trust to use their ratings, blue for delivered, green to mean the Trust is on track to deliver, amber some concerns and red is not on track to deliver.

Ms Symington asked at what point the CQC would take action. Mrs McNair stated that their action would be to close beds so the Trust needs to ensure that patients are not being harmed. There is the wider system piece to reduce bed occupancy and use staff in a different way. The CQC know the Trust is doing everything it can and it is unusual not to get shifts filled by the expensive agency.

Mr Morritt stated that it was likely that CQC will return to Scarborough in the next few months and that it is likely they will also visit York to provide a balanced approach. Mrs McNair stated that the latest CQC engagement meeting had been cancelled.

Mrs Mellor stated that the summary of the report still needs some work, and she was also confused by the RAG status. She thought that some of the Key Milestones needed key dates adding.

The Board:

- **Received the action plan and update;**
- **Fully supported the implementation of the actions.**

19/102 Quality & Resources Committees – Items for escalation

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

- A growing concern about safety running through all the reports and the absolute need to have a broader discussion around safety and finance;
- A useful discussion around the Quality Strategy and the need to raise the profile of quality and support it as an organisation.

Mrs Scott noted some of the key points from her winter planning paper which she had taken to the Quality Committee and stated that the increased demand (activity) and acuity of patients during the winter period and the Trusts ability to meet this additional demand is a key area of concern. A key priority is patient safety during this challenging period. The winter planning paper described the winter schemes that have been initiated to mitigate the risks described above but it also noted the residual capacity gap as a result of the systems inability to fund all winter schemes and therefore the associated risks. The paper also highlighted the impact of the transformation schemes underway on bed capacity and demand for example SAFER and impact on patient LOS. Despite these projects on both York and Scarborough sites, there remains a potential gap between anticipated demand and capacity over the winter period.

Ms Symington stated that she had recently visited Bridlington and staff were asking why more patients cannot go to Bridlington? Mrs Scott stated that Bridlington has similar issues to Scarborough in particular medical staffing. Mrs McNair stated that the risk is phenomenal in relation to which patients can go to Bridlington, as there is only on resident medical officer (RMO). Mr Taylor stated that the RMO is there predominantly to support orthopaedics which is not particularly risky and they also cover the wards, but there is still an element of risk with rehab patients who can deteriorate suddenly. Any increase in activity would require an increase in medical staffing. It was noted that medical staffing has improved at Scarborough, but that it was from a low base point. Mr Taylor stated that the 7 day services work also illustrates a weekend effect as performance drops at the weekend.

Mr Morritt stated that he is flagging risks with the regulators and the regional office and that it is also about thinking about what capacity can be put into the system outside the hospital. He is still waiting for a response, but stated that he was reasonably optimistic of some support.

Mr Morritt stated that the Quality Strategy should not be driven by CIP, but should be driven by what needs to be done to increase quality.

It was also noted that the Committee had raised concerns about the industry around the generation of data and the validation process as this takes a lot of manpower. Mrs Scott stated that mortality audits were done manually and the Trust was an outlier. Staff had to trawl the data to then prove the Trust is not an outlier. The other issue is that the Trust does not have a cancer information system and reports need to be pulled together manually.

There was also a discussion about the balance between capital and revenue and how it is prioritised. Mr Morritt stated that he had tasked Mr Bertram to look at this following the Executive Time Out.

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

- Workforce – the Clever Together feedback in relation to bullying and harassment of BAME staff. This is in relation to the LLP and Ms McMeekin has asked ACAS to come in and work with the Trust on this. There was also the issue in relation to statutory and mandatory training compliance.
- Workforce – electronic job planning is ongoing.
- Workforce – working on a just culture.
- Estates – size of the maintenance challenge and how it is prioritised. More assurance is being sought on this. It was noted that there are concerns around refurbishing wards in relation to IPC issues as there is a lack of decant facilities and that the NEDs want faster action on an HPV business case. Improvements in theatre cleanliness were noted.
- Finance – a good end to the half year position was achieved, but there are now significant challenges in relation to a series of unbudgeted expenditures and the CIP position was not going as well. It was also noted that there were very few tender opportunities.
- Digital – a draft strategy had been received and a new delivery group had been set up to improve engagement. The Committee felt that some independent advice was required in this area. Mr Morritt stated that he had asked for a realistic assessment of the Trust's digital position and he would look at getting some external advice.

Mr Bertram stated that in relation to capital it was likely that the Trust would only be able to do replacement and maintenance work going forwards, unless the Trust was able to obtain any external support for estate development. He noted that availability of capital was a national problem. Mrs Adams expressed concern about having to service the loans already in place which cut into the capital programme.

Mrs Mellor stated it would be good to get some external advice on digital as there needed to be a strategic thread through the Trust and linking, the system and national strategy. It was important that the Trust was in step with Humber, Coast and Vale.

Action: A Board discussion around safety and finance needs to be scheduled.

The Board:

- **Received the items for escalation;**
- **Noted the concerns around safety and requested a session to debate this.**
- **Noted the request for external advice on digital and that Mr Morritt is looking at this area.**

19/103 Chief Nurse Report

Infection Control – Mrs McNair stated that the report provided details of the outbreak at Scarborough and that the Trust remains an outlier in relation to C. Dif, but that the position at York was of more concern. One of the issues was around having HPV facilities. Mrs McNair had invited NHSI in to see if the Trust was missing anything. She noted that the fabric of the buildings is a concern preventing the trust from resolving the issues. Refurbishment of wards needed to be tied into capital conversations and there needed to be a call to action to address some of the underlying issues. The C. Dif figure is at 90 which is significantly above the target of 68 and the Trust is now into norovirus season. Mrs McNair stated that the system plan is in and an SOP on moving patients had also been developed. Mrs McNair stated that the good news was that the team was now fully recruited to although some of the team still need competencies signing off.

Mrs McNair stated that there is still work to do on staph aureus, but no themes or trends had been noted and E coli is on track.

Ms Symington asked if there was much in the way of norovirus about at the moment. Mrs McNair stated not as yet.

Mr Holmberg thanked Mrs McNair for approaching NHSI as the issue does triangulate with other things like training and capital availability.

MCA DoLS- Mrs McNair stated that the Audit Committee had asked for the report and this was about providing assurance that the Trust is doing everything that it should be. She stated that the Trust is compliant, but that things were changing and the statutory responsibility would pass from the Local Authority to the Trust. This will need working through and is becoming an issue in a number of Trusts.

Mrs McAleese stated that the Trust was already doing this work so was probably good news. It was thought that the responsibility will fall to the bed managers and the most senior person on site.

Mrs Adams noted the large section on DoLS in the data pack and asked if this could be reduced into something more meaningful.

The Board:

- **Noted the reports;**
- **Were concerned about infection control and supported the work being done by the Chief Nurse and Infection Control Teams.**

19/104 Perinatal Mortality Review Tool Report

Mrs McNair stated that this report was a statutory requirement and looked at all stillbirths and neonatal deaths in the Trust to ensure learning. Mrs McNair provided an overview of the cases and the action taken. Mr Taylor provided an overview of the medical involvement and action being taken as a result. He noted that Scarborough deals with deliveries of 34 weeks and above, consequently it is then difficult when a patient presents as an emergency with a pregnancy below this number of weeks. A number of issues have been looked at including maintaining experience and hierarchical escalation.

Mrs McNair stated that the Trust report will form part of a national report which looks at learning.

The Board:

- **Noted and approved the report.**
- **Noted that action was being taken to look at the issues raised by the report.**

19/105 Medical Director Report

Patient Safety Walkrounds – Mr Taylor stated that the walkrounds captured a number of issues including those to do with the environment and backlog maintenance. Mr Morritt stated that spend was being prioritised on maintenance and getting the basics right. He noted that the senior team had had a conversation about how to address estate issues. Mr Golding stated that if there was genuine concern about an area, spend could be re-prioritised. Mrs McNair stated that she was currently walking round with a member of the LLP facilities team to look at side room use and that this was generating a list which would be reviewed. Mr Bertram stated that it should be remembered that £18m of the £40m capital bid would deal with backlog maintenance at Scarborough. It was noted that the Board were really interested in this and that it was not about how things looked, but about escalating items which were linked to safety issues.

7 Day Services – Mr Taylor stated that the Trust were not compliant with Standard 2 which was about consultant review within 14 hours. Overall the data showed that there was work to do especially at weekends. However, he did stress that the audit rules kept changing so it was difficult to compare them. One example of a change the Trust has implemented was in relation to recording information both electronically and in writing. This had now been changed to make CPD the single method of recording. He was also aware that surgical colleagues saw their patients every day and were not recording it so it was truly difficult to obtain a benchmark.

Mrs Adams stated that the Data Quality Group had noted that the figures do not match and Mr Taylor stated that this was to do with recording things in different places and should change now that CPD was the single recording method. He also noted that there had been a change to CPD in the middle of the audit week which had affected data. Mr Taylor stated that as issues are uncovered, they are standardised so things should improve.

Mr Holmberg asked how accurate the data was and whether Mr Taylor had a feel for areas which were falling down. Mr Taylor stated that there was room for improvement and Care Groups could now see where the gaps were so could work on these. Some of it was to do

with compliance and some areas, for example did not have a consultant of the day. Mr Taylor stated that it was not possible to identify where all the shortcomings were at the moment.

Ms Symington expressed some exasperation and stated that 7 day working should be at the heart of the system and is critical to the smooth flow of patients in our trust. Mr Taylor highlighted a lack of resources as there was a significant cost attached to getting staff to work over 7 days which is not part of the consultant contract.

National Audit Data – Mr Taylor stated that the cataract outcomes evidenced really good quality care and was worth celebrating.

Theatre Productivity – this was moving forward and is contributing to transformation.

Mrs Adams asked about the new medical examiners roles and the timescales for getting all the roles in place. Mr Taylor stated that the national timescale is April 2020, but that the Trust only has Peter Wanklyn in place so far as there has been no response to the advert. Mr Taylor stated that he is having some conversations with local GPs who are interested and there are some officer roles which are likely to be nurses which need to be looked at. It is likely that the roles will need a modest amount of money and Mr Taylor and Mrs McNair are looking at how the officer roles can be wrapped up as part of the Safety/Governance Teams.

Action:

The Board:

- **Noted the report;**
- **Were keen to see areas of backlog maintenance and safety issues escalated in relation to the re-prioritisation of capital monies.**

19/106 Performance Report

Digital Ready Workforce Programme – Mrs Scott stated that she had spoken to the new programme manager and provided some feedback around the session received by the Board. Wave 2 is due to be launched and the Trust has been asked to consider if it wants to participate. The Board needs to consider whether it wants to be 1 of the 7 pilots. It will entail a Board workshop and a Chief Executive workshop. The Board discussed whether to get involved and Mr Morritt will discuss it further outside the meeting with Mrs Scott, taking into account whether it is a precursor to more money being made available.

In relation to performance, Mrs Scott highlighted the following:

ECS

Month	ECS	ranking
Sep-19	78.13%	96th (national position)
Oct-19	80.38%	93rd (national position)
Nov-19 MTD	76.15%	86th (national position)

- YTD – additional 8,870 patients across all sites (7% increase)
- YTD – additional 6,029 for Type 1 only (9% rise)
- 16 x 12 hour trolley waits at Scarborough
- Ambulance arrivals – continue to be above 2 year average, October figure of 4,512 was third highest in last 2 years

Non-elective Admissions

- Adult: YTD up 4% from last year, an additional 1,165 patients - No change in 0 LoS.
- Paeds: YTD up 12% from last year, an additional 602 patients - 33% change in 0 LoS.

Super Stranded Patients - There has been real progress in relation to addressing super stranded patients. The dashboard is now live and actively monitors this cohort of patients. Trust is currently achieving a 33% reduction against the 40% target.

Cancer – Mrs Scott noted the improved cancer performance position and the fact that the Trust is consistently out-performing the national position in relation to 62 day performance.

14 Day FT (target 93%) – September 90.9%, above national average of 90.1% 54% of breaches due to capacity (diagnostics), 31% complex pathways and the remainder patient initiated delays. October (not yet declared): 93.8% - this will be the first pass since February 2019. November to date: 92.3% (unvalidated). YTD continued increase in numbers, up 9.9% - this impacts capacity available for routines (diagnostics, outpatients, inpatients), affecting RTT etc. It is worth noting that it is 24.2% higher than the same period in 2017.

62 Day (target 85%) - September 79.4%, above national average of 76.9%. October (not yet declared): 78.4%. November to date: 72.4% - only one month since October 2017 has been below 75%, which was July 2018 (72.0%) – exceptionally challenging position at present. Diagnostic and pathology delays impacting particularly late IPTs which then impact breach allocation.

RTT - End October: 29,442, which is below trajectory of 31,846. RTT position 75.4% which is below the 80% trajectory and 18+ waiters increased by 2% (Current position: 29,036 and 74.5%). YTD 3.6% reduction in GP referrals.

Mrs Scott stated that there is a robust programme of work, led by the Corporate performance team in relation to the recovery of performance across all Care Groups

Ms Symington asked if the new Endoscopy Unit was making a difference for patents who are waiting for endoscopy services. Mrs Scott responded that there have been a number of contributory factors that have contributed to the increase in the endoscopy waiting list. In part this is due to a growth in demand but also the impact of the pension tax changes and the lack of additional work undertaken by doctors. The new endoscopy unit provides the additional space required; work is underway to expedite the opening of the additional rooms and recruitment of staff to support get these up and running.t The Trust has been visited by the national elective intensive support team who have undertaken a table top exercise to review diagnostics. A report is anticipated.

DToCs - In September 2019, the Trust ranked 11th nationally in the highest number of delayed days – a total of 1,690 across all sites. This equated to 1,355 acute delayed days (average of 45 patients per day) and 335 (average of 11 patients per day) in non-acute setting.

Mrs Adams asked if all the actions were helping the conversion rate come down. Mrs Scott stated that she suspected that things like SDEC are working and the change is quite significant.

Mrs Scott highlighted that the number of paediatric admissions is increasing up year on year. The year to date figure is 12% which is a significant increase in demand. Mrs Scott stated that the Care Group Director is reviewing the drivers for this increase. One reason might be that more experienced GPs retiring and the new GPs are perhaps less confident. Dr Boyd stated that this can have a snowball effect and that people decide the right thing to do is just to go to ED. It was thought that a significant number were being seen in the assessment unit. It was thought this may need to be resolved at a system level. Mr Morritt asked if this could be differentiated by short stay and admission.

Ms Symington challenged the directors to provide visible leadership in the hospitals during the winter months to provide support to staff.

Actions: Mrs Scott to have the paediatric data broken down by short stay and admissions.
Directors asked to provide visible leadership in the hospitals.

The Board:

- **Noted the Mrs Scott's briefing;**
- **Were concerned about performance as longer waiting times and backlogs impacted on patient safety.**

19/107 Partnership & Alliance Report

Mrs Scott provided an overview of the paper stating that system partners are being asked to comment on the McKinsey Phase 2 Scarborough Acute Services Review Report and sign it off. It is anticipated that a stakeholder workshop will be organised for January. She noted the significant programme of work in relation to Humber, Coast and Vale and that all Care Groups were fully engaged with this and she also referenced the long standing relationship with Harrogate and that both Trusts continue to work together. Her last point was in relation to national challenge in respect of oncology tumour sites and that a sustainable service model for medical oncology services for the patch were still being explored with HUTH, who currently provide medical oncology services in Scarborough and Bridlington.

The Board:

- **Received and noted the report.**

19/108 Director of Estates & Facilities Report

Mr Golding stated that the Resources Committee had discussed the governance arrangements around how the Board would receive information about the LLP following his retirement from the role of Director of Estates and Facilities. The EPAM terms of reference had been approved at a previous meeting and the first EPAM would be held in a few days. The meetings would formally manage the contract between the two organisations. Mr Golding would then formally stand down from his role at Director of Estates and Facilities and this portfolio would be distributed; compliance to the Finance Director, Health and Safety to the Chief Nurse and sustainability would go into the LLP.

Mr Golding stated that the LLP had a Management Group which was currently chaired by a NED who could report up through the Resources Committee and the EPAM would look at contract management. Mrs Adams stated that it was important that the Board maintained visibility of the LLP.

Mr Golding highlighted the current 2 corporate risks in relation to the LLP and Trust:

- LLP – Fire alarms – York is in the final testing stage and Scarborough's has been installed but not fully commissioned. This risk has been de-escalated. The work done by the LLP has saved approximately £200k.
- Trust – Capital availability for both backlog maintenance and strategic development. The backlog maintenance score is increasing due to lack of funds, but the strategic one is improving as the outline business case for the £40m development at Scarborough as NHSI is discussing access to money to pay fees with the Trust.

Mr Golding stated that in relation to the mortuary in Scarborough, 3 things were happening:

- The Capital Programme Executive Group had identified funding to allow the body store to be replaced with immediate effect.
- The Trust is working with NHSI to see if funds can be drawn down from the £40m in order to refurbish the mortuary which is part of the £40m plan.
- The Bereavement Team have put a bid in for charitable funds to do some minor works.

Mr Golding stated that there were no RIDDOR reportable incidents this month and he had provided the Resources Committee with assurance around cleaning scores. The annual PLACE inspections have taken place and he wished to thank the external assessors for their time and effort as the inspections could not take place without them.

Ms Symington thanked Mr Golding for his report and asked him to attend the December Board so that the Board could properly thank him as she had not realised this would be his last Board meeting. Mr Golding stated that the recruitment process for a new LLP Managing Director had already commenced.

The Board:

- **Noted the report;**
- **Were pleased to see progress around the mortuary at Scarborough and asked to be kept informed of developments.**

19/109 Finance Report & Efficiency Report

Mr Bertram stated that the Trust had a £20m year end deficit target to achieve. In month 7 the target was an £11.8m deficit and the Trust was currently £0.5m the wrong side of this at £12.3m. The position was fluctuating each month and was a symptom of how fragile the position is and how stretching the plan was. The £12.3m deficit position meant the Trust was not eligible for the sustainability funding this month, which added a further £800k deficit and took the variance from plan to £1.3m. Mr Bertram noted that NHSI do not look at the position until the end of the quarter and therefore all steps will be taken to ensure that the trust is in the best possible position at the end of the quarter, which may include performing a mini year end.

Mr Bertram stated that there was significant pressure on the position and that some difficult decisions had been made around system delivery and dealing with backlogs. However, safety concerns were now emerging and the decisions taken had not seen savings materialising as an underspend. In fact, there was £2m of pressure, £1m in relation to the money spent following CQC raising concerns about staffing and £1m in issues dealing with backlogs in reporting in radiology and histopathology.

In relation to the forecast outturn, the Trust is still reporting that it will hit plan, but this is a very precarious position and the share of the system deficit will impact on this position. Mr Bertram stated that he met with NHSI last week and discussed the position with them. He stated that the Board were aware of the precarious position and that there is a serious risk that the Trust will not hit the target. He also raised the growing concerns around safety and noted that finance had potentially been dominating the debate, however, a safe space was now required to have a conversation about the growing safety concerns and how these are dealt with.

Mr Bertram stated that the Trust had met £11m of the £17m CIP target, of which £8m was recurrent. He noted that the Trust had sufficient plans to meet the £17m, but that the Care Groups were currently behind on plan and work was ongoing to bring them back on track. The Care Group position had been supplemented by corporate savings especially procurement which has achieved £2.8m savings. Next year's CIP target is around £15m to £16m which is coming down but still represents approximately 3% of turnover.

Mr Bertram stated that the team is constantly looking for ways to refresh the CIP programme and using quality improvement with CIP as a by product is the way forward. He noted that the transformational part of programme had still not quite developed any traction with the only notable exception being the development of the LLP.

Mrs Mellor stated that she had enquired about being clear about what transformation income is coming into the Trust at the Resources Committee. She stated that Mr Bertram had discussed transformation income at the Resources Committee and noted that work is being done to look at bringing private endoscopy work back to the Trust to use out of hours capacity. Mr Bertram stated that he is working with a number of clinicians to develop a private practice policy which he will bring back to the Board when it is ready for discussion. He also noted that capture of overseas visitor income has improved.

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number of clinicians to develop a private practice policy which he will bring back to the Board when it is ready for discussion. He also noted that capture of overseas visitor income has improved.

Mrs Adams stated that the tender report seen at the Resources Committee showed little opportunity for any developments in the short to medium term which was a reflection of the commissioner position. It was recognised that a change in thinking was required as there would only be one pot of money for the system which was a change to the way things had been and that system solutions were required about how money was spent in a different way. Mrs McAleese stated that at a recent course in London it was very made very clear that there is no longer a split between providers and commissioners and that the structure is only there to allow the money to flow down from the centre.

Mr Bertram noted that if the Board stated that they were not going to meet the target, then the Board would have to formally sign up to a paper in month 9 stating this. The Board or representatives would then be summoned to NHSI and asked to prepare a recovery plan which would ensure that the Trust did hit the target. The decision would have to be made for the right reasons and the Board would have to ensure that it was clear what the drivers were as any perception of a loss of control would not be tolerated. The Board would need to be clear that decisions had been taken in order not to compromise on safety and be able to articulate the impact of financial decisions on safety.

Mr Morritt stated that the key point was around loss of control and that it does not change the process as the Trust needed to be able to tell a story which related to safety and quality. The Board would need to be very explicit about the risks and mitigations. Mrs McNair stated that examples were in relation to endoscopy waits and ophthalmology backlogs. Mrs Scott highlighted the system decision to extend waiting times. Mr Bertram stated that it was around things that the Trust would have done if it had the money to expedite things and Mrs Scott stated that this was about the radiology and endoscopy backlogs. Mrs Scott also noted that the Trust was not compliant with 70 hours of the frailty service due to financial constraints.

Mr Taylor stated that he had just received emails about 2 safety incidents, one was a delay in diagnosis due to waiting for an endoscopy and the other was around a delay in radiology reporting. He stressed that these have not yet been investigated so the full story was unknown. Mrs McNair stated that the concern was around the matters/incidents which had not yet come to light.

Mr Holmberg stated that he was pleased to hear that the Trust was developing a clinical strategy which he sees to be crucial, as it was important that the facilities were the right size to do the work.

The Board:

- **Noted the report;**
- **Discussed at length the financial position and its correlation to the impact on safety and patient care and expressed concern over the fragility of the position.**

19/110 Director of Workforce Report

Ms McMeekin highlighted job planning and the chart on page 279 of the pack. She had been keen to get to 100%, but this had been a little too ambitious and the operational review may have delayed matters. She noted that the Trust had come from a low baseline and that previously it had been more of a paper exercise. The Trust was considerably further along than in previous years. The new round of job planning will commence in January.

Ms McMeekin also noted that the CQC report had raised issues around statutory and mandatory training and that the figures had now been further broken down in order not to mask areas of poor compliance. This had highlighted poor compliance from medical and dental staff with particular concerns around safeguarding, resus and infection control training. The Care Groups now have clear oversight and are able to drill down into the areas of concern and the feedback is positive. Ms McMeekin stated that medical and dental staff will now receive letters highlighting the need to improve compliance, however, it was noted that the CQC target was ambitious as the Trust was now heading into winter.

The Board discussed remote access and online training and whether participants could opt straight for a test. It was agreed that training needed to be streamlined. Ms McMeekin confirmed that any juniors providing evidence of previous training could have this uploaded. Mrs McNair stated that it was about risk appetite and that currently the Trust is requesting the gold standard for training.

Mrs McAleese asked about whether sickness could be shown in an SPC chart format. Ms McMeekin stated that the reports available are from the payroll system. She noted that the Trust is an outlier for sickness at 4.3%, but there were significant gains to be had by changing behaviours. Ms McMeekin will look into presenting the data in SPC charts.

Mr Holmberg asked about the breakdown between junior and consultant staff and Ms McMeekin stated that the main concern was in relation to consultants. It was noted that statutory and mandatory compliance training was part of the appraisal process. Ms McMeekin had also agreed some flexibility with SPA time through the LNC so that staff can work offsite in SPA time if up to date with training.

Ms Symington stated that part of the work Mr Morritt was doing around 'Our Voice, Our Future' was about contributing to the work place. Mr Morritt asked when statutory and mandatory training requirements had last been reviewed and it was noted that it was currently under review.

Action: Ms McMeekin to look at presenting sickness information in SPC format.

The Board:

- **Noted the report including the high sickness rate and the actions being taken to increase uptake of training.**

19/111 Reflections on the Meeting

BAF – Ms Symington stated that the patient safety concerns raised at the meeting already score highly on the BAF. Mr Morritt confirmed that the Executive Team review the BAF. It

was noted that the only item not covered was in relation to sustainability. Mrs Adams stated that the Resources Committee had looked at the BAF following each item, but had not felt that there was anything which needed to be reviewed. However, she noted that the Ms McMeekin did have an LLP risk on her part of the Corporate Risk Register which needed moving over to the LLP risk register. Mr Bertram stated that the full BAF came to the Executive Board last week for review and was reflected on at the end of the meeting.

Action: HR LLP risk to go to the LLP Management Group

The Board

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

19/112 Any other Business

December Board – Ms Symington stated that the next private meeting of the Board would be held on the 18 December at the Folk Hall in New Earswick. She noted that the new Board calendar will be brought to that meeting.

Action: 2020 Board calendar to come to the December meeting.

No further business was discussed.

19/113 Date and Time of next meeting

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

Outstanding actions from previous minutes

Minute No. & month	Action	Responsible Officer	Due date
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~~ Jan 20
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 Jan 20
19/82	Internal and system winter plans to be brought to the next meeting.	Mrs Scott	Completed
19/85	A discussion with Mrs Hoskins around the provision of patient safety walkround action information.	Mrs Provins	Completed
19/92	The Executive Team to look at the scoring of risk 6.	Ms McMeekin	Completed

19/93	Mrs Hoskins will be asked to look at the areas for patient safety walkrounds.	Mrs Provins	Completed
19/93	Mortuary to be kept under review on the action list.	Board	Until completed
19/106	To have the paediatric data broken down by short stay and admissions.	Mrs Scott	Jan 20
19/106	Directors asked to be visible in hospital.	Executive Team	Ongoing
19/110	To look at presenting sickness information in SPC format.	Ms McMeekin	Jan 20
19/111	HR LLP risk to go to the LLP Management Group	Ms McMeekin	Dec 19
19/112	2020 Board calendar to come to the December meeting.	Mrs Provins	Completed

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Humber, Coast and Vale Health and Care Partnership

Update Report

December 2019

The following report provides an overview of the issues and topics discussed at the December 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

There was a shortened meeting of the Partnership Executive Group again in December to enable a workshop on Collaborative Partnership Working to take place. The workshop was part of the Integrated Care System (ICS) Accelerator Programme that the Partnership is currently participating in – see below for further details.

Independent Chair's Report

The Independent Chair's report focused on the issue of winter planning. In recognition of the increase in demand already being experienced by organisations across the NHS and wider health and social care sector, it was agreed that contingency plans for the system need to be robust. Partners discussed the plans that were already in place and looked at some actions that are being taken elsewhere in the country. Arrangements for coordinating responses to winter pressures will continue to be managed through the three A&E Delivery Boards that are in place at sub-system level (North and North East Lincolnshire; Hull and East Riding and York and North Yorkshire).

The Chair's report also included an update on the ICS Accelerator Programme (see below). In addition, the Chair updated the Executive on the plans to recruit a Clinical Lead to join the core Partnership Team. Plans are also underway to develop a Workforce Lead role to support the Partnership to work collectively on this critically important area.

The role of the Partnership Clinical Lead is to bring the voice of the health and care clinical and professional community into the:

- Delivery of the Partnership's vision and ambitions that are around the triple aims: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable;
- Strategy, planning and co-ordination of collaborative work that drives the development of new clinical models and proposals for the transformation of services;
- Oversight and assurance of Partnership performance and progress including health outcomes and quality of care, alongside operational and financial performance.

The Clinical Lead will chair the Clinical Advisory Group/Forum, champion health and care clinical and professional engagement and represent the health and care clinical/professional community on relevant Humber, Coast and Vale forums such as the Partnership Executive Group and regional and national forums. The closing date for expressions of interest for the role is 12 noon on 10th January 2020. Further information is available **via the Partnership Office**.

Cancer Alliance Update

An update on the work of the Cancer Alliance was provided to the Executive at its recent meeting. The update was provided by Phil Mettam, Accountable Officer for Vale of York Clinical Commissioning Group, who has recently assumed the role of Chair and Senior Responsible Officer (SRO) for the Humber, Coast and Vale Cancer Alliance.

In November 2018, the Humber, Coast and Vale (HCV) Cancer Alliance was one of ten alliances nationally to be selected to take part in an external review to offer insight into respective strengths and weaknesses. The review identified a number of important successes as well as key opportunities for improvement for the Alliance. One of the important areas highlighted was the need for the Alliance to have a more direct impact on improving performance of cancer services within Humber, Coast and Vale.

Following the review, the Cancer Alliance now has a renewed focus on clinical engagement; supporting and empowering clinicians to redesign services to better meet the needs of patients in our region. The Alliance will also take a more active role in oversight and assurance, with a particular focus on improving performance. In addition, we will now work more closely with our neighbouring Cancer Alliances in West Yorkshire and Harrogate and South Yorkshire and Bassetlaw to create more of a 'family' of Alliances and secure benefits from collaboration on a larger scale. The Cancer Alliance is currently undertaking a targeted recruitment process to appoint a Managing Director, who will be responsible for leading the work of the Alliance on a day to day basis.

Partnership Transformation Funding

A brief update was provided on the current position regarding transformation funding that we are expecting to receive for our Partnership during the period 2020/21 to 2023/24. The Long Term Plan Implementation Framework, which was published in June 2019, describes the types of funding available to Partnerships and sets out the indicative funding allocations that are expected to be available to support delivery of key aspects of the Long Term Plan for the next five years. These areas are: Mental health; Primary and Community Care; Cancer and Other, which includes Cardiovascular Disease (CVD), Respiratory, Stroke, Maternity and Prevention.

The Partnership has agreed to manage these funding allocations through our existing clinical programmes and the three sub systems, in line with the process undertaken to develop the Partnership Long Term Plan. It is expected that funding allocations will be aligned to support the delivery of the detailed implementation plans for the clinical programmes that are being finalised over the course of the next few months to March 2020.

Other News from the Partnership

Personalised Care

A key aspect of our Partnership Long Term Plan is our work to introduce more personalised care. Personalised care empowers people by giving them more choice and control over how they interact with professionals, book appointments and access their care records, including through the use of digital technologies.

In December 2019, the Partnership hosted a Personalised Care Development Day, which provided an opportunity for colleagues from local authorities, NHS organisations and the voluntary and community sector to share what they are already doing well across Humber, Coast and Vale and to learn from one another. The workshop covered various aspects of personalised care, including Patient Activation Measure, Social Prescribing and Shared Decision-Making, and considered opportunities for how these can be developed into business-as-usual activity across partner organisations.

A personalised care network is being developed following the event to ensure sharing and collaboration can continue to embed personalised care across Humber, Coast and Vale in the coming years. Further information is available through the **Partnership Office**.

ICS Accelerator Programme

The Accelerator Programme is an intensive programme of hands-on support, facilitation and shared learning that supports local Partnerships to develop and achieve Integrated Care System (ICS) status. Within Humber, Coast and Vale the Accelerator Programme is focusing on four key areas of development:

- Collective Partnership Working
- System Operating Arrangements
- Stakeholder Engagement
- Population Health Management

The programme has been ongoing for the last three months and will formally end on 31st January 2020. The Partnership will then agree a continual development plan to support us to achieve ICS status and continue to develop our collaboration over the coming months and years.

Stakeholder Engagement

The stakeholder engagement programme currently includes a focus on embedding health and social care professional engagement across the Partnership. The aim of this work is to improve the culture and processes within our health and care system so that engagement with the professionals delivering services is the norm. Around 60 health and social care professionals from a wide range of backgrounds attended the recent Health and Social Care Professional Engagement workshop that took place in December 2019. The workshop explored the benefits of and opportunities for greater involvement of front line staff in the work of the Partnership across all areas. A range of ideas were developed and pitched to a panel of representatives from across the Partnership.

The next workshop will take place on **22nd January 2020** and will look in more detail at how we might implement some of the programmes and projects that were devised during our engagement session in December 2019. These projects are just some of the ideas that will help us to improve the way in which our emerging Integrated Care System engages with and involved frontline clinicians and professionals in designing better, more integrated care in Humber, Coast and Vale.

Population Health Management Programme

Alongside the ICS Accelerator Programme, the Partnership has also been selected to participate in the national Population Health Management (PHM) Development Programme. Population Health Management is about applying advanced analytics and intelligence to design interventions that will improve the health of local populations, in particular, specific groups or cohorts of people.

In addition to the National PHM Development Programme we are also carrying out a skills mapping exercise across all partner organisations in order to provide a clear picture of existing analytical capability and capacity within the Partnership that would support population health management activities. This mapping activity will be undertaken collectively, with support provided by Public Health England.

Further information about all the work being undertaken through the ICS Accelerator Programme is available from the Partnership Office.

Board of Directors – 29 January 2020
Quality Committee Minutes – 27 November 2019

Attendance: Lorraine Boyd (LB) (Chair), James Taylor (JT), Helen Hey (HH), Fiona Jamieson (FJ), Wendy Scott (WS), Helen Noble (HN), Jenny McAleese (JM), Nicky Slater (NS), Heather McNair (HM), Steve Holmberg (SH), Charlotte Craig (CC), Lynda Provins (LP), Anne Whiteside for the Quality Strategy item only (AW)

1. Apologies for Absence (1 minute)

Rebecca Hoskins

The meeting was declared quorate.

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 25 September 2019 (2 minutes)

The minutes were accepted as a true and accurate record.

4. Matters arising from the minutes and any outstanding actions (3 minutes) BAF

4.1 Options for flexible use of specialist nurses - The Heads of Nursing have reviewed work plans and 'hot clinics' with the specialist nurses. There is an opportunity for ward work, discharge avoidance work, and delivery of additional 'hot clinics' over the winter period. Heads of Nursing will work with the teams to risk assess an work that will not be undertaken over winter as the specialist nurses make a greater contribution to ward work and patient flow. The Specialist Nurses will have ownership of their contribution and as such will be held accountable for delivery.

4.2 Patient Experience Group - This has been successfully relaunched and terms of reference have been agreed.

This led to a discussion on the work plan of the Quality Committee and the possibility of focusing on a specific topic at each meeting in the New Year. Inviting staff who are knowledgeable on a particular subject matter was also suggested to give a more rounded assurance.

Action: LB and HM to discuss
Action: LP to circulate 2020 dates to the committee.

5. Escalated Items (9 mins)

Duty of Candour (Audit Committee) – Duty of Candour was given limited assurance, consequently Quality Committee was asked to review this further. FJ stated that the governance team are simplifying the process, and reminding staff to send the letters. The Trust is currently at 80% compliance. A Duty of Candour dashboard is being produced; governance facilitators are working within Care Groups; and the governance team provides advice and guidance. The Committee were assured that the process around Duty of Candour is more robust. Further monitoring of this process will continue through the Medical Director reports to Quality Committee

Action: JM to update Audit Committee

Cancer Care Pathway Review (Audit Committee) - The Audit Committee were concerned that, the visibility of this report was an issue and the actions developed in relation to the report were not being reported or monitored. There was very little progress that could be evidenced.
Wendy Scott is the Executive Lead for this audit, WS agreed to review the audit report, action plan and report progress.

SH asked JT if the GIRFT report would be able to provide all the information we need. JT replied that this is a governance issue - GIRFT is a small committee and would need more members.

This discussion identified some broader issues suggesting inconsistency in the way some audit and review information is dealt with when coming into the Trust, and how they are progressed to an appropriate committee.

Action: WS and JM to discuss formalising associated governance structures re: internal and external audit intelligence and report back to the next meeting.
Action: JT to consolidate information streams from multiple external sources into, and within the Trust. To report back at the next meeting

Winter Plan Modelling (Board) - This will be discussed later in the meeting.

6. Medical Director Report (71 minutes) BAF

6.1 Quality Strategy 2019-20- AW presented the Quality Strategy 2019 - 2025 document. The aim of the strategy is to embed a culture of continuous improvement across the Trust.

AW is delivering a Leaders of Improvement Programme training course over 6 months. This will give attendees the tools and techniques to make improvement a reality. A central hub of expert knowledge, with links Trustwide and to Finance, will receive requests for QI project approval. They will be able to escalate if a project needs help/ support/ funding. Project leaders need to be able to measure data using a standardised approach, so they know if their outcome is achieved. The learning will be shared Trustwide. The Committee discussed the report and endorsed the plan to develop and provide a supported network to underpin Quality, and Quality Improvement as a key driver to the work of the Trust.

Escalate to the Board: highlight the good work of this report creating the foundations for Quality Improvement throughout the organisation and ask the Board to support the development of the QI programme as a key driver.

6.2 Cancer Audit Mortality report - JT stated the anomaly in the Bowel Cancer Audit was a single month's variation; it has been investigated and is not relevant. The colorectal team use an American risk assessment of 1-6 for bowel cancer patients, and he reported patients had been under-graded and the assessment was not used correctly. This has now been addressed.

There are potential issues with data collection for lung cancer; it requires a significant amount of manipulation once received. The cancer teams need to be able to track patients through a cancer pathway; using a new system or further investment in CPD.
The Trust needs another lung cancer nurse in Scarborough and is currently developing a business case for this. Kim Hinton is working on the data – when the Trust knows what type of patient is presenting, we can develop treatment strategies.

This opened up a wider discussion about data, and data handling within the Trust. Overall it was concluded that the data is essentially reliable, but the processes for gathering and in particular validating the data is laborious and time consuming. It is often a manual process and there is a risk of transcription errors. Much of the validation process is undertaken by Clinicians, at the expense of clinical duties, which may be contributing to some of the Trusts Performance challenges.

Escalate to Board: concerns about inefficiencies of the data and data handling processes within the Trust.

6.3 Radiology backlog - Unfortunately due to the backlog there is a potential risk of harm to patients. There has been a modest improvement in urgent backlog, but deterioration in unreported images, which represents a degree of unknown risk. There is no funding to improve this situation so are moving deadlines into April 2020. This led to a discussion on the wider, interrelated challenges our Trust is facing: challenging sustainable recruitment in Scarborough; inability to refurbish wards for 3 years raising the infection risk; community; maternity; lack of money; retention of staff; culture and behaviours.
HM recently spoke to student nurses at University of York; many have had placements at the Trust – but the behaviours they witnessed mean they are looking elsewhere for employment.

As these issues conflate concerns are increasingly not just discussed in terms of quality and performance, but also about the risk to safety. The need to more clearly capture and respond to potential harms is acknowledged along with the importance of linking, where appropriate, to the wider Trust challenges and the system financial challenges. This information would be invaluable as the Trust prioritises use of resources to ensure continued delivery of a safe service.

Escalate to Board: the Quality Committee has a growing concern around the ability to maintain safe services, and would welcome a full Board discussion on how to prioritise resources and activity in the light of this.

6.4 Learning from deaths - JT informed the Committee that we do not have compliance with SJCRs (Structured Judgement Casenote Reviews) across the board, which should be

10% of all deaths. However, there is now enough data to use it in a meaningful way. JT reported that learning from each case is understood and the actions to address identified learning are being followed. JT reported that the focus should now be on the outcomes of the learning to date. There are no surprises in reported themes and they remain consistent, for example: no senior review; lapses in care; poor communication; and lack of DNACPR. A summary of themes will be shared with all Care Groups.
An SOP has been created for SJCRs including timeframe, feedback, outcomes and tools available.

With the Medical Examiner in place, the Trust have advertised for a support team but had no interest internally. Therefore the plan is to advertise again and consider external options. The obstacle may be the pension tax allowance charges. The Committee took assurance that learning and actions are appropriate, but note there is still work to do to improve engagement and compliance with the processes through the Care Groups.
With SHMI data and SJCRs there is a wealth of information to use.

Action: HN to send Mortality Steering Group minutes to SH.

6.5 SIs - 2019/16240 Medication incident - The Committee took assurance that learning will be shared.

2019/14876 Alleged abuse - The Committee took assurance that this was an isolated event and processes have been followed and reviewed.

6.6 National Ophthalmology Database Audit - Ophthalmology is producing excellent results with its cataract patients. The team have spent time and effort to manage the data, and this has increased productivity.

The Committee received and discussed the Medical Directors report.

7. Chief Nurse Report (46 minutes) BAF

7.1 Acuity and Dependency - the Trust is required to undertake this report twice annually. 25 wards reported good correlation between planned and actual staffing levels. There are a number of staffing levels and workforce review being undertaken and planed for January 2020. There are number of wards which look understaffed with required staffing levels much higher than actual numbers. However, professional judgement would indicate this is incorrect. An example, Ward 37 where all the patients have dementia and score 1b. As many of the patients have a long length of stay, they are settled and know the ward routines well and therefore could be reclassified, even with this confirmed dementia diagnosis. This highlights why the data cannot be taken in isolation and must be used alongside professional judgement.

The Committee received and discussed the report, taking assurance from the actions to guide efficient use of staff resource whilst maintaining patient safety.

7.2 IPC Q2 - the outbreak of C.Difficile on the Scarborough site was declared over on 17 September 2019. There has been learning from this, and the action plan is mostly completed. Concern remains that there is an unacceptably high back ground C.diff level across both sites, but more so on the York site. This is partially being addressed by raising awareness of the importance of basic IPC practices. The contribution of the environment is

a significant factor too: limited HPV decontamination; growing backlog maintenance; inability to refurbish wards; lack of decant facilities; bed capacity compromising patient flow and resultant patient transfers; lack of side rooms as isolation facility. A proposal to revert side rooms, currently being used as offices, back into side rooms is being presented to Corporate Directors. The recent MRSA case in SCBU was a single isolated case. The learning from the Norovirus outbreak highlights the need to limit patient transfers. Within the IPC team some staff are not fully IPC trained, but there are no current vacancies.

HPV decontamination continues to be a challenge; the Resource Committee asked this Committee to monitor the progress of the business case. Damian Mawer will be asking Care Groups to do targeted work to reducing infection issues, and work on engaging staff in training.

Action: JM asked for a hyperlink to informational appendices instead of including them in the report. Still to include essential appendices.
Action: QC to monitor the progress of HPV business case
The Quality Committee received and discussed the report, acknowledging the continued challenges around IPC and the actions to mitigate the risks.
Escalate to Board: awareness of IPC challenges will be raised in CN report.

7.3 Nurse Care and Staff Report - The Trust continues to report weekly to the CQC. The vacancy rate is improving; however, there remains a number of wards above 30% vacancy level, specifically in older peoples care. The newly qualified nurses all have their professional registrations and are working through their competencies. There are a smaller number of nurses who qualify in Spring and the Trust is recruiting for both sites, currently 13 have been secured from the Spring cohort: 11 for York and 2 for Scarborough.

The 30 International recruits come from UAE, Africa, India and the Philippines and are passing OSCEs, working through competencies, and settling into the wards. They are given good pastoral care; in Scarborough there are already strong communities; in York the cost of living is higher and the staff are being supported by the Trust with accommodation searches. There have been a small number of cultural differences reported; which the Chief Nurse Team is working through with ward leaders.
Will Thornton is working on a business case to undertake more international recruitment in 2020. The Trust is good at retention, outperforming other Trusts regionally and nationally. NHSI have undertaken 4 programmes of work nationally on recruitment and as a high performer the Trust was asked to join Cohort 5. The Deputy Chief Nurse and Workforce Lead have analysed the data and determined that a piece of work is progressed Care Group 3, as although not significant for our Trust, they have the highest turnover. A specific piece of work will be to look at the existing exit interview process, and to target staff who leave within 2 years of employment.

The Committee received and discussed the report, noting the early promise of the recruitment programmes and the need to focus on the challenges of retention.

7.4 CQC Summary Improvement Plan - The CQC Summary Improvement Plan will be overseen by the CQC Programme Group and escalate to QC by exception monthly. The TOR were reviewed and discussed. The first meeting in the Trust went well, staff were engaged. The plan is to report monthly to this Committee. The Quality Committee asked for assurance that any actions signed off remained under scrutiny. FJ confirmed that she would establish a system to revisit all sections of the Implementation Plan to ensure

actions were embedded and where revised , or new actions were identified these were followed up.

The Committee took assurance that the CQC Programme Group will provide the required oversight and meaningful actions.
Action: monthly updates from CQC Programme Group to be presented to QC and added to work programme

7.5 Risk Management Update was received - Discussion was limited due to time constraints.

The Chief Nurse report was received and discussed.

8. Performance Report (12 minutes) BAF

The Performance Report was also referenced in the discussions in the earlier parts of the meeting, being one of the inter-related issues concerning the Committee. WS explained that in relation to performance, November was challenging, with a 7% increase in activity and sixteen reported 12 hour trolley breaches. Colleagues from ECIST have been working alongside Trust staff to test ambulatory care pathways – an SDEC 'Perfect Day' has been launched on both sites. Whiteboards were deployed in all areas to capture what went well, and what did not.

The Trust has not achieved the national Emergency Care Standard of 90% since March 2014. As at October 2019 the Trusts performance against the standard was 80.4%, below the national position of 83.6%. The Trust achieved 90.9% against the 14 day Fast Track Cancer standard. National performance was 90.1%. The Trust achieved 79.4% against the Cancer 62 day standard. National position was 76.9%.

The Trusts Referral to Treatment (RTT) Total Waiting List (TWL) at the end of October 2019 was 29442. Due to a growing demand the Trust is keeping pace, but not addressing the backlog. This is compounded by consultants dropping weekend clinics due to Pension Tax Allowance Charges. The pensions tax 'cliff-edge' which may be faced when annual taxable income goes over £110,000 – as this could result in large increases in annual allowance tax bills. Many of those who expect to be affected by pensions tax issues have or are considering reducing their hours, and avoiding promotions or additional work. The Secretary of State stated that a change in guidance to last month allows NHS trusts to introduce flexibilities immediately, to ensure that doctors can do the work and the overtime that they need without being penalised. Urology refer patients for robotic surgery to Hull or Leeds, there are long waits for both hospitals. Hull will be purchasing an additional robot in April 2020. The new Endoscopy unit is open and should help reduce Colorectal waiting lists.

8.1 Winter Plan Monitoring - WS explained that work is progressing to develop same day emergency care and to reduce length of stay, working with system partners. HH referenced an SI about long ambulance queue in ED, from which only 5 patients were admitted. HH has spoken to YAS about how the other 10 patients could have been treated differently, as they did not need to go to ED. The super stranded patient (21+ days) situation is improving.

The Trust has bid for additional winter monies to support Frailty services at both York and Scarborough Hospital. This would support the existing service in York, and support the initiation of a frailty service in Scarborough.

A paper was shared that highlighted the risks associated with winter. Bed modelling suggests that there will be inadequate bed capacity on both sites to manage demand. Winter schemes aim to mitigate the risk associated with high bed occupancy, but it is clear that despite these winter schemes there is a significant risk of a deterioration in performance against the: ECS standard, 12 hour trolley waits and corridor care, resulting from overcrowded EDs. The Board needs to be aware of these risks.

Escalate to Board: significant risk of inadequate bed capacity and deterioration of performance over the winter period.

9. Board report (1 minute)

No additional concerns were raised from the Board report

10 Reports to receive and note (3 mins)

The following reports were received by the Committee. Comments or concerns were invited. Discussion was limited due to time constraints.

10.1 Lead Health Care Science Report
10.2 Q2 Sepsis Report
10.3 Scarborough Hospital SJCR Review
10.4 Patient Safety Group Minutes
10.5 Medication Safety Strategy Update
10.6 Medication Examiner Implementation Plan
10.7 Patient Experience Report
10.8 Q2 Pressure Ulcer Report - HN apologised for the mistake in the appendices.
10.9 Q2 Fall Report
10.11 Perinatal Mortality Review Tool Report - HM drew attention to a high risk pregnancy where twins died, and concerns over decision making had been raised.
10.12 National IP Survey Report - SH queried how this information is used to improve patient experience and this will be addressed via the refreshed Patient Experience Group, which is in the process of updating and agreeing TOR.
10.13 DoLS Next Steps/ Liberty Protection Safeguards - The imminent introduction of Liberty Protection Safeguards and implications for the Trust were noted.

11. Board Assurance Framework – Corporate Risk Register (2 minutes)

Due to time constraints the BAF was not formally discussed, however, it was noted that BAF 1-7 were all discussed in some depth during the meeting. Gaps in assurance in relation to CRR were also discussed during the meeting.

12. Reflections on the meeting (minutes)

The Committee felt the agenda was too long, and allowed insufficient time for full discussion and to do the papers justice. Themes were: money versus safety tension, data quality and timeliness, and priorities.

The CN, MD and Chair will work together to improve the structure and content of the meeting, to ensure focus on assurance and supporting information to come to the Committee via a process of reporting by exception. This should ensure the work of the Committee becomes both manageable and relevant.

Action: HM, JT & LB to agree changes to structure and content of meeting.

Attention to the Board

- QC wish to highlight the importance of The Quality Strategy document creating the foundations for Quality Improvement throughout the organisation, and ask the Board to support the development of the QI programme as a key driver.
- Raise concerns about inefficiencies of the data and data handling processes within the Trust.
- The Quality Committee has a growing concern around our ability to maintain safe service, and would welcome a full Board discussion on how we prioritise our resources and activity in the light of this.
- Ensure Board awareness of IPC challenges which will be raised in CN report.
- Ensure Board awareness of the significant risk of inadequate bed capacity and deterioration of performance over the winter period.

