York Teaching Hospital
NHS Foundation Trust

Board of Directors – Public

25 March 2020

Please note this meeting was not held in public due to current government guidelines. The papers which are normally presented at the Board of Directors Public meeting are included within this information pack.

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public)
Information pack

Register of directors' interests
March 2020

York Teaching Hospital
NHS Foundation Trust

Additions:

Changes:

Mr Dillon—now LLP Members Representative
Mrs Brown - acting removed

Deletions:

Mr Keaney has given up his Non-executive Director position

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

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

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

Public Board Minutes – 29 January 2020

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
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

Mrs L Brown	Acting Director of Communication

In Attendance:

Trust Staff

Mrs L Provins	Foundation Trust Secretary

Observers: Lesley Pratt, Healthwatch York
Rebecca Buckley, Public
Jill Sykes, Staff Governor
Margaret Jackson, Lead Governor & York Public Governor
Delroy Beverley, Public
Sheila Miller, Ryedale Public Governor
Andrew Butler, Ryedale Public Governor
Raj Purewal, Nuance Communications UK
Jeanette Anness, Ryedale Public Governor

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

20/01 Apologies for absence

Apologies were received from Mr Keaney (Non-executive Director), Ms L Mellor (Non-executive Director) and Mr J Dillon (Non-executive Director).

20/02 Declarations of interest

No further declarations of interest were raised.

20/03 Minutes of the meeting held on the 27 November 2019

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

19/107 – Partnership & Alliance Report – first paragraph, line 7 should read national challenge in respect of ~~oncology tumour sites~~ recruitment of oncologists.

The Board:

- **Received and approved the minutes of the Board meeting held in public on the 27 November 2019.**

20/04 Matters/actions arising from the minutes

Mrs McAleese noted that on page 12, the international nurse who had spoken at the last public meeting felt she had not been made very welcome. Mrs McAleese asked what had been done to address this?

Ms McMeekin stated that in relation to the comments about not being supernumerary, the rotas had been checked and it indicated that the nurse was supernumerary. However, the meaning of being supernumerary had been discussed with the wards to ensure a common understanding. The OSCE training experience had received very good feedback.

Mrs McAleese stated that her concern was about the reception from the existing staff and not feeling part of a team. Mrs McNair stated that there was more work to do in that area as there were issues on some wards. However, there was also some good feedback and Ms McMeekin stated that feedback had been received that some of the nurses were now getting their friends to come and join them which was due to their positive experience.

Action Log:

19/68 - Primary Care Networks (PCN) – Ms Symington and Mr Morritt would like to have an introduction to PCNs factored into a Board meeting on or before April.

19/93 - Scarborough Mortuary – Mr Bertram stated that requisitions had gone in for the refurbishment of the relatives area and these were being supported by the charity. A new body store and related hard standing would be finished by April 2020. In relation to the delivery of a full replacement of the mortuary which was linked to the Scarborough Capital build (£40m bid); there are talks at a national level to see if approval to release the money early can be brought forward. Mr Bertram stated that there is a willingness at a national level to move forward with this.

19/106 - Paediatric Data – Mrs Scott stated the information was provided on page 98 of her report.

19/106 - Visibility – Ms Symington repeated her request for directors to make time to walk about the Trust and talk to staff. This is critical in the development of our organistaional culture.

19/110 - Sickness Information – Ms McMeekin stated that this was being modelled and would appear in her February report.

19/111 - HR LLP Risk – Ms McMeekin stated that this was completed and it was noted that Mr Dillon would provide the link in from the Resources Committee to the LLP going forwards.

No further items were discussed.

The Board:

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

20/05 Patient Story

Mrs McNair stated that she wished to raise a real issue for the Trust in respect of patient safety. She noted the case of an elderly patient who had been admitted to Scarborough Hospital and then transferred to a nightingale ward where the patient stayed for 23 days. Whilst on the ward, the patient contracted C. Dif which was identified as the same ribotype as two other patients. Investigations showed that there were clear lapses of care in the environment. Unfortunately, the patient died as a result of co-morbidities and C Dif was listed as a contributory factor on the death certificate.

Dr Mawer, Consultant Microbiologist and Deputy Director of Infection Control joined the meeting and provided a presentation on Infection, Prevention and Control, noting that it had already been given to the Executive Board in January and showed not only the challenges the Trust faces, but also some of the underlying problems. He asked the Board to hold the Trust to account for the changes required.

Ms Symington thanked Dr Mawer for attending and sharing the very powerful and informative presentation.

Mr Holmberg stated that the presentation was comprehensive and helpful. Mr Holmberg asked about:

- The confidence level in the hand hygiene audits and whether any triangulation in terms of external review had been carried out as this can provide a different perspective?
- Whether it was right to just think that cutting antibiotic usage was the solution as surely it was more about focusing on actual antibiotic usage?
- Whether Dr Mawer was assured by the culture around the uptake of mandatory training in relation to IPC?

Dr Mawer stated that it was recognised that any ward based hand hygiene audits which had a score of 100% were unrealistic so they had used a ‘mystery shopper’ approach and the scores had been in the region of 50% to 70%, which was far more realistic. The IPC team were putting on additional training which included monthly hand hygiene audits.

In relation to antibiotic usage, Dr Mawer was not suggesting stopping antibiotics, but he highlighted that one of the bi-products of the drive to tackle sepsis was that patients with sepsis like symptoms were given antibiotics and then later found not to have an infection- meaning that patients could find themselves taking antibiotics unnecessarily in the event He also noted the ARC data which showed that antibiotic de-escalation was not happening.

Dr Mawer stated that uptake of training was high for nursing staff (80% to 90%), but that take up was not as high for AHPs and doctors and there needed to be greater drive to achieve a higher compliance level. He noted this as an area for concern.

There was considerable debate about the provision of isolation beds in the event of infection and decant facilities for subsequent deep cleaning. Facilities are inadequate and the board recognise this to be a risk to the trust and its patients.

Mrs McNair stated that a useful discussion had been held at Quality Committee which included timescales and resource in relation to IPC.

Corona Virus – Dr Mawer stated that Public Health England had stated that the risk to the UK was low; however, he noted that there were a lot of Chinese students and tourists in York. The team had worked hard over last week and a plan for the isolation and assessment of potential cases had been put in place. Dr Mawer did acknowledge that any cases would be extremely challenging for the organisation as it would be for all Trusts especially as it is the middle of the winter period. Dr Mawer was confident that there was now a plan in place for isolation and assessment and he pointed out that ED has posters up in both English and Mandarin advising individuals with symptoms of what to do.
The Board:

- **Received the very interesting and thought provoking presentation and thanked Dr Mawer for his candour. The board remain concerned about facilities in the management of infection and its control.**

20/06 HYMS Development Update

Dr Jayagopal provided a presentation on the status of the HYMS building development. He noted that the Trust was competing with other Trusts to get doctors and that one of the competitive challenges was the working environment. He asked for the Board's help to move the innovative project forward and in the first instance to form a group with an executive lead to help to drive the project.

Mrs Adams stated that funding was obviously the key issue and she would be interested to find out whether there were other sources of funding available? Dr Jayagopal stated that the development of the land could provide valuable resources both as a learning hub for students (of all disciplines) as well as in respect of staff wellbeing, for example, a gym and a crèche, which could be commercialised, but also be accessed by staff, which would be helpful for staff retention. . The development would be significant for both the recruitment of students to the trust, enhancing existing job roles with state of the art teaching facilities and retention of staff by providing enhanced facilities. It would also be a central pillar in the sustainable development of our trust.

Mrs Adams asked if it would be the Trust's responsibility to service any debt? Mr Bertram stated that there were 2 key stages, development of the vision which could be used to sell the development and understanding the financial implications. He stated that a draft business case had been reviewed this week and would go to Executive Board and then come to Board in due course. The case describes the income projections and the teaching component which then identifies what funding is required after direct costs are taken out, however, the Trust will still have to service the debt. Mr Bertram stated that there is an income stream that comes with the development and it could be seen as a stand-alone venture. The income will cover some cost and then there would be other commercial opportunities. Mr Bertram stated that there is a plot of land and it is about making the best use of it. He has talked to NHS Property Services and the CCG about the development of Bootham Park especially the connections that could be made and he noted that this was a really exciting opportunity.

Mr Jayagopal stated that there was also an opportunity to build some staff residences again and this would be a huge benefit to attracting staff from abroad who often found coming to work in a new country daunting enough without the issue of finding accommodation on top.

Mrs McAleese stated that it all sounded very exciting, but asked where this fit with the overall Trust strategy? She noted that the Board had just received a presentation which showed some awful pictures of the current environment and it is about the Trust having one piece of land and needing to use it wisely. Mr Jayagopal was aware of the current position, but stated that the Trust cannot lose sight of the long term as it is already lagging behind other organisations and it was about getting the best staff in order to protect the future.

Mr Morritt stated that the Executive Team were starting to look at the capital programme and how best to prioritise the work required to better address the existing fabric and also understand the short to medium term key priorities. He also noted that the Trust is going to have to do something in respect of training new staff and if it is not on site then it will have to be provided for elsewhere. Relationships with partners such as the University of York, the Council and the new owners of Bootham Park were key to this development and both the maintenance of the site and this development were necessary. He stressed that the piece of land available was not going to solve the problems of the 1970s build on the York site.

Ms McMeekin added that the Trust would have issues competing for new doctors in light of the new build at Hull. Mr Morritt stated that it was also about students getting a good experience at the Trust.

Mr Holmberg asked about the recent student survey? Mr Jayagopal stated that HYMS had been at the bottom of the league table, however, the experience locally was seen as good and HYMS were asking what was done here so that they could bring up the standard in the rest of the school. However, the Trust was still also competing with the likes of Sheffield and Leeds.

Ms Symington thanked Mr Jayagopal and invited him to provide another update at the Board in 6 months.

Action: Invite Mr Jayagopal to the Board in 6 months for a HYMS development update.

The Board:

- **Thanked Mr Jayagopal for a very interesting update and welcomed the work to look at prioritising work on short and medium term priorities.**

20/07 Chief Executive Overview

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

Care Quality Commission (CQC) – Mr Morritt stated that the Board had signed off an action plan in November 2019 and had been working hard to deliver the actions. Prior to Christmas a further data request had been received from the CQC as the Trust was in the bottom quartile for performance and Scarborough in particular had poor type 1 performance so the further interest was not a surprise. Earlier in January the ED departments in Scarborough and York had received unannounced visits from the CQC and the CQC had also followed up on some of the medical staffing issues at Scarborough which had been noted at the visit in the summer. Following the visit the CQC had placed some conditions on the Trust's registration around mental health provision and having paediatric nurses in ED. The Trust had provided an immediate response and is awaiting further communication from the CQC. In addition, the Trust had received a warning notice which raised a number of other issues as well that need to be addressed by the end of April 2020 and the Trust is working hard to address those concerns. Mrs McNair stated that most of the points in the warning notice had been picked up by the CQC in the summer and were already in the action plan. She highlighted that it is likely the CQC will revisit Trust sometime after the April deadline and put the board on notice to this effect.

East Coast Medical Oncology Update – Mr Morritt provided a brief overview stating that this issue also affected NLAG and was related to the difficulties Hull was having in recruiting oncologists. He noted that there were a number of conversations in progress and that temporary changes had been made on safety grounds so that all first appointments would take place at Castle Hill. The vast majority of follow up appointments will still be provided locally. Humber, Coast and Vale were working with the cancer networks to find ongoing sustainable solutions and further information would be provided as it became available.

Mrs Adams expressed concern at the variable approach to transport arrangements for patients who need now to travel to their oncology appointments and Mr Morritt stated that this has been picked up with the CCG.

Scarborough Day Case Unit – Mr Morritt stated that this development was now underway and would hopefully be completed by the end of the financial year.

Our Voice Our Future – Mr Morritt stated that 2000 staff had accessed the Clever Together site and analysis was being done and would be fed back in February.

Mrs McAleese stated that sometimes people underestimate the value of saying thank you and she thought the NEDs could contribute to that as her personal experience is that it can

have a huge impact. It was noted that appreciation cards had been launched at the Staff Brief last week as a reminder that it was important to say thank you.

Mr Morritt stated that this needed encouraging across the Trust and that one of the most rewarding things he was involved in was the Star Awards which were fantastic and it was about encouraging people to recommend others doing the job to the best of their ability.

Mrs Adams stated that one of the most surprising things for her was that recycling was such a high priority for staff and that it was also a big factor in attracting staff.

Ms Symington advised of the importance of modernising the Trust's practice in terms of recruitment and tailoring employment offers.

Mr Morritt stated that carbon reduction had been featured in Staff Brief last week.

The Board:

- **Received the update and noted the position with the CQC and wished to be kept informed.**
- **The board showed great interest in the work of Clever Together and look forward to seeing the analysis of their findings.**

20/08 Integrated Care System Update

Mr Morritt highlighted the HCV update on page 29 and that it had come to the end of the accelerator programme. The intention was to apply for full Integrated Care System status on from the 1 April 2020. Mr Morritt stated that Mr Eames was very keen that partners support proceeding to ICS status. Mr Eames had been invited to the February Board and Mr Morritt was keen for a paper on governance arrangements of the ICS to come to the Board for approval. The ICS will mean a change in the relationships with the regional office and a significant proportion of performance management will be delivered through ICS. . Mr Morritt stated that a new term was being used: 'system by default' and it signifies the shift which is intended that partners will be managed as a system.

Mrs Adams stated that as the accelerator programme is coming to a close, was there any real pace in the work? Mr Morritt stated that the programme was a means to an end and that there is pace towards becoming an ICS and the accompanying infrastructure which was not related to the programme. Mr Morritt stated that the anxiety in the system was that the pace was too fast and his personal anxiety was that it was important to bring to the Board a discussion around the governance and what this meant for the statutory position of the Trust. Mr Morritt also stated that it is likely that there will be some supporting legislation in the near future.

The Board:

- **Received the update and noted that Mr Eames will be attending the February Board.**

20/09 CQC Action Plan Monitoring Report

Mrs McNair provided an overview of the action plan stating that some constructive challenge had been received at Quality Committee around the pace of delivery. She noted that areas of slippage were highlighted and these were for genuine reasons.

Mrs McAleese was concerned that some of these actions needed a whole organisational approach and the timescales were really tight. It was noted that the need for the Entonox business case had only just come to light and would require significant funding. There were a number of wider organisational requirements and it would be useful for the big ones to be separated out.

Mr Taylor stated that for him the concern was around access, flow and discharges and he was not sure the clinical workforce fully understood the amount of risk in the system. He stated that currently the focus was on safety incidents when thought should be given to risk and safety.

Mrs Scott agreed with Mr Taylor, stating that ECIST were highlighting that there needed to be a reduction in overcrowding in ED and that patients needed seeing in a timely manner in order to facilitate discharge from the trust contributing to reducing the pressure around flow and bed occupancy. She stated that while work was in progress, it was also about changing hearts and minds of staff and encouraging them to work differently.

Mr Taylor stated that while the focus was currently on acute and urgent care, work was required on some of the backlog ares of tensions including continuing elective work whilst under pressure from increased acute admissions.

Mrs McNair stated that she did not disagree with the comments around patient flow, but she reminded the Board that this was core business and should not deflect attention away from the work required to achieve the CQC requirements.

Action: Mrs McNair to separate out the bigger organisational requirements.

The Board:

- **Received the action plan and update;**
- **Noted the competing priorities and the significant issues around funding some of the actions and wished to see the bigger organisational requirements separate out for further consideration.**

20/10 Quality & Resources Committees – Items for escalation

Committee Chairs were asked to give an overview of the items for escalation and then these could be picked up during director reports.

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

Board to ward assurance – she noted that there are still lots of gaps in understanding of how this works and the practicalities needed to be worked through so that the Trust can work efficiently. This needed to include feed-up from the Care Groups to provide assurance.

BAF/CRR – Dr Boyd stated that risks were looked at in isolation and they need to fully reflect the overall risk. An example of this being that data was not delivering what was required so the need to look at what data is being used for cumulatively instead of individually.

Resources Committee –Mrs Adams stated that the Committee were putting in place a work programme to look at two of the four areas in detail every month with a short report coming from the other two areas and then this would be reversed the following month. Finance and digital had been the two main topics this month and she wished to reflect the essence of the discussion.

Mrs Adams stated that the items for escalation were:

Finance - The Committee were pleased that the Q3 PSF funding had been secured, but it was evident that this left little room for any contingencies in Q4. The Committee asked for assurance that grip and control of the finances had not been lost and were assured that this was not the case. The deteriorating financial position was down to a number of specific and distinct matters including the aligned incentive contract (AIC) risk share, the extra expenditure on staffing due to the CQC requests and additional expenditure on long-waiters. Mrs Adams also noted that the AIC risk had been flagged to the Committee and Board throughout the year. The year-end shortfall was discussed at length and the Board had also been made aware of this, before this was highlighted to NHSI. The Committee remained concerned about the possibility of unknown risks emerging especially around the CQC visits and backlog maintenance.

BAF/CRR - Mrs Adams stated that the Finance Director had been asked to review his risks and the Board were asked to think about its appetite for risk in respect of the financial position which is precarious.

Backlog Maintenance - Mrs Adams also highlighted backlog maintenance and the lack of cash set out on page 133. She noted that there would be very little in the pot for next year if the control total is not met. Mrs Adams stated that lots of requests for capital were received and it was also a theme coming out of this meeting. She was keen that there was focus on the key priorities and robust processes put in place to evidence this prioritisation.

Mrs Adams also raised decant facilities so that HPV fogging could take place. Mrs McNair stated that work had been commissioned to look at Haldane Ward at Scarborough to see if it was feasible to reopen despite it being a nightingale ward as this would provide a decant facilities. There would need to be some electrical work which would require funding and relocation of the prayer room at the end of the ward. It was noted that the HPV fogging equipment was now on both sites and staff were being trained.

The Board:

- **Received the items for escalation;**
- **Directors were asked to cover these items as a priority during their feedback.**

20/11 Medical Director Report

Corona Virus – Mr Taylor observed that if you compare and contrast coronavirus with flu, there were 20,000 deaths from flu in the USA last year and 5,000 this year. He asked the board to consider the threat from coronavirus in this perspective, recognising that there is always a fear of the unknown.

7 Day Services – Mr Taylor stated that one of his objectives is to improve 7 day working as it underpins quality patient care. He stated that there is an urgent need for improvement in the ability to record real time review on the CPD system. He noted that some senior colleagues seemed to be unaware of the guidance so this will be reissued. The process for the single electronic system for medicine is complex so is being simplified and specialty recording will be added later.

Sepsis – The data from the audit is not comparable to previous audits due to the change in process

ED Audit findings – Mr Taylor has talked to colleagues about improvement work and this will be integrated with the general improvement work.

Mr Taylor stated that a number of actions are required following the review of three cancer pathways.

Ms Symington showed frustration in the move toward 7 days working and suggested that the Board needed to lead the way in relation to 7 day working.

Mrs Adams stated that there was loads of information in the report, but that it would be helpful if Mr Taylor could pick out any items of real concern on the front sheet together with the actions being put in place to address the concerns.

Action: Report front sheets to include items of real concern for Board discussion together with actions to address the concerns.

Mr Holmberg asked if Mr Taylor knew how the Trust's sepsis scores compared to other Trusts? Mr Taylor stated that he did not as the methodology kept changing.

Mr Holmberg shared Mr Taylor's need to prioritise 7 day services as they also set the culture for working every day and the focus would be extremely valuable. He stated that key clinical standards need to mandate 7 day working and the Trust needed to know where the gaps are.

Ms Symington referred to page 61 and timely consultant reviews. She wondered if the Trust needed to do more than simply ask consultants to undertake this task in a disciplined way? Mr Taylor stated that he was dealing with this and that some colleagues needed to be asked whereas others needed to be told.

Mrs Adams stated that the medical staffing levels were good news at the Resources Committee, but that there did not seem to be much progress around recruiting senior clinicians for Care Group 2 and she was concerned about the establishment as she was not sure it was correct. It was noted that it was difficult to move forward when 100% staffing was never achieved and that the acute medical model was predicated on a different number of senior leaders downstream and this has not been fulfilled. Mr Taylor stated that they were already looking at more effective and efficient ways of working and

there was clearly room for improvement with the doctors in situ. Ms McMeekin stated that there was a specific action related to this in the CQC action plan and this will be formally reviewed against the Royal College guidance to show where the gaps are and what the plan looks like.

Mr Holmberg asked if the fill rate for doctors was more to do with getting a higher number of junior doctors rather than getting permanent staff? It was agreed that this was the case. Ms McMeekin stated that medical recruitment on the East Coast at a sub-consultant level has improved.

The Board:

- **Noted the report;**
- **Supported the objective on 7 day working;**
- **And wished to see greater use of report front sheets to direct and prioritise Board discussions.**

20/12 Performance Report

Mrs Scott stated that the report had been discussed at the Quality Committee last week. Particular highlights to note, included that a Frailty Unit had been opened in Scarborough on the 6 January, co-located with ED and had already seen 200 patients of which 81.5% had been discharged straight home instead of spending a long time in ED or being admitted - this was a huge success for the patients and also for the trust. It was being called the Home First Unit and work was underway with the Community Partnership Board stakeholders re developing an integrated frailty service.

In relation to Same Day Emergency Care (SDEC), work was in progress. Data suggests that approximately 130 ED attenders were being seen in SDEC with between 20% and 30% of ED attenders going on to be admitted to downstream beds. 24% of all ED attenders had converted to a downstream admission during December, either directly or through SDEC. This is a slight reduction on October (24.1%) and November (24.4%). Including direct GP admissions and elective activity, there are between 200 and 250 SDEC patients per week (up from 150-200 prior to November 2019, and 100-150 in early 2019), with between 15% and 25% admitted downstream.

Pressures continue in ED as attendance continues to rise, but SDEC is beginning to have an impact.

Mrs Scott stated that in relation to the total waiting list position, the waiting list is currently 3,000 open clocks above the required target. More work is required to validate the waiting list.

Mrs Scott stated that work continues in relation to fast track cancer patients which means balancing a number of risks and issues relating to undertaking elective work - this work is sighted on by the Care Groups.

Mrs McAleese asked if ECIST were focused on the amount of specialist work that takes place on the York site? Mr Taylor stated that this had generated a lot of debate with clinical colleagues and that often clinicians come to work in an organisation that they are attracted to, particularly to do what interests them. The challenge is to get the balance

right, between specialist 'interesting' work and essential team discipline work He noted that there is more work to do in relation to this area and that it may historically have been an unintended consequence of PbR

Dr Boyd asked what was being done to reduce any harm which was a consequence of a longer waiting list? It was noted that how the Trust assures itself that patients are not coming to harm due to waiting lists and backlogs was being discussed with commissioning colleagues and there was no guidance around this area. Advice is being sought further afield. NLAG put in place an improvement framework for assessing risks following a CQC inspection about 18 months ago and HCV are facilitating a workshop on this. Executive Board is also sighted on this and asking Care Groups for assurance around prioritisation of patients and identifying patients at risk.

Ms Symington noted the number of external teams now working in the trust to provide support, (listed on page 81 of the pack) and observed that despite all of this additional support the rubicon had still not yet been crossed. It was noted that the teams are valuable and bring expertise and advice and share learning about what works. There is a national ED initiative about streaming away patients, but often these are the patients that staff like to manage: ED should only manage those patients who truly need to be seen and changing some ways of working is challenging. Mr Morritt was clear that the external teams need to stay as the Trust needs to see sustainable change before they leave.

Mrs Adams highlighted that there has been a reduction in delayed transfers of care. Mrs Scott stated that there was some traction on this but it was not an overnight fix.

The Board:

- **Noted the report and the huge amount of work being progressed.**

20/13 Partnership & Alliance Report

Mrs Scott stated that this report is a regular update and asked if there were any questions.

Mr Bertram provided a short update on the pathology collaboration which was looking at the best configuration between Hull and York Pathology Departments to deliver the theoretical £3m savings, along with multiple patient related benefits. A project board compromising both clinical and managerial staff had been put in place and a business case was being drafted and would come to Board in March or April. The business case would evaluate the fundamental structural changes required and consideration was being given to a number of options. It was also noted that Mr Dillon would sit on the project board.

Mrs Adams asked about the East Coast Service Review. Mrs Scott stated that the stakeholder group were meeting on Friday to consider and sign off the phase 2 report. Potential service options as described in the phase 2 report are being worked up in more detail. The phase 2 report will be distilled so that it can be more public facing and there were key elements of the Clinical Senate review to factor in which had looked at Urology and Paediatric pathways. The Clinical Senate review will be discussed at the February Board.

The Board:

- **Received and noted the report.**

20/14 Finance Report & Efficiency Report

Mr Bertram stated that the Board had already noted the Q3 position so he wished to focus on the forecast outturn. He stated that NHSI had been made aware of the possible £4m shortfall and if that happened the Trust would lose a further £5m PSF funding, making it a £9m deficit. NHSI understand the Trust's position and recognise the Trust had not lost control of its finances, but still required the Trust to hold the line on general levels of spend. Mr Bertram stated that he was working with NHSI to describe a series of mitigating actions to land the position at the end of the year or as close to it as possible.

Mr Bertram stated that NHSI expect the Trust to take action on discretionary spend and push expenditure into the new fiscal year where possible or practicable. He noted that there were a number of technical issues to explore and NHSI were helping with this and these would be discussed at Audit Committee, where appropriate, to ensure that they did not raise concerns further down the line.

Mr Bertram stated that NHSE had noted the Trust was under-trading on its specialist commissioning contracts and were prepared to pay the Trust at planned levels which would help to close the gap. Mr Bertram stated that it was going to be a difficult Q4 with a significant number of quality and safety issues. He will continue to keep the Board updated and stressed that he had not given up hope yet and he was discussing with NHSI whether the control total can be relaxed in light of the significant safety requirements which emerged from the CQC visits. He noted that if the Trust does not get the PSF at the end of Q4, this will cause problems with cash flow next year.

Ms Symington asked about the pressure the Trust faces next year and whether the new fiscal year would bring any improvement to the overall financial position? Mr Bertram stated that the operating framework guidance was due out this week and a draft plan would be due in on the 5 March so the reworked 2020/21 financial year from the medium term financial plan will be brought to the Board in February. The final submission is required at the end of April which will need to be signed off by the Board. Guidance is also due on the emerging constitutional standards around patient choice and access so discussions will be required around what this means for the system. It will show a significant challenge and the high running costs for Scarborough Hospital will need to be continually highlighted.

Mrs Adams asked about backlog maintenance issues and the prioritisation required? Mr Bertram stated that this detail will feature in the operational plan being brought to the through the Committees and Board in February. He gave a brief overview which noted £4.8m left after all pre-commitments, £2m for backlog maintenance, £1.8m for IT, £350k for medical equipment, £500k for contingencies and £400 for minor works. However, this did not include the far from aspirational requirement for a second CT scanner at Scarborough. He was also aware that the estate condition survey may throw up more urgent requirements. He noted that there were some difficult conversations required and Executive Board would need to prioritise the spend.

Ms Symington asked if there were any hints around improved central funding? Mr Bertram stated that the Trust was well on the way to gaining the £40m capital monies (£22m for ED

and £18m for backlog maintenance) in Scarborough. He stated that there is no clarity around the new capital regime and the level of concern in other organisations and at the centre remain. However, if funding is made available, he stressed that the Trust needed to be in a position to move very quickly.

The Board:

- **Noted the finance report and remain concerned about the Q4 position and prioritisation of backlog maintenance work.**

20/15 Director of Workforce Report

Ms McMeekin wished to bring reducing the nursing and medical staff vacancy rate and statutory and mandatory training to the attention of the Board. She noted that recruitment continues to be strong in nursing and that page 158 of her report tracked the position. She stated that a workstream has been established to review the nursing establishment as it had last been reviewed in 2015 and demand for temporary nurse staffing remains high with 79wte more staff being requested than last year (CQC requirements = 70wte). Ms McMeekin highlighted the medical vacancy rate which was 8.4% for York and 16% for Scarborough.

Ms McMeekin stated that statutory and mandatory training was now broken down by staff group and the CQC had raised concerns about IPC, safeguarding and resus training which had been included in the action plan as medical and dental uptake was low and there had only been a modest 1% increase. A formal letter had been sent out from her and Mr Taylor to this group which she hoped would lead to a significant rate of compliance. She noted that Mr Taylor and Mrs McNair were reviewing the training needs analysis.

Ms McMeekin stated that the trust had been clear about the expectations of compliance, but it was still about staff being freed up to undertake training during the winter period.

Mrs McAleese asked about page 169 which stated that St Monica's medical staff stood at zero? Dr Boyd explained that GPs were commissioned to provide this service and they will have had this training as part of their GP training requirements so a way to cross-report compliance was needed.

Mr Holmberg asked about job planning and whether this was being used to ensure compliance? Ms McMeekin stated that the 2019-20 round was concluding so that it falls in line with the business planning cycle. She stated that a cultural shift was required and the Care Groups were working hard on this. She noted that compliance was hardest to achieve at Scarborough.

Mrs McAleese asked if staff who were not complying, were told it was mandatory and not a choice? Ms McMeekin stated that there is also a tool in the national contract which can be used as a lever, so that anyone not completing training can be stopped from receiving increments. However, this was a significant problem due to the pension tax issues as many medical staff are now actively trying not to get an increment. She was in discussions trying to get training linked to appraisal compliance so that the appraisal is not signed off unless medical staff are fully compliant with training. Mrs McAleese asked if there was anything further which could be done to help? Mr Taylor stated that the main issue was compliance and he would pick this up outside of the meeting. He did note that it

had been agreed at LNC that statutory and mandatory training could be done in SPA time and compliance was also linked to working from home.

Mrs Adams referred to the meeting etiquette document in the pack and in the essence of saying something positive wished to note the charts for vacancy rates which were pretty impressive and credit should be given to the effort involved to getting vacancy rates down.

Mrs McNair stated that she was still anxious about the really big vacancies at Scarborough.

The Board:

- **Noted the report;**
- **Wished to be kept informed regarding statutory and mandatory training compliance.**

20/16 Governance Documents

Mrs Provins provided an overview of the request for Board approval of the Scheme of Delegation and Reservation of Powers, Standing Orders and Standing Financial Instructions which had already been approved by the Audit Committee. Mrs Provins also specifically highlighted the additional amendment made to the Scheme of Delegation and Reservation of Powers concerning delegated powers to on-call teams which had been added after Audit Committee approval. Mr Bertram added that the on-call arrangement was important so as to protect staff out of hours. Mrs McAleese stated that the Audit Committee had taken reassurance that Mr Bertram had been through the documents in detail.

The Board:

- **Approved the documents including the additional amendment in relation to on-call staff.**

19/17 Reflections on the Meeting

BAF - Ms Symington stated that nearly all the strategic risks had been covered and Mr Morritt noted that some of the BAF scores had been reviewed at Corporate Directors in light of the latest CQC visit and he suggested that the BAF was amended and circulated so that a fuller discussion could take place at the February Board. Ms Symington stated that environmental sustainability had not been discussed and Mrs Provins noted that a sustainability report was coming to the Resources Committee in February.

Actions: BAF to be amended in light of the discussions at Corporate Directors and will be added to the February Board agenda.

Mr Taylor stated that his perspective of risk was changing and that for him the biggest risk to the Trust was around quality and safety and that the other risks described such as finance and workforce were only enablers to quality and safety - as our core business was healthcare. He noted that previously the finance and workforce risks had been scored higher than the quality and safety ones and that this was being redressed.

Reflections on the Meeting – Mr Holmberg stated that having the director's reports following the Committee escalation logs had worked so that concerns could be raised and then addressed as part of the directors reporting.

Mr Bertram stated that time had been carved out for two very interesting presentations which had been very informative and were key matters for Board consideration.

Mrs McAleese stated that the Chair had taken the Board through a difficult agenda very well and it was noted that a Chief Nurse report had not been submitted so that more time was given to the IPC update.

Mr Holmberg stated that the Care Groups still needed to feed into the Board and Mrs Provins noted that Care Group 1 is due to present at the next Board meeting. Mrs Scott stated that a paper has been done on Outpatient transformation work by Care Group 5, but she thought it would be much more useful if the Care Group could be invited to present as it would be better than just receiving a paper and it also links to the digital strategy.

Mrs Adams stated that there had been lots of discussion around digital and especially slippage around projects and she expressed concern that the governance needs to be right. Mr Bertram stated that a Digital Strategy Group had met for the first time on Monday and terms of reference and a work programme were being drafted. He noted that there had been a long and detailed discussion about the prioritisation of the work load and there would be further discussion at the February Executive Board.

Mrs McNair stated that there had been a debate about the Ward to Board flow of information at Quality Committee and she stated that there had been agreement that the Care Group Quality Committee Chair's should attend the meetings. The Board thought this was a good approach.

Action: Invite Care Group Quality Committee Chair's to the Quality Committee

The Board

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

20/18 Any other Business

Meeting Etiquette - Ms Symington highlighted that these principles had worked well at the Council of Governors and it was setting the expectation for how people behave at Board meetings.

Corona Virus – This had been covered earlier in the meeting. However Mrs McNair stated that new operational guidance had just been received which was being looked at. She provided some context and stated that 96 individuals had been tested already in the UK and all had been negative.

No further business was discussed.

20/19 Date and Time of next meeting

The next public meeting of the Board will be held on 17 March 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	Completed
19/66	Sustainability Report to the Board in January 2020 – Going to the Resource Committee in Feb 20	Mr Golding	Completed
19/68	Consider in discussion with new CE, PCN presentation to board.	Ms Symington	Oct 19 Jan 20
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	Completed
19/106	Directors asked to be visible in hospital.	Executive Team	Ongoing
19/110	To look at presenting sickness information in SPC format – this will be in the February 2020 report	Ms McMeekin	Completed
19/111	HR LLP risk to go to the LLP Management Group	Ms McMeekin	Completed
20/06	Mr Jayagopal to provide an update to the Board on the plans for a new build in 6 months.	Mrs Provins	July 20
20/09	Mrs McNair to separate out the bigger organisational requirements in the CQC action plan.	Mrs McNair	Feb 20
20/11	Report front sheets to include items of real concern for Board discussion together with actions to address the concerns.	All	Feb 20
20/15	Wished to be kept informed regarding statutory and mandatory training compliance.	Ms McMeekin	Monthly
20/17	Invite Care Group Quality Committee Chair's to the Quality Committee	Mrs Provins	Feb 20
20/17	BAF to be amended in light of the discussions at Corporate Directors and will be added to the February Board agenda.	Mrs Provins	Feb 20

Blank page

York Teaching Hospital
NHS Foundation Trust

StarAward

A monthly award which recognises the achievements of staff and volunteers

Nominations Booklet
March 2020

StarAward

A monthly award which recognises the achievements of staff and volunteers

Joanne Chambers
Community Midwife

Community

Nominated by
Bev Waterhouse
Colleague

Maternity services are currently undergoing a large transformation. One of the most challenging elements of this is Continuity of Carer - where the midwifery team provide all elements of care for women on their caseload - including labour. This is a significant change to our traditional model. Jo initially felt concerned and anxious about how this change would affect her. However she has dealt with this in a positive and proactive way, going over and above to ensure that she felt prepared for the changes ahead. Her passion and enthusiasm is infectious, and she states that she feels she now enjoys her job even more than she did. A woman she has met with recently has decided to have her baby in Scarborough, despite having her other babies at a neighbouring Trust, because of Jo's positivity and the offer of receiving all her care from Jo and her team.

Melanie Linley
Community Nurse

Community Setting

Nominated by
Emma Coleman
Colleague

Mel works for the North Community District Nursing team. The team has been through lots of change recently and Mel has remained extremely supportive to all members of the team. She remains positive and every shift she is on is a relaxed and happy shift and any issues are dealt with swiftly, calmly and professionally by Mel. I am proud to work alongside such a supportive member of our team. I am fairly new to the team and I find Mel always has time for me to deal with any issues I may be experiencing. I would like for her to be recognised for her never ending positiveness and support.

Peter Lawrence
Generic Support Worker

Community Setting

Nominated by
Tracey Sutton
Colleague

We have a patient on our caseload who's has been self neglecting for a long time. He struggles with extremely low mood since the loss of his wife and Social isolation. He has no family and no next of kin. Peter has been working with the patient and has made a real difference to his quality of life. Peter compiled a list of Social activity clubs in the patient's area and has encouraged him to make contact with them. The patient is now enjoying his wood modelling classes very much and is joining some more. He stated Peter has helped him stop existing and start living. The change in this patient is immense. He is looking after himself, enjoying his life, and feels like he has a purpose again. This is largely down to the work Peter has done with him, and I would like Peter to know what a fantastic job he has done and he should be very proud of himself. I certainly am very proud of him.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Kirkbymoorside Community Nursing Team	**Community Setting**	**Nominated by Charlotte Larson Relative**

The recent care and professionalism shown by the staff at Kirkbymoorside surgery to my poorly mum and the family was outstanding. From the reception staff, the wonderful community nurses and of course, Dr Hughes. They were with us every step of the way as we cared for Mum at home until she passed away. We felt they genuinely empathised with us and the dignified way they treated Mum was beautiful. We will never forget our experience with you; you truly made a difference and made a heartbreakingly sad situation so much more bearable, thank you.

Natalie Ross Occupational Therapist	**Community Based**	**Nominated by Becky Macfarland Colleague**

Natalie gives 110% to her job, she is always willing to help, always positive and keeps the St Helens community team smiling! Natalie goes above and beyond for her patients and the team. In any situation Natalie stays calm and does the best for her patients.

Gemma Barnes Consultant	**New Selby War Memorial Hospital**	**Nominated by Sammy Lambert Relative**

Dr Barnes has been treating my baby. She has shown kindness and empathy that I am grateful for. She has offered practical solutions and has been available for any of our queries throughout. She genuinely cares about her patients and their families and has a lovely manner. She always runs clinic on time and gives everyone her time freely.

Dean Webster Print Department Manager	**Scarborough Hospital**	**Nominated by Sarah freer & Kerry Bryan Colleagues**

Dean always goes above and beyond to support the ward areas, nothing is too much trouble and he will provide stationary during high operational pressures at a moments' notice. We have recently set up the "Home First Unit" within the Emergency Department at Scarborough Hospital which required some brand new paperwork to be printed and organised to support safe patient attendances within the unit. Dean worked hard to support the unit and managed to ensure there was plenty of new paperwork and pro-formas made available for use. As a care group we wanted to recognise Dean for the continued support he provides, "thank you"

StarAward

A monthly award which recognises the achievements of staff and volunteers

Christopher Swain **Scarborough Hospital** **Nominated by Stephanie**
Healthcare Assistant **Relative**

Christopher treated my dad with dignity and respect throughout his 5 weeks stay which included end of life care. He told us what he would be doing for my dad and why. Christopher also looked after us as a family including myself by explaining what mediation is and providing us with tea, coffee and biscuits. Christopher is an assent to the Scarborough team and has definitely made good memories in my heart.

Sarah Hann **Scarborough Hospital** **Nominated by Ed Smith**
Radiologist

Sarah is an experienced, dedicated and hardworking radiographer. Although she has a number of specialist skills and expertise, including being a reporting radiographer, this nomination is based on evidence of living the trust values. Sarah was working as radiographer in the Emergency Department and demonstrated a high degree of attention to the care needs of the patients in the corridor with respect to hydration and nutrition as well as comfort. She took time to listen to the patients and act on their requests. Although this would not be strictly her role she acted as part of the team dealing with an over stretched emergency care system. She is always professional and has a high level of skill and expertise but also demonstrated that she was putting the patient at the centre of everything we do. Thank you Sarah.

Stephanie Grainger **Scarborough Hospital** **Nominated by Sarah Cowling**
Haematology Co-ordinator **Colleague**

I am nominating Steph as I feel she is a true example of someone working to the trust values. When there were staffing shortages she stepped up and went above and beyond her role. This included contacting patients to rearrange appointments and liaising with consultants and management to ensure the service was still able to run. She has a real connection to all the haematology patients and is able to tell you exactly where each are in their treatment journeys. She did all this and remained calm and approachable throughout the difficult week. She is a real asset to the team.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Darren Ford
CT Radiographer

Scarborough Hospital

Nominated by
Phil Dickinson
Colleague

On two occasions recently the single CT scanner at the Scarborough Hospital site has either failed or been unavailable when a major trauma victim has required a time critical CT Scan. On both occasions Darren has worked with the trauma team to try and resolve this by facilitating the use of the mobile CT scanner in the Car park. Whilst using this scanner is far from ideal this is better than having to transfer the patient to another hospital for assessment. Darren has been extremely proactive, coming to the Resuscitation room to liaise with the team and gone above and beyond to always do what he can to be helpful, explore all available options and provide the best service possible in the circumstances. Darren and the wider CT Radiographer team consistently live the trust values, and is always pleasure to work with.

The Home First Unit

Scarborough Hospital

Nominated by
Louise Brown
Colleague

This unit opened with very short notice on 6/1/2020 and the staff have all stood up to the task at hand and with hard work and dedication made it a success. They have been assessing and managing frail and elderly patients and discharging same day with the home first ethos. This has meant patients who potentially could have been admitted to the trust are able to quickly see a dedicated specialist multi-disciplinary team within 30 minutes or less of arriving in the emergency department. The unit will assess and ensure that patients are keep active and mobile throughout their stay in the department whilst providing the care they require to go home the same day. The unit received some amazing feedback from a relative on day 2 of opening stating what a sterling job was done by the staff in the newly formed First Home Unit. The relative reported that the team were outstanding; from a clinical point of view and as practitioners working cohesively to solve problems holistically. The relative went on to say she observed genuine kindness and interest in providing compassionate care. As a family she reports they were listened to and felt that their wishes were taken account of in all decision making. They felt that this innovation is a timely and extremely promising development that will hopefully prevent patients, like their mother, from being admitted, which the family felt is not necessarily the best place for people to recover and to ultimately facilitate a return home. Really great and promising start to this new venture at Scarborough Hospital, all thanks to the dedicated team that work in the unit, I feel they deserve recognition for their hard and caring work.

Courage Young **Staff Nurse**	**Scarborough Hospital**	**Nominator wishes to remain anonymous**

An outstanding International Nurse who works with compassion and great competence. As an International Nurse new to the UK's learning new ways of doing things, he has adapted quickly and strives to learn amidst workload at work.

Ben Richardson **Specialist Physiotherapist**	**Scarborough Hospital**	**Nominated by** **Natasha Scarth** **Colleague**

Ben deserves a star award due to him being the driving force and advocate for a patient whose discharge destination was at one point unknown, and a care home was possibly the only option. The patient had a condition where it was thought rehab was not an option. Following a meeting with the patient's family, where it was found the family had made some progress with the patient Ben made it his goal to explore all options for the patient regarding rehab. Ben drew on the expertise of his other colleagues in therapy, set a side time to see the patient nearly every day to go through their therapy and progress was made. Due to Ben's tenacity the patient was re-assessed by a rehab facility which had previously rejected the patient. On the second assessment, due to the progress the patient had made and because of Ben's determination, they accepted the patient for rehab. Ben is very modest, and says it was a team effort; however Ben had the foresight to draw on expertise from his colleagues, work closely with the patient's family and believed that this patient deserved the rehab they will now get.

Donna Walker **Directorate Secretary**	**York Hospital**	**Nominated by** **Ruth Mayhew** **Colleague**

Donna is amazing at responding to the needs of our children's bowel and bladder service supporting with ordering equipment, arranging training days and much more! This is in addition to all she does for other services in our care group. Despite the demands from so many Donna is able to respond and make us feel like we are valued and important. In doing so Donna is able to impact the children lives we see through the support she gives us for which we are grateful.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The A&E, Children's Ward and Fracture Clinic Teams on duty Boxing Day 2019 | **York Hospital** | **Nominated by Claire Brackley Relative**

On Boxing Day my youngest son had an awful fall and badly broke his wrist. The care he received during his time at York Hospital was exemplary. Every member of the team we dealt with was equally caring, efficient and very patient. My son was terrified and in awful pain and they did everything within their power to help him get through a really tough time. Oliver still has a way to go until he is 100% but know under the care of these wonderful professionals he will make a full recovery.

Amy Sharp Staff Nurse | **York Hospital** | **Nominated by Neil Norman Colleague**

Amy was involved in a blue light ambulance transfer to Leeds Hospital where she not only demonstrated the Trust values but also went above and beyond in the care of her patient who had multiple and distressing medical conditions, despite the unfamiliar environment and challenging situation, Amy was calm, confident and reassuring to her patient and effectively communicated with the wider multi-disciplinary team to ensure the best outcome possible.

Sian Jones Senior Orthoptist | **York Hospital** | **Nominated by A patient**

I telephoned the department with a query as I couldn't get an appointment, Sian followed up my call without delay. I felt she went the extra mile to ensure my query was answered punctually.

The Head and Neck Outpatients Team | **York Hospital** | **Nominated by Alexandra Clark Colleague**

One of our anaesthetic ultrasound machines for theatres became out of action, which was extremely challenging for our department and without it would mean we may delay patient's treatment. The Head and Neck Outpatients Team very kindly offered for us to use their machine for the several week long period that our machine was out of action. The team even offered to come and take the machine back to their department when they needed it for clinic and despite several occasions where the machine was in use when they needed it back, were incredibly helpful, kind and understanding despite this being an inconvenience to them. We are nominating the team for a star award for the wonderful cross department team working they demonstrated and the help they provided to the anaesthetic team - thank you from all of us in theatres!

StarAward

A monthly award which recognises the achievements of staff and volunteers

Nicola Fox
Healthcare Assistant

York Hospital

Nominated by
Pamela Corkill
Colleague

Nicola proposed an idea which would provide comfort and alleviate a patients' anxiety while waiting to be collected for theatre. The idea was to provide opaque panelling along the patient lounge doors so patients waiting are not continuously disturbed and on edge when there are sudden movements of opening and closing doors. This creates further anxiety to already existing anxiety from the journey of pre-operative care to post-operative care. The idea Nicola proposed protects patients dignity safety and confidentially.

Nicola Topping
Consultant

York Hospital

Nominated by
Elizabeth Charnock
Patient

I have been under the care if Miss Topping for approximately 18 months and during this time I have found miss Topping to be an extremely warm and caring individual who really does put the individual at the very heart of their treatment. I am a severely disabled individual with complex needs and sometimes my needs and individual disabilities go unnoticed by clinicians, which in the main is not a result of neglect or ignorance but rather an inability by specialist to view me holistically. I often feel as though I am just a diabetic or a neuro or a urology patient but Miss Topping never approaches me in a manner that makes me feel like "just an eye patient" and this is more valuable to me than words can express. Recently, I attended an outpatient appointment with Miss Topping for a post-operative assessment, during my consultation I discussed 2 incidences of total blindness which had occurred the previous day after my sutures had been removed. Given that Miss Topping was familiar with my complicated medical history she immediately shared with me her suspicion that I may have had 2 TIA's and given the seriousness of this she immediately initiated a referral to the stroke clinic. Her tentative diagnosis was later confirmed by the appropriate medical tests. I was admitted to the stroke ward in York Hospital later that day. Due to Miss Toppings' vigilance and individualistic approach to my healthcare a major stroke was avoided and I am now receiving medication to avoid any further TIA's. I would like to nominate Miss Topping for a Star Award because not only is she an excellent medical professional she is also human and her ability to engage with her patients on a human level makes such a difference to the patient experience. Her quick thinking, knowledge and experience quite possibly saved my life and for that I am eternally grateful. It us a pleasure to be treated by Miss Topping and I truly believe that certainly in my case she went above and beyond the call of duty but in all honesty she is just amazing. Thank you for taking the time to consider my nomination, I hope her achievements are recognised by a star award.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Yvonne Doherty
Senior Clinical Psychologist

York Hospital

Nominated by
Elizabeth Charnock
Patient

Yvonne has been assisting me to accept and overcome some serious life changing health problems and I wish to nominate her for a star award for the following reasons. Last year I attended a therapy session with Yvonne and towards the end of the session I advised her that I was unable to see out of my left eye. (I am on the blind register and whilst I do still have some functional vision it is very low however at the time of the event in question the change in my vision was significant). Yvonne asked me what I intended to do about the drop in my vision and I explained that I had an outpatient appointment in Leeds General Infirmary the next day so I would discuss it with my consultant at my next appointment. Yvonne expressed some concern about this and suggested that I may need to access treatment earlier. I didn't know what to do but having carefully considered Yvonne's argument that speed was of the essence, I advised Yvonne that I would call into A&E at York Hospital later that day. At the time I was wheelchair bound after undergoing an amputation and was battling a serious infection, I felt really quite dreadful and presenting in A&E was the last thing I felt like doing. Upon reflection, I was merely attempting to appease Yvonne by agreeing to attend accident and emergency, but in reality the likelihood of me doing so where slim to none given that I was immobile and in a transfer wheelchair with no assistance. At the end of my therapy session Yvonne asked me how I felt about her speaking to a specialist in the eye department for advice. I agreed thinking at the time that it was a considerate and compassionate thing for her to do and I really felt valued as a human being. The fact that Yvonne identified my medical needs and appropriately responded to them when it was apparent that I lacked the resources to do so myself was invaluable to me. I felt quite humbled by the depth of care and compassion shown to me by Yvonne and other clinical staff involved at the time. To cut a long story short, Yvonne made the call and the duty consultant Mr Taylor agreed to see me immediately. Yvonne transferred me in my wheelchair from the diabetes centre to the eye clinic and handed over my care to the eye clinic staff. I was diagnosed with a new condition within the hour, which is so rare few clinicians have ever seen a presenting case in clinic! Fundamentally, Yvonne's willingness to think outside of the box and consider my needs in a holistic manner meant that I received both a diagnosis and treatment quickly. Had I stuck to my original plan and delayed seeking treatment until the next day there is a very high possibility that I would be completely blind now. I wish to nominate Yvonne for a star award because she is a true star in my eyes and an absolute asset to the NHS as well as York Hospital. I am sure all of Yvonne's patients value and appreciate the high standard of care provided to them by her and I am equally sure that they communicate this to Yvonne however I think it is very important that staff members receive recognition for the difficult work they do and feel valued by both patients, their colleagues and superiors particularly when the work they do supersedes all expectations. If saving someone's sight doesn't deserve a Star Award then I am not sure what does but in my eyes Yvonne is a star whatever the outcome if this nomination. Thank you for taking the time to read my nomination.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Jessica Dixon **York Hospital** **Nominated by**
Clerical Officer **Vicky Mulvana-Tuohy**
Colleague

Jess has been instrumental in changing the way Allied Health Professionals are able to collect, analyse and start to see the trends of inpatient activity across the organisation. She is modest in her contribution but she is a spreadsheet wiz and has radically changed the processes AHPs use to record data. She has challenged clinical staff thinking to ensure there is consistency in the recording methods and presentation of the data to enable us to meet national recommendations regarding data sets. This means our team managers have a much better understanding of the activity our teams do and staff can be moved and used better as a result of this information. We could not have done this transformational change without her – and I wanted to say thank you in a public forum. Not only this everyday Jess demonstrates positivity and always says yes especially to a challenge – she is a really valuable member of the team and demonstrates trust values in abundance.

Mohamad Kajouj **York Hospital** **Nominated by**
Doctor **Nasser Ayoubi**
Colleague

I would like to nominate Dr Mohamad Kajouj for a star Award as recognition of his exceptional hard work for the Head & Neck department over the last year. He has been very supportive to his colleagues since he started as he had more experience in ENT, by staying with them many times beyond his duty, to ensure the best quality of care and patients safety. He also, joined his colleagues in clinics to help them with practical skills many times even when he is not meant to be working. He is praised by his colleagues for his friendly attitude and passion about patients. He has received many cards from patients to thank him for his outstanding care. Also he is thanked by colleagues in the emergency department for helping them whenever he is on night duty but not busy with work towards ENT. Mohamad also stepped in to help us on many occasions when we needed him to cover the on call duties in the absence of his colleagues. As Mohamad is coming to the end of his rotation with Head & Neck next month, awarding him a star award would be the best way to recognise his hard work and going beyond his duties in many occasions.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Samantha Hibbs **York Hospital** **Nominator wishes to remain anonymous**
Healthcare Assistant

Sam is a hardworking and dedicated Healthcare Assistant who works for the Chronic Pain Team, she works long hours and is often the first to arrive and last to leave the department doing many hours of unpaid overtime for the benefit of the patients in her care. Sam is the first friendly face our patients see in the busy and challenging chronic pain unit and is always cheerful, has a friendly smile and a hand to hold for the often scared and confused elderly patients who visit with multiple complex problems. Sam deserves a star award for the hard work, care and compassion she puts in, not just when things are going well but every day.

Helen Landray **York Hospital** **Nominated by**
Healthcare Assistant **Jayne Smithson**
Colleague

I am a new member of the NHS, and since starting Helen has been so helpful, and thoughtful she shines like a star in everything she does, giving 100% effort all the time and never judges anyone. Helen has been teaching me over the last 4 weeks and the way she is at teaching is impeccable. I would love to see her get a star award because she simply is one.

Jo Welch **York Hospital** **Nominated by**
Sister **Emma George**
Colleague
Amy Watson
Colleague

Emma Said:
Jo is a peer vaccinator, she administers the flu vaccine, this winter Jo has vaccinated 327 members of front line staff which equates to 35 % of the Care Group One numbers, she is always available to vaccinate and walks round the ward areas which is a better way to target frontline staff We are very proud of Jo for all that she has done to protect our staff and patients and think she deserves to be recognised for this.

Amy Said:
I would like to nominate Jo for her invaluable support during bereavement. I was widowed and my young daughter has been struggling with her mental health. Not only has Jo helped me to return to work slowly over a period of a year, she has also helped me to arrange a 9-5 Monday-Friday secondment for 3 months at short notice so that I can give my daughter a stable routine for a few months whilst her grief settles. Jo has shown me true compassion and support during a very turbulent time in my life.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Colonoscopy Team **York Hospital** **Nominated by**
22/1/2020 **Ian Simpson**
Patient

I was booked for an endoscopy on 22 January 2020. The patient experience I received was beyond my expectation in the professionalism and care taken by all the team. The procedure was explained fully, with constant attention to my comfort and welfare throughout. The new unit is a delight to be in and not forgetting the volunteer tea lady in the recovery area. Thank you team for making such a procedure easier and for the care you gave.

The team on Ward 32 **York Hospital** **Nominated by**
John Furnival
Patient

The professionalism of the diagnostic team and the care and attention of the ward staff was eye opening. As I had to stay overnight because of an operating theatre emergency, I was able to see the extent of care accorded to the other four patients in the ward who were much worse off than myself. I can say I was at ease at all times and I thank them all.

Nova Watkinson **York Hospital** **Nominated by**
Midwife **Amy Smith**
Patient

Nova delivered my second baby in September 2018. I was so scared during the birth as everything happened so quickly. But thinking back to it even now 16 months down the line I'll never forget how kind and reassuring Nova was towards me. I have always felt that I didn't get to thank her properly after the birth, but hopefully this recognition would be a start. Thank you so much Nova. If I were to have a 3rd baby I would be putting your name on my birthing plan!

James Wilcockson **York Hospital** **Nominated by**
Doctor **Emma Nield**
Lucy Rouse **Colleague / Relative**
Staff Nurse

James and Lucy looked after my mum in A&E, she suffers from dementia and is unable to communicate verbally, they both showed so much care and compassion towards her, ensuring they explained everything they were doing step by step and using the least distressing treatment methods they could. All the staff we came into contact with were brilliant with my mum and considering the busy department nothing felt rushed.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Iza Falkowska, Sarah Scott and Mandy Boyd Uniform Implementation Team

York Hospital

Nominated by Mandy Boyd John Dickinson Colleagues

Mandy Said:

Iza and Sarah have been instrumental in the roll out of the new clinical uniforms across both Scarborough and York sites. They have worked tirelessly and put in long and arduous days to ensure that we could distribute the new uniforms to staff. Despite the hard work and long hours they have not complained at the work and created a dynamic team to ensure that the task could be done. Without them it would have been impossible to get through the work and I feel that they should be recognised for going above and beyond.

John Said:

Mandy, Iza and Sarah have gone above the call of duty in sorting out the new staff uniforms for clinical staff. The implementation of the programme has been met with several difficulties such as wrong sizes and shortages, which the team have dealt with quickly and always with a smile on their faces.

Jane Blundell Porter

York Hospital

Nominated by Mandy Coverley

I work as a domestic on main entrance of York Hospital; I currently have a medical issue and was in severe pain with it Jane was on reception at the time and quickly rushed to my aid. She took me through to A&E where she stayed and supported me with personal care and keeping me calm when the pain got worse even though her shift had finished, Jane stayed with me until I was taken to a cubical. I had to stay in hospital a couple of days and Jane kept popping up to see me and if I needed anything she would happily get it. I nominate Jane because she went above and beyond to help me and honoured all the trust values. I want her to know how thankful I am to her, thank you Jane.

The Post Room Team

York Hospital

Nominated by Mandy Boyd Colleague

For the past few months the Post Room has struggled with staffing and the staff currently working in there are all part time. They have given up their own hours to come in to ensure that the Trust can be provided with a service even at a detriment to their own personal lives. These months have been difficult due to the pressures and yet the staff have worked tirelessly and effortlessly together without complaint and I couldn't ask for a harder working team. I would like them to know how much they are appreciated not just by myself but by the Trust for the work that they undertake.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Emma Shaw
Deputy Sister

York Hospital

Nominated by
Helen Tulloch
Colleague

I'm a Speech and Language Therapist and I've worked with a number of people with learning disabilities and complex swallowing and communication needs during their inpatient stays on ward 34 in the past few months. Emma deserves a Star Award because she has consistently facilitated high standards of patient care for people with Learning Disabilities, supported patient and carer well-being and progressed often complicated multi-agency, multi-factorial discharge planning alongside her other duties on a busy ward. Emma has made appropriate referral and further contacts with SaLT, she's shown active awareness of MDT working by including SaLT in joint problem solving with herself and others and really listened to our recommendations making appropriate, often small, adjustments to help poorly, sometimes frightened and disorientated patients feel settled - within safe working practice. She clearly thinks about individual patients' needs. Emma has understood and incorporated our assessment advice, ensuring bedside environment is as homely as possible, facilitating supported / assisted meal times, advising carers and she has done all of this with such a positive, caring and realistic, "can do" attitude that it's a real pleasure to work with her on the ward. As a relatively new employee, I feel that Emma demonstrates all the trust's values and behaviours to a high level.

Sue Kelly
Sister

York Hospital

Nominated by
Cathy Booth
Colleague

I would like to nominate Sister Sue Kelly for a Star Award. Sue is sister of the orthopaedic clinic and has had to manage and support her staff through very difficult times over this last year. It has been a very challenging time for her to give the best support and advice to her staff with so many changes in the department and with the department being developed over four sites. Sue has had to manage her staff through a crisis of staff sickness and reduced qualified plaster technicians at no small cost to her own stress levels. Sue wants the best for her staff as she is very much aware that the patients will have the greatest benefit if her staff are happy and proactive in their work. I work in clinic as a clinician so have been observing the trials and tribulations that Sue has been through these last few months and if nothing else nominating Sue will make her feel that she does make a difference and is worth it.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Jennifer Moran
Administration Team Leader

York Hospital

Nominated by
Alex Sharp
Colleague

I've been working on capacity and demand in Dermatology and identified 200 patients that we could bring forwards from April and bring the waiting list numbers significantly down. I've forecast the number of Fast track appointments that we'll need (including DNA rates etc.) so we know exactly how much capacity we will need and how much should be free. I shared this information with the team to come up with ideas on how we could make the moves, accommodate the forecast fast tracks, and hopefully not kill our follow up capacity too much. Within a week Jenny had come up with a plan and checked with the nursing teams to make sure they would cope with the increase in new patients (for biopsies etc.) and fast tracks at the weekends etc. Jenny presented a solid case for being able to accommodate everything. All patients were brought forwards and the templates adjusted for the forecast fast track capacity. All in all an amazing job for an already busy person/team.

Hayley Briggs
Diabetic Liaison Nurse

York Hospital

Nominated by
Nicola Lloyd-Jones
Colleague

I would like to nominate my colleague, Hayley Briggs, who is a fellow Diabetes Specialist Nurse. Never one to avoid jumping into the breech, Hayley has proved an invaluable support to me and the diabetes service. Her ongoing commitment to the service is unquestionable and she does not shy away from taking on extra responsibilities despite being incredibly busy herself. Hayley runs a very busy clinic away from the hospital every Tuesday and does so with little complaint. She also leads on our renal diabetes patients which includes regular visits to the renal unit and lots of support for patients at home. Hayley is passionate about teaching and educating and has formed a brilliant relationship with practice nurses and other healthcare professionals. This has been achieved by her hard work and determination. In terms of my own development, Hayley has taken me under her wing and provided support in work hours but also in her own time to help me progress. She is always available to contact and follows up on any difficult cases or clinics I may have experienced. I can honestly say without Hayley's help I would be in a much less positive place than I currently am and I am eternally grateful for her support. Hayley doesn't always possess confidence in herself or her abilities and knowledge and I would be delighted if she could be considered for this award to enable me to say thank you.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Eion O'Cuinneagain and Ollie Milner **Information Technology Support Manager and Assistant Information Analyst**	**York Hospital**	**Nominated by** **Susan North** **Colleague**

Eion & Ollie have added the space for ICE (In Case of Emergency) details to be added on our ordercomm forms. This has proven to be a lifesaving addition as we recently had a patient request from Tees & Esk area that would have been very difficult to locate without the ICE details. The Troponin result for the patient was very high and life threatening, the patient needed to be admitted in hospital to be given urgent treatment. Luckily the doctor had put their contact details on the Ice form so we then could contact them immediately.

Sharon Warters and Samantha Hibbs **Healthcare Assistant s**	**York Hospital**	**Nominated by** **Nicola Stewart** **Patient**

I recently had a procedure carried out on the Day Surgery Unit. I was extremely apprehensive about it and was quite upset. Sharon was amazing at keeping my spirits up in the ward whilst I was waiting for my procedure. She laughed and joked with everyone on the ward and nothing was too much trouble for her. Samantha was my designated hand to squeeze whilst having the procedure. She kept me talking and calm throughout and I honestly can say I wouldn't have gotten through it without her. They are both a shining credit to the NHS and to York Hospital especially. Please thank them both for me. I can't express exactly how much they both made a positive difference to my day.

Paul Adams and Steve Mitchell **Support Workers**	**York Hospital**	**Nominated by** **Eve Graham** **Colleague**

Paul and Steve are support workers in the Vascular Image Unit (VIU). They always go above and beyond to support us nurses, the patients and the rest of the VIU team. Nothing is ever too much trouble for them. They never complain, they are always positive and interested in boosting the wellbeing of patients and staff alike. I'm always happy when they're around. Care giving, positivity and hard work are just some of their attributes.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Bev Peel
Specialist Nurse

York Hospital

Nominated by
Andrea Marsch
Colleague

At the end of a work day Bev assisted a man who had fallen off his bike and was lying unresponsive on the pavement. She assessed his condition ensured he had an airway and was breathing and called for an ambulance. She stayed with him until paramedics arrived.

Leah Moorhouse
Assistant Recruitment Manager

York Hospital

Nominated by
Julie Southwell
Colleague

Leah has worked tirelessly over the past year to recruiting nurses to work for the Trust. She has built a relationship with University of York, which has enabled us to hold recruitment events on their premises to attract student nurses to apply for jobs with us. Leah has also built relationships with other universities which, has meant that our vacancies are advertised on their internal communication boards. Attending these events has meant that Leah has worked in her own time, including weekends, and her hard work has resulted in a healthy number of nurses applying to work for us.

Kath Noon
Senior Staff Nurse

York Hospital

Nominated by
Donna Sykes
Colleague

Kath is a core member of the vascular team in York theatres, and we get a lot of patients undergoing procedures under a local anaesthetic. The whole team know that if Kath is with us, the patients will be put at ease, with her easy conversations, and it never ceases to amaze me that whoever the patient and whatever their background, she can always find a common ground for something to chat about. We all can, I know, but she can do this for the length of the cases, sometimes an hour or more.

The Star award nomination form can be accessed through the Star Award link on the website and Staff Room.

Telephone:
01904 726491

Email:
Events@york.nhs.uk

Follow us:
Twitter @YorkTeachingNHS
Facebook York Teaching Hospital NHS Foundation Trust
Instagram YorkTeaching NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 March 2020
Resources Committee Minutes – 18 February 2020

Attendance: Jennie Adams (JA) (Chair), Lynne Mellor (LM), Jim Dillon (JD), Andrew Bertram (AB), Graham Lamb (GL), Adrian Shakeshaft (AS), Steven Kitching (SK), Polly McMeekin (PM), Kevin Beatson (KB), Lynda Provins (LP), Jane Money (JM), Andy Betts (ABe), Tracy Astley (TA) (minute taker)

Apologies for Absence: Brian Golding (BG)

Observing: Sheila Miller (Public Governor for Ryedale & East Yorkshire), Michael Reakes (Public Governor for York)

1. Welcome

JA welcomed everyone and declared the meeting as quorate. She welcomed the two observers and explained to the committee that they were there to observe the NEDs as part of the appraisal process.

JA thanked everybody for getting their papers in on time and asked that this be repeated every month.

2. Declarations of Interests

There were no new/changes to the DoI register.

3. Minutes of the meeting held on 21 January 2020

The minutes of the meeting held on the 21 January 2020 were approved as a correct record subject to the following amendments:

GL explained that there is an opportunity to receive a discount of ~~£1.2m~~ £0.5m this year which is related to the Trust meeting key maternity standards.

4. Matters arising from the minutes and any outstanding actions

- Clarification of catering hygiene results – ABe advised that the internal catering hygiene audits were carried out on a quarterly basis by the Trust's Compliance Team. This was backed up by an external hygiene audit carried out by the local council. The results were 5 stars everywhere apart from the York site that was given 4 stars. They highlighted a number of storage related issues and ABe has asked the Trust's Compliance Team to look closely at those examples.

He explained that from the audit results a quarterly report and an action plan was produced. He gave examples of catering issues recently found and how these issues were progressed through the action plan to completion. As a result, the catering operatives in that area have refreshed their IOSH catering hygiene training. ABe also informed that they were in the process of recruiting internal catering hygiene trainers which will allow staff to annually refresh that qualification.

He informed that the hygiene audits, together with the related action plan, were held on the LLP drive but his intention was to also make them available on the Trust drive.

JA highlighted that the LLP report was a different format this time with less data. She asked if some of the KPIs could be made available for the committee to look at, especially cleanliness, to give assurance to the committee.

LM agreed that the committee would like sight of the data to ensure the Trust was meeting national standards.

Action: BG to add catering hygiene scores and action plan together with summary of actions to LLP report each quarter to Resources Committee.

- Update on HPV equipment business case – on agenda.

- Report on backlog maintenance priorities and costs – on agenda.

- Develop Estates section for integrated Board Report – JA asked if this could be a single page update. ABe advised that BG was in the process of creating a summary report from the EPAM meetings which would give assurance to the Resources Committee.

  Action: BG to add Estates Summary Report to the IBR each month and Summary EPAM report with key metrics to come to the Resources committee for assurance.

- Clarification of carbon emissions data – on agenda. Remove.

- Review of BAF/CRR scores on finance part – AB confirmed this had been completed. Remove.

- Provide update on GIRFT – SK confirmed that the benefits will be presented at the March meeting.

- Escalate agreed items to Board – JA confirmed that she had escalated the agreed items from January meeting to Board and will continue to do so after each monthly meeting. She asked if the Escalation Log produced by the Chairs of the committees for Board meetings were useful and added that they would continue to use this.

- Papers to be submitted in line with committee deadline – JA thanked everyone for doing this for the meeting.

- Notification to be sent to NHSI/E regarding Q4 financial position – AB confirmed that this had been completed. Remove.

- Minutes from committees reporting into Resources Committee to highlight items for escalation or be FIO – JA highlighted that a number of minutes were being presented at the meeting containing very little items for escalation. She advised that if there was nothing to escalate then the minutes will be classed for information only and be put under 'Items to Note' on the agenda.

- Concerns on litigation increases and learning to be escalated to Quality Committee – LP confirmed that she had escalated this to the Quality Committee. Remove.

- Report cover sheets to include a narrative highlighting areas for committee to focus on – LP asked that authors be absolutely clear under the recommendations section what they were asking the committee to do. It will be assumed that committee members will have read the papers prior to the meeting and will ask for clarification if required. In order to bring an issue to the attention of the Board it was imperative that this be made clear in the recommendations section.

- Obtain additional information on special funding for areas of population growth and feedback to Andrew Butler – AB advised this was related to S106 grant funding and said that he was exploring this option but it was quite difficult to get. He advised that the Capital Programme Executive Group had picked this up and was to speak to the local authorities to take this forward. Remove.