13. Any other business (1 minute)

No other business to discuss.

Next meeting of the Quality Committee: 21 January 2020, Boardroom, York Hospital

Action Log

Date of Meeting	Item No	Action	Owner	Due Date	Comments
31/7/19	6	FJ to lead improving performance on Duty of Candour.	FJ	Nov 19	Ongoing
25/9/19	8.4	Progress report on 14 hour consultant review	JT	Nov 19	Ongoing - agenda item
31/7/19	8.1	Provide more assurance around outputs & triangulation with numbers.	HM	Jan 20	Ongoing
27/11/19	7.4	monthly updates from CQC Programme Group to be added to work programme	LP	Jan 20	Completed
25/9/19	10	Additional meeting to consider potential 2020/21 Quality Priorities	LP	Jan 20	21.01.20 4.30

27/11/19	5	WS & JM to discuss Cancer Pathway Review governance pathway & report back to next meeting.	WS JM	Jan 20	
27/11/19	6.4	HN to send Mortality Steering Group minutes to SH.	HN	Jan 20	
27/11/19	7.2	To provide a hyperlink to informational appendices instead of including them in the report. Still to include essential appendices	HM	Jan 20	
27/11/19	4.2	To circulate 2020 dates	LP	Jan 20	On agenda
25/9/19	4.2	12 hour breach review work.	RH	Feb 20	
27/11/19	5	JT to consolidate information streams from multiple external sources into, & within the Trust. To report back at Feb meeting.	JT	Feb 20	
27/11/19	7.2	QC to monitor the progress of HPV business case	HM	Mar 20	
27/11/19	12	HM, JT & LB to agree changes to structure and content of meeting	HM JT LB	Mar 20	
27/11/19	4.2	LB & HM to discuss inviting knowledgeable staff to meeting	LB HM	Mar 20	

Completed Actions

Date of Meeting	Item No	Action	Owner	Due Date	Comments
31/7/19	6	FJ to lead improving performance on Duty of Candour.	FJ	Nov 19	Ongoing
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	8.2	Consider assurance process in relation to patient movements & IPC	HM	Nov 19	Completed - agenda item
31/7/19	8.3	Review complaint response times	HM	Nov 19	Update to QC Nov 19
25/9/19	7.4	Explore options for more flexible use of specialist nurses	HM	Nov 19	Completed - agenda item
25/9/19	7.5	Update Acuity Audit	HM	Nov 19	Completed - agenda item
25/9/19	7.6	Progress update from PEG relaunch	HM	Nov 19	Completed - agenda item
27/11/19	5	JM to update Audit Committee re DoC progress	JM	Dec 19	Completed 3/12/19

Board of Directors – 29 January 2020
Resources Committee Minutes – 27 November 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 5 only), Joanne Best (JB) (minute taker)

Apologies for Absence: Mike Keaney (MK)

1. Welcome

JA welcomed everyone and declared the meeting as quorate.

JA informed the committee that as mentioned in the previous minutes the agenda would be rotated to allow Executives to have equal share of airtime, listing the order as follows:-

Workforce
Estates
Digital
Finance

2. Declaration of Interests

There was no new declaration of interests.

LP requested that that in future everyone could be more disciplined with regards to the Board Assurance Framework (BAFF) register and how it linked to the Corporate Risk Register (CRR).

3. Minutes of the meeting held on 25th September 2019

The minutes of the meeting held on 25th September 2019 were approved as an accurate record subject to the following amendment: -

P.8 – Patchwork App – 3rd Paragraph – LP asked if there were any other apps, should read LM asked if there were any other apps to benchmark against.

P.8 – Patchwork App – 2nd Paragraph & P9 Board Assurance Framework – 3rd Paragraph - change spelling of ‘license’ to ‘licence’.

P.9 – BAF – 3rd Paragraph – LM asked if they would need as much capital as they move to a more ‘software as a service’ model on the cloud.
Change to - LM asked if they would need as much capital as they move to a more ‘software as a service’ model on the cloud, which tends to be more OPEX based.

P.9 – BAF – 4th Paragraph - LM added that one financial benefit was that they did not need ownership of the infrastructure.

Change to - LM added that one financial benefit was they did not needs as much ownership of infrastructure as they move to a more Cloud based model.

JA addressed the committee checking that the minutes had been sent out in good time to allow everyone to review it. There were no further changes to the minutes.

4. Matter arising from the minutes and action log

The following matters recorded in the Action Log were discussed:

Action Log:

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

Theatre cleaning action plan – BG has covered this in his report

Digital – draft needs a further month for completion, just waiting for final changes but should be ready for January 2020 KB/AS

Infection prevention - BG – the business case for HPV infection prevention will be complete by Friday (29th November 19) and will be on the business case panel agenda in December 19.

JA asked if it would be possible for it to be presented to an earlier panel, GL suggested that he would review the case next week prior to 9th December panel.

JA requested ongoing updates and expressed concern that this vital element of IPC was taking a long time to resolve when the Trust was struggling to get on top of C-diff.

Theatre cleaning – BG – new equipment has been purchased to support the Theatre cleaning performance. This was purchased using NHSI capital funding.

Maintenances back log – Maintenance issues were discussed between BG & JA,

JA reported that a meeting had taken place in October with Andrew Bennet presenting the methodology of the condition survey undertaken by a third party on behalf of the Trust and completed in the summer.

Whilst this was useful background NEDs had not been able to get assurance that we are currently prioritising backlog maintenance on the basis of the highest risks to patients and staff. It was not clear what the scale of the backlog maintenance challenge was within the Trust and what gap there may be in terms of HR and finance resources to address it.

NEDs have expressed their concern that there may be issues akin to the SGH mortuary that they are unaware of. BG explained that this will be the next stage in the process and that he was asking Andrew to prepare a report which would answer these key questions.

ACTION: BG to present report from Andrew Bennet detailing priority backlog maintenance including outline costings.

A discussion took place with regards to maintenance which requires action and what needed to be prioritised.

JA referred to the IPC report which suggested that there were no funds for ward refurbishment. AB responded stating that this is not quite true as there was funding but as there was no ward space available to decant to while ward refurbishments were carried out the funding had been used elsewhere and that this was the second year this had happened.

A discussion took place with regards to possible maintenance work that could be carried out while patients are on the wards.

BAME bullying issue

PM stated that the Trust were engaging with ACAS on this issue – they have a successful track record in this area.

LM stated that she was happy with the plan of action, JA asked that the Committee be given regular updates.

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

Board Assurance Framework (BAF)

LP informed the Committee that the BAF had been presented to the Board on 7th November 19 and that it would be reviewed quarterly and that it would be shared with the Executive Board for the first time at the end of the month.

The Committee agreed that this had proved useful and moving forward they will be presented to the Board quarterly.

It was noted that some scores had moved up and some down.

LP noted that appointments to review the CRR will be sent to Executives diaries. The Resources Committee will move to monthly from January 2020 and intend to review both the BAF and the CRR scores in relation to each item.

JA noted that there had been quite a few changes, noting that these were now highlighted.

JA asked PM about the Workforce changes in particular she asked why the healthy workforce risk figure had changed.

PM noted that she had reviewed all areas, stating that there had not been enough staff to manage shifts and that there had been a nurse shortage in Scarborough over the summer months.

PM noted that vacancy rates were significantly healthier than they had been earlier in the year and that she is confident that the Care Group changes will support this going forward.

JA suggested that this would be an appropriate time for LP to leave, but LP was happy to stay at the Committee a little longer.

Items from Board Report or sister committees

JA asked about any escalated items from other committees. There was nothing to feed-back from quality and safety and the Audit Committee had not yet met. It was noted that the estates team is now in single figures for the number of outstanding internal audit actions BG will be attending the next Audit Committee with Andrew Bennett.

Post Meeting note: BG/AB did not attend December Audit Committee.

JA noted her concern in relation to backlog maintenance and wondered if there was enough estates related information in the Board pack – but too much information in some other areas that was of limited use. PM suggested that there should be a constant review of what goes in the board report.

Action: for Brian Golding – to develop an Estates section for the integrated Board pack

LM made a similar point around the digital agenda suggesting that further information to be included in the report in future.

LM asked if it would be possible for an 'on line feed' to a more detailed report.

JA asked the committee where the sickness vacancies in the LLP referred to in the HR part of the data pack should sit in terms of the CRR and if this was down to PM's team to manage the risk or the responsibility of the LLP.

Brian suggested that this should be a joint effort between himself and PM

LP was now invited to leave the meeting and thanked for her contribution.

AB then referred back to the previous ward funding discussion and read out a statement from the July DIPC report noting that as the £300k was not able to be used as intended it was used elsewhere. Confirming that provision **had** been made for ward improvements.

LM asked the committee about issues highlighted following a ward walk around, and asked how these could be addressed; the committee was told that these issues would be addressed by the minor works department.

JA noted that although the larger issues could not be addressed at this time due to the lack of a ward to decant to she asked that estates are as creative as possible to address as much as possible without decanting.
BG stated that it was difficult to address items when the wards are occupied. AB assured the committee that there is a minor works fund to address issues on the wards.

The committee continued to have a discussion with regard to what minor works could be carried out while patients occupied ward areas.

JD noted that small issues such as duct tape on the flooring in the main corridor is portraying the wrong impression of the Trust.

6. Director of Workforce Report

BAF Risks: 6, 7 and 8

Nursing recruitment update

PM told the committee that the Trust had appointed 92 new nurses over the previous two months, 65 at York and 27 at Scarborough along with 22 further international nurses which means that a total of 49 nurses have been appointed via the international nurse recruitment programme across York and Scarborough. (12 of these nurses are based at Scarborough and the other 37 based at York).

PM told the committee that a further 67 arrivals are planned for 2020, 51 of these for Scarborough and 16 planned for York. The overall vacancy position for registered nurses and midwifes has improved significantly across the Trust to 11.6% at the end of October 2019, it was 17.4% in May 2019.

Medical Staffing

PM noted that the Trust is now reporting 9.8% medical vacancy figure across its main sites this will be monitored going forward. It was noted that the vacancy fill has improved on the East Coast stating that there are only seven vacancies outside of Consultant and SAS Grades which the Trust is now seeking to fill.

Job Planning

PM noted that the Trust is working towards NHS Improvement's Levels of Attainment for E-Rostering and E-Job Planning, with a target of 90% utilisation of both systems by clinical staff to be achieved by March 2021.

It was noted that as of October 2019 the job planning system was being utilised by 94% of the Trust's Consultants and SAS Doctors with the majority of their Job Plans either awaiting sign-off or close to final submission. These should be signed-off between January 2020 and April 2020.

It was noted that many medical staff had not experienced this way of working previously but that they are getting to grips with electronic job planning.

JA asked PM if the use of electronic job planning had shown any productivity opportunities? JA noted that Model Hospital benchmarking data shows the Trust to be at the top end of Consultant numbers for a Trust of our size in a number of departments. PM replied that it had potential and that discussions had occurred and agreement obtained regarding SPA time and location.

JA / PM discussed the need to ensure that clinicians are up to date with training, noting that this could happen both on and off site. PM noted that this was one of the purposes of job planning noting that the job plans should be in – line with business planning. It was noted that this is a work in progress.

PM gave the committee an overview of the structure of job plans and the theory behind them along with the expected outcome.

Flu Campaign

PM noted that the Trust is making strong progress with its 2019-20 Flu Campaign, noting that 57.6% front line staff have already been vaccinated. It was noted that during the first week of this campaign one peer vaccinator was able to administer more than 253 'flu jabs'.

The Trust is working with the NHSE & I target for 80% of frontline staff to receive the vaccination before the end of February 2020.

Statutory and Mandatory Training Update

PM highlighted to the committee that a change had been made in reporting compliance within the Medical and Dental staff group. This had been identified as an issue by the CQC's recent report. The changes will improve non-compliance visibility which will allow trainers to tackle gaps in training records. The Humber Coast and Vale Streamlining Programme should also drive up compliance in the longer term.

The intention is to write to medical staff with poor compliance. Their individual record will be provided with a deadline for them to improve their compliance.

JA asked what if any penalties could be implemented if staff did not comply with required training. The appraisal process was one route but some consultants were happy to waive their pay increments to avoid tax problems which removes one lever from the Trust.

Staff Survey

PM noted that the staff survey response was at 40.5%, this is possibly as it has not been promoted as much this year with focus on Clever Together. The 'Clever Together' scheme has identified a number of areas where staff and teams experience barriers that stop them from working to their full potential.

Carer Friendly Employer

PM – the Trust is striving to become more flexible to support staff who have carer responsibilities outside or work statistics show that the one in nine people in workforce are caring for someone outside of work.

The Trust is in the process of applying to be recognised as a 'Carer Friendly Employer'.

LM told PM that the use of pictures (P87) was a positive development. She also enquired about social media / patch work app. The patchwork business case was due to go to panel on 11 November and PM hoped this would be approved to allow it to move forward.

JA discussed the impact on finance given the new influx of nurses. PM noted that a workforce request is submitted monthly to Exec Board.

JA / PM would it be possible in future to submit a chart showing workforce vacancy rates over time, this would help trends.

JD addressed the committee stating that he felt the Clever Together Scheme would have a positive impact. A group discussion continued in relation to the scheme. It was noted that this is a good sign of culture changing.

NHSI Retention Support Programme

This report was accepted by the committee.

PM noted that the Trust Care Group 3 has proportionally higher turnover rates amongst registered nurses with less than 2 years service but noted that this rate was lower than the national average. PM highlighted that of these leavers over 50% recorded the reason for leaving as 'unknown'.

LM enquired why this was and suggested that there should be a focused interview prior to leaving the Trust.

PM noted that they do approach registered nurses asking if they would like to return to the Trust, but agreed that they should be approached earlier. PM noted that the new structure would be used to embed this in to each area.

JA asked PM if there was a stability index for the LLP, but PM thought it was in line with the Trust average overall.

The committee looked back at the BAF and CRR for Workforce and were happy with the current Risk scores.

7. Director of Estates & Facilities Report

BAF Risks – 4,6 and 11

BG told the Committee that the terms of reference and contract management for the YTHFM had now been approved by the Board of Directors at YTHFT.

BG noted that he will no longer be a Director for Estates and Facilities and that the residual corporate responsibilities will be divided into three;

- YTHFM contracting management (including compliance – Director of Finance
- Tryst-wide Health and Safety – Chief Nurse
- Sustainable Development – leadership to be procured from YTHFM

BG noted that this would be the last report in this current format.

BG – the board of the LLP will consist of himself as Managing Director, Mike Keaney as Chair, (Graham Lamb to cover in Mikes absence).

A discussion continued in relation to the LLP Board, noting that the LLP will be treated as the seventh care group and that if specific issues arise that require a mention at Board then this will happen.
A discussion continued with regards to BG continuing to attend the Resources Committee Meetings as MD of the LLP, it was agreed that as a high level of assurance would be required for the LLP he should still attend.

Review of Corporate Risk

BG reminded the committee that following the September discussion with regards to the risks associated with the replacement of the fire alarm system at both the York and Scarborough sites this has been de-escalated and is no longer a feature on the corporate risk register. It was noted that there are still two remaining risks the first relates to limited access to capital to develop the Estate strategically and the second risk is to keep on top of backlog maintenance. BG stated that both risks are worsening as capital constraints tighten.

BG discussed the plans for the estate teams on both sites merging their existing asset management plans into one overarching document, noting that for the following year all maintenance plans will be prioritized based on the level of risk identified in the conditional survey.

It was noted that a request to obtain some of the £40m Scarborough Acute village capital early to facilitate project planning has been looked on favorably, but that confirmation is still needed.

JA enquired if this could be extended to cover the Scarborough Mortuary and AB suggested that this was likely to be the case as part of early preparatory work.

Health, Safety and Security

BG was pleased to report that there were no RIDDOR incidents reported in the previous month.

Estates and Facilities Compliance

The Estates & Facilities Compliance report was attached as appendix 2 noting that the report will be presented to the LLP Management group's November meeting.

Cleaning performance

BG stated that following on from the previous discussion at this meeting with regards to the Kitchen and Theatre areas, York continues to score Amber for theatre cleanliness. He noted that the standard is set very high and that Amber is an acceptable score marker.

Further floor cleaning equipment has now been purchased with a hope that this will support the issues.

PLACE inspection

This was completed during September and October, it is anticipated that the scores will be published nationally in January 2020.

Sustainable Update

Following the agreement that this report would be quarterly the next report will be January 2020.

Limited Assurance Audit Reports

BG noted that the financial planning and budget audit actions in relation to the YTHFM have largely been dealt with and that there are no further issues to discuss. Noting that these issues are the responsibility of both the Trust and the LLP.

GL stated that the audit report referred to items already being addressed.

LM noted that it is good to hear that we are addressing these items and that the Trust need to be clear what YTHFM are doing.

JA noted the statement that there has been little improvement relating to the organisation's NHS Premises Assurance position at most sites and an issue with transparency of evidence to support compliance. BG stated that this had already been covered in the report and that when YTHFM is live there is an expectation that there will be a significant rise in available data. BG noted that looking forward he can see improvement.

AB noted that the computer management system is key to recovering this data.

A discussion continued with relation to asset tracking of equipment and how this could be done in the future. It was noted that there had historically been a system but that this is no longer in use. BG will look into this further with the medical engineering team.

The Committee felt that there was a theme emerging from these FM issues – namely that the rush to establish the LLP had meant that there was quite a lot of catching up being done to establish management and governance procedures.

Action: BG to report back on asset tracking discussions with medical engineering team.

Space Management

BG referred to p83, section 11 noting that non clinical space is now 23.11%, vacant space 2.80% which is up on 2.5% but that 247 sqm is within acceptable range.

Income Opportunities from LLP

JA enquired if there might be any income opportunities.

BG / JD discussed the 12 opportunities that that have been highlighted and noted that these will be picked up at Exec Board.

JA / BG had a further discussion in relation to the appointment of a new Business Manager.

JA asked BG if there were any other items which needed to be flagged at this time. The Governance will be discussed at Board, also the continued absence of Mike Keaney will be discussed, with the thought that one of the other NED's may be needed to step in for a short time.

With regards to the issue of who would give feedback to the Resources Committee, following a discussion by the group it was agreed that Brian Golding as MD of the LLP would still attend.

It was also agreed that as the Resources Committee will meet monthly from January 2020, but that only two areas will give a full report at each meeting – alternating. In their "off" month the other two areas will provide a very brief exception report.

8. Digital Report

BAF Risk: 5

GP Connection

KB told the committee that work is ongoing with the NHS Digital team and that it is expected that CPD will successfully be connected to the GP system early next year. This will provide the Trust access to GP records.

Endoscopy Requesting

KB noted that a new CPD model is being trailed to allow the triage and requesting of endoscopy. This will improve data quality and support paperless working within the endoscopy service. The hope is that this will enable the endoscopy unit to be fully paperless within the next ¼ calendar year.

Community Mobile Worker Project

KB stated that 28% of the community team have now moved to mobile working, they will also move to a 'care plannng' approach by the end of this week. This will be funded by NHSI. This will be a significant change reporting care rather than activity

AS noted that this project is on target to be completed June / July 2020.

Draft Digital Strategy

LM requested that if in future the team could include a section on AI (artificial intelligence) to their report. She thanked them for their report and noted that it was positive.

LM discussed 5G and future technology which could have an impact on the Trust. A discussion continued with regards as to how this could be linked to the Trust's organisational strategy and how this could be resourced. Who could support them develop a business case.

JD explained that his thought is that they should be looking at what the Trust should look like in 5years time and work backwards in how to deliver this within the transformation programme. This discussion continued referring to how other hospitals are digitally positioned and what we can learn from digital exemplars.

JA enquired if as she understood the intention of the Trust is to keep their CPD programme as the backbone of any future development? She wondered if this would this

restrict the development and add on of other products. Is there a different system which could be considered?

JA asked whether the financial and human resources required to deliver the strategy had been calculated and, if so, how this compared to the resources actually available?

KB explained that if the Trust moved from CPD this would create higher costs and more disruption to the system. He explained that the use of plug-ins to improve the CPD system and confirmed that the system would be continually reviewed.

The committee continued to discuss the development of CPD and other systems that other Trusts use. AB noted that there is not a national system in use.

AB noted that Simon Morritt has requested that AB offer pastoral care to KB and AS until a new Director had been appointed.

He noted that all three of them had met with Simon Morritt and Donald Richardson to discuss creating a digital delivery group with the aim or providing visibility and leadership. The first meeting is being scheduled for January with the full executive team.

AB stated that the reality of changing from CPD would be a massive programme for the Trust and Simon thought there should be an independent review of the system. AB suggested that there is a need to understand the functionality of CPD in relation to fitness for purpose and to avoid confusion with speed of access being a CPD issue. This programme and review will be managed by the new Digital Delivery Group.

A group discussion continued referring to the Humber Coast and Vale's new digital strategy which has been published. A need to ensure the Trust digital strategy ties in well with the national and STP strategy was discussed. The discussion agreed that the Trust should look at what they want to achieve before moving forward.

JA asked if the risks and risk scores on the BAF/CRR correctly reflected the current position. KS and AS felt that they did.
Action: Full digital enabling strategy to come to committee in January KB/AS

9. Finance Report

BAF Risks: 9, 10 and 12

GL reported that the income and expenditure positon for month 7 has not met its pre-PSF control total. The control total was a deficit of £11.8m, the Trust's position being a deficit of £12.3m, resulting in an adverse variance to plan of £0.5m.

It was noted that the most material pressure on the Trust position is associated with additional nursing as a result of the CQC's intervention. Noting that this is £1.0m to date although this is an approved spend it was not in the financial plan and represents an in-year cost pressure.

JA noted her concern over the financial position and asked if there are any other items which should be highlighted.

There were a number of unplanned for cost pressures emerging as the year progresses largely relating to outsourcing of work to address long waiting times.

JA queried the delivery of transformational efficiencies such as theatre efficiency and improvements from GIRFT initiatives. AB shared his disappointment with the committee that GIRFT had not produced a transformational piece of work yet. He felt that the reports often focused on lost income due to coding issues but he confirmed that as the programme matured in some specialties then more transformational efficiency gains were expected.

Action: Further updates on GIRFT to come to the Committee later in the New Year.

10. Efficiency Report

SK delivered an overview noting that in month 7 £11.0m had been delivered against an annual target of £17.1m Risk continued in the Care Groups over the last few months but this is now settling down. Part year delivery is £0.5m ahead of the profiled plan submitted to NHSI.

JA / SK discussed the plans to support the Care Groups over the coming months to review moderate and high risk plans and bridge the planning gap to ensure the Trust is fully planned for 2020/21 prior to the annual plan submission.

LM thanked SK noting that the plans sound very positive. LM suggested that when looking at efficiency we should be looking at schemes that could generate growth income as well

LM suggested that the endoscopy unit could be explored with a possibility of using it as a private patient facility to support income.

11. Overseas Visitors Activity Update

This paper was taken as read by the committee.

12. Tender Opportunities

This paper was taken as read by the committee.

AB gave a very brief overview of the report, highlighting the integrated sexual health service which has a value of £2.7m, but noting the risk of pressure from commissioners on squeezing Trust margins going forward. It was noted that the contract for cervical screening had been lost by the Trust but AB stated that this had been built in to the financial plan as this was a known loss following a national tender exercise.

The Committee expressed some general concern that there were not many significant opportunities in the tender pipeline to boost Trust income.

Finance BAF / CRR Scores

JA asked if the Finance team were content with the risk scores currently showing on the CRR and BAF finance sections – given the deterioration in the financial position.
AB was satisfied that risks were adequately reflected in the current scores.

13. BAF / CRR

JA confirmed with the committee that each executive had had a chance to comment on the risks and risk scores within their areas and agreed they should stay at the level noted.

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

HR: Clever together, Job Planning, Statutory Mandatory training; vacancy improvements East Coast.

Estates: Governance Structure concerns, maintenance.

Digital: draft strategy; independent review; digital delivery group; resources concerns.

Finance – Expenditure pressures, Care group CiP challenges.

JA – BAF & CRR has been covered by the committee

15. Time and date of next meeting

JA – noted that the Resources Committee Meeting moving forward will be monthly, noting that two areas will be delivered to the Committee verbally, with the other two areas delivering papers. This will alternate monthly.

The Committee agreed with this plan.

ACTION LOG

Meeting Date	Action	Owner	Due Date
29.05.19	Highlight new limited assurance audits in their report to the Committee.	Executives	Every month
25.09.19	Add deadlines and responsible owners to the Theatre Cleaning Performance Action Plan	BG	Complete
27.11.19	Clarify catering hygiene results and add action plan and narrative where scores have declined.	BG	Feb 2020
25.09.19	Review the risk scores on the finance part of the BAF & CRR.	AB	Complete
27.11.19	Produce finalised of Digital enabling strategy for next meeting	KB/AS	Jan 2020
25.10.19	Provide update on GIRFT projects to November meeting	AB	Complete
27.11.19	Provide update on HPV equipment business case progress and plan for use	BG/AB	Jan 2020

25.09.19	Provide Committee with assurance on backlog maintenance following October meeting	JA	Complete
25.10.19	Consider appropriate actions following E&D report – BAME bullying issue	PM	Complete
27.11.19	Provide a report on backlog maintenance priorities and costs	BG	Feb 2020
27.11.19	Develop Estates section for integrated Board Report	BG	Feb 2020
27.11.19	Update on asset tracking discussion with medical equipment team	BG	Feb 2020
27.11.19	Include GIRFT updates when appropriate	AB	Mar 2020
27.11.19	Escalate agreed items to Board	JA	Nov 2019
27.11.19	Develop some metrics for SNS section of integrated board report	KB/AS	Mar 2020

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 29 January 2020
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 Services (7DS)

Performance with standard 2; Consultant review within 14 hours declined during October, with further decline in November, with the position being reported as:
Trust 56%
York 57%
Scarborough 54%

On examination of the data, it was apparent that a change to the automated function for recording of post take review occurred in mid-October. As a result, the patient safety team undertook an audit of 50 patient records where, according to CPD, the patient did not have a post take review, or senior review recorded within 14 hours.

Sepsis
The National Contract kept the same parameters as the previous CQUIN and requires Trusts to audit 50 inpatients and 50 Emergency Department patients per quarter. Identification of patients with sepsis is closely linked to the introduction of NEWS2.

ED Audit findings

79 cases were retrospectively audited in order to identify 50 patients eligible for the audit; 29 had a clear other cause for the high NEWS for which they were receiving emergency treatment and therefore were excluded.

	2019/20 Q2 % of patients that met criteria and were screened	**2019/20 Q2 % of patients that were screened, met criteria for treatment and received IV antibiotics within the hour**
TRUST	78%	62%
Scarborough ED	72%	73%
York ED	84%	52%

Inpatient audit findings

226 cases were reviewed, of which 37 met the criteria of a new NEWS of 5 or greater without a clear other cause. Therefore, the audit methodology of 50 patients has not been met.

	2019/20 Q2 % of patients that met criteria and were screened	**2019/20 Q2 % of patients that were screened, met criteria for treatment and received IV antibiotics within the hour**
TRUST (inc. community inpatient units)	62%	43%
Scarborough	44%	33%
York	75%	38%

Recommendation

Board of Directors is asked to note the Medical Directors Report for January 2020.

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

Director sponsor: Mr. James Taylor, Medical Director

Date: January 2020

1. Introduction and Background

The Medical Director's report provides an update against key areas of work identified within the Patient Safety Strategy.

2.2 Areas of Frequent Harm

2.2.1 Sepsis

The National Contract kept the same parameters as the previous CQUIN and requires Trusts to audit 50 inpatients and 50 Emergency Department patients per quarter. Identification of patients with sepsis is closely linked to the introduction of NEWS2.

ED Audit findings

79 cases were retrospectively audited in order to identify 50 patients eligible for the audit; 29 had a clear other cause for the high NEWS for which they were receiving emergency treatment and therefore were excluded.

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TRUST (inc. community inpatient units)	62%	43%
Scarborough	44%	33%
York	75%	38%

Next steps

To monitor the trends and compliance of the adult sepsis screening tool and national contract audit data on an ongoing basis at sepsis steering group level, with escalation to Quality Committee as appropriate.

Future audits to be adapted for improved learning:

Was there a Yorkshire Ambulance Service (YAS) pre-alert?
Was the patient screened within an hour of NEWS 5 or greater?
If an inpatient had a deteriorating NEWS, was any existing antibiotic prescription reviewed?

To support ongoing sepsis projects aimed at increasing early recognition and management within the Trust

The full Q3 report can be found in Appendix A.

2.2.2 ED long waits & 12 hour breaches

A task and finish group has met for the second time and the 12 hour breach report has been reviewed following feedback form the group. Additional parameters have been added, for example, reviewing any hypoglycemic episodes in diabetic patients. Furthermore, in order to provide assurance on the care of patients experiencing long delays in ED, who are not subject to a breach review, an audit is to be undertaken for a sample of patients who have waited longer than 8 hours in ED and who were subsequently admitted. The methodology of this has been agreed with Heads of Nursing and the findings of this will be shared.

2.3 Consistency of Care

2.3.1 Patient Safety Group

The minutes of the Patient Safety Group meeting in November 2019 are available in Appendix B.

2.3.2 Seven Day Services (7DS)

Performance with standard 2; Consultant review within 14 hours declined during October, with further decline in November, with the position being reported as:

Trust 56%
York 57%
Scarborough 54%

On examination of the data, it was apparent that a change to the automated function for recording of post take review occurred in mid-October. As a result, the patient safety team undertook an audit of 50 patient records where, according to CPD, the patient did not have a post take review, or senior review recorded within 14 hours. The results were as follows:

Scarborough (n20)
A Consultant review within 14 hours was recorded for 3 patients.
There were 12 patients that did not receive a Consultant review within 14 hours.

There were 3 patients who did have a Consultant review but outside of the 14 hour target.
There were 2 patients where it was not clear from the notes if a Consultant was present or at what time the review took place.

York (n30)
A Consultant review within 14 hours was recorded for 6 patients.
There were 11 patients that did not receive a Consultant review within 14 hours.
There were 2 patients who did have a Consultant review but outside of the 14 hour target.
There were 11 patients where it was not clear from the notes if a Consultant was present or at what time the review took place.

Care Group Directors are asked to ensure patients receive timely Consultant review.

2.3.5 Cancer Alliance Update

York Teaching Hospitals NHS Foundation Trust had three pathways externally reviewed as part of the Quality Surveillance Programme in October 2019. These pathways were Skin at York, Acute Oncology and Scarborough and Lung at Scarborough. Across the three reviewed 6 serious concerns were raised, three for acute oncology and three for lung. These were:

Lung serious concerns

1. Under resource of CNS time
2. Under resource of medical time – accepting that this was a recruitment based issue
3. The delays to CT guided lung biopsy – accepting that the timeframe given was anecdotal rather than evidence based – evidence to be requested

Acute oncology serious concerns

1. The lack of a 7 day Acute Oncology Service but acknowledging a business case is in progress to address this
2. The lack of dedicated job planned HuTH Consultant time to provide face to face Acute Oncology assessment of inpatients
3. Concerns that the HuTH MSCC pathway is not in keeping with the latest NICE guidance and that the pathway relies solely on the decision/advice of a Neurosurgeon, whereas best practice is for an Oncologist and Neurosurgeon to discuss the patient and give joint advice/make a decision on care

No concerns were highlighted in the Skin review.

The Trust has been asked to develop action plans to address these concerns which were submitted on the 2 December 2019.

The full report is available in Appendix C.

2.4 Learning from Death

2.4.1 Learning from Death Policy

The Learning from Death policy has been reviewed and will be presented for approval at the next Patient Safety Group meeting.

2.4.2 Mortality Outlier Alerts

The Trust has received notification that our responses to information requests relating to mortality outlier status are as follows:

Other Psychoses – The CQC has concluded that we do not need to undertake any further review regarding this alert, and they confirm that the outlier case is now closed.

Septicaemia (except in labour) - This case has now been passed to our local inspection team who will follow up on progress with implementing the action plan. Once the inspection team has confirmed that they are satisfied that sufficient action has been taken to reduce the risks to patients in relation to issues identified by the review of the alert, the outlier case will be closed.

Excision of Colon and / or Rectum – The CQC has considered the mortality data provided by Imperial College alongside other relevant information held internally. Based on these findings, the CQC have requested information from the Trust to enable them to review the matter further. This information is due to the CQC by 4 February 2010.

2.4.2 Organ Donation

2018/19 was another record year for organ donation in the UK with 1600 patients donating organs following their death. In the first six months of 2019/20, 135 people benefited from a solid organ transplant in Yorkshire and Humber. However, 19 people died on the transplant waiting list during this time and 490 people were still waiting as of the 30 September 2019.

The Trust has received confirmation on how we contributed to this performance, as well as highlighting ways to maximise donation opportunities.

From 8 consented donors, York Teaching Hospital NHS Foundation Trust facilitated 4 actual solid organ donors resulting in 8 patients receiving a transplant during the time period. This is in comparison to the first six months of 2018/19 when the Trust facilitated 5 actual solid organ donors from 5 consented donors.

When compared with national data, during the time period the Trust was in line with the national average for the referral of potential organ donors and in line with the national average for Specialist Nurse presence when approaching families to discuss organ donation.

The Trust referred 35 patients to NHSBT's Organ Donation Services Team; 28 met the referral criteria and were included in the UK Potential Donor Audit. There were a further 2 audited patients that were not referred. A Specialist Nurse was present for 12 organ donation discussions with families of eligible donors. There was 1 occasion when a Specialist Nurse was absent for the donation discussion.

There were 3 (7%) missed opportunities to follow best practice out of 43 during the time period, compared with 0 (0%) out of 35 in the first six months of 2018/19. The details of these missed opportunities are as follows:

One patient had been referred to us, but the plan changed for her to be extubated and transferred to the stroke unit; unfortunately the patient deteriorated after extubation and died.
One patient was a late referral; the family had already had the withdrawal conversation and did not want to wait, after consultant approach the family declined transplantation on timing.
One patient was a consultant approach; the patient was screened but no transplantable organs available.

3 Recommendation

Board of Directors is asked to note the Medical Directors Report for January 2020.

Appendix A

York Teaching Hospital NHS Foundation Trust

Sepsis Steering Group – January 2020
Quarter 2 Sepsis Report

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

To provide assurance on the progress of the Sepsis programme within the Trust and an outline of how the audit of compliance with the National Contract will be conducted.

Executive Summary – Key Points

- National Contract Audit commenced in August 2019
- The results of the quarterly audit will be fed back through the Sepsis Steering Group
- The new Adult Sepsis Screening Tool was launched on paper on 7th August 2019 to all acute adult areas

Recommendation

The Sepsis Steering group are asked to note performance in the screening and treatment of Sepsis.

Author: Clare O'Brien, Lead Nurse for Patient Safety; Helen Noble, Head of Patient Safety

Director Sponsor: Mr. James Taylor, Medical Director

Date: January 2020

1. Introduction and Background

Sepsis National Contract

The National Contract kept the same parameters as the previous CQUIN and requires Trusts to audit 50 inpatients and 50 Emergency Department patients per quarter. Identification of patients with sepsis is closely linked to the introduction of NEWS2.

The national contract requires that 90% (based on a sample size of 50)

- Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis
- Service Users who are inpatients with a deterioration in NEWS who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis

It was agreed that in the patients best interests the Trust would use "time zero" as being the time of the first NEWS of 5 or above.

2. Audit

The new Sepsis screening tool was introduced across the Trust on 7 August 2019 using the internationally agreed definitions for sepsis and red flags. Consequently the audit data for Q2 only covers August and September 2019.

This data is not comparable to previous audits due to the change in process, introduction of NEWS2 and the introduction of the new sepsis pathway.

Both audits were carried out by clinical staff, able to exclude patients who had clear causes for the high NEWS other than sepsis.

Due to data problems it was difficult to identify patients whose NEWS score had deteriorated following admission. This required review of a large volume of inpatient records with a small number of patients being identified that met the criteria.

2.1 Emergency Department audit

79 cases were retrospectively audited in order to identify 50 patients eligible for the audit; 29 had a clear other cause for the high NEWS for which they were receiving emergency treatment and therefore were excluded.

	2019/20 Q2 % of patients that met criteria and were screened	2019/20 Q2 % of patients that were screened, met criteria for treatment and received IV antibiotics within the hour
TRUST	78%	62%
Scarborough ED	72%	73%
York ED	84%	52%

In York ED there were an additional 2 patients that had evidence of infection but were not screened for sepsis however did receive appropriate treatment i.e. oxygen, IV fluids and IV antibiotics within the hour.

2.2 Inpatient audit:

226 cases were reviewed, of which 37 met the criteria of a new NEWS of 5 or greater without a clear other cause. Therefore, the audit methodology of 50 patient has not been met.

	2019/20 Q2 % of patients that met criteria and were screened	2019/20 Q2 % of patients that were screened, met criteria for treatment and received IV antibiotics within the hour
TRUST (inc. community inpatient units)	62%	43%
Scarborough	44%	33%
York	75%	38%

3. Quality Improvement

3.1 Adult Sepsis Screening Tool

The updated Trust adult sepsis screening tool was launched on paper on 7 August 2019 (Appendix 1). This is in line with the 2016 International Definitions and the Sepsis Six treatment pathway recommended by the UK Sepsis Trust. ELearning packages have been developed for both the community sepsis screening tool and the acute adult sepsis screening tool. Ward-to-ward teaching has been provided to spread awareness that the Trust have changed to the new screening tool. The Trust sepsis policy has been updated to reflect these changes.
Outcome, process and balancing measures have been agreed and will be reported through the Sepsis Steering Group.

3.2 Other Screening Tools

A maternity screening tool is under-development. Further information is awaited from the department and Royal College of Obstetricians and Gynaecologists, prior to a testing phase.

The Trust has received permission to adapt the Leeds NHS Teaching Hospitals Trust Paediatric sepsis screening tool to make it applicable the Trusts' needs. Following testing the plan is for this to be used in both ED's and the paediatric wards.

The Easingwold renal dialysis unit has adapted the adult sepsis screening tool to make it fit their escalation process. This is pending approval at the Renal development group meeting.

3.3 Patient Information Leaflets

Since the last report, patient information leaflets are available for staff to order on: Discharge advice for patients with an infection – symptoms of sepsis; and Post-sepsis syndrome.

3.4 Sepsis Emergency Department Operational Groups

The Scarborough ED operational group continues to have excellent attendance and be proactive.
The York ED operational group has had fewer attendees and recent meetings have been cancelled. A new group has been formed and future meetings are planned.

3.5 Sepsis Collaboration

The sepsis collaboration has been ongoing between CCG/YAS/primary care/out-of-hours care around how to improve early recognition of sepsis within the local health economy however there is poor attendance from primary care colleagues. The terms of reference for the meeting will be reviewed and new membership sought.

4. Next Steps

4.1 To monitor the trends and compliance of the adult sepsis screening tool and national contract audit data on an ongoing basis at sepsis steering group level. This will be escalated to the board where necessary.

4.2 Future audits to be adapted for improved learning:

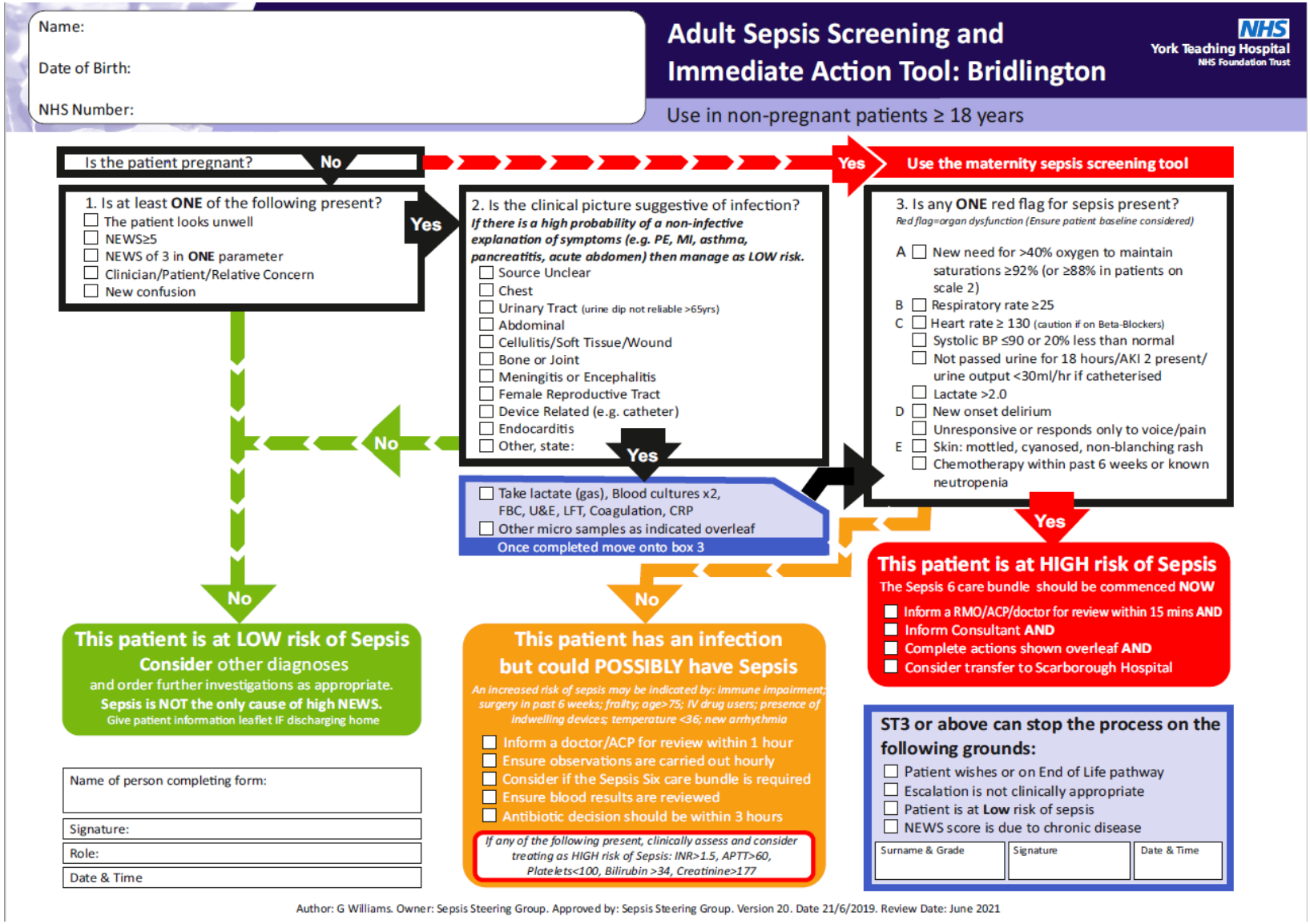
Was there a Yorkshire Ambulance Service (YAS) pre-alert?
Was the patient screened within an hour of NEWS 5 or greater?
If an inpatient had a deteriorating NEWS, was any existing antibiotic prescription reviewed?

4.3 To support ongoing sepsis projects aimed at increasing early recognition and management within the Trust.

5. Recommendation

The Sepsis Steering group is asked to note performance in the screening and treatment of Sepsis.

Appendix 1


Name:
Date of Birth:
NHS Number:
Adult Sepsis Screening and Immediate Action Tool: Bridlington
NHS York Teaching Hospital NHS Foundation Trust
Use in non-pregnant patients ≥ 18 years
Is the patient pregnant?
No
Yes
Use the maternity sepsis screening tool
1. Is at least ONE of the following present?
The patient looks unwell
NEWS≥5
NEWS of 3 in ONE parameter
Clinician/Patient/Relative Concern
New confusion
Yes
2. Is the clinical picture suggestive of infection?
If there is a high probability of a non-infective explanation of symptoms (e.g. PE, MI, asthma, pancreatitis, acute abdomen) then manage as LOW risk.
Source Unclear
Chest
Urinary Tract (urine dip not reliable >65yrs)
Abdominal
Cellulitis/Soft Tissue/Wound
Bone or Joint
Meningitis or Encephalitis
Female Reproductive Tract
Device Related (e.g. catheter)
Endocarditis
Other, state:
No
Yes
3. Is any ONE red flag for sepsis present?
Red flag=organ dysfunction (Ensure patient baseline considered)
A New need for >40% oxygen to maintain saturations ≥92% (or ≥88% in patients on scale 2)
B Respiratory rate ≥25
C Heart rate ≥ 130 (caution if on Beta-Blockers)
Systolic BP ≤90 or 20% less than normal
Not passed urine for 18 hours/AKI 2 present/ urine output <30ml/hr if catheterised
Lactate >2.0
D New onset delirium
Unresponsive or responds only to voice/pain
E Skin: mottled, cyanosed, non-blanching rash
Chemotherapy within past 6 weeks or known neutropenia
Take lactate (gas), Blood cultures x2, FBC, U&E, LFT, Coagulation, CRP
Other micro samples as indicated overleaf
Once completed move onto box 3
Yes
No
No
This patient is at HIGH risk of Sepsis
The Sepsis 6 care bundle should be commenced NOW
Inform a RMO/ACP/doctor for review within 15 mins AND
Inform Consultant AND
Complete actions shown overleaf AND
Consider transfer to Scarborough Hospital
This patient is at LOW risk of Sepsis
Consider other diagnoses
and order further investigations as appropriate.
Sepsis is NOT the only cause of high NEWS.
Give patient information leaflet IF discharging home
This patient has an infection but could POSSIBLY have Sepsis
An increased risk of sepsis may be indicated by: immune impairment; surgery in past 6 weeks; frailty; age>75; IV drug users; presence of indwelling devices; temperature <36; new arrhythmia
Inform a doctor/ACP for review within 1 hour
Ensure observations are carried out hourly
Consider if the Sepsis Six care bundle is required
Ensure blood results are reviewed
Antibiotic decision should be within 3 hours
If any of the following present, clinically assess and consider treating as HIGH risk of Sepsis: INR>1.5, APTT>60, Platelets<100, Bilirubin >34, Creatinine>177
ST3 or above can stop the process on the following grounds:
Patient wishes or on End of Life pathway
Escalation is not clinically appropriate
Patient is at Low risk of sepsis
NEWS score is due to chronic disease
Surname & Grade
Signature
Date & Time
Name of person completing form:
Signature:
Role:
Date & Time
Author: G Williams. Owner: Sepsis Steering Group. Approved by: Sepsis Steering Group. Version 20. Date 21/6/2019. Review Date: June 2021

Name:

Date of Birth:

NHS Number:

Sepsis Six Care Bundle

For use if patient has sepsis or septic shock

NHS York Teaching Hospital NHS Foundation Trust

DATE:

TIME ZERO:

TIME CONSULTANT INFORMED

The following actions should all be completed within one hour.
The consultant should be informed of any patient at high risk for sepsis.

		Time	Name	Reasons not administered
1	**Administer supplementary oxygen if required** Target oxygen saturations to 94-98% if on scale 1 Target oxygen saturations to 88-92% if on scale 2	Time	Name	Reasons not administered
2	**Take blood cultures & appropriate microbiological samples** Ideally TWO sets of blood cultures are taken before antibiotics Consider SOURCE of infection (see table below) - do surgeons or radiologists need to be involved for source control?	Time	Name	Reasons not administered
3	**Give IV antibiotics** For sepsis this should be TWO antibiotics (please see antibiotic formulary posters for further information)	Time	Name	Reasons not administered
4	**Give a fluid challenge** If systolic blood pressure <90 **OR** lactate >2 - Give 500ml of 0.9% Saline or Hartmanns over 15 minutes (250ml if in cardiac failure) - Repeat if necessary to total of **30ml/kg** (2-2.5litres) If systolic blood pressure >90 **AND** lactate <2 *consider* a fluid bolus	Time	Name	Reasons not administered
5	**Check serial lactates** (arterial or venous) Recheck lactate after an hour to ensure it is falling until it is <2	Time	Name	Reasons not administered
6	**Measure urine output and complete frequent observations as per policy** Commence hourly fluid balance chart & consider catheter Monitor observations every 15-30 minutes until NEWS≤3	Time	Name	Reasons not administered

If your patient is not responding to sepsis management or meets one of these criteria your patient MUST be transferred to an acute hospital.