  JM advised that her colleague attended a meeting of the York Council's Local Plan where it was announced that 800 homes per year were to be built around York, totaling 20,000 new homes. The Council had not consulted the Trust on the impact of this on York Hospital or the health services required.

  LM asked if this information had been fed back to Board. JM advised that they had only just become aware of this. It was only at the discussion stage but the information had been given to Andrew Bennett. JA advised that it should be raised at Board level. JD informed that it took years to get a plan in place and the committee might be a bit premature.

  JM advised that although money comes from the developers and might take a while to get to those targets, the S106 funding was allocated by the local authority and the Trust needed to make the council aware that money was needed to fund the health care of an increasing population.

- Governance of the LLP and representation at the Resources Committee – JA advised that going forward the plan was to have the new MD of the LLP to attend the meeting. Remove.

- Clarification of items on the action log – LM asked that the items on the action log refer to the sections in the minutes to make them clearer.

  Escalate to Board: Proposition from the Council to build 800 new homes per year. Consultation needed with regard to healthcare needs.

5. Escalated Items

JA noted that the Audit Committee had highlighted their confusion around the assurance mechanism from the LLP. She advised that this had been cleared up during the earlier discussion about producing a summary report to be included in the IBR.

JA noted that the Quality Committee wanted PM to talk about job planning in the workforce section of the meeting today, in particular consultant job planning and bench marking of the medical workforce. PM acknowledged she will reference it in the workforce section.

6. Integrated Board Report (IBR)

JA asked if anybody had any questions about the information contained in the IBR. It was acknowledged that the committee should be aware of what was happening with regard to the Emergency Care Standard, C.diff, bed occupancy and long waits as they were all huge challenges for the Trust and all impacted on resources. JA highlighted that there was a presentation on C.diff by the Deputy DIPC/Chief Microbiologist at the Board last month and he was saying that he thought whatever the Trust would have received in fines for C.diff was being waived with an expectation that the Trust would invest in reducing C.diff. She asked if the Trust was dealing with this issue. AB replied that it was very difficult to do this given the financial climate. He advised that the funds received for the HPV machines came from a bid that was nationally funded. The contract agreed with the commissioners this year was a very restricted block contract in which it was agreed not to fine the Trust. The comment made at Board was a comment from the CCG in which there was an expectation that the Trust would invest that money to reduce C.diff.

LM highlighted that she had asked a number of times for the business to work with KB/AS around their digital priorities in order to start to see some performance measures of digital success and quantifiable benefits which will help drive the digital strategy forward.

JA stated that there were two big gaps in the IBR, the digital agenda and the estates agenda. They were not represented as yet and this needed to be worked through. AS advised that the digital section will be added to the IBR next month.

Action: AS/KB to add Digital section to IBR in March.

7. LLP Report

BAF Risks : 4, 11

JA stated that she assumed the committee members had read the papers and referred to JM/ABe to give highlights.

<u>Sustainability Report</u>

JM gave an overview of the report and stated that it was around developing a 5-year plan. She advised that some new guidance had recently been produced and the topics that they now needed to incorporate were: -

- greenhouse gas projections and a plan to achieve a reduction in accordance with the Climate Change Act.
- to demonstrate how the Trust's premises were being adapted to tolerate the changing climate and also achieving a net zero carbon emissions from the Trust's premises.
- the need to reduce the impact of procurement through improved selection of products and services.

She gave an overview of the carbon reduction project and advised that they had just had a quarterly review. The main three issues coming out of that was the need to catch up on some of the projects they were behind on, to ensure there was Trust wide senior management support and the fact that the MD of the LLP was retiring and the support he had given needed to continue by his successor who should be thoroughly briefed so that the project was seen as a corporate priority.

With regard to the Travel plan, she advised targets had been met in relation to cycling, walking and car sharing.

Referring to the Waste data, JM advised that there had been a significant reduction in carbon due to the Trust's waste initially going to a Waste to Energy Plant instead of going into landfill. Currently they had no choice but to incinerate the waste as contracted by NHSI. However, future plans will be to send the waste to a Waste to Energy Plant in order to meet the Trust's targets. JD commented that from a business point of view for the LLP this could be used as a source of income by having its own incinerator on site. ABe replied that this was something they were looking into. It was estimated that it could bring in a possible income of £1m per year. Capital was needed to invest in this and a current business case was ongoing.

LM highlighted the increase in clinical waste incineration with Mitie given that the Trust was supposed to be reducing it. She felt this was an issue that needed to be looked at and suggested recycling would be a good start with a communication campaign on recycling throughout the Trust.

JA commented that when the figures were received from the old Estates Committee, procurement was a huge source of carbon generation. ABe replied that there were competing factors. For example, purchasing food locally would be beneficial but then it was 20% or so more expensive. It was a real challenge when the Trust was struggling financially.

LM asked if the NHS target standards were linked to the national standards. JM confirmed they were linked. LM said it would be useful to see some data on how the Trust performed nationally.

With regard to travel and transport and the use of Skype, LM stated that it seemed a slow process introducing it across the Trust. She did not get a sense of quantifiable efficiency benefits on travel and transport. ABe advised that they were rolling out Webex instead of Skype. He explained that some of the PCs were too old to run the Webex function and PCs were being replaced to strategic staff that would make use of Webex. He advised that all their management meetings now happen by Webex. The ability to display information in real time, to record meetings, the ability to live work on maintenance, was really beneficial. He believed that one to one discussions through Webex worked better

than a group around a PC as it was possible to lose sound. It was also noted that Webex did not run very well on PCs without Windows 10. He stated that the use of Webex had been encouraged across the LLP with a view to promoting it across the Trust. It was a positive step but required support from the IT network for it to move forward. LM commented that Webex can be used on a number of devices and can be used one to many not just one to one and there was other technology, such as polycomms, surface hubs, that could be used for Webex and it was not restricted to PCs.

LM made reference to the fact that there were risks around the introduction of Skype and travel in the report but there were no risks associated with clinical waste even though it was a key risk on the BAF.

JA commented that the Sustainability Team did not feel that the Sustainability Agenda had the profile required in the Trust. She gave JM the opportunity to say what needed to happen in the Trust to help meet targets. JM replied that there was not enough senior prioritisation on this. She suggested having documentation given to all staff and new starters, including asking them to join the Sustainability Group. She believed it was necessary to review how things were being done and to do it differently. Sustainability had to be included in everything that was being carried out in the Trust. LM agreed and said it was an attraction for new recruits. PM advised that in light of the Sustainability Agenda all recruitment was digitalised but she thought what was needed was good news stories on what the Trust had achieved to show progress because it was recognised how important it was for candidates and the Trust needed to show that it was not just talking about it but had evidence on what the Trust had managed to save. JA agreed that the Trust would have to evidence the Trust's progress going forward as it was mandated. JM replied that they had some evidence of technological fixes, but it was about people reviewing what they were doing and doing it differently and recognising that carbon reduction and efficiency was part of that.

JM advised that Green Champions had been recruited who meet quarterly. It was an opportunity to discuss what projects were going on in the Trust and it was also a good opportunity to ask for ideas. Information was cascaded through the Chief Executive's staff brief, Staff Matters and on Staff Room. The meetings were being themed with the first one being about Warp-it, the second one was on Switch It Off and the next one will be on transport. A future meeting will be around raising awareness of waste.

ABe moved on to discuss the current fleet of electric vehicles and advised that they were looking at replacing these as feedback from users was that the drive range was inadequate at only 85 miles instead of the projected 105 miles. There would be financial costs involved. JM commented that through progressive technology the range had more than doubled. ABe also informed that they were working with the local council to try and secure some rapid charging stations as the current ones were taking several hours to charge the vehicles.

JA felt that the issues around Sustainability needed to be escalated to Board as there was concern that more support was needed.

JM highlighted that medical and clinical equipment was the biggest carbon items that they needed support with.

JA commented that there was only one specific risk on the BAF which scored 4 and questioned whether this score was too low given as it did not reflect the information which was being presented at the meeting. JM agreed that the score was too low and now she had the new guidance it would be useful to review the risk. JA informed that the Board tended to concentrate on the red risks.

Action: JM to report on Trust performance against NHS/National standards regarding carbon/waste for next meeting.

Action: JM to review any risks in relation to Sustainability on BAF/CRR. Escalate to Board: Sustainability and carbon reduction.

HPV update

ABe gave an overview of his report. The key points were:-

- National funding had been secured to purchase new equipment.
- HPV cleaners were being trained to use the new equipment.
- Working in-house gave the flexibility of providing a 24/7service.

JD asked about the challenge to decant in order to clean a ward. ABe said that a lot of the work being carried out now was reactive whereas being pro-active was really key. With regard to backlog maintenance ABe advised that this was very limited due to finances. It was very hard to clean an area if the condition of the environment was poor.

ABe commented that he had been asked to look into bringing back the use of a Nightingale Ward in Scarborough for decanting patients. The roof needed replacing and he was currently working up a cost. Over the past 12 months, lack of staff numbers had not allowed the ward to be used.

ABe stated that initially the business case had looked at providing 24/7 staffing, but this would have cost approximately £1m and the case was declined. The business case had now been moderated to a cost of around £300,000.

JA informed that they were quite shocked when they heard at Board that the Trust was an outlier with this issue and asked when the business case was going to a panel. GL replied that he had a meeting with Tom Jacques on Thursday to finalise the business case and then it will go to the directors either next Monday or the Monday after. PM added that it would be going to the Executive Committee for approval the third week in March.

LM asked what the biggest risk was to this. ABe replied that the biggest risk would be the availability of staff. The recruitment of domestic staff and additional staff would be a challenge in that area.

JA commented that this puts quality and safety up against finance. AB replied that the nursing staff were delighted with the machines and the machines had been in use for a few weeks now. It takes half the time to re-process that room to use it again. It was a massive step forward.

AB went on to say that as a Board they were going to be prioritising whether they ignore some of the recommendations around essential backlog maintenance for the sake of

moving with the creation of decant spaces on both sites to move this forward. He had no idea why the revenue side of the business case had taken so long but the Trust had got the machines and the story was improving.

Escalate to Board: HPV Business Case

Backlog Maintenance

JA commented that a lot of the content of the report had been seen before but now there seemed to be the addition of a timeline that would provide a picture of what was essential, what the cost of those essential things were, and then to start addressing them. It would clarify to the committee what the high risk items were. ABe spoke about the Gleeds condition survey and how everything was being cross-referenced and being risk rated. He said that the situation was constantly moving and gave an example of a risk at Scarborough with the roof due to the recent adverse weather.

JA asked whether the Capital Programme Executive Group had sight of the list of things that were in the worst condition and whether the LLP and clinicians were duly represented on that group. AB replied that he chaired that group which concentrated on managing the programme and did not prioritise or agree any spend. He gave an overview of how the Capital Programme will be presented to the Executive Committee and the Board in March for approval going forward.

Escalate to Board: Backlog maintenance challenge

Asset Tracking

JA was concerned by an Internal Audit report which suggested that the Trust was unsure about where some of the Trust's equipment was. From reading the paper there were technical solutions to this but it came at a price. She asked that given the cost would this fall down the list of priorities. ABe replied that it was very likely to. LM commented that she raised an action to review asset tracking as it would be a truly transformational programme which would warrant the spend to reduce the inefficient use of staffing resources searching for equipment and prevent loss of equipment. AS informed that the Trust did have Aeroscoat for a number of years and a previous staff member was the champion and main user of the system. Unfortunately, when he retired the enthusiasm for the system waned. He stated that they could put technological solutions in place but if people were not willing to use it then it would fail. It required a lot of time and effort for the user to get the best out of the system. JA commented that a cost benefit that could justify the spend was that the Trust would be aware of all equipment and its location.

Action: Resources Committee to review future plan for Asset Tracking.

EPAM Minutes

LP noted from the minutes that the LLP Business Plan for 2019/20 would not be finalised until March. She commented that the plan had to go to the Board for approval in March as one of the recommendations made by the Trust's External Auditors following year-end needed to be incorporated in the plan to cover 2019/20. She highlighted her concern and

that the plan needed to be in place by the end of March. ABe replied that the Business Plan was with BG to complete.

JA stated her concern was that she wanted to see the LLP finance performance stacked against the original business case. It would be important as a Board to ascertain whether this experiment had actually paid off. ABe commented that within the business case there was a commitment to life cycle funding for big projects to replace things as and when. As of today the LLP have not received life cycle funding for the endoscopy unit and as a consequence the LLP Business Case will not work without life cycle funding. AB stated that a decision still had to be made on life cycle funding. JD asked what happened to the profit of the LLP. ABe replied that it went back into the Trust. JA thought this should be escalated to Board to ascertain what the Trust's strategy was with the LLP.

JA commented that the committee did not have any KPIs to assess on how the LLP was performing which would be useful in future reports as well as more focus on providing assurance and highlighting risks.

JA asked if the risk scores on the BAF reflected the current situation described at meeting. ABe replied that one or two items may need revising.

Action: BG to add KPIs to future LLP reports to show performance and highlight risks so as to provide assurance to the Resources Committee

Escalate to Board: LLP business plan deadline
Escalate to Board: Life cycle funding for the Endoscopy Unit

8. Director of Workforce Report

BAF Risks: 6,7,8

Job Planning

PM advised that the job planning roll out began using a software package called PReP last year. The introduction was quite challenging with many push backs. At the last count in October 2019 there were 94% of consultants and SAS grades engaged in the job planning process. The introduction of the Care Group structure had delayed the roll out a little. 40% of the job plans were ready to be signed off.

She gave an overview of job planning, the appraisal process and revalidation of medical staff. The consequences of medical staff not taking part in the job planning process were still being discussed. She also advised that the rules around SPA time had been relaxed to allow medical staff to perform their SPA time remotely providing their statutory and mandatory training was up to date.

PM stated that where job planning did not help was how effectively the staff were working their direct clinical care (DCC) time.

JA asked whether PM thought the Trust was an outlier in having excessive amounts of SPA time. PM replied that the Trust was not an outlier for average times of SPA.

Recruitment

PM advised that recruitment continues to be extremely strong. Nurse recruitment in particular was in a much stronger position compared to the same time last year. She gave an overview of the business case to approve a further 60 nurses from international recruitment and the success at recent local events which secured 42 job offers. A lot of effort will now go into the onboarding process. The offers were not reflected in the figures in the report due to the length of time before they start/receive PIN numbers. She wanted to highlight that they were working with the Chief Nurse Team to carry out a whole scale review of the nursing establishment across the Trust which will shape the workforce plan and highlight the gaps. PM anticipated that the RN vacancy rate was likely to increase following this review.

PM stated that the Chief Nurse had commissioned an external review into compliance of safe staffing and the maintaining workforce safeguards recommendations. His report had highlighted that the Trust had some way to go to get that assurance. She explained Safe Staffing required reporting real time data and acknowledged that there had been problems with the tablets purchased and there will be a project ongoing with the Chief Nurse Team to rectify that.

JA commented that the agency spend continued to be high and wondered whether the establishment was the issue rather than the actual vacancy rate. It maybe that the CQC was picking up on that and did not feel the establishment was high enough. PM replied that when the vacancy rates were compared to last year and the year before, the vacancy rates were much lower but the demand for temporary staffing was much higher which would suggest the establishment requires reconfiguring. This was why there was a need to carry out the establishment review. Rising sickness was also a possible contributory factor.

<u>Sickness absence</u>

PM stated that sickness absence was reported at 4.56% across the Trust and 7.4% for the LLP. The integrated report contained a SPC sickness chart which was useful and the recommendation to the LLP Management Group would be that they changed their threshold to 6%. The two main reasons for sickness were mental health and MSK. She spoke about some of the interventions that were in place within the Trust.

PM thought the real gains would be from the Clever Together output which will form the Workforce Strategy for the next 12 months. The Flexible Working Policy will also be re-written to support the Trust's long term plan. The Trust needed to totally embrace agile working and offer a number of jobs for staff to work flexibly.

LM welcomed the review of nurse staffing and asked if there was anything more the committee could do to help. PM replied that there was no question that the IT Digital agenda was key to agile working.

LM commented that the Trust had been shortlisted for a major research award. PM replied that unfortunately they had been unsuccessful. However, it was very competitive and they were pleased to be shortlisted.

JA highlighted that there was a Board to CoG in April around how the NEDs obtained assurance around the CQC action plan and a lot of the actions were around workforce.

She asked if she was right in assuming the Quality Committee was receiving assurance on the CQC action plan which included workforce. PM confirmed that this was correct. AB also confirmed that the Board had sight of the progress being made with the CQC action plan.

Gender Pay Gap

PM commented that this was the third year reporting and the paper gave a snapshot of pay on the 31 March each year. She explained that Gender Pay highlighted the imbalances of average pay across the Trust, apart from the LLP, and the Trust was mandated to report this.

She explained that the Trust Gender Profile was 81% female and 19% male. The mean hourly rate of pay for males was £7.55 higher than that of females giving a gender pay gap of 33.41%; the median pay for males was £3.19 higher than females, a gender pay gap of 19.08%. The reason for that predominantly related to the establishment of the LLP and the TUPE of staff. Regarding the Agenda for Change staff pay across all bands was fairly equitable but for very senior managers there was a 53% pay gap. She advised that if the medical and dentist group was removed from the calculations then the gap was reduced and women were paid proportionately more. Maternity leave was not a negative factor in determining pay compared to a male colleague but it did place women a year behind to complete their training leaving male colleagues to progress slightly quicker to Consultant level.

JA commented that there was a need to encourage more women to apply for the more senior roles. PM replied that there was a need to have more family friendly policies and hopefully there was a potential agreement with the LNC to have an alternative to the CEA payment and for it to be used as an automatic uplift.

Staff Survey

PM explained that the Trust was one of 48 Acute & Community Trusts in their benchmarking group and it was decided to go with a full census. She advised that the decision was taken not to promote heavily the staff survey as the Clever Together project was going on at that time. The results did not include the staff from the LLP. The results showed that:-

- 7 of the scores had been retained
- 4 of the scores had deteriorated
- No improvement was seen in any of the scores
- The most deterioration was in the quality of appraisals.
- Health & Wellbeing and Equality, Diversity & Inclusion scores were above their benchmarking group.
- Under ‘Morale’ there was a 5.2% reduction in staff thinking about looking for another job in the next 12 months which contradicted with a 7.9% increase in staff stating they will leave the Trust as soon as they find another job.

JA asked if the LLP was included in last year’s scores as it was known that bullying in the LLP was high and the score this year seemed to have improved. PM replied that the Trust had scored average but that they have seen bullying and harassment from patients and relatives increase and it was a concern.

JA commented about the reporting of incidents under 'Safety Culture' and asked about the feedback given. The Trust stood at 55% against a "best in group" score of 70%. JA felt this theme should be raised through the Quality Committee.

PM advised that with regard to the quality of appraisals they were implementing an appraisal window. They had totally re-written the appraisal documentation and for the first time had a draft talent management framework. It was discussed at the Corporate Directors meeting yesterday and will be rolled out from March to June. The challenge was to ensure that all line managers were aware of this new framework.

LM referenced PMs statement that some organisations did not use the staff survey and were still strong on engagement – LM queried what methods they used.. PM replied that those companies tended to use companies like Clever Together or 'pulse' surveys. It was mandatory that the Trust had to undertake the annual staff survey and the CQC relied heavily on the staff survey.

LM said she was pleased to hear about the talent management and was shocked to see that there was physical violence from colleagues at work. PM responded that this fed into their next steps with Clever Together. The Trust's behaviours were to be ratified at Board. The online workshop closes tomorrow. There was a need to be clear about what the Trust's expectations were on staff behaviour.

JD asked about the effectiveness of appraisals and whether recommendations, development, etc., were followed up. PM replied that there was now a requirement for a six month review. This was a challenge in nursing due to staff turnover as a B5 staff appraisal was carried out by a B6 and to retain consistency the same B6 needed to carry out the six month review.

JA referred to the BAF/CRR and asked if PM was happy with the current risk scores. PM advised that once the establishment review had been completed then the risk scores will be reviewed.

Action: PM to review Workforce risks in the BAF/CRR once establishment review has been completed.

Escalate to Quality Committee: Staff Survey Safety Culture

Escalate to Board: Staff survey – making appraisals more productive. Issue around learning from incidents.

9. Finance & Efficiency Report – Summary Report

BAF Risks: 9, 10, 12

Finance Report

GL informed that at Month 10 January the pre-PSF deficit stood at £17.7m against a plan of £16m placing the Trust £1.7m adrift of plan. It was therefore not appropriate to apply FRF for the month 10 position. After applying the relevant sustainability funding for the period April through to December the Trust reported a deficit of £2.9m against a planned

deficit of £0.2m, therefore reporting an adverse variance to plan of £2.7m. This position was subject to the usual quarterly assessment process and there may be time to recover the position.

He explained the spend pressure areas remained the same as those reported to the Board in recent months.

- Agency expenditure – the £15m cap had been breached and spend at month 10 stood at £17.2m with total expenditure set to exceed £20m at year end.

- Efficiency Programme – delivery stood at £16.5m against a £17.1 target.

The Trust's forecast of a £4m shortfall has been discussed with NHSI.

JA challenged that the Trust was £500k over plan at the end of the third quarter and now they were reporting that the Trust was currently £2.8m under plan which was a serious deterioration. GL replied that this was due to a £4.1m overspend on staff and part of that was the premium paid out on agency staff especially due to the CQC requirements. JA questioned the additional measures that the Trust was hoping to put in place to get to the £4m plan. AB replied that most of this will kick in at the end of the year. Some other items will be technical adjustments.

JA clarified with AB whether the committee should not be overly anxious with the underlying deterioration as most of those additional measures would not kick in until the end of the financial year. AB replied that he was anxious as in the revised forecast it was anticipated a £400k deterioration against plan and currently it stands at £1.7m. JD asked what the consequences would be if the Trust did not meet its target. AB replied that the consequences would be that the Trust would lose the £5m sustainability funding and the Trust would then need to borrow cash. There would be ongoing financial consequences of that and the NHSI expectation was that the Trust will correct it internally.

LM asked about any supplementary actions to be taken to mitigate risk. AB responded that there would be.

JA said that her concern was that NHSI's support was dependent on the Trust finding a way forward to overcome some of the shortfall. JD added that actions needed to be taken at very senior level or it just will not happen. AB replied that it was difficult as at times safety was inappropriately linked to some spend to drive it through and that was where it became increasingly frustrating as it was hard to challenge.

LM asked if the Care Groups had come up with ideas. AB responded that in the main they should be playing their part and were working with the Trust. The challenge was to reach those decision-makers within the organisation and ensure they were aware of the Trust's current financial status when making decisions. The Trust spent around £1.5m per day and almost all of that expenditure was not visible in the moment. There will be a team brief this week around finances followed up with some more direct communication with requisitioners within the organisation to ask them to defer spending for six weeks until year end.

Escalate to Board: Financial position

Efficiency Report

SK reported that the position was really positive. He advised that efficiency delivery within the Care Group structure made it harder and there was a need to work with the individual specialties. The focus now was on next year's planning to change non-recurrent to recurrent.

JA referred to GIRFT and commented that the non-clinical elements have seen delivery in terms of back office savings but trying to get the transformational savings was more challenging. Although it will not help this year there was a need to put some pressure on to reduce costs going forward.

JA asked if the BAF/CRR scores had been reviewed. AB confirmed that the scores had been reviewed and showed a fair reflection of the financial risks the Trust was currently facing.

10. Digital Report – Summary Report

BAF Risks: 5

JA advised that the Digital Strategy would not be discussed at today's meeting but will be discussed at the Executive Committee meeting tomorrow. She asked that if anybody had any feedback to email KB within the next 24 hours.

KB wanted to highlight the video consultation pilots which related to discussions earlier in the meeting. There was Refero now live in Diabetes York and Cancer Services. The Diabetes Scarborough pilot was estimated to go live early March. The Diabetes pilot started in January and although there were not a massive number of patients on it there had been some really positive feedback. They were looking to get different specialties involved. Since then they have also engaged with NHS Digital to secure funding for long term pilots to test another product until March next year. The second pilot, Attend Anywhere, has been secured for Sexual Health, Dietetics, Rheumatology and Dermatology Nurses. This will give them the opportunity to test both technologies to ascertain which worked best for the Trust.

LM commented that she thought it was great to see that linkage with PM regarding agency spend on nursing staff and anything to reduce that would be beneficial. She also suggested that they needed to secure funding from businesses to support their various projects.

JA asked if they had enough human resources to deliver on these projects in such a small amount of time. KB replied that the work had been ongoing for some time and there were small teams of individuals already working on each project. One exception was community mobile working which was resource intensive.

JA mentioned the inaugural meeting of the Digital Delivery Group and confirmed that Simon Morritt will be chairing it. AB added that the Care Group Directors will be invited to attend going forward to improve clinical engagement.

JA asked if the risk scores in their section of the BAF/CRR were correct. AS advised that they should probably be revised in the light of the funding situation.

Actions: KB/AS to review Digital risk scores on BAF/CRR

Escalate to Board: Digital Delivery Group and involvement of the Care Groups

11. Reflections on the meeting

JD suggested discussing smaller items first and then the person(s) could leave the meeting.

It was agreed that the committee work towards gaining assurance from a questions and answer session around each subject as the papers should have been read prior to each meeting.

12. Items to note

The committee noted the following reports and no further questions were asked.

- Efficiency Delivery Group Minutes
- Procurement Efficiency Delivery Group Minutes

13. Any Other Business

No further business was discussed.

14. Items to be escalated to Board

- Sustainability and Carbon Reduction
- HPV business case
- Backlog maintenance challenge
- LLP business plan and assurance challenges
- Financial Position
- Staff survey – making appraisals more productive, issue around learning from incidents
- Digital Delivery Group and involvement of the Care Groups
- Life Cycle funding for the Endoscopy Unit

AB advised that with regard to life cycle funding a decision had not yet been made. It was clearly something that had come out of the Master Service Agreement documents. At this moment in time the resources may be needed elsewhere. It needed to go through the Board. He added that the backlog maintenance bill across the Trust was huge.

15. Time and date of next meeting

The next Resources Committee meeting will be held on Tuesday 17 March 2020 at 9.00am in the Boardroom, Trust HQ, 2nd Floor, York Hospital.

ACTION LOG

Meeting Date	Action	Owner	Due Date
29.05.19	Highlight new limited assurance audits in their report to the Committee.	Executives	Every month
30.01.20 25.10.19	Provide update on GIRFT	AB	March 2020
27.11.19	Escalate agreed items to Board	JA	Monthly
27.11.19	Develop some metrics for SNS section of integrated board report	KB/AS	Mar 2020
21.01.20	Papers to be submitted in line with Committee deadline to enable effective dissemination of the agenda	All	Monthly
21.01.20	Minutes from committees reporting into resources committee to highlight items for escalation or be FIO	All	Monthly
18.02.20	Add catering hygiene scores and action plan together with summary of actions to LLP report each quarter to Resources Committee.	BG	May/June
18.02.20	Add Estates Summary Report to the IBR each month and Summary EPAM report with key metrics to come to the Resources committee for assurance.	BG	Monthly
10.02.20	Digital section to be added to IBR in March.	AS/KB	March
18.02.20	Report on Trust performance against NHS/National standards regarding carbon/waste for next meeting.	JM	March
18.02.20	Review any risks in relation to Sustainability on BAF/CRR.	JM	March
18.02.20	Add KPIs to future LLP reports to show performance and highlight risks so as to provide assurance to the Resources Committee through to Board.	BG	Monthly
18.02.20	Review Workforce risks in the BAF/CRR once establishment review has been completed.	PM	Ongoing
18.02.20	Review Digital risk scores on BAF/CRR in light of capital availability.	KB/AS	March
18.02.20	Review future plan for Asset Tracking.	Resources Cttee	March

Board of Directors – 25 March 2020
Quality Committee – 18 February 2020

Attendance: Lorraine Boyd (LB) (Chair), Lynda Provins (LP), Stephen Holmberg (SH), Rebecca Hoskins (RH), Fiona Jamieson (FJ), Wendy Scott (WS), James Taylor (JT), Nicky Slater (NS), Tara Filby (TF), Helen Hey (HH), Jenny McAleese (JM), Rhiannon Heraty (RH2) (minutes)

Apologies for Absence: Heather McNair (HM)

1. Welcome

LB welcomed everyone and declared the meeting as quorate.

2. Declaration of Interests

There were no declarations of interests declared.

3. Minutes of the meeting held on the 21 January

The minutes of the last meeting held on 21 January were agreed as a true and accurate record.

4. Matters arising from the minutes

The following matters recorded in the minutes and action log were discussed:

Item 7.2 IPC Q2: Office space conversion – JM asked about progress. HH said it has been with Brian Golding's team to cost and examine complexities. It is to be discussed at the next CPEG meeting

CQC Action Plan Monitoring – JM asked about ligature-free rooms progress and FJ confirmed end of Feb/beginning of March. WS confirmed that system Patient Safety Group (established off the back of the CQC report) was held on 13 Feb and that the action plan has been updated and CQC are aware. SH asked what the purpose of Patient Safety Group is and WS confirmed that the Trust were asked to set up a system group by CQC. It is a monthly Quality and Safety Group with system parties around the table and chaired by Margaret Kitching to work through CQC actions (quality and safety issues) and escalate issues that they cannot resolve. JM said this is another assurance that the action plan is being monitored. WS said the CQC are clear that they are regulators and therefore only in attendance at the group. WS said she would share the terms of reference with the Committee. FJ confirmed to JM that fortnightly meetings are still continuing alongside this.

'To consolidate information streams from multiple external sources into, & within the Trust' – FJ confirmed this started by looking at 'knowns' such as pharmacy, NHSI alerts etc and that there is audit work to identify the 'unknowns' by canvassing to build a process. JM said assurance was needed that any external guidelines are acted upon and FJ said we cannot give full assurance as this is a problem that many other organisations also have. RH asked if this was an opportunity for care groups to find a controlled way to share info and JT said all medical alerts go directly to Chief Pharmacist who acts and escalates if needed. The Committee noted that there needs to be clarity around what information goes to whom and how it is escalated. WS said it should be discussed through the care group structure and escalated through their monthly meetings so that care groups take responsibility if further development is required.

'QC to monitor the progress of HPV business case' – HH confirmed the equipment was up and running and has halved the process time.

'FJ to provide Duty of Candour update at Feb meeting' – FJ confirmed performance figure of 82.6% with 144 incidents, 119 of which were fully compliant. Last year there were 162 incidents rated at the level of moderate harm or above and that Duty of Candour applied to 48.2%. There has been some improvement in Scarborough as well as Care Groups 1, 2 & 3. Care Group 6 has struggled but there is now an embedded live dashboard for care groups to see and actively follow up.

'HM to review and par down the Nurse Staffing Report' – HH confirmed the data is not received until 15 March. WS said we need to revise and develop the report with a narrative so there is less need for numerous reports. WS said she had looked at the Chesterfield IBR model that RH shared with the Committee and will try and draft up a version, and added that Simon Morritt had suggested not to do executive reports. LP stressed the importance of using front sheets to highlight what the Committee should be focused on.

'HM to look at the Health & Safety report and how often it should be received' – LP confirmed this will come quarterly.

'JT to give an update on clinical comms/info app at next QC' – JT confirmed plan to pilot this in Scarborough in March.

The Committee:

- **Noted the establishment of the System Quality and Safety Group and take some assurance from the system recognition and response to the CQC findings**
- **Noted the continuation of the fortnightly internal CQC Plan monitoring meetings**
- **Noted the limited assurance on consistency in the processes relating to incoming clinical guidelines and sharing of recommendations and look forward to future updates and clarity**

Action: WS to share TOR of System Quality & Safety Group

5. Escalated Items

LP said there was a paper around a staff survey and concern was expressed about the safety culture. 55.1% of staff said they feel they are treated fairly, which means that nearly half of staff said they don't feel protected. JM confirmed that this means there is a reluctance to report a near-miss or an incident for fear of being treated unfairly. RH asked if there was a comparison to last year and LP said she would send the Resources Committee paper to RH. RH added that the safety climate was picked up in 'Just Culture' meetings and that she is waiting on Clever Together work re this to be confirmed. SH asked why this was being escalated to Committee and LP said that Resources Committee expressed concern and asked for it to be escalated.

JM said the Audit Committee relies on assurance from Quality Committee around clinical audit and currently the Clinical Effectiveness Group is not meeting. FJ said that Tariq Hoth is working with her and a small team to provide clinical leadership to this agenda and to put some changes in. JT noted that Tariq Hoth has been asked to come to Audit Committee to update them on clinical audit. JM expressed concern and JT said that he has spoken to Care Group Managers about governance meetings and 'Clinical Effectiveness'' is now a standing item at the Care Group Board meetings and Quality and Safety Committee.

The Committee:

- **Noted the concerns relating to safety culture and received some assurance that this will be addressed via the adoption of 'Just Culture' approach to safety concerns and the Clever Together directed culture change within the organisation**
- **Noted gaps in assurance around clinical audit and plans to address this through Care Group governance meetings**

Action: FJ to provide an update to Audit Committee at March meeting

6. Performance Report

WS said the performance levels remain challenging and the Committee referred to the performance report (paper B, P31). WS said the month to date is 78.21%, which marks a 3% improvement, and confirmed that we are continuing to work with ECIST around SDEC, front door streaming and ambulance handover. There is a paper around site management at the York site regarding how to streamline this and WS said rather than nationally mandated improvement, it should be done locally. The Committee noted those new emergency care standards are due. SH asked what would be three things that we would like to see improved. WS said that these would be:

1) How ED coordinate and organise staff to manage patients and risk as there has been resistance to change, and advised that ECIST is coming on 28 Feb to meet with the ED team.

2) There is still some difficulty around embedding SAFER – some ward areas and staff have embraced this but there is still resistance. Group noted that JT and HM have picked up the executive lead on this and ECIST support it.

3) YORCARE and the sharing/delivery of urgent care centre. WS said we are working with CCG re how to deliver integrated front door streaming and that some progress is being made.

SH asked what can be done to help and WS said engaging external partners and clinicians such as Nick Roper and Kevin Maynard as there is still some difficulty getting buy-in from some clinicians. JT said the reluctance around delivery/employment is due to ownership issues and JM said this was the biggest challenge of management and leadership. JM added it is difficult to exercise authority in the middle of a staff shortage and JT said there isn't a fear around expressing authority but that staff threaten to leave before this happens.