- ☐ Lactate not improving or blood pressure remaining low (systolic blood pressure <90) after fluid resuscitation
- ☐ Significantly abnormal blood gas (lactate >4, BE>-10, Bicarbonate <15 or pH<7.2) at any point
- ☐ Requiring ≥60% oxygen
- ☐ Significant organ dysfunction

Probable Source	Recommended Microbiology Samples
Source Unclear	Urine Culture (Red top Boric acid bottle)
Chest	Sputum, viral throat swab (winter), urine (legionella antigen – white top bottle)
Urinary Tract	Urine Culture (Red top Boric acid bottle)
Abdominal/Biliary	Urine Culture, in-dwelling drain fluid, Stool culture/C Diff if indicated
Soft Tissue	Abscess aspirate or pus in bottle, lesion swab (nil else available)

Probable Source	Recommended Microbiology Samples
Bone or Joint	Joint aspirate, bone biopsy
CNS	CSF for MCS/viral PCR; Pneumo/meningo PCR (EDTA blood)
Reproductive	High vaginal, endocervical and rectal swabs
Device Related	Paired Blood Cultures, line tip MCS (+/- device removal)
Endocarditis	Contact microbiology

Appendix B

York Teaching Hospital NHS Foundation Trust

MINUTES

Title:	**Patient Safety Group**
Date:	Tuesday 19th November 2019
Time:	08:00 – 09:30
Location:	Ophthalmology Seminar Room, York Hospital with VC to Cedar Room, Scarborough Hospital
Chairing:	Donald Richardson (DR)
Attendees:	Clare O'Brien (COB), Helen Holdsworth (HH), Jan Godwin (JG), Helen Noble (HN), Fiona Jamieson (FJ), Chris Foster (CF), Neil Todd (NT)
Apologies:	Becky Hoskins (BH), Jim Taylor (JT), Sandra Tucker-Quinn (STQ), Ed Smith (ES), Vicky Mulvana-Tuohy (VMT), Jonathan Thow (JTh)

No	Item/Discussion	Lead for actions
1.	**Apologies**	
	DR welcomed everyone to the meeting and gave apologies as above.	
2.	**Notes from the meeting held on 17th September 2019 and Matters Arising**	
	The minutes from the 17th September 2019 meeting were agreed as an accurate record. **Interviews re: escalation with Judith Dyson** – DR chased Judith Dyson for feedback from the interviews which took place earlier this year but has not yet received a reply. **Clinical Guidelines** – BH and CF met to discuss the gaps in the clinical guidelines. CF has sent an email to the Care Group Directors highlighting there out of date documents and asked if there was any documents they need (gaps), no responses have been received. DR agreed to raise this at Executive Board and suggested CF send the email onto Heads of Nursing, Matrons, Sisters and Junior Doctors to identify if they are aware of any gaps.	**CF to email HON, Matrons, Sisters, Junior doctors re: gaps.**
3.	**SI Trends and Learning (Standing Item)**	
	During the past 12 months there have been 163 SI's declared. The 163 SI's were for the following categories: • 65 x Clinical • 53 x 12 hour breach • 19 x Falls • 26 x Pressure Ulcers FJ informed the group a never event was declared on Monday 18th November for wrong site surgery. The key themes over the past 12 months are: • Failure to escalate the deteriorating patient and not pursuing the	

	escalation if no response received • Delayed diagnosis – radiology reporting times and misreporting • Delayed treatment – Outpatients, Ophthalmology, Glucoma pathway – there is a RAG system in place to try and address the issues. • Lack of waiting list validation – this has been picked up by the CQC • Suboptimal care DR informed the group CARS is in test mode at the moment and will be switched on in December.	
4.	**Clinical Guidelines (Standing Item)**	
	There are 1304 clinical guidelines of which 78 are out of date. There are 288 corporate guidelines of which 77 are out of date. 6 of these are for Human Resources, it was suggested they extended the review date however this was declined. CF is sending a monthly email to the Care Group Managers regarding their outstanding guidelines.	
5.	**NEWS2**	
	When NEWS2 was switched onto live there were a large number of areas not stating their patients were confused. There have been amendments made to the system for staff to be able to say if the patient has new confusion or not, since this went live there has been a 5% increase in patients marked as confused. There was a discussion that education and engagement is required to ensure all staff understand the term of confusion. DR informed the group a member of the SNS team is creating a dashboard for NEWS2 which will show how each ward is doing. There have been 130 less patients escalated per week since put confused on the system.	
6.	**Sepsis update**	
	The Q2 National Sepsis Report has not been completed due to problems with the audit data. Previously we have achieved 63% compliance to receiving antibiotics within one hour but this quarter it has dropped to 13%. The Patient Safety Team have been in contact with SNS who are pulling another report with refined criteria to identify if there was an issue with the previous data. BH has contacted the CCG to advise them that we will not be submitting a report for Q2. On the 10th February 2019 there will be a sepsis event held at York Sports Club, it has been suggested this could also include sessions on deteriorating patient, DNACPR, NEWS, etc.	
7.	**7 days service update**	
	The 7 day service audit took place during the 21st October to 28th October 2019. For this all patients were reviewed who were admitted during the week.	

	The target for 14 hour senior review is 90% for weekdays and the weekend, we achieved overall 69.5% (74.2% week day and 61% weekend). Data was sent to each Care Group to check. There are 4 standards to the 7 day audit all are ok apart from achieving the 14 hour senior review. A report has been written which will be taken to the Quality Committee on the 27th November and then submitted to NHSI. HN received feedback from one Care Group that the reviews had dropped due to it been half term. DR highlighted the alert for post take was turned off in the middle of October and colleagues now need to enter this manually.	
8.	**Frailty**	
	Sonia Archer and Jena Raby are the frailty team and they held a session with the Patient Safety Team, Clinical Colleagues, Outreach, Nursing to inform them that it will be mandatory to carry out the Rockwood frailty assessment on all patients over 65 which raised concerns. The plan is the ED staff will do a 90 second frailty assessment and enter the result onto the system. The concerns raised were: • If it is expected the nurses in ED will assess the patients frailty this is an added job when patients are sick. Is this the correct time and place? • What is the score used for? • When the frailty score is entered onto CPD will Clinicians use the score to aid ceiling of care decision / DNACPR • No plans to reassess the frailty score when move to an inpatient ward • GPs use a different frailty scoring system BH suggested at the frailty session a group should be formed with the correct colleagues to discuss the frailty scoring and safety. DP informed the group Dr Sally Irwin and Dr Rachel Davidson are the medical leads for frailty. DR asked COB to contact Mike Harkness, Ed Smith to nominate a medical lead to be part of the group. DR to inform Danny Holdsworth not to put the system live until further discussions have taken place.	**COB to contact MH & ES for medical leads to attend the meeting.** **DR to inform DH not to put the system live.**
9.	**Items to escalate to the Board of Directors (standing item)**	
	The Patient Safety Group acknowledge the 7 day audit report is going to the Board of Directors and it highlights deteriorating patient and projects in place.	
10.	**Sub Group Action Logs** **Papers circulated with the agenda** • **Alcohol Steering Group**	

	• **Blood Transfusion Group** • **Clinical Ethics Committee** • **Deteriorating Patient Group** • **Falls Steering Group** • **Medicines Management Group** • **Mortality Steering Group** • **Obstetrics and Gynaecology Clinical Governance Scarborough** • **Safeguarding Adults Governance Group**	
	<u>Medicines Management Group</u> **Prescribing of patients medications** – there have been a number of datix reports submitted because patients have not had their medication prescribed because the clerking doctor did not have access to the summary care records (SCR). In ED ward clerks upload SCR to CPD on admission however this does not always happen out of hours or when a patient is admitted direct to the ward for example surgery. DR said if he had a patient on ward 33 and they did not have the SCR on CPD he would ring down to ED and the ward clerk will upload this, all wards should follow this process. **Discharge medicines issues** – A discharge group was put together which was led by COB to look at the discharge checklist. COB informed the group Helen Hey is now the lead for this group and no further meetings have taken place. DR asked for Helen Hey to be invited to the Patient Safety Group to provide an update of what is happening with the discharge group. COB informed the group she also attended the Care Home Meetings which have also been handed over to Nursing.	**DP to invite Helen Hey to the next meeting to provide an update on the discharge group.**
11.	**Any Other Business**	
	There were no items to discuss under any other business.	

Next Meeting	
Date & Time:	Tuesday 21st January 2020, 08:00 – 09:30
Location:	VC – Ophthalmology Seminar Room (York) & Cedar Room (Scarborough)

York Teaching Hospital
NHS Foundation Trust

Cancer Alliance System Board 13 January 2020 External Quality Surveillance Programme Review York Teaching Hospitals NHS Foundation Trust 2019/20

Recommendation

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

Purpose of the Report

To brief the Cancer Alliance System Board on the outcome of the recent external Quality Surveillance Programme reviews undertaken at York Teaching Hospitals NHS Foundation Trust of the York Skin service and the Scarborough Lung and Acute Oncology Services.

Executive Summary – Key Points

York Teaching Hospitals NHS Foundation Trust had three pathways externally reviewed as part of the Quality Surveillance Programme in October 2019. These pathways were Skin at York, Acute Oncology and Scarborough and Lung at Scarborough. Across the three reviewed 6 serious concerns were raised, three for acute oncology and three for lung. These were:

Lung serious concerns

1. Under resource of CNS time
2. Under resource of medical time – accepting that this was a recruitment based issue
3. The delays to CT guided lung biopsy – accepting that the timeframe given was anecdotal rather than evidence based – evidence to be requested

Acute oncology serious concerns

1. The lack of a 7 day Acute Oncology Service but acknowledging a business case is in progress to address this
2. The lack of dedicated job planned HuTH Consultant time to provide face to face Acute Oncology assessment of inpatients
3. Concerns that the HuTH MSCC pathway is not in keeping with the latest NICE guidance and that the pathway relies solely on the decision/advice of a Neurosurgeon, whereas best practice is for an Oncologist and Neurosurgeon to discuss the patient and give joint advice/make a decision on care

No concerns were highlighted in the Skin review.

The Trust has been asked to develop action plans to address these concerns which were submitted on the 2 December 2019.

Recommendation

The Cancer Alliance System Board is asked to note this report.

Author: Laura Millburn, Head of Cancer and Deputy Care Group Manager, YTHNHSFT

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: 16 December 2019

1. Introduction

York Teaching Hospitals NHS Foundation Trust had three pathways externally reviewed as part of the Quality Surveillance Programme in October 2019. These pathways were Skin at York, Acute Oncology and Scarborough and Lung at Scarborough.

2. Pathway Reviews

2.1 York Skin Service

The service had no immediate risks or serious concerns raised. The external review team praised the Skin service for their openness and honesty and the high quality evidence they supplied to the reviewing team. They were identified as a well-functioning team with clear close working relationships with CCG partners. The team demonstrated that they were patient driven and focused and they had evidently improved based on patient feedback and that the team were prepared to identify the gaps in service provision and patient experience.

The review team was impressed with the triage process that has been implemented and the process for sub-specialty referral, which evidences the streamlining of the pathway and the reduction of pathway delays.

The review team commented that they had found it very difficult to find areas to improve. The areas raised were:

- Formal job planning of telederm triaging
- Update teleconference equipment
- Accreditation of GPwSI via audit
- Updating of Operational policy, work programme, annual report due to change in MDT leadership
- Evidence process of feedback from Spec MDT to demonstrate the improved communication of patient plans

2.2 Scarborough Lung Service

The external team fed back that the Lung service clearly had a very committed team who have adopted and developed areas of good practice such as virtual working, planning between MDTs and reducing delays to patient pathways, compliance with the national optimal lung cancer pathway and completing regular audits to inform service improvement.

They acknowledged that the team had achieved all that despite the obvious constraints on the service.

There were 3 serious concerns raised by the external team:

4. Under resource of CNS time
5. Under resource of medical time – accepting that this was a recruitment based issue
6. The delays to CT guided lung biopsy – accepting that the timeframe given was anecdotal rather than evidence based – evidence to be requested

The team summarised that with those concerns in mind, they still felt we are providing a good and safe service and that we are clearly constrained by capacity presently.

2.3 Scarborough Acute Oncology Service

The external review team fed back that they acknowledged the huge amount of work that has been undertaken within the service to bring it back from crisis point. They were impressed with the optimistic and fully established service it is presently. They could see that the service now has a strong team in place and that team demonstrated good working relationships with their palliative care team partners who provide a 7 day service at Scarborough for patients.

The external review team were pleased that the team is led by an Advanced Clinical Practitioner (ACP) and that the ACP was chemo unit based, offering outpatient services to acute oncology patients. This was noted as very forward thinking and patient experience driven. They acknowledged that by having this in place the service was demonstrating they were reducing unnecessary admissions, an area of good practice. The external review team made note to the informal support in place with HuTH clinicians to review inpatients and that they were particularly impressed with the respite care in Whitby and Filey which is available to our patients and provided in conjunction with York Against Cancer.

However the team found three areas of serious concern:

4. The lack of a 7 day Acute Oncology Service- acknowledging a business case is in progress to address this
5. The lack of dedicated job planned HuTH Consultant time to provide face to face Acute Oncology assessment of inpatients
6. Concerns that the HuTH MSCC pathway is not in keeping with the latest NICE guidance and that the pathway relies solely on the decision/advice of a Neurosurgeon, whereas best practice is for an Oncologist and Neurosurgeon to discuss the patient and give joint advice/make a decision on care. The team appreciated that the service were constrained by the existing HuTH's pathway and confirmed that they would write to Hull to inform them of the need to update their pathway

3. Agreed Actions

The Trust was asked to submit action plan to address the serious concerns raised by the 2 December 2019. This has been completed and the action plans attached:


SCB Lung action plan following external rev


Copy of AOT Action plan following extern

Author: Laura Milburn, Head of Cancer and Deputy Care Group Manager

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: 06 December 2019

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 29 January 2020
Q3 Performance and Operational Update

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

This report provides an update on performance recovery of national operational standards. These are: Emergency Care Standard (ECS) including Same Day Emergency Care (SDEC), Cancer Wait Times, RTT, Follow Up Partial Booking waits and 6 Weeks Diagnostics. The report highlights key risks to delivery of these standards along with recovery actions that have and are being implemented.

Executive Summary – Key Points

The Board of Directors is asked to:

- Discuss and note the content of this report;
- Discuss, debate and confirm the key actions that support performance recovery and note outstanding risks to delivery.

Author(s):

Andrew Hurren, Deputy Head of Operational Planning and Performance
Nicky Slater, Head of Information
Gary Hardcastle, Deputy Head of Information
Lucy Turner, Deputy Chief Operating Officer
Melanie Liley, Deputy Chief Operating Officer

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: January 2020

1. National Standards

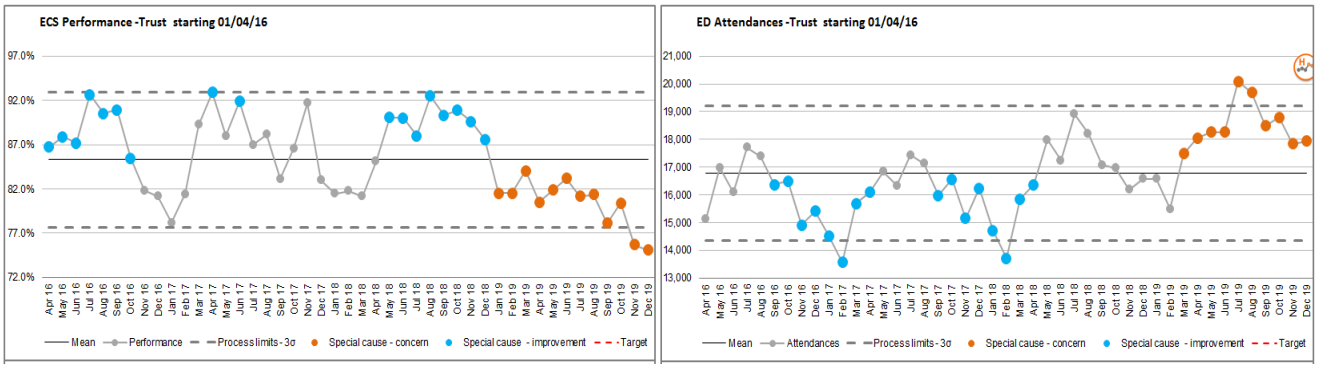
The report outlines performance against national standards at the end of Quarter 3 2019-20 (November for the Cancer 62 day standard as reported one month behind), together with providing analysis on contributory factors within the wider system which are impacting on Trust performance and the mitigations that are in and being put in place.

1.1 Emergency Care Standard (ECS)

For December 2019, the Trust achieved 75.1% which was below the national position of 79.8% (the lowest national performance since the standard was implemented in 2004). The Trust ranked 70th nationally out of 137 providers.

Key points:

- Pressures on beds, particularly at Scarborough, partly due to Flu and Norovirus negatively impacted on ECS performance during December 2019.
- Forty 12 hour breaches, all at Scarborough, have occurred in Q3 on days when non-elective demand and workforce deficits have been high and when wards / beds have been closed with the higher than expected presentation of patients with flu, respiratory viruses and D&V.
- The ECS performance upper control level is below the national target of 95%, this signifies that the target is unlikely to be achieved unless Trust and wider system transformation is implemented.
- The SPC shows 'special cause concern' since January 2019 as performance has continually been below the mean.
- ECS performance fell below the lower control limit in November and December 2019
- ED attendances increased above the mean in March 2019 and moved outside the upper control limit in July and August 2019.
- ED attendances have seen a statistically significant increase with 10 points above the mean since March 2019 signifying a 'special cause concern'.



The year to date position to the end of December 2019 has seen attendances increased by 11,894 (8%) compared to 2018/19. The main Emergency Departments (Type 1) have seen an additional 6,877 patients, a rise of 8%. York ED Type 1 has seen a 6% rise with Scarborough ED Type 1 up 10% compared to 2018/19.

Of note, the Type 1 increase is above the national growth of 4.7% seen in Type 1 ED attendances in the 3 months to December 2019 (source: NHS England December 2019 A&E Statistical Commentary).

Delivery is therefore not in line with the trajectory agreed with NHSI as part of the Trust's operational plan.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Improvement Trajectory	85.0%	86.0%	87.0%	88.0%	89.0%	90.0%	90.0%	90.0%	90.0%
ECS Performance 2019/20	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%
ECS Performance 2018/19	85.1%	90.1%	90.0%	88.0%	92.5%	90.3%	90.9%	89.6%	87.6%

Recovery Actions

The Trust and wider York and Scarborough system has been identified as needing support in order to address the performance challenges. In order to address these challenges the Trust is working in partnership with the Emergency Care Intensive Support Team (ECIST). ECIST is working alongside care group teams to observe, advise and facilitate change.

In addition, the national Same Day Emergency Care (SDEC) Team, 7 Day Working Team, Long Length of Stay Team and more latterly the National Elective Intensive Support Team (NEIST) have all been mobilised by NHSI/E to support the Trust. This is being co-ordinated via the ECIST lead, Marie Herring.

Specific mitigating actions to reduce the number of 12 hour breaches, which are a priority area, include the relaunch of SAFER, the focus on SDEC (including the opening of surgical SDEC and frailty SDEC as well as the refresh of medical SDEC and extension of opening for paediatric SDEC) and a revision of the testing procedures and isolation plans for flu/respiratory presentations to support and improve patient flow.

The 12 hour breaches have occurred when hospitals have triggered OPEL 4. OPEL 4 Hot Debrief sessions have been introduced to review reasons why OPEL 4 was triggered, what went well and what could have been done differently, as well as main lessons learned in order to prevent future occurrences. The Hot Debriefs are scheduled for 24 hours after the site has de-escalated from OPEL 4 and includes the key Operational Managers, Matrons, Silver and Gold command. Key messages and learning points are recorded on the on call portal on the Trust intranet to ensure that learning can be shared and accessed by other staff.

A task and finish group has been established to review the current 12 hour breach report to ensure it supports learning from each occurrence. The group has agreed some additional parameters that need to be included in the reviews, for example, diabetic patients experiencing hypoglycemic episodes whilst delayed in ED. Care Group Heads of Nursing will assume responsibility for reviewing all 12 hour breach reports.

In addition to those patients experiencing a 12 hour breach, it is recognised that other patients experience long delays in ED but do not breach 12 hours. In order to provide assurance on the care of these patients, an audit is to be undertaken on a sample of patients who have waited longer than 8 hours in ED and who were subsequently admitted to understand if patients delayed in ED are coming to harm. The methodology of this is has been agreed with Heads of Nursing and a dashboard of all patients with a stay in ED of 8 hours or more, subsequently admitted, is being developed to support future reviews/audit.

Trust Acute Board, chaired by the Trust CEO meets monthly and 'holds the ring' on this programme of work. Site specific working groups have been established; these are Care Group led.

Key messages from ECIST include:

- The Trust appears to be focused on specialty work and this can be at the expense of 'acute work' which appears to be secondary to this. This is further exacerbated by the 'carve out' of specialty beds – general medical patients aren't always 'owned', can be stranded on the assessment floor and have longer lengths of stay as a result.
- The Trust is focusing on two key areas of work which will help to 'unlock' the acute pathway, reduce overcrowding in ED and promote better flow through the hospitals – SDEC and SAFER.
- SDEC has been strengthened in York, seeing a significant increase in the number of patients streamed from ED directly to the Medical SDEC area; in Scarborough a new Acute Frailty Unit (the Home First Unit) has been opened.
- SAFER relaunched and reframed as a safety tool, sponsored by the Medical Director and Chief Nurse.
- A review of the integrated discharge approach on the York acute floor is underway to bring together DLT, Social Workers, CRT, RATS and the therapists to better support the acute teams with discharges.
- Weekly Long Length of Stay Reviews at both sites embedding with reduction in number of patients in hospital 21+ days (target of a 40% by March 2020 – current achievement of 12%).
- Continuing to develop the review process on the York acute assessment floor for patients 'stranded' > 72 hours - the value of having an ED consultant as part of the team is recognised as providing the opportunity to challenge decisions made (from an ED perspective) about admitting specific cohorts of patients.
- A significant number of patients appear to be admitted with low level mental health needs. ECIST has supported a mental health mini-MADE event and the outcomes of this will be shared with partners at a workshop in Q4 to generate discussion about next steps.
- The Trust Outpatient Anti-Microbial Therapy (OPAT) service – A review of coordination, processes, choice of lines, microbiology involvement to consider sensitivity testing for community management as well as 'acute management' is being undertaken. Three key pathways are being addressed; post-operative wound infections, myelitis and endocarditis.
- The Winter Plan 19/20 for YFT & system partners mobilised and 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 following the ECS Risk Summit. These are captured in a single system workplan held by the A&E Delivery Board & System Resilience Group. For YTHFT these include: communication plans and learning from stakeholder engagement; increased 'virtual bed' capacity; increased decision making capacity; and temporary changes to the function of some wards.

1.1.1 Same Day Emergency Care (SDEC)

The Trust has seen above anticipated increases in non-elective admissions compared to 2018/19. Year to date the national growth in emergency admissions is estimated by NHSE&I to be 2.4%, York is above this at 3.3% and Scarborough has seen a 9% rise, these rises are partially attributable to a change in practice relating to SDEC.

The Trust has therefore committed to providing a service where all patients are considered for same day emergency care. SDEC is for patients who are deemed on arrival at ED to have an 80% chance of being able to go home the same day. If a patient attending ED meets defined criteria they will be streamed from ED to the appropriate SDEC area. The majority of patients streamed to SDEC areas will be assessed, undergo diagnostic tests, have treatment and go home the same day. Some

patients streamed to SDEC areas may, after assessment and diagnosis, need to be admitted to an inpatient ward for treatment. Patients who require hospital care and do not meet the criteria for assessment in SDEC areas will be assessed and treated in ED and if required may still be admitted to an inpatient ward. This approach seeks to ensure that the maximum number of patients benefit from rapid access to the right treatment in the right place and aims to reduce the number of patients admitted to an inpatient ward overnight because they are awaiting assessment, diagnostic test, or treatment. All SDEC patients are counted as Non-Elective admissions.

To support the process changes needed to increase numbers of patients streamed to SDEC areas, and maximise the impact of SDEC for patients and the organisation, the Trust has worked in partnership with the ECIST team, which has experience of supporting SDEC implementation nationally.

York SDEC: In November ECIST supported York to test additional SDEC pathways and this has led to:

- An increase in the number of ED attenders being streamed to acute medical and surgical SDEC units for their care, from 32% to 43%, partially mitigating the impact of overcrowding in ED due to the significant increase in ED attenders and supports ECS performance.
- Medical, ACP and nursing staffing for the York Medical SDEC being increased, to care safely for the rise in patient numbers seen in the unit.
- Paediatrics SDEC service extended to 24/4 in York for the winter period, to address sustained increased demand from late evening and throughout the night.
- The creation of a SDEC dashboard, providing clinical and management leaders with daily updates about SDEC patient numbers and performance in their areas and the Trust as a whole.
- The causes of variability in the number of patients streamed from ED to SDEC areas each day being explored and addressed by ED and SDEC teams, for example by setting up Nurse streaming training delivered by the ECIST team on 9th January 2020.
- Funding being secured to open the Acute Frailty Unit (Rapid Access Frailty Assessment service) at weekends over winter.
- Processes for requesting ultrasound and x-ray scans for ED attenders and patients seen in SDEC being reviewed to reduce waits; continuous learning, via cross-departmental case review of streamed patients and proactive process improvement, to strengthen confidence in using the new pathways amongst ED and SDEC area staff.
- Embedding local resilience frameworks in SDEC areas, to ensure surges in patient numbers can be better managed by reassigning staff flexibly.

Scarborough SDEC: In November ECIST supported Scarborough to test new pathways to SDEC areas which have resulted in:

- Establishment of a new surgical SDEC area (SAU on Maple Ward).
- Review of estate to create space for the launch of an Acute Frailty Unit (the Home First Unit) whilst this is not ideal as space is limited, it has enabled the team to go live as planned.
- The Home First Unit opened on 6th January 2020.
- A workforce review is underway to extend the Home First Unit service to 7 days.
- A workshop is planned with North Yorkshire County Council to agree processes and ways of working for social care assessment in the Home First Unit to expedite discharges.
- Review and refresh of ways of working of Rapid Assessment and Treatment Services (RATS) Therapists to strengthen support to frail patients.

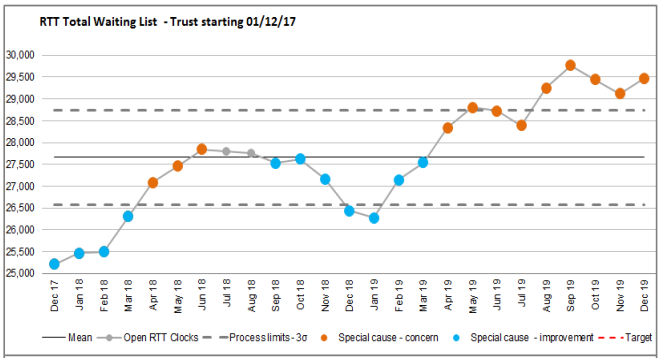
Winter operational pressures mean that, along with other Trusts, we have experienced both sites at full capacity and had to on occasion convert SDEC areas to accommodate patients requiring inpatient beds. We are working to minimise the impact of this upon the functioning of our SDEC services while winter pressures continue. ECIST are continuing to support us to embed SDEC and improve urgent and emergency care services, and in York, will be undertaking focused work in ED throughout January and February to build upon improvements made to date.

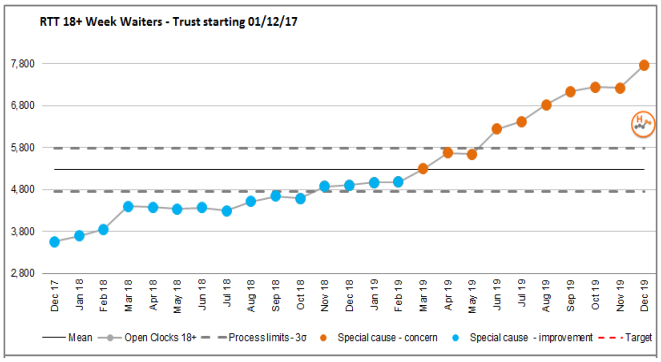
1.2 Referral to Treatment Incomplete Standard (RTT)

The 2019/20 recovery trajectory submitted to NHSEI forecasted returning to the March 2018 position of the TWL size (26,303) by March 2020, with no patients waiting over 52 weeks.

The total incomplete RTT waiting list (TWL) provisionally stood at 29,477 at the end of December, an increase of 354 clocks on the end of November position. This is ahead of the trajectory of 30,202 submitted to NHS England and NHS Improvement but above the March 2018 target to have below 26,303 open clocks by the end of March 2020. The Trust's performance against standard for December was 74.0%, which is below the trajectory of 80.0%.

The Trust has seen 7% more Fast Track referrals April-November, compared to the same period last year. This increase in demand impacts on capacity available for routine outpatient appointments and diagnostics, negatively impacting on the RTT Incomplete performance.



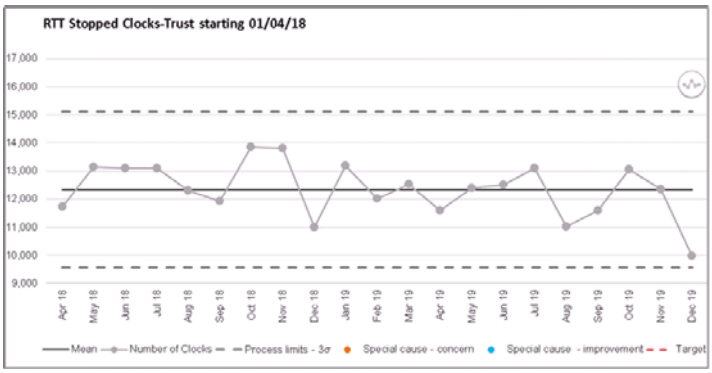


Key points:

- The total waiting list (TWL) data has shown special cause since April 2019.
- The TWL position moved outside the upper control in August 2019.
- Special cause concern is seen in RTT breaches (18+ waiters) since March 2019 due to the continual increase.
- RTT breaches have been above upper control limit since June 2019.

1.2.1 Activity V's Plan

At the end of December the Trust was 8% behind planned activity levels for elective inpatients, 3% behind plan on day cases and has not delivered the planned level of outpatient appointments; down 6% for First and 8% for Follow Up attendances. In comparison to the end of December position for 2018/19 the Trust is 3% down on elective inpatients, 1% up on Day Cases and overall 1% down on Outpatients.



- The impact of being behind plan and 2018/19 outturn has resulted in a fall c 6% in the number of RTT Clock Stops year to date compared to 2018/19.
- Performance against the Elective inpatient plan is not expected to recover due to winter bed pressures.

Efficiency panels have been held with all Care Groups, chaired by the Chief Executive, to further understand the reasons that the Trust is behind planned elective activity levels and ensure that opportunities to ensure productivity and use of capacity are maximised.

The increase in non-elective admissions has adversely impacted the ability to admit elective patients contributing to the Trust being behind plan.

The cessation of outsourcing elective work to the private sector in Orthopaedics and Ophthalmology in July 2019 (a decision taken to support system financial recovery) has had a substantial impact on the RTT TWL. It has been assessed that this has resulted in 500 less clock stops in Q3 and Q4 than was anticipated in the original elective planning for 2019/20. In addition, the significant delay in the opening of the Community Stadium has adversely affected the planned outpatient activity in specialties such as Ophthalmology, Sleep Studies and Rheumatology. This additional space was integral to the delivery of additional clinics.

The delay in the opening the new Endoscopy Unit has negatively impacted day case activity and has contributed to the Trust being 3% behind plan. Space has been a key contributing factor to the ability to undertake the required amount of endoscopy activity.

The Trust at the end of November 2019 had a medical and dental vacancy rate of 8% (9% at Scarborough, York 8%), again contributing to the reduction in planned elective activity. Unanticipated workforce gaps have contributed to under delivery of plans in certain specialties for example General Surgery and Urology in Scarborough, Ophthalmology in York and General Medicine specialties across the Trust.

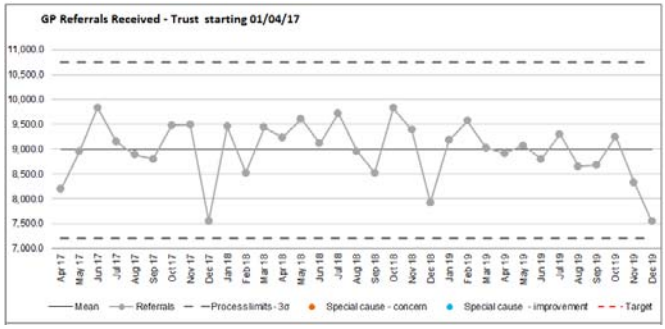
Further CEO led efficiency panels are due to be held in January and February 2020.

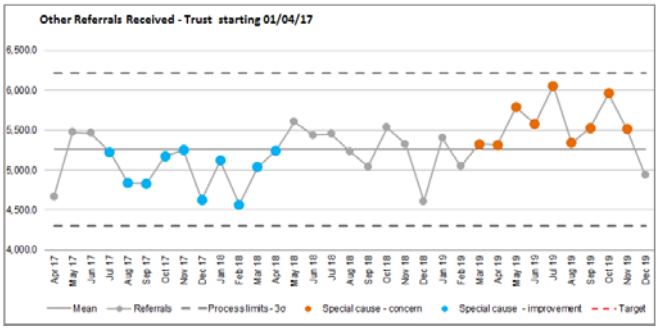
Activity planning for 2020/21 has been completed in line with NHSE/I requirements. The guiding principles being, maintaining the RTT total waiting list at March 2018 levels and reducing any follow up backlogs. Overall the Trust is planning to stop more clocks than 2019/20. Given concerns that activity planning for 2019/20 was perhaps overly ambitious, the Trust has for the first time approached planning in two ways; firstly a plan using a top-down corporate calculation was completed. Validation of the plan was gained by a bottom up approach conducted by our Care Groups with the Deputy Head of Operational Planning and Performance working through any discrepancies with the Care Group Business and Finance Managers. There are two outstanding areas; Gastroenterology on the East Coast and Ophthalmology Follow Ups (Trust wide) where capacity will not be sufficient to meet demand.

1.2.2 Outpatient Referrals

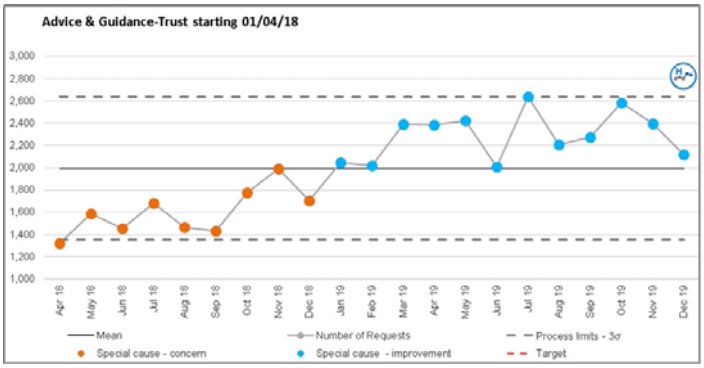
Key points:

- Year to date there has been a 4% decrease in GP referrals compared to the same period in 2019/20.
- GP referral reductions offset by a 6% rise in 'Other' referrals. Examples of 'Other' referrals are where the source of referral is other healthcare professionals including dentists, optometrists and AHPs. One notable increase over the past 2 years has been from Yorkshire Doctors (coded under the General Medicine Practitioners Specialty) which has seen an increase of 26% since April to December 2017. This is also prevalent within Trauma & Orthopaedics with a 19% increase from the same referral source.
- Overall referrals are down 0.1% (-132) compared to 2018/19.
- Overall year to date clock starts are down 5% compared to 2018/19.
- Reduction in clock stops linked to increase in cancer referrals and focus on other tasks such as Advice and Guidance requests.
- Special cause concern is seen in 'Other' referrals from March 2019 onwards.





1.2.3 Advice and Guidance requests (A&G)



The number of A&G requests received by the Trust has increased by 46% year to date compared to 2018/19, an additional 6,627 requests.

In terms of impact on clinician time, if we assume each request takes 10 minutes to action, this has resulted in over 1,100 additional hours on top of planned capacity.

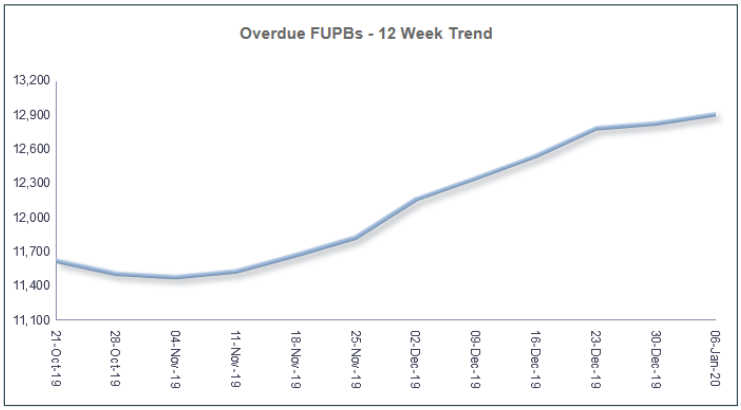
In addition the proportion that has converted to an outpatient appointment within 6 months has increased from 38% to 42% (+1,800 appointments) putting further pressure on routine outpatient capacity. In light of the increase, and fact that in 42% of cases it has only delayed an outpatient appointment, the use of A&G will be reviewed with CCGs over the next few months.

Recovery 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 programs covering theatre productivity, outpatient 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. Ongoing work with commissioners to reduce referral demand.
- Targeted Consultant validation of all patients waiting 15+ weeks without any future booked activity commenced on the 25th November.
- Robust winter planning to limit loss of routine elective surgical activity where possible
- £110k additional RTT monies secured from NHSE&I for Orthopaedics (11 cases), General Surgery (30), Ophthalmology (23) and Urology (5) to target long waiters.
- The Trust is not expected to meet the RTT TWL of 26,303 open clocks by the end of March 2020.

1.3 Follow Up Partial Booked (FUPB) Patients



The latest position shows 12,916 patients whose FU appointment is overdue. This is an increase of 12%, an additional 1,431 overdue patients compared to the beginning of November.

The Trust currently (for some specialties) manages patients who require a future booked outpatient appointment on a 'follow up partial booking' (FUPB) pathway; others have their appointment booked directly. Patients on a FUPB pathway are recorded with a date range of when their next appointment is due, for example in 9 months. The total number of patients on an FUPB pathway by due date is available to Care Groups via Signal reports, and is included in the weekly performance meetings.

Recovery Actions

- The Medical Director has tasked Care Groups with outlining their current processes for clinical risk assessment and mitigation of backlogs and waiting lists.

1.4 Cancer Wait Times

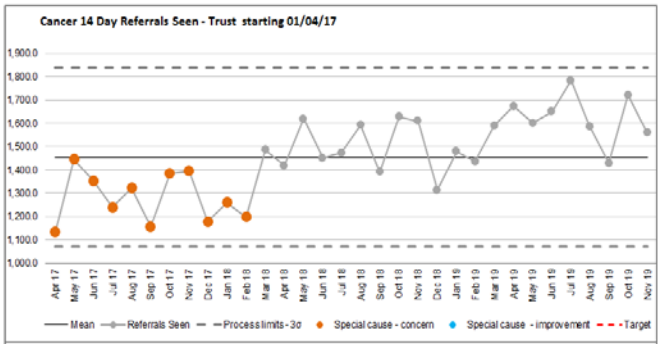
Cancer performance is reported 6 weeks behind other standards, therefore the declared December position is not yet available.

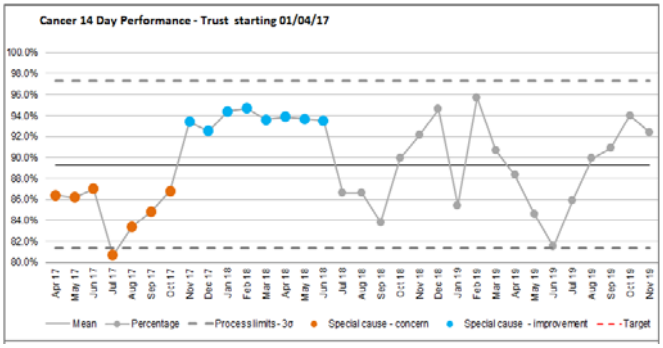
			Quarter 2 2019-20				Quarter 3 2019-20	
	Indicator	**Target**	Jul-19	Aug-19	Sep-19	**Q2**	Oct-19	Nov-19
1.1	14 day Fast Track	**93%**	85.9%	89.9%	90.9%	**88.7%**	94.0%	92.4%
1.2	14 day Symptomatic Breast	**93%**	95.2%	97.1%	98.1%	**96.8%**	98.0%	97.6%
2.1	31 day 1st treatment	**96%**	99.1%	99.5%	97.5%	**98.7%**	98.8%	96.4%
2.8	31 day subsequent - surgery	**94%**	93.8%	84.4%	100.0%	**92.6%**	97.2%	97.8%
2.8	31 day subsequent - drug	**98%**	100.0%	100.0%	100.0%	**100.0%**	98.8%	98.8%
3.1	62 day 1st treatment	**85%**	79.8%	81.2%	80.2%	**80.3%**	78.9%	75.9%
4.1	62 day screening	**90%**	100.0%	90.6%	100.0%	**96.2%**	98.0%	91.4%
	Shadow reporting, new target from April 2020:							
17.1	**28 day Faster Diagnosis Standard**	**TBC**	**63.1%**	**60.2%**	**59.6%**	**61.0%**	**64.9%**	**68.9%**

1.4.1 14 day Fast Tracks

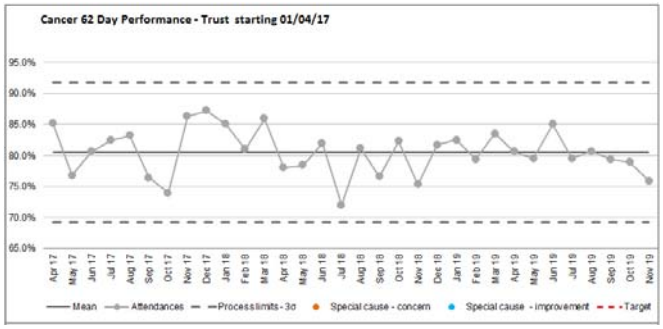
Key points:

- Number of patients seen has been above the mean for 8 of the last 9 months.
- Improvement has been seen over the last year, with achievement of the 93% standard on four occasions.
- The Trust has seen 7% more Fast Track referrals April-November, compared to the same period last year. This increase in demand impacts on capacity available for routine outpatient appointments and diagnostics, negatively impacting on the RTT Incomplete performance.





1.4.2 62 Day Treatments



Performance against the 62 day target from referral to treatment was 75.9% in November. National performance for November was 77.4% and this was the first time in the last 12 months that the Trust hasn't outperformed the national position.

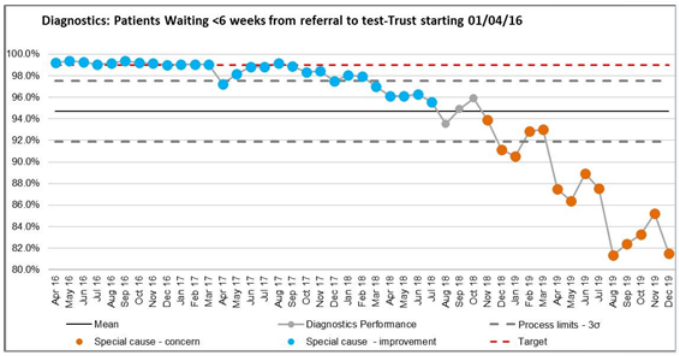
Achievement of the 62 day standard remains difficult, primarily due to challenges within diagnostics.

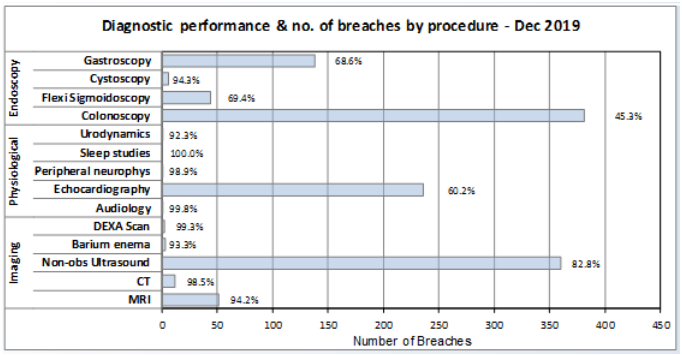
In November 62 day performance was below 50% for Colorectal; 11.5 accountable breaches, including 4 patients requiring a Clinical Harm Review (CHR) and Head & Neck (4 accountable breaches). Seven Urological patients required CHRs; there are delays in booking in theatre procedures for those having surgery at the Trust. Haematological achieved 100% for the second month running.

Cancer Recovery 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.
- A Weekly 'Cancer Wall' meeting has been 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 supported by the Cancer Alliance.
- We are developing a Rapid Diagnostic Centre (RDC) for patients with vague symptoms and Upper GI referrals utilising Cancer Alliance funding, first patient in January 2020.
- NHSI Elect are facilitating a rapid improvement project to reduce delays in Head and Neck pathway.
- A focused project on 28 day referral to diagnosis, overseen by Cancer Delivery Group which is a subset of Cancer Board is underway.

1.5 Diagnostics





The diagnostic target of 99% has not been achieved since September 2017. Radiology, endoscopy and echocardiogram have all been under significant pressure due to staffing and capacity constraints.

Radiology has seen significant improvement against trajectory, reducing breach numbers in all but non-obstetric ultrasound due to unexpected staff shortages.

There have been recognised capacity issues in endoscopy to manage diagnostic and surveillance demand, and an unmet need to support the bowel cancer screening programme. As a result there was approval and completion of a new build to support the long term increase in demand for Endoscopy which opened on the 17th October 2019.

There was significant deterioration in the 6 week diagnostic performance in August 2019 and a paper was submitted to Executive Board outlining the increasing demand and capacity constraints. The lack of capacity due to the delay in the new Endoscopy Centre opening coupled with the growth in cancer referrals has resulted in little improvement to the diagnostic position and a worsening surveillance backlog since August 2019.

1.5.1 Endoscopy Surveillance

The surveillance backlog has been reviewed and colour coded as Red (surveillance date has passed), Amber (patient is within three months of the surveillance date), Green (longer than 3 month until their surveillance date is due). The current total position is:

Red – 1,209 patients
Amber – 528 patients
Green – 4,233 patients

Recovery Actions:

- Review of patient pathways involving Radiology. MSK Radiologist started at the Trust in January 2020 to provide capacity lost from the MSK Consultant who left the Trust in September 2019.
- The Elective Improvement Support Team (IST) was asked by the NHSE&I North Region to review the Trust's diagnostic processes, reports and systems. The Trust completed the IST Diagnostic Sustainability Assessment Tool (SAT) and an onsite review structured around the tool was undertaken by the IST on 19th November 2019.

    - The IST Team will be providing support in the following areas:
        a) Undertake demand and capacity analysis in endoscopy, radiology and echo cardiology services.
        b) Use the IST Pathway Analyser Tool to prospectively populate data against key admin pathway milestones in radiology from request to reporting.
        c) Revise the Trust access policy to ensure it is consistent with national rules regarding management of overdue planned patients.
        d) Develop a standard operating procedure for endoscopy scheduling meetings.
        e) Develop a KPI dashboard in radiology to support performance improvement against key access standards.

- Endoscopy; a number of recovery actions have been identified:
    - **Clinical Validation**; Royal College Best Practice Guidance changed in October 2019 and as a result of the change in guidance fewer patients will require follow up surveillance endoscopy. Initial validation has resulted in a discharge rate of 60%.
    - **Opening Room 5**; equipment has already been procured, recruitment completed in December 2019 and Room 5 will be operational from the 3rd of February.
    - **Opening Room 6;** Finance Director confirming business case requirement for equipment to support room 6 opening and Endoscopy management commence the recruitment of staff to support opening room 6.
    - **Seven day working Nurse Endoscopists**; a consultation process to be undertaken with the Nurse Endoscopists in early 2020 to move towards seven day working in 2020 so that Saturday lists can be provided consistently.
- £209,700 additional monies secured from NHSE&I for Endoscopy and MRI. Will be used to tackle the endoscopy backlog and to maintain the low numbers of MRI waiters.

2 Year End Performance Forecast

Whilst every effort is being made to bring performance back on line by March 2020, there remains risk to recovery due to the issues raised above. It should be noted that the Targets discussed are inter-dependent. For example:

- The increase in non-elective admissions adversely impacts the ability to admit elective patients and increases the potential of RTT 52 week waiters.
- The increase in cancer fast track referrals reduces routine outpatient and diagnostic capacity increasing follow up appointment wait times.
- SDEC pathways to avoid downstream non-elective admissions potentially increases the number of 'Other' outpatient referrals.

The latest year-end performance projections are shown in the table below:

Target	Trajectory	Forecast/Risk
ECS	90%	80%
RTT TWL	26,303	c.29,800
RTT 52 Week Waits	0	Risk to delivery due to winter pressures, financial constraints and current waiting times
Cancer 62 Day	85%	80%
6 Week Diagnostic	99%	85%

The challenges associated with the Financial Recovery Plan must be considered alongside performance recovery.

Performance and Activity Report

December 2019 performance

Produced January 2020

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

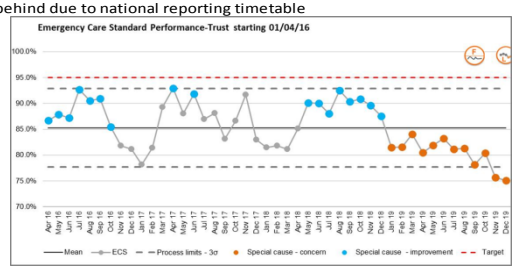
To support an engaged, healthy and resilient workforce

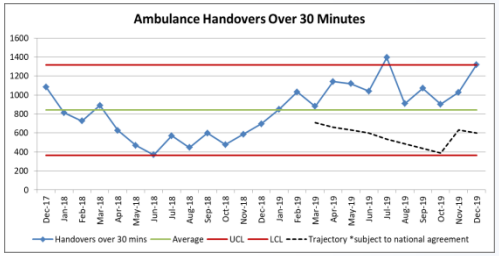
To ensure financial stability

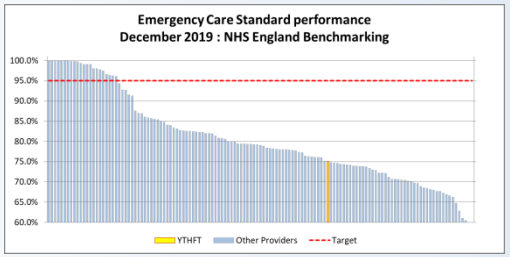
Assurance Framework Responsive — Key Performance Indicators – Trust level

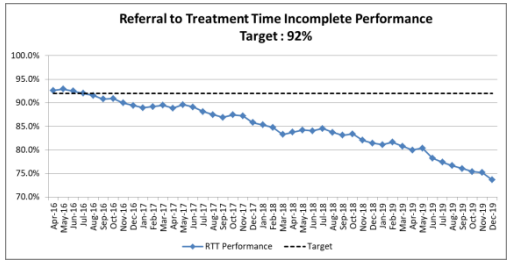
Operational Performance: Key Targets	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Emergency Care Standard Performance	95%	87.6%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%
Ambulance handovers waiting 15-29 minutes	0	1083	935	892	915	956	1072	978	988	983	969	1112	994	1068
Ambulance handovers waiting 30-59 minutes	0	463	470	556	484	593	671	587	723	547	605	571	552	652
Ambulance handovers waiting >60 minutes	0	233	380	477	397	548	449	453	673	362	466	332	476	668
Stranded Patients at End of Month - York, Scarborough and Bridlington		368	439	386	442	422	406	397	394	409	397	363	363	377
Super Stranded Patients at End of Month - York, Scarborough and Bridlington		116	153	130	153	138	143	135	140	148	136	125	105	139
Diagnostics: Patients waiting <6 weeks from referral to test	99%	91.1%	90.6%	92.9%	93.0%	87.5%	86.4%	88.9%	87.5%	81.7%	82.4%	83.3%	85.0%	81.5%
RTT Incomplete Pathways	92%	81.5%	81.1%	81.7%	80.8%	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%	75.2%	73.6%
RTT Total Waiting List (RTT TWL)	26,303	26,433	26,278	27,144	27,536	28,344	28,809	28,724	28,394	29,252	29,771	29,442	28,775	29,477
RTT 52+ Week Waiters	0	0	0	0	3	0	0	3	0	1	1	0	0	0
Cancer 2 week (all cancers)	93%	94.6%	85.4%	95.7%	90.7%	88.3%	84.6%	81.5%	85.9%	89.9%	90.9%	94.0%	92.4%	-
Cancer 2 week (breast symptoms)	93%	92.8%	93.4%	93.2%	90.7%	79.6%	91.4%	93.8%	95.2%	97.1%	98.1%	98.0%	97.6%	-
Cancer 31 day wait from diagnosis to first treatment	96%	96.8%	96.4%	98.7%	96.9%	96.7%	98.3%	98.8%	99.1%	99.5%	97.5%	98.8%	96.4%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	95.0%	90.5%	92.3%	97.4%	94.3%	95.1%	96.9%	93.8%	84.4%	100.0%	97.2%	97.8%	-
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%	98.8%	98.8%	-
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	81.7%	82.5%	79.4%	83.5%	80.6%	79.5%	85.0%	79.8%	81.2%	80.2%	78.9%	75.9%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	88.6%	90.6%	89.1%	92.7%	100.0%	92.1%	100.0%	100.0%	90.6%	100.0%	98.0%	91.4%	-
Cancer 28 Day Wait - Faster Diagnosis Standard	TBC	66.7%	63.3%	69.6%	67.5%	67.4%	62.1%	66.8%	63.1%	60.2%	59.6%	64.9%	68.9%	-

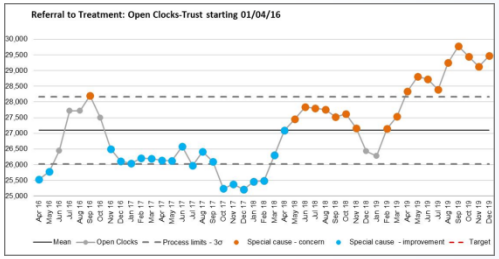
note: cancer one month behind due to national reporting timetable

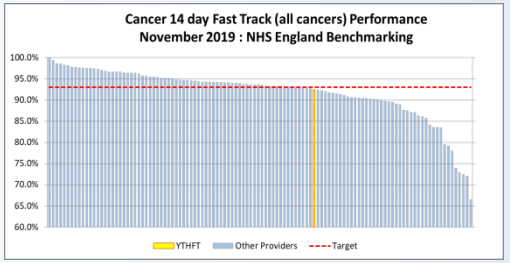


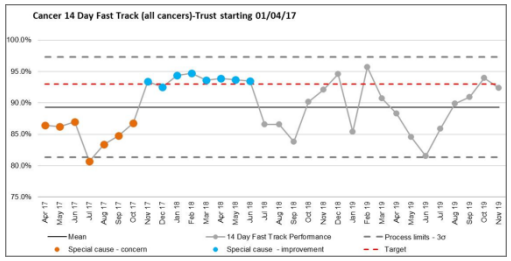


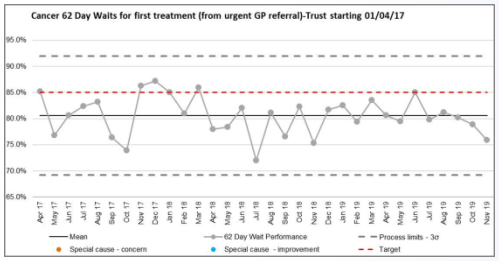


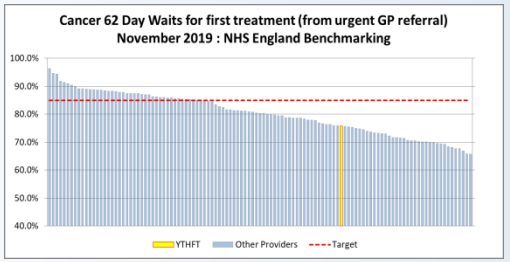












Assurance Framework Responsive

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

Operational Performance: Unplanned Care	Target	Sparkline / Previous Month	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Emergency Care Attendances		▲	16571	16575	15500	17489	18055	18270	18256	20101	19683	18486	18800	17848	17926
Emergency Care Breaches		▲	2059	3069	2863	2791	3525	3310	3067	3785	3671	4043	3689	4337	4471
Emergency Care Standard Performance	95%	▼	87.6%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%
ED Conversion Rate: Proportion of ED attendances subsequently admitted		◀▶	41%	38%	38%	36%	36%	37%	38%	38%	38%	37%	30%	42%	42%
ED Total number of patients waiting over 8 hours in the departments		▲	324	904	802	687	1,007	972	799	1,029	912	1,275	817	1,200	1,499
ED 12 hour trolley waits	0	▲	0	16	8	28	24	26	2	1	7	32	16	9	15
ED: % of attendees assessed within 15 minutes of arrival		▲	63%	62%	59%	63%	58%	59%	59%	53%	55%	54%	54%	51%	54%
ED: % of attendees seen by doctor within 60 minutes of arrival		▲	50%	43%	40%	38%	37%	37%	36%	34%	33%	32%	32%	31%	32%
ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▲	2.9%	3.0%	3.1%	3.2%	3.7%	4.0%	4.4%	4.8%	4.4%	4.6%	4.1%	3.0%	3.1%
ED - Median time between arrival and treatment (minutes)			181	191	192	190	205	197	196	201	206	219	202	223	226
Ambulance handovers waiting 15-29 minutes		▲	1083	935	892	915	956	1072	978	988	983	969	1112	994	1068
Ambulance handovers waiting 15-29 minutes - improvement trajectory			-	-	-	846	829	812	795	778	761	744	727	710	694
Ambulance handovers waiting 30-59 minutes		▲	463	470	556	484	593	671	587	723	547	605	571	552	652
Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	380	365	350	335	319	304	289	274	361	342
Ambulance handovers waiting >60 minutes		▲	233	380	477	397	548	449	453	673	362	466	332	476	668
Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	330	297	281	264	215	182	149	116	271	257
Non Elective Admissions (excl Paediatrics & Maternity)		▲	4713	4524	4029	4580	4521	4733	4761	5070	4871	4553	5142	5048	5089
Non Elective Admissions - Paediatrics		▼	942	921	865	891	745	729	711	808	658	790	944	1045	1011
Delayed Transfers of Care - Acute Hospitals		▲	1212	1093	1067	1178	1456	1529	1486	1346	1325	1355	1215	1054	1183
Delayed Transfers of Care - Community Hospitals		▲	337	385	295	377	277	303	352	235	333	335	342	182	230
Patients with LOS 0 Days (Elective & Non-Elective)		▼	1375	1421	1278	1362	1241	1386	1550	1609	1472	1364	1663	1782	1692
Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▲	1085	1151	991	1097	1102	1157	1076	1241	1115	1139	1116	1112	1197
Ward Transfers - Non clinical transfers after 10pm	100	▲	85	100	71	94	87	87	76	87	72	89	104	99	123
Emergency readmissions within 30 days		▲	875	852	741	876	925	912	941	1044	936	876	991	946	-
Stranded Patients at End of Month - York, Scarborough and Bridlington		▲	368	439	386	442	422	406	397	394	409	397	363	363	377
Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▲	376	431	433	409	405	399	373	390	384	380	361	362	376
Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▲	116	153	130	153	138	143	135	140	148	136	125	105	139
Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▲	129	151	166	143	147	134	141	138	134	138	129	109	118

Operational Performance: Planned Care	Target	Sparkline / Previous Month	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Outpatients: All Referral Types		▼	16888	19856	19315	18908	18613	19475	18939	20251	18266	18722	20052	18415	16917
Outpatients: GP Referrals		▼	8624	10038	10416	9801	9515	9760	9497	10044	9361	9463	10049	9110	8359
Outpatients: Consultant to Consultant Referrals		▼	1961	2537	2221	2251	2181	2380	2233	2306	2075	2222	2364	2244	1998
Outpatients: Other Referrals		▼	6303	7281	6678	6856	6917	7335	7209	7901	6830	7037	7639	7061	6560
Outpatients: 1st Attendances		▼	8059	9868	9005	9312	8605	9210	9208	9875	8307	8731	9878	9196	7958
Outpatients: Follow Up Attendances		▼	14446	18028	15417	16441	15046	16386	15098	16844	14095	14869	16990	16491	13141
Outpatients: 1st to FU Ratio		▼	1.79	1.83	1.71	1.77	1.75	1.78	1.64	1.71	1.70	1.70	1.72	1.79	1.65
Outpatients: DNA rates		▼	6.4%	6.1%	5.7%	5.5%	5.9%	6.1%	5.9%	6.3%	6.0%	6.0%	5.9%	6.0%	5.8%
Outpatients: Cancelled Clinics with less than 14 days notice	180	▼	162	206	193	209	180	179	198	243	240	232	270	213	164
Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	620	837	803	979	993	945	883	987	1214	1316	1474	1076	1303
Diagnostics: Patients waiting <6 weeks from referral to test	99%	▼	91.1%	90.6%	92.9%	93.0%	87.5%	86.4%	88.9%	81.7%	81.7%	82.4%	83.3%	85.2%	81.5%
Elective Admissions		▼	602	614	554	687	649	682	724	692	579	685	762	753	520
Day Case Admissions		▼	5344	6621	5868	6082	5843	6061	5879	6232	5901	6135	6684	6411	5640
Cancelled Operations within 48 hours - Bed shortages		▲	33	22	10	17	32	66	59	32	13	60	26	41	48
Cancelled Operations within 48 hours - Non clinical reasons		▼	91	114	90	141	130	147	194	229	85	173	148	173	152
Theatres: Utilisation of planned sessions		▼	88%	86%	87%	90%	92%	86%	89%	89%	91%	91%	95%	94	88%
Theatres: number of sessions held		▼	523	586	506	576	576	602	609	712	501	588	640	561	498
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		▲	66	53	89	108	99	43	83	104	92	48	66	52	70

Assurance Framework Responsive

Performance Summary by Month – Trust level continued

18 Weeks Referral To Treatment	Target	Sparkline / Previous Month	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Incomplete Pathways	92%	▼	81.5%	81.1%	81.7%	80.8%	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%	75.2%	73.6%
Waits over 52 weeks for incomplete pathways	0	◆▶	0	0	0	3	0	0	3	0	1	1	0	0	0
Waits over 26 weeks for incomplete pathways	0	▲	1943	2192	2066	2220	2468	2657	2558	2735	3239	3595	3508	3526	3957
Waits over 36 weeks for incomplete pathways	0	▲	431	497	530	606	669	632	660	632	868	887	1076	1168	1302
RTT Total Waiting List (RTT TWL)	26,303	▲	26433	26278	27144	27536	28344	28809	28724	28394	29252	29771	29442	29123	29477
Number of patients on Admitted Backlog (18+ weeks)		▲	2352	2463	2470	2738	2850	2877	2847	3338	3543	3639	3686	3711	3919
Number of patients on Non Admitted Backlog (18+ weeks)		▲	2550	2500	2505	2556	2825	2769	3391	3079	3283	3445	3554	3512	3850
Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)	8.5	▲	-	-	-	-	-	-	-	-	-	-	11.6	12.0	12.4

Cancer (one month behind due to national reporting timetable)	Target	Sparkline / Previous Month	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Cancer 2 week (all cancers)	93%	▼	94.6%	85.4%	95.7%	90.7%	88.3%	84.6%	81.3%	85.9%	89.9%	90.9%	94.0%	92.4%	-
Cancer 2 week (breast symptoms)	93%	▼	92.8%	93.4%	93.2%	90.7%	79.6%	91.4%	93.8%	95.2%	97.1%	98.1%	98.0%	97.6%	-
Cancer 31 day wait from diagnosis to first treatment	96%	▼	96.8%	96.4%	98.7%	96.9%	96.7%	98.3%	98.8%	99.1%	99.5%	97.5%	98.8%	96.4%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	▲	95.0%	90.5%	92.3%	97.4%	94.3%	95.1%	96.9%	93.8%	84.4%	100.0%	97.2%	97.8%	-
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%	98.8%	98.8%	-
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▼	81.7%	82.5%	79.4%	83.5%	80.6%	79.5%	85.0%	79.8%	81.2%	80.2%	78.9%	75.9%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	▼	88.6%	90.6%	89.1%	92.7%	100.0%	92.1%	100.0%	100.0%	90.6%	100.0%	98.0%	91.4%	-
Cancer 28 Day Wait - Faster Diagnosis Standard	TBC	▲	66.7%	63.3%	69.6%	67.5%	67.4%	62.1%	66.8%	63.1%	60.2%	59.6%	64.9%	68.9%	-

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 achieved ECS performance of 75.1% in December. The last twelve months have been below the rolling four-year average of 85.5%. The Trust performed below the national position for December (79.8%) (nationally this is the worst performance since the standard was introduced in 2004) ranking 70th nationally out of 137 providers.

Unplanned care demand continues to be challenging, with type 1, 2 and 3 attendances up 8% for the year to date on the same period in 2018/19. In total an extra 11,882 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 6,876 patients; a rise of 8%.

Fifteen twelve-hour trolley breaches were reported in December 2019 at Scarborough Hospital. The breaches were reported to NHS England and NHS Improvement as required, the breaches were due to capacity constraints in ED and a lack of capacity within the inpatient bed base. In total there were forty twelve hour trolley breaches declared in Q3, all at Scarborough.

High levels of Ambulance arrivals continue to impact the two main EDs, with the last three months above the two-year average, the 4,596 ambulance arrivals in December was the highest ever received at the Trust. Overall Ambulance arrivals are up 3% on 2018/19 a rise of 1,254. The continued demand during December contributed to 1,320 ambulances being delayed by over 30 minutes, above the revised improvement trajectory* of 599 submitted to NHS England and NHS Improvement. The increase in ambulance arrivals has seen twelve consecutive months where the number of ambulances being delayed by over 30 mins has been above the two-year average.

The Trust continues to experience bed pressures, with Scarborough Hospital experiencing bed occupancy of above 90% at midnight on 26 days during the month. York Hospital had above 90% bed occupancy for 23 days. The acute Delayed Transfers of Care (DToC) position in December was the second lowest this financial year but remained above target (December data is not available at the time of this report), this is a continuation of a fluctuating and unpredictable position over the last fourteen 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.

*Trajectory subject to national agreement.

The Trust's Winter Plan was mobilised on the 1st of December.

Targeted actions

- York SDEC: The causes of variability in the number of patients streamed from ED to SDEC areas each day being explored and addressed by ED and SDEC teams, for example by setting up streaming training delivered by the ECIST team on 9th January 2020, Paediatrics SDEC service extended to 24/4 in York for the winter period, to address sustained increased demand from late evening through the night and ACP and nursing staffing for the York Medical SDEC is being increased, to care safely for the rise in patient numbers seen in the unit.
- York ED – Streaming training day supported by ECIST on 9th January.
- Scarborough SDEC: The Home First Unit opened on 6th January 2020, workshop is planned with North Yorkshire County Council to agree processes and ways of working for social care assessment in the Home First Unit and workforce review is underway to extend the Home First Unit service to 7 days
- Development of SDEC 'real time' dashboards to monitor against national standards and indicators, together with additional metrics including areas such as 'lost opportunity' where 0 LoS patients are being admitted to non SDEC areas.
- SAFER relaunched and reframed as a safety tool, sponsored by the Medical Director and Chief Nurse.
- A review of the integrated discharge approach on the York acute floor is underway to bring together DLT, Social Workers, CRT, RATS and the therapists to better support the acute teams with discharges.
- Weekly Long Length of Stay Reviews at both sites embedding with reduction in number of patients in hospital 21+ days (target of a 40% by March 2020 – current achievement of 34% - on target, so locally supporting teams to achieve 50% reduction by March 2020)
- The Winter Plan 19/20 for YFT & system partners mobilised and 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 following the ECS Risk Summit. These are captured in a single system workplan held by the A&E Delivery Board & System Resilience Group. For YTHFT these include: communication plans and learning from stakeholder engagement; increased 'virtual 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 December 2019 was 90%.

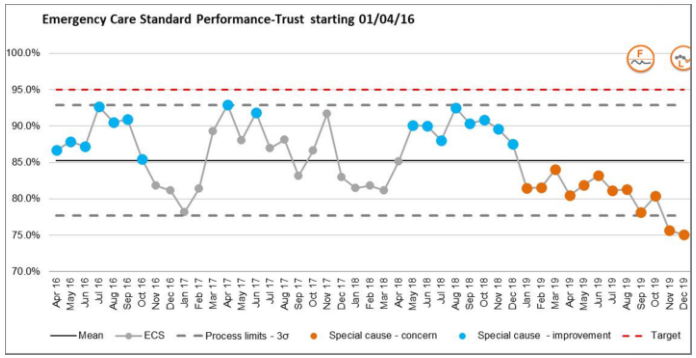
Consequence of under-achievement

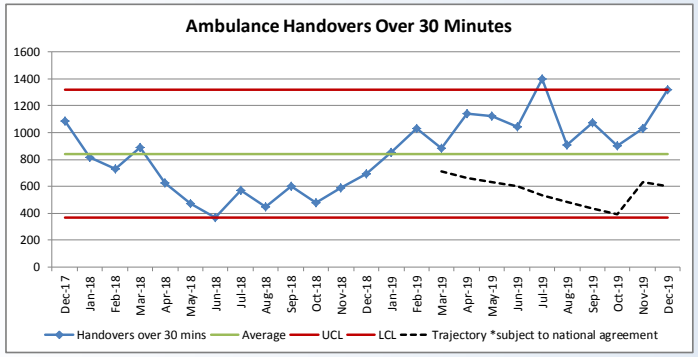
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

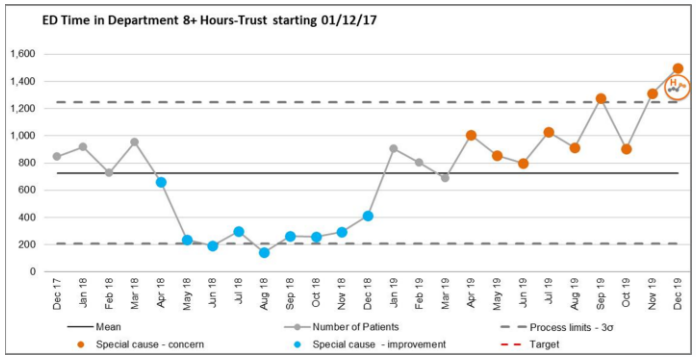
Performance Update:

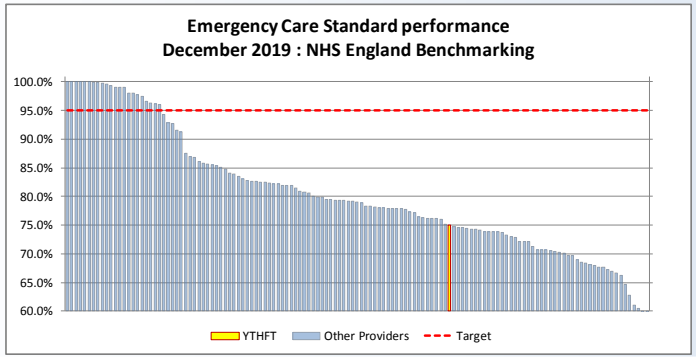
- The Trust achieved 75.1% in December 2019.
- For the year to date there has been an 8% rise in attendances on the same period in 2018/19. In total an extra 11,882 patients have attended the main EDs, UCCs and MIUs, with the main EDs (type 1) seeing and treating an additional 6,876 patients; a rise of 8%. Scarborough ED has been under significant pressure, up 10% year to date compared to 2018/19.
- The number of patients waiting over 8 hours remains high, in December 2019 there were 1,499 patients who waited over 8 hours, the twelfth consecutive month above the four-year average.
- There were fifteen twelve hour trolley waits reported on the Scarborough site.
- Ambulance arrivals have seen twelve consecutive months where the number of ambulances being delayed by over 30 mins has been above the two-year average.

Performance:









Assurance Framework Responsive

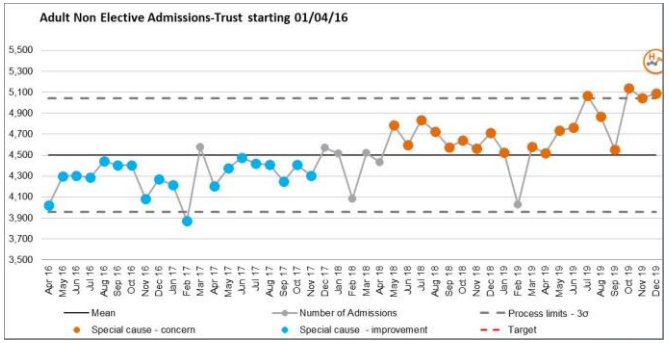
Unplanned Care

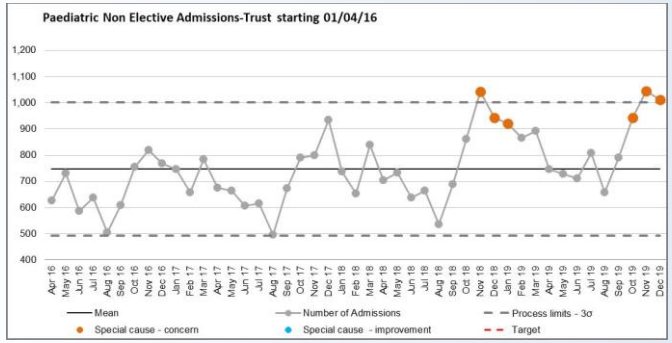
Performance Update:

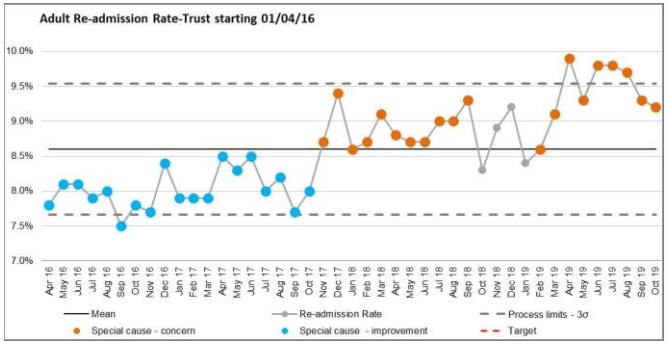
- The number of adult non-elective admissions for the year to date has increased by 5% in 2019/20 compared to 2018-19 (+1,551). For nineteen of the past twenty months adult admissions have been above the four year average. Paediatric non-elective admissions have been above the four year average for the past four months and are 10% up YTD compared to 2018/19. The rise in paediatric admissions has been seen in children with respiratory conditions. There has been a rise of 38% (+184 admits) for children admitted with a primary diagnosis of asthma and a 58% (+230) increase for upper respiratory infections. The increase has been in 'short stay' patients with those with a zero night LoS increasing from 52% to 69%.

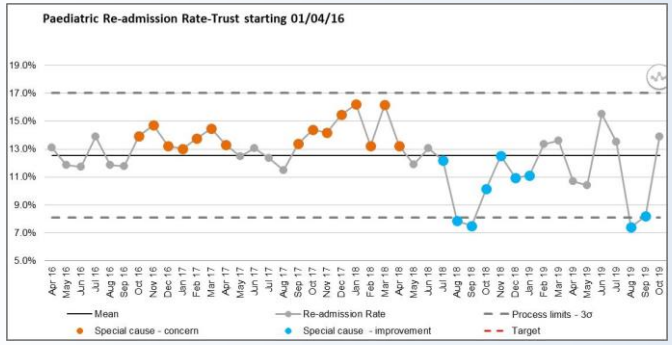
- The adult readmission rate continues to be above the four year average, analysis by the Trust's analytics team identified that there is an issue with the merging of two patient spells on CPD where it has been identified that a patient has been discharged in error. This can occur if a patient has been 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. Therefore the belief is that this is a data issue rather than a true rise in readmissions.

Performance:









Assurance Framework Responsive

Cancer Waiting Times

(Reported a month in arrears)

Operational Context

Overall, the Trust achieved 92.4% against the 14 day Fast Track referral from GP standard in November this was the second consecutive month the Trust had outperformed the national position (91.3%).

The Trust continues to experience high numbers of Cancer Fast Track (FT) referrals, with a 7% increase in FT referrals seen to the end of November 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 75.9% in November. National performance for November was 77.4% and this was the first time in the last 12 months that the Trust hasn't outperformed the national position. The Trust's performance in November equated to 145 accountable patients treated in November, with 35 accountable breaches (41 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, 5% relate to delays for medical reasons, 55% due to delays to diagnostic tests or treatment plans/lack of capacity, 33% relate to complex or inconclusive diagnostics and 7% due to patient delay.

Progress towards the April 2020 target to diagnose patients within 28 days continues, with improving performance of 69.9% in November, up 5% on October performance. 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.
- Focused 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.

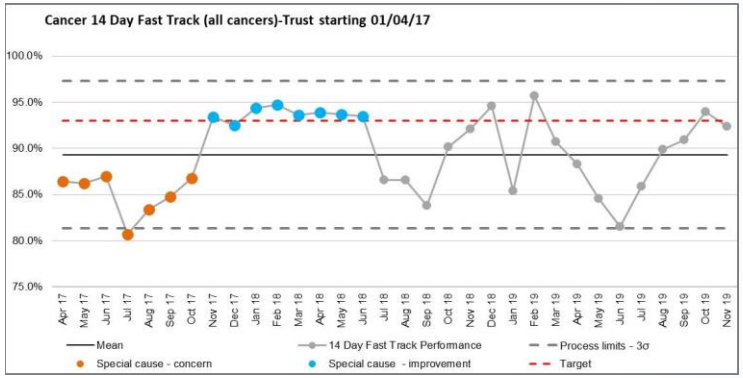
Consequence of under-achievement:

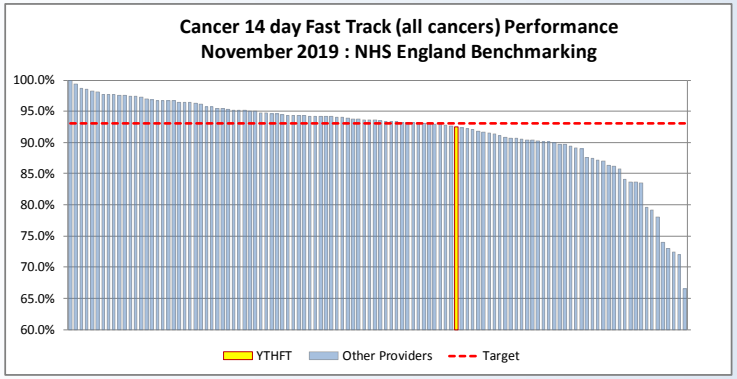
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

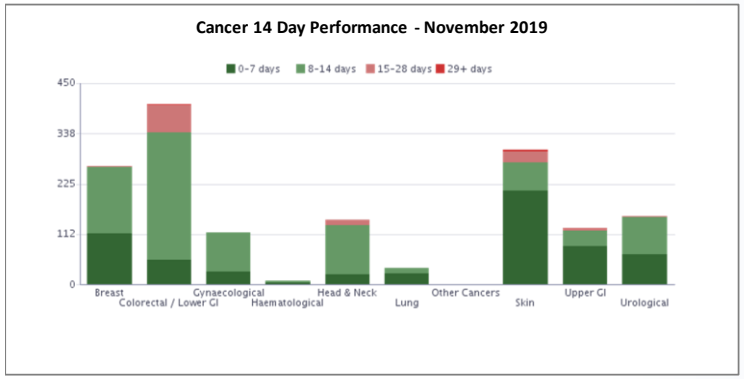
Performance Update:

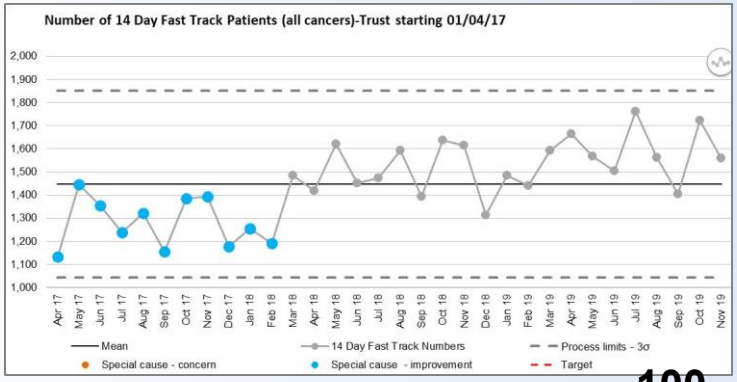
- Overall, the Trust achieved 92.4% against the 14 day Fast Track referral from GP standard in November.
- The Trust continues to experience high numbers of Cancer Fast Track (FT) referrals, with a 7% increase in FT referrals received April to November 2019-20 compared to 2018-19.

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.

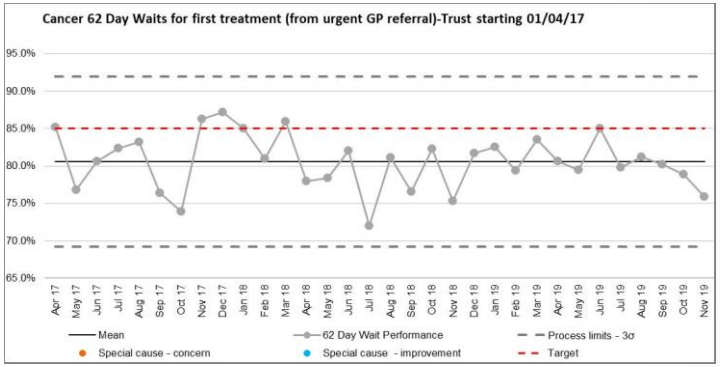
Consequence of under-achievement:

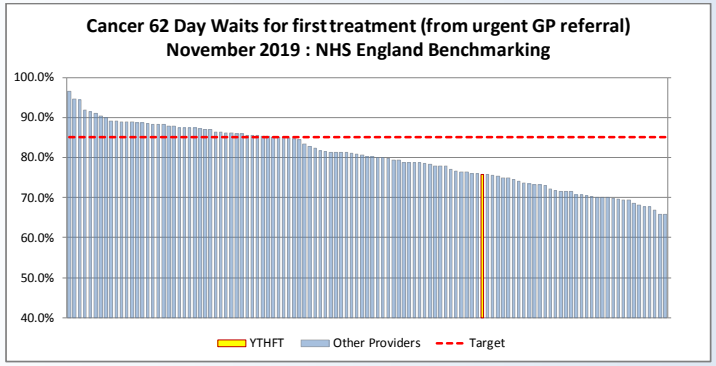
Patient experience, clinical outcomes and potential impact on timely access to treatment.

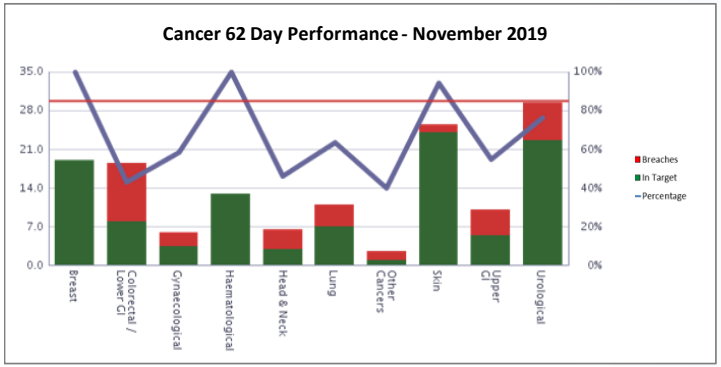
Performance Update:

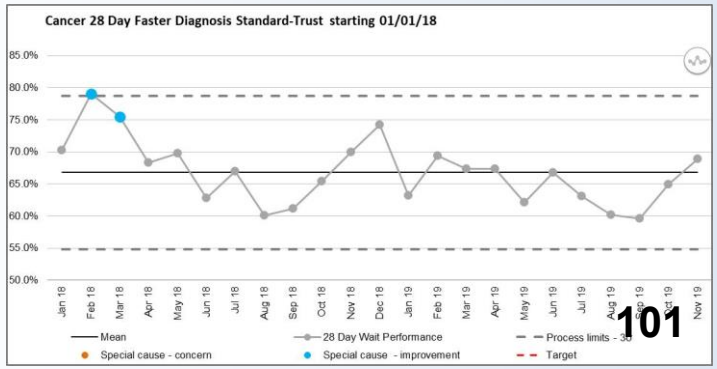
- Performance against the 62 day target from referral to treatment was 75.9% in November.
- The Trust's performance equated to 145 accountable patients treated in November, with 35 accountable breaches (41 patients). The breaches were spread across a range of tumour pathways, with the highest number of breaches seen in Colorectal and Urological cancers.
- Of the reported patient breaches, 5% relate to delays for medical reasons, 55% due to delays to diagnostic tests or treatment plans/lack of capacity, 33% relate to complex or inconclusive diagnostics and 7% due to patient delay.

Performance:









Assurance Framework Responsive

Planned Care

Operational Context

The provisional total incomplete Referral to Treatment (RTT) waiting list (TWL) provisionally stood at 29,477 at the end of December, up 354 clocks on the end of November position. This is better than the trajectory of 30,202 submitted to NHS England and NHS Improvement but above the target of 26,303 open clocks (March 2018 position) by the end of March 2020.

GP referrals received by the Trust in December were below the four year average for the tenth consecutive month, the number received for the year to date is a 4% reduction on those received in the same period in 2018-19. However the reduction in GP referrals has largely been offset by a 6% rise in referrals from 'Other' sources. Examples of 'Other' referrals are where the source of referral is other healthcare professionals including dentists, optometrists and AHPs. One notable increase over the past 2 years has been from Yorkshire Doctors under the General Medicine Practitioners Specialty which has seen an increase of 26% since April to December 2017. This is also prevalent within Trauma & Orthopaedics with a 19% increase from the same referral source. Overall referrals from all sources are down by 0.3% compared to 2018-19.

The Trust's provisional RTT position for December was 73.6%, 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 546 (8%).

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 December there were 3,957 patients waiting 26 weeks or over; an increase of 431 on the end of November position. The number of long wait patients (those waiting more than 36 weeks) increased by 134 at the end of December. 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 December.

The Trust has seen an decline against the national 6 weeks diagnostic target in December, with performance of 81.5% against the standard of 99%. National performance for December was 97.1%. 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 has been impacted by the 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 5th room at York on the 3rd of February 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 programme of work due to start in January.

Targeted actions

- 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. Ongoing work with commissioners to reduce referral demand.
- Targeted Consultant validation of all patients waiting 15+ weeks without any future booked activity commenced on the 25th November.
- Support from the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services. Programmes of work agreed; demand and capacity analysis in endoscopy, radiology and echo cardiology services, utilising the IST Pathway Analyser Tool to prospectively populate data against key admin pathway milestones in radiology, Development of a standard operating procedure for endoscopy scheduling meetings and Development of a KPI dashboard in radiology to support performance improvement against key access standards.
- £110k additional RTT monies secured from NHSE&I for T&O (11 cases), Gen Surgery (30), Ophthalmology (23) and Urology (5).
- £209,700 additional monies secured from NHSE&I for Endoscopy and MRI. Will be used to tackle the endoscopy backlog and to maintain the low numbers of MRI waiters.

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.

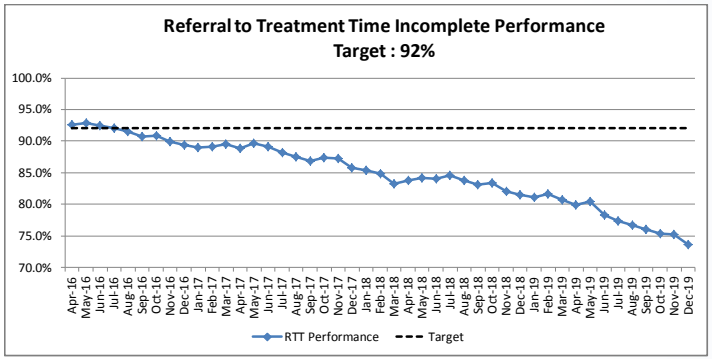
Consequence of under-achievement:

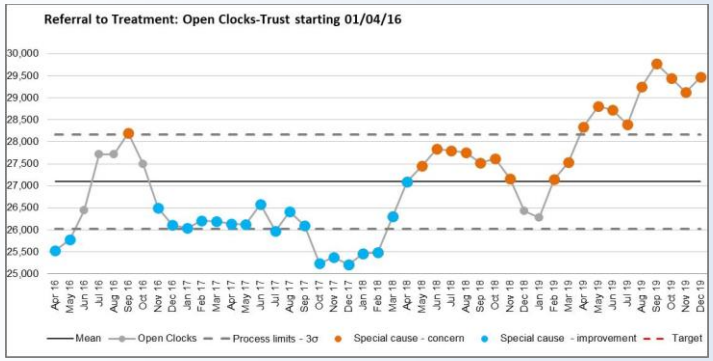
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

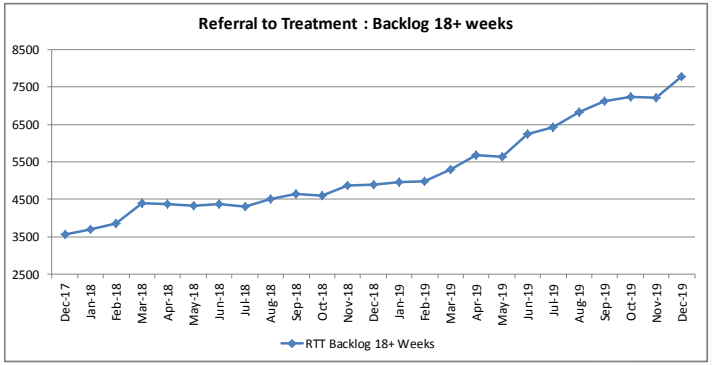
Performance Update:

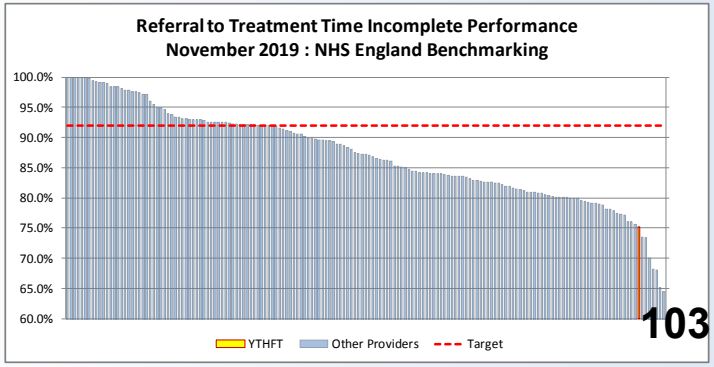
- The total incomplete Referral to Treatment (RTT) waiting list (TWL) provisionally stood at 29,477 at the end of December, up 354 clocks on the end of November position. This is above the target to have below 26,303 open clocks (March 2018 position) by the end of March 2020.
- The Trust achieved 73.6% RTT at the end of December, below the 80.0% trajectory submitted to NHS England and NHS Improvement.
- The Trust's 'Did Not Attend/Was Not Brought' (DNA) rate fell to 5.8% in December, performance has now remained below the two-year average for twelve 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.

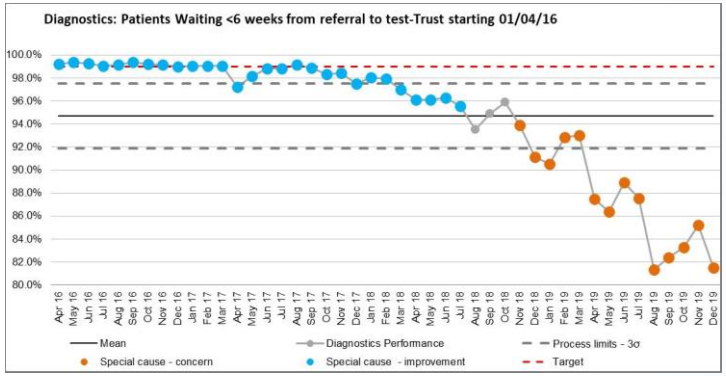
Consequence of under-achievement:

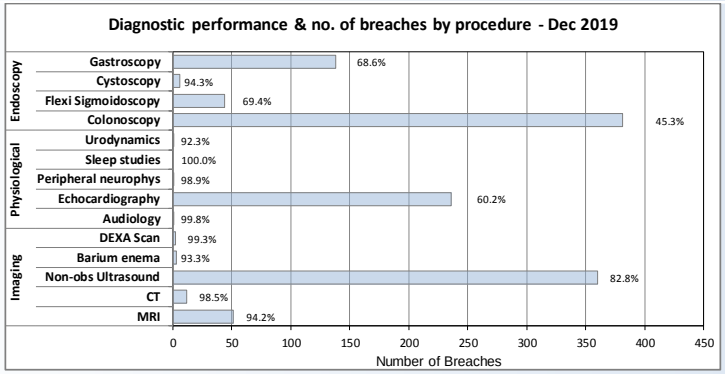
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

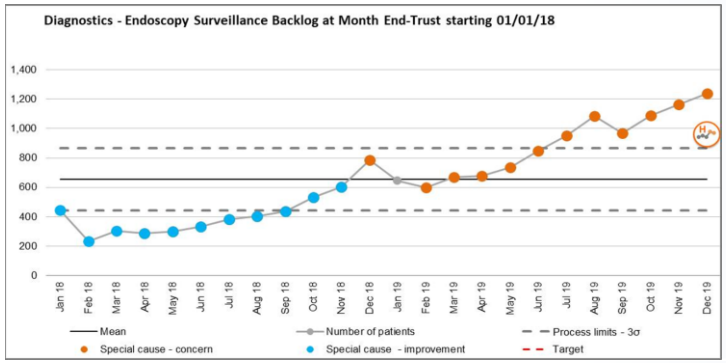
Performance Update:

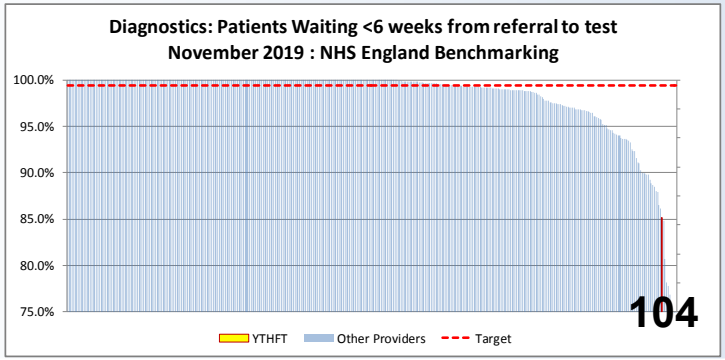
- The Trust has seen an decline against the national 6 weeks diagnostic target in December, with performance of 81.5% against the standard of 99%.
- Support from the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services. Programmes of work agreed; demand and capacity analysis in endoscopy, radiology and echo cardiology services, utilising the IST Pathway Analyser Tool to prospectively populate data against key admin pathway milestones in radiology, Development of a standard operating procedure for endoscopy scheduling meetings and Development of a KPI dashboard in radiology to support performance improvement against key access standards.

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**	**Amber – difficulties in capturing medication review element. Discussion with CCG ongoing.**	**Amber**
CCG9: Six Month Reviews for Stroke Survivors	Wendy Scott	Gemma Ellison	**Achieved**	**Achieved**	**Amber – Latest Performance below trajectory**	**Amber**
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**	

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Board of Directors – 29 January 2020
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 next steps following 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 imminent implementation of the Radiology Reporting Hub
- the imminent finalisation of procurement of a joint Laboratory Information Management System(£2.6m) across YTHFT and HUTHT
- 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: January 2020

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.

Going forward, the next stage of the Review process will focus on progression of the clinical models in key specialty areas to ensure continuous sustainable hospital service provision.

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 are well underway 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.

An updated narrative document summarising the progress made in Stage Two and future next steps for hospital and out of hospital service provision is currently being finalised and will be published shortly.

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 an Outline Business 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 this 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 continuing to develop 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 Strategic Services Board (with Executive Director Leadership) has been established 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 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 (£2.6m) 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. Following progression of a comprehensive procurement process, it is anticipated that this can be finalised shortly and that the system can be in place by mid-2020.

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.

A temporary service pathway change for Scarborough and Bridlington patients across non Breast Oncology services on the grounds of patient safety (involving the continuation of most Chemotherapy and follow up outpatient appointments locally and patients travelling to Hull for their first outpatient appointments and complex treatment) is being implemented in late January.

This arrangement will be reviewed by all four Trusts and the respective Humber Coast and Vale and West Yorkshire Cancer Alliances as part of the medium to long term strategy for the service across the extended geographical patch.

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 – 29 January 2020
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 Board of Directors of the financial position for month 9 (Quarter 3) of the 2019/20 financial year.

Executive Summary – Key Points

The income and expenditure position for month 9 (Quarter 3) of the 2019/20 financial year confirms the Trust has met its pre-PSF control total. It is therefore appropriate to apply PSF and FRF to the quarter 3 position.

For the period April to December the Trust's pre-PSF control total was a deficit of £15.0m. This planned position has been achieved. After applying sustainability funding the Trust is reporting a deficit of £0.8m against a planned deficit of £1.3m, therefore reporting a favourable variance to plan of £0.5m.

The Board are aware that quarter three reporting requires a formal update to the Trust's forecast outturn. As we have discussed over a number of months our forecast outturn is being impacted by the CQC staffing requirements at Scarborough and from the system risk share impacting in March, where it has not been possible to implement aggressive system savings to deliver the plan. The report confirms the forecast outturn is a deficit against plan of £4m (before sustainability funding adjustments). This comprises a forecast before mitigation of £6m but includes early thoughts, discussed with NHSE/I, of potential mitigating action of £2m. Work is underway to develop further the mitigation action plan.

Engagement with NHSE/I has commenced.