WS said there was a conversation between SDEC and ED to try and stream patients away from ED, which has now led to concerns that ED consultants will feel disempowered. WS said we need peer pressure to push forward and expose ED et al to new ways of working. SH asked if this was just clinicians and JT said there is a degree of nursing staff that also need this exposure and confirmed that Mike Harkness (Care Group 1 Manager) is having regular conversations in ED to try and improve performance. WS said two new ED consultants have been appointed that should bring fresh ideas. LB commented that it is good to know that there is progress. WS said that the planning guidance noted a requirement to achieve max 92% bed occupancy and that there is a national requirement for 5000 additional beds to be opened. WS added that it may be a requirement for HCV to have more beds and noted that bed occupancy in Scarborough can be as high as 98% at times. WS added that NS is doing some work on this. WS said that re waiting list position, there was a requirement to achieve 26303 open clocks by March 2020 but that the national guidance has now changed setting a new baseline of the waiting list position at the end of January 2020. The new target is 29583 or less by end of March 2020. WS said that re diagnostics position, we have been working with Elective Intensive Support Team around addressing work such as capacity and demand modelling and that there is positive feedback that we are aware of our challenges. WS confirmed that we are entitled to up to eight days of support from the team and agreed to send the report to the group. WS said the national guidance highlighted that patients have the right to be offered choice at 26 weeks due to inability to see them, which means that up to 4000 patients could be offered this. However there could be issues with patients not wanting to travel to other Trusts and that it is not clear how the 26 week wait is going to be implemented. WS confirmed a session is being set up with NLAG who have done some work on waiting list harm risk assessment and that there is the potential to adopt the process.

The Committee:

- **Received and discussed the Performance Report**
- **Acknowledged the improvement in ECS along with the significant ongoing challenge**
- **Noted new Emergency Care Standards for 2020/21 are awaited**
- **Discussed the cultural barriers to change and received some assurance that improvements are happening on the ground and the expectation is that this will translate into improved metrics in due course**
- **Took assurance from the engagement of external partners and clinicians to support the changes**
- **Noted the challenge to meet the 2020/21 planning guidance of maximum 92% bed occupancy**

- **Noted the change in national guidelines resetting the baseline waiting list position to reflect the end of January 2020 figure (29583)**
- **Were assured that the focus on risk of harms whilst on waiting lists will continue and welcomed the shared learning from NLAG**

7. CQC Action Plan

FJ gave an overview of the report (paper C) and confirmed that there is work to do around mental health and ED. FJ advised that a presentation was due to be delivered at the relevant Care Group Board /c 10 Feb. LB asked if we are on track and FJ confirmed that York is seeing progress around the development of draft mental health pathways, paediatrics and paediatric mental health, as well as having confirmed dates for ligature-free rooms. SH said it was hard to understand status around ligature-free rooms as being red despite there being progress on this and FJ advised that the action had red status as it was due to be delivered by 30/11/2029. FJ advised that she was looking at how the presentation of information in the Action Plan could be improved to include a section on narrative, in future reports, which will include the same actions but simplified. HH said one of the complexities is that we have had several updates, which have altered the reporting timelines. JM said that she was assured that we are on the right track. WS said we need a highlight report around the highest risks/concern and FJ confirmed the new format would reflect this. WS said she had asked the CQC if it would have been a different outcome had we said that we only had eight staff instead of ten but that we were aware and that the system was working, and they confirmed the notice would not have been served.

HH articulated that the issue around the children's pathway was that staff were unable to describe it when asked by the CQC. HH said that work was being undertaken by Managers to ensure that staff were aware of how to answer CQC questions whilst also advising that they were aware of the limitations of the pathway are but that patient care is not affected. WS said that the Patient Safety Group is a good opportunity to show that we are doing everything we can and that CQC need to be aware that information is being shared with the Board. TF said the key is for meetings to be aligned and to ensure that anything that goes to Patient Safety Group has already been to Board. SH agreed that CQC need to see that the Patient Safety Group meeting is the most important one and JT said we have a positive story to share around the paediatrics pathway. WS said we need to be clear on what goes where/to whom in order to give assurance to CQC. FJ said that item 1.5 (around incident reporting) required a response by 18 Feb - we responded on 11 Feb and that no further information was required. WS said we are expecting a report back and FJ confirmed that CQC are working on this. The Committee noted that the weekly CQC monitoring on both sites has been stepped down.

The Committee:

- **Received and discussed the CQC Action Plan**
- **Acknowledged the conditions imposed by CQC and the monitoring plan**
- **Discussed progress against Section 29A actions and assurance given that they are on track as outlined**
- **Noted the removal of SD22 and SD30 as completed**
- **Discussed progress on items with Red Status, noting some confusion re the implications of this**

- **Noted that the weekly nurse staffing monitoring by CQC has been stepped down**

Action: FJ to review the presentation of the Action Plan to improve clarity and highlight the items of highest risk/ concern

8. Infection Prevention & Control Report

HH said the report needed to be reviewed before it goes to Board. SH commented that the report reads as a passive documentation of position rather than an action log of what we can do to improve and that it needs improving in order to provide assurance. HH gave an overview of the report and confirmed new HPV equipment is on-site working well and has reduced cleaning time by 50% as well as reducing cost but that more staff are needed to operate it. JM asked for a lead time and LP confirmed it was going to Board for discussion in March. LP said the cost has been reduced from £1m to £300k. WS said there will be an update at the end of February to go to Board.

The lack of a full ward refurbishment programme is a significant concern and HH said Damian Mawer would like assurance that there is a programme in place.

HH noted that Tom Jacques leaves at the end of the month and that there has not been any appointment yet. HH said mandatory reporting figures are largely the same but noted that C.diff is now at 123 cases as opposed to 106 for Q3. HH confirmed that Damian Mawer raised lack of attendance at C.diff meetings and that there is a risk on both sites with 6 cases at York last week. LB asked if it was still flagged appropriately on the risk register and HH confirmed it is. HH said one of the biggest risks is the lack of a nursing lead. JM asked if we could learn anything from Tom Jacques' departure but HH confirmed it was due to work/life balance and that it will be hard to find someone to do this particular job. WS suggested approaching the barracks on a secondment basis as Tom's background is military and HH said she would speak to Richard Chadwick about this.

WS discussed coronavirus and confirmed there is a booked call twice a week with national and regional teams as well as a requirement to have a pod on each site with a phone linked to 111 that patients are being directed to. WS said we need an environment where we can deal with multiple patients and confirmed two specially-designed portacabins have been ordered for six months at £48k as we are anticipating an increasing need for isolation. WS added there is a rapid piece of work to sign off pandemic flu protocol and confirmed there is a temporary pod on each site at the moment.

The Committee:

- **Received and discussed the IPC Report**
- **Noted the seasonal flu peak had passed and the plan had worked well**
- **Noted there had been a flu death which occurred on a Nightingale Ward reflecting an ongoing risk for these wards**
- **Discussed progress with the HPV business case**
- **Noted the ongoing challenges around C diff and MRSA**
- **Noted the IPC challenges as a result of estate constraints and agreed this is accurately reflected in the Risk Register**

- **Received a verbal update on Coronavirus and acknowledged this is likely to represent a rapidly changing risk**

Action: HH to speak to RC re an IPC secondment placement from barracks

9. Perinatal Mortality Review Tool

HH gave an overview of the report as a regulatory requirement. LB asked if timescales were met as assurance needed and JT confirmed yes. The Committee received and noted this report on behalf of the Board.

The Committee:

- **Received and discussed this report on behalf of the Board**

Attention to the Board: Report to be highlighted at Board

10. Medical Director Report

JT gave an overview of the report and advised that there was a safety concern raised w/c 11 Feb around medical staffing in Scarborough. There is an ongoing conversation between JT, Mike Harkness, Helen Noble, David Thomas and Tim Houghton about this and there has been a request for support from York. This was escalated w/c 11 Feb due to locum doctor that was covering Lilac Ward taking leave at short notice as well as two substitute consultants (one of which was working on Beech Ward) taking emergency leave. JT said a Scarborough walk-around identified some chronic issues around systems and processes in place including a lack of teamwork on some medical wards but there are no immediate risks. JT said we have temporarily lost a Medical Examiner (stroke consultant) and a locum doctor in York has left at short notice as well as part-time stroke doctor in Scarborough. Peter Wanklyn has temporarily withdrawn from Medical Examiner role to support the stroke service. JT confirmed successful appointment of three Medical Examiners to support Peter Wanklyn but that there is still a question around how quickly they can begin in-post and expand the scope of part-time jobs. JT expressed concern about the stroke service. Hull have been involved and offered a provisional capacity for patients presenting with TIA but further action may be required at end of month. JT said that mandated start was moved back a year so we are not currently mandated to have a Medical Examiner this year.

JT referred to paper F (P39) and gave a brief sepsis summary, and confirmed that he has met with ED and will do so again to discuss issues in the report. SH said he didn't understand the report and RH said we do not have a national benchmark to compare to other Trusts. Scarborough site leads the Sepsis Delivery Group, which has some good ideas and attendance. RH noted that York has slipped slightly but has since been invigorated. JT said there has been some improvement in screening but an overall reduction in antibiotics. RH said that only 16 patients were identified as appropriate for audit purposes as set by the national contract and said that the report gives little back story to this. JT added that the targets are aspirational. JT said that sepsis should improve

with the new critical care response team in York, which goes live in May, and RH said sepsis screening electronic tool has been delayed but will aid inpatient screening.

JT said that there has been triangulation in learning from deaths and that no avoidable deaths were found in the analysis (P45). SH said he struggled to understand that all deaths were unavoidable and JT explained that this was highlighted and challenged with Medical Examiners who confirmed this. JM referred to P39-40 of report re escalated items from Patient Safety Group and asked what is done with escalated items. JT confirmed he had asked the group to escalate their concerns and that POCT has an action plan, and also said that there is a plan for NEWS2 training.

JT referred to Staff Room functionality and confirmed a document management system has been proposed that Lucy Brown is currently looking into. This has been quoted at £75k with a running cost of £15k per year, and there has not been a procurement exercise as yet. LB asked for assurance that policies are up to date and the group commented it was difficult to know as people have difficulty finding the policies in the current Staff Room format, but FJ & RH confirmed that authors get update notifications six months in advance.

The Committee referred to the draft Learning Strategy Paper F1 (P83) and JM asked where this paper has been, and confirmed it needs to go to Executive Board and then come back to Quality Committee. WS said the issue is that if the policy is agreed and ratified, there is confusion re if it needs to come back to the Committee.

The Committee referred to P101 and JT confirmed that Ruwani Rupesinghe has been appointed as Guardian of Safe Working who will report to JT and bring the report forward.

The Committee:

- **Received and discussed the Medical Directors Report**
- **Noted the fragility of medical cover at Scarborough Hospital and the potential risk to service delivery**
- **Noted the medical staffing issues in Scarborough Stroke Service, the short term impact and potential medium term impact on service, including the potential need for major service delivery change to mitigate the associated safety risk**
- **Acknowledged the temporary redeployment of the Medical Examiner to support the Stroke Service and the potential impact on the development of the Mortality Review processes**
- **Welcomed the appointment of 3 additional Medical Examiners to provide support once training completed**
- **Noted the escalated concern from PSG, including POCT training and supported the plan to address this gap in assurance**
- **Discussed the PSG escalated concern around staff room functionality and difficulty accessing clinical guidelines, acknowledging this as a potential clinical risk and agreed to escalate to the Board**
- **Received and discussed the sepsis paper, noting some gaps in assurance and plans to address these**
- **Received and discussed the Q3 Mortality Report**
- **Received and discussed the Guardian of Safer Working report and .commended the quality of this report.**

- **Welcomed the confirmation that Ruwani Rupesinghe has been appointed Guardian for Safe Working**
-

Attention to the Board:

- **To escalate loss of Medical Examiner and resignation of part-time stroke doctor (SGH) and locum doctor (YH) at short notice to the Board**
- **To escalate Staff Room functionality as a risk to patient safety to the Board**
- **To share draft Learning Strategy with the Executive Board for approval**

11. Patient Experience Quarterly Report

HH gave an overview of the report and said there are still significant concerns around timeliness of responses but that HM has seen improvement re actions taken. Complainants have been asked for feedback as there is still a negative connotation that complaints will result in worse care for patients, and HH confirmed there is an acknowledgement letter to confirm that care will not be affected. HH said action plans can be weak and it has been determined that opportunities to share learning are being missed. Ombudsman activity remains very low - three cases are awaiting decisions. HH said there has been positive news regarding volunteering and that two amounts of money have been received – one as a result of winter planning to secure training programmes and the other directly from Marie Curie.

HH noted that the Urgent and Emergency Care summary was completed in 2017 but only came to us in November 2019. Patient Experience team have met with Care Group 1 (currently working through action plan) and are meeting Care Group 2 at the end of February, which should provide the Committee with more insight reports. SH asked about Friends & Family test in ED and HH confirmed the York test is poor due mostly to waiting times but we have no further insight other than this. SH asked what can be done to make the wait times more manageable and WS & HH confirmed that currently snacks and phone chargers are being provided in waiting areas. HH said there is a piece of work in York ED around how best to communicate that there are three queues in the one area – fracture clinic, ED and urgent care – and that people aren't queue-jumping. JM noted there is a mismatch between our perception of the Trust and how others see it. SH added that ED volunteers have historically not been made to feel welcome and that Catherine Rhodes struggles to place volunteers on wards as a result.

The Committee:

- **Received and discussed the Patient Experience Q3 report and the ongoing improvement work was noted**
- **Noted gaps in assurance relating to the dissemination of learning from complaints or impact on types of complaints and plans to address this through the Learning Strategy and Care Groups**

12. Items to note

Q3 Pressure Ulcer Report
Q3 Falls Report

The Committee had no questions on the reports.

13. Reflections on the meeting

JM asked if risk 2 on the BAF was being reviewed. WS said the Scarborough Acute Services Review is focused around services needed to provide front door streaming in ED and that there is a sustainability review in Scarborough that is going to Executive Board that has a pre-populated template of all Scarborough services. Once reviews are in, she will review the risk.

14. Any other business

The Committee had no further business.

15. Consideration of items to be escalated to the Board or other Committees

PMRT report to be shared at Board.

Scarborough medical staffing and related safety issues.

LP added loss of Medical Examiner and resignation of part-time stroke doctor (SGH) and locum doctor (YH) at short notice to the Board

Staff Room functionality as a risk to patient safety to the Board.

16. Time and Date of next meeting

The next meeting will be held on 17 March 2020 at 2pm in the Boardroom, 2nd Floor at York Hospital.

Action Log

Date of Meeting	Item No.	Action	Owner	Due Date
25/9/19	1.	Progress report on 14 hour consultant review	JT	Ongoing – agenda item
31/7/19	2.	Provide more assurance around outputs & triangulation with numbers.	HM	Ongoing

27/11/19	3.	To provide a hyperlink to informational appendices instead of including them in the report. Still to include essential appendices	HM	Ongoing
27/11/19	4.	JT to consolidate information streams from multiple external sources into, & within the Trust. To report progress back at April meeting.	JT	April 20
27/11/19	5.	QC to monitor the progress of HPV business case and update at next meeting	HH/HM	Mar 20
27/11/19	6.	HM, JT & LB to agree changes to structure and content of meeting	HM, JT LB	Mar 20
27/11/19	7.	LB & HM to discuss inviting knowledgeable staff to meeting	LB HM	Mar 20
21.01.20	8.	FJ to provide Duty of Candour update at Feb meeting	FJ	Ongoing
21.01.20	9.	LP to look at agenda and work programmes going forward	LP	Feb 20
21.01.20	10.	LP to invite Care Group Quality chairs to March meeting	LP	March 20
21.01.20	11.	HM to review and par down the Nurse Staffing Report	HM	Completed
21.01.20	12.	HM to look at the Health & Safety report and how often it should be received	HM	Completed
21.01.20	13.	SR/HM to provide update on quality indicator development once formalised	SR HM	Mar 20
21.01.20	14.	JT to give an update on clinical comms/info app at next QC	JT	Mar 20
21.01.20	15.	IPC report to be a standing agenda item and escalated to Board of Directors – LP to add to the board work programme	LP	Mar 20
17.02.20	16.	WS to share TOR of System Quality & Safety Group	WS	Completed
17.02.20	17.	FJ to provide an update to Audit Committee at March meeting	FJ	Mar 20
17.02.20	18.	FJ to review the presentation of the CQC Action Plan to improve clarity and highlight the items of highest risk/ concern	FJ	Mar 20
17.02.20	19.	HH to speak to RC re an IPC secondment placement from barracks	HH	Mar 20

CHAIR'S LOG: Chair's Key Issues and Assurance Model

York Teaching Hospital NHS Foundation Trust

Committee/Group: Resources	Date: 18.03.20	Chair: Jennie Adams

Agenda Item	Issue and Lead Officer	Receiving Body, ie. Board or Committee	For Recommendation or Assurance to the receiving body
Finance Report	**Covid:** Treasury offering generous financial aid for additional costs incurred. Year end accounts prep will go ahead but many governance documents may be waived (Annual Report/ Quality Report etc) PSF loss due to failure to meet CT is less likely now. Procurement – help from NHS Supply Chain but interruption to some supplies already emerging (hand gel PPE). **AOB Exception report**: Month 11 shows further deterioration from plan with more PSF missing (£1.5m). Staffing overspend levelling off. Now £7-8m behind plan. Still need £3m of additional actions to secure match funding from non CCG contracts. Likely to miss CT by a small margin but risk to PSF reduced (see above). £18m of working capital loans due for repayment in 2020/21 but expectation is they will be rolled over or added to PDC.	Board	**Recommendation:** Assurance: financial backing from government on covid costs. Likely to miss CT but threat to PSF receding. To be aware of loans falling due but assured that they will not have to be repaid. **Gaps**: Procurement concerns and potential interruption of key supplies Spend on agency staff continues to be of concern
LLP Report	**Covid:** Successful reconfiguration of clinical areas to support operational plan for pandemic. Additional space plans not well advanced Catering has stepped up food production and some stock levels to build in some resilience. Cleaning risk to non-covid wards and areas as covid areas take priority. Staff risk from absence (many over 70's on the bank) and anxiety. Early thoughts on enlisting further staff from outside the Trust **AOB Exception Report:** 5 year YTHFM coming to Board	Board	**Recommendation:** Board /Covid groups to consider how to advance external staffing and space requirements at pace. **Gaps**: Current cleaning plans represent significant risk to patients and staff.

	New governance and mgt. groups now running PLACE survey results a concern Cleanliness audits remain a concern Backlog maintenance plans delayed until April Sustainability risks detailed and BAF score needs to rise		
Workforce Report	**Covid**: Massive effort on number of fronts including PPE fit testing/training, ID staff skills; ID remote workers, sick pay solutions, mental health support, timely staff bulletins. Staff absence already growing. Lack of VPN capacity for home working (see below) PPE is top concern of staff re availability, effectiveness and policy. **AOB Exception report** HEE self-assessment – to be resubmitted in more appropriate format. Concern re unfilled nurse staffing shifts – absolute and %.	Board/ Quality Committee	**Assurance:** Evidence of wide staff engagement and communication. **Concerns:** Plans for covering staffing gaps from growing absence. Adequacy of mental health support – more digital solutions to reach more staff? Lack of capacity for mobile working
Digital Report	**Covid:** Identifying potential remote workers and their needs via Care Groups Enabling webmail quick fix (exceeding licence limits not real risk) Existing 770 VPN stock only enables 50 concurrent users. 1000 new VPNs ordered (1-2 week wait) but bandwidth an issue Patient facing measures such as virtual clinics still at early stage. **AOB Exception report:** Slow progress on some key projects (windows 10) Audit of IT assets and ability to track flagged concerns Strategy paper out for comment by Care Groups. Committee keen to see more robust cost benefit approach on digital priorities.	Board	**Assurance:** Actions to increase mobile working capacity. **Concerns:** Lack of cloud based approach limits ability to achieve scalable solutions rapidly such as mobile working at scale. We need both a short, medium and longer term plan Can this be accelerated? IT audit of assets concern given risks and limitations reported Capacity to move at pace with patient facing and point of care projects that could help deliver care more effectively in the crisis.

York Teaching Hospital NHS Foundation Trust

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee/Group: Quality	Date: 18.02.20	Chair: Lorraine Boyd

Agenda Item	Issue and Lead Officer	Receiving Body, ie. Board or Committee	For Recommendation or Assurance to the receiving body
6	There was discussion about how Performance should be reported in the coming months. We were assured that there are plans to continue to closely monitor performance relating to cancer diagnosis and treatment as well as harms associated with long waits in ED and WL. This will support compliance with the NHSI/E aim that emergency admissions, cancer treatment and other clinically urgent care should continue unaffected.	Board	For assurance
7	The CQC action plan was reviewed and discussed, progress and risks to delivery were noted. There significant risk to delivery of some elements as a result of the COVID 19 pandemic. We were assured that the Trust will maintain a focus on delivering the CQC Action plan, notwithstanding these risks	Board	For assurance and further discussion
8	There has been significant progress on Nurse recruitment, however the COVID19 pandemic will inevitably impact adversely on nurse staffing levels with associated rise in safety risk	Board	For assurance: assurance gap Recommendation: review nurse staffing risk in light of current situation
9	Informed that 3 wards are closed as a result of Norovirus, creating further pressure on capacity and raising further IPC concern	Board	For assurance: assurance gap. Recommendation: Board discussion and triangulation with Resource Committee concerns

10	Health and Safety Report update was received and approved	Board	Recommendation: Board to approve
AOB	Updated on COVID 19 preparations to date and were assured that incoming guidance is reviewed and actioned appropriately. A governance structure to support the COVID response has been developed, and will continue to evolve as required. Plans are being stress tested and business continuity plans in place. Consideration has been given to leadership continuity and the need for visible leadership. There is a need to review the focus of assurance to ensure all time is spent to best effect.	Board	Recommendation: review of Risk Registers in light of pandemic Consider assurance requirements during pandemic in relation to CV19 response and business as usual Receive update on current situation

York Teaching Hospital
NHS Foundation Trust

Board of Directors - 25 March 2020
CQC Summary Improvement Plan 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

Members of the Board will be aware that the CQC Programme Group has been established to ensure that progress against actions is monitored on a fortnightly basis. The Summary Improvement Plan which is attached to the report provides details on the current status and RAG rating.

Executive Summary – Key Points

This paper provides an overview on progress being made against those areas where a Section 29A has been issued by the Care Quality Commission. The attached Summary Improvement Plan details the current status and RAG rating for each 'Must Do' and 'Should Do' action.

For note: RAG rating indicates

Blue: Action fully delivered
Green: Action on target for delivery
Amber: Action behind delivery, but with moderate change to delivery date
Red: Action: Actions overdue. Significant change to delivery date

Please note that the RAG ratings at the end of the Summary Action Plan indicate the rating for each action.

The report also notes the CQC's decision, under the Health and Social Care Act 2008, the Urgent notice to impose conditions on York Teaching Hospital's registration as a service provider in respect of a regulated activity (Section 31) and the Section 29A Warning Notice

The Board is asked to note that those actions relating to the Regulation 29A are now situated at the top of the Summary Improvement Plan.

Recommendation

- Members of the Board are asked to note the progress of the actions associated with the Section 29A Warning Notice
- Note those actions with delivered status and approve their removal from the Summary Improvement Plan
- Note those actions identified as being significantly overdue, (Red Status) and the actions being taken.

Author: Fiona Jamieson, Deputy Director of Healthcare Governance

Director Sponsor: Heather McNair, Chief Nurse

Date: March 2020

1. Introduction and Background

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

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

The Trust was subsequently visited on 13 and 14 July when the CQC undertook spot inspection of ED and the Medical Wards in Scarborough, and ED in York. On the 17th January, the Trust received correspondence from the CQC which indicated an intention to pursue Section 31 Enforcement Action for both ED's. This was followed by correspondence on 21 January indicating that the CQC had issued Section 29A Warning Notices covering a number of issues that are to urgently be addressed.

On 20/02/2020 the Trust received two further reports from the CQC that indicate that the CQC have rated both York and Scarborough Emergency Departments as Inadequate in the Safe, Responsiveness and Well Led domains. The issues raised in the reports reflect the areas for improvement identified in the Section 29A's that were issued on 21 January 2020.

2. Detail of Report and Assurance

This report identifies those actions for removal from the Improvement Plan. Each of these actions can be evidenced. The report also escalates those actions where there has been some slippage and therefore has a revised delivery date. Pease note that only when all areas of an action are completed will the entire standard be considered as delivered.

It is important to note that organisational preparedness for COVID-19 may have an impact on our ability to deliver sustained improvement in all areas identified for immediate improvement.

3. Progress against Section 29A Actions

The Section 29A warning notice issued by the CQC on the 21 January 2020 required urgent action to be taken by the Trust on the following 6 issues.

3.1 'Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services)'

- Strategic group established for York with YTHFT and TEWV, draft pathways in the process of being established for MH Triage, CAMHS Pathway , ED MH referral pathway, MH Paediatric Referral Pathway. Work also to be

undertaken in Scarborough where a different service is commissioned. TEWV are to be invited to participate in the Quality and Safety Meeting
- Mapping of current service provision for both in and out of hours is being undertaken as part of the work above in York
- Multi –Agency Review of top 10 frequent flyers at Scarborough continues to ensure that patients have a clear care pathway in place. Commenced October 2019 and continues
- Work to create an appropriate space for Mental Health patients will be completed in Scarborough and York is now awaiting the arrival of specialist doors

No risk to delivery in York, potential risk to delivery in Scarborough where a different MH service is commissioned.

3.2 'Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm'.

Response required by 21/4/2020

Site Management and Escalation

Achievements to Data: York Site

- Commencement of boarding for acute medical wards at the start of the day as 'business as usual'
- Roles and Responsibilities of Site Management Team reviewed, including interim solution for senior vacancy, testing new roles, development of 'Standard Work' for operational managers, bed managers and first on call manager to reduce duplication in activities
- Internal escalation procedures in ED and across the site reviewed and updated, including OPEL score calculation, coordination of escalation approach utilising community capacity, actively managing transfers of patients waiting for other acute hospitals. Started to embed ICU Discharges SOP; reaffirmed ED admitting rights to prevent delays
- Inter-hospital divert policy drafted for formal approval in March 2020
- Daily operational management meetings and site management information reviewed; operational meetings reconfigured to make them more structured, methodical and action-focussed with clear lines of responsibility; mechanisms to escalate delays added; reporting formats improved; community and acute capacity reporting aligned; a format for overnight reporting introduced

<u>Achievements to date: Scarborough site</u>

- Boarding well established on all risk assessed wards
- Site escalation processes enhanced with introduction of action cards and close loop reporting

- Inter-hospital divert policy drafted for formal approval in March 2020
- System response this winter has been more positive.

The next step is to develop a System wide Full Capacity Protocol and Partner OPEL action cards to enable targeted de-escalation from high OPEL situations.

ED Systems and Processes

Achievements to date: York site

- OPEL escalation implemented in Ambulance handover area for the timely escalation of handover delays with established warning and trigger responses
- Role of YAS Operational Demand Manager agreed and commencing March 2020
- CRT Diversionary pathway in place
- Agreed command and control principles to address issues with department's operational running and patient flow, through development of EPIC & NIC SOP
- Developed an 'at a glance' board in ED to support early trigger of response to operational pressure and aid command and control of the department
- Developed new medical and nursing staffing model, based on meeting hour to hour demand and optimising flow; pending investment
- Agreed streaming of suitable patients to Medical SDEC to relieve pressure in ED; further PDSA 09 March 2020 – supported by AEC Accelerator Programme
- Closer working between clinical teams in ED and Medical SDEC, to improve flow out of ED
- Half day session with ECIST Medical Director to support development of ED clinical leadership (28 Feb 2020)
- Capital works commenced (awaiting delivery of specialist doors) for the Mental Health assessment room; the risk assessment process in ED has been introduced

Achievements to date: Scarborough site

- ED Board Rounds well embedded every 2 hours
- Developed an 'at a glance' board in ED to support early trigger of response to operational pressure and aid command and control of the department
- Education and coaching of new ED teams (esp. Middle Grades) underway
- Streaming to Medical SDEC and Home First Unit (HFU) continues to develop – supported by AEC Accelerator Programme; SDEC and HFU teams pro-actively pulling patients into these zones on a regular basis. Still waiting for Vocare to implement Greenbrook streaming model which is projected to stream an additional circa 25 patients per day from ED / Medical SDEC / HFU to the UTC

There is a risk to delivery.

3.3 'Neither emergency department were meeting the standards from the Facing the future: standards for children in emergency settings'.

Response required by 21/4/2020

- Both Emergency Departments have engaged in a review of the Facing the Future Standards - gap analysis undertaken in Scarborough with action plan in draft
- York action plan to be completed by the end March 2020
- Requirement for two Registered Sick Children's Nurses on each ED shift being progressed through temporary staffing which has resulted at York in at least 1 dedicated paediatric nurse being on shift with a mixture of agency cover and our own substantive staff from the Children's Assessment Unit. This is a greater challenge on the Scarborough site where the use of agency staffing is less successful
- Sufficient capacity in place for all relevant staff that need to complete UK Resuscitation Council PILS course. Target completion date 31/3/2020
- The Trust has requested 8 places on the Sick Children's Course for 2020/2021: Response awaited from HEE
- Small waiting areas have been established for children in both York and Scarborough ED's. Outline agreement has been reached for an improved children's waiting area within the ED at York and additional treatment space from the current Urgent Treatment Centre Capacity to create further separation from the main department
- Longer term plans for a children's area in Scarborough will feature as part of the new build

There is a risk to delivery.

3.4 'Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients'.

Response required by 21/4/2020

A range of measures are being undertaken to improve the quality of recording clinical information, risk assessments and care plans across the Emergency Departments and on the Medical Wards including but not limited to:

- Nursing has agreed to return to a paper based assessment process as an interim measure until a future digital solution is developed and delivered. This is currently at the stage of costing the print run prior to the order being placed
- Ongoing process of audit of compliance with record keeping standards are now undertaken by Matrons and reported to each Care Group Quality Committee
- Standardised tool has been developed for the audit of Medical keeping standards and will be rolled out

- The Trust is currently in the process of recruiting a Director of Digital with interviews taking place in April 2020

This is a risk to delivery.

3.5 'Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients'.

Response required by 18/2/2020

Response was provided on 7/2/2020. CQC have confirmed no further response required.

3.6 'We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites'.

Response required by 21/4/2020

- Workforce review of B4, ACP's and AP's currently being undertaken
- Deputy Chief Nurse working with Heads of Nursing on Workforce Review
- Staffing immediately increased Beech Ward and the Coronary Care Unit post the inspection in June 2019. Skills mix review has been completed with the business case for the permanent uplift in establishment now approved
- International Nursing Project - 12 internationally recruited nurses to Scarborough Hospital with a further 15 due to start at the end of March 2020. Board have approved a further 60 international recruits for 20/21
- Continued use of international recruitment for medical posts with some success in Radiology, Gastroenterology and Histopathology.
- Surgical roster implemented for Scarborough

There is a risk to delivery.

4. Items for Removal from the Action Plan: Delivered Status

The following actions are recommended for removal from the Summary Improvement Plan as they have achieved 'delivered' status. These are

SD7: The service should consider having a designated Paediatric area within the first assessment and majors areas of its urgent and emergency care service at Scarborough hospital.

SD24: The service should ensure that community equipment which requires calibration has this completed as per maintenance schedule.

SD35: Staff at each local induction will be taught about what equipment is on each unit and how to clean it.

SD41: **The service should replace or repair broken equipment in a timely manner and [ensure] safety equipment is available to meet the needs of the patient.**

5. Next Steps

The CQC Programme Group will continue to meet on a fortnightly basis to review progress against the Summary Improvement Plan and report and any removals/escalations on a monthly basis to the Board of Directors.

6. Detailed Recommendation

- Members of the Board are asked to note the progress of the actions associated with the Section 29A Warning Notice

- Note those actions with delivered status and approve their removal from the Summary Improvement Plan

- Note those actions identified as being significantly overdue, (Red Status) and the actions being taken.

York Teaching Hospital NHS
NHS Foundation Trust

Care Quality Commission Summary Improvement Plan

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

Version Control

Version 7

6 March 2020

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

What are we doing?

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

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

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

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

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

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

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

The CQC Improvement Plan was signed off by the Board on 7 November 2019 and sent to the CQC on 13 November 2019.. The plan ensures that the format and content align to the CQC reporting domains and that there is further clarity of the intended outcomes and key performance indicators across the programme of improvement. This will assist in the process to ensure that improvement actions align with the improvement recommendations.

Who is responsible?

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

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

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

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

The format of this plan.

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

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

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

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

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

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

How will we communicate our progress to you?