Recommendation

The Board of Directors is asked to:

- Confirm delivery of the quarter 3 position
- Confirm that the Trust is forecasting to miss its control total at year end. This is a formal board declaration. The Resources Committee (as the Finance Committee of the Board) will be asked to make this declaration on behalf of the Board as the quarter 3 formal return (including revised forecast outturn) must be submitted to NHSE/I on Thursday 23 January.
- Discuss and support the mitigating intervention to reduce the impact of the current forecast outturn.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

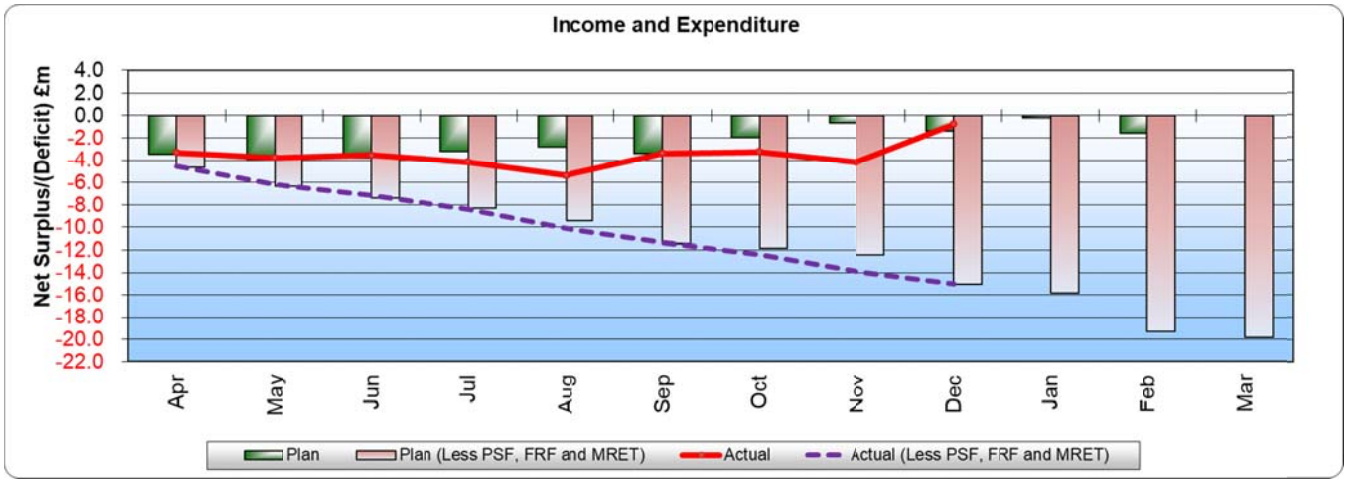
Date: January 2020

1. Year to date Summary Financial Position

The income and expenditure position for month 9 (Quarter 3) of the 2019/20 financial year confirms the Trust has met its pre-PSF control total. It is therefore appropriate to apply PSF and FRF to the quarter 3 position.

For the period April to December the Trust's pre-PSF control total was a deficit of £15.0m. This planned position has been achieved. After applying the sustainability funding the Trust is reporting a deficit of £0.8m against a planned deficit of £1.3m, therefore reporting a favourable variance to plan of £0.5m.

The chart below summarises the pre and post PSF plan for the year alongside the actual performance for the year to date.



Whilst the Q3 position has been secured, the latest forecast outturn positon confirms the discussions the Board has had in recent meetings that indicate delivering Q4 (and therefore the full year plan) is unlikely. This places Q4 sustainability funding of £5m at risk.

2. Summary Financial Commentary

NHS Clinical Income remains behind plan by £1.2m (no real movement from last month) 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 positive miscellaneous income variances to plan. Total income, from all sources, is showing a positive variance to plan of £2.0m.

The operational expenditure variance to plan has improved slightly from £2.2m at month 8 to £1.8m at month 9.

The analysis undertaken last month of expenditure pressures impacting the position has been updated. This is sumamrised in the table below.

		O/Spend Dec-19	
Care Group	**Issue**	**£k**	**Notes**
1. Acute Elderly Emergency General Medicine and Community Services - York	ED Consultant Rota	87	Unplanned excess staffing above 8:8:5 rota by self-rostered team. Management Team have stopped in December.
1. Acute Elderly Emergency General Medicine and Community Services - York	Junior doctors	225	Various additional unfunded posts but necessary to support rotas.
2. Acute Emergency and Elderly Medicine - Scarborough	CQC initiated Nursing costs	1,379	Response to CQC request on Scarborough site to enhance staffing levels on key wards
2. Acute Emergency and Elderly Medicine - Scarborough	CQC initiated Medical Staff Costs	600	Response to CQC additional medical staff requirements
2. Acute Emergency and Elderly Medicine - Scarborough	ED Weekend Consultant shift	49	Unfunded additional weekend shift but supporting patient flow and safety concerns
4. Cancer and Support Services	MRI Mobile at Scarborough	141	Continuation of mobile MRI beyond capital funded scheme
4. Cancer and Support Services	Histology Outsourcing	156	Histology outsourcing, net of saving on Consultant vacancies, to address safety concerns from significant reporting backlogs for key patient diagnostic pathways
4. Cancer and Support Services	Endoscopy Outsourcing	178	Unplanned and unfunded diagnostic capacity but necessary on the grounds of safety concerns relating to long waiting patients
4. Cancer and Support Services	Everlight /RRO	300	Unplanned and unfunded diagnostic reporting capacity to address safety concerns from significant reporting backlogs for key patient diagnostic pathways
4. Cancer and Support Services	Lloyds Pharmacy	173	Unexpected charge for increased activity
6. Specialised Medicine & Outpatients Services	RMO at Bridlington	168	Unexpected charges following difficulty with the supplier meeting service requirements
TOTAL		**3,456**	

Some respite against these various pressures has been accommodated in the position through slippage on planned investments but the pressure and stretch on the plan at the start of the financial year has resulted in insufficient headroom to manage all in-year pressures.

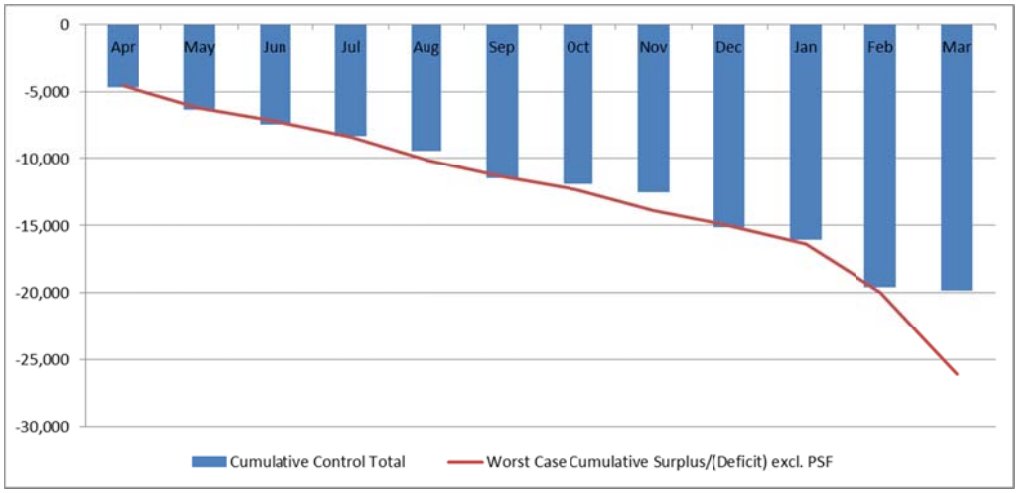
Notwithstanding the vacancy position in terms of medical and nurse staffing the Trust continues to materially breach its agency expenditure cap. Spend to month 9 now exceeds the annual cap of £15m. A simple extrapolation suggests the annual cap of £15m will be

breached by some £5m, with total expenditure set to exceed £20m at year end. Close monitoring and continued improvement action are necessary and the medical staffing team continues to work with NHSE/I in this regard.

In terms of the Trust's efficiency programme, in-month delivery for December has moved delivery to £14.7m of the £17.1m target. Recurrent delivery stands at £9m. Continued focus and energy is required to ensure delivery of the programme. Plans continue to match the programme target.

3. Forecast Outturn

The forecast outturn has been updated and this is summarised in the chart below. Income is based on agreed AC contracts in the main but includes estimates for other PbR contracts and other non-clinical income sources. The AC contract element is adjusted for the impact of the system risk share falling into place at month 12, as has been discussed throughout the year. Forecast expenditure is based on established trends and adjustments have been made for known spend changes in the final quarter.



The analysis confirms that as the position stands, using established trends, the Trust will fall short of the Q4 position by £6m.

Income in month 12 (March) is significantly down on trend as in the plan this included the full impact of the £3.7m system risk share. At Q3 we should be running with a positive variance to plan of around £3m in anticipation of the income reduction. However, due to the Board's intervention following the CQC concerns around staffing numbers at Scarborough, and due to a number of other exceptional safety concerns with associated spend decisions, this has not been possible. At month 9 we have been able to cover these costs but this has been at the expense of building the contingency necessary to cover the system risk share.

These safety related costs will continue in the final quarter of the financial year plus the full system risk share impact will hit. The forecast outturn suggests the adverse variance to

plan at year end will be around £6m if no further remedial action can be delivered in the final quarter or if no additional support can be secured.

The key drivers of this variance in full year forecast terms are:

	£m
CQC Related Additional Nurse Investment	£2.4
CQC Related Additional Doctor Investment	£1.0
Additional Safety Expenditure	
Outsourced Radiology Report to address backlog issues and cancer reporting concerns	£0.4
Outsourced Histopathology Report to address backlog issues and cancer reporting concerns	£0.2
RMO Cover at Bridlington Hospital	£0.2
ED Consultant Rota Enhancements	£0.2
Subtotal CQC and Safety Expenditure	**£4.4**

Net Impact of System Risk Share	£2.6
Impact of Current Expenditure Control & Provisions	(£0.9)
Grand Total	**£6.1**

It should also be noted that a further risk exists in relation to PDC charges following an early indication from the District Valuer as to an inflationary increase in the asset revaluation indices. This will not be known until the valuation work is completed as part of the year end accounting procedures. This could be a further £0.7m pressure on the position.

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 these previously reported actions.

In addition, further mitigating action for the final 3 months of the financial year is now necessary. Discussions with NHSE/I have commenced in this regard. These actions include:

- The imposition of even tighter discretionary expenditure controls with a clear message that any and all expenditure that can safely be deferred to April should be postponed. There should be no exceptions to this principle. The Board is asked to both practice and to promote this principle.
- Discussions have commenced with NHSE/I as to the potential availability of support against the CQC required additional and exceptional safety expenditure (above the original agreed and stretching plan).
- Discussions have also commenced with NHSE/I on other potential mitigating action that could be taken; reviewing and checking that the Trust is maximising any

potential for mitigation from initiatives undertaken by similarly challenged organisations.
- Discussions should commence with commissioners under the York and Scarborough System as to the management of the year end position in the context of at risk sustainability funding and associated cash consequences.

In discussion with NHSE/I, whilst recognising the high risk nature of successfully delivering mitigating actions, an assumption has been made that initial proposed actions could deliver a £2m improvement to the Trust's position, reducing the forecast £6m adverse variance to plan to £4m.

These exceptional mitigation actions will be key for the Board to monitor during the final quarter.

5. Recommendation

The Board of Directors is asked to:

- Confirm delivery of the quarter 3 position
- Confirm that the Trust is forecasting to miss its control total at year end by £6m but is working on mitigation to reduce this to £4m. This is a formal board declaration. The Resources Committee (as the Finance Committee of the Board) will be asked to make this declaration on behalf of the Board as the quarter 3 formal return (including revised forecast outturn) must be submitted to NHSE/I on Thursday 23 January.
- Discuss and support the mitigating intervention to reduce the impact of the current forecast outturn.

Finance Performance Report

December 2019

Produced January 2020

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

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

To support an engaged, healthy and resilient workforce

To ensure financial stability

Summary Income and Expenditure Position
Month 9 - The Period 1st April 2019 to 31st December 2019

NHS York Teaching Hospital NHS Foundation Trust

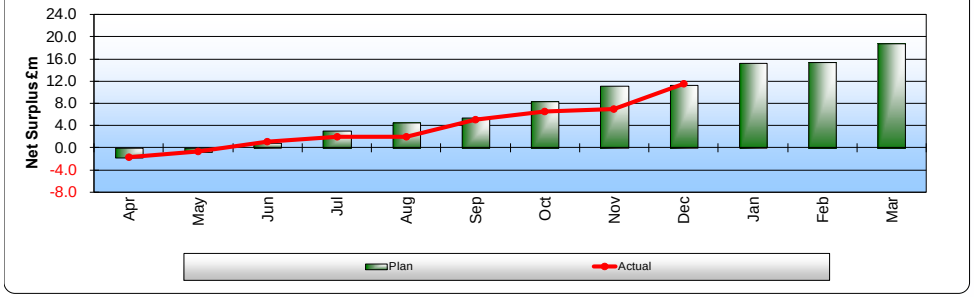
Summary Position:

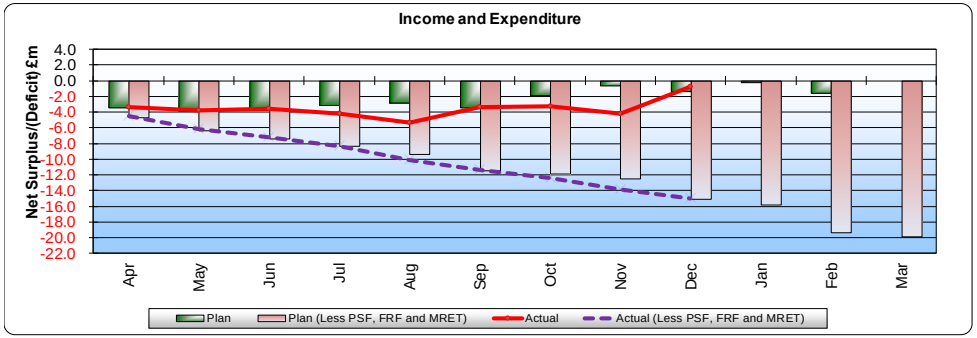
* The Trust is reporting an I&E deficit of £0.8m, placing it £0.6m ahead of the operational plan.

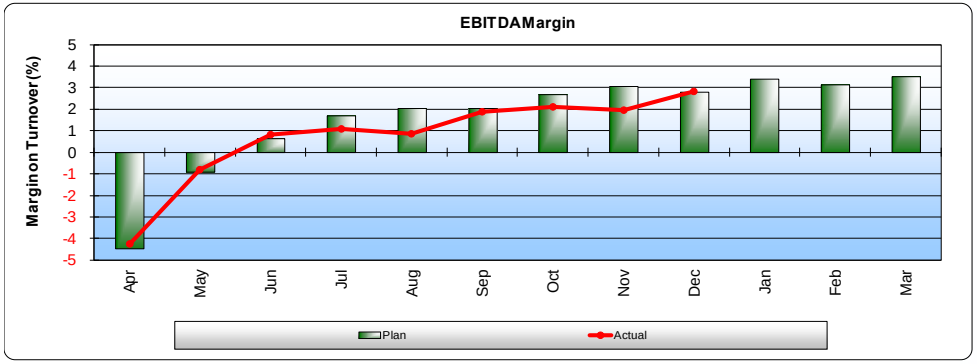
* Income is £2.1m ahead of plan, with NHS clinical income being £1.2m behind plan.

* Operational expenditure is £1.8m ahead of the operational plan, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £11.5m (2.84%) compared to plan of £11.3m (2.8%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	24,605	20,459	20,046	-413	24,138	-467
Planned same day (Day cases)	40,791	31,833	31,186	-647	40,161	-630
Non-Elective Income	140,704	105,447	105,707	260	141,110	406
Outpatients	64,943	49,287	47,710	-1,577	62,922	-2,021
A&E	20,491	15,661	15,827	166	20,703	212
Community	20,169	15,127	15,130	3	20,173	4
Other	108,018	81,445	82,526	1,081	107,724	-294
Pass-through excluded drugs expenditure	44,685	33,778	33,745	-33	45,586	901
	464,406	**353,037**	**351,877**	**-1,160**	**462,517**	**-1,889**
Non-NHS Clinical Income						
Private Patient Income	1,105	828	917	88	1,218	113
Other Non-protected Clinical Income	1,863	1,435	1,531	96	2,033	170
	2,968	**2,263**	**2,448**	**184**	**3,251**	**283**
Other Income						
Education & Training	17,365	13,026	14,340	1,313	19,043	1,678
Research & Development	2,425	1,819	2,432	614	3,230	805
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	623	467	433	-34	577	-46
Other Income	27,131	19,804	20,374	570	24,463	-68
PSF, FRF and MRET	19,814	13,528	14,100	572	15,716	-4,098
	67,357	**48,644**	**51,679**	**3,035**	**65,629**	**-1,728**
Total Income	**534,731**	**403,944**	**406,003**	**2,059**	**531,397**	**-3,334**
Expenditure						
Pay costs	-360,130	-269,976	-272,790	-2,814	-363,952	-3,822
Pass-through excluded drugs expenditure	-44,685	-33,778	-33,778	0	-45,586	-901
PbR Drugs	-8,983	-6,724	-6,657	67	-8,081	902
Clinical Supplies & Services	-52,345	-39,583	-37,412	2,171	-48,091	4,254
Other costs (excluding Depreciation)	-53,862	-41,402	-43,851	-2,449	-57,230	-3,368
Restructuring Costs	0	0	0	0	0	0
CIP	2,423	-1,177	0	1,177	0	-2,423
Total Expenditure	**-517,583**	**-392,640**	**-394,488**	**-1,848**	**-522,940**	**-5,357**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**17,149**	**11,304**	**11,515**	**211**	**8,457**	**-8,691**
Profit/ Loss on Asset Disposals	0	0	0	0	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation - purchased/constructed assets	-10,000	-7,500	-7,200	300	-9,600	400
Depreciation - donated/granted assets	-400	-300	-300	0	-400	0
Interest Receivable/ Payable	130	98	156	59	208	78
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-936	-702	-709	-7	-945	-9
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	0	0	0	0
PDC Dividend	-5,641	-4,231	-4,231	0	-5,641	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**2**	**-1,331**	**-769**	**562**	**-8,231**	**-8,222**

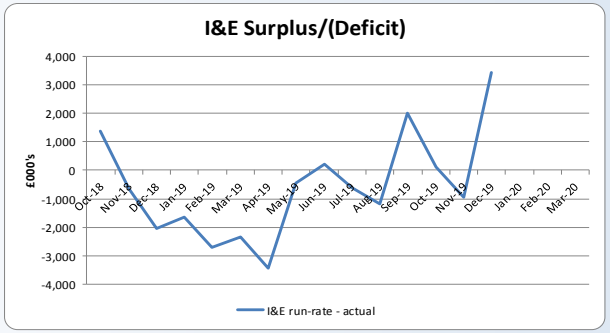
Summary Trust Run Rate Analysis
Month 9 - The Period 1st April 2019 to 31st December 2019

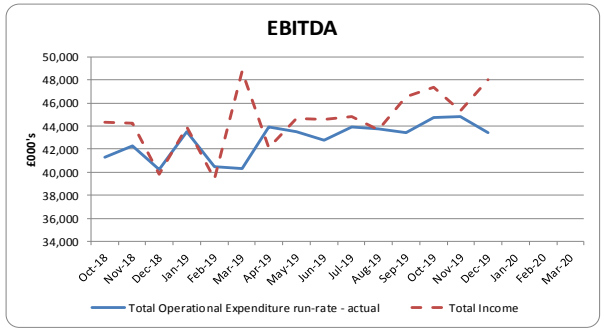
York Teaching Hospital NHS Foundation Trust

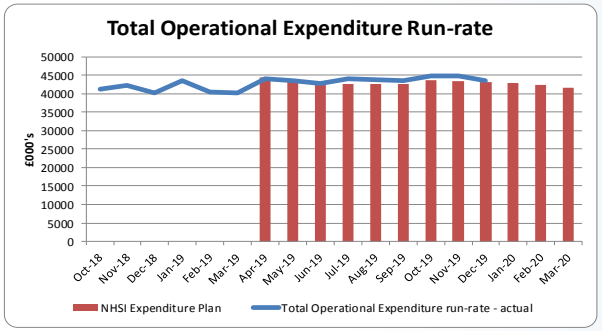
Key Messages:

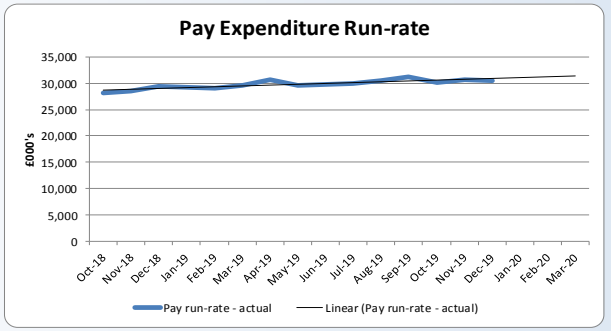
* The total operational expenditure in December was £43.5m. The average total operational expenditure in the previous fourteen months was £42.8m. Resulting in an adverse variance of £0.7m.

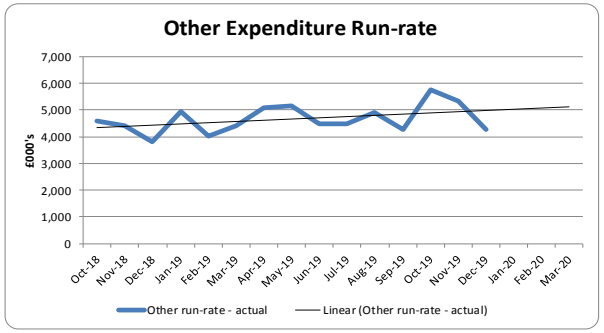
* In month operational income exceeded expenditure by £4.5m, resulting in a positive EBITDA for the month.

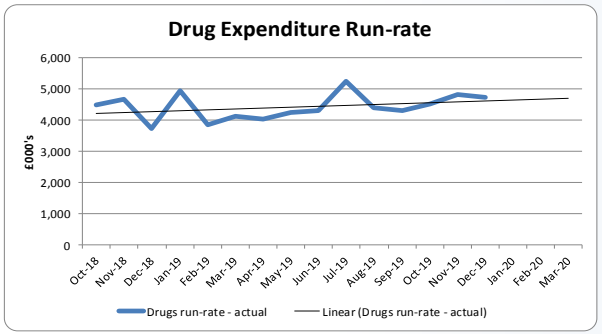


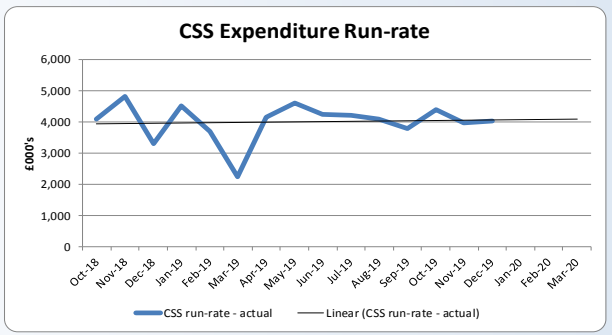












	Monthly Spend																	Monthly Ave	Variance
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		
Total Income	44,347	44,277	39,808	43,908	39,422	48,743	42,117	44,632	44,555	44,837	43,700	46,556	47,330	45,327	47,985	0	0	0	44,254	3,731
Pay Expenditure	-28,178	-28,451	-29,396	-29,165	-28,990	-29,535	-30,660	-29,593	-29,785	-30,001	-30,390	-31,102	-30,100	-30,690	-30,469	0	0	0	-29,717	-752
Drug Expenditure	-4,465	-4,660	-3,711	-4,934	-3,824	-4,117	-4,009	-4,230	-4,280	-5,234	-4,391	-4,282	-4,513	-4,793	-4,704	0	0	0	-4,389	-315
CSS Expenditure	-4,071	-4,796	-3,301	-4,494	-3,677	-2,235	-4,146	-4,587	-4,235	-4,206	-4,080	-3,790	-4,377	-3,963	-4,028	0	0	0	-3,997	-31
Other Expenditure	-4,575	-4,409	-3,820	-4,949	-4,029	-4,411	-5,088	-5,138	-4,483	-4,481	-4,907	-4,265	-5,759	-5,341	-4,251	0	0	0	-4,690	439
EBITDA	3,058	1,961	-420	366	-1,098	8,445	-1,786	1,084	1,772	915	-68	3,117	2,581	540	4,533	0	0	0	1,462	3,071

Contract Performance

Month 9 - The Period 1st April 2019 to 31st December 2019

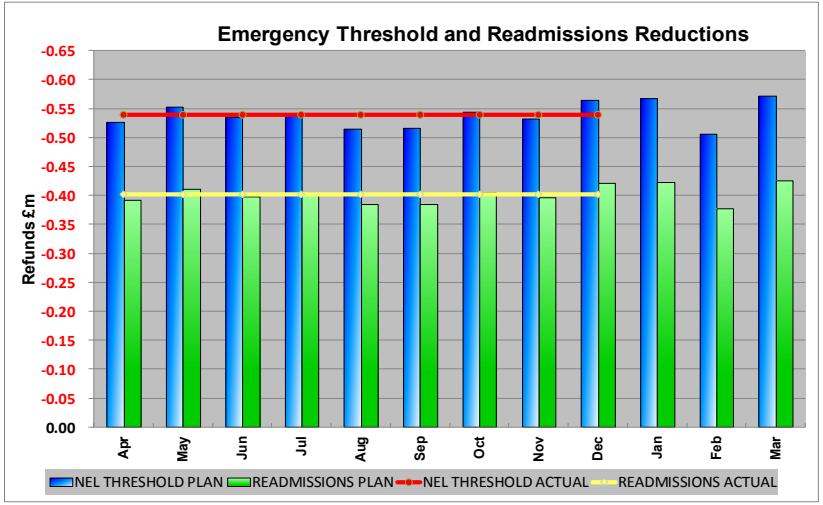
York Teaching Hospital NHS Foundation Trust

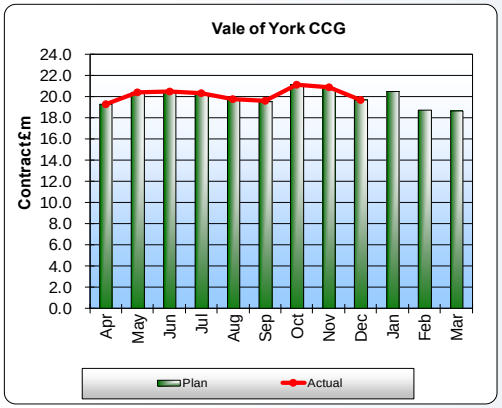
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	239,634	181,683	181,683	0
Scarborough & Ryedale CCG	84,719	65,457	65,457	0
East Riding CCG	47,438	35,895	35,895	0
Other Contracted CCGs	18,675	14,002	14,375	373
NHSE - Specialised Commissioning	47,216	35,255	34,502	-753
NHSE - Direct Commissioning	15,115	11,198	10,731	-467
Local Authorities	4,343	3,258	3,262	4
Total NHS Contract Clinical Income	**457,140**	**346,748**	**345,905**	**-843**

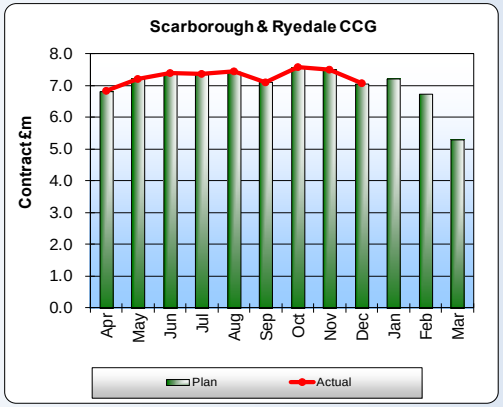
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	5,723	5,132	5,972	840
Risk Income	1,543	1,157	0	-1,157
Total Other NHS Clinical Income	**7,266**	**6,289**	**5,972**	**-317**

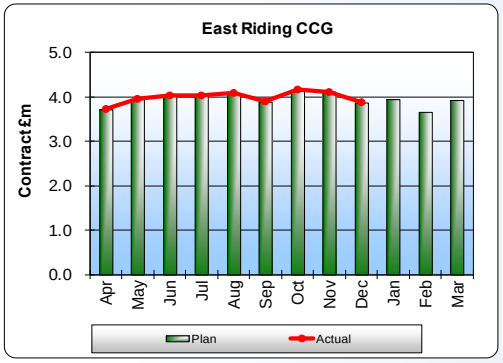
Total NHS Clinical Income	**464,406**	**353,037**	**351,877**	**-1,160**

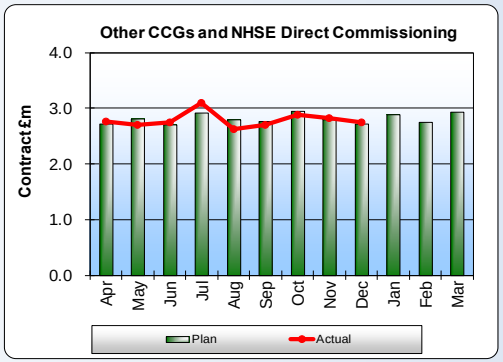
Activity data for December is partially coded (59%) and November data is 90% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

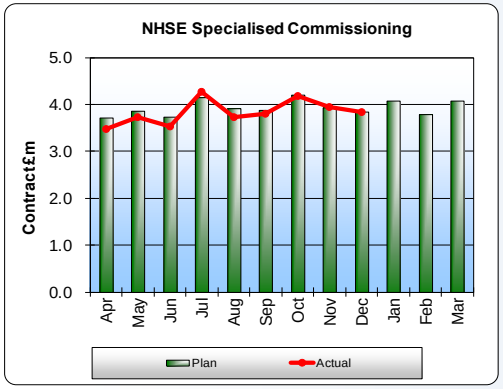


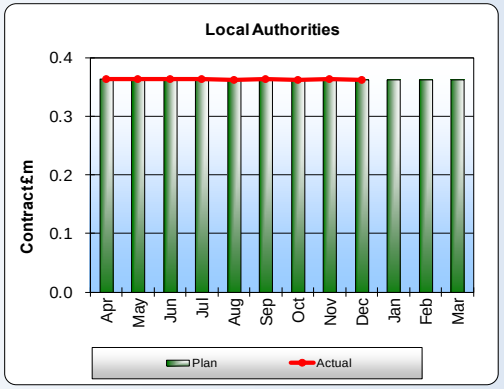












Agency Expenditure Analysis

Month 9 - The Period 1st April 2019 to 31st December 2019

York Teaching Hospital NHS Foundation Trust

Key Messages:

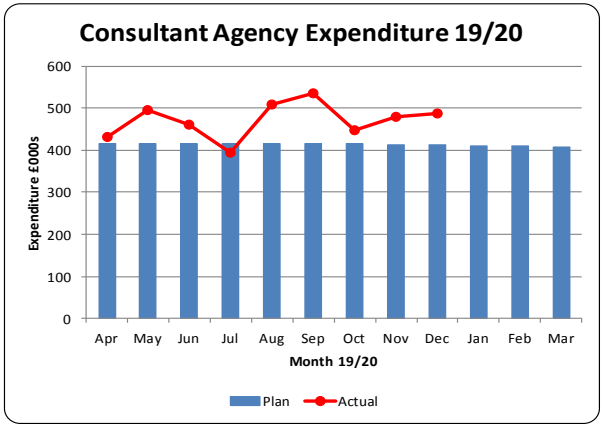
* Total agency spend year to date of £15.7m, compared to the NHSI agency ceiling of £11.5m.

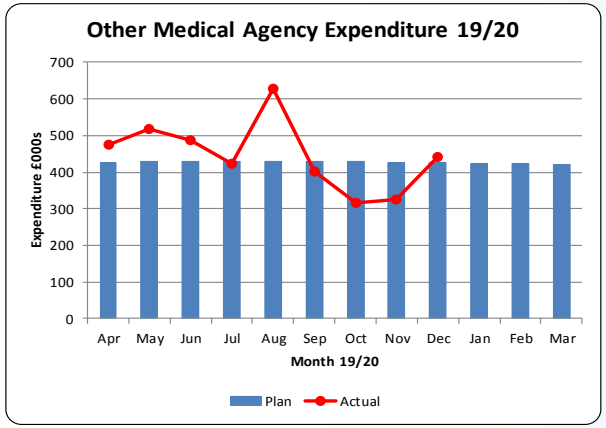
* Consultant Agency spend is £0.5m ahead of plan.

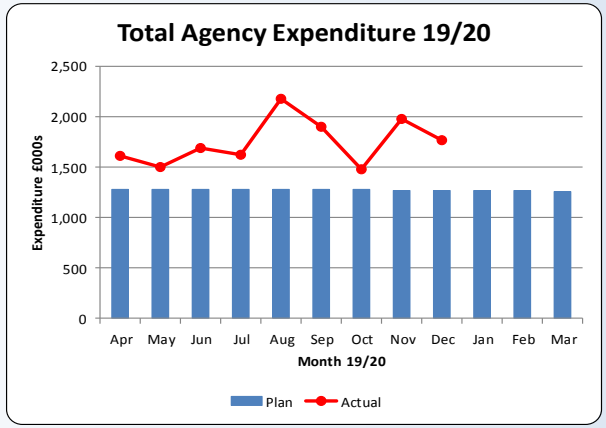
* Nursing Agency is £3.5m ahead of plan.

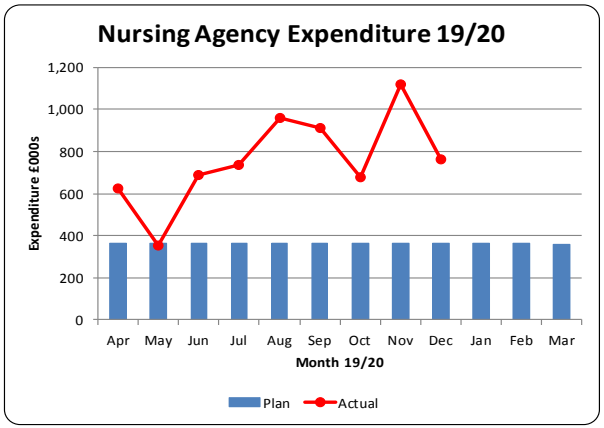
* Other Medical Agency spend is £0.2m ahead of plan.

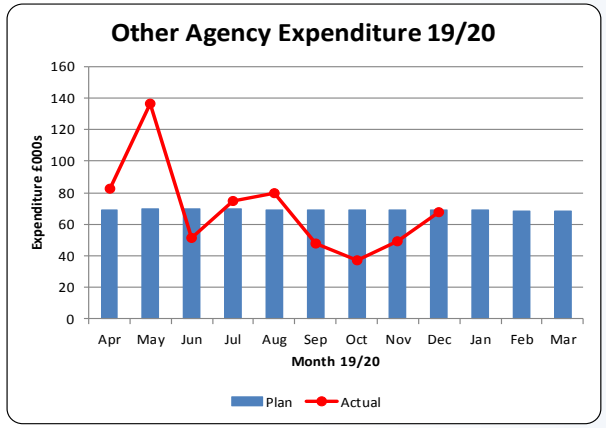
* Other Agency spend is broadly on plan.

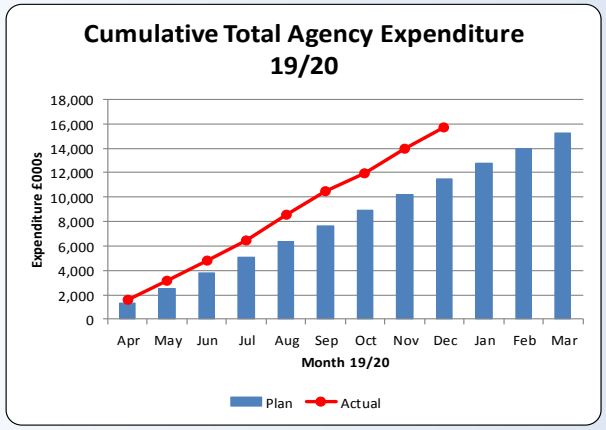












Expenditure Analysis

Month 9 - The Period 1st April 2019 to 31st December 2019

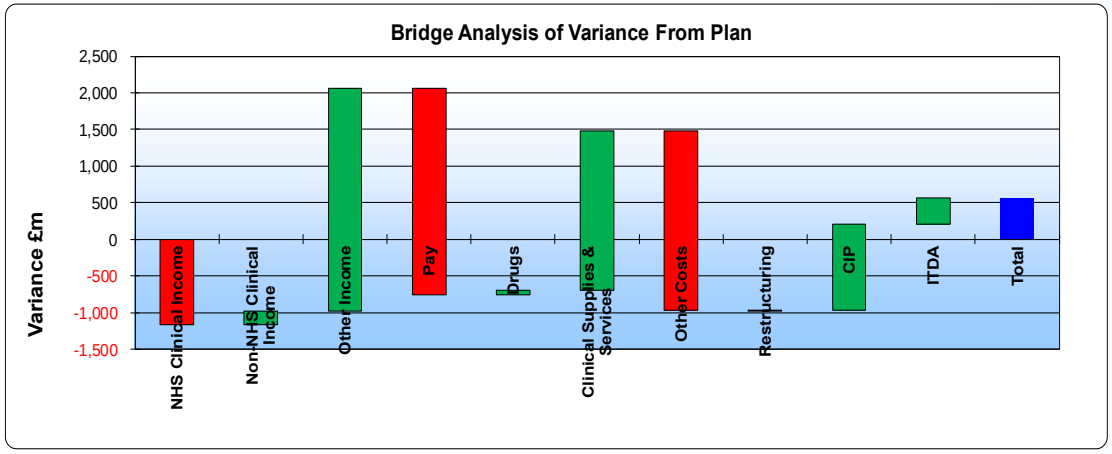
York Teaching Hospital NHS Foundation Trust

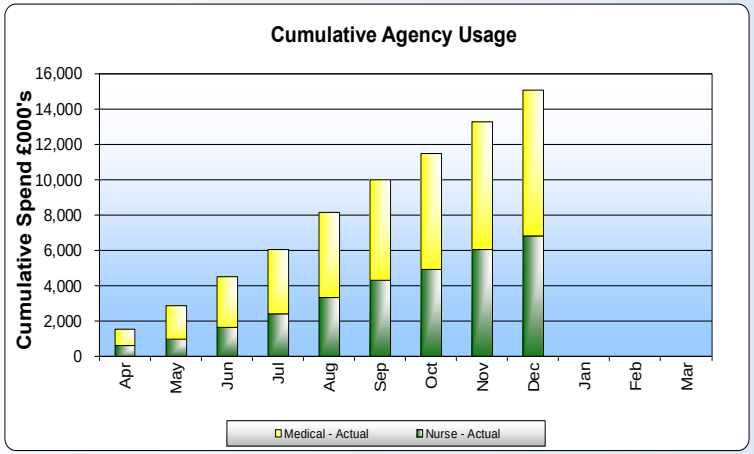
Key Messages:

There is an adverse expenditure variance of £1.8m at the end of December 2019. This comprises:

* Pay expenditure is £2.8m ahead of plan.
* Drugs expenditure is £0.1m behind plan.
* CIP achievement is £1.1m ahead of plan.
* Other expenditure is £0.2m ahead of plan.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	63,516	47,255	41,385	-	1,071	-	4,242	46,699	556	0	
Medical and Dental	36,037	26,804	29,509	-	167	-	4,013	33,690	-6,886	0	
Nursing	93,724	70,214	59,805	406	121	8,979	6,820	76,131	-5,917	0	
Healthcare Scientists	11,592	8,704	9,269	18	13	6	128	9,434	-730	0	
Scientific, Therapeutic and technical	16,569	12,359	11,726	62	3	24	38	11,854	505	0	
Allied Health Professionals	24,796	18,438	17,414	154	174	-	59	17,800	638	0	
HCAs and Support Staff	50,348	37,572	34,671	622	56	37	296	35,683	1,889	0	
Chairman and Non Executives	198	147	137	-	-	-	-	137	10	0	
Exec Board and Senior managers	15,178	11,294	10,689	6	-	-	-	10,695	598	0	
Admin & Clerical	40,556	30,361	29,469	6	1	-	113	29,588	773	0	
Pay Reserves	6,425	5,935	-	-	-	-	-	0	5,935	0	
Apprenticeship Levy	1,192	894	1,081	0	0	0	0	1,081	-187	0	
TOTAL	**360,130**	**269,976**	**245,154**	**1,274**	**1,607**	**9,046**	**15,710**	**272,790**	**-2,814**	**0**	





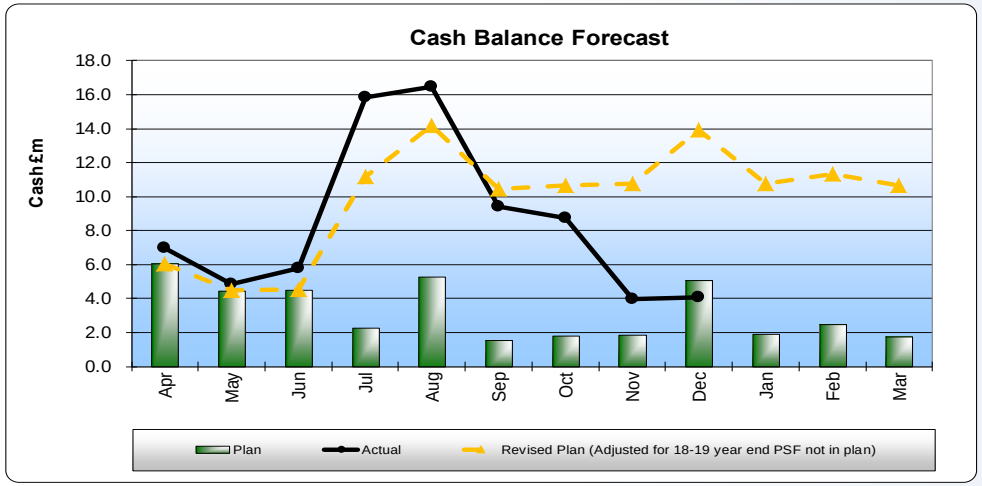
Cash Flow Management

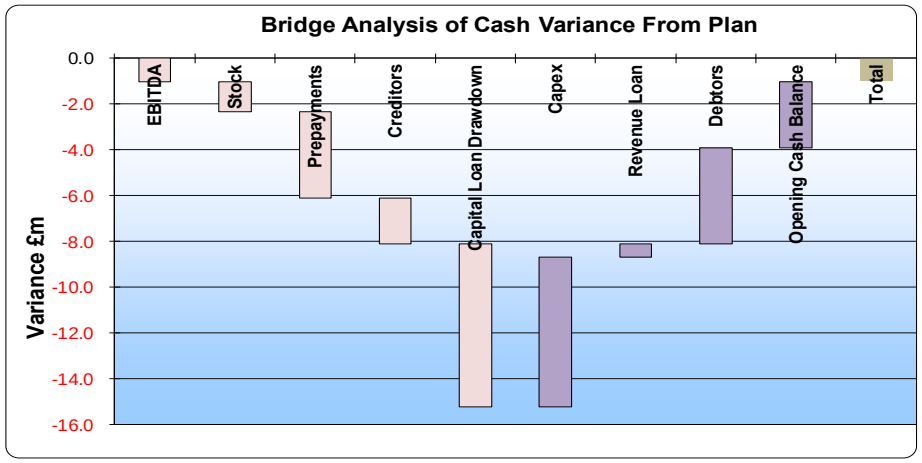
Month 9 - The Period 1st April 2019 to 31st December 2019

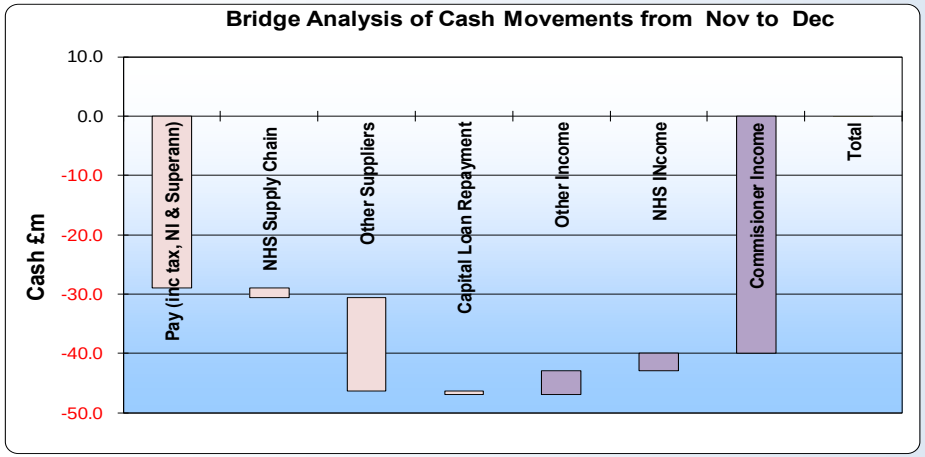
York Teaching Hospital NHS Foundation Trust

Key Messages

* The cash position at the end of December was £4m, which is £1m below plan, and £9.9m below the revised profile following receipt of the extra PSF in connection with 18-19.
* This is due to £1m defict plus £3.5m of prepayments (£2.5m CNST) the remaining £4.5m is due to a reduction in creditors
* The remaining movement is due to the timing of working capital movements.







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Cash Flow Management
Month 9 - The Period 1st April 2019 to 31st December 2019

York Teaching Hospital NHS Foundation Trust

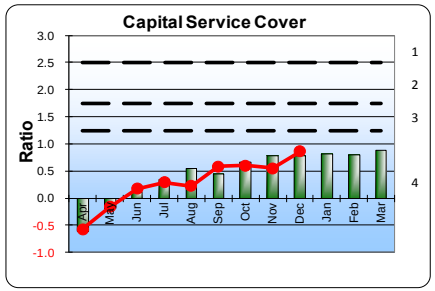
Key Messages:

* The receivables balance at the end of December was £10.1m, which is slightly below plan.
* The payables balance at the end of December was £14.8m, which is slightly below plan.
* The Use of Resources Rating is assessed is a score of 3 in December, and is reflective of the I&E position.

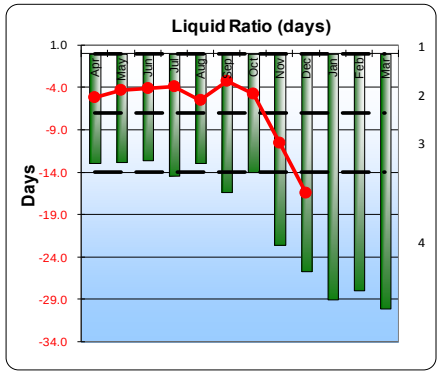
Significant Aged Debtors (Invoices Over 90 Days)

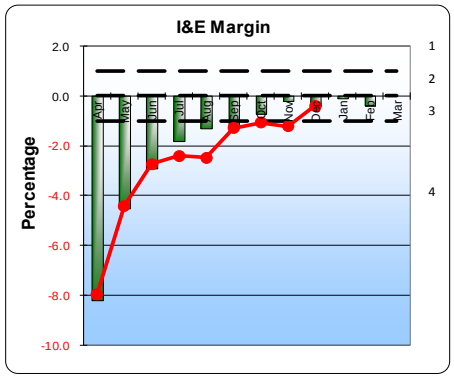
Harrogate & District NHS Foundation Trust	**£507K**
Vocare	**£326K**
Humber NHS Foundation Trust	**£301K**
NHS Property Services	**£257K**
NHS Vale of York CCG	**£148K**
Hull University Teaching Hospitals NHS Trust	**£144K**

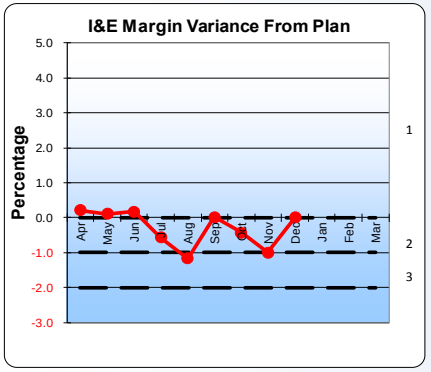
	Current	1-30 days	31-60 days	Over 60 days	Total
	£m	£m	£m	£m	£m
Payables	4.76	2.51	1.29	6.22	14.78
Receivables	5.06	1.60	0.71	2.76	10.12

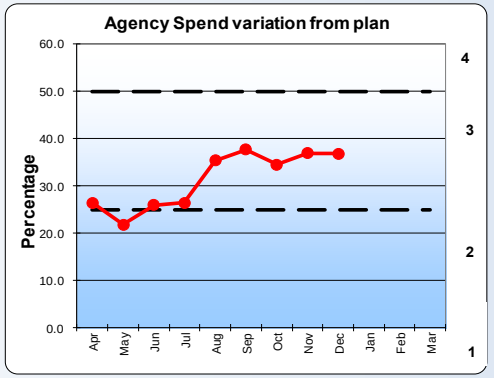


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Capital Service Cover (20%)	4	4	4	4
Liquidity (20%)	4	4	4	4
I&E Margin (20%)	2	3	3	2
I&E Margin Variance From Plan (20%)	1	1	1	1
Agency variation from Plan (20%)	1	1	3	1
Overall Use of Resources Rating	**3**	**3**	**3**	**3**









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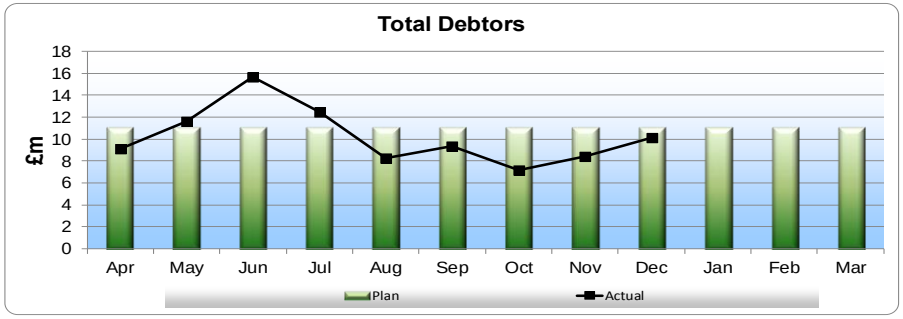
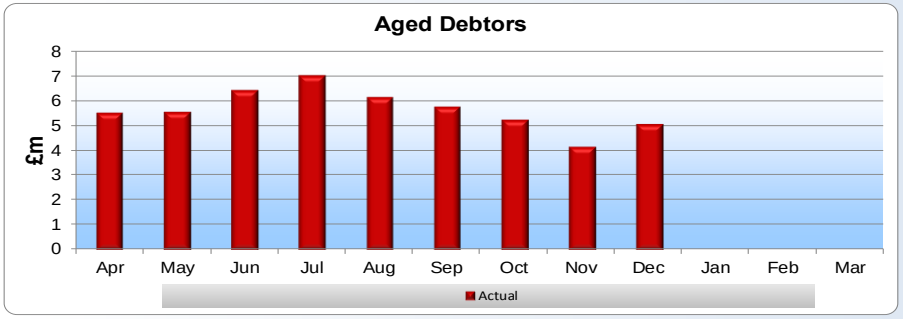
Debtor Analysis
Month 9 - The Period 1st April 2019 to 31st December 2019

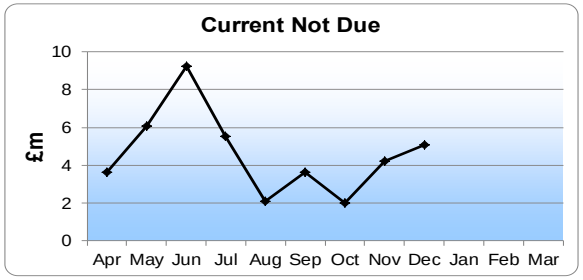
York Teaching Hospital NHS Foundation Trust

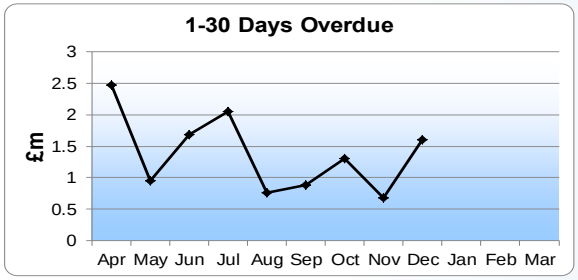
Key Messages

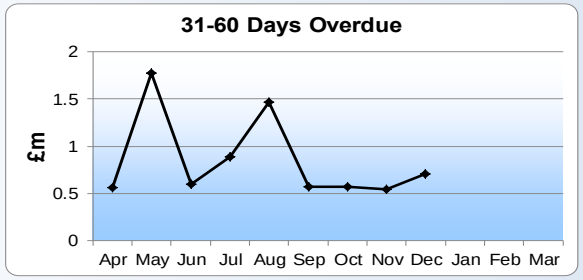
* At the end of December the total debtor balance was £10.1m, which is slightly below plan.
* £5.1m of the total debtor balance relates to 'current' invoices not due for payment. Aged debt totalled £5m.
* Aged Debt has increased by £1m from the November position but remains in line with the prior year comparator for December.
* Long term debtors (Over 90 Days) have reduced by £200k on the November position and continue to be a focus area for the Trust
* Accrued income is slightly below plan. This is due to recent focus ensuring that invoices are raised in a timely manner to maintain cash flow.