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

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

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

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

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

Actions Relating to Regulation 29A

Section 29A (Action 1) MD7	Executive Lead: Jim Taylor	The service must ensure it takes action to improve its performance in the RCEM audit standards in its urgent and emergency care service at Scarborough Hospital	Delivery RAG Rating
Scarborough site CG2			Amber

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 7.1	Undertake a gap analysis against previous RCEM audit standards and as necessary develop and action plan that delivers improved performance against the standards	Medical Director CG2 Clinical Director CG1 Clinical Director	Progress to be reviewed at CG2 QC Feb 2020	31 01 2020	Work continues in CG2 with a focus on Paediatrics, VTE , Obs, Frailty and Mental Health In York Strategic Group established with TEWV to map the service in an out of hours Full Gap analysis of RCEM Guidelines by 7/2/2020	Seeking evidence from CG2 Quality Committee

MD 7.2	Based on the review report develop an auditable plan to improve performance against the RCEM audit standards	CG2 Clinical Director CG1 Clinical Director		31 03 2020	Auditable improvement plan Minutes of CG2 Quality Assurance Meetings Quarterly report to CEM audit standards at Care Group 2 Board Meeting	Achievement of RCEM audit standards are sustained and embedded in CG2 performance

Section 29A Action 1 SD6 CG2	Executive Lead: Brian Golding	The service should consider having a designated ligature free room in its urgent and emergency care service at Scarborough hospital for patients suffering from mental illnesses	Delivery RAG Rating **RED**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 6.1	Immediate action: Whilst all rooms are observed at all times and the risk for injury from ligature is low an immediate action has been made to identify a room for high risk patients. This will be used as part of routine business and patients at high risk will be moved to this room as soon as it is available to further minimise any risk of injury from self- harm	CG2 Head of Nursing Head of Estates and Facilities		31/1/2020 – Behind target- Space allocated cross site but plans needed finalising and work Scarborough room to be completed by 28/2/2020 and York by 31 3 2020: Specialist doors on order	Consultation room 1 or 2 will adapted to care for high risk patients Completion of work and communication with staff about use of the room	Assurance is the establishment of the rooms

SD 6.2	A designed ligature free room will be part of the planning for the new build Emergency Department at Scarborough Hospital	CG2 Head of Nursing Head of Capital Planning	See attached project programme (subject to regular review and update) Acrobat Document	Ongoing See also attached project programme (previous column)	Specific sections of minutes when detailed planning commences	• Minutes of project Board and Project Team meetings • Project Programme • Approved SOC, OBC, FBC business cases • Approved designs and specifications (FBC-stage) • Construction procurement

Section 29a Action 2 MD9 Scarborough site CG2	Executive Lead: Wendy Scott	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital: • The median time from arrival to treatment • The percentage of patients admitted, transferred or discharged within four hours • The monthly percentage of patients that left before being seen	Delivery on track RAG Rating **AMBER**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 9.1	Develop, review and deliver against the actions in the Recovery Plan	Deputy Chief Operating Officer (Acute Care)	Plan developed and signed off at Trust Board	Completed	ECS Recovery Plan and schedule for review and reporting Acute Pathway's Programme Board overseeing a programme of work with ECIST is being developed, to strengthen site management at York, and improve flow and performance in Emergency Departments in York and Scarborough. Opened Home First Unit	Trust Performance Reports in place and will be reviewed at Care Group and Trust Board level every month Minutes of Trust Board

		CG2 Care Group Manager	Improvement trajectory achieved	31 03 2020	SGH Monthly Performance Reports presented to and discussed at Trust Board Trust Board meeting minutes	
MD 9.2	Engage with the offer of support from ECIST to further develop approaches to improve the Trusts' performance as identified during the CQC visit	Deputy Chief Operating Officer (Acute Care) CG2 Care Group Manager	Engagement offer from ECIST to be determined and key individuals to be identified to link with ECIST on a programme of work Programme of work to be determined and key objectives and actions, with leads and timescales to be presented to Trust Board	Completed 31 01 2020 To be presented to Acute Board Feb 2020	Terms of engagement and timescales presented by Chief Operating Officer to Trust Board Present the programme of work to Trust Board	Update 15Jan20 ECIST are supporting the Trust with Delivery of Same Day Emergency Care. The SDEC programme covers: Streaming in ED; process and workforce review and redesign to optimise use of SDEC areas in York and Scarborough hospitals. There is an agreed programme plan for SDEC with clear milestones, timescales, leads and risk

						management in place. Progress against plans is overseen at Care Group level by Care Group Boards. At a corporate level assurance for progress against plans is provided to Executive Board via SDEC programme inclusion in the monthly corporate Performance Report, and by a quarterly highlight report from Acute Pathways Programme Board for SDEC setting out achievements and risks to delivery against plan. During Jan20 a further programme of work with ECIST is being

						developed, to strengthen site management at York, and improve flow and performance in Emergency Departments in York and Scarborough Progress against the programme of work, including successes, challenges and obstacles to be presented to the Trust Board (quarterly), Internal Acute Board and monitored at OPAMs (both monthly.

Section 29A Action 2 SD10	Executive Lead: Wendy Scott	The service should ensure it continues to look at new ways of working to improve patient flow from its urgent and emergency care service at Scarborough hospital	Delivery RAG Rating
CG2			**AMBER**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 10.1	Develop SDEC Model Create appropriate space to support delivery of SDEC Model Review and revise staffing model to effectively deliver SDEC, ensuring the correct level of medical and nursing leadership has oversight of how the SDEC Model is developed and governed	CG2 Clinical Director CG2 Head of Nursing		30 04 2020	Improved ECS : Being overseen by the Acute Pathways Programme Board.	
10.2	Review and revise the delivery of SAFER • SAFER engagement event with staff • Consider small scale project creating and exemplar ward and	CG2 Head of Nursing CG2 Clinical Director		29 02 2020	JB CG2 task and finish group assigned .Chief Nurse convening a meeting 27 Feb 2020 DC leading at YDH	

	then a programme to roll out SAFER more effectively					

Section 29A Action 3 MD2 – CG2 MD3 – CG2	Executive Lead: Polly McMeekin	CG2 The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department	Delivery RAG Rating
Scarborough site CG2			**RED**

MD 3.1	For immediate improvement: For immediate improvement: • Ensure that there is adequate and accessible multi-professional paediatric life support training sessions for staff to access	Sandra Tucker Quinn	Review of paediatric life support provision to ensure the delivery meets the needs of staff	Completed	Sufficient sessions are being sourced to deliver training by 31/3.2020, however some staff have not attended when booked. Non attenders to be escalated to the appropriate Heads of Nursing	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly
	• Medical and nursing staff in emergency and	CG2 Clinical Director and Head of Nursing	Training plan for paediatric life support for	Completed		Mandatory Training compliance

	acute care at Scarborough Hospital should undertake paediatric life support and 80% compliance should be maintained at all times		current staff All appropriate staff to be trained in PILS by 31/3.2020	31 03 2020		presented to Trust Board by Director of Workforce and Organisational Development monthly

Section 29A Actions 1 & 3 MD4 Scarborough site CG2	Executive Lead: Polly McMeekin	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting	Delivery RAG Rating **RED**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 4.1	Review the RCEM standards for staffing and undertake a gap analysis. Present findings to Trust Board	Director of Workforce and Organisational Development	Currently ongoing	Completed .	Jan 2020: Director of Workforce and Organisational Development presented report to the Board of Directors	Set a six monthly schedule for repeat gap analysis and risk assessments so the Trust Board understand the continued level of risk
MD	Medical recruitment plan in	Director of	February 20:	Complete	Vacancy level for medical	Medical staffing

4.2	place and performing well	Workforce and Organisational Development with CG2 Clinical Director	An ED doctor identified on every shift as the 'paeds' doctor so the nurse has an immediate point of contact.		staff: 10.6% at Scarborough Jan 2020 but still using agency and locums in ED, Appts made in radiology, gastroenterology Vacancy levels reported to Trust Board	levels monitored Vacancy level Turnover
MD 4.3	Implement the BEST nursing workforce analysis tool and use this for the basis for workforce redesign	Deputy Chief Nurse with CG2 Head of Nursing	Procure hardware and software and engaged with IT to support programme Analyse data and set a 6 monthly rolling programme for data collection and analysis	31 01 2020 not on target (changed from 30/11), BEST not appropriate tool – R Brownhill ECIST arranging for both EDs to be part of pilot for a new tool which looks at twice daily input and includes corridor care. York to run pilot on 24/2/2020, Scarborough	Data collection, analysis and report completed and presented to CG2 Quality Assurance Committee and included in Chief Nurse report for Trust Board Next steps for workforce redesign to be informed by data on other intelligence	Hardware has been procured and is being used in both Emergency Departments prior to wider roll out Six monthly audit schedule for nurse staffing workforce using approved tool

				3/3/2020 - Feedback on the exercise for York has been provided 9/3/2020		
4.4	Develop a nursing recruitment plan which includes projections and risk analysis and mitigation plan acknowledging registered nurse recruitment at Scarborough is challenging	CG2 Head of Nursing		31 01 2020 currently ongoing	Recruitment plan with quarterly reviews and updated recruitment plans in place	Registered nurse staffing levels monitored Vacancy level Turnover
4.5	Utilising the east coast review work, undertaken by the external reviewers, the Trust will determine and approve the scope of the paediatric service at Scarborough hospital which may impact the staffing levels and paediatric training level requirements	Chief Executive with Executive Director colleagues CG2 Clinical Director CG5 Clinical Director		30 04 2020	System wide presentation and approval of scope of paediatric services at Scarborough Hospital Fully aligned medical and nursing staffing and training plan to meet the needs of children who present as an emergency or urgent case . Review has taken place of 100 paediatric admissions in 2019/20 to inform the work	
4.6	Immediate action to	Director of	Training	31 01 2020.	Urgent and emergency	Ongoing / rolling

	undertake a training needs gap analysis for the current substantive medical and nursing workforce, aligned to the RCEM recommendations and examine the opportunities to upskill our current staff to better meet the needs of children who present as an emergency or urgent case	Workforce and Organisational Development	needs gap analysis undertaken and presented Internal and external training opportunities explored to deliver most appropriate training	TNA completed 2. To link RCEM & RCPCN baseline assessment work as interlinked. Learning HUB to run lists of training needs for staff 3. Capacity Issues for ANTT training – potential issues Update 5.3.20 from S Tucker-Quinn. Training is taking place and DNA participants are reported to HON for follow up. A trajectory update has been requested as potentially we are on track for PILS but not for EPALS – Update report to	care RCEM aligned training plan and dates booked for specific training as required Staff attendance / achievement of recommended training monitored on the Learning Hub	programme of training for nursing and medical staff who are not paediatric trained; acknowledging recruiting paediatric trained medical and nursing staff is a challenge at Scarborough hospital – February 20 Regular nursing shifts are now out for 2 x paeds nurses for York ED 24/7. (Mostly)this has resulted in at least 1 dedicated paediatric nurse being on shift with a mixture of agency cover and our own substantive staff from the Children's assessment

				follow. ANTT training being reviewed and streamlined to support compliance and training.		

Section 29A Action 3 SD7 CG2	Executive Lead: Brian Golding	The service should consider having a designated Paediatric area within the first assessment and majors areas of its urgent and emergency care service at Scarborough hospital	Delivery RAG Rating **Delivered**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 7.1	Immediate action: Department review to examine whether improvements such as wall art or a screened area can be created. If feasible remedial work to be undertaken	CG2 Care Group Manager Head of Estates and Facilities	Report with departmental review and options	Now completed	New designated area for paediatrics	Revised date of 29/2/2020 from 31/12/2019. Evidence in place
SD 7.2	A designed area for the management of paediatrics will be part of the planning for the new build Emergency Department at Scarborough Hospital	CG2 Care Group Manager Head of Capital Planning	See attached project programme (subject to regular review and update)  Acrobat Document	Ongoing See also attached programme (previous column)	Specific sections of minutes when detailed planning commences This will be part of the new build. Suggest this is removed as it won't be delivered for a number of years	• Minutes of project Board and Project Team meetings • Project Programme • Approved SOC, OBC, FBC business cases • Approved designs and

						specifications (FBC-stage) Construction procurement

Section 29A Action 3 MD2 – CG2 MD3 – CG2 MD11 – CG3 MD19 – CG5 MD22 – CG3	Executive Lead: Polly McMeekin	CG2 The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training CG2 The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department CG3 The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with Trust policy (MD11 Scar and MD22 Brid) CG5 The service must ensure that all medical staffing complete mandatory training and safeguarding training modules in accordance with trust policy	Delivery RAG Rating
Scarborough site CG2 CG3			**GREEN**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 2.1	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Agreement of 'common standards' across STP for the 'Training Passport'	April 2021 (two year programme commenced April 2019)	Training Passport in place and aligned to Trusts 'Learning Hub'	Improved compliance with all aspects of mandatory training
MD 2.2 S 29A	For immediate improvement: • Ensure that there is adequate and accessible mandatory training sessions for staff to access including those required for the management of paeds in ED	Director of Workforce and Organisational Development / Chief Nurse / Medical Director	Review of mandatory training provision to ensure the delivery meets the needs of staff (TNA) (professional input sought from CN and MD)	Completed	Currently no waiting lists except for manual handling. PILS training to be completed by 31/3/2020 Revised TNA applied and compliance assurance provided to Board	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly
	• medical staff in urgent and emergency care will be issued with	CG2 Clinical Director	Correspondence with each member of the medical staff	Letters have been issued	Compliance matches	Mandatory Training compliance presented to Trust Board by Director

	their individual compliance data and set a target date for full compliance		Monthly monitoring of the progress through CG2 Quality Assurance Committee		Trusts target for each element of mandatory training on 'Learning Hub'	of Workforce and Organisational Development monthly
MD 11.1 MD 19.1 MD 22.1	For immediate improvement medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	CG3 Clinical Director	Correspondence with each member of the medical staff Monthly monitoring of the progress through CG3 Quality Assurance Committee	Letters have been issued	Compliance matches Trusts target for each element of mandatory training on 'Learning Hub'	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly

Section 29a Action 4 MD12 – CG3 MD14– CG3 Scar MD17 – CG2 MD26 – CG3 Brid SD27 – CG5 SD28 – CG5 SD42 – CG2 Brid	Executive Lead: Jim Taylor	CG3 The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy CG3 The service must ensure that all records are secure when unattended (MD14 Scar and MD26 Brid) CG2 The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided CG5 The service should ensure that all entries to women's records are legible CG5 The service should ensure that patients records trolleys are locked CG2 The service should make certain that staff adhere to record keeping policies and follow record keeping guidance in line with their registered professional standards	Delivery RAG Rating **AMBER**
Scarborough site Bridlington site CG3 CG2 CG5			

IMPLEMENTATION PLAN

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

	Assurance Committees. Compliance to be monitored closely at Care Group level, with evidence of associated action plans or individual performance management where necessary		audits are going to be undertaken produced	undertaking audits,	Evidence of improvement plans or individual performance management as necessary Evidence of improvement against audit	
MD 14.1 MD 26.1	Matrons to undertaken quality audits and spot checks which include secure management of patient electronic and paper records	CG3 Head of Nursing		Ongoing	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme, minutes of Quality Committee
SD 27.1	Medical and nursing staff documentation audit	Maternity Quality Assurance team		Completed	Audit schedule Audit report	Evidence requested
SD 27.2	Audit results and compliance will be monitored and any necessary associated remedial actions taken	Maternity Quality Governance Manager		Completed and ongoing	Audit reports and minutes of meetings where governance is discussed	Evidence requested
SD 28.1	The notes trolley in midwifery is being situated behind a lockable door	Head of Midwifery Head of Estates and Facilities		Completed	Commission for work Completion of remedial work	Evidence requested
MD 12 14 18 26	Medium / long term action: Chief Executive to examine recruiting to an executive director position which has a specific focus	Chief Executive		30 04 2020	Executive level appointment who has lead for digital , interviews to take place in April 2020	This timeframe may be revised as recruitment has only just commenced

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

MD15 **Section 29A Action 6**	Executive Lead: Jim Taylor Polly McMeekin	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients	Delivery RAG Rating
Scarborough site CG2			**GREEN**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 15.1	Immediate action: Where the Trust has unfilled shifts bank, agency and locums are employed. Daily monitoring is in place to ensure the safety of the wards	CG2 Care Group Director	Weekly Reporting		Weekly reporting to the CQC	Weekly reports now stepped down as od 7/2/2020
MD 15.2	Review, recruitment and retention strategic approach for Scarborough site	Medical Director Director of Workforce and Organisational Development	Workforce Strategy ratified by Board June 2019. East Coast Medical Recruitment Project made	Complete	Vacancy rate monitored monthly and report to Board of Directors. Reduced rate from 21% in July 2018 to 9.8% October 2019. Currently at 10.6% for Scarborough	Reported to Board of Directors bi-monthly (public Board)

			substantive – Corporate Directors July 2019			

Section 29a Action 6 MD16	Executive Lead: Heather McNair Polly McMeekin	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards at Scarborough Hospital site to promote safe care and treatment of patients	Delivery on track RAG Rating
Scarborough site CG2			**AMBER**

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 16.1	Immediate action: Where the Trust has unfilled shifts bank, agency and locums are employed. Daily monitoring is in place to ensure the safety of the wards	CG2 Head of Nursing		Complete	Weekly CQC return and letter: CQC Ceased weekly monitoring from 7/2/2020	
MD 16.2	Immediate action: On identified wards the staffing plan was increased. The establishments will be reviewed and realigned as required to ensure safe patient care	CG2 Head of Nursing CG2 Head of Nursing		Completed 31 01 2020 revised date 29.2.20	Weekly CQC return and letter Amber Workforce review undertaken Beech/CCU– Business case and paper required from HON JB for	Evidence received and ongoing Require evidence

					evidence and actions. Funding has been agreed for additional staffing for BEECH and CCU post skills mix review	
MD 16.3	Reporting internal and external to CQC	CG2 Head of Nursing Deputy Director of Healthcare Governance		Complete and ongoing Complete and Ongoing	Nurse staffing levels are reported monthly on the Unify return as per national standards Nurse staffing levels and vacancy levels are reported to Trust Quality Committee A letter goes to the CQC on a weekly basis as part of weekly monitoring **CQC advised that weekly monitoring has been stepped down. As of 7/2/2020**	SafeCare audit is scheduled to be undertaken 21 10 2019 for two weeks. The data will be analysed and feed into workforce planning There is a plan to alter some of the wards on the Scarborough site as part of plans to sustain and grow the SDEC model. Nurse staffing workforce plans will be reviewed as part of the bed modelling exercise
MD 16.4	Review, recruitment and retention strategic approach for Scarborough site	Director of Workforce and Organisational Development	Workforce and OD Strategy ratified by Board of	Completed	NHS I Retention programme project plan submitted. International nurse	Vacancy data and stability index shared with Board of Directors bi-monthly.

			Directors June 2019. East Coast Medical Recruitment Project made substantive July 2019	30 6 2020	recruitment programme to deliver a further 48 nurses to Scarborough	

IMMEDIATE ACTIONS FROM JUNE 19 VISIT

Issue No	Action	Lead responsibility	Key Actions	Target date	Measure or evidence of completion	Audit or ongoing assurance
IA 1	Assurance required to ensure sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed at night for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients **NB: This action links to MD2; MD3; MD4; MD11; MD 19 and MD22**	Medical Director CG2 Clinical Director	Delivery of the Hospital At Night project	31 01 2020 (was 31/12/2019) Now to be piloted during March 2020	Hospital at Night Project Plan and Implementation Plan Medical staffing reported to CQC on weekly return Digital solution for bleep filtering and task allocation in place Junior doctor induction schedule and content to include bleep filtering and SBAR (AIRA course and links with Outreach Nurses)	The project plan requires updating to reflect the change in timeline for the Bleep filtering App Continues Currently over due to the delay in the App for bleep filtering being delayed Completed.

CQC MUST DO AND SHOULD DO IMPLEMENTATION PLAN FROM REPORT

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 1.1	Undertake promotion exercise to ensure ALL staff understand the current processes for identifying learning from deaths and SIs	Deputy Director of Healthcare Governance		31 12 19 (to be 31/1/2020 Completed QC on 18/2 and to EB March 2020	Article in Staff Matters Presentation at each Care Groups Quality Assurance Committee Presentation at Executive Board Develop presentation for medical staff induction	In Jan 2020 Staff Matters Policy to Feb Quality Committee June 2020 Presentation of Policy to EB March 2020 undertaken Survey Monkey Audit to

						test that staff understand the current processes for identifying learning from deaths and SIs
MD 1.2	Develop a strategy for the identification of learning from deaths and serious incidents	Deputy Director of Healthcare Governance	Listening exercise with Care Groups. Aim to receive multi-professional feedback on current process	31 12 19 (Now 31/1/2020 to allow for comments on draft Policy) Policy went to Quality Committee in Feb 2020 and to go to EB in March 2020	Learning from Deaths and Serous Incidents Strategy document Sign off at Trust Quality Committee and Trust Board Evidence that the new strategy has been presented through the Care Groups Quality Assurance Committees – Feb 2020 Ongoing evidence that this is presented at appropriate groups, such as, at junior Doctor induction	See Actions for 1.1
MD 1.3	Undertake a multi-professional engagement exercise and in response review and revise the processes for the dissemination of learning	Deputy Director of Healthcare Governance	Engagement events	Linked to the actions 1.1 and 1.2	Report on what our staff think could be better about learning from deaths and serious incidents from the engagement events	Review document Revised processes and publications

	from deaths and serious incidents				Revisions to current processes (to be determined)	

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

IMPLEMENTATION PLAN

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

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

	The key messages sheet will be included in local induction packs for all new starters The key messages sheet will be included in local induction packs for all new starters				Local induction pack	
MD 5.3	Matrons to undertaken quality audits and spot checks which include the safe storage of medicines	CG 2 Head of Nursing		Completed (being done by Healthcare Governance and Matrons) Results show varying performance	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme
MD 5.4	Chief Pharmacist has commissioned Internal Audit to undertake: Safe and Secure Handling of Medicines Audit	Chief Pharmacist Lead Nursing Medicines Management	Scope of audit approval Draft report Final report	31 12 2019 31 01 2020 Update 7.2.20:Draft Audit report received and discussed 5.2.20 – once final report received and approved will need: Due	Scope of audit Schedule for audit Audit Report	Actions generated from audit will be management through the Medicines Management Group

				march 2020 Action plan Inspection tool Re audit in 2021		
SD 16.1 SD 38.1	Develop the current Fridge temperature monitoring Policy to include ambient temperature monitoring for all clinical areas	Chief Pharmacist		30 04 2020	Updated policy Evidence of compliance with monitoring ambient room temperatures	
SD 32.1	All wards and units in midwifery have a signing sheet for daily fridge temperature checks. The completion of this will be audited on a weekly basis by ward sister, in her absence Matron will be responsible and any lapses in compliance addressed	Head of midwifery		Completed	Weekly audit reports Copies of signing sheets Evidence that compliance is discuss at CG5 governance meetings – minutes of meetings	But need to continue review to ensure this is embedded

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 6.1	Information Governance Training contains information about securing patient detailed guidance on computer screens. Compliance with Information Governance mandatory training to be maintained at the nationally target of 95%	CG2 Clinical Director CG2 Head of Nursing		Completed	Learning Hub compliance with Information Governance Training Information Governance Training forms part of induction for all new starters Information Governance training compliance discussed at CG2 Quality Assurance meeting – meeting minutes	Provision of Training information Monitoring of New Starters at Induction Continuous review of training compliance
MD 6.2	Information Governance Team peer reviews which	Deputy Director of Healthcare		Completed	Schedule for peer review.	Review schedule in

	provide an opportunity for immediate rectification and for staff feedback on all information governance concerns	Governance			Reports, actions and feedback from peer reviews.	place, immediate feedback provided with follow up. Reported to IGEG
MD 6.3	Matrons to undertaken quality audits and spot checks which include secure management of patient electronic and paper records	CG2 Head of Nursing CG3 Head of Nursing		Ongoing – requires evidencing Whilst there are some spot checks taking place a standardised audit tool is needed; work is underway with the HON CG1/2/3 and the DCN to look at sourcing/developing a tool. Therefore this has moved from green to amber rag rating. Care Groups report audit activity being undertaken and evidence to be provided	Audit and spot check tools Matrons Audit programme Matrons Reports and action plans Matrons	Rolling audit programme undertaken by Healthcare Governance and Information Governance Team

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 8.1	Review current appraisal rate for nurses in urgent and emergency care and set a trajectory for appraisals to be	CG2 Head of Nursing		29 02 2020 30 June 2020	Learning Hub compliance with appraisal rates for nurses Appraisal Windows in the	Schedule of appraisals Evidence required – agenda/minutes from

	undertaken to achieve 85%				Trust will now run between 1 March and 30 June, Commencing with Directors and cascading down. Completion to be measured at the end of June 2020	CG2 resource committee/OPAMS/CG2 Board
MD 13.1 MD 23.1	Review current appraisal rate for nurses in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	CG3 Head of Nursing		29 02 2020 30 June 2020	Trust will now run between 1 March and 30 June, Commencing with Directors and cascading down. Completion to be measured at the end of June 2020	Schedule of appraisals Appraisal rates monitored through CG3 Quality Assurance Committee – meeting minutes
MD 13.2 MD 23.2	Review current appraisal rate for medical staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	CG3 Clinical Director		29 02 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals Appraisal rates monitored through CG3 Quality Assurance Committee – meeting minutes
SD 29.1	Review current appraisal rate for midwives and medical staff in CG5 and set a trajectory for appraisals to be undertaken to achieve 85%	CG5 Head of Midwifery CG5 Clinical Director		29 02 2020	Learning Hub compliance with appraisal rates for nurses -	Schedule of appraisals

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 10.1	CG2 Management Team to review, revise and deliver a Governance	CG2 Clinical Director		31/1/2020 (was 31/12/2019 on target	CG2 on target CG3 not on target but working towards Amber	

SD 17.2 SD 48.1	Management structure that meets the needs of the new Care Group	CG2 Care Group Manager CG2 Head of Nursing		All Care Groups have agreed that structures will be in place by the end of **March 2020**	Separated on the summary improvement plan for CG2 and CG3 as CG 2 on target and CG 3 working towards but behind target. Minutes of CG2 governance management meetings Risk Register Evidence of escalation to Trust Board Performance Reports	Quality Committee, Governance and Resource Committee Minutes
SD 17.2 CG3 SGH SD39 CG3 BH	CG3 The service should continue to implement and embed the new governance structure and processes	CG3 Clinical Director CG3 Care Group Manager CG3 Head of Nursing	CG3 still being formalised	31/1/2020 (was 31/12/2019 CG3 not on target currently. All Care Groups have agreed that structures will be in place by the end of **March 2020**	CG3 to produce a paper detailing their governance management and escalation structure Minutes of CG3 governance management meetings Risk Register Evidence of escalation to Trust Board Performance Reports	Quality Committee, Governance and Resource Committee Minutes
MD	Executive oversight of	CG2 Clinical		CG2 on target	Schedule of Care Group	

10.2 SD 17.2 SD 48.2	CG2 and CG3 management of risks, issues and performance and governance will be managed through the CG2 and CG3 Care Group Boards	Director CG2 Head of Nursing CG3 Clinical Director CG3 Head of Nursing Deputy Director of Healthcare Governance		CG3 : Progress made with Quality Committee now having met – evidence requested Completed	2 Care Group Board meeting with executives Minutes of meetings CG2 Risk Register and evidence of escalation of risks to Corporate Risk Register Performance reports Development of Governance Dashboards	

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 18.1	A review of all substances hazardous to health to health to be undertaken to ensure only appropriate substances are stored correctly and that COSHH risk assessments are in place	Head of Safety and Security		Completed	Review report COSHH assessments in date across all areas	All Wards have files in place, but need to provide assurance. Evidence requested
MD 18.2	Up to date list of COSHH leads for all areas to be provided and reported through CG2 Quality Assurance Meeting	CG2 Head of Nursing		Completed	Up to date list of COSHH assessors	List held by CLAD Evidence requested

	Appropriate training or training updates to be delivered to COSHH Leads	Head of Safety and Security		Completed	COSHH training records	50-60 staff have been trained
18.3	COSHH Leads to provide local training and ensure staff in each department understand their roles and responsibilities associated with the management of hazardous substances	CG2 COSHH Leads		31 03 2020	Learning Hub compliance with CG2 basic Health and Safety mandatory training Evidence of local COSHH training initiatives	Evidence requested

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 20.1 MD 25.1 SD 15.1 SD 21.1	Delivery of the Outpatients Transformation Programme	CG6 Manager	Introduce: -Rapid expert opinion -Patient Initiated Follow Up in Rheumatology -Video Consultation Diabetes & Cancer -2 way text reminders for all Outpatient appointment & follow up	1/04/2020 Completed 29/2/2020 30 6 2020	Programme Plan Highlight Reports Enhanced management of Follow up partial booking Currently being rolled out in Diabetes and will follow in cancer &, gastro	Evidence of SOP development and integration Video consultation has now commenced
MD 20.2 MD 25.2 SD 15.2	An RTT Recovery Plan is being updated to clearly state the projections for service delivery and backlog reduction	Chief Operating Officer Care Group Managers All Care Groups	RTT backlog to be reduced to 28,880 (78% performance delivery)	31 03 2020 and ongoing	Updated RTT Recovery Plan Presentation / minutes of Trust Board meeting which reference monthly RTT performance	Weekly Performance Meetings with all Care Groups Weekly Performance Overview

						Documents at Care Group and Trust level
SD 15.3	Reducing patient cancellations	CG3 Manager	30% reduction in same day cancellations	Q1 20/21 Completed	**IP Cancellations** Develop Day Unit Recovery area on Scarborough hospital site General Surgery rota changes have moved cancer colorectal resections to York to alleviate bed pressures and long Length of stay at Scarborough Hospital site	Day Unit area operational
SD 20.1	Risk assessment of patients waiting beyond recommended appointment dates	Clinical Directors All Care Groups	Reduce longest follow up partial booking waiters	Completed a Paper to Exec Board 15/1/2020 highlighting the risk and Care Group actions. Care Groups are now undertaking the relevant reviews…progress being sought from each care group.	Risk assessment process tested and delivered reduced longest waiters. Risk assessment processes embedded in Ophthalmology and Gastro Further risk assessment processes being	Governance meetings Risk Registers

					undertaken as required at Care Group level Reported in monthly Clinical Governance meetings as part of the standard template Very long waits added to Care Group risk registers and discussed through governance meetings	

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 21.1	Supporting Performance Delivery Paper presented to Trust Board which provided a detailed recovery plan for any specialty or cancer site that was not achieving RTT and cancer waiting times	Chief Operating Officer Care Group Managers		Complete Refreshed Paper to be produced March 2020	Trust Board minutes Trust Board minutes	
MD 21.2	Progress against the Performance Delivery Paper is monitored at Trust Board .	Chief Operating Officer	On going	Completed Monthly and	Update report on progress to be presented at Executive Board in November 2019 Progress against	Performance

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

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 2.1	Determine nature and scope of Clinical Strategy Completion of Clinical Strategy document	Wendy Scott	Executive Board – Workshop to develop this. Identification of lead Drafting of Strategy Sign off by Executive Board and Board of Directors	29/2/2020 29/2/2020 Date to be confirmed	Appoint a lead by 29.2.20 to do this work. JD being completed for this role Interviews take place in March 2020 Aim to appoint by April 2020 Completed Document approved by Executive Board and Board of Directors	Use of document as reference tool in future Board of Directors, Executive Board and Care Group Performance Review Meetings.

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 4.1	Chief Executive to examine recruiting to an executive director position which has a specific focus on digital and performance reporting and who on appointment undertakes a review of reporting systems and develops a Digital Strategy which encompasses performance reporting infrastructure	Simon Morritt		30 04 2020	Successful appointment Digital review Digital Strategy	Interviews taking place April 2020
4.2	Immediate action: New Care Group Dashboard have been developed on gone 'live'	Head of Information		Completed	Care Group Dashboards	

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

IMPLEMENTATION PLAN

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

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 9.1	Medical; Midwifery and Allied Healthcare Professionals have Clinical Supervision in place. Policies in place Develop at Clinical Supervision Policy / Strategy for nursing	Medical Director/Head of AHP Deputy Chief Nurse		Complete 31 01 2020 not on track for this date 17.2.20 revised date for completion	Policies, Policy now in draft and to go for approval **March 2020**	Staff feedback / staff survey Staff feedback / staff survey

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
11.1	Identify most frequently issued leaflets to be translated into most frequently used languages	Lead for Patient Equality and Diversity / CG2 Head of Nursing	Most commonly requested leaflets in emergency and urgent care to be translated into the most frequently requested language translations.	31/3/2020 Leaflets identified , have been identified and are in the process of review Not completed as still no PILS review. Lists sent to HON CG2/3 however, now to be put into specialities	Leaflets accessible in most commonly requested languages and available within the department Completion date changed to 31/3/2020 from 31/1/2020	Most commonly requested translations identified ED Patient Info leaflets currently working to ensure compliance with standards

				CG2 CD will review leaflets cross site in EDs		
11.2 44.1	Improve staff awareness and approach to Accessible Information compliance	Lead for Patient Equality and Diversity	Posters advertising communication needs to be displayed	Completed	Visible posters available throughout the emergency and urgent care department	Posters have been developed and approved
		CG2 Clinical Director/ CG2 Head of Nursing	Staff to undertake e-learning on Accessible Information standard	Date revised to 31/3/2020 from 31/12/2019 Behind plan training has been made available but slow take up due to current pressures	All staff have undertaken Accessible Information standard	
		CG2 Clinical Director/ CG2 Head of Nursing	Staff to undertake e-learning on updating patient communication needs on CPD	Date revised to 31/3/2020 from 31/12/2019 Behind plan training has been made available but slow take up due to current pressures	All staff know how to add or maintain patient communication needs on CPD	
		Lead for Patient Equality and	Develop arrangements	Timeframe revised to	Library of easy read leaflets available to be	

		Diversity / CG2 Head of Nursing	for information to be available in easy read format	31/3/2020 from 30/1/2020 Timeframe may slip as review of leaflets takes place	printed when required.	
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Patient Leaflets to be available in MP3/audio format	Completed	Library of MP3/audio recordings of leaflets available to be played/emailed to patients by staff when required.	functionality for producing audio format leaflets now available… communication to be sent out during December on how this format can be accessed.
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Staff awareness of how to book interpreter and translation services	Completed	Staff are confident in knowing how to make interpreter bookings and knowing how to request translation of documents.	Information is now on Staffroom
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Staff to be made aware how to access leaflets electronically and how to make into large print.	Completed	Staff are confident in knowing how to access leaflets held electronically and produced in the patients chosen large print format	Information is now on Staffroom

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
13.1	Perfect Ward providers visit to hospital to present their app	Deputy Chief Nurse		Completed	Presentation	
13.2	Business Case to be written and presented to panel to seek funding for Perfect Ward App and delivery of quality data that can be displayed on a dashboard	Deputy Chief Nurse		Completed	Business case panel Corporate Directors Action Log	
13.3 (New ACTION)	Implementation of Perfect Ward App	Deputy Chief Nurse HH		31/7/2020 Full implementation by 30/9/2020	Evidence of APP in use and increase in compliance	

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
18.1	Matrons to undertaken quality audits and spot checks which include the resuscitation trollies	CG 2 Head of Nursing CG5 Head of Midwifery CG6 Head of Nursing		Completed with ongoing monitoring	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme Healthcare Governance Completing monthly checks, outcomes escalated to Matrons. HoN and CN

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

IMPLEMENTATION PLAN

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

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
34.1	Testing undertaken and all levels are within normal limits	Head of Health and Safety		Complete	Testing results	
34.2	Re-testing of levels schedule in place to provide further assurance that the results are consistently within normal limits	Head of Health and Safety		Complete	2nd set of testing results indicate Entonox levels on both labour wards are out of normal limits. A Business Case is being established to address this to go to Business Case Panel in Jan 20.	Results of 2nd test and Subsequent Business Case. This leads to a third and new action
34.3	Development of Business Case to ensure that levels of Entonox gas are removed from the	Head of Health and Safety	Presentation of Business Case to Business	31 01 2020 This will be subject to CPEG approval	Business case sent 28 Jan 2020 –requires further clarification and steer from Corp Directors	

	atmosphere in labour ward		Case Panel	for the preliminary design work. Health & safety Lead to confirm any mitigation and seek independent advice. Verification of Entonox results via and external review to be undertaken		

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
40.1 46.1 TW	Deliver complaints letter writing training to new managers and matrons	Lead for Patient Experience	Training undertaken September 2019	Reported as Completed but evidence requested.	List of people who attended complaints letter writing training and course details Letter writing training course attenc Writing-to-customers -course-V2.pdf	Monthly OPAM and EPAM reports highlight breaches and areas for improvement ~ escalated to care group managers

40.2 46.2 TW	Complaints Management Policy review and revision	Lead of Patient Experience	Survey of staff to understand their concerns Listening exercise with care group management to inform review	31 01 2020 (was31/12/2019) Draft policy out for comments by 21.2.20Jan 2020 HH to obtain an update from J Harle	Revised Complaints Management Policy	Monthly and quarterly Board reports highlight good practice and areas of concern. In-house complaints management training will be delivered in Q4 once policy has been ratified
40.3 46.3	Complaints management in accordance with Trust policy	CG3 Head of Nursing CG2 Head of Nursing		31 01 2020 Update provided improving compliance against Trust standard CG3 slow progress 34% CG2 progress being made 71% compliance Evidence Lead for Patient experience.	Good compliance with timeliness Action log from CG3 OPAM CG3 Patient Experience dashboard	Evidence demonstrating improvements has been requested

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
41.1	Ensure each ward unit and department manager or team leader understands the process for reporting broken equipment and how to escalate if the correct equipment is not available for their patients	Estates (change from HON) Deputy Chief Nurse		Reported as Completed, evidence requested.	Communication with senior nurses at Bridlington Hospital Staff Matters article	

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

IMPLEMENTATION PLAN

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

	Development group to embed mental capacity assessment and related documents electronically		electronic system will act as a prompt to consider capacity throughout patient journey	with IT Development group to embed mental capacity assessment and related documents electronically Red rated . Update from L Haigh this has not started.	capacity consideration required under the Mental capacity Act.	be discussed. Progress will be monitored by the Safeguarding Adults Governance Group.

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 45.1	A comprehensive piece of transformation work as to how Johnson Ward functions as a rehab ward with some palliative care beds is due to commence November/December 2019. This project will focus on the workforce model (People), refresh the processes that underpin how Johnson Ward functions (SAFER) and how Johnson Ward fits with the various community and local authority offers that are in place.	CG2 Care Group Manager CG2 Head of Nursing	Project scope and Project plan in place. Confirmation of patient criteria for transfer onto Johnson Ward Revised workforce model	Commencing Dec 2019 This work is part of the same initiatives therefore SD45.1 not progressed as SD 47.1 underpins the recommendations. X2 admission criteria: 1. Inpatient bed 2. ED 31 01 2020	LOS data for patients on Johnson Ward Draft admission guidance currently being reviewed. LOS data monitored at CG2 Quality Assurance Committees – minutes of meetings This will involve system stakeholders and the date of 31/3/2020 may be extended. To consultation needs AHP review. Consultation ends 17.2.20 and go live	Trust Performance Reports in place and will be reviewed at Care Group and Trust Board level every month Minutes of Trust Board

				31 03 2020	planned the week following.	Reported as completed, evidence sought

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

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
47.1	Develop an admissions criteria for Johnson ward at Bridlington hospital site	CG2 Head of Nursing AHP Lead for Professional Standards		31 12 2019	Admission criteria document See SD45 above	See above action

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

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

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

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

York Teaching Hospital
NHS Foundation Trust

Board of Directors- 25.03.2020
Infection Prevention & Control Briefing Paper

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 briefing paper is to update Board members on the current status of Healthcare Associated Infections (HAI) and infection control measures in York Teaching Hospitals NHS Foundation Trust.

Executive Summary – Key Points

This report provides an overview of infection prevention and control with particular reference to the incidence of Healthcare Associated Infections (HAI) against NHSE/I targets for infection control. The report provides updates on:

- Infection rates reported as part of national surveillance systems
- COVID-19 IPC Team contribution
- Outbreak data

Recommendation

The Board is asked to note this report.

Author: Martine Tune

Director Sponsor: Heather McNair

Date: 25.03.2020

1. Introduction and Background

One of our key clinical priorities is to protect our patients, visitors and staff from the risk of healthcare-associated infections caused by bacteria (germs). This is in accordance with the requirements of the Code of Practice on the prevention and control of infections and related guidance, under the Health and Social Care Act 2008.
York Teaching Hospitals is absolutely committed to patient safety, and that includes doing everything we can to prevent people in our care acquiring any sort of infection.

Key Healthcare Associated Infection Headlines for March 2020

Like every other NHS Trust in England, York Teaching Hospitals reports numbers of particular infections to the national surveillance system. These infections include bloodstream infections (also called bacteraemias) caused by MRSA and cases of C. difficile infection.

Please see attached Infection Prevention Weekly Update dated 20/03/20 (Appendix 1)

2. Detail of Report and Assurance

Key Risks

The ongoing risk is that current operational pressure related to COVID-19 is likely to continue and this consumes the majority of the IPC team's time, energy and attention. Although this work is imperative it does mean that other important routine IPC business, Back to Basic Audits and Post Infection Reviews, areare not automatically being prioritized which has the potential to have an adverse impact on patient safety and quality of care.

Novel Coronavirus (COVID-19)

The infection Prevention and Control team, Microbiologists and Occupational Health Team are working together to ensure key frontline staff have full Personal Protective Equipment (PPE) and training in the event of caring for potential and confirmed cases.
Work is progressing to develop pathways across primary, community and secondary care involving all key stakeholders aligning with Health protection guidance on the safe management of patient groups.

It should be recognized that the IPC Team is responding to the dynamic situation and an increased volume of requests for IPC advise in often difficult situations

The IPC Team

The trust has a specialist Infection Prevention and Control Team (IPCT) based at York and Scarborough hospital sites. Among other activities, the team provides training and education, advises on isolating patients and other protective measures, and monitors the cleanliness of the hospitals. The team is also closely involved with all new developments to make sure that infection prevention and control is an integral part of everything we do. Unfortunately, following national recruitment, we were unable to fill the vacancy for our IPC Lead Nurse post. Additional nursing leadership support has been provided to the IPC team based at Scarborough in the interim. An alternative IPC leadership structure has been

agreed and interviews are to be held on 26th March 2020. Some further temporary additional administrative support has been identified for the team following redeployment of Research & Development staff as a result of COVID-19.

Outbreaks

A full outbreak meeting was held on Tuesday 17th March 2020 to review the current situation and agree key immediate actions.

A summary of the most recent outbreak data can be seen in the table below.

Date Closed	Ward	Hospital	Bay	Reason Closed	Date of Next Review by IPN	Date of Opening
11/03/2020	26	YH	Full Ward	Confirmed Norovirus	21/03/2020	-
12/03/2020	WXC	WXC	Full Unit	Confirmed Norovirus	21/03/2020	-
16/03/2020	37	YH	Full Ward	Confirmed Norovirus	21/03/2020	-
17/03/2020	39	YH	1	? Respiratory Virus	21/03/2020	-

Future Work plan

Revised National Cleaning Standards are expected imminently, and it will be important for us to review and confirm our approach to providing assurance regarding the adequacy of cleaning standards across all hospital sites.

3. Detailed Recommendation

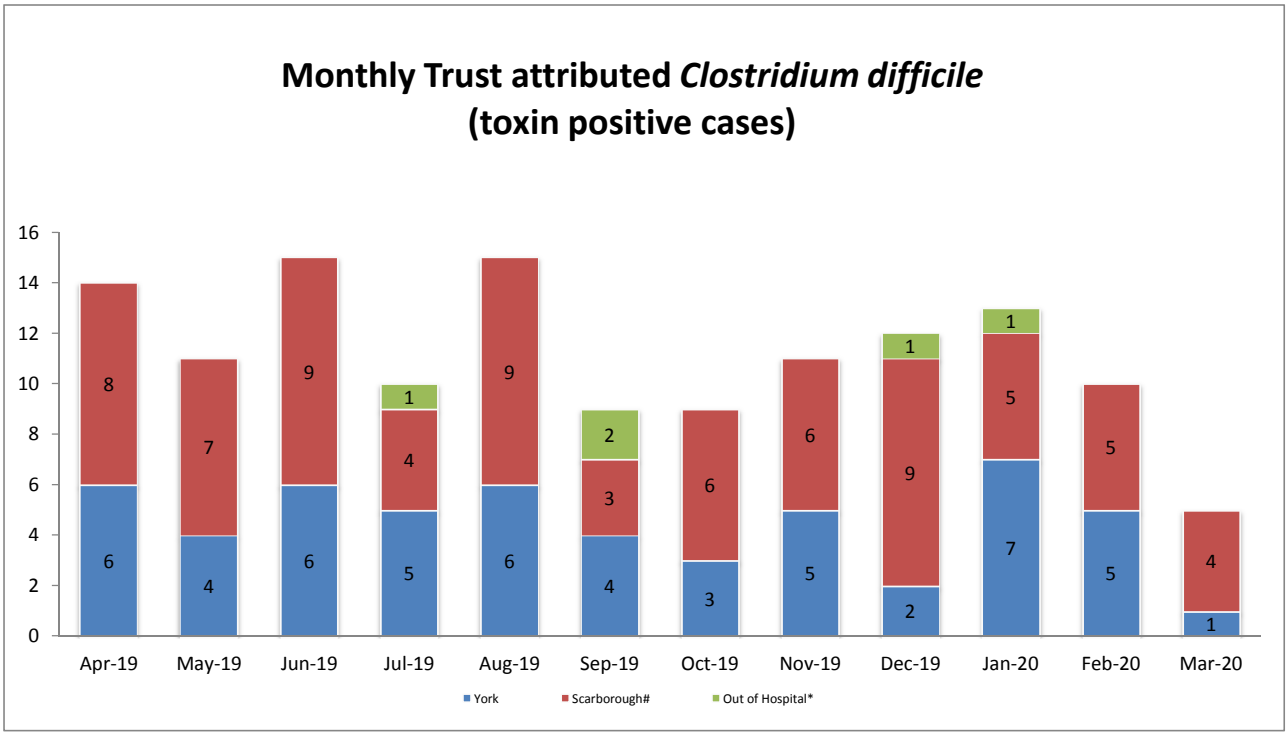
The Board is asked to note this report.

York Teaching Hospital NHS
NHS Foundation Trust

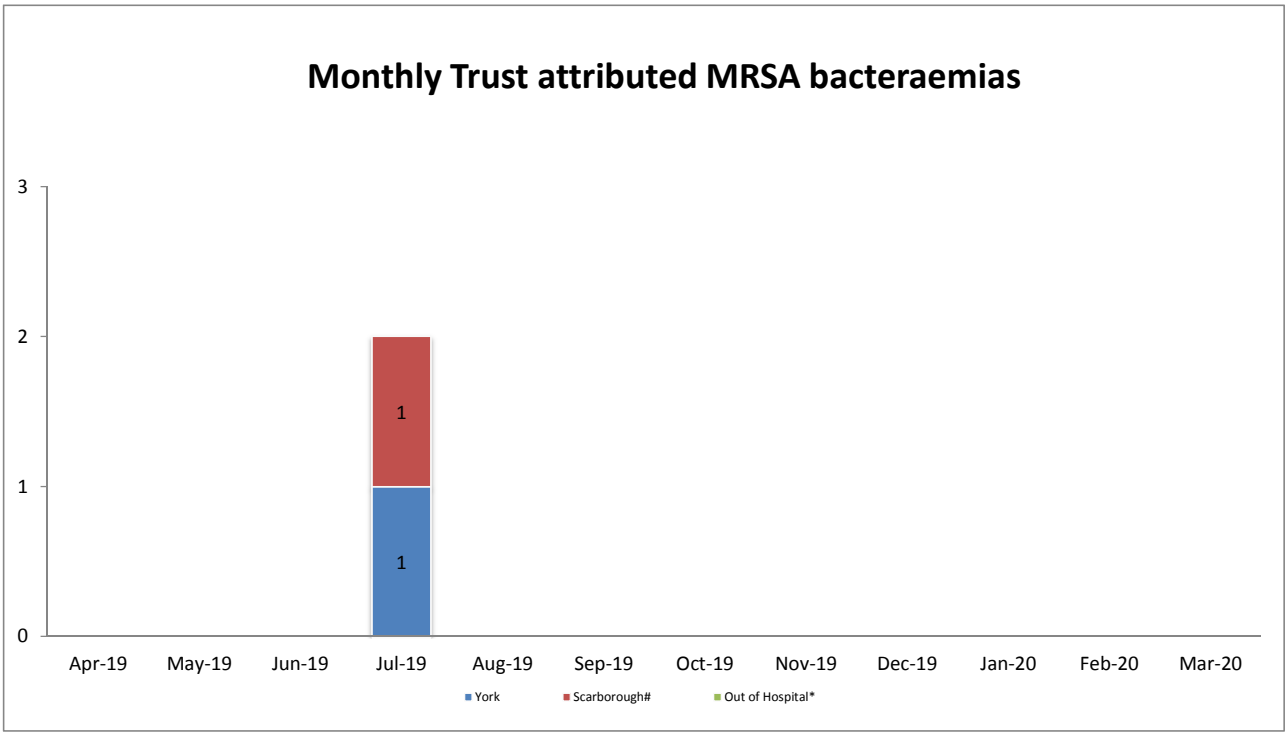
Infection Prevention Health Care Acquired Infection incidence

#Scarborough includes Bridlington
*Out of hospital includes Selby, St Monicas and Rehabilitation units

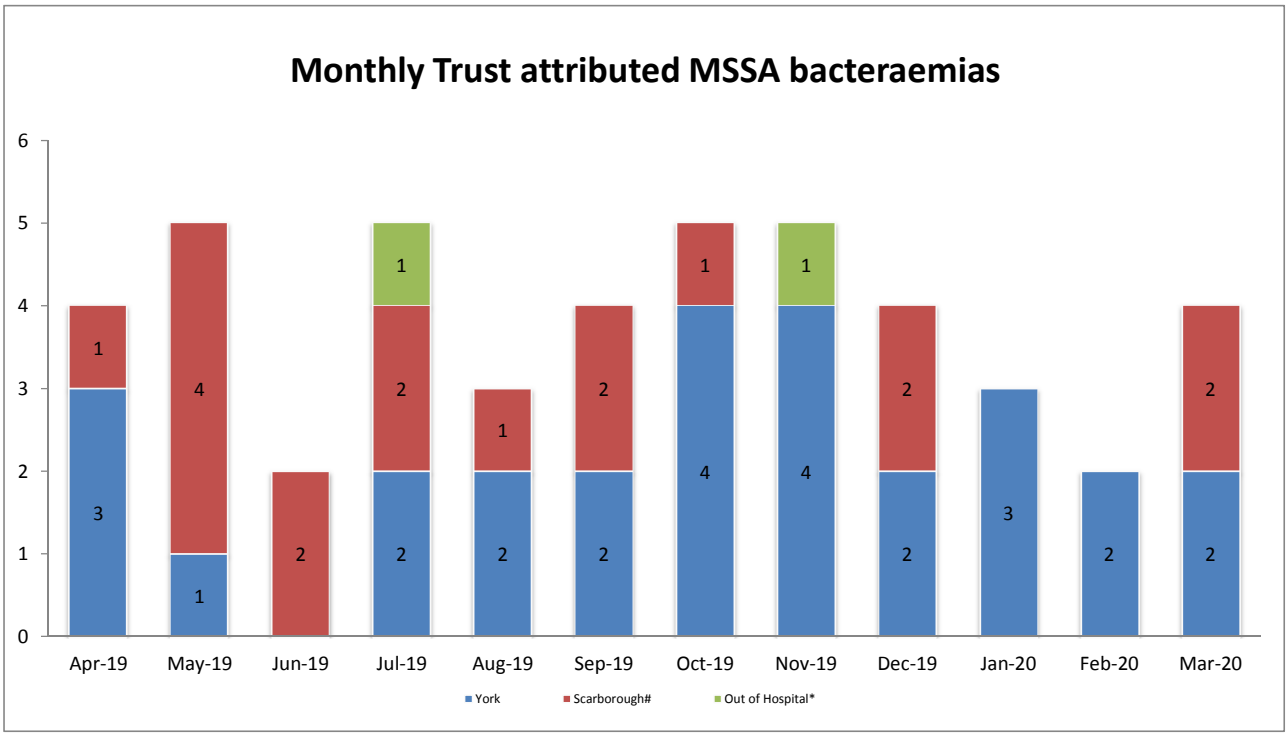
Clostridium difficile toxin			Days since last case on 20/03/2020			
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
09/03/2020	11	15/03/2020	5	24/01/2020	56	
Clostridium difficile toxin	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumu-lated total**	**Accumu-lated threshold**
Apr-19	6	8	0	14	14	5
May-19	4	7	0	11	25	10
Jun-19	6	9	0	15	40	15
Jul-19	5	4	1	10	50	20
Aug-19	6	9	0	15	65	25
Sep-19	4	3	2	9	74	30
Oct-19	3	6	0	9	83	35
Nov-19	5	6	0	11	94	40
Dec-19	2	9	1	12	106	45
Jan-20	7	5	1	13	119	50
Feb-20	5	5	0	10	129	55
Mar-20 to date	1	4	0	5	134	61
Total	**54**	**75**	**5**	**134**		**61**



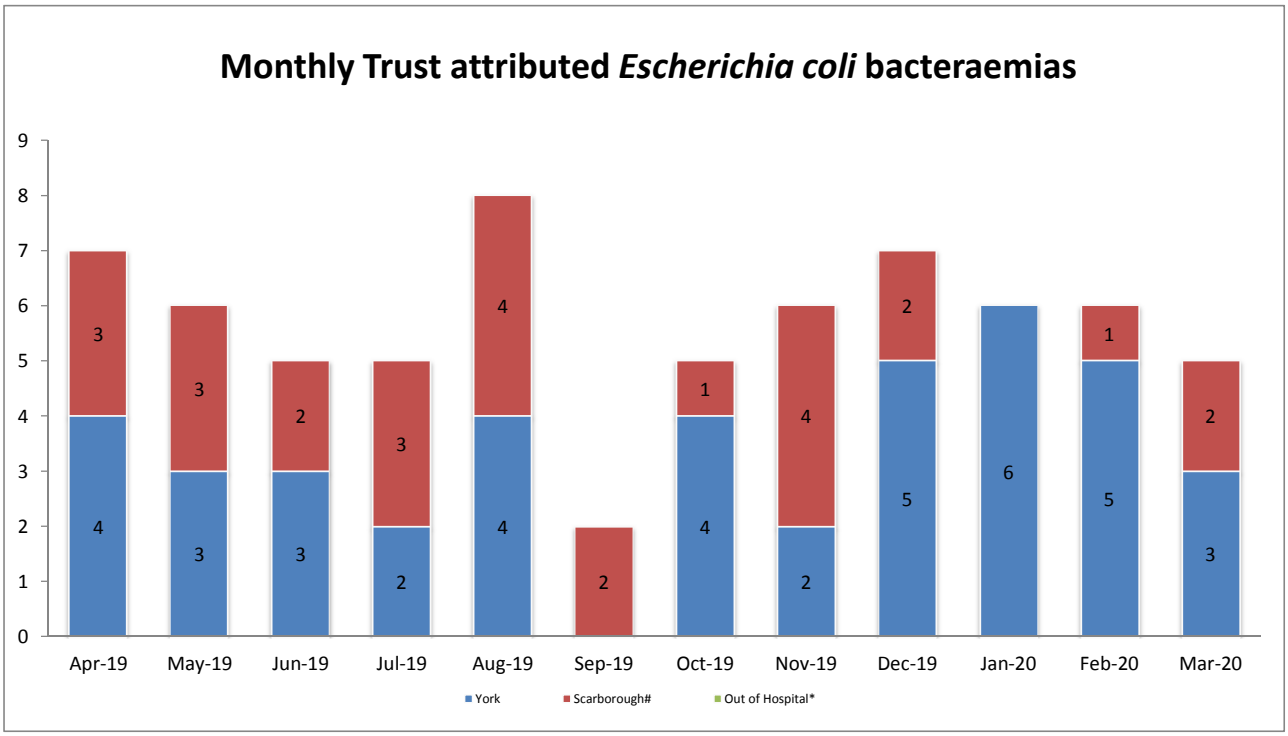
MRSA bacteraemia			Days since last case on 20/03/2020			
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
22/07/2019	242	11/07/2019	253	07/10/2016	1260	
MRSA bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumu-lated total**	**Accumu-lated threshold**
Apr-19	0	0	0	0	0	**Threshold = zero tolerance**
May-19	0	0	0	0	0	
Jun-19	0	0	0	0	0	
Jul-19	1	1	0	2	2	
Aug-19	0	0	0	0	2	
Sep-19	0	0	0	0	2	
Oct-19	0	0	0	0	2	
Nov-19	0	0	0	0	2	
Dec-19	0	0	0	0	2	
Jan-20	0	0	0	0	2	
Feb-20	0	0	0	0	2	
Mar-20 to date	0	0	0	0	2	
Total	**1**	**1**	**0**	**2**		



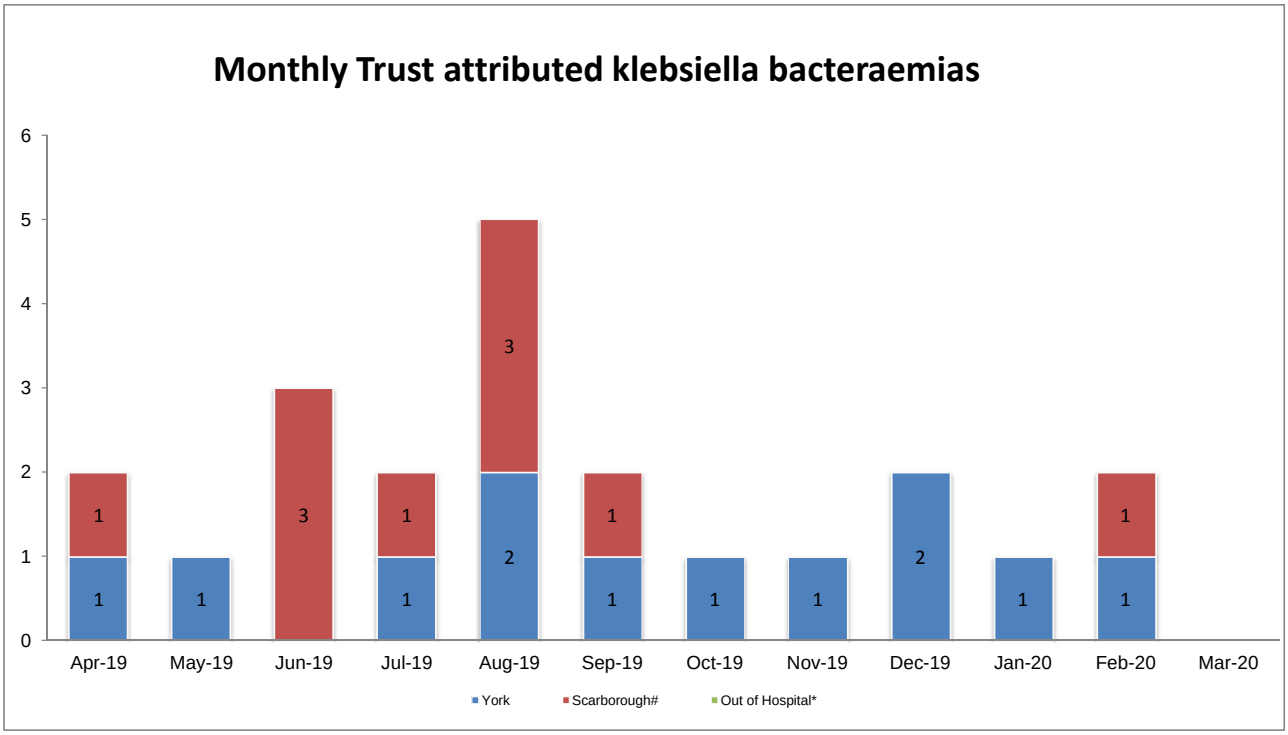
MSSA bacteraemia				Days since last case on 20/03/2020		
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
15/03/2020	5	03/03/2020	17	26/11/2019	115	
MSSA bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumu-lated total**	**Accumu-lated threshold**
Apr-19	3	1	0	4	4	3
May-19	1	4	0	5	9	5
Jun-19	0	2	0	2	11	8
Jul-19	2	2	1	5	16	10
Aug-19	2	1	0	3	19	13
Sep-19	2	2	0	4	23	15
Oct-19	4	1	0	5	28	18
Nov-19	4	0	1	5	33	20
Dec-19	2	2	0	4	37	23
Jan-20	3	0	0	3	40	25
Feb-20	2	0	0	2	42	28
Mar-20 to date	2	2	0	4	46	30
Total	**27**	**17**	**2**	**46**		**30**



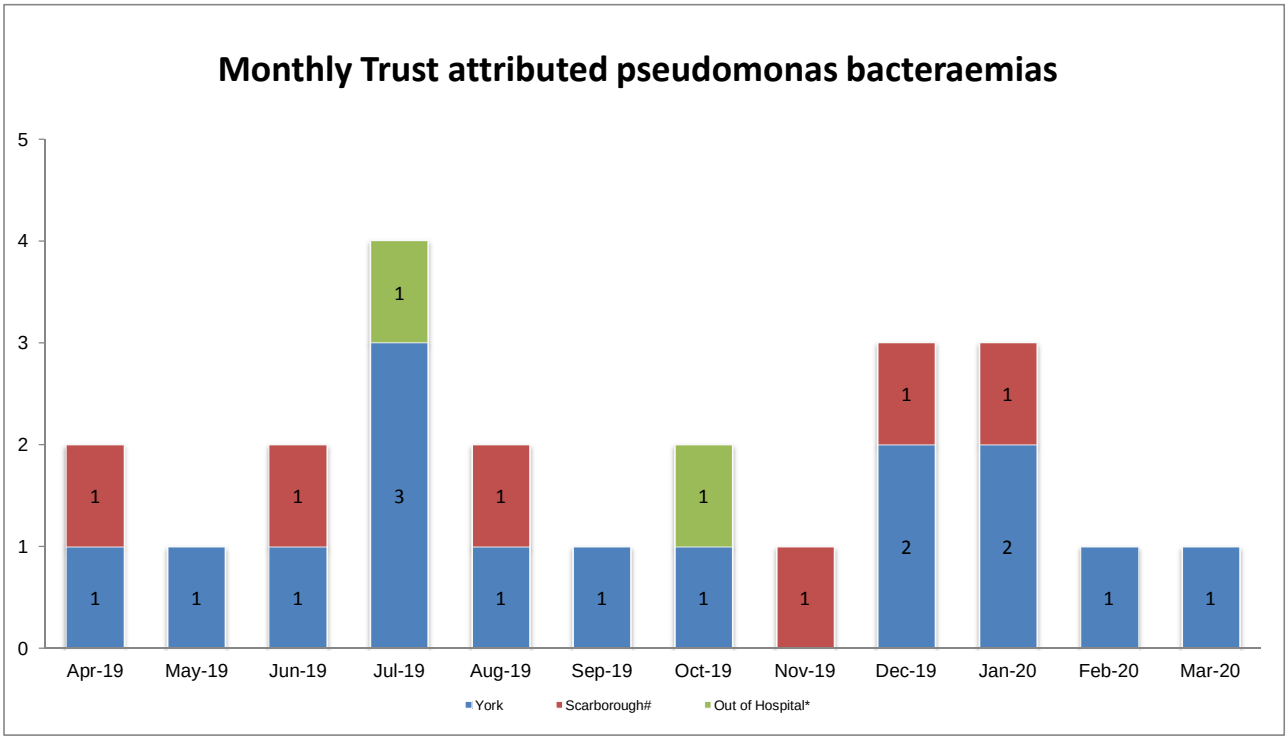
E Coli bacteraemia				Days since last case on 20/03/2020		
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
15/03/2020	5	05/03/2020	15	24/01/2019	421	
E coli bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumu-lated total**	**Accumu-lated threshold**
Apr-19	4	3	0	7	7	5
May-19	3	3	0	6	13	10
Jun-19	3	2	0	5	18	15
Jul-19	2	3	0	5	23	20
Aug-19	4	4	0	8	31	25
Sep-19	0	2	0	2	33	30
Oct-19	4	1	0	5	38	35
Nov-19	2	4	0	6	44	40
Dec-19	5	2	0	7	51	45
Jan-20	6	0	0	6	57	50
Feb-20	5	1	0	6	63	55
Mar-20 to date	3	2	0	5	68	61
Total	**41**	**27**	**0**	**68**		**61**



Klebsiella species bacteraemia				Days since last case on	20/03/2020	
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
07/02/2020	42	07/02/2020	42	12/02/2019	402	
Klebsiella bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumulated total**	**No threshold**
Apr-19	1	1	0	2	2	
May-19	1	0	0	1	3	
Jun-19	0	3	0	3	6	
Jul-19	1	1	0	2	8	
Aug-19	2	3	0	5	13	
Sep-19	1	1	0	2	15	
Oct-19	1	0	0	1	16	
Nov-19	1	0	0	1	17	
Dec-19	2	0	0	2	19	
Jan-20	1	0	0	1	20	
Feb-20	1	1	0	2	22	
Mar-20 to date	0	0	0	0	22	
Total	**12**	**10**	**0**	**22**		



Pseudomonas bacteraemia			Days since last case on 20/03/2020			
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
01/03/2020	19	17/01/2020	63	26/10/2019	146	
Pseudomonas bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumulated total**	**No threshold**
Apr-19	1	1	0	2	2	
May-19	1	0	0	1	3	
Jun-19	1	1	0	2	5	
Jul-19	3	0	1	4	9	
Aug-19	1	1	0	2	11	
Sep-19	1	0	0	1	12	
Oct-19	1	0	1	2	14	
Nov-19	0	1	0	1	15	
Dec-19	2	1	0	3	18	
Jan-20	2	1	0	3	21	
Feb-20	1	0	0	1	22	
Mar-20 to date	1	0	0	1	23	
Total	**15**	**6**	**2**	**23**		



Blank page

York Teaching Hospital
NHS Foundation Trust

Health and Safety Policy

Author:	Andrew Hamer, Health and Safety Manager (interim) Colin Weatherill, Head of Safety and Security
Owner:	Heather McNair, Chief Nurse
Publisher:	Corporate Services
Date of first issue:	December 2012
Version:	1.9
Date of version issue:	05 August 2019
Approved by:	H&S/NCRG/Resources Committee & Board of Directors
Date approved:	25 March 2020
Review date:	March 2021
Target audience:	Trust Wide
Relevant Regulations and Standards	Health and Safety at Work etc, Act 1974. The Management of Health and Safety at Work Regulations 1999 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Care Quality Commission (Registration) Regulations 2009 (Part 4) – Regulation 18

Executive Summary

This policy sets out Health and Safety Policy for York Teaching Hospital NHS Foundation Trust.

Version History Log

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

Version	Date Approved	Version Author	Status & location	Details of significant changes
York 4	October 2006			• Sections 4 and 9 added and section 8 expanded • Employees responsibilities – link to disciplinary policy and procedure added
5	October 2007			• Change of Owner/Lead Director from Director of Nursing/Chief Operating Officer to Director of Human Resources and Legal Services. • Section 5.5 - Responsibilities included for Safety Representatives. Arrangements Section: • Non Ionising section added • Slips and Trips section added
5.1	January 2008			"Who is Who" section: • Details of Radiation Protection Supervisor removed, and replaced by Radiation Protection Advisor • Patient Safety Manager / Health & Safety Lead post replaced by Trust Risk Manager post • Risk & Safety Advisor post replaced by Health & Safety Manager post Arrangements section:

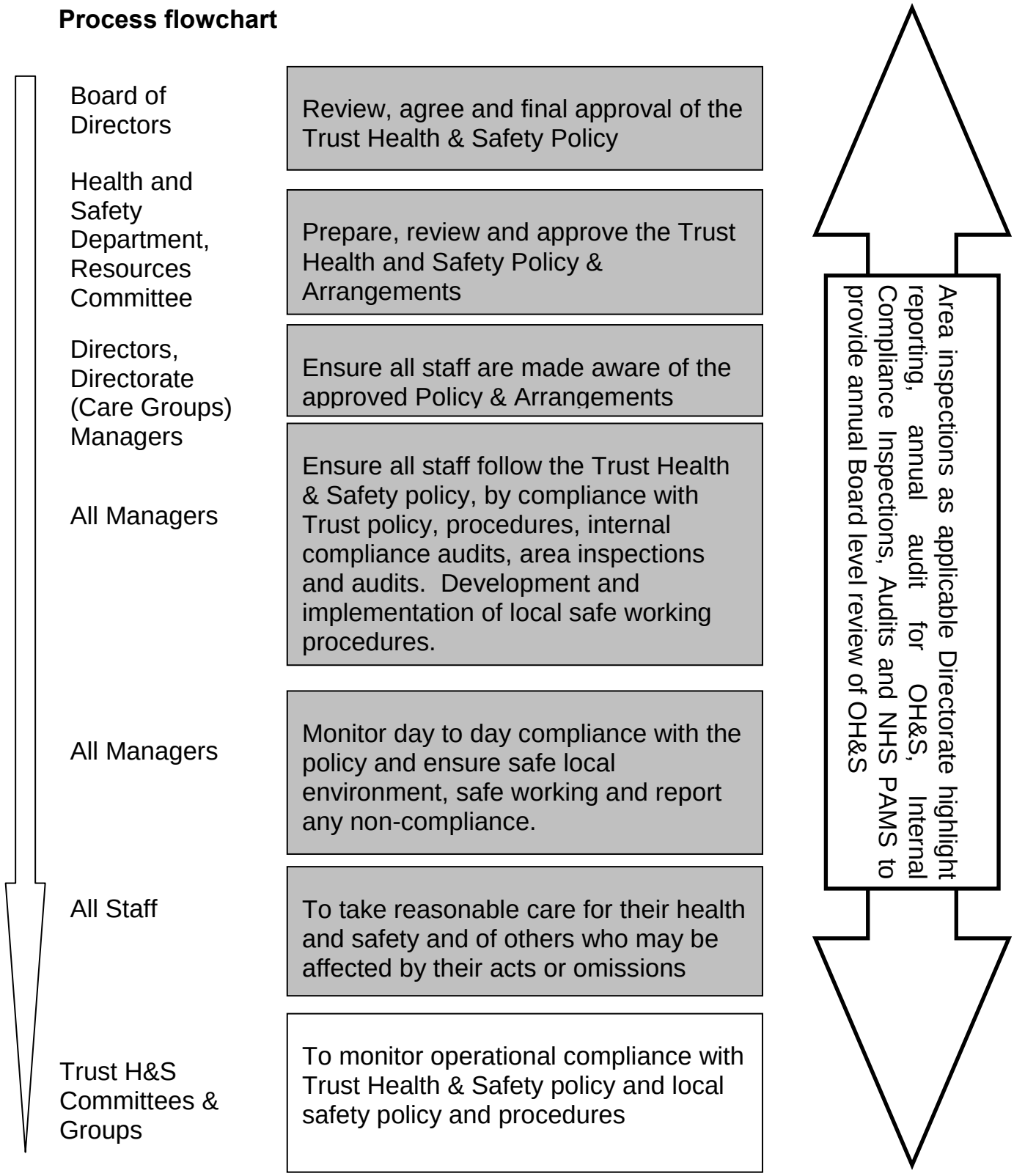
				• Inclusion of Non-Ionising Radiation (s29) in table of contents
6	June 2009	Carol Adams		Policy re-written to current trust template. Complete re- structure of policy to ensure current legal compliance and trust procedures
7	June 2010	Carol Adams		Policy updated to reflect current Health and Safety Management system Policy re-written to current trust template
8	May 2011	Elaine Miller	Horizon	Policy updated to reflect Trust Governance structure
Scarborough **4.05**	June 2011	Colin Weatherill	SNEY Website	Policy Reference HSS01 Policy updated as part of standard review
Re-issue details 1	December 2012	K Needham / Colin Weatherill	Approved Staffroom	Full policy review, new Trust policy for integrated organisation OH&S arrangements across the enlarged organisation Review of 1st Draft against legislative OH&S policy good practice requirements. Amend 3.5 safety management standard now reads system. 10.2 Standards and KPI's replaced annually by risk based Trust management objectives for the Trust.