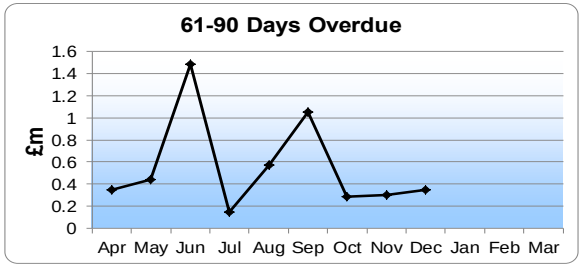


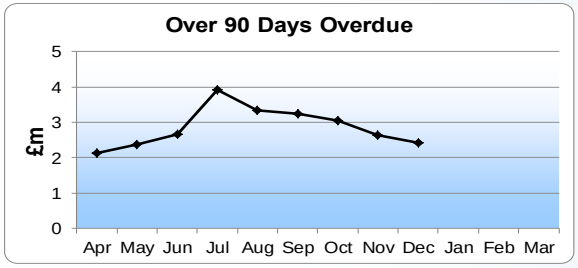


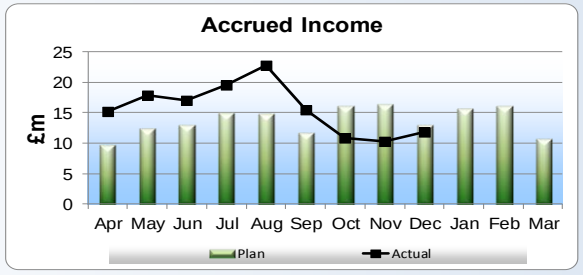












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Capital Programme
Month 9 - The Period 1st April 2019 to 31st December 2019

NHS York Teaching Hospital NHS Foundation Trust

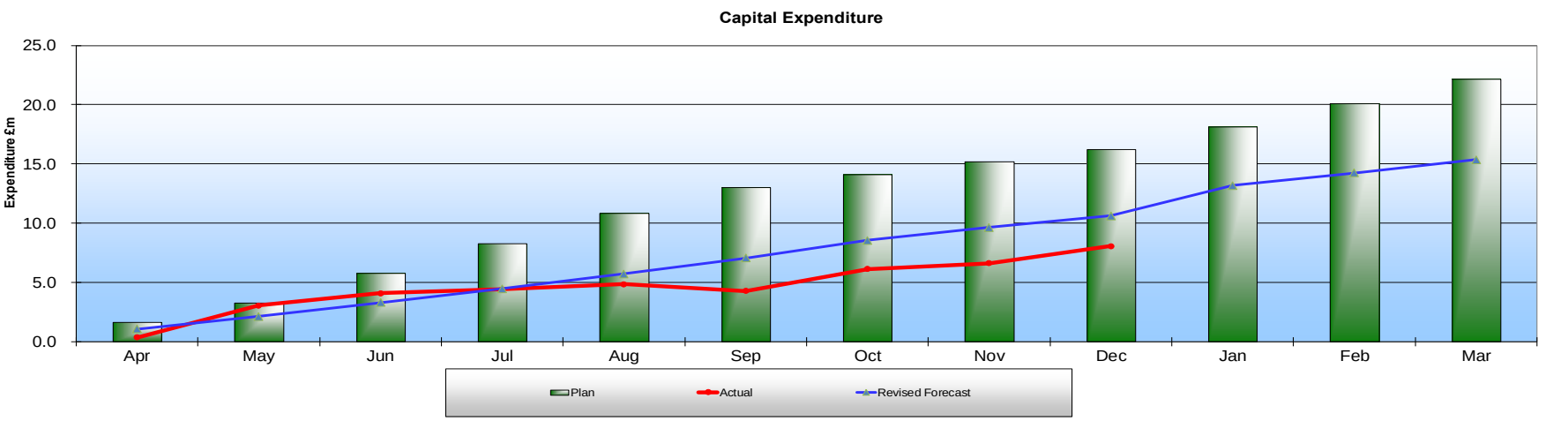
Key Messages:

* Total spend to the end of December is £8.1m, £2.8m behind the revised plan.

* Slippage is due to final account for the York Endoscopy scheme to be agreed and the VIU Extension detailed design work to be completed.

* SGH Estates are on plan and are due to deliver all their individual work plans this financial year.

* Minor schemes completed are the replacement of the theatre lights at both Scarborough and York.



Scheme	Revised in-year Expenditure	Year-to-date Expenditure	Year to date Forecast Expenditure	Variance Forecast v Actual	Comments
	£000	£000	£000	£000	
Community Stadium	1,530	43	30	-13	
York Electrical Infrastructure	500	5	200	195	
Fire Alarm System SGH	820	744	820	76	
Other Capital Schemes	828	670	658	-12	
SGH Estates Backlog Maintenance	900	842	707	-135	
York Estates Backlog Maintenance - York	900	240	708	468	
Cardiac/VIU Extention	2,500	647	1,418	771	
Medical Equipment	200	240	178	-62	
SNS Capital Programme	1,800	959	1,427	468	
Capital Programme Management	1,372	1,248	1,086	-162	
Endoscopy Development	3,000	1,876	3,000	1,124	
Charitable funded schemes	624	468	468	0	
Wave 4 STP Fees	933	86	210	124	
Slippage	-547	0	0	0	
TOTAL CAPITAL PROGRAMME	**15,360**	**8,068**	**10,910**	**2,842**	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£000	£000	£000	£000	
Depreciation	10,400	4,986	5,436	4,964	
In Year Loan Repayments	-3,047	0	0	-3,047	
Loan Funding	6,000	2,528	4,418	1,582	
Charitable Funding	624	468	468	156	
Finance Lease funding	450	0	0	450	
PDC funding	933	86	210	723	
TOTAL FUNDING	**15,360**	**8,068**	**10,910**	**2,464**	

Key Messages:

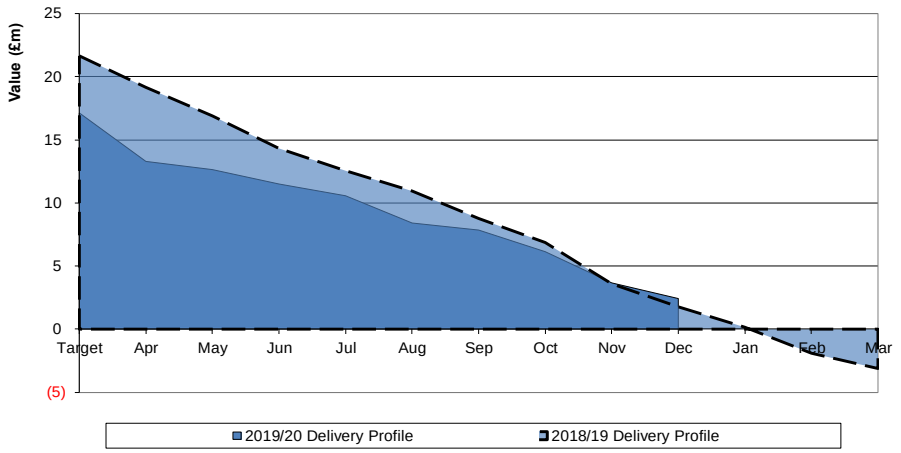
* Delivery - £14.7m has been delivered against the Trust annual target of £17.1m, giving a gap of £2.4m.
* Part year NHSI variance - The part year NHSI variance is £1.2m ahead of plan.
* Four year planning - The four year planning gap is £13.6m.
* Recurrent delivery is £9m in-year, which is 52.4% of the 2019/20 CIP target.

Efficiency - Total CIP

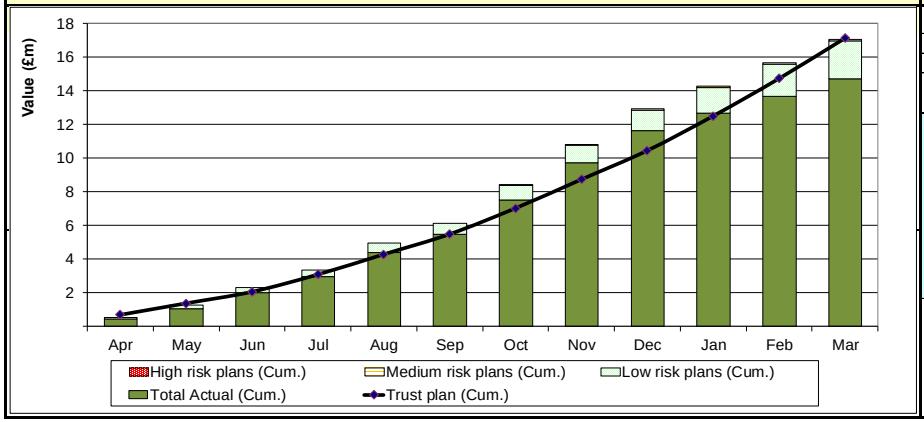
Executive Summary

	£m
2019/20 CIP Target	**£17.1**
In Year Delivery	
NHSI YTD Target at Month 9	£10.5
Actual Delivery at Month 9	£11.6
NHSI Variance Month 9	**£1.2**
Recurrent Delivery	£9.0
Non Recurrent Delivery	£5.7
Total Delivery	**£14.7**
In Year (Gap)/Surplus to Delivery	**-£2.4**
In Year Planning	
Forecasted Delivery	£17.1
Forecasted Planning (Gap)/Surplus	**-£0.0**
Long Term Planning	
4 Year CIP Target (19/20 to 22/23)	**£42.6**
4 Year Plans	£29.1
4 Year Planning (Gap)/Surplus	**-£13.6**

Gap to delivery 2019/20 - Progress profile compared to 2018/19



In Year CIP Delivery and Future Plans by Risk



Governance Risk Heat Map

Total Number of Schemes	333
Total Number of Assessed Schemes - Directorate	212
Total Number of Assessed Schemes - Signed Off	203

Probability/ Likelihood	Negligable - None				Catastrophic/death
Almost Certain	0		1		
	0				
	0	2			
	4	3	1		
Rare	173	25	3	0	

Consequence/Severity

Key Messages:
* Transactional CIP schemes represent £14.0m of the £17.1m Efficiency Target.
* Delivery at Month 9 is £12.9m of which £7.1m is recurrent.

Efficiency - Transactional CIP

Executive Summary

	£m
2019/20 Transactional CIP Target	**£14.0**
In Year Delivery	
NHSI YTD Target at Month 9	£8.7
Actual Delivery at Month 9	£10.3
NHSI Variance Month 9	**£1.6**
Recurrent Delivery	£7.1
Non Recurrent Delivery	£5.7
Total Delivery	**£12.9**
In Year (Gap)/Surplus to Delivery	**-£1.1**
In Year Planning	
Forecasted Delivery	£14.0
Forecasted Planning (Gap)/Surplus	**-£0.0**
Long Term Planning	
4 Year Transactional CIP Target (19/20 to 22/23)	**£36.7**
4 Year Plans	£23.1
4 Year Planning (Gap)/Surplus	**-£13.6**

Governance Risk Heat Map

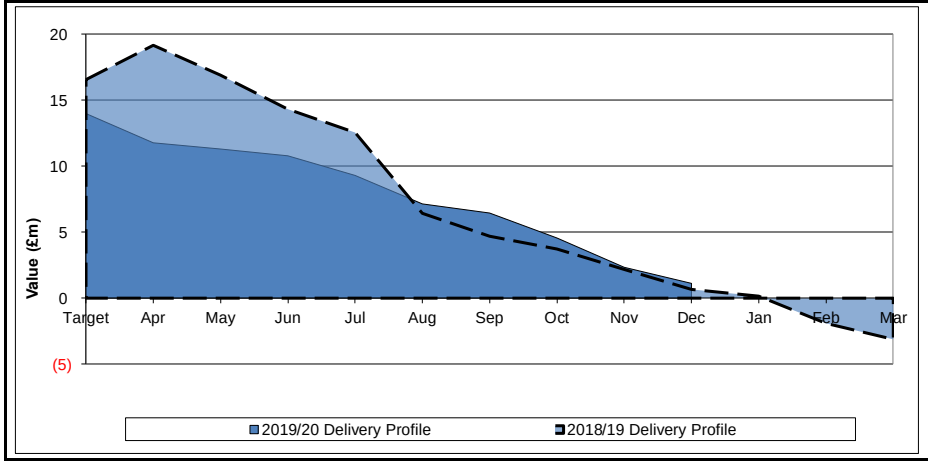
Total Number of Schemes	329
Total Number of Assessed Schemes - Directorate	208
Total Number of Assessed Schemes - Signed Off	199

Probability/ Likelihood	Negligable - None				Catastrophic/death
Almost Certain	0	0	1	0	0
	0	0	0	0	0
	0	2	0	0	0
	4	3	1	0	0
Rare	169	25	3	0	0

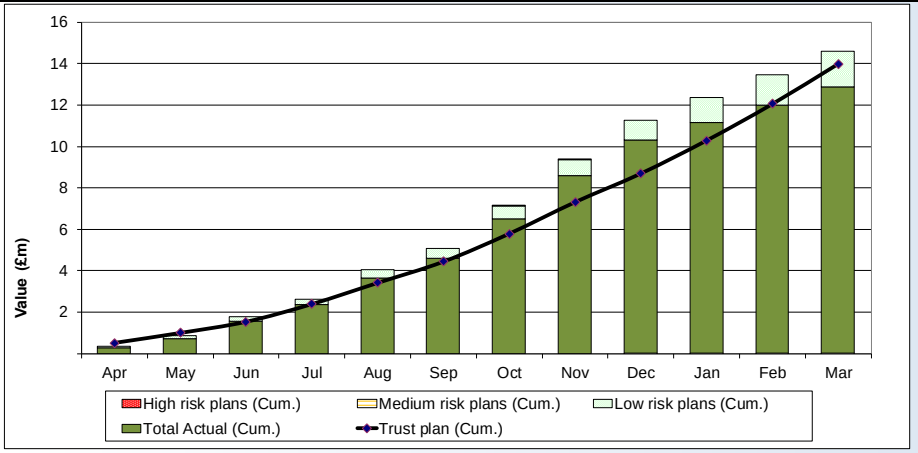
Consequence/Severity

Moderate Risk Plans:

Gap to delivery - 2019/20



In Year CIP Delivery and Future Plans by Risk



Key Messages:

* 5 Transformational schemes represent £3.1m of the £17.1m Efficiency Target.
* Delivery at Month 9 is £1.8m, of which £1.8m is recurrent.
* Project Plans are being developed for Transformational Schemes; the main themes are Outpatient Productivity, Theatre Productivity, Pharmacy Biosimilars, SNS Paperlite and Printer Strategy, E&F ADM and SIP.
* An Executive Summary of each Transformational Scheme forms part of the reporting pack.

Efficiency - Transformation Programme

Executive Summary

	£m
2019/20 Transformation CIP Target	**£3.1**
In Year Delivery	
NHSI YTD Target at Month 9	£1.8
Actual Delivery at Month 9	£1.3
NHSI Variance Month 9	**-£0.4**
Recurrent Delivery	£1.8
Non Recurrent Delivery	£0.0
Total Delivery	**£1.8**
In Year (Gap)/Surplus to Delivery	**-£1.3**
In Year Planning	
Forecasted Delivery	£3.1
Forecasted Planning (Gap)/Surplus	**£0.0**
Long Term Planning	
4 Year Transformation CIP Target	**£5.9**
4 Year Plans	£5.9
4 Year Planning (Gap)/Surplus	**£0.0**

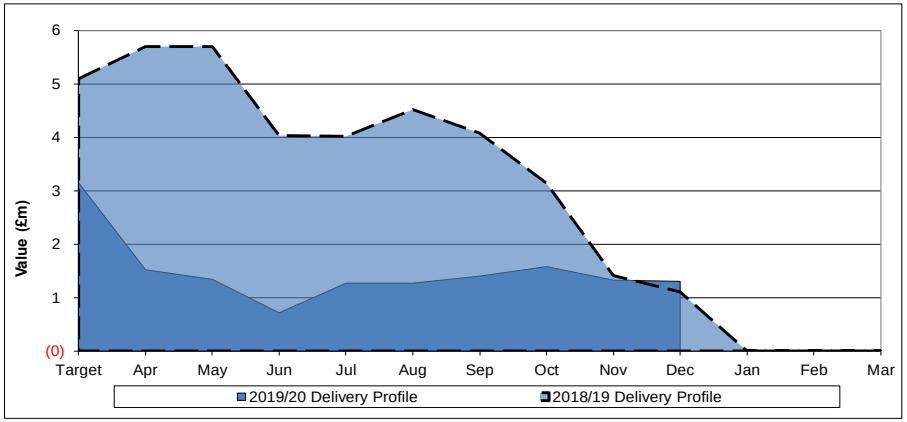
Governance Risk Heat Map

Total Number of Schemes	4
Total Number of Assessed Schemes - Directorate	4
Total Number of Assessed Schemes - Signed Off	4

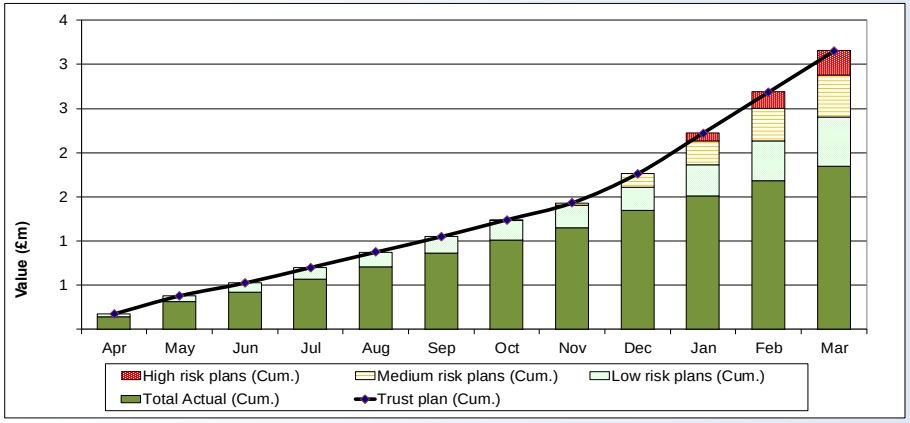
Probability/ Likelihood	Negligible - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	4	0	0	0	0

Consequence/Severity

Gap to delivery - 2019/20



In Year CIP Delivery and Future Plans by Risk

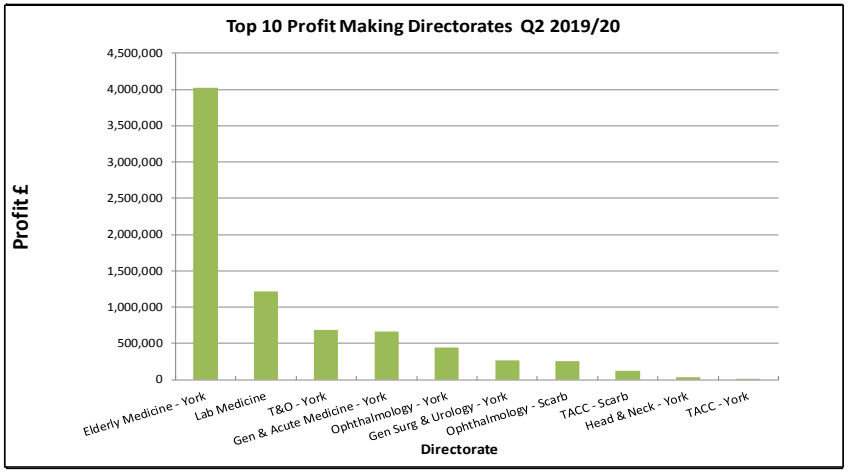


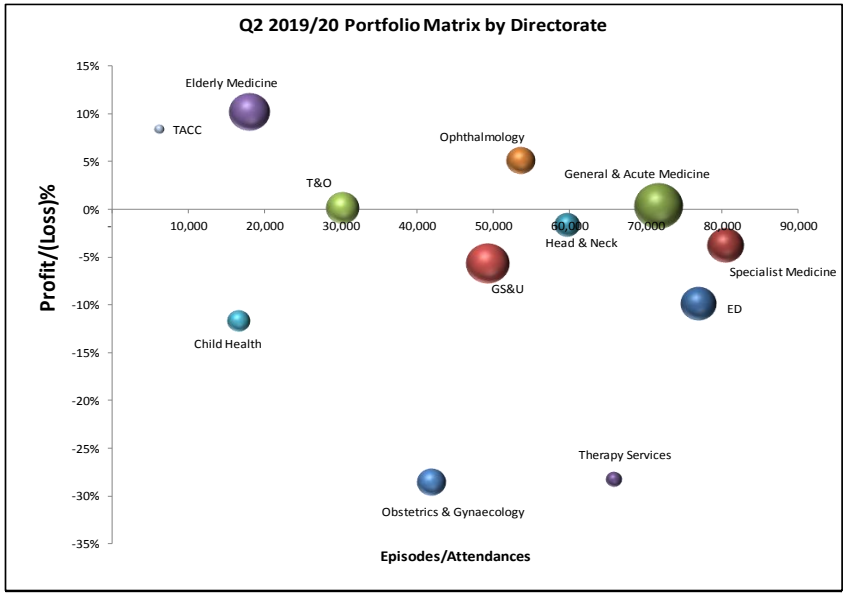
Service Line Reporting
Month 9 - The Period 1st April 2019 to 31st December 2019

York Teaching Hospital NHS Foundation Trust

Key Messages:

* Current data is based on Q2 2019/20
* The 2018/19 mandatory NHS Improvement National Cost Collection was successfully submitted in August 2019
* Q3 2019/20 reports are now a key focus for the team
* The SLR system configuration is on-going to ensure the year 2 NHS Improvement Costing Transformation Programme requires are achieved





DATA PERIOD	Q2 2019/20
CURRENT WORK	*The Q3 2019/20 reports are now the key focus for the team. * The Q3 2019/20 SLR reports will be delayed while the team work to configure the system for the new NHSI National Cost Collection requirements. * Work is on-going with SNS to replace the Directorate reporting field with Care Group information to allow the PLICS data to reported by Care Group
FUTURE WORK	* Care Group reports are bring developed to allow the SLR / PLICS data to be more easily interpreted and understood. * System configuration for the NHSI National Cost Collection PLICS submission is planned to run throughout 2019/20.

FINANCIAL BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£3.73m**

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NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 29 January 2020
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 (92% Low Risk and 8% Medium Risk). Full year delivery as at December 2019 is £14.7m.

The key risks to the programme are:

2019/20 - recurrent delivery £9.0m.
2020/21 - planning gap of £9.9m plus high risk plans of £1.7m
2021-24 - planning gap of £37m.

Recommendation

The Board of Directors is asked to note the December 2019 CIP position.

Author: Wendy Pollard, Deputy Head of Resource Management

Director Sponsor: Andrew Bertram, Finance Director

Date: January 2020

1. Summary reported position for December 2019

1.1 Current position – highlights

Delivery – Full year Delivery is £14.7m as at December 2019 which is (86%) of the target and has improved in month by £1.2m with the balance of £2.4m to be delivered over the final 3 months. This position compares to a delivery position of £19.9m in December 2018.

Part year delivery is £1.2m ahead of the profiled plan submitted to NHSI.

In year planning – At December 2019 the target of £17.1m is 100% planned (Low Risk £17m and Medium Risk £0.1m).

Five year planning – Five year planning (19/20 – 23/24) shows a gap of £47.5m.

Recurrent vs. Non recurrent – Of the £14.7m full year delivery, £9.0m has been delivered recurrently which is 53% of the overall target for 2019/20, an improvement of £0.5m in month. Recurrent delivery at December 2018 was £11m.

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

Delivery Performance
Delivery across Care Groups has improved in Month 9 with delivery of £1.2m. **Appendix 2 – Care Group and Directorate Performance** summarises delivery performance.

Transactional and Transformational schemes
Transactional schemes account for 82% of plans and full year delivery has improved by £1.2m. Transformation schemes account for 18% of Plans and delivery has remained static at £1.8m. At month 9 the ADM is £0.3m behind plan.

Appendix 3 – **Summary of Schemes by Category** summarises the year to date and full year delivery position. Month 9 showed an improvement on delivery across all Care Groups and Directorates.

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 2020/21 – 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	10,005	9,934	8,873	9,042
Initial non recurrent to recurrent carry forward	6,004	6,219	5,623	5,505
Total Target	**16,008**	**16,153**	**14,496**	**14,547**
Plans				
Low Risk	3,135	1,803	923	905
Medium Risk	1,246	391	1,121	833
High Risk	1,708	1,551	66	0
Total Plans	**6,089**	**3,745**	**2,110**	**1,738**
Shortfall against Target	**-9,919**	**-12,408**	**-12,386**	**-12,809**

Get It Right First Time (GIRFT)

Appendix 4 – GIRFT Highlight Report provides an update on the GIRFT Programme.

Reference Costs - National Cost Collection

The SLR & Costing team successfully submitted all the required 2018/19 National Cost Collection data to NHS Improvement on 8th August 2019. This encompassed the Reference Cost Submission and the newly mandated Patient Level Costing submission.

The National Cost Collection is an annual mandatory cost collection return that all providers of NHS healthcare are required to complete and submit to NHS Improvement / England.

In December 2019 the 2018/19 National Cost Collection summary results were published, with the Trust returning an overall index score of 94. The index score of 94 indicates that we have costs below the national average for our activity case mix, with 100 being the average. This index score has moved down 2 points from 96 in the 2017/18 submission.

This score provides a good level of assurance that the National Cost Collection process and the underlying data feeds are providing consistent data and accurate cost information outputs.

The national schedules of providers' PLICS data are expected to be published by the 30th January 2020. These are the full results from the National Cost Collection submission.

NHSI Support

The NHSI Review of the Back Office, Workforce and Procurement plans in December was favourable and demonstrated an improvement in plans with key actions having been addressed. Work is continuing to develop and implement plans.

Governance and Assurance

Quality Impact Assessment (QIA)

Quality Impact Assessments (QIA) are carried out following the Trust's Risk Management Framework.

Table 2 below tracks performance on QIA's from July to December.

Table 2 – QIA Performance

QIA 2019-20						
	July	Aug	Sept	Oct	Nov	Dec
Total No of schemes	270	280	306	315	342	333
Extreme	0	0	0	1	1	1
High	0	0	0	0	0	0
Moderate	15	9	6	6	6	6
Low	109	79	96	134	133	205
To be assessed	146	192	204	174	202	121

The Extreme and Moderate risk plans have been reviewed with JT (Medical Director) and these are summarised in **Appendix 5 – QIA**.

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 Care Groups.
- 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.
- Support from NHSEI.

RISK SCORES - DECEMBER 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	61%	HIGH	43%	HIGH	37%	HIGH	49%	HIGH	12	HIGH	26%	HIGH
CG2. Acute, Emergency and Elderly Scarborough	2,107	4,992	31%	HIGH	20%	HIGH	9%	HIGH	48%	HIGH	12	HIGH	33%	HIGH
CG3. Surgery	3,611	9,853	77%	HIGH	43%	HIGH	26%	HIGH	41%	HIGH	12	HIGH	88%	LOW
CG4. Cancer and Support Services	3,176	8,139	60%	HIGH	38%	HIGH	29%	HIGH	64%	HIGH	12	HIGH	65%	MEDIUM
CG5. Family Health	2,180	5,243	60%	HIGH	38%	HIGH	13%	HIGH	33%	HIGH	12	HIGH	34%	HIGH
CG6. Specialised Medicine	3,095	8,165	131%	LOW	74%	LOW	41%	HIGH	78%	HIGH	8	MEDIUM	70%	MEDIUM
Corporate Functions														
Chief Nurse Team	275	441	66%	HIGH	17%	HIGH	0%	HIGH	41%	HIGH	12	HIGH	33%	HIGH
Chairman and CEO	165	316	282%	LOW	224%	LOW	2%	HIGH	147%	LOW	6	LOW	0%	HIGH
SNS	215	431	46%	HIGH	46%	HIGH	17%	HIGH	29%	HIGH	12	HIGH	22%	HIGH
Ops Management	928	2,221	46%	HIGH	46%	HIGH	17%	HIGH	29%	HIGH	12	HIGH	0%	HIGH
Medical Governance	1,149	2,560	113%	LOW	95%	LOW	6%	HIGH	63%	HIGH	8	MEDIUM	0%	HIGH
Finance	1,211	3,240	236%	LOW	209%	LOW	103%	LOW	100%	MEDIUM	5	LOW	91%	LOW
Workforce and Organisational Development	54	98	290%	LOW	149%	LOW	2%	HIGH	263%	LOW	6	LOW	100%	LOW
Estates and Facilities	294	704	163%	LOW	91%	LOW	91%	LOW	89%	HIGH	6	LOW	100%	LOW
TRUST SCORE	**0**	**0**	**100%**	HIGH	**86%**	LOW	**52%**	LOW	**68%**	HIGH	**8**	MEDIUM	64%	MEDIUM

APPENDIX 2 - CARE GROUP AND DIRECTORATE PERFORMANCE TO MONTH 9 2019/20

		September			October			November			December			In Month Delivery		
Care Group	**Directorate**	**R**	**NR**	**Total**	**R**	**NR**	**Total**	**R**	**NR**	**Total**	**R**	**NR**	**Total**	**R**	**NR**	**Total**
1. Acute, Emergency and Elderly Medicine (York)	Community	19,910	0	19,910	19,910	0	19,910	102,897	3,170	106,067	102,933	3,170	106,103	36	0	36
	ED York	121,413	0	121,413	121,413	0	121,413	222,658	0	222,658	222,896	0	222,896	238	0	238
	General Medicine York	473,304	156,347	629,651	475,304	165,679	640,983	479,684	165,679	645,363	481,701	290,679	772,380	2,017	125,000	127,017
	Medicine for the Elderly York	160,737	0	160,737	160,737	0	160,737	162,197	0	162,197	162,666	0	162,666	469	0	469
1. Acute, Emergency and Elderly Medicine (York) Total		**775,364**	**156,347**	**931,711**	**777,364**	**165,679**	**943,043**	**967,436**	**168,849**	**1,136,285**	**970,196**	**293,849**	**1,264,045**	**2,760**	**125,000**	**127,760**
2. Acute, Emergency and Elderly Medicine (Scarborough)		137,557	163,940	301,497	137,575	216,440	354,015	175,055	240,688	415,743	190,632	251,788	442,420	15,577	11,100	26,677
2. Acute, Emergency and Elderly Medicine (Scarborough) Total		**137,557**	**163,940**	**301,497**	**137,575**	**216,440**	**354,015**	**175,055**	**240,688**	**415,743**	**190,632**	**251,788**	**442,420**	**15,577**	**11,100**	**26,677**
3. Surgery	GS&U	191,465	79,582	271,047	243,053	96,381	339,434	273,478	496,510	769,988	542,975	298,898	841,873	269,497	-197,612	71,885
	Head and Neck	141,441	35,612	177,053	142,517	35,612	178,129	142,629	35,612	178,241	142,689	35,612	178,301	60	0	60
	TACC	323,946	304,868	628,814	350,308	304,868	655,176	357,574	320,868	678,442	164,597	212,312	376,909	-192,977	-108,556	-301,533
3. Surgery Total		**656,852**	**420,062**	**1,076,914**	**735,878**	**436,861**	**1,172,739**	**773,681**	**852,990**	**1,626,671**	**850,261**	**546,822**	**1,397,083**	**76,580**	**-306,168**	**-229,588**
4. Cancer and Support Services	Cancer	8,684	10,000	18,684	8,684	10,000	18,684	8,789	70,000	78,789	9,961	70,000	79,961	1,172	0	1,172
	Endoscopy	1,166	0	1,166	1,166	0	1,166	40,231	60,000	100,231	40,963	60,000	100,963	732	0	732
	Lab Medicine	202,787	42,142	244,929	202,787	42,142	244,929	300,420	85,366	385,786	300,420	85,366	385,786	0	0	0
	Pharmacy	364,512	0	364,512	364,512	0	364,512	367,177	0	367,177	378,273	0	378,273	11,096	0	11,096
	Radiology	201,717	69,998	271,715	202,195	69,998	272,193	206,772	69,998	276,770	217,413	93,883	311,296	10,641	23,885	34,526
4. Cancer and Support Services Total		**778,866**	**122,140**	**901,006**	**779,344**	**122,140**	**901,484**	**923,389**	**285,364**	**1,208,753**	**947,030**	**309,249**	**1,256,279**	**23,641**	**23,885**	**47,526**
5. Family Health	Child Health	171,911	178,315	350,226	173,081	178,315	351,396	194,691	296,431	491,122	194,885	296,431	491,316	194	0	194
	Sexual Health	6,114	119,842	125,956	6,114	119,842	125,956	19,113	155,366	174,479	19,113	155,366	174,479	0	0	0
	Womens Health	15,347	37,266	52,613	16,011	37,266	53,277	67,801	73,936	141,737	70,597	89,954	160,551	2,796	16,018	18,814
5. Family Health Total		**193,372**	**335,423**	**528,795**	**195,206**	**335,423**	**530,629**	**281,605**	**525,733**	**807,338**	**284,595**	**541,751**	**826,346**	**2,990**	**16,018**	**19,008**
6. Specialised Medicine	Ophthalmology	20,637	43,000	63,637	20,637	43,000	63,637	20,637	148,000	168,637	20,637	148,000	168,637	0	0	0
	Orthopaedics	279,721	49,000	328,721	282,417	49,000	331,417	297,872	34,000	331,872	506,864	142,556	649,420	208,992	108,556	317,548
	Specialist Medicine	915,289	52,603	967,892	903,817	302,427	1,206,244	903,860	818,429	1,722,289	903,904	818,429	1,722,333	44	0	44
6. Specialised Medicine Total		**1,215,647**	**144,603**	**1,360,250**	**1,206,871**	**394,427**	**1,601,298**	**1,222,369**	**1,000,429**	**2,222,798**	**1,431,405**	**1,108,985**	**2,540,390**	**209,036**	**108,556**	**317,592**
7. Corporate Functions	Chief Exec	208	234,180	234,388	208	272,420	272,628	3,208	312,404	315,612	3,208	365,639	368,847	0	53,235	53,235
	Chief Nurse Team	0	48,000	48,000	0	48,000	48,000	0	48,000	48,000	0	48,000	48,000	0	0	0
	CIP Reserve	2,662,243	108,347	2,770,590	3,356,447	610,206	3,966,653	3,356,447	627,136	3,983,583	3,356,447	1,292,875	4,649,322	0	665,739	665,739
	Estates and Facilities	383,967	0	383,967	413,137	0	413,137	413,137	0	413,137	584,687	0	584,687	171,550	0	171,550
	Finance	268,742	227,971	496,713	272,960	255,779	528,739	298,302	293,417	591,719	302,163	312,649	614,812	3,861	19,232	23,093
	Medical Governance	3,195	0	3,195	3,195	3,966	7,161	3,195	48,184	51,379	3,195	50,487	53,682	0	2,303	2,303
	Ops Management	26,931	18,672	45,603	30,543	7,668	38,211	30,543	52,668	83,211	31,077	52,668	83,745	534	0	534
	SNS	0	50,000	50,000	17,115	50,000	67,115	17,115	240,000	257,115	17,115	240,000	257,115	0	0	0
	Workforce & organisational developm	3,449	148,700	152,149	3,473	148,700	152,173	3,473	307,383	310,856	3,473	322,551	326,024	0	15,168	15,168
7. Corporate Functions Total		**3,348,735**	**835,870**	**4,184,605**	**4,097,078**	**1,396,739**	**5,493,817**	**4,125,420**	**1,929,192**	**6,054,612**	**4,301,365**	**2,684,869**	**6,986,234**	**175,945**	**755,677**	**931,622**
Grand Total		**7,106,393**	**2,178,385**	**9,284,778**	**7,929,316**	**3,067,709**	**10,997,025**	**8,468,955**	**5,003,245**	**13,472,200**	**8,975,484**	**5,737,313**	**14,712,797**	**506,529**	**734,068**	**1,240,597**

Appendix 3 - Summary of Efficiency Programme by Category

The 3 tables below summarise the position of the overall Efficiency Programme by category.

- **Table 1** provides a summary of the over-arching Efficiency programme.
- **Table 2** provides a summary of the Transformational schemes.
- **Table 3** provides a summary of the over-arching Efficiency programme analysed by Carter category. This will include both transformational and transactional schemes.

Table 1: Efficiency Programme Summary

Programme Category	Annual Plan £'m	Full Year Delivery £'m	Full Year Recurrent Delivery £'m	Full Year Non Recurrent Delivery £'m	NHSI Plan YTD £'m	Total Delivery YTD £'m
Transactional	£14.0	£ 12.9	£ 7.2	£ 5.7	£ 8.7	£ 10.3
Transformational	£ 3.1	£ 1.8	£ 1.8	£ 0.0	£ 1.8	£ 1.3
Total Programme	**£17.1**	**£ 14.7**	**£ 9.0**	**£ 5.7**	**£ 10.5**	**£ 11.6**

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	£ 0.7	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
Outpatients	£ -	£ -	£ -	£ -	£	£ -
ADM	£ 0.8	£ 0.4	£ 0.4	£ 0.0	£ 0.6	£ 0.3
Pharmacy	£ 1.3	£ 1.3	£ 1.3	£ 0.0	£ 1.0	£ 1.0
Paperlite	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ -	£ 0.0
Printer Strategy	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
Scarborough Single Improvement Programme	£ 0.1	£ 0.0	£ 0.0	£ 0.0	£ 0.2	£ 0.0
Ophthalmology	£ 0.1	£ 0.0	£ 0.0	£ 0.0	£ 0.0	£ 0.0
District Nursing	£ 0.1	£ 0.1	£ 0.1	£ 0.0	£ 0.0	£ 0.0
Total Transformational Schemes	**£ 3.1**	**£ 1.8**	**£ 1.8**	**£ 0.0**	**£ 1.8**	**£ 1.3**

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	£ 0.7	£ 0.6	£ 0.1	£ 0.5	£ 0.6
Carter W/force (Nursing)	£ 1.4	£ 1.0	£ 0.8	£ 0.2	£ 0.8	£ 0.8
Carter W/force (AHP)	£ 0.2	£ 0.4	£ 0.4	£ 0.0	£ 0.1	£ 0.3
Carter W/force (Other)	£ 1.8	£ 2.0	£ 0.1	£ 1.8	£ 1.3	£ 1.8
Carter Procurement	£ 3.2	£ 3.3	£ 2.0	£ 1.2	£ 2.2	£ 2.4
Carter Hospital Medicine & Pharmacy	£ 2.0	£ 1.7	£ 1.7	£ 0.0	£ 1.4	£ 1.3
Carter Corporate & Admin	£ 0.5	£ 3.7	£ 1.7	£ 2.0	£ 0.4	£ 2.9
Carter Estates & Facilities	£ 1.0	£ 0.8	£ 0.8	£ 0.0	£ 0.7	£ 0.6
Carter Imaging	£ 0.5	£ 0.3	£ 0.2	£ 0.1	£ 0.4	£ 0.2
Carter Pathology	£ 0.6	£ 0.3	£ 0.3	£ 0.1	£ 0.3	£ 0.3
Other Savings Plans/Unidentified	£ 3.9	£ 0.5	£ 0.4	£ 0.2	£ 2.4	£ 0.4
Total Programme by Carter Category	**£17.1**	**£ 14.7**	**£ 9.0**	**£ 5.7**	**£ 10.5**	**£ 11.6**

It should be noted that Transformational Schemes will also be included in the Carter Categories.

Appendix 4 - Highlight Report

GIRFT Assurance Board Update at 7th January 2020

This report provides a brief update of work completed for the period from 1st November to 31st December 2019.

Progress Update at 31st December 2019

Shared Learning – following an initial meeting with the Learning Hub administrator (Steph Wild) there is now a dedicated space on the Trust's Learning Hub. This will provide the local GIRFT team with the opportunity to develop a *Shared Learning* area and share its content across the Trust. This work continues and further updates will be provided.

NHS Litigation Review – the initial review of open surgical claims highlighted in the last report has now been completed with initial observations being captured by Richard Khafagy. A further meeting is planned for this month with the Trust's Legal team to assess progress and agree next steps.

New Datix Dashboard –has been created within Datix that helps Care Groups to see their current legal claims more easily. This new dashboard will help to support the litigation review work going forward and should improve the visibility of legal claims currently in progress.

Internal Review Meetings – there have been two internal review meetings with Respiratory Medicine and Renal Medicine. A GIRFT dashboard and associated actions are being finalised with Respiratory Medicine. A key action for Respiratory Medicine is to review their data collection processes as this was highlighted as a weakness.
Work has already started on investigating the accuracy and completeness of Outpatient procedures / diagnostic coding and has highlighted omissions within the CPD system. The internal GIRFT project team are seeking support from the SLR team and Informatics team to help resolve this issue.

External Review Meetings & National Reports Issued – there have been two deep dive GIRFT visits in December for Acute & General Medicine and Rheumatology. We are expecting the deep dive reports in January 2020. Review meetings will be scheduled early in New Year to identify and agree follow on actions.

GIRFT Activity Highlights: 1st November to 21st January 2020

Date	Activity	Next Steps
12th Nov	Internal review meeting with Respiratory Medicine and follow on actions agreed with GIRFT dashboard completed.	Monitor progress against agreed actions.
18th Nov	Request for second review meeting for Vascular surgery received	CG3 scheduling meeting
19th Nov	'Shared Learning' space created on Learning Hub and training provided to GIRFT project team	Develop 'Shared Learning' pages on learning hub and gather feedback
25th Nov	Neonatology data packs completed and returned to national team	Await data for visit from national GIRFT team
December		
2nd Dec	External GIRFT Deep Dive meeting| Acute & General Medicine delivered	Wait for Observation report to be published in January 2020
10th Dec	Internal review meeting with Renal Medicine	Agree follow on actions from GIRFT recommendations
10th Dec	External GIRFT Deep dive meeting Rheumatology	Await Observation report expected January 2020
20th Dec	Received Deep dive request for Lung Cancer	Requested dates from Care Group 4
Jan		
7th Jan	External GIRFT Vascular Surgery Revisit	Scheduled
21st Jan	External GIRFT Deep dive meeting Cardiology	Await Observation report expected February 2020

Appendix 5 - Directorate QIA Assessment - Extreme and Moderate Risk Schemes - DECEMBER 2019

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	2019/20 Scheme Value £'000	Month 8 - Responses to Medical Director Queries High/Mod Risk Schemes
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	64.5	I can confirm that the transformation was informed by a detailed scoping exercise carried out over a year looking in depth at the tasks being done by teams using the Calderdale approach. It was written up as a proposal which went to Board (copy saved in scheme log) In implementing the project, detailed work was undertaken to understand the size of each caseload within the five new teams and allocate an equitable number of care hours for each team. The risk being described is that there could be some element of these calculations that turns out to be wrong (either a flaw in the extracting from SystmOne or the methodology that was used to make the calculations). We have mitigated this through the involvement of frontline staff in developing the programme and also by re-running the numbers prior to go live. I think the assessment of the potential harm level, and that this is unlikely, feel accurate but I am confident that we have the right level of awareness of the potential risks and the monitoring of this to allow us to take action to address any adverse consequences.
CG 2	Care Group 2	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	40.5	We are happy for this to be recorded as Low Risk.
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	I think there is some confusion. Additional activity doesn't improve access targets and performance if it is delivered with no additional capacity as it creates longer waiting times.
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	20	
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	6	
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	The risk is we have no plaster technician cover at the east coast so will not be able to provide the full plaster service for fracture clinics. We cannot also source locum cover. The consequence is delays in plaster fro fractures or patients having to travel to York
												TOTAL	177	

Corporate Efficiency Team Sign Off (Please return with	
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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 29 January 2020
Workforce Report – January 2020

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 December 2019 where available); and an overview of work being undertaken to address workforce challenges.

Executive Summary – Key Points

- The Trust continues to welcome International Nurses to the Trust, with a total of 49 international recruits joining the Trust since May 2019.
- 67% of frontline healthcare workers in the Trust have received the 'flu vaccine (up to 3rd January 2020).
- Statutory and Mandatory training reports shows that compliance within the Medical and Dental staff group remains challenging across all six Care Groups and medics are now being written to urging them to take steps to improve their compliance.
- Nearly 2,000 staff participated in the Our Voice Our Future online workshops. Feedback will be analysed and plans cascaded to the organisation after being shared with the Board in February.

Recommendation

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

Author: Siân Longhorne, Deputy Head of Resourcing

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

Date: January 2020

1. Introduction and Background

January's Workforce Report sets out the current position for vacancies, sickness absence, temporary staffing utilisation and statutory and mandatory training. There is additional coverage of ongoing health and wellbeing and staff engagement initiatives.

2. Vacancies

Appendices one to five show the detail of vacancies within: nursing and midwifery (including unregistered workforce); medical and dental; and other registered workforce, including tracker graphs showing the nursing and medical and dental vacancies rates since October 2018 (i.e. when we first started to report vacancies in the current format).

International nurse recruitment update

The International Nurse Recruitment Project has welcomed 49 nurses across the Trust since May 2019, 37 in York and 12 in Scarborough. Six nurses returned to Northampton during week commencing 6th January; four to re-sit their OSCE and two to complete their ID checks and so they are expected to be registered with the NMC shortly after that.

The team welcomed 16 nurses (10 from the HEE Global Learners Programme) on Friday 10th January ready for their induction at Scarborough the following week, and they are scheduled to take their OSCE in Ulster on the 5th February.

We are expecting a further 10 to join us in York next month. We are now being approached by nurses who are friends of those who have already joined us generating another pipeline for candidate attraction. We are also supporting four current members of staff, who are qualified nurses in their own country, with their NMC application and who will join the OSCE preparation programme as soon as they are able.

Medical vacancies

The Trust is continuing to report a medical vacancy figure below 10% on each of its main hospital sites with the overall vacancy rate at the start of January 2020 being 6.8%.

There have been 16 new starters across all medical grades over the two months (November and December 2019) since the last report. This includes seven Consultants; three at the Scarborough site in Anaesthetics, Orthopaedics and a Locum Consultant in Gastroenterology and four at the York site in Gastroenterology, Ophthalmology and two (including one Locum Consultant) in Anaesthetics.