				Review of policy to reflect the needs of the wider Trust and to ensure the document complies with the policy template
1.2	December 2014	K Needham / Colin Weatherill	Approved Staffroom	Annual review
1.3	March 2016	K Needham / Colin Weatherill	Approved Staffroom	Annual review & update of policy to reflect changed H&S committee structure.
1.4	March 2017	K Needham / C Weatherill	Approved Staffroom	Annual review, legislative reference, reduction of wording & update of policy to reflect changed H&S committee and management structure.
1.5	February 2018	K Needham / C Weatherill	Approved Staffroom	Annual review & update of policy. Replace risk management strategy with framework. Include associated regulations on policy statement and make clear the underpinning of policy by specific and topic procedures, plans and SSOW's (Section 5).
1.6	March 2019	K Needham / C Weatherill	Approved Staffroom	Annual review & update of policy. Addition of compliance with NHS PAMS and internal compliance audits in managers responsibilities. Update with new committee structures Resource Committee, include Care Group Managers at Directorate Manager level. Include reference to York Teaching Hospital Facilities Management Limited Liability

				Partnership Health and Safety Policy in associated Trust documentation.
1.8	August 2019	C Weatherill	Staffroom	Change policy statement to reflect appointment of new CEO.
1.9	March 2020	A Hamer / C Weatherill	Staffroom	Annual review & update of policy. Minor grammatical changes, section format and layout. As applicable replace divisional manager with care group manager in sub sections. Inclusion of 'ensure relevant health and safety is discussed' to section 4.16 Trust Committees and Groups. Replace resource committee with quality and safety to reflect changes in operational reporting and amend section 6.1 as consulted stakeholder.

Contents

Process flowchart



1 Introduction & Scope

The York Teaching Hospital NHS Foundation Trust ("the Trust") recognises its duty to ensure 'so far as is reasonably practicable', the safety of patients, employees and others arising from Trust work activity. The Trust is committed to achieving compliance with relevant UK health and safety legislation by maintaining a high standard of health, safety and welfare by recognising the importance of clearly defined management responsibility and arrangements.

This policy sets out the minimum standards which all employees of the organisation are to work to, and encompasses the following:

- Chief Executive's Statement;
- Organisation Accountability and Responsibilities;
- Risk Management Framework, Policy & Procedure;
- Health and Safety related policies
- General Arrangements;
- Arrangements for Occupational Health and Safety Monitoring and Review.

The Trust is committed to continuous improvement for Health and Safety by the implementation and maintenance of an effective Health and Safety policy, procedure, systems and processes.

This Policy applies to all the Trust's properties and sites under the control of the Trust and other locations where Trust staff carry out duties. At locations under the control of other employers, Trust staff are expected to comply with any additional safety requirements of the host.

This policy will be communicated to all staff, including permanent, temporary, voluntary workers, agency or locum. The Trust also recognises its statutory obligations in ensuring a safe environment for all employees, patients, contractors, visitors[1] within the Trust.

This policy supersedes all previous versions of Trust Health, Safety and Welfare policies.

[1] Visitors include trespassers

2 Policy Statement

York Teaching Hospital NHS Foundation Trust Board will ensure that all activities carried out on its premises or undertaken by its employees (or their agents) are managed in such a way as to avoid, reduce or adequately control all foreseeable risks to the health and safety of any person who may be affected by the Trusts undertakings.

The Trust is committed to ensure the provision a safe and healthy environment for employees, patients and others who may be affected by the Trust's work activities, by ensuring all reasonably practicable measures are taken to comply with the Trust's duties set out in the Health and Safety at Work etc Act 1974.

The Trust has in place policies and procedures to ensure a healthy & safe environment by ensuring:

- A safe place in which to work with safe means of access and egress;
- Suitable and sufficient information, instruction, training and supervision to enable all employees to undertake their duties safely;
- The provision of safe plant, equipment and systems of work;
- Arrangements for the safe use, handling, storage and transport of articles, materials and substances;
- Appropriate management procedures and consultative arrangements to monitor and audit compliance with the Trust policies;
- Appropriate arrangements to assess and control the risks associated with work activities;
- Appropriate procurement policies to ensure that only competent contractors and suppliers are engaged by the Trust;
- To consult with all staff groups on matters of health/safety matters, in particular the health safety and welfare, and other associated committees/groups.

The Trust is committed to adopting best practice in health and safety management; the Trust's Board of Directors is committed to meeting its duties set out in the Health and Safety at Work etc Act 1974 and associated regulations.

The York Teaching Hospital NHS Foundation Trust formally approved this Policy Statement 25 March 2020.

Simon Morritt
Chief Executive

York Teaching Hospital NHS Foundation Trust

3 Equality Impact Assessment

The Trust' statement on Equality is available in the Policy for Development and Management of Policies at Section 3.3.4.

A copy of the Equality Impact Assessment for this policy is at Appendix A.

4 Accountability & Responsibilities

Corporate accountabilities are detailed in the **Policy for Development and Management of Policies** at section 5. Operational implementation, delivery and monitoring of the policy reside with:-

4.1 The Board of Directors

The Board of Directors are responsible for setting the strategic direction, policies, and objectives. The Board will ensure this is discharged through a delegated structure, ensuring the necessary support and resources are made available to allow for effective implementation of this policy.

4.2 Chief Executive

The Chief Executive is ultimately responsible for the adherence to health and safety legislation within the Trust, and is accountable for the establishment and achievement of health and safety polices and procedures within the Trust.

In the event of the Chief Executive's absence, a Board nominated Director will take up these responsibilities.

4.3 Executive Directors & Non-Executive Directors

Directors are to have active involvement in the management of health and safety in their areas of control and collective responsibility for health and safety in the organisation.

Directors are responsible for the safety of their staff and the activities in their charge. They are expected to promote a high degree of health and safety awareness amongst all their personnel.

4.4 Nominated Director for Health & Safety

The Director of Nursing is the nominated Director for health and safety arrangements within the Trust and is to champion health and safety in the Trust.

The nominated Director is responsible for ensuring effective arrangements, systems and plans are in place for the management of health and safety risks. The nominated Director is to address health and safety and risk management issues at a strategic level as part of the Trust governance requirements.

4.5 Care Groups managers, Heads of Department and Ward Managers Responsibilities

Managers and heads of departments are responsible for the impact of the overall health safety and risk on their ward/departments as it may relate to staff, patients or visitors and have the responsibility to ensure this is effectively managed.

4.6 Head of Safety and Security / Health and Safety Manager

The head of safety and security is responsible in setting the strategic direction of the Trust health and safety direction, supporting and advising the Trust on health and safety matters.

The health and safety manager is functional responsibility for health and safety matters in the Trust. Advising on issues relating to health and safety, development of the Trust's health and safety policy and practices to include as required other associated policies.

4.7 Designated Care Group Managers

Designated care group managers are responsible for implementing the Trust's health and safety at work policy at care group level and for ensuring the Trust's health and safety management system is in place within their area of responsibility, by supporting the nominated senior managers or nominated line/operational managers who have overall responsibility for their area with regards to health and safety.

They must ensure departments under their jurisdiction are safe to work in, and all practicable measures taken to provide for the health and safety, by implementing an effective risk assessment programme for their area of responsibility.

Ensure staff in their area of control is consulted about health and safety matters, through representation on local health and safety groups and committees.

In line with Trust policy all incidents are reported within the correct timescale and full investigations are carried out as quickly as possible.

Directorate (care group) managers are to attend specific health and safety training provided by the Trust to enable them to fulfil this role.

4.8 Specialist Advice

The Trust has in place specialist advisors and functions to provide for a safe environment, providing support and advice to the Trust and its employees.

Each position and function has defined roles and responsibilities. Further information on these can be gained from the specific individual or function.

4.9 Employee Safety Representatives

The Trust promotes active involvement and encourage employee safety representatives are appointed by trades unions to represent their members on health and safety issues. Employee safety representatives are to be involved in discussions regarding staff health safety and welfare issues.

4.10 Employees

All staff, including work experience, agency, temporary, and volunteers within the Trust are required to accept responsibility for carrying out and adhering to the health and safety polices of the Trust.

All employees are to comply with their duties set out in UK health and safety legislation by taking reasonable care for themselves and others who may be affected by their acts or omissions. Employees are accountable to their line managers and assist towards making the Trust a safe and healthy place in which to work.

In all cases, failure to comply with health and safety responsibilities could result in disciplinary action being taken as set out in the Trust's Disciplinary Policy and Procedure.

4.11 Others Persons (Contractors)

Any person who is not directly employed by the Trust but is undertaking work on its premises, for or on the Trust's behalf, must not act in a manner that is prejudicial to the safety of others, whilst conducting their work and observe Trust health and safety policy and procedures.

No contractor is to work on Trust premises unless the correct type of method statement and/or risk assessment has been completed and agreed by the relative manager.

If work to be undertaken is particularly hazardous this must not commence until the appropriate permit to work is obtained from the appropriate relative source/manager.

4.12 Quality and Safety Committee.

The quality and safety committee is a committee of, and is accountable to, the Board of Directors.

The Committee supports the Board in its role of assuring effective health and safety management systems are in place and that its systems support and promote their aims, by monitoring the organisations ability to meet its principal objectives.

The Committee seeks assurance the organisation is identifying and managing the principal risks to achieving its objectives, advising the Board on risk management and governance (clinical and operational) issues which may affect the Trust's business operations.

The Committee consider and report the most significant current issues identified to the Board of Directors.

4.13 Trust Health, Safety and Non Clinical Risk Group (NCRG)

The NCRG is responsible for overseeing health and safety and for identifying the implications of non-clinical risks and confirming their action plans.

The NCRG will provide assurance all significant, emerging non-clinical risks have been identified, and appropriate action plan has been prepared and is being implemented. The NCRG will consider and advise on non-clinical risks and assurance, identify and address both new and changing health and safety legislation, guidance and develop key performance indicators for Health and Safety as required.

4.14 Trust Health Safety Committee

The Health and Safety Committee of the Trust is to be reflective of the Trust's service provision and business activities. In addition to this, as and when required this committee liaises and works with other committees on related subjects.

The Committee will also be responsible for satisfying the statutory requirement to convene a Health and Safety Committee as laid down under the Safety Representative and Safety Committee Regulations 1977, and the Health and Safety (Consultation with Employees) Regulations 1996, as amended.

4.15 Care Group, Specific Departmental Governance Groups, Risk & Specialist Health & Safety Groups & Committees

These groups and committees will ensure effective communication between the Trust's quality and safety, health, safety and non-clinical risk group, the Trust's health & safety committees and each care group, department/risk & specialist area. Each group will evaluate recommendations from any audits, inspections, reports, reviews, by incorporating the findings into directorate/department/risk & specialist action plans, or, if appropriate the directorate or corporate risk register.

4.16 Trust Committees & Groups

All Trust Committees and Groups are to have specific terms of reference, ensure relevant health and safety issues and concerns are discussed at meetings, this is formally recorded and minutes retained. The Trust Committee and Group structure can be found on the Trust Intranet.

5 Trust Health and Safety Management Arrangements

The Trust recognises the activities undertaken by employees are varied, carried out in many properties and locations across the organisation. The Trust activities encompass many tasks and work stream all of which carry some element of risk, the Trust will 'so far as is reasonably practicable' ensure systems and procedures for health and safety are in place thus affording the highest standards of safety to all those affected by the Trusts activities.

The Trust has in place a Board authorised risk management framework, Health and safety strategy, health and safety procedure which sets out a recognised process to manage health and safety and risk in the Trust.

The aim of this Trust policy is to create and encourage an embedded and pro-active health and safety culture, which involves all employees of the organisation. The implementation of health and safety strategy and policy allows flexibility in its application of operational and departmental specific health and safety management through the risk assessments process and risk action plans.

The Trust risk management framework and health and safety strategy/policy contains the elements of Trust wide statutory compliance with the general requirements of Health and Safety at Work etc Act 1974 (HSWA74); this policy is supported by specialist and topic specific operational plans, procedures and safe systems of work made under this policy.

The Trust has developed a safety management system, which will ensure, a systematic inspection and audit of the effectiveness of compliance with this policy and associated health and safety policies and procedures is in place. This will be undertaken as part of a Trust wide health and safety monthly and annual review of safety information and reports and specific departmental operational inspection and audit schedules.

All employees are informed they are to be reasonable in their actions and cooperate with the Trust managers in achievement of the following programmes/action plans.

6 Consultation, Assurance and Approval Process

6.1 Consultation Process

A list of consulted stakeholders are:

- Health and Safety Department;
- Chief Nurse;
- Healthcare Governance (Risk);
- Health and Safety Committee;
- Wider Groups via the Health and Safety Committee;
- The Health, Safety and Non-Clinical Risk Group;
- Quality and Safety Committee;
- Board of Directors.

6.2 Quality Assurance Process

Following consultation with stakeholders and relevant consultative committees, this policy will be reviewed and published by the compliance unit.

6.3 Approval Process

Following completion of the consultation process, this policy, and any subsequent policy revisions will require the approval of the Board of Directors.

7 Review and Revision Arrangements

The date of review is given on the front coversheet.

This policy will be reviewed annually or earlier should there be a legislative any other reason to do so; once reviewed the Board of Directors will consult and ratify this policy.

The review of this policy will be in conjunction with those named in section 6.1 above.

The Compliance Unit will notify the author of the policy of the need for its review six months before the date of expiry.

On reviewing this policy, all stakeholders identified in section 6.1 will be consulted.

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

Subsequent reviews of this policy will continue to require the approval of the appropriate committee as determined by the Policy for Development and Management of Policies.

8 Dissemination and Implementation

8.1 Dissemination

Once approved, this policy will be brought to the attention of relevant staff as per the **Policy for Development and Management of Policies**, section 8 and Appendix C - Plan for Dissemination .

Additionally, the policy and procedure will also be shared with all Directors, Clinical Directors, Care Group Managers, Senior Managers and Matrons for them to be advised of and to act accordingly. Staff will be made aware of the new version through Team Brief and via staff room. It will be included in the health and safety/risk management mandatory training sessions. The policy should be discussed with all staff at the local induction.

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

8.2 Implementation of Policies

This policy will be implemented throughout the Trust by the Directors, Care Group Managers and Department Managers.

This policy is available on the Trust's Intranet site and the contents are covered in mandatory training.

9 Document Control including Archiving

The register and archiving arrangements for policies will be managed by the compliance unit. To retrieve a former version of this policy the compliance unit should be contacted.

10 Monitoring Compliance and Effectiveness

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

The monitoring of this policy is achieved through the findings obtained through the implementation of health and safety inspections, audit and monthly and annual reports supported by the individual monitoring processes of those relevant polices referred to in this document.

These findings of these reports, inspections and audits will be presented in an annual report to the Trust health and safety committee, health, safety and non-clinical risk group and summarised to the Trust Board.

10.1 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and to ensure that the minimum requirements are met, the policy will be monitored as follows:

Evidence	Monitoring /Who by	Frequency (as a minimum)
Risk Assessments, risk registers and treatment plans	Care group managers/heads of department and appointed local managers	Annually as per Risk Management Policy & Procedure
Incidents DATIX AIRS Relevant Committees/Groups documentation	Divisional managers/Heads of Department Relevant Groups will provide highlight reports to Trust NCRG & Quality and Safety Committee	Ongoing Group frequency dependant

Area Inspections Report on OH&S inspections and Incident data	Divisional (care group) Managers/Heads of Department Health and Safety Manager	Monthly (as defined) Annual
Health and Safety Training reports provided by CLaD	CLaD/Divisional Managers/Heads of Department	Quarterly
Health and Safety Objectives and Plans – papers to Non Clinical Risk Group	Non Clinical Risk Group	Annually

10.2 Standards/Trust H&S Performance Indicators

The Health and Safety Department report on H&S performance and will ensure the 4 key board assurance areas of leading, process, lag and competence indicators as set out in the Trust strategy are monitored and reported on.

The key aims are to reduce health and safety risks so far as is reasonably practicable and to provide a safe working environment for staff, patients, visitors and others by achieve a positive health and safety culture through communication with all stakeholders on all health and safety issues.

Achieving excellence in the management of health and safety through compliance with statutory duties and continuous improvement.

Trust H&S Performance Indicators

The Health Safety and Non-Clinical Risk Group will review the incident and accident data pertaining to the Trust OH&S performance and from this review will, as appropriate advise and support the health and safety department in development of any risk based Trust health and safety management objectives for approval by the Board.

Approved plans will be developed to achieve the effective delivery of these objectives; performance of these objectives will be monitored by the quality and safety committee and reported on annually to the Board of Directors.

11 Training

See section 11 of the **Policy for Development and Management of Policies** for details of the statutory and mandatory training arrangements.

All Designated Directorate Safety Managers and Risk Assessors are expected to undertake specialist health and safety training prior to them commencing their role. Designated Directorate Safety Managers are expected to gain[2] and maintain specific safety related knowledge pertaining to their area of work.

Specialist training is carried out by specialist advisors or identified training providers. Courses include Incident Investigation, DSE Assessment, COSHH Assessment and Risk Assessments.

12 Trust Associated Documentation

YHFT [CORP.RL10] Policy Development Guideline
YHFT (CORP.RL1) Adverse Incident Reporting System, (AIR's) Policy and Procedure
YHFT Risk Management Framework
YHFT Managing Stress in the Workplace
YHFT Slips Trips and Falls Policy (Patients)
YHFT Slips Trips and Falls Policy (Employee & others)
YHFT Serious Incidents Policy
YHFT Manual Handling Policy
YHFT Waste Management Policy
YHFT Health and Safety Strategy
York Teaching Hospital Facilities Management Limited Liability Partnership Health and Safety Policy

Other Health and Safety related Trust policies, plans and procedures - stored on QPulse and available via Staffroom

13 External References

Health and Safety at Work etc. Act 1974
Associated Occupational Health and Safety Regulations
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

[2] Specific knowledge is to be commensurate to their role and can include training, instruction and sources safety information to maintain a safe environment.

Approved Codes of Practice
NHS Technical Guidance (HTM's, HBN's)
NHS Specific Guidance
Specific OH&S Guidance

14 Appendices

Appendix A **Equality Impact Assessment**

Appendix B **Checklist for Review and Approval**

Appendix C **Dissemination Plan**

Appendix A: Equality Impact Assessment Tool

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

Name of Policy:	Health and Safety Policy

1.	**What are the intended outcomes of this work?** The policy sets out the process for the Trust for effective health and safety management across all sites.	
2	**Who will be affected?** All staff, visitors, patients and public etc.	
3	**What evidence have you considered?** Legislative compliance, NHSLA requirements, CQC fundamental standards guidance for providers of Quality and Safety and advice from the Inclusivity Lead.	
a	**Disability -** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
b	**Sex -** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
c	**Race** - This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
d	**Age** .- This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
e	**Gender Reassignment** - This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
f	**Sexual Orientation -** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
g	**Religion or Belief** - This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
h	**Pregnancy and Maternity -** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	

i	**Carers** - This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
j	**Other Identified Groups** - This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
4.	**Engagement and Involvement** This policy is inclusive and does not differentiate between people on the basis of this characteristic.	
a.	Was this work subject to consultation?	See below
b.	How have you engaged stakeholders in constructing the policy	See below
c.	If so, how have you engaged stakeholders in constructing the policy	See below
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs Engagement and involvement of the development of the policy has included relevant staff at all sites within the Trust, relevant Executive Directors and the Trust's Inclusivity Lead.	
5.	**Consultation Outcome** The policy conforms to the requirements of the Policy for the Development and Management of Policies, relevant legislation and the requirements of the relevant CQC Outcomes. *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	The policy is inclusive
b	Advance Equality of Opportunity	The policy is inclusive
c	Promote Good Relations Between Groups	The policy is inclusive
d	What is the overall impact?	The policy is inclusive
	Name of the Person who carried out this assessment: Andrew Hamer/Colin Weatherill	

	Date Assessment Completed **13 February 2020**
	Name of responsible Director **Heather McNair**

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

Appendix B Checklist for the Review and Approval

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

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1	**Development and Management of Policies**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or procedures?	Yes	
2	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Has an operational, manpower and financial resource assessment been undertaken?	Yes	
4	**Content**		
	Is the document linked to a strategy?	Yes	
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5	**Evidence Base**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
5a	**Quality Assurance**		
	Has the standard the policy been written to address the issues identified?	Yes	
	Has QA been completed and approved?	Yes	
6	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the staff side committee (or equivalent) approved the document?	Yes	
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
10	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Heather McNair	Date	13/02/2020
Signature	*Heather McNair*		
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	17/03/2020
Signature	Chair Quality and Safety Committee On Behalf of the Board of Directors		

Appendix C Plan for dissemination of policy

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

Title of document:	**Health and Safety Policy**
Date finalised:	**TBC**
Previous document in use?	**Yes**
Dissemination lead	**Andrew Hamer/Colin Weatherill**
Which Strategy does it relate to?	**Health and Safety Risk Management**
If yes, in what format and where?	**Electronic and Paper via Intranet**
Proposed action to retrieve out of date copies of the document: **Compliance Unit will hold archive**	

Dissemination Grid

To be disseminated to:	**1) All Staff**	**Through Trust safety committees, staff room.**
Method of dissemination	**Posted on Staffroom**	**Electronic.**
who will do it?	**Healthcare Governance**	**Health & Safety Manager**
and when?	**After ratification**	**April 2020**
Format (i.e. paper or electronic)	**Electronic**	**Intranet** http://staffroom.ydh.yha.com/policies-and-procedures/health-safety

Dissemination Record

Date put on register / library	**April 2020**
Review date	**March 2021**
Disseminated to	**All staff**
Format (i.e. paper or electronic)	**Electronic**
Date Disseminated	**On approval**
No. of Copies Sent	**As above**
Contact Details / Comments	**Policy will also be emailed to staff as per section 9.1 by Andrew Hamer/Colin Weatherill**

York Teaching Hospital
NHS Foundation Trust

Board of Directors - 25 March 2020
Maternity Services Annual Report 2019

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

To inform the Board of Directors of annual activity from January to December 2019 including achievements, risks, priorities and future development of maternity services

Executive Summary – Key Points

Maternity transformation based on Better births 2016 gathered pace and traction in 2019. Significant structural and personnel changes took place in Humber, Coast and Vale Local Maternity System (LMS). Major focus remained on building the delivery of continuity of carer to 35% by March 2020 and 51% by March 2021. York Trust has a strategy on place to meet 35%; further work is needed on a strategy to meet 51%.

Saving Babies Lives version 2 (SBLv2) care bundles were launched in March 2019 and to be included in the standard NHS contract by March 2020, these are also included in NHS Resolution maternity safety standards for 2020. The aim of these is to continue the work to reduce stillbirths to meet the ambition of halving rates nationally. Significant stretch has been added to these standards and an additional element which will require investment in order for York Trust to comply.

In April 2019 York commenced wave 3 of the national maternity and neonatal health safety collaborative quality improvement programme, this work around reducing neonatal hypoglycemia is starting to see reductions in numbers of babies requiring admission for neonatal care through hypothermia and hypoglycemia. This work assists with the Atain project around reducing term admissions to neonatal units. Pathways for transitional care were developed in 2019 to reduce unnecessary separation of mothers and babies, further work and investment will be required in 2020 to strengthen further.

Maternity and neonatal Safety Champions meet bi-monthly with the Chief Nurse who is board level Safety champion to discuss the maternity safety plan. In 2019 a non executive director joined the Maternity safety champion team.

The birth rate on York site has fallen by 5.3% in 2019, with Scarborough falling by 1%. The complexity, acuity and dependency of women accessing services continue to rise which is challenging for services. An additional challenge has been created by transient holiday population on the East coast presenting with complex issues, within the stillbirth and neonatal death cases in 2019 several were women not booked for maternity care with York Trust.

Changes to Trust structures moving into care groups are providing further opportunities for close team working between Child Health and Obstetrics and Gynaecology.

Significant data quality work and changes to electronic collection systems have shown significant increase to One to one care in labour being recorded at consistently high levels. Supernumerary role of the Labour Ward Co-coordinator can also be demonstrated at a very high level, there is mitigation in place for both sites when sudden increased activity challenges the ability to provide either.

In Line with the national trend there is a reduction in experienced middle grade doctors, along with the changes in rules regarding entrustability this is providing challenges for medical cover.

Maternity services on the East Coast underwent CQC inspection in July 2019 which resulted in a rating of good, which is an improvement on the previous rating of requires improvement.

Service development for 2019 includes;

- Transitional care pathway developed to meet British association of perinatal medicine guidance (BAPM)
- ATAIN project (Avoiding Term Admissions into Neonatal units) focusses on four key areas relating to term admissions – hypoglcaemia, jaundice, respiratory conditions and asphyxia. It also includes keeping babies temperature at an optimum level. There is an MDT case review of all term admissions to SCBU.
- MatNeo health safety collaborative wave 3 work on neonatal hypoglycaemia launched.
- SBLv2 launched and project lead in post part time
- Continuity of Carer, whole service change to East coast planned 2019 and implemented January 2020 to achieve 35% by March 2020.
- Perinatal mental health midwife post (NICE recommendation and NHS long term plan 2019 to improve PMH care) in post May 2019

Maternity successfully achieved 2019 CNST maternity safety standards following significant work by the teams; this led to a 10% rebate of maternity premium.
CNST 2020standards have been published with evidence to be submitted by September

2020. This year significant stretch and detail in the standards has been added. Care group 5 will be seeking additional investment via business case in order to try to achieve these standards, without this compliance will not be possible.

Recommendation

The Board is asked to note involvement in national and regional maternity transformation plans through the Humber, Coast and Vale Local Maternity Systems and recognition of developments in risk management and service improvement in maternity services.

Author: Freya Oliver, Head of Midwifery

Director Sponsor: Heather McNair, Chief Nurse

Date: 28 February 2019

1. Introduction and Background

Maternity transformation is progressing with the Humber, Coast and Vale Local Maternity System (LMS) however this requires further work following the publication of the NHS long term plan in January 2019 to continue work to improve safety and outcomes, implement continuity of carer to most women by 2021 and improve perinatal mental health services.

2. Detail of Report and Assurance

Detail of activity, workforce, achievements and challenges including plans to meet national, regional and local priorities, develop the service and reduce and mitigate risk is as follows;

2.1 Maternity workforce strategy

The Obstetrics and Gynaecology Directorate submitted a strategic 5 year workforce plan in February 2017.

The Midwifery workforce has been reviewed against the nationally recognised maternity workforce tool Birthrate plus in a table top exercise in June 2019 (6 monthly review) and January 2020 (annual review). This demonstrates that staffing establishments are currently meeting service need and the total of specialist midwifery and management roles does not exceed the 10% allowed for within the tool.

Midwifery staff ratios are currently 1 midwife per 26 births which is above the national recommendations of 1 midwife per 29.5 births for hospital and midwifery led units. York site now meet national recommendations whilst Scarborough site are higher than recommended levels due to the minimum level of staff required to provide a safe service.

Trust midwife ratio per births	**York site**	**Scarborough site**
1 midwife : 26 births	1: 29	1: 23

The average fill rates for midwifery shifts are as follows;

York 82% average across the year
Scarborough 98% average across the year

Escalation policies are followed and staff moved fluidly between clinical areas and community to meet demand where full shift fill is not achieved in line with actual clinical activity.

In 2019 births have remained relatively static on Scarborough site; there has been a slight reduction in births in York by 3.6%. This has improved the overall midwife to birth ratio, however the trend of rising acuity seen regionally and nationally has been echoed in York.

One to one care in labour	**York**	**Scarborough**
2018	81%	88.7%
2019	92.4%	96.35%

Supernumerary status of the Labour Ward Co-coordinator is consistently above 90% on both sites with mitigation in place for periods of high activity.

Mitigating action;

- Labour Ward on call midwife in place to provide support in periods of high activity and acuity.
- Maternity escalation plan in place to manage activity and acuity. Labour Ward staffing guidance aims for the Labour Ward Co-coordinator to remain supernumerary.
- NICE red flag staffing incidents recorded and discussed at weekly risk meeting (summarised in risk management section)

The age profile of midwives in 2019 demonstrates a change in age demographic compared to 2018(table below). Levels of retirement have resulted in a rise in the younger age groups which is helpful in sustainable staffing models. Recruitment of midwives has not been problematic on either site.

Midwives age range (years)	**Total midwives %** (actual numbers) 2018	**2019**	**Band 7 %** (actual numbers) 2018	**2019**
40 or less	**49.4% (115)**	**56.77% (109**	**36.4% (12)**	**43.33%(13)**
41 to 50	**16.7% (39)**	**15.63%(30)**	**21.2% (7)**	**20%(6)**
51 to 55	**21.5% (50)**	**15.1%(29)**	**30.3% (10)**	**30%(9)**
56 and above	**12.4% (29)**	**12.5%(24)**	**12.1% (4)**	**6.67%(2)**

Aspirational midwifery roles the service continues to aim to develop are:

- Consultant midwife/Advanced Midwifery Practitioner (recommended Safer childbirth 2007)
- Public health midwife and substance misuse midwife to improve outcomes (NICE and NHS long term plan to improve public health, reduce smoking in pregnancy and levels of obesity)

Roles implemented in 2019 include;

- Saving Babies lives care bundle version 2 project lead
- Perinatal mental health midwife post (NICE recommendation and NHS long term plan 2019 to improve PNMH care)
- Increased bereavement Midwife hours to commence March 2020

Future Plans:

- Continue to Increase Maternity Support Workers roles on postnatal ward and in community to support the midwife role, promote healthy lifestyles, increase breastfeeding, reduce readmission of babies to children's services and enhance the patient experience.
- Implement a dedicated Neonatal support worker role on postnatal areas to deliver transitional care pathways consistently in this area. This is subject to a business case.

- Continue to analyse maternity staffing requirement to achieve 51% offer of Continuity of Carer pathway by March, develop a business case to support this and access transformation funding once available.
- Due to increased requirements for mandatory training for midwives, will increase to 37.5 hours per year each, establishment to be reviewed in 2020.
- To consider purchase of an updated version of Birthrate plus tool in financial year 20/21.

Medical Staffing

With the introduction of the Care Group structure, O&G medical staff are now managed by a Clinical Director (CD) covering both sites, with a lead clinician (LC) on the Scarborough site. Both CD and LC are accountable to the Care Group Director.

The directorate has faced unprecedented pressures and challenges in the last few months pertaining to:

1. Pension scheme changes affecting consultants. This has led to 3 consultants dropping PA and the majority of consultants declining to do any sessions with extra-contractual payment. This has resulted in lost clinical activity with the loss of fast track clinic capacity and leading to up to 24 weeks wait for first appointment in Gynae outpatient clinics.

2. Senior consultants nearing the age of retirement account for a quarter of the consultant body. All have requested to reduce their job plan to less than full time or come off on calls. This will have a huge impact on the on call frequency (1:8 in York and 1:5 in Scarborough) and will be addressed at care group director level in the next few weeks.

3. A full time consultant resident post commenced in September 2019. This gap was filled in by a locum consultant who went off sick from May 2019 leading to reliance on agency cover.

4. Middle grade staff:
    a. Nationally, there are fewer doctors applying for a career in O&G along with a higher attrition rate compared to other specialties. This has resulted in a national shortage in middle grade trainees and this is of a particular concern for this Yorkshire and Humber region. The middle grade rota was severely affected until August due to maternity leaves and less than full time trainees with the need to use costly agency staff to cover the gaps. Covering both Labour ward sites with full junior (first tier) and middle grade Obstetrics and Gynaecology doctors (second tier) rota is challenging and will continue to be so over the coming years.
    b. The middle grade rota has been better staffed since August but the trainees allocated to York are very junior and inexperienced and have therefore been requiring very close supervision. When on call out of hours, non-resident consultants are being contacted more often for advice and asked to come in for procedures that trainees have not been signed off to undergo independently.

c. A new RCOG training curriculum was introduced in August redefining the competencies of trainees in 'entrustability levels'. A trainee is therefore not allowed to do unsupervised elective or emergency work until they are ST5-7. The curriculum is expected to be implemented with immediate effect and by August 2020 the latest. Our services will need to be restructured with an overhaul in the workforce with less reliance on trainees for service provision.
d. The GMC National Training Survey data for both Scarborough and York demonstrates negative changes due training opportunities being lost due to gaps in the rota. The college tutors have implemented changes across sites including a bleep free teaching session on Wednesday lunchtime in York and teaching sessions have been moved to different days to allow for better attendance in Scarborough. This will be formalised into an action plan which will be shared with the board.