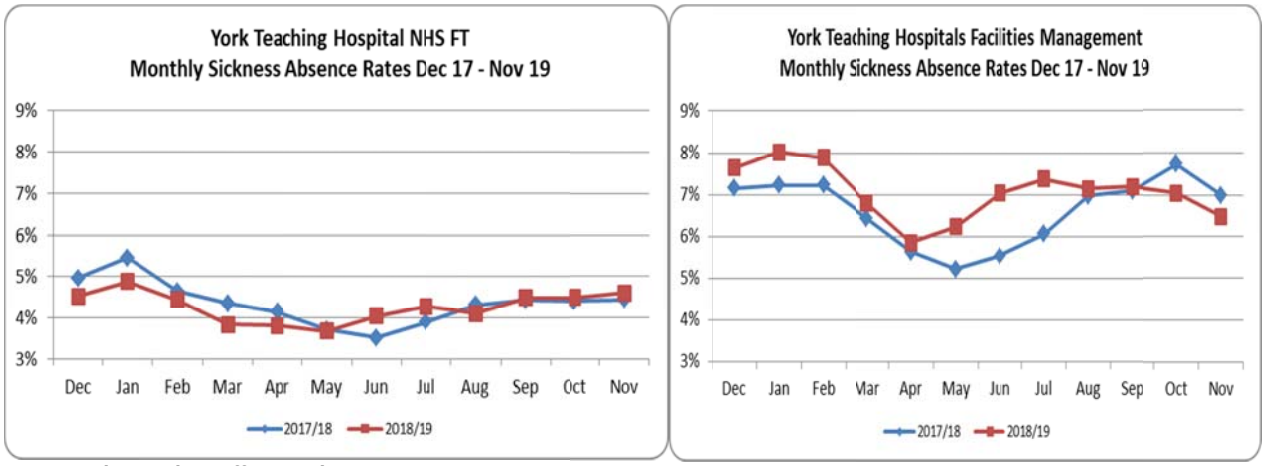
Other vacancies

Appendix 5 shows the detail of vacancies within other staff groups. This does not include pending starters.

3. Health & Wellbeing

Sickness absence rates

Charts 1 and 2 – Monthly Sickness Absence Rates



Source: Electronic Staff Record

Charts 1 and 2 show monthly sickness absence rates for the Trust and York Teaching Hospital Facilities Management (YTHFM), covering the period December 2017 to November 2019.

The monthly absence rate in the Trust in November 2019 was 4.60%; in the last three months for which there is data available, the Trust's monthly absence rate has been slightly above the rate in the same month of the previous year.

YTHFM continue to report a higher rate of absence. In November 2019, this was 6.49%. However, this was the first time in six months that the rate had fallen below 7%. In the last two months for which there is data available, the absence rate has been below the rate reported in the same month of the previous year.

Health and Wellbeing Initiatives

A review of the Sickness Absence policy commenced in November 2019. A review of the Sickness Absence training will also take place in the first quarter of 2020.

A sickness strategy action plan has been compiled for NHSI and some of the key actions on this include the introduction of Care Group/LLP Sickness Scrutiny Meetings and the identification of sickness hotspot areas within the Care Groups and the LLP.

The Trust is reviewing its flexible working policies in 2020. Flexible working is a key contributor to employee health and wellbeing and diversity in the workplace and has been raised as part of the Staff survey on-line workshops. The policy review will also link with existing Trust practices such as our eRoster requirements to ensure a joined up approach.

The Mental Health Working Group will be re-established in 2020. Current work for early 2020 will include exploring Mental Health First Aid courses, in partnership with trade unions and continuing to progress mental wellbeing initiatives such as Schwartz Rounds,

RAFT (Risk Assessment Following Trauma) and RPGs (Reflective Practice Groups) which are ongoing and are well received.

'Flu Campaign

The Trust has a vaccination rate of 67% at 3 January 2020. The target for frontline staff vaccinations this campaign is 80%. This needs to be achieved by the end of February 2020. The Trust achieved 71% in 2018/19. Historically vaccine uptake slows considerably in January and February and so significant efforts are required if we are to meet the target, as this equates to 887 frontline staff. However the Trust has 17 trained peer vaccinators across the organisation who are able to provide a targeted and responsive vaccination service to the Care Groups. Data has been shared with operational managers and peers vaccinators to target wards and service areas with low frontline vaccination rates. There are also Occupational Health run clinics on Scarborough and York sites in January. Whilst the vaccine is not mandatory, medical and nursing colleagues are being reminded it is their professional duty to be vaccinated.

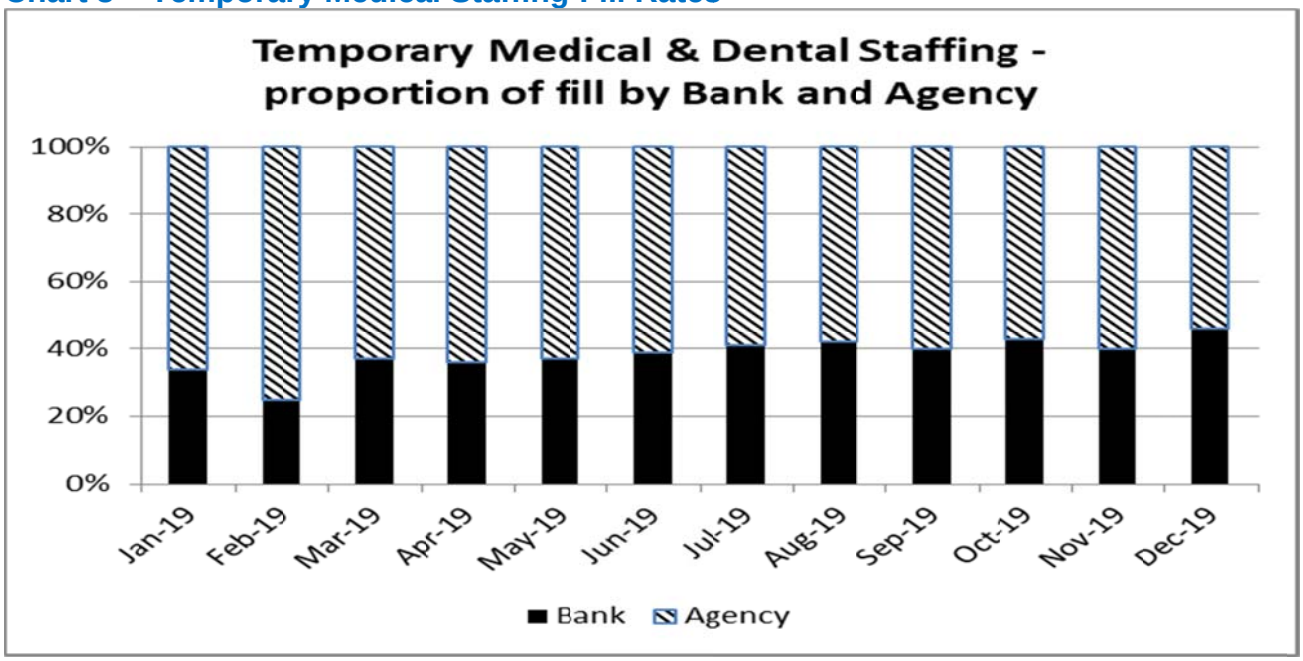
4. Temporary Staffing

Temporary Medical Staffing

During December 2019, 105.14 FTE Medical & Dental roles were covered by a combination of bank (46%) and agency workers (54%).

A Business Case has recently been approved for the Trust to procure 'Patchwork' a bank management technology solution. During a pilot of using this system for management of medical temporary staffing requirements in 2019, the Trust saw benefits in terms of increasing bank uptake and achieving back office efficiencies in managing the associated administration processes. A meeting is due to take place later in January with the Patchwork team to improve the availability of management information from the system.

Chart 3 – Temporary Medical Staffing Fill Rates



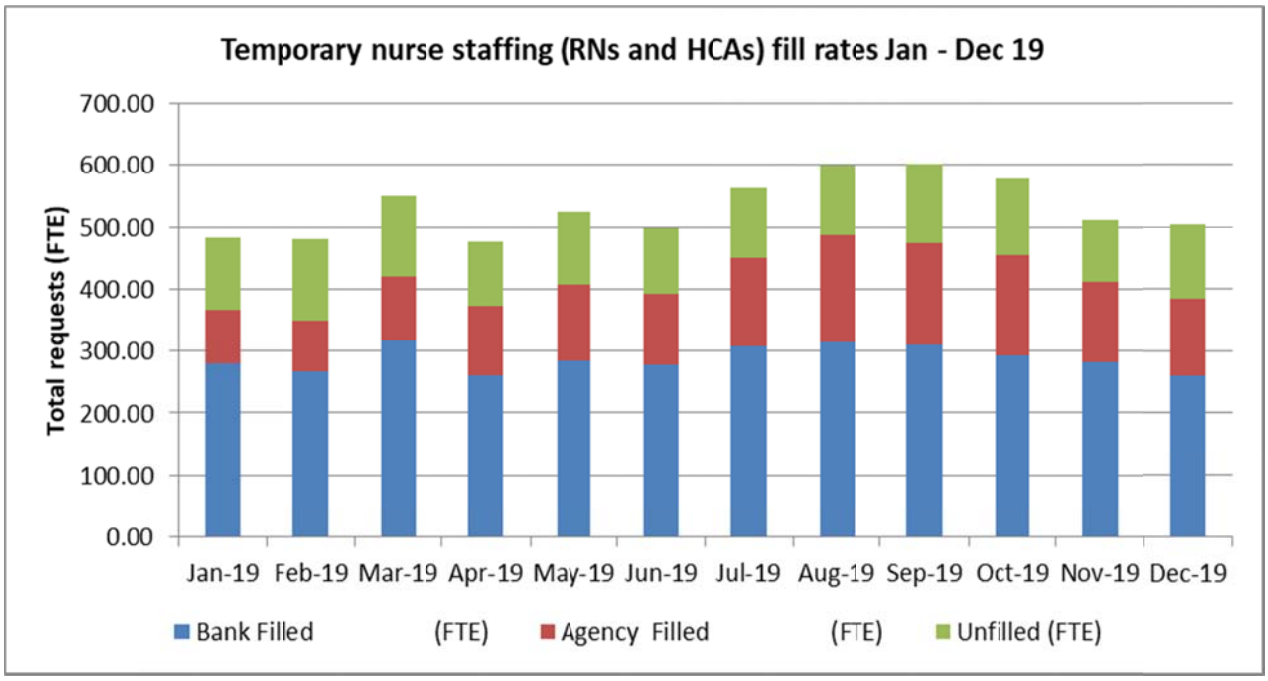
Source: Medical Rostering Records

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) across the Trust during the quarter October – December 2019 was, on average, 531 FTE per month. Whilst this was a reduction compared to the previous quarter (July – September 2019) when demand was, on average, 588 FTE per month, it is significantly higher than in the same period of the previous year (October – December 2018) when demand was, on average, 452 FTE per month. The reasons for this are not changed for those previously reported, i.e. a higher level of sickness amongst registered staff, a higher real-time vacancy level at Scarborough Hospital and increases to staffing following the inspection by the Care Quality Commission.

Chart 4 shows the number of all shifts requested that were either filled by bank, agency or were unfilled in each of the last 12 months. On average, 52.59% of shift requests in the quarter October - December 2019 were filled by bank staff. The average agency fill rate for the same period was 25.84%. The Trust is currently offering an incentivised rate of pay to bank staff for the winter period. This represents a 15% increase for substantive staff working on the bank; and 10% for bank-only workers.

Chart 4 – Temporary Nurse Staffing Fill Rates



Source: BankStaff

5. Statutory and Mandatory Training Update

Corporate Induction compliance in December 2019 was 95%, while overall compliance with Statutory and Mandatory Training was 84%.

As has previously been reported, the Trust's priority is to improve compliance within the Medical and Dental staff group. This staff group is not currently achieving core training compliance with the target of 85% in any Care Group. Medics in Care Groups 2 and 3 were written to by the Medical Director and Director of Workforce and OD in December

2019 with a copy of their training records urging them to prioritise improving their compliance over the next two months. There are plans to continue this programme across the other Care Groups in due course.

Appendix 6 presents core and essential training compliance by Care Group and also detailed compliance for the medical and dental staff group.

6. Implementation of CQC Recommendations

ED Rotas

Care Group 1 is reviewing its Emergency Department workforce as a priority, including recommendations from ECIST. The review covers Medical, Nursing, AHP and potentially some non-clinical roles. Specifically it will include a re-design of the medical Senior Decision Makers rota, to ensure cover makes allowance for the variation in patient footfall at different times/days of the week. It will also include ring-fenced Emergency Physician in Charge (EPIC) and Nurse in Charge (NIC) roles. The nursing review also includes a skill mix change to ensure senior cover is available in relevant areas at appropriate times throughout the day/week. The Care Group have recently appointed two x 6 month clinical improvement posts (1WTE), one for streaming in ED and one for SDEC in medicine to lead the frontline changes required to develop in these areas. Other priorities include making the junior medical rota compliant with a 1 in 3 weekend (currently a 1 in 2), filling the large number of medical vacancies, and addressing age profile issues such as developing ENPs of the future.

Care Group 2 is also reviewing its Emergency Department staffing requirements and rotas. This work will form part of the wider medical and clinical staffing modelling work which is a key part of the Care Group's Single Improvement Programme for 2020. The review will consider all staff groups (ie AHP and Nursing as well as medics) and the role of system partners to ensure a broad approach. Specifically it will likely include a re-design of the ED Tier 2 rota from next August and a deep dive into the hospital's "on call" team who effectively sit as part of the Front of House and provide an important input to the ED, particularly out of hours. Options such as annualisation will be explored and current consultant on call working arrangements will be reviewed.

Care Groups 1 and 2 will work collaboratively to ensure any changes which could impact on the overall organisational approach are picked up.

7. Culture and Engagement

The Our Voice Our Future online workshop closed on 24 December 2019, after being open for approaching 11 weeks. Nearly 2000 staff have accessed the site, suggesting 460 ideas with over 1200 comments and 11445 votes. The most popular ideas include increasing our recycling in the hospitals, sourcing a new intranet and staff wanting kindness to be a behaviour championed across the Trust. The next steps are for the data to be analysed by Clever Together who will also use the findings from the latest staff survey. They will theme the feedback and present the initial findings and plans at the beginning of February. Further clarification will be sought through an additional, 10 day

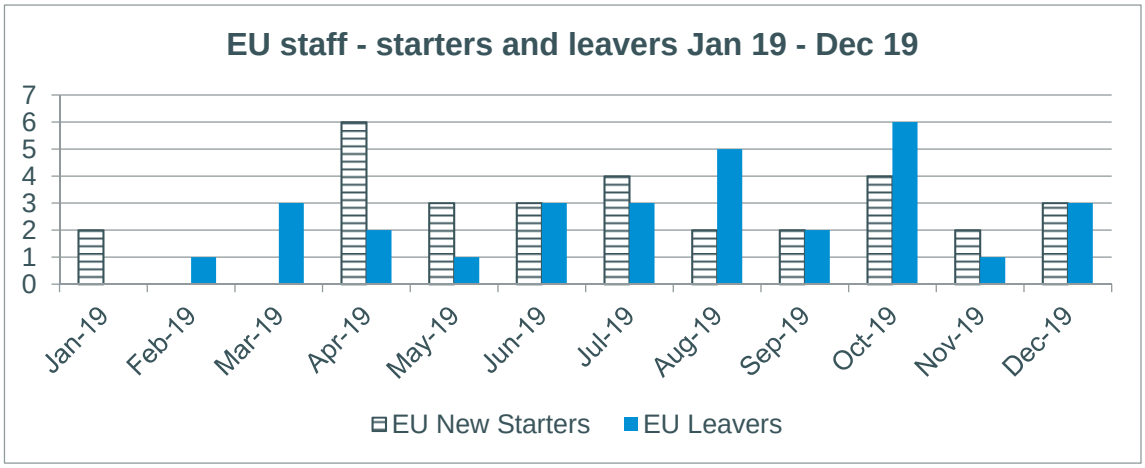
'validation online workshop' as a sense check with the expectation that the plans will be shared with the Executive Board and Trust Board in February and then cascaded out to the organisation.

In the interim, the Trust is keen to show that we have listened to staff's ideas and has started to move forward with a variety of proposals both corporately and within individual Care Group/Directorates from both the online workshops and the staff survey results. These will be communicated throughout January.

8. EU Workforce and Brexit

As at 31 December 2019, 283 EU nationals were employed by the Trust on permanent or fixed term contracts. In the year to December 2019 a total of 31 staff from within the EU joined the organisation while 30 staff left over the same time period. The turnover rate of permanent EU staff (based on headcount) between 1 January 2019 and 31 December 2019 was 10.67%.

Chart 6 – EU Staff Starters and Leavers



9. Detailed Recommendation

The Board of Directors is asked to read the report and discuss.

Appendix 1 – Nursing and midwifery vacancy position to end of December 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	2,121.53	96.03	1,019.07	1,879.69	115.51	960.07	34.16		25.23	207.68	-19.48	33.77	9.79%	-20.29%	3.31%

York

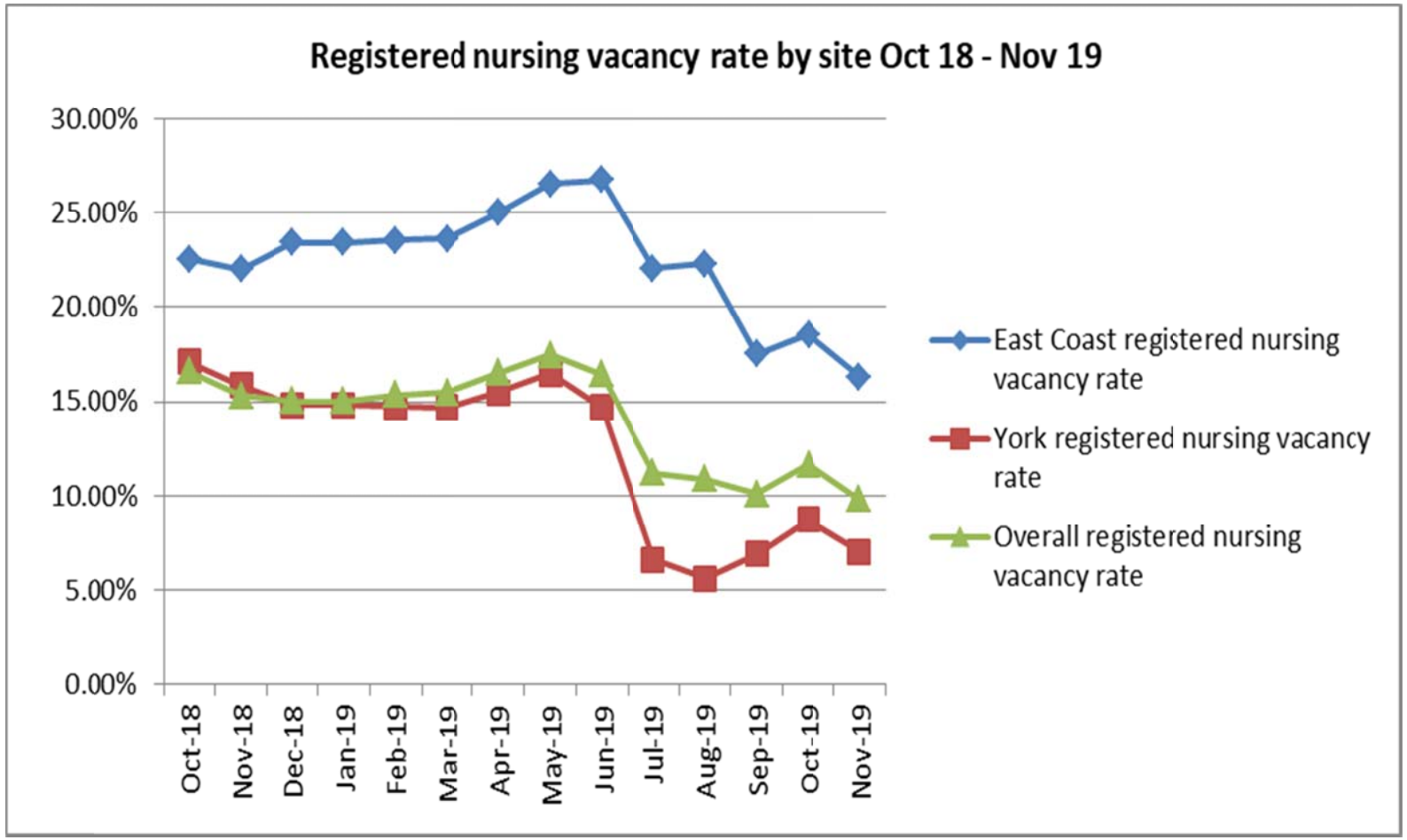
	Budgeted Establishment			Staff in post			Starters in next 3 month			Net Vacancy					
										WTE			%		
	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3	B5-7	B4	B2-3
York	1,483.58	76.27	675.87	1,363.24	87.04	636.81	16.62		23.83	103.72	-10.77	15.23	6.99%	-14.12%	2.25%

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 & Bridlington	637.95	19.76	343.20	516.45	28.47	323.26	17.54		1.4	103.96	-8.71	18.54	16.30%	-44.08%	5.40%

*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 Nursing Vacancy Position October 2018- November 2019



Appendix 3 – Registered medical and dental vacancy position January 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%**	**16**	**2**	**1**	**0**	**18.8%**	**54**	**3**	**2**	**4**	**1.9%**	**27**	**1**		**0**	**3.7%**	**122**	**13**	**3**	**6**	**8.2%**
Elderly Medicine	5	1	0	1	**0.0%**	2	0			**0.0%**	16	1	0	1	**0.0%**	5	0			**0.0%**	28	2	0	2	**0.0%**
Emergency & Acute Medicine	7	2	0	1	**14.3%**	11	2	1	0	**27.3%**	17	1	2	3	**0.0%**	4	0			**0.0%**	39	5	3	4	**10.3%**
General Medicine	13	4		0	**30.8%**	3	0			**0.0%**	21	1	0	0	**4.8%**	18	1		0	**5.6%**	55	6	0	0	**10.9%**
Care Group 3	**22**	**2**	**1**		**13.6%**	**15**	**0**	**1**	**0**	**6.7%**	**16**	**3**	**1**	**3**	**6.3%**	**10**	**0**		**0**	**0.0%**	**63**	**5**	**3**	**3**	**7.9%**
General Surgery & Urology	4	0	1		**25.0%**	5	0		0	**0.0%**	7	3	1	3	**14.3%**	9	0		0	**0.0%**	25	3	2	3	**8.0%**
Head & Neck						3	0			**0.0%**						1	0			**0.0%**	4	0	0	0	**0.0%**
Theatres, Anaesthetics & CC	18	2	0		**11.1%**	7	0	1	0	**14.3%**	9	0		0	**0.0%**						34	2	1	0	**8.8%**
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	**19**	**3**	**0**		**15.8%**	**4**	**0**	**0**		**0.0%**	**16**	**1**	**0**	**0**	**6.3%**	**6**	**0**	**0**		**0.0%**	**45**	**4**	**0**	**0**	**8.9%**
Child Health	11	3	0	2	**9.1%**	1	0			**0.0%**	8	1	0	0	**12.5%**	4	0			**0.0%**	24	4	0	2	**8.3%**
Obstetrics & Gynaecology	8	0			**0.0%**	3	0	0		**0.0%**	8	0	0	0	**0.0%**	2	0	0		**0.0%**	21	0	0	0	**0.0%**
Care Group 6	**17**	**0**	**0**	**0**	**0.0%**	**9**	**2**		**0**	**22.2%**	**9**	**2**		**1**	**11.1%**	**2**	**0**			**0.0%**	**37**	**4**	**0**	**1**	**8.1%**
Ophthalmology	3	0		0	**0.0%**	3	2		0	**66.7%**	1	0			**0.0%**						7	2	0	0	**28.6%**
Specialist Medicine	6	0			**0.0%**	1	0			**0.0%**	3	1		1	**0.0%**						10	1	0	1	**0.0%**
Trauma & Orthopaedics	8	0	0		**0.0%**	5	0		0	**0.0%**	5	1		0	**20.0%**	2	0			**0.0%**	20	1	0	0	**5.0%**
Total	**89**	**15**	**1**	**4**	**13.5%**	**44**	**4**	**2**	**0**	**13.6%**	**95**	**9**	**3**	**8**	**4.2%**	**45**	**1**	**0**	**0**	**2.2%**	**273**	**29**	**6**	**12**	**8.4%**

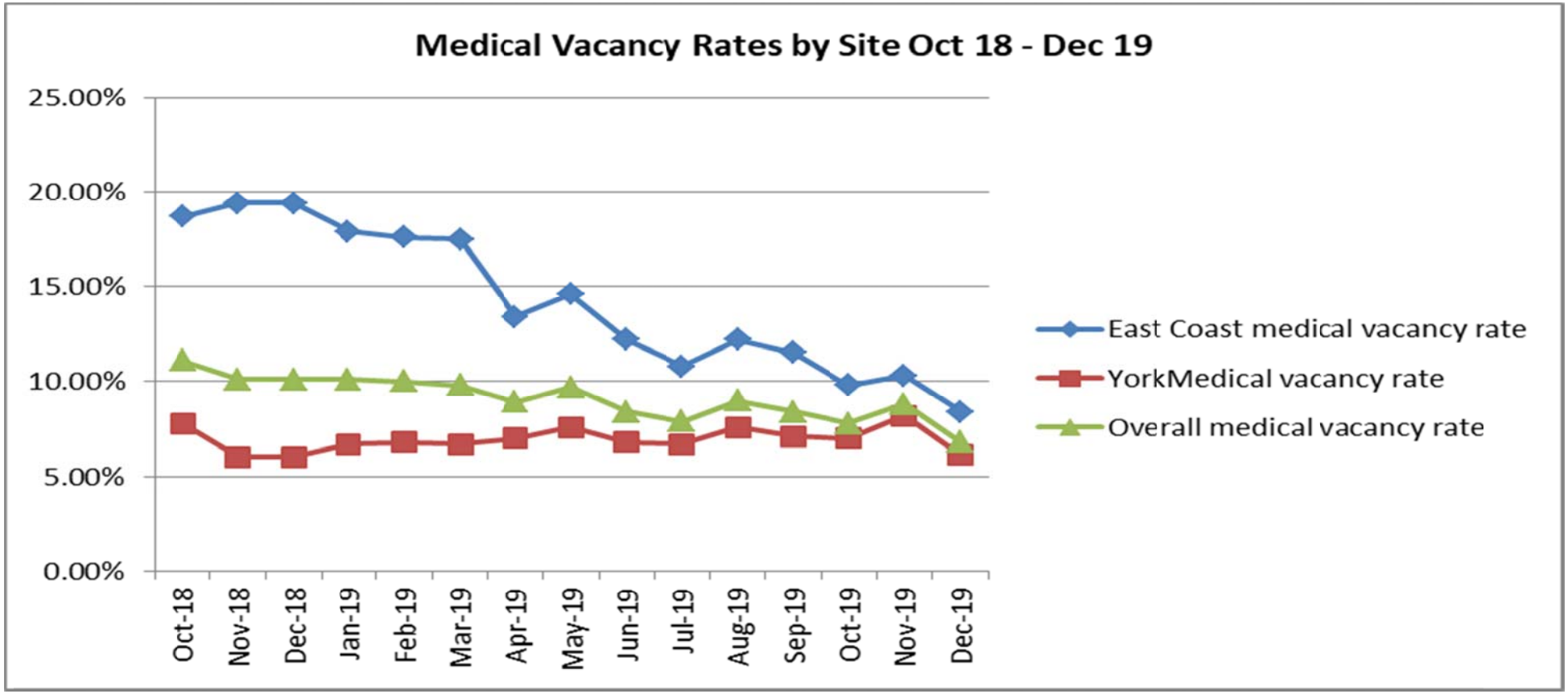
York

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	**72**	**9**	**3**	**3**	**12.5%**	**15**	**5**			**33.3%**	**68**	**8**	**2**	**3**	**10.3%**	**38**	**0**			**0.0%**	193	22	5	6	**10.9%**
Community											1	0			**0.0%**						1	0	0	0	**0.0%**
Elderly Medicine	14	2	0		**14.3%**	2	0			**0.0%**	19	1	2	1	**10.5%**	6	0			**0.0%**	41	3	2	1	**9.8%**
Emergency & Acute Medicine	23	5	2	2	**21.7%**	7	3			**42.9%**	21	4		2	**9.5%**	8	0			**0.0%**	59	12	2	4	**16.9%**
General Medicine	35	2	1	1	**5.7%**	6	2			**33.3%**	27	3	0	0	**11.1%**	24	0			**0.0%**	92	7	1	1	**7.6%**
Care Group 3	**108**	**3**	**1**	**2**	**1.9%**	**31.7**	**3.3**	**0**	**4**	**-2.2%**	**57**	**2**		**0**	**3.5%**	**15**	**1**			**6.7%**	211.7	9.3	1	6	**2.0%**
General Surgery & Urology	39	0			**0.0%**	12	2	0	4	**-16.7%**	18	1			**5.6%**	12	1			**8.3%**	81	4	0	4	**0.0%**
Head & Neck	20	0		0	**0.0%**	12	1		0	**8.3%**	15	1		0	**6.7%**	0	0				47	2	0	0	**4.3%**
Theatres, Anaesthetics & CC	49	3	1	2	**4.1%**	7.7	0.3	0		**3.9%**	24	0		0	**0.0%**	3	0			**0.0%**	83.7	3.3	1	2	**2.7%**
Care Group 4	**53**	**5**	**0**	**2**	**5.7%**	**3**	**2**	**0**		**66.7%**	**16**	**0**		**0**	**0.0%**	**2**	**0**			**0.0%**	74	7	0	2	**6.8%**
Cancer Support	12	0		0	**0.0%**	2	1			**50.0%**	5	0		0	**0.0%**	2	0			**0.0%**	21	1	0	0	**4.8%**
Laboratory Medicine	16	4	0	1	**18.8%**						5	0		0	**0.0%**						21	4	0	1	**14.3%**
Radiology	25	1	0	1	**0.0%**	1	1	0		**100.0%**	6	0			**0.0%**						32	2	0	1	**3.1%**
Care Group 5	**32**	**3**	**0**	**1**	**6.3%**	**9**	**1**	**0**		**11.1%**	**32**	**2**		**0**	**6.3%**	**8**	**0**			**0.0%**	81	6	0	1	**6.2%**
Child Health	17	1		1	**0.0%**	1	0			**0.0%**	17	0		0	**0.0%**	4	0			**0.0%**	39	1	0	1	**0.0%**
Obstetrics & Gynaecology	13	2	0		**15.4%**	1	0	0		**0.0%**	12	1			**8.3%**	2	0			**0.0%**	28	3	0	0	**10.7%**
Sexual Health	2	0			**0.0%**	7	1			**14.3%**	3	1			**33.3%**	2	0			**0.0%**	14	2	0	0	**14.3%**
Care Group 6	**62**	**3**	**2**	**2**	**4.8%**	**20**	**4**	**0**	**3**	**5.0%**	**29**	**2**	**0**	**0**	**6.9%**	**4**	**0**			**0.0%**	115	9	2	5	**5.2%**
Ophthalmology	20	1	2	1	**10.0%**	7	0		0	**0.0%**	6	0		0	**0.0%**						33	1	2	1	**6.1%**
Specialist Medicine	28	2	0	1	**3.6%**	5	3	0	2	**20.0%**	14	1	0	0	**7.1%**						47	6	0	3	**6.4%**
Trauma & Orthopaedics	14	0			**0.0%**	8	1		1	**0.0%**	9	1		0	**11.1%**	4	0			**0.0%**	35	2	0	1	**2.9%**
Total	**327**	**23**	**6**	**10**	**5.8%**	**78.7**	**15**	**0**	**7**	**10.5%**	**202**	**14**	**2**	**3**	**6.4%**	**67**	**1**	**0**	**0**	**1.5%**	**675**	**53**	**8**	**20**	**6.1%**

Net vacancy % = (Vacancies + Leavers Pending - Starters Pending) / Establishment
Leavers = currently serving notice
Starters = accepted appointment, now pending start date

948	**82**	**14**	**32**	**6.8%**

Appendix 4 – Medical and Dental Vacancy Position October 2018- December 2019



Appendix 5 – Other registered staff - vacancy position to end of November 2019

	Establishment	Staff in post	Vacancies
Registered AHPs;			
Radiographers	169.72	155.77	13.95
Physiotherapists	168.30	164.59	3.71
Speech and Language Therapists	39.81	41.34	
Dietetics	30.51	29.82	0.7
Occupational Therapists	82.65	81.44	1.21
AHP Total	**490.98**	**472.96**	**18.02**
Registered Scientific & Technical			
Pharmacists (includes Technicians)	157.56	130.59	27.00
ODPs	87.10	89.7	
Scientific & Technical Total	**244.66**	**220.26**	**24.4**
***Registered Healthcare Scientists**	**147.53**	**152**	

Appendix 6 – Core and Essential Training compliance by Care Group to end of December 2019

Overall compliance by Care Group

Care Group	Core Training	Essential Skills
419 CG 1 Acute Elderly Emergency General Medicine and Community Services York	87%	86%
419 CG 2 Acute Emergency and Elderly Medicine-Scarborough	86%	88%
419 CG 3 Surgery	86%	89%
419 CG 4 Cancer and Support Services	92%	94%
419 CG 5 Family Health & Sexual Health	86%	89%
419 CG 6 Specialised Medicine & Outpatients Services	90%	91%
419 CG Corporate Services	71%	66%
419 CG Trust Estates and Facilities Management	98%	100%
419 LLP CG Estates & Facilities	86%	88%

Core compliance – Medical and Dental

Monthly Care Group Compliance for Medical Staff	Adult DNACPR	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 Level 1	Infection Prevention and Control Level 2	Information Governance	Manual Handling Practical	Manual Handling Theory	Paediatric DNACPR	Paediatric Life Support	PREVENT Awareness	PREVENT Level 3	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Safeguarding Children Level 3 Modules (Core Staff)	Safeguarding Children Level 3 Modules (Specialist Staff)
CG1 Acute Elderly Emergency Gen Med & Community Services York																							
Community Directorate																							
419 cc St. Monicas Medical Staff	100%	0%	0%	0%		0%	0%	0%		0%	0%	0%	0%				100%		0%		0%		
Emergency & Acute Medicine York Directorate																							
419 cc Acute Snr Med - York	100%	83%	83%	83%		67%		83%		83%	83%	50%	83%				100%		100%		100%		
419 cc ED Jnr Med - York	65%	90%	45%	95%		60%	25%	80%		70%	60%	25%	85%		35%		45%		45%		62%	57%	
419 cc ED Snr Med - York	100%	100%	91%	91%		100%		100%		100%	100%	100%	91%		82%		100%		100%			100%	
419 cc General Medical Jnr Med	67%	67%	33%	77%	82%	56%	23%	69%		72%	62%	10%	72%				49%		62%		43%	50%	
End of Life Directorate																							
419 cc Palliative Care Sen Med York	100%	100%	100%		100%	100%		100%		100%	100%	100%	100%				100%		100%		100%		
General and Acute Medicine Dir																							
419 cc Cardiology Jnr Medical Staff	83%	50%	17%	100%		83%	50%	67%		67%	67%	0%	67%				67%		33%		67%		
419 cc Cardiology Snr Med	89%	67%	78%	67%		89%		78%		67%	89%	33%	78%				78%		89%		67%		
419 cc Chest Medicine Jnr Med	100%	100%	100%		100%	100%		100%		100%	100%	100%	100%				100%		100%		100%		
419 cc Chest Medicine Snr Med	100%	100%	100%		100%	100%		100%		83%	83%	83%	83%				100%		100%		100%		
419 cc Gastroenterology Jnr Med	33%	67%	33%	100%	50%	67%	50%	83%		83%	67%	0%	83%				33%		83%		83%		
419 cc Gastroenterology Snr Med	83%	50%	83%		83%	67%		83%		83%	100%	50%	67%				67%		83%		67%		
419 cc Hepatology	100%	100%	100%		100%	0%		100%		100%	0%	100%	100%				100%		100%	100%			
419 cc Psychiatry Jnr Medical Staff	67%	100%	50%	100%		83%	67%	83%		83%	67%	0%	83%				83%		50%		50%		
419 cc Renal Medicine Jnr Med Staff	33%	100%	33%	100%		33%	0%	100%		100%	67%	0%	100%				33%		67%		67%		
419 cc Renal Medicine Snr Med	67%	100%	89%	100%		89%		67%		89%	78%	56%	89%				89%		89%		78%		
Medicine for the Elderly York Directorate																							
419 cc Elderly Jnr Med	68%	68%	37%	95%		53%	33%	79%		68%	47%	16%	79%				42%		63%		61%	0%	
419 cc Elderly Snr Med	91%	100%	73%	91%		73%		100%		91%	73%	73%	91%				100%		82%		91%		
419 cc Stroke Medical Staff York & Scar	100%	100%	50%	75%		75%		100%		100%	75%	75%	100%				75%		100%		100%		

CG2 Acute Emergency and Elderly Medicine-Scarborough																						
Back of House Directorate																						
419 cc Cardiology - Sgh	75%	63%	75%	75%		88%	50%	88%		100%	75%	50%	88%			88%		88%		75%		
419 cc Care Of The Elderly	50%	50%	60%	80%		60%	0%	70%		70%	60%	40%	60%			50%		40%		80%		
419 cc Elderly Jnr Med Staff - SGH & Brid	56%	56%	50%	90%	83%	56%	31%	75%		69%	63%	13%	69%			44%		56%		56%		
419 cc Gastroenterology Medical Staff - Sgh	60%	40%	80%		100%	80%	0%	80%		60%	60%	20%	60%			60%		60%		80%		
419 cc General Medicine - Scar	82%	71%	43%	100%	78%	79%	43%	82%		75%	71%	7%	82%			54%		68%		64%		
419 cc Medicine Academic Foundation Year 2	100%	100%	33%	100%		100%	100%	100%		100%	100%	0%	100%			100%		100%		100%		
419 cc Respiratory - Sgh	67%	100%	100%	67%		67%		67%		67%	67%	100%	67%			100%		67%		100%		
Enabler Directorate																						
419 cc Out of Hospital Placements Scarborough	67%	100%	67%	100%		67%	100%	67%		67%	67%	67%	67%			67%		67%		67%		
419 cc Palliative Care Jnr Med Scarb	50%	100%	50%	100%		50%	50%	50%		50%	50%	0%	50%			50%		100%		100%	0%	
Front of House Directorate																						
419 cc AMU Medical Staff	86%	57%	43%	86%		100%	40%	57%		71%	100%	43%	71%			57%		71%		71%		
419 cc ED Med Staff - Scarborough	73%	77%	42%	85%		65%	33%	92%		77%	73%	42%	69%		54%	62%		62%		100%	46%	
CG3 Surgery																						
General Surgery & Urology Directorate																						
419 cc General Surgery - Sgh	67%	67%	67%		67%	33%	0%	67%		33%	67%	33%	33%			67%		67%		67%		
419 cc General Surgery Snr Med YH	88%	82%	82%	82%		88%		91%		88%	91%	53%	88%			85%		85%		85%		
419 cc Non-Trainee Junior Doctors Scarb - GS&U	100%	100%	67%	100%		67%	33%	100%		67%	67%	0%	67%			100%		100%		100%		
419 cc Non-Trainee Junior Doctors York - GS&U	33%	50%	33%	83%		50%	50%	50%		50%	50%	0%	50%			33%		33%		33%		
419 cc Trainee Junior Doctors Scarb - GS&U	73%	87%	67%	93%		80%	64%	93%		80%	73%	20%	87%			67%		73%		73%		
419 cc Trainee Junior Doctors York - GS&U	64%	55%	30%	85%		58%	36%	64%		61%	55%	9%	64%			42%		46%		52%		
419 cc Urology - Sgh	50%	100%	100%	100%		100%		50%		50%	50%	100%	100%			100%		100%		100%		
419 cc Urology Snr Med YH	100%	100%	100%	80%		80%		100%		60%	100%	60%	60%			100%		80%		80%		
Head & Neck Specialties Directorate																						
419 cc ENT - Scarborough	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	50%	100%			100%		100%		100%		
419 cc ENT Jnr Med	9%	46%	18%	82%		46%	11%	64%		36%	46%	18%	36%			18%		36%		27%		
419 cc ENT Snr Med	100%	89%	89%	100%		89%		89%		89%	89%	78%	89%			78%		89%		89%		
419 cc Maxillo Facial Jnr Med	58%	83%	42%	75%		58%	36%	67%		58%	58%	17%	58%			50%		50%		58%		
419 cc Maxillo Facial Snr Med	100%	60%	100%	100%		100%		80%		100%	80%	20%	100%			80%		80%		60%		
419 cc Orthodontic Jnr Med		100%	100%		100%	100%		100%		100%	100%	100%	100%			100%		100%		100%		
419 cc Orthodontic Snr Med		100%	100%		100%	100%		100%		100%	100%	33%	100%			100%		100%		100%		
419 cc Orthodontics - Sgh	0%	0%	0%		0%	0%	0%	0%		0%	0%	0%	0%			0%		0%		0%		
419 cc Restorative Dentistry Senior Med	50%	100%	100%		50%	100%		100%		100%	100%	100%	100%			100%		100%		100%		
419 cc Restorative Dentistry Sgh	0%	0%	0%		0%	0%	0%	0%		0%	0%	0%	0%			0%		0%		0%		

Theatres Anaesthetics & Critical Care																						
419 cc Anaesthetics Jnr Med	68%	65%	47%	85%		74%	27%	91%		88%	77%	24%	82%			62%		71%		81%	0%	
419 cc Anaesthetics Jnr Med - SGH	63%	75%	31%	100%		63%	25%	94%		88%	75%	25%	88%			50%		44%		63%		
419 cc Anaesthetics Snr Med	94%	90%	88%	94%		92%		94%		92%	96%	84%	92%			94%		94%		92%		
419 cc Anaesthetics Snr Med - SGH	94%	88%	94%	94%		100%		100%		100%	100%	94%	100%			94%		94%		94%		
CG4 Cancer and Support Services																						
Cancer Services Directorate																						
419 cc Clinical Haematology Jnr Med	25%	75%	25%	100%	50%	50%	0%	75%		75%	75%	0%	75%			50%		50%		50%		
419 cc Clinical Haematology Snr Med	100%	100%	100%		100%	100%		100%		100%	100%	67%	83%			83%		100%		100%		
419 cc Oncology Jnr Med	67%	0%	33%	100%		67%	0%	100%		67%	67%	0%	67%			33%		33%		67%		
419 cc Oncology Snr Med York	83%	83%	83%	50%		83%		83%		83%	67%	17%	67%			67%		83%		67%		
Lab Med Directorate																						
419 cc Biochemistry Snr and Jnr Med	100%	100%	100%		100%	100%			100%		100%	100%	100%			100%		100%		100%		
419 cc Histopathology Jnr Med		50%	50%	100%		0%			0%		50%	0%	50%			0%		0%		0%		
419 cc Histopathology Snr Med		100%	100%		86%	86%			100%		100%	57%	86%			100%		100%		100%		
419 cc Microbiology Jnr Med		100%	50%	100%	100%	100%			100%		100%	0%	100%			100%		100%		100%		
419 cc Microbiology Snr Med		75%	75%		50%	75%			75%		75%	50%	75%			100%		75%		50%		
Radiology Directorate																						
419 cc Radiology - Scarborough	100%	0%	100%	100%		100%		100%		100%	100%	0%	100%			100%		100%		100%		
419 cc Radiology Medical Staff	92%	80%	96%		88%	84%		92%		88%	88%	52%	92%			100%		88%		88%		
CG5 Family Health & Sexual Health																						
Child Health Directorate																						
419 cc Paediatrics - Scarborough	71%	76%	62%	91%		71%	58%	76%		67%	76%	62%	67%	79%	57%	71%		71%		80%	100%	67%
419 cc Paediatrics Jnr Med	70%	52%	44%	91%		74%	39%	87%		65%	70%	0%	61%	15%	52%	74%		61%		83%		18%
419 cc Paediatrics Snr Med		88%	94%	93%	100%	100%		88%		88%	88%	56%	88%	69%	81%	94%		100%				69%
Sexual Health Directorate																						
419 cc Medical Staff	80%	90%	80%	0%	89%	70%	57%	90%		100%	90%	60%	100%			80%		60%		100%	56%	
Womens Health Directorate																						
419 cc Obs & Gynae Jnr Med Scarb	46%	73%	36%	73%		55%	46%	82%		64%	73%	18%	64%			64%		55%		100%	33%	
419 cc Obs & Gynae Jnr Med York	57%	79%	43%	100%	71%	64%	0%	79%		86%	71%	7%	86%			79%		64%		100%	18%	
419 cc Obs & Gynae Snr Med Scarb	100%	100%	100%		63%	100%		88%		88%	100%	75%	75%			88%		100%			75%	
419 cc Obs & Gynae Snr Med York	92%	100%	83%		92%	92%		92%		92%	92%	83%	100%			100%		100%			100%	

CG6 Specialised Medicine & Outpatients Services																					
Dermatology Directorate																					
419 cc Dermatology Jnr Med	80%	40%	80%		80%	80%	25%	80%	80%	80%	20%	60%		80%		80%		80%			
419 cc Dermatology Jnr Med/GPSI Scarb	0%	0%	0%		0%	0%	0%	0%	0%	0%	0%	0%		0%		0%		0%			
419 cc Dermatology Snr Med	80%	80%	80%		80%	90%		70%	80%	90%	60%	80%		90%		70%		80%			
Diabetes/Endocrinology Directorate																					
419 cc Diabetes Jnr Med	50%	50%	50%	100%		75%	25%	100%	75%	75%	50%	75%		100%		75%		50%			
419 cc Diabetes Snr Med	100%	75%	100%	100%		100%		100%	100%	100%	50%	100%		100%		75%		100%			
419 cc Diabetic Medical Staff	100%	100%	100%		100%	100%		100%	100%	100%	100%	67%		100%		100%		100%			
419 cc N Yorks Retinopathy Screening	0%	0%	0%		0%	0%	0%	0%	0%	0%	0%	0%		0%		0%		0%			
Neurosciences Directorate																					
419 cc Neurology & Neurophysiology Jnr Med	50%	0%	50%	100%	100%	50%	0%	100%	100%	100%	0%	100%		0%		50%		50%			
419 cc Neurology & Neurophysiology Snr Med	100%	100%	100%		100%	100%		88%	88%	100%	75%	88%		100%		88%		100%			
Ophthalmology Directorate																					
419 cc Ophthalmology - Scarborough	100%	100%	100%		100%	100%	50%	100%	100%	80%	60%	100%		80%		100%		100%			
419 cc Ophthalmology Jnr Med	75%	58%	67%	100%	78%	67%	42%	83%	75%	58%	25%	83%		50%		67%		67%			
419 cc Ophthalmology Snr Med	90%	90%	84%	50%	94%	90%		90%	90%	90%	95%	95%		90%		95%		95%			
Orthopaedics Directorate																					
419 cc Orthopaedic Snr Med YDH	92%	100%	69%	77%		92%		92%	92%	92%	54%	92%		85%		92%		92%			
419 cc Orthopaedics Jnr Med YDH	45%	60%	35%	90%		60%	17%	50%	55%	60%	25%	55%		45%		45%		50%			
419 cc Orthopaedics Med - Sgh	77%	77%	71%	88%		77%	57%	88%	82%	77%	65%	94%		77%		71%		88%			
Rheumatology Directorate																					
419 cc Rheumatology Jnr Med York	100%	100%	0%	100%	100%	100%	0%	100%	100%	100%	0%	100%		100%		100%		100%			
419 cc Rheumatology Snr Med Scarb	67%	67%	67%	100%	100%	100%		100%	100%	100%	33%	67%		100%		67%		100%			
419 cc Rheumatology Snr Med York	100%	100%	100%		100%	100%		100%	100%	100%	100%	100%		100%		100%		100%			
CG Corporate Services																					
Medical Governance Directorate																					
419 cc Medical Governance Office	0%	100%	0%		100%	100%		100%	0%	0%	0%	0%		0%		0%		0%			
419 cc Quality & Safety	100%	0%	100%		100%	100%	0%	100%	0%	100%	0%	100%		100%		100%		0%			
Workforce and Organisational Development Directorate																					
419 cc CLRN Delivery Staff	0%	0%	0%		0%	100%		0%	100%	0%	0%	100%		0%		0%		100%			
419 cc General Practice F2 Posts	75%	100%	38%	100%		50%	38%	88%	88%	75%	13%	88%		50%		38%		75%			
419 cc GP Trainee Doctors	63%	61%	37%	89%	65%	61%	14%	77%	70%	56%	14%	67%		26%		56%		63%	67%	20%	
419 cc Locum Doctors	39%	57%	25%	47%		45%	23%	39%	41%	45%	14%	37%		23%		38%		41%			
419 cc Occupational Health		0%	100%		50%	100%		100%	100%	100%	100%	100%		100%		100%		100%			
419 cc Post Grad ME Scarb			0%		0%	100%		100%	100%	100%	0%	100%		100%		100%	100%				

Essential compliance – Medical and Dental

Monthly Care Group Essential Skills Compliance for Medical Staff	Blood Safety	Dementia Awareness	Dementia Higher Level	End of Life Care (Medical Staff) Initial and Updates - April 2019	Female Genital Mutilation (FGM)	Learning Disabilities Awareness	Medical Devices Awareness (Medical Staff)	Sepsis Awareness
CG1 Acute Elderly Emergency General Medicine and Community Services York								
Community Directorate								
419 cc St. Monicas Medical Staff	0%	0%		0%		0%	0%	
Emergency & Acute Medicine York Directorate								
419 cc Acute Snr Med - York	100%	100%		83%		100%	100%	
419 cc ED Jnr Med - York	65%	67%	67%	30%	100%	70%	70%	70%
419 cc ED Snr Med - York	100%	100%		91%		100%	100%	100%
419 cc General Medical Jnr Med	69%	68%	73%	56%	100%	77%	74%	77%
End of Life Directorate								
419 cc Palliative Care Sen Med York	100%	100%		100%		100%	100%	
General and Acute Medicine Dir								
419 cc Cardiology Jnr Medical Staff	83%	60%	67%	50%		83%	83%	67%
419 cc Cardiology Snr Med	100%	100%		78%		100%	100%	100%
419 cc Chest Medicine Jnr Med	100%	100%		100%		100%	100%	100%
419 cc Chest Medicine Snr Med	100%	100%		100%		100%	100%	
419 cc Gastroenterology Jnr Med	83%	100%	100%	40%		67%	100%	83%
419 cc Gastroenterology Snr Med	100%	100%		67%		100%	100%	100%
419 cc Hepatology	100%	100%		0%		100%	100%	
419 cc Psychiatry Jnr Medical Staff	83%	80%	0%	50%	100%	50%	83%	67%
419 cc Renal Medicine Jnr Med Staff	67%	67%	0%	33%		67%	67%	67%
419 cc Renal Medicine Snr Med	89%	89%		89%		100%	100%	

Medicine for the Elderly York Directorate								
419 cc Elderly Jnr Med	68%	100%	47%	47%	100%	68%	79%	79%
419 cc Elderly Snr Med	91%		91%	82%		91%	100%	
419 cc Stroke Medical Staff York & Scar	100%	100%	100%	75%		100%	100%	
CG2 Acute Emergency and Elderly Medicine-Scarborough								
Back of House Directorate								
419 cc Cardiology - Sgh	100%	100%	100%	75%		100%	100%	100%
419 cc Care Of The Elderly	50%	67%	56%	50%		60%	60%	33%
419 cc Elderly Jnr Med Staff - SGH & Brid	56%	54%	60%	38%	100%	56%	63%	69%
419 cc Gastroenterology Medical Staff - Sgh	80%	60%		40%		60%	80%	50%
419 cc General Medicine - Scar	71%	76%	50%	50%	100%	68%	79%	79%
419 cc Medicine Academic Foundation Year 2	100%	33%	100%	33%		100%	100%	100%
419 cc Respiratory - Sgh	100%	100%		100%		100%	100%	
Enabler Directorate								
419 cc Out of Hospital Placements Scarborough	67%	100%	0%	67%		67%	67%	67%
419 cc Palliative Care Jnr Med Scarb	50%	0%	100%	50%		50%	50%	50%
Front of House Directorate								
419 cc AMU Medical Staff	71%	57%	100%	43%		71%	71%	60%
419 cc ED Med Staff - Scarborough	65%	73%	100%	42%	100%	77%	62%	65%
CG3 Surgery								
General Surgery & Urology Directorate								
419 cc General Surgery - Sgh	67%	67%		67%		67%	67%	0%
419 cc General Surgery Snr Med YH	91%	91%	100%	71%		88%	91%	100%
419 cc Non-Trainee Junior Doctors Scarb - GS&U	100%	67%	100%	33%		67%	67%	100%
419 cc Non-Trainee Junior Doctors York - GS&U	50%	40%	100%	33%	100%	50%	50%	50%
419 cc Trainee Junior Doctors Scarb - GS&U	87%	93%	100%	73%		87%	93%	93%
419 cc Trainee Junior Doctors York - GS&U	61%	61%	83%	39%	100%	70%	70%	67%
419 cc Urology - Sgh	100%	100%		100%		100%	100%	
419 cc Urology Snr Med YH	100%	100%		100%		100%	100%	
Head & Neck Specialties Directorate								
419 cc ENT - Scarborough	100%	100%		50%	100%	100%	100%	100%
419 cc ENT Jnr Med	36%	36%		27%		36%	46%	46%
419 cc ENT Snr Med	89%	100%		78%		100%	89%	
419 cc Maxillo Facial Jnr Med	67%	73%	0%	50%		67%	67%	75%
419 cc Maxillo Facial Snr Med	100%	100%		100%		100%	100%	
419 cc Orthodontic Jnr Med		100%				100%	100%	100%
419 cc Orthodontic Snr Med		100%				100%	100%	
419 cc Orthodontics - Sgh	0%	0%				0%	0%	

419 cc Restorative Dentistry Senior Med	100%	100%				100%	100%	
419 cc Restorative Dentistry Sgh	0%	0%				0%	0%	
Theatres Anaesthetics & Critical Care								
419 cc Anaesthetics Jnr Med	85%	78%	100%	59%		85%	82%	85%
419 cc Anaesthetics Jnr Med - SGH	75%	75%		56%		81%	75%	94%
419 cc Anaesthetics Snr Med	96%	96%		94%		96%	96%	100%
419 cc Anaesthetics Snr Med - SGH	100%	100%		94%		100%	94%	
CG4 Cancer and Support Services								
Cancer Services Directorate								
419 cc Clinical Haematology Jnr Med	50%	50%		50%		75%	75%	75%
419 cc Clinical Haematology Snr Med	100%	100%		83%		100%	100%	
419 cc Oncology Jnr Med	100%	100%		33%		100%	67%	100%
419 cc Oncology Snr Med York	83%	83%		67%		83%	83%	
Lab Med Directorate								
419 cc Biochemistry Snr and Jnr Med		100%					100%	
419 cc Histopathology Jnr Med		50%				100%		
419 cc Histopathology Snr Med		57%				100%	86%	
419 cc Microbiology Jnr Med		100%		100%			100%	
419 cc Microbiology Snr Med		50%					100%	
Radiology Directorate								
419 cc Radiology - Scarborough		100%				100%	100%	
419 cc Radiology Medical Staff		100%				96%	96%	
CG5 Family Health & Sexual Health								
Child Health Directorate								
419 cc Paediatrics - Scarborough	71%	71%	100%	100%	62%	81%	81%	86%
419 cc Paediatrics Jnr Med	83%	71%	100%	100%	57%	83%	87%	100%
419 cc Paediatrics Snr Med	88%	94%			81%	94%	94%	100%
Sexual Health Directorate								
419 cc Medical Staff	0%	89%		100%	90%	100%	90%	100%
Womens Health Directorate								
419 cc Obs & Gynae Jnr Med Scarb	64%	64%	100%	55%	46%	55%	73%	55%
419 cc Obs & Gynae Jnr Med York	71%	67%	100%	50%	50%	64%	71%	71%
419 cc Obs & Gynae Snr Med Scarb	100%	100%		100%	100%	100%	100%	
419 cc Obs & Gynae Snr Med York	92%	92%		75%	92%	92%	92%	100%
CG6 Specialised Medicine & Outpatients Services								
Dermatology Directorate								
419 cc Dermatology Jnr Med	100%	80%		80%		80%	80%	80%
419 cc Dermatology Jnr Med/GPSI Scarb		0%		0%		0%	0%	0%
419 cc Dermatology Snr Med	90%	90%		70%		90%	80%	

Diabetes/Endocrinology Directorate								
419 cc Diabetes Jnr Med	75%	75%		50%	100%	75%	100%	100%
419 cc Diabetes Snr Med	100%	100%		75%		100%	100%	
419 cc Diabetic Medical Staff	100%	100%		100%		100%	100%	
419 cc N Yorks Retinopathy Screening	0%	0%		0%		0%	0%	
Neurosciences Directorate								
419 cc Neurology & Neurophysiology Jnr Med	50%	100%	0%	50%		50%	100%	50%
419 cc Neurology & Neurophysiology Snr Med	100%	100%		88%		100%	100%	
Ophthalmology Directorate								
419 cc Ophthalmology - Scarborough	80%	80%				80%	80%	100%
419 cc Ophthalmology Jnr Med	67%	73%	0%			58%	67%	67%
419 cc Ophthalmology Snr Med	67%	94%	67%	100%		95%	95%	
Orthopaedics Directorate								
419 cc Orthopaedic Snr Med YDH	100%	100%		85%		92%	100%	
419 cc Orthopaedics Jnr Med YDH	60%	63%	40%	35%	100%	65%	55%	55%
419 cc Orthopaedics Med - Sgh	77%	87%	50%	77%		82%	82%	78%
Rheumatology Directorate								
419 cc Rheumatology Jnr Med York	100%	100%		100%		100%	100%	100%
419 cc Rheumatology Snr Med Scarb	100%	100%	100%	100%		100%	100%	
419 cc Rheumatology Snr Med York	100%	100%		100%		100%	100%	
CG Corporate Services								
Medical Governance Directorate								
419 cc Medical Governance Office	0%	0%		0%		100%	0%	
419 cc Quality & Safety	100%	100%		100%		100%	100%	
Workforce and Organisational Development Directorate								
419 cc CLRN Delivery Staff	100%	100%				100%	100%	
419 cc General Practice F2 Posts	88%	86%	0%	100%		75%	75%	75%
419 cc GP Trainee Doctors	56%	51%	100%	16%	100%	61%	63%	62%
419 cc Locum Doctors	59%	56%	94%	13%	100%	56%	55%	100%
419 cc Occupational Health		100%				100%	100%	
419 cc Post Grad ME Scarb	100%	100%				100%	100%	

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 29 January 2020
Review of Corporate Documents
(Revision of the Reservation of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions)

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

The purpose of the report is to highlight to the Board that Reservation of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions have been reviewed and the amendments listed for approval. The documents were reviewed and approved by the Audit Committee on the 3 December 2019 and are now recommended to the Board for approval.

Executive Summary – Key Points

The Trust reviews the corporate governance documents on an annual basis.

Reservation of Powers and Scheme of Delegation has been reviewed. Amendments have been made in relation to changes in positions/portfolios together with some changes to ensure that limits correlate with HR policies. There are also a number of general housekeeping amendments like duplications, grammar and references to Monitor. Therefore the revised version is attached for comment.

Please note that one amendment has been made to the Reservation of Powers and Scheme of Delegation after approval was received from the Audit Committee. This amendment is as follows:

Planning & Budgetary Control	Emergency & urgent expenses necessary to ensure continuing safety and function of the site	2nd on call		

Standing Orders have been reviewed. The amendments are listed below:

Section	Insertion/Deletion
Introduction – statutory framework	Chairman replaced with Chair
1 Interpretation - 'Constitution'	States - approved by the Council of Governors – inserted 'and Board of Directors'
3.8 Annual General Meeting	Inserted '/Annual Members Meeting'
5 Committees	Deleted Corporate Risk Committee
10.2 Sealing of Documents	Deleted directorate and inserted Care Group

Standing Financial Instructions have also been reviewed. The amendments are listed below:

Section	Insertion/Deletion
1.2 Terminology – 'Authorisation'	NHS England added – Provider Trusts deleted
1.2 Terminology – NHS Improvement	NHS England added
3.1 Preparation and approval of Business Plans and Budgets (3.1.2)	Monitor deleted and NHS England and NHS Improvement added
3.5 Monitoring Returns (3.5.1) 4 Annual Accounts and Reports (4.3) 6.2 Fees and Charges (6.2.1) 7 NHS Service Contracts for Provision of Services (7.2)	NHS England added
8.2 Funded Establishment (8.2.2) 8.4 Processing Payroll (8.4.1b) 8.5 Contracts of Employment (8.5.1a)	Deputy removed to leave Director of Workforce - and Organisational Development added
9.4 Building and Engineering Transactions (9.4.1) 9.5 Tendering Quotation and Contract Procedure (9.5.2c)	Procure 21+ changed to Procure 22
10.2 Private Finance (including leasing) (10.2.2c)	Any finance or operating lease must be agreed and signed by the Finance Director - 'or any individual with delegated authority specifically agreed by the Finance Director' added.

A copy of SFIs and SOs will be available for inspection at the Board meeting, but not sent out with the papers due to the minor amendments requiring approval.

Recommendation

The Board is asked to consider and approve the revised documents.

Author: Lynda Provins, Foundation Trust Secretary and Steve Kitching, Head of Corporate Finance & Resource Management

Director Sponsor: Simon Morritt, Chief Executive

Date: January 2020

York Teaching Hospital NHS
NHS Foundation Trust

RESERVATION OF POWERS

AND

SCHEME OF DELEGATION

Author: Foundation Trust Secretary
Owner: Chief Executive
Publisher: Compliance Unit
Date of Issue: ~~January 19~~
Version: 1~~5~~3
Approved By: Audit Committee and Board of Directors
Review date: January 2021~~February 2020~~

Table of content

Reservation of Powers to the Board of Directors and Delegation of Powers

Introduction

The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board of Directors. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the Board of Directors expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive or other Executive Directors. ~~The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.~~

Comment [PL1]: duplication

Purpose

1.1 The purpose of this document is to define the control framework set by the Board for committing trust resources. The Board reserves certain matters to itself which are set out in the Schedule of Matters Reserved to the Board. The Scheme of Delegation identifies which powers and functions the Chief Executive shall perform personally and those which he has delegated to other Directors and Officers.

1.2 All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. In the absence of the Chief Executive the powers of the Chief Executive are delegated to the Deputy Chief Executive.

1.3 The Scheme of Delegation shows only the top level of delegation with the Trust. The Scheme is to be used in conjunction with the Trust's Standing Orders, Schedule of Matters Reserved to the Board, Standing Financial Instructions including the system of budgetary control and other established policies and procedures within the Trust.

1.4 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that Director of Officer's superior unless alternative arrangements have been approved by the Board. If the chief Executive is absent, powers delegated to him may be exercised by the Director who has been duly authorised to act up for him taking appropriate advice from the Chair~~man~~.

Scope

2.1 To ensure that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures.

2.2 The Scheme of Delegation is consistent with the NHS Code of Conduct and Accountability and NHSI's~~Monitor's~~ Code of Governance. Directors and Officers are reminded that powers are delegated to them on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause

for public concern. The Code of Conduct of Accountability in the NHS and the Code of Governance sets out the core standards of conduct expected of NHS managers.

2.3 Provides details of delegated limits to all officers holding responsibilities. Budget Holders agree to operate within the budget limit and within the delegated limits as outlined in this document. It is their responsibility to manage within their budget and to identify any changes to the budget assumptions surrounding activity, timing and staffing issues which may result in changes to financial risk. If a proposed transaction is beyond their authority and outside the Annual Plan, it should be referred to their manager. Failure to do so may result in disciplinary action.

2.4 The document forms part of the Trust's corporate governance framework, which is the regulatory framework for the business conduct of the Trust within which all Trust officers are expected to comply. The aim is not to create bureaucracy but to protect the Trust's interests and to protect staff from any accusation that they have acted less than properly. It does this by ensuring that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures. The key documents in this framework include the following and should be read in conjunction with the Reservation of Powers by the Board of Directors and Delegation of Powers:

- Standing Orders.
- Standing Financial Instructions

2.5 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them. This aligns with section 1.2.2 of the Standing Financial Instructions.

Principles of the Scheme of Delegation

3.1 Principles that are followed by the Scheme of Delegation

- There is no expenditure beyond authorised limits except with the express written approval of the Chief Executive or Finance Director.
- The business case process is mandatory.

Governors' legal responsibilities

4.1 The Trust has a body of elected individuals that make up the Council of Governors. Governors have a number of legal rights and responsibilities. These include:

- The appointment or dismissal of the Chair~~man~~ and Non-executive Directors
- The approval of the appointment of the Chief Executive
- At a general meeting the Council of Governors will:
  - receive the annual accounts annual report and q~~Q~~uality r~~R~~eport and annual audit letter from the external auditors
  - approve the remuneration and allowances and other terms and conditions of the office of the Chair~~man~~ and Non-executive Directors
  - appoint or replace the Trust's auditor at a general meeting
- Providing the views of the Council of Governors to the Board of Directors for the purposes of the preparation by the Board of Directors of the document containing

information as to the Trust's forward planning in respect of each Financial Year to be given to NHSI~~Monitor~~
- Receiving and considering the views of the Members on matters of significance to the future plans of the Trust
- Approval of any amendments to ~~the amended of~~ the constitution
- Hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors
- Represent the interests of the NHS Foundation Trust members and the public served by the Trust
- Approving significant transactions that fall within the definition
- Appointment and removal of the External Auditors
- Approval of the increase of non- NHS income where it is 5% or more in any one year

Scheme of matters reserved for the Board

5.1 General enabling provision

The Board may determine any matter (for which it has delegated or statutory authority) it wishes in full session within its statutory powers, subject to any restrictions contained in the Trust's Constitution and/ or terms of the Licence.

5.2 Constitutional Powers

- To exercise all powers of an NHS foundation trust set out in the NHS Act 2006, subject to any restrictions in the Trust's Licence; enforcement undertakings given to regulators or as delegated in accordance with this Scheme of Delegation. (Constitution section~~paragraph~~ 4)
- Determine the composition of the Board of Directors (Constitution section~~paragraph~~ 9)
- Make available for inspection by members of the public the following: ~~register of Members;~~ register of members of the Council of Governors; register of interest of members of the Council of Governors; register of members of the Board of Directors; register of interests of members of the Board of Directors; Constitution; Licence; latest Annual Accounts and Auditor's report on them; latest Annual Report and Forward Plan; and any notice issued by NHSI~~the Monitor~~ under Section 52 of the NHS Act 2006.
- Appoint the Returning Officer
- Approve payment of expenses and remuneration to Returning Officer
- Make available for inspection by members of the public statements of nominated candidates and nomination papers.
- Approve and deliver to the Returning Officer a list of Members eligible to vote
- Retain documents relating to elections to the Council of Governors and make these for inspection by members of the public, subject to any restriction in the Election Rules.
- Approve proposals to amend the Constitution which must be approved by the Council of Governors.
- Specify Partnership Organisations
- Receive and determine disputes under the Constitution, including disputes between the Council of Governors and the Board of Directors.
- Present Annual Accounts, any reports of the Auditor on them and the Annual Report at the Annual General Meeting.
- Prepare the Annual Report

- Prepare the Forward Plan

5.3 Regulation and controls

- Approval, suspension, variation or amendment of Standing Orders, Reservation of Powers and Delegation of Powers and Standing Financial Instructions for the regulation of its proceedings and business
- Approval of the Reservation of Powers and Delegation of Powers from the Board to officers
- Requiring and receiving the Declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration
- Requiring and receiving declaration of interest from officers which may conflict with those of the Trust.
- Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property
- Approval of the arrangements for dealing with complaints
- Adoption of the organisational structure, processes and procedures to facilitate the discharge of business by the Trust and to agree any modification there to
- To establish terms of reference and reporting arrangements of all committees established by the Board of Directors
- To receive reports from committees including those which the Trust is required to provide by the Secretary of State, NHSI~~Monitor~~ or other regulatory body or regulation to establish and to take appropriate action thereon
- To confirm recommendations presented to the Board of Directors by the Trust's Committees
- Ratification of any urgent decisions taken by the Chair~~man~~ in accordance with Standing Orders
- Approve the Trust's Major Incident Plan
- Prescribe the Financial and Performance reporting arrangement required by the Board of Directors
- Approval of arrangements relating to the discharge of the Trust's responsibility as a corporate trustee for funds received in trust and f~~F~~unds h~~H~~eld on Trust
- Approval of the Trust's banking arrangements (SFI 5.2)
- Authorise use of the common seal of the Trust (SO10)
- Ratify or otherwise instances of failure to comply with Standing Orders (SO3.13)
- Discipline members of the Board of Directors or Officers who are in breach of statutory requirements or Standing Orders
- Call meetings of the Board of Directors (SO3.1)
- Resolve to require withdrawal of the press and public from meetings of the Board of Directors
- Approve minutes of the proceedings of the meetings of the Board of Directors (SO 3.12)
- Resolve to adjourn any meeting of the Board of Directors

5.4 Appointments/ Dismissal

- The appointment and dismissal of Board Committees
- The appointment of the Vice Chairman in consultation with the Council of Governors

- The appointment of the Senior Independent Director in consultation with the Council of Governors
- Through the Remuneration Committee the appointment and appraisal of Executive Directors and the disciplinary procedures of the Trust
- Ratification of the appointment of senior medical staff
- Approval of all new consultant appointments related to a business case
- The appointment of membership of the Board sub-committees
- The appointment of any representative body outside the organisation

5.5 Policy Determination

- The Board of Directors will approve policies that require specific Board approval including:
    - Management of Risk
    - Fire Safety Policy
    - Health and Safety Policy
    - Security Policy

This is not an exhaustive list.

5.6 Strategy and plans

- Define and approve the strategic aims and objectives of the Trust
- Approve strategic business plans incorporating a programme of investment in respect of the application of available financial resources
- Approve proposals for ensuring quality and safety and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State
- Approve annually Trust budgets (SFI 3.1.1)
- Approve final business cases for the use of private finance for capital schemes (SFI 10.2)
- Approve proposals for action on litigation against or on behalf of the Trust
- Review use of NHSR~~LA~~ risk pooling schemes, commercial insurers and self-insurance (SFI 18.3)

5.7 General matters

- Acquisition, disposal of land/ or buildings above a value of £1m.
- Change of use of land
- Joint ventures
- To agree actions on litigation against or on behalf of the Trust
- Any investment regardless of size of new activity or any disinvestment
- Purchase and maintain insurance against liability.
- Approve opening and closing of any bank or investment account (SFI 5~~.1.3~~)
- Approve proposals for action on litigation against or on behalf of the Trust

5.8 Financial and reporting management arrangements

- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust
- Consideration and approval of the Trust's Annual Report and Annual Accounts prior to submission to Parliament

- Receive the annual management letter from the external auditor and agree proposed action taking account of the advice, where appropriate, of the Audit Committee

Summary of Delegated Authorities

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders. All reference material is available from staffroom

General Area	Delegated matter	Authority delegated to	Scope of Delegation	Details/ Reference
Accountability	Accountable through NHS Accounting Officer to NHS Improvement for the stewardship of Trust Resources	Chief Executive	Full	Accountable Officer Memorandum
	Ensure the expenditure by the Trust complies with NHS Improvement requirements	Chief Executive	Full	Accountable Officer Memorandum
	Ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness	Chief Executive Finance Director Foundation Trust Secretary		
Declaration of Interests	The keeping of a declaration of board members and officers' interests	Foundation Trust Secretary		SO 6
Receipt of Gifts and Hospitality	Receipt or provision of hospitality and gifts	All Trust employees have a duty to declare		Standards of business conduct policy
	Approve procedures for declaration of hospitality and sponsorship	Board of Directors		
	Maintenance of gifts and hospitality register	Foundation Trust Secretary		
	Approval of receipt of both individual and collective hospitality	Prime budget holder		
Financial Procedures and Trust	Approve and communicate all financial procedures and Trust accounting policies	Finance Director Audit Committee	All	FReM and NHS Improvement

accounting policies				guidance SFI 1.1.3
Asset Register	Maintenance of the asset Register	Deputy Head of Corporate Finance	All	SFI 10.3
Investment of funds	Investments – Annual programme agreed by the Board of Directors	Finance Director	All	Treasury Management Policy
Capital Investment and Business Cases	Any urgent approval can be agreed by the chair of the relevant group (Any urgency must be justified).	Capital Programme Executive ~~Management~~ Group	Up to £100k	SFI 10
		Chief Executive & Finance Director through Capital Programme Executive Group	£100k-£500k	
		Executive Board	£500k - £1m	
		Board of Directors	Over £1m and all PFI proposals	
All Business Cases revenue investment	Captured in the business cases (Any expenditure over £25k must be advertised under procurement rules. Further advice should be sought from procurement) Any urgent approval can be agreed by the chair of the relevant group (Any urgency must be justified).	Prime budget holder	Up to £50k	
		Chief Executive	£50k - £500k	
		Executive Board	£ 500k-£1m	
		Board of Directors	Over £1m All PFI proposals All new (non-replacement) consultant appointments	
Expenditure variations on capital schemes	Variations Any urgent approval can be agreed by the chair of the relevant group (Any urgency must be justified).	Capital Programme Executive ~~Management~~ Group	Up to 10k	SFI 10
		Chief Executive and Finance Director through Capital Programme Executive Group	Up to £500k	

		Executive Board	£500k-£1m	
		Board of Directors	Unlimited	
Planning & Budgetary Control	Prepare and submit an Annual Plan including any in year adjustment to the Annual Plan	Finance Director		SFI
	Management of budgets for the totality of services	Chief Executive		SFI
	At Care Group~~Directorate~~ level Prime budget holders are Care Group ~~Clinical~~ Directors and Directors who hold all operating budgets for the Care Groups~~Directorate's~~ they manage including, where appropriate, income, activity and expenditure. Care Group~~Directorate~~ Managers who provide professional support to practising Care Group~~Clinical~~ Directors have also been granted Prime budget holder status.	Prime budget holder		Trust Finance Manual Section 8
	At individual budget unit level (pay and non-pay) Prime Budgets Holders can delegate budgetary authority to delegated budget holders. These are typically lead clinicians, senior and other operational managers who control budgets on a day to day basis.	Delegated budget holder		Trust Finance Manual Section 8
	Virement (planned change in use) of resources between care groups~~directorate~~ or specialty/department budgets (per annum):	Finance Director		SFI Trust Finance Manual Section 8.2.~~3~~2
	Non pay requisitions – Decisions to rent or lease in preference to outright purchase	Head of Corporate Finance		SFI
	Authority to change clinical template activity	Chief Operating Officer and Finance Director		
	Emergency & urgent expenses necessary to ensure continuing safety and function of the site	2nd on call		

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Non-pay revenue expenditure within budgets (Note: over £50K the Business Case procedure shall apply)		Prime budget holder (if within available budget resources as agreed with the Finance Director)	Prime budget holders are expected to set delegated limits for delegated budget holders and advise the Assistant Director of Finance – Financial Management for inclusion in the authorised signature list	SFI Trust Finance Manual Section 5.2 Section ~~8.2.1~~9
	Medical equipment (i.e. medical, scientific, technical and x-ray equipment) – individual items. Funding to be managed within Capital Programme allocation	Medical Equipment Resource Group (MERG)	over £1k and up to £50K supported by a MERG Form	
	Establishment of escalation facilities at short notice and associate costs	Chief Operating Officer		
	Non-pay expenditure for which no specific budget has been established and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above).	Finance Director		SFI 9.2.6(e)
	Purchasing Cards: Authority to issue purchasing cards and setting of limits	Head of Corporate Finance		
Clinical and Contract income credit notes		FRAC Analyst/Senior Analyst	Up to £250	
		Income Accountant	£250 to £10k	

		Deputy Director of Contracting	£10k to £1m with a retrospective report to the Finance Director and Deputy Finance for all transactions over £100k	
		Finance Director Deputy Finance Director	Over £1m	
Non clinical income credit notes		Prime budget holder	Up to £50k	
		Assistant Director of Finance – Financial Management	£50k to £500k	
		Deputy Finance Director	£500k to £1m	
		Finance Director	Over £1m	
Credit notes / refunds to correct posting errors and duplicate payments		Accounts Receivable Team Leader	Up to £1k	
		Financial Accountant / Payroll Manager	£1k to £10k	Payroll manager for payroll invoices up to £10k
		Deputy Head of Corporate Finance	£10k to £500k	
		Head of Corporate Finance	£500k to £1m	
		Finance Director	Over £1m	

Write offs		Accounts Receivable Team Leader	Up to £50	
		Financial Accountant	£50 to £250	
		Deputy Head of Corporate Finance	£250 to £1000	
		Head of Corporate Finance	£1000 to £10,000	
		Finance Director	Over £10,000	
Bidding for Work	Decision to bid or not, under a re-procurement exercise, for an existing contract	Chief Executive Board of Directors	Up to 1% of trust turnover More than 1% of trust turnover or If it is anticipated that not re-bidding for a contract of up to 1% of turnover is likely to involve significant reputational and political concern then this matter reverts to the Board of Directors for approval	SFI 9.5
Quotations, Tendering and Contracts	Obtaining a minimum of 3 written competitive tenders for goods/services over £25K	Head of Procurement	Over £25k	
	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders)	Head of Procurement Chief Executive and Finance Director	Under £50k Over £50k	SFI 9.5

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	Opening tenders – manual	All Executive Director and the Foundation Trust Secretary		SFI 9.5
	Opening tenders – electronically the system prevents quotes/tenders from being opened before the deadline	Head of Procurement		
	Acceptance of quotations/ permission to consider late quotations	Head of Procurement	Under £50k	
	Acceptance of tenders/permission to consider late tenders	Chief Executive	Over £50k	SFI 9.5
	Accepting contracts and signing relevant documentation	Head of Procurement Chief Executive and Finance Director	Under £50k Over £50k	
Attestation of sealing in accordance with standing orders	Attestation of sealing	Chairman or designated NED and Chief Executive or designated Executive Director	All	SO10
	The keeping of the seal	Foundation Trust Secretary		
Insurance policies	Insurance	Head of Corporate Finance		
	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Health and Safety Manager		
Bank accounts and loans	Loan arrangements	Finance Director		SFI 5
Petty cash disbursements	Expenditure	Petty cash holder	Up to £50 per item	
		Finance Director	Over £50 per item	
	Reimbursement of patient	Delegated budget	Up to £250	

	monies	holder		
		Prime budget holder	Over £250	
Property transactions	Disposal and acquisition of land and buildings	Chief Executive, Finance Director Capital Programme Executive Group	Up to £500k	SFI
		Executive Board	£500k - £1m	
		Board of Directors	Above £1m	
	Lets and Leases			
	Preparation and signature of all tenancy agreements/ licenses for all staff subject to Trust Policy on accommodation for staff	LLP Managing Director on behalf of the Trust~~Director of Estates and Facilities~~		
	Extensions to existing leases	LLP Managing Director on behalf of the Trust~~Director of Estates and Facilities~~		
	Letting of premises to outside organisations, subject to business case limits	LLP Managing Director on behalf of the Trust~~Director of Estates and Facilities~~		
	Approval of rent based on professional assessment	LLP Managing Director on behalf of the Trust~~Director of Estates and Facilities~~		
Setting of Fees and Charges	Private patient, overseas visitors, income generation and other patient related services	Finance Director		SFI 6.2.3 Provider Licence
	Financing content of NHS contracts	Finance Director		
	Approval of healthcare contracts and other agreements resulting in income to the Trust	Finance Director		
	Approval of variations of healthcare contracts:	Finance Director		

Losses and compensation	All losses, compensation and special payments shall be in accordance with current DOH guidance & details of all such payments shall be presented to the Audit Committee	Audit Committee		~~SFI~~
	Maintain a losses and special payments register	Finance Director		~~SFI~~
	Clinical Cases	Settled by NHS Resolution~~Litigation Authority~~		
	Non-clinical cases	Finance Director	Up to £150k	
		Chief Executive	£150k - £500k	
		Executive Board	£500k-£1m	
		Board of Directors	Over £1m	
	Review schedules of losses and compensations and make recommendations to the Board	Audit Committee		
	Special payments – outside the terms of any contract obligation	Treasury approval		
Condemning and disposal - Equipment	Items obsolete, obsolescent, redundant, and irreparable or cannot be repaired cost effectively (note: For disposal including those for sale the tendering and quotation limits shall apply)	Executive Director responsible for the area		SFI 12 Disposal and Transfer policy
Provision of services to other organisations	Legal and financial arrangements for the provision of services to other organisations and individuals	Director of Finance		SFI 6.2~~.3~~
	Signing agreement with other organisations and individuals			
Audit and Accounts	Approve the appointment and where necessary dismissal of the External Auditors	Council of Governors		SFI 4
	Receive the annual management letter from the External Auditor.			
	Receive the annual management letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee	Board of Directors		
	Receive an annual report from the Internal Auditors and agree action	Audit Committee		

Annual Report and Accounts	Receive and approve the Annual Report and Accounts and Quality Report	Board of Directors		SFI 4
	Receive the Annual Report and Accounts and Quality Report and any comments on them at the Annual General Meeting	Council of Governors		
	Sign the annual statements including the annual accounts on behalf of the Board of Directors	Chair, Chief Executive and Finance Director		
	Implementation of internal and external audit recommendations	Finance Director		SFI 2.2
Retention of Records	Maintaining archives of records to be retained	Chief Executive		SFI 17
Research and development	Approval of Trust research and development contracts to be supported by a business case including workforce implications (including variations or extensions): NB: Generic research to be signed off by Deputy CE~~/ or~~ Finance Director or Chief Executive	Head of Research & Development	Up to £200K	
		Deputy CE~~/ or~~ Finance Director	£200K to £500K	
		Executive Board	£500k -£1m	
		Board of Directors	£1m and over	
Personnel and Pay	Approve management policies including personnel policies incorporating arrangements for the appointment, removal and remuneration of staff	Director of Workforce & OD~~Chief Executive~~		
	Authorisation of timesheets (including agency timesheets)	Line Manager~~Delegated budget holder~~		
	Agency nursing staff	Matrons~~Chief Nurse's Office~~		
	Authority to fill funded post on the establishment with permanent staff	Vacancy Control~~Chief Executive~~		SFI 3.3
	Authority to appoint staff to post not on the formal establishment	Finance Director~~Chief Executive~~		SFI 3.3
	Granting of additional increments to staff within the context of policy (HR process up to 2 incremental points	~~Deputy~~ Workforce Lead in conjunction with the delegated budget holder~~Director of Workforce~~	All subject to compliance with A4C regulations	SFI 3.3
	Above policy level	Director of Workforce & OD~~Chief Executive~~		
	Chief Executive and Director posts including Corporate and	Remuneration Committee		

	Executive Directors	Chair~~man~~ of the Trust as Chair of the Remuneration Committee		
	Non-executive Directors and Chair	Council of Governors		SO 2.2
	Upgrading and re-grading Subject to compliance with regulations	~~Deputy~~ Director of Workforce & OD		SFI 3.3
	Variations to existing consultant contracts/job plans Subject to compliance with regulations	Medical Director ~~Deputy~~ Director of Workforce & OD and Chief Operating Officer		
	Authorising overtime	Delegated Budget Holder		SFI 8.4.3
	Authorising travel and subsistence	Line Manager and Delegated Budget Holder		
	Authority to pay clinical excellence awards to Consultants	Board of Directors endorse decision of Committee chaired by the Chief Executive or ~~Deputy~~ Director of Workforce & OD		
	Authority to pay discretionary points to staff grade and associate specialist doctors	Medical Director and ~~Deputy~~ Director of Workforce & OD		
	Consider and approve recommendations on behalf of the Board on the remuneration and terms of service of corporate directors to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff	Remuneration Committee		
	Approval of annual leave	Line Manager~~Delegated budget holder~~		Annual Leave and Bank Holiday Policy and Procedure

	Annual leave – approval of carry forward	Line Manager~~Delegated budget holder~~	Up to a maximum of 5 days in exceptional circumstances only:	
		Over 5 days in exceptional circumstances only:		
		Care Group Director~~Medical Director~~	Medical Staff	
		Line Manager~~Prime budget holder~~	Other Staff	
	Approval of compassionate leave	Line Manager~~Delegated budget holder~~	Up to 5 days	Special Leave Guidance
		Prime budget holder in consultation with HR	Up to 10 days	
	Special leave	Line Manager~~Delegated budget holder~~	Paternity	Special Leave Guidance
		Line Manager~~Delegated budget holder~~	Other	
		Line Manager~~Delegated budget holder~~	Maternity leave	
		Line Manager~~Delegated budget holder~~	Leave without pay	
		Chief Executive	Medical staff leave of absence – paid and unpaid	Special Leave Guidance
		Line Manager~~Prime budget holder~~	Time off in lieu	Special Leave Guidance
		Line Manager~~Delegated budget holder~~	Flexible working arrangements	Flexible Working Policy
		~~Deputy~~ Director of Workforce & OD	Extension of sick leave on half pay up to three months	Sickness Absence Policy
		~~Deputy~~ Line Manager~~Director~~	Return to work part	

		~~of Workforce~~	time on full pay to assist recovery	
	Study Leave			
		Clinical Director	Study leave outside the UK – medical	Learning Leave Guidance
		Clinical Director~~Prime budget holder~~	Study leave outside the UK – other	
		Clinical Director ~~Delegated budget holder~~	Medical staff study leave (UK)	
		Clinical Director~~Delegated budget holder~~	All other study leave (UK)	
	Rent and House Purchases: Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Prime Budget Holder Finance Director	up to £6,000 (non-medical staff)	Relocation Expenses Policy
		Chief Executive Medical Director Finance Director	up to £6,000 (medical staff)	
		Chief Executive Medical Director Finance Director Director of Workforce & OD	£6,000 - £8,000	
		Chief Executive	Over £8,000	
	Requests for new posts to be authorised as car users or mobile phone users	Prime budget holder		Lease Car and Mobile Communication Equipment Policies
	Renewal of fixed term contracts Must be linked to business needs and available funding	Vacancy Control~~Prime budget holder~~ ~~Deputy Finance Director~~		
	Authorisation of retirement on the grounds of ill health.	~~Deputy~~ Director of Workforce & OD (the decision can only be made by the NHS Pensions Agency)		
	Authorisation of staff redundancy	Chief Executive Finance Director Director of		Redundancy Policy

		Workforce & OD		
		Finance Director (with HM Treasury approval where required)	Any termination settlement	
	Authority to suspend (non clinical) staff	Head of Employee Relations & Engagement, ~~Prime budget holder~~ ~~Deputy~~ Director of Workforce & OD		Disciplinary Policy and Procedure
	Authority to exclude clinical staff	Deputy Director of Workforce, Deputy Chief Nurse, Medical Director~~Chief Executive~~		
	Authority to restrict practice	Medical Director Chief Nurse Director of Workforce & OD~~Chief Executive~~		MHPS guidance
	Authorisation of staff dismissal	Anyone reporting directly to a Director e.g. Care Group~~Directorate~~ Manager/Head of service (or delegated deputy)~~, Senior Nursing Team~~		
	Engagement of staff not on the establishment supported by a business case	Corporate Directors		
	Booking of bank and agency staff	**Under cap** – Care Group Director **Over cap** – Medical Director or Director of Workforce & OD **Over £100 per hour** – Chief Executive~~Prime budget holder~~	Medical Locums	
		Matrons – off framework – Chief Nurse~~Prime budget holder and through the Chief~~	Nursing	

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		~~Nurse's office~~		
		Prime budget holder	Clerical	
Facilities for staff not employed by the Trust to gain practical experience	Professional recognition, honorary contracts and insurance of medical staff, work experience students	~~Deputy~~ Director of Workforce & OD and Medical Director		
Security and risk management	Corporate responsibility for implementation of the Security Policy	LLP Managing Director on behalf of the Trust~~Director of Estates and Facilities~~		Security Policy
	Overall statutory responsibility for security management within the Trust	Chief Executive		
	Where an offence is suspected	LLP Head of Security	Criminal offence of a violent or clinical nature	
		LLP Head of Security (theft)/ Local Counter-Fraud Specialist (fraud)	Where a fraud or theft is involved	
	Authority for the issue of ID and security badges and car park passes	Delegated budget Holder		Security Policy ID Badge policy
Authorisation of new drugs	Yearly cost of drugs	Care Group~~Directorate~~ managers Chief Pharmacist	Estimated total yearly cost per individual drug up to £25,000	
		DTC recommendation, subject to business case procedure and Executive Board approval	Estimated total yearly cost per individual drug above £25,000	
	Authority to purchase/contract:			
		Senior Technician	Up to £5K	

		Countersigned by Principal Pharmacist	£5K - £50K	
		Countersigned by Chief Pharmacist	£50K - £100K	
		Finance Director	£100K to £150K	
		Chief Executive	£150K to £500K	
		Executive Board	£500K - £1m	
		Board of Directors	Over £1m	
	Approval of nurses and others to administer and prescribe medication beyond the normal scope of practice	Director of Nursing or Medical Director or Chief Pharmacist		Nurse, Midwives, HV Act, Midwives Rules/Codes of Practice, NMC Code of professional Conduct/ CSP Rules of Professional Conduct
Patients and relatives' complaints	Overall responsibility for ensuring that all complaints are dealt with effectively	Head of Patient Experience		Concerns & Complaints Policy and Procedure
	Responsibility for ensuring complaints relating to a Care Group~~Directorate~~ are investigated thoroughly	Head of Patient Experience		Concerns & Complaints Policy and Procedure Complaints Policy
	Agreement of financial compensation	Finance Director		Losses procedure
Extra Contractual Payment	Authority to undertake and approval to pay waiting list initiatives	Finance Director or Medical Director~~Chief Operating Officer~~		
Engagement of Trust's Solicitors		All Directors, Foundation Trust Secretary, Deputy Director of Healthcare Governance , Head of Procurement		

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Board Assurance Framework

York Teaching Hospital
NHS Foundation Trust

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	~~12~~16 ↓~~6~~ ~~†~~	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 – Oct19)(Nov 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	- 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	- 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 – further CQC requests in Dec 19) - Infection Rates - Limited capital - Under performance against key national targets and standards - Safeguarding – specifically Adult MCA/DoLS Actions (Identify plans to address gaps)

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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 - Statutory and mandatory training – trained professional staff - A number of local adaptations in relation to 7 day working - Lead medical examiner role introduced	- 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 - 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 – Nothing raised by CQC - Performance recovery plans - Performance framework (OPAMs)	- Mortality – Team to support Medical Examiner also linked to PS & HCG Team restructure (Apr 20) - Staffing – East Coast Review looking at sustainability – CQC weekly monitoring - Infection Control - ~~Capital Programme in respect of backlog maintenance (reviewed at Resources) (Oct 19)~~ NHSE/I Lead Review & Report – HPV Business Case approved & machines on site (Jan 20) - Care Group improvement programmes & performance recovery plans developed by each Care Group (reviewed & updated monthly~~Nov 19~~) - CQC Unannounced visit & Well Led action plans (monthly monitoring at Board) - MCA/DoLS action plans/reaudit- took place in Nov 19 with action plans now in place & no significant concern raised. ~~(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 – Oct19)(Nov 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 o Peer Review	- 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 to review Phase 2 of McKinsey Review due to be held on 31.01.20 ~~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. - McKinsey Review – oversight now by Programme Director - 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 - Yorks & Humber Clinical Senate Review of proposed paediatric & urology clinical/service models

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		- Clinical senate review document to Board (Feb 20)

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 – Oct19)(Nov 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	- 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 approved & machines on site (Jan 20)~~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

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Plan o Trust Operational Plan - Training & Development		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 - CEO led Acute Board responsible for oversight of York & Scarborough improvement plans - 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 – Oct19)(Nov 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~~.~~ – scrutiny at Resources Committee - 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) EPAMs commenced – approved minutes to Resources Committee (feb 20) - Business Case – computer aided facilities management system (Jul 19) – approved now being implemented – goes live (Apr~~Jan~~ 20)

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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 – Oct 19)(Resources - Nov 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 - Digital Delivery Group to meet monthly as par of Corporate Directors meeting (Jan 20) - Building a Digital Ready Workforce engagement ongoing (review tbc~~Oct 2019~~) - Board lead for digital under discussion (~~Oct 2019~~in progress) - Digital maturity to be scored via EMR Adoption Model (EMRAM) (Mar ~~Nov~~ 20~~19~~) - User feedback to be gained via a number of methods; surveys, email, roadshows, user training

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		(ongoing, review Feb ~~Dec~~ 20~~19~~ inc. Clever Together feedback) - 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 – Oct 19)(Nov 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 - Objective Structural Clinical Exam (OSKE) ~~- 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 (FebJan 20) - Health & Wellbeing Initiatives being implemented (Sept 20) - Workforce Plan (Oct 2019) - Apprenticeship Steering Group Outputs (Apr 20) - Implementation of e-Job Planning (May 20Nov 19) - Continue to develop Bank (Apr 20 - HCV HCP Workforce Action Plan (Oct 2019)

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			~~- Salary Flexibility (Oct 19)~~ - East Coast medical recruitment project (Jan 20) - Recruitment Initiatives (Mar 20) - NHSE response to pension tax - International Nurse recruitment

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 – Oct 19)(Nov 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= ~~3~~4 Score: 1~~2~~6	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) Continued Implementation of RAFT (Nov~~19~~20) Implementation of Health & Well being Strategy (Dec 20~~19~~) Workforce Plan implementation (Oct 20~~19~~) Flu Vaccinations (Feb 20) Safer Working Group Feedback initiatives (continuous) Line Manager Competency Training (Oct 20) Clever Together Programme (Jun 20)

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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 – Oct 19)(Nov 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 Board Development Up to date Succession Plan **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 agreed at the December Board – Programme starts (Jan 20) ~~being drafted (Dec 19)~~ ~~SM 100 days incorporating the Clever together work and CQC Report (Dec 19)~~Development of Talent Management Framework (Jun 20) CQC Action Plan in place – monitored monthly at Board (monthly) Clever Together Report in February to inform future plans (Feb 20) Board recruitment in progress (Apr 20) Succession Plan being developed (May 20)

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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 – Oct 19)(Nov 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 Executive Management 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 - HCV Partnership work - North Yorkshire & York Leadership System - Primary Care Networks through CCGs - Engagement with stakeholders - Engagement with Local Authorities - Engagement with Partner Trusts (Harrogate, Hull & Leeds)	- 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 – MD, CN & DoWF scrutiny & challenge of agency rates, structured review of long term commitments each week. - 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 including the ID of recovery plans where necessary. - Enhanced expenditure control actions implemented (CEO & FD briefing to organisation).

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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 – Oct 19)(Nov 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) - Quarterly System Finance Meetings

	Assurance Level		
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 – Oct 19)(Nov 19 – Resources) **Director Lead:** Director of Estates and Facilities (reviewed Oct 2018)	Original Risk Score RAG Rating – 5x5 Likelihood = 5 Severity= 4 Score: 20	Residual Risk Score RAG Rating – 5x5 Likelihood = 2 Severity= 2 Score: 4	Target Risk Score RAG Rating – 5x5 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 - Travel Survey	- Engagement of staff - Raised awareness when procuring - Energy Management Group – Business Case being drafted - National Clinical Waste Provision Issue - Travel Survey Analysis - Long Term Climate Change Act target changed to 0 carbon by 2050 - NHS Long Term Plan targets **Actions** (Identify plans to address gaps) - Sustainable Development Management Action Plan (reviewed annually~~Oct 19~~) to include Climate Change Act targets - Sustainable Development Assessment Tool Action Plan (~~Apr 20~~reviewed annually) - Clinical Waste – NHSI to monitor contract – interim contract with Leeds signed – awaiting further developments (Jan 20) - Travel Survey actions to be included in the Travel Plan (Apr 20) - Review being conducted against Long Term Plan targets (Apr 20)

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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 – Oct 19)(Nov 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 Executive Group 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. - Performance recovery plans developed as necessary. - Enhanced expenditure control action implemented (CEO & FD briefing). - System partner Board to Board meetings arranged to discuss financial issues.

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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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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 29 January 2020
Good Meeting Etiquette

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 request that the Board adopts the same Good Meeting Etiquette principles adopted by the Council of Governors.

Executive Summary – Key Points

The Council of Governors has adopted the attached Good Meeting Etiquette principles and it has become a standard part of their agenda presentation and has also been adopted by their sub-groups and various other groups in the Trust.

The principles set out the expectations on people attending meetings to ensure the smooth running of the meeting and ensure people attend prepared.

Recommendation

The Board are asked to adopt the attached Good Meeting Etiquette principles which are used by the Council of Governors.

Author: Lynda Provins, Foundation Trust Secretary

Sponsor: Susan Symington, Chair

Date: January 2020

Good Meeting Etiquette

KEY POINTS

- Good meeting behaviour contributes to good meeting outcomes.
- Effective meetings need forethought and preparation.
- Listening, respecting your colleagues' right to express their views and making your points constructively are the cornerstones of good meeting etiquette.

The checklist below includes activities you could go through at the start of your meeting. They give you a clear summary of what everyone should expect to be able to do, and how they can expect to be treated.

ASK YOURSELF, *HAVE I...*

- ✓ read and understood the minutes and papers?
- ✓ checked the agenda?
- ✓ made notes on what I want to say?
- ✓ got written responses to anything I've been asked to address?
- ✓ arranged to be there for the whole meeting?

TELL YOURSELF, *I WILL...*

- ✓ actively participate ensuring I stick to the point, but do not dominate the meeting.
- ✓ really listen to what people say.
- ✓ compliment the work of at least one colleague.
- ✓ try to make at least one well prepared contribution but not repeat what someone else has said.
- ✓ remember it is about representing members and not bring personal experiences to the meeting.

ENVIRONMENT

- ✓ can I hear/see everything that is going on?
- ✓ is my phone switched off?