Risks and plans to mitigate risks

- Decrease in experienced middle grade.

Consultant midwives/Advanced Midwife Practitioners have been identified in the Maternity workforce strategy (recommendations from Safer Childbirth 2007) to provide advanced skills. An advanced midwife practitioner would aid the medical workforce issues in maternity; the directorate will explore these options of advancing midwifery roles.
Plans for nurse colposcopist to run pessary change clinics taking these patients out of consultant Gynae clinics.
The directorate is also considering appointing or training a nurse colposcopist/hysteroscopist to help with the surge in referrals expected with the changes in the national cervical screening programme later in 2020.

- Consultants Dropped PA will be used to appoint to a new consultant post early this year. This post is aimed at restoring some of the lost activity incurred by the changes to consultant job plans following the Pension scheme changes.

2.2 Risk Management

Risk management retains a significant high focus for maternity. The maternity Quality and Governance team undertake a weekly Maternity case review (MCR) meeting on both sites weekly with presence from paediatric teams which identifies learning and good practice which is shared via learning from slides sent to all team members.

2.2.1 NHS Resolution Maternity Incentive scheme (CNST)

Maternity services declared compliance with all 10 maternity standards, signed off by the Trust Board and submitted in July 2019. This led to York Trust receiving a 10% rebate of its contribution into the incentive fund plus a share of unallocated funding.

CNST 2020 standards have been published in December with evidence to be submitted September 2020; a revised version was issued in February 2020.
This year the overall standards have remained the same, however significant stretch and detail in systems and evidence required has been added. There is significant work around

the NHS digital agenda needed to be fully implemented by November 2020 and a full paper will be submitted to board from the IT department in April in relation to this.

The care group recognise there is a significant risk of not achieving all 10 standards in 2020 without investment in services. A Business case has been submitted in relation to this. Risks have been discussed at the care group meetings and remain on the risk register. The care group will continue to highlight via OPAM.

2.2.2 Maternity Dashboard

Yorkshire and Humber regional dashboard
An annual report of the dashboard 2017/8 was published in November which details where trusts in the region compare with each performance indicator.

A national maternity dashboard is in development (recommendation from the National Maternity review 'Better Births' 2016) however not yet published.

Q1 2019/20 dashboard (published in October 2019) to note for this quarter;

- Stillbirth rate remains below regional average at 2.1%
- Normal birth rate is higher than the Yorkshire and Humber regional average at 65.9%
- Assisted vaginal birth rate is higher than the regional average at 12.6%
- Caesarean section rate for this quarter is again below the regional average at 22.4%
- Third and fourth degree perineal tear rate is also lower than the regional average.

The Trust local monthly dashboard;

Significant data quality work is ongoing in relation to completion of the local dashboard using Signal for source data as well as local collection systems.

- Provision of one to one care in labour data has improved since the field was mandated on the maternity System in June 2019, this is now consistently above 90% on both sites and 100% in several months.

- Bookings more than 13weeks seen within 2 weeks have been consistently under 75% over the course of the year at York site with some variation seen in the rates at Scarborough, but currently very good. This is due to a data quality issue in relation to the date of first contact not being consistently entered on the system and is impacted by missing EDD until first scan. The department is in the process of mandating the date of first contact field on the system and until then will continue manual data quality work.

- In September there was an additional measurement added to the local dashboard - cold babies; this is babies measured as having a temperature lower than 36.5 degrees on admission to SCBU. Currently the figures are high at York site with ongoing work through the Maternity/Neonatal collaborative project to reduce this, a reduction has been seen in January and February 2020.

- Breast feeding initiation rates are below the National average at Scarborough site and smoking at the time of delivery higher than average also.

- PPH rates (post-partum haemorrhage) rates are high at York site. There is currently a large audit underway to diagnose trends and themes, with a view to initiating the Wales pathway.

Maternity dashboards are discussed at the Labour Ward Forums with highlight reports sent to the Clinical Governance Forums.

2.23 Incidents (Datix)

Total number of Datix reported to for 2019 was 1601, demonstrating an excellent reporting culture in Maternity.

Every Datix is reviewed at the weekly Maternity Case Review (MCR) meeting including NICE red flags, duty of Candour, RCOG Each Baby Counts, NHS Resolution and Healthcare Safety Investigation Branch (HSIB) cases. Monthly reports are produced, discussed at the labour ward and maternity risk forum and circulated to all staff. Serious incident investigation outcomes and recommendations are included in this report. Learning from communication is sent to all including a 'learning from' newsletter sent at least once a quarter.

The top four NICE red flags reported were;

York site:

- Delay in suturing >1hour (13 out of the 14 reported).

Scarborough site:

- Delay of 2 hours or more between admission and starting the induction process.
- Delay in suturing >1hour
- Delay in elective LSCS until the next day

Periods of high activity and acuity is identified as having an impact on the delays in treatment seen above.

Top 10 Datix reported in 2019;

DATIX	York
Post partum haemorrhage >= 1500mls	117
Transfusion of any blood products	105
Readmission of either mother or baby	89
Unanticipated admission to SCBU	59
3rd/4th degree perineal tear	45
Failure to adhere to policy/ procedure/ standards	38

Shoulder dystocia	36
Born before arrival at hospital	35
Low cord (below pH7.1 venous or below 7.05 arterial)	32
Intrauterine transfers out: lack of neonatal unit cot or gestation of pregnancy	19

DATIX	Scarborough
Readmission of either mother or baby	58
Unanticipated admission to SCBU	49
Intra-uterine transfers out: lack of neonatal unit cot or gestation of pregnancy.	30
Failure to adhere to policy/ procedure/ standards	30
Post-partum haemorrhage >= 1500mls	30
Transfusion of any blood products	26
3rd/4th degree perineal tear	21
Born before arrival at hospital	15
Shoulder dystocia	15
Unavailability of any facility or equipment	13
Community staff brought to work in maternity unit	12

- Readmission of mother and/or baby at both sites has been a top trigger for reporting this year. Audits have been carried out at both sites into themes for women being readmitted. A proportion of the women at York had been readmitted with wound infections which led to environmental updating on the labour ward. A system to encourage senior medical review of post-natal patients has also been implemented on the back of the recent audit of these women. No particular themes were found with the audit carried out at Scarborough site.

- Post-partum haemorrhage and transfusion of blood products are also in the top 10 triggers for both sites. A large audit is ongoing into the cases for York site with a view to implementing the Wales pathway documentation in line with LMS direction.

- Intra-uterine transfers have increased at Scarborough site, most likely secondary to changes in capacity on SCBU which has increased the minimum gestational age to 34 weeks.

- All unanticipated admissions to SCBU of term babies are looked at via the weekly MCR meeting (usually with paediatric and maternity presence), and also by staff undertaking ATAIN work- (a project designed to reduce the numbers of babies admitted to neonatal units).

- All the clinical incidents such as shoulder dystocia, third/fourth degree tears, born before arrival are looked at by the Maternity risk team and/or discussed at the weekly risk meeting. Any themes or trends with these incidents will be addressed.

There have been 4 serious incidents declared this year; three at Scarborough site, (one being a never event) and one at York site.

- Three out of the four cases have been concluded and reports produced with recommendations. The fourth case was declared in November, so the investigation will be presented to SI panel in due course.
- An additional case from York site was reported to the Health Care Safety Branch (HSIB) and NHS resolution in November- this investigation remains ongoing.

Recommendations from previous SIs are followed up by the maternity risk team and Trust compliance manager.

2.23.1 Stillbirth and Neonatal deaths

In November 2017 the Secretary of State for Health announced a new maternity strategy to half rates of stillbirth by 2025. The government planned to offer independent investigations in review of cases and the Healthcare Safety Investigation Branch (HSIB) aims to standardise investigations so that the NHS learns as quickly as possible from what went wrong and shares the learning to prevent future tragedies. Since HSIB began work in York area two cases have been referred for investigation. One case has been concluded with no significant recommendations, the second is ongoing.

There were 3 Neonatal deaths in 2019 which were reported to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), this is a decrease on 2018 figures.

All deaths are discussed at the multidisciplinary Perinatal Mortality and Morbidity meeting and are reviewed using the national Perinatal Mortality Review Tool (PMRT).

All early neonatal deaths (death within 7 days of birth) are reported to RCOG each baby counts and also reviewed at the York and North Yorkshire Child Death Overview Panel (attended by the Head of Midwifery and Paediatric Consultants)

2019 figures	YORK	SCARBOROUGH
Stillbirths	2	9
NND	2	1
TOP >24 weeks	2	0

Stillbirths
Of these 2 were unbooked pregnancies, so no antenatal care given.
One was born before arrival whilst on holiday, so received antenatal care out of our Trust.
A set of Twins were not booked in our trust but were on holiday so received antenatal care out of our Trust.
One parent moved to our Trust from another area two days before presenting with an intra uterine death (IUD).
One baby was a twin that died in utero.

NND
One baby was born alive at 19+3 but died due to extreme prematurity.

One baby (out of twins) was born alive but died shortly after, (the other twin was a known IUD but pregnancy was continuing.)

Stillbirth number/rates	York	Scarborough	Trust
2014/15	14 4.1:1000	8 4.9:1000	22 4.4:1000 births
2015	7 2.0:1000	4 2.5:1000	11 2.2:1000 births
2016	9 2.6:1000	4 2.5:1000	13 2.6:1000 births
2017	11 3.45:1000	4 2.7:1000	15 3.2:1000 births
2018	7 2.2:1000	1 0.7:1000	8 1.76:1000 births
2019	2 0.45:1000	9 6.43:1000	 1.89:1000 births

The data above shows site variation in line with the narrative above and overall a very slight rise in percentage overall. Variation is expected year on year- it is evident that trust wide a reduction of more than 50% has been achieved over the last five years.

MBRRACE-UK annual report published 2019; Perinatal Mortality Surveillance report covers perinatal deaths from January to December 2017.

This national report provides summary rates of fetal loss, stillbirth and neonatal death. MBRRACE-UK have provided Trust specific data with comparisons to similar Trusts. Overall this is a positive report for York Trust, showing a continued year on year reduction in the rates of both stillbirth and neonatal death.

Perinatal Mortality rates for York Trust from 2017 MBRRACE-UK report is as follows;

Type	Per 1000 births (stabilised and adjusted)	Range	Comparison to the average for similar Trusts
Stillbirth	3.63	(3.08 to 4.41)	Up to 5% lower
Neonatal	1.15	(0.69 to 1.84)	Up to 15% Lower
Extended perinatal both together	4.78	(4.17 to 5.96)	Up to 5% Lower

The report compares the Trust case mix to the national picture by maternal age, socio economic deprivation, ethnicity and gestational age.

- Age of mother: The proportion of mothers under 25 years of age was higher than that of the UK as a whole: 20.3% versus 17.5%.
- Socio-economic depravation: The mothers giving birth in your Trust were considerably less likely to live in areas of high deprivation than those giving birth across the UK as a whole.
- Ethnicity of baby: The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 4.7% versus 21.7%.

- Gestational age: 9 babies (0.2%) were born at 24 to 27 weeks gestational age, lower than the 0.4% seen in the UK as a whole. However, the percentage of babies born at 28 to 31 weeks was similar to the national average: 0.7% versus 0.9%.

Main recommendations of the report;

- Utilize the new national review tool (PMRT) to analyze cases and identify learning
- Ensure timely reporting of cases by 30 days to MBRRACE-UK
- Continue to work on public health initiatives such as smoking and obesity reduction
- Ensure provision of unbiased counselling for post-mortem for parents
- Ensure placental histology is undertaken for all stillbirths

All recommendations are being worked towards with the PMRT tool in use since January 2018 and completed in an MDT group, Quarterly reports are submitted to Trust board to evidence full compliance with use. Timely reporting of cases to MBRRACE-UK and continued initiatives to reduce smoking and obesity in pregnancy. Training for midwives and medical staff to discuss and undertake consent for postmortem is ongoing.

Serious incident investigations are triggered for all stillbirths where the baby was alive at the onset of Labour or if concern is found regarding care provided (in line with regional practice). York Trust has seen over 50% reduction of stillbirths over the last 4 years.

Saving Babies Lives care bundles Version 2 (SBLv2)

The second version of these care bundles was introduced in March 2019; there are now five elements as follows;

- Reducing Smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of growth restriction
- Raising Awareness of reduced fetal Movements
- Effective Fetal Monitoring in Labour
- Reducing Preterm Births

A fixed term band 7 project lead has been appointed to coordinate work to meet the care bundles. Work to address individual criteria within each element is ongoing, however it is acknowledged investment is required in scanning capacity and electronic fetal monitoring equipment as well as increased clinic capacity in order to meet requirements. A business case is in process to address this.

York trust is engaged in completing region wide surveys of progress towards full implementation, two surveys have been completed to date by the clinical network.

Trusts can introduce alternative interventions for the elements than those recommended, however this needs to be agreed by commissioners and clinical networks. York trust does not plan to directly adopt all interventions so liaison with commissioners and clinical networks is planned following the outcome of the business case.

Reduction of smoking rates in pregnancy remains high on the maternity services agenda both locally, regionally and nationally (NHS Long term plan January 2019)

The 2019 rates of Smoking at time of Delivery (SATOD) are as follows;

York	10.4%
Scarborough	18.6%

These rates demonstrate a small reduction for both sites on the previous year, ongoing work is in place jointly with commissioners and an incentive scheme is being considered for 2020.Significant training has been undertaken for midwives and e-learning is mandated for staff.

2.23.2 MBRRACE-UK report Saving Lives, Improving Mothers Care (published 2019)

MBRRACE report *SAVING Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015 – 2017* was launched in November 2019. This was presented by the maternity Quality and governance Midwife at the O&G Clinical Governance forum in February 2020.

The report highlighted the following;

- In 2015-17209 women of the 2'280'451 women giving birth died during or within 6 weeks of pregnancy
- Heart disease remains the leading cause of maternal death followed by thrombosis and thromboembolism.
- Maternal suicide is the fifth leading cause during pregnancy and immediately afterwards, however in the first year following birth it is the leading cause.
- Women from black and ethnic minorities or deprived areas continue to have higher death rates

The multidisciplinary governance group agreed actions from the report to aim to improve awareness of cardiac and VTE conditions;

- Clinical skills Midwives to add to mandatory training information about cardiac conditions
- Staff training and update in VTE risk assessment to continue through PROMPT training.

2.23.3 Clinical claims

A dashboard of clinical claims has been developed by the Trust legal team in 2019 and the directorate reviews this content at clinical governance meetings to look for themes and trends in order that any learning may be identified.

2.23.4 Risk register

The O&G Risk register is reviewed monthly at the Quality and resource group meeting. Maternity specific risks include;

- Nitrous Oxide exposure higher than recommended levels in 50% of rooms on Labour ward at Scarborough (Risk rating 15).This risk is also at a corporate level and a paper supporting independent assessment and possible further remedial works has been reviewed by corporate directors.

- Unable to achieve 35% Continuity of Carer by March 2020.
- Risk of not achieving CNST 2020 standards.
- Changes to National curriculum in relation to entrust ability of trainees creating shortfall in medical workforce.

  Work in the care group to address these risks is ongoing, in relation to the Nitrous oxide this is being led by the Trust health and safety team.

2.24 Patient Experience and User involvement

Maternity Voices Partnership (MVP)

Service user involvement has increased in 2019. In line with recommendations from Better Births 2016 a hub and spoke model of MVP groups has been developed with Humber, Coast and Vale Local Maternity System (LMS).
A chairperson has been appointed to the LMS overarching group with local groups across Humber, Coast and Vale feeding in. MVP work plans are in development.

At York Trust there are two groups, York and district MVP and Coast and Country MVP. Both have service user chairs and service user representative. Remuneration is provided by commissioners for those involved.

York and district MVP are organizing bespoke sessions on topics such as mental health, and feeding to attract different women to attend the groups to offer their input and have recently undertaken a survey of 500 women's opinions on maternity services.
Coast & Country, by moving their venue across Scarborough and District are engaging different groups of women to contribute and report that they are gaining momentum in attendance. Current themes are around raising the profile of the MVP amongst maternity staff and different ways of engaging women so that a wide spectrum of opinion and need can be gathered. Both the York and Coast & Country MVPs continue to raise the profile of women's voices across the organization. Both groups continue to feed in to the LMS MVP leads.

A 'Whose Shoes' event is planned for both groups in 2020 with HCV LMS providing funding. The findings of this will be included in the directorate patient experience action plan for 2020-21which will incorporate the results from the national maternity survey expected January 2020) and friends and family test, as well as direct feedback from women gained at the MVP group meeting.

2.24.1 Complaints and compliments

In the 2019 there were 24 formal complaints and 21 PALS enquiries in relation to maternity care.

Staff are given support in responding to complaints from the senior midwifery and medical team and given the opportunity to reflect on situations and cases. Midwifery staff can access Professional Midwifery Advocates (PMA) for support around responding to concerns and clinical care.

Patient Advice and Liaison Services (PALS) enquiries are often resolved by speaking directly to the person. Themes from PALS include;

- concern regarding birth experience wanting debrief
- attitude of staff

Positive feedback is also received from PALS contacts.

There continues to be an increase in women requesting a formal debrief following birth. Following identification of this as a theme, increased capacity has been created to deliver this and the appointment of PMH midwife has also been extremely helpful in providing this to women who need debriefing.

Complaints top five themes

Sub-subjects	Community Midwives	Labour Ward	Maternity Unit	Obs and Gynae Medical Team	Ward G2	Ward G3	Labour Ward Triage Unit York	Total
Attitude of nursing staff/midwives	1	0	2	1	1	1	1	7
Mismanagement of Labour	0	1	2	1	0	0	1	5
Communication with Patient	0	0	1	2	0	0	0	3
Care needs not adequately met	0	0	2	3	0	1	0	6
Inadequate pain management	0	0	1	2	0	0	0	3
Total	1	1	8	9	1	2	2	24

PALS top five themes

	Community Midwives	Labour Ward	Maternity Unit	Obs and Gynae Medical Team	Ward G2	Hawthorn Ward	Early Pregnancy Assessment Unit	Antenatal Clinic	Total
Attitude of nursing staff/midwives	1	1	0	0	1	0	0	1	4
Mismanagement of Labour	0	1	0	0	0	2	0	0	3
Communication with	0	0	0	4	0	0	0	0	4

Patient									
Communication - Clinical Advice	0	1	1	2	0	0	1	1	6
Attitude of medical staff	0	0	0	0	2	0	0	2	4
Total	1	3	1	6	3	2	1	4	21

Learning from complaints is shared within the Maternity service, by email and directly with staff individually. A learning from bulletin has been developed and is sent out to all staff.

Specific learning from a complaint has led to a change being made to services to allow easier direct access between 16-20 weeks of pregnancy. Other learning has been used to help inform mandatory training in relation to the importance of communication and documentation being clear.

The service has a good response rate from FFT surveys with many positive comments, a quarterly report is sent to all staff with themes and trends.

2.24.2 Perinatal Mental Health (PMH)

Suicide remains a leading cause of maternal death in pregnancy and up to 12 months following birth (Confidential Enquiry into Maternal Death 2019).
In 2019 the service appointed a PMH specialist midwife role.

The PMH Specialist Service continues to be provided by Tees, Esk and Wear valley (TEWV) with the PMH specialist midwife accessing weekly meetings, where possible. The LMS working group continues to look at bringing together services across the LMS, identifying gaps and highlighting good practice. The Trust PMH Guideline has recently been updated to include improved triage processes.
Weekly clinics are now held by the PMH midwife cross-site and these include a debrief service. Increasing access IAPT provide clinics at both Scarborough and York sites. Future plans would include involvement from TEWV in Consultant led clinics.

2.24.3 National maternal and neonatal health safety collaborative (#MatNeo)

MatNeo is an NHS Improvement programme supported by the Academic Health Science Network (YHAHSN). The aim is to create “a national safety quality improvement movement” Safer Maternity Care: Next Steps (2017)

York Teaching Hospitals NHS FT is currently participating in the Maternal and Neonatal Safety Improvement Programme #MatNeoSIP (formerly known as the Maternal and Neonatal Health Safety Collaborative). Four team members (one Obstetrician, one Paediatrician and two midwives) have undertaken external training in quality improvement training to support the programme. The Chief Nurse is Executive Sponsor for the programme and progress is discussed at the Maternity Safety Champions.

The overarching aim is to reduce the proportion of term babies admitted to the neonatal unit with hypoglycaemia incidence by 5% by March 2020.

Four projects have been established to support this aim:-

- 50% of parents who are told their baby is at risk of hypoglycaemia (predicted low birth weight and mother on hypertensive medication in pregnancy) receive written and verbal information to increase their understanding of this by March 2020.
- 50% of parents who are told their baby is at risk of hypoglycaemia (predicted low birth weight and mother on hypertensive medication in pregnancy) receive verbal and written information to encourage and support antenatal colostrum harvesting by March 2020.
- ≥ 90% of all babies have been fed appropriately as per their care needs and this is recorded accurately.
- The number of term babies admitted to the neonatal unit with hypothermia is reduced by 25% by March 2020.

The current area of focus is on the Labour Ward at York and optimising room temperature at birth.

Following the SCORE culture survey and the feedback sessions for all staff further management and leadership training will be rolled out. It is hoped that a Greatix system can be implemented and this will improve the visibility of positive feedback to staff. Some localised work, at ward level, is going to begin in shortly so each team can develop their own 'house rules'.

A system wide piece of MatNeo SIP work for Yorkshire and the Humber will commence in 2020. This work will continue the philosophy of quality improvement taught this year and is going to focus on getting the right babies, at the right gestation, born in the right place.

2.24.4 Avoiding Term Neonatal Admissions into Neonatal Units (ATAIN)

NHS Improvement published a resource pack in February 2017 to support maternity and neonatal services to improve their service and reduce separation of mothers and babies. An action plan is in place to address all aspects of care.

Achievements;

- Transitional care models are in place on both sites to support keeping mothers and babies together. A cross-site group has been established to develop transitional care further and work towards British Association of Perinatal Medicine (BAPM) standards.
- Hypoglycaemia of the Newborn guidance has been updated and published in June 2018. The new guideline aligns with the BAPM standards.
- Increased use of drugs antenatally to improve outcomes; regionally York are reported to have a good use of antenatal steroids (to reduce respiratory problems) and magnesium sulphate (for neuro protection).
- Cases for shared learning are discussed at the perinatal mortality and morbidity MDT meetings. York staff attend the Yorkshire and the Humber Joint Perinatal Outcomes Forum (newly formed in 2017) and the Yorkshire and the Humber

Maternity Safety Learning Network; both of these forums extend the opportunity to share learning on a wider footprint**.**

- Reduction in cold babies admitted to SCBU through warm baby champion work, now monitored through maternity dashboard.

- Reduction in the term admission rates from 4.6% at the start of the project to 3.5%

Plan:

- To continue to work with pediatricians, SCBU and the neonatal ODN in Avoiding Term Neonatal Admissions into Neonatal Units (**ATAIN**)
- Develop transitional care further cross site and with an MDT approach. This will require resource therefore a business case has been developed.
- Continue with work around PReCePT (Preventing Cerebral palsy in pre term): a national programme aimed at increasing the numbers of eligible women offered magnesium sulphate to prevent cerebral palsy in preterm infants (NICE recommendation).

The Atain action plan and updates are shared with the board level safety champion and neonatal safety champion at the Bi-monthly Safety champions meetings.

2.24.5 National Bereavement Care Pathway (NBCP)

National bereavement care pathway (NBCP)

The NHS England Yorkshire and Humber strategic clinical network stillbirth steering group have embedding the nine standards into the audit tool to address the recommendation for improving stillbirths and bereavement care in Yorkshire and Humber maternity services. Each trust within the region completes the audit, on a 6 monthly basis. Once completed and submitted, it is then shared across the region. The first round for the new audit will commence early next year.
Work continues across the Trust to engage staff with the NBCP in order to embed the national guidance into every day practice irrespective of where the bereavement occurs when a baby dies.

Bereavement Facilities.
York site currently have a charitable funds appeal to create a new maternity bereavement suite.
The Butterfly Appeal so far has raised £200,234.72 of the £250,000 required. It is hoped building works can commence in the summer of 2020.

2.24.6 Antenatal Day Services

Provision of Flu and Pertussis vaccines

Provision of the flu and pertussis vaccine as a secondary offer to that made by GP practices was commenced in 2017 and continues in the consultant antenatal clinics on both sites.
There is a desire to further increase uptake and the service is currently looking jointly with commissioners into the feasibility of vaccination being offered more routinely through maternity.

Changes have been made to the antenatal day services pathway to widen the gestational range of women able to access services on a direct referral from a midwife to increase satisfaction in experience.

2.25 Professional Midwifery Advocates (PMA)

The PMA role is a new support role for midwives, using the A-EQUIP model. At the start of the year York Teaching Hospitals had seven PMAs, with a further three qualifying through the year, and one still in training. PMAs are provided 7.5 hours PMA time each per month.

	No of midwives seen
Group Restorative Clinical Supervision (RCS)	210
Individual Restorative Clinical Supervision	85
Revalidation	21

The PMA team have provided stands at a trust open day on both sites and for the International Day of the Midwife.

Four PMAs attended the National PMA conference, and three attended the PMA forum for the North of England.
Two PMAs have had articles published in The Practicing Midwife. Regular monthly group RCS sessions are held off site in Scarborough.
Magic moments box has been launched at York to recognize positive aspects of work and staff.

AIMS for next year;

To raise the visibility of PMAs across the unit by having a PMA of the week at York and linking a PMA to each continuity team in Scarborough.
To work more closely with new starters, particularly newly qualified midwives.

2.26 Maternity Transformation

Humber, Coast and Vale Local Maternity System (LMS) continue working towards an LMS plan for maternity services to;

- Ensure the implementation of Better Births by 2021

- Support the Secretary of State's ambition to reduce the rate of stillbirths, neonatal and maternal deaths and brain injuries by 50% by 2025. This is now included in the long term NHS plan January 2019

Funding was provided to the LMS senior team to support implementation of the plan.

The trust has representatives in each work stream and attendance from Head of Midwifery at LMS delivery board and the Chief Nurse at executive oversight and assurance board.

HCV LMS launched a website for both professionals and service users in 2019.

NHS planning guidance includes a trajectory to 35% of women across the LMS Continuity of Carer in antenatal, intrapartum and postnatal periods by March 2020and 51% by March 2021.

The NHS long term plan (January 2019) states that by 2021 most women will receive continuity of the person caring for them during pregnancy, birth and postnatally. Women who receive Continuity of Carer (CoC) are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth. CoC will be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.

York Trust has continued to develop its plans with regard to continuity of midwifery carer. In January 2020 Scarborough site adopted a whole scale approach to continuity – with 5 continuity teams caring for all women booked for maternity care. These teams will be supported by core maternity staff, who will remain hospital based. This phase will allow approximately 27% of our Trust's maternity service users to receive the known benefits of continuity of midwifery care. This process will be closely monitored and refined using a PDSA approach.

In March 2020 on the York site further a further team will launch, this will contribute to the 35% target. The first York team will be community based, and carry a mixed risk caseload. Plans are being made to assess staffing requirements for further teams on York site; it is likely this will require staffing investment. Working groups have been established, with the aim of creating sustainable, staff-led changes. It is anticipated that the current plans in place will allow for compliance with 35% by March 2020.

These teams will add to our knowledge base of the implementation of continuity of carer, allowing us to progress to 2021's target of 51% with confidence.

Funding was requested and received from the LMS as part of Maternity transformation funding which has supported a project lead role, equipment and some staffing resource on a temporary basis.

Digital Maturity is part of the LMS plan and the NHS long term plan. Maternity services submitted a Digital Maternity Assessment in June 2018 with input from IT.
The long term plan aims to have all women able to access their maternity notes and information through their smart phones and other devices by 2023/24.

Plan;

- Continue plans to work towards achieving 35% CoC by March 2020 and 51% by 2021 with focus on women from BAME and vulnerable groups.
- Continue to actively participate in working groups to progress the LMS plan with the LMS lead midwives
- Bid for any available transformation funding
- Develop a full plan for York site and subsequent business case.

2.7 UNICEF Baby Friendly Initiative (BFI)

The maternity services have fully accredited Baby Friendly status, awarded by UNICEF. The units are due to be reassessed against the BFI standards near the end of 2020 and a rigorous auditing process is in place to monitor compliance. Once the unit has been successfully reaccredited, it is the intention to work towards 'Gold' status in 2021.

Achievements in 2019

The capacity of the specialist breastfeeding service at York has increased through an additional staff member trained in frenotomy and more appointments slots being available. This has significantly reduced waiting time.

Appointments are available with the Infant feeding Co-coordinator at Scarborough within the Children's Centre for assessment and management of breastfeeding problems.

'Drop in' sessions have been instituted at approximate fortnightly intervals at York and Scarborough for pregnant women to have the opportunity to speak to the Infant Feeding Co-coordinator about any feeding concerns that they might have or to collect an antenatal colostrum harvesting pack.

Antenatal colostrum harvesting has become embedded within the maternity service, focusing on women whose babies are predicted to be put on the hypoglycaemia pathway. Antenatal clinic staff discuss colostrum harvesting at the 36 week appointment, provide women with the necessary information and pack, and then give her details to the Infant Feeding Co-coordinator for telephone follow-up. 'Drop in' sessions are also available as a back-up. Patient information leaflets on the subject are in the process of being validated and a clinical guideline is under development.

Two breastfeeding volunteers have been recruited for the Scarborough / Whitby area and another person has expressed an interest in volunteering at York hospital.

The Newborn Feeding Policy, the 'Breast pump cleaning' guideline and the 'Hypothermia of the Newborn' guideline were updated in 2019

Monthly auditing of the use of artificial supplements, readmissions of infants under 28 days old and of staff documentation continues.

The 2 day BFI 'Breastfeeding and Relationship' building course was ran on four occasions (twice per hospital site) with maternity staff, Paediatric nurses and SCBU nurses as participants.

Paediatricians were registered onto the UNICEF e-learning course and received face to face training with the Infant Feeding Co-coordinator.

Plans for 2020

UNICEF reassessment of the services to achieve reaccreditation of 'Baby Friendly' status.

Update information on the Trust website regarding breastfeeding support groups and liaise with the 'Treasure Chest' Breastfeeding support group to consider whether an expansion into the Scarborough /Whitby / Bridlington area is feasible.

Reduce breastfeeding discontinuation prior to hospital discharge through improved implementation of the 'reluctant feeder' protocol on the postnatal wards.

Continue to ensure all new maternity staff receive the 2 day BFI course within 6 months of start date, solidify Paediatric training on infant feeding issues and implement a training programme for SCBU and Paediatric nursing staff.

2.8 Antenatal and Newborn Screening

The Antenatal and Newborn screening (ANNB) team have worked hard to develop the service and achieve the service requirements in 2019.

An external quality assurance assessment of the antenatal and newborn screening programmes was undertaken in October. There were no immediate concerns about the trust's delivery of the screening programmes raised, a full report has just been received in Trust and an action plan has been developed to address the recommendations.

The ANNB screening team have continued to make improvements with the Newborn Blood spot avoidable repeat KPI meeting the acceptable standard for the last 4 quarters and are working towards meeting the achievable standard.

The fetal anomaly screening programme was involved in a laboratory SI in August when 31 first trimester screening samples were delayed in transit for York to Sheffield laboratories for testing. We were able to repeat samples for 28 patients and offered private screening for three patients who were outside of the screening window for repeat screening. All patients received low chance screening results. Duty of Candour letters were sent to all patients and all first and second trimester screening samples are now sent via courier to prevent this issue from occurring again. Positive feedback has been received from PHE on the Trusts proactive, collaborative response to this incident.

3. Next Steps

Work continues to progress, develop and improve maternity services in line with national regional and local plans, making maternity care safer by;

- Continued work to reduce stillbirths, reducing term admissions to SCBU and improve neonatal outcomes.
- Implementing the LMS plan to achieve recommendations in 'Better Births' and improve outcomes.
- Offering 35% of women continuity of carer by March 2020 and 51% by 2021
- Continued work on Matneo local and regional projects
- Work towards implementation of SBLv2
- Continued engagement in regional and national maternity work

4. Detailed Recommendation

The report aims to provide information to the Quality committee of activity, achievements and challenges faced by maternity services in 2019 with future plans outlined to improve and provide a safe quality service meeting local, regional and national priorities.

Quality and Safety, Workforce, Finance, Research and Development and Performance Integrated Report

February 2020

Produced March 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

Quality and Safety Report

February 2020

Produced March 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

Quality and Safety by Month – Trust level (i)

Serious Incidents (data is based on SI declaration Date)	Sparkline / Previous Month	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
Number of SI's reported		17	20	12	23	5	12	10	11	14	12	16	11	13
% SI's notified within 2 working days of SI being identified		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
* this is currently under discussion via the 'exceptions log'														
Compliance with Duty of Candour for Serious Incidents*:														
-Verbal Apology Given		-	-	2	9	1	5	3	-	-	-	-	-	-
-Written Apology Given *		-	-	1	8	5	1	3	-	-	-	-	-	-
-Invitation to be involved in Investigation		-	-	0	1	1	3	4	1	2	1	0	0	1
-Given Final Report (If Requested)		-	-	2	5	3	0	1	1	3	2	2	1	0

* Duty of Candour reporting has been revised to report from the beginning of the 2019-20 financial year.

Duty of Candour (All Incidents - data is based on the incident date) *	Target	Sparkline / Previous Month	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
Incident Graded Moderate or Above			-	-	11	18	5	16	15	14	17	12	10	10	145
Verbal Apology Given			-	-	8	15	1	13	11	6	10	8	7	5	101
Written Apology Given			-	-	8	13	5	12	12	8	13	7	6	5	108
Duty of Candour Complete			-	-	11	18	5	16	13	10	12	9	7	5	125
% Compliiance with Duty of Candour			-	-	1	100.0%	100.0%	100.0%	86.7%	71.4%	70.6%	75.0%	70.0%	50.0%	86.2%

Note: Duty of Candour data is based on the dates incidents were reported, not the incident date, so the number of incidents graded as moderate or above harm in the DoC data may be different to those in the incident data. All harms of moderate or above are subject to ongoing validation, so degree of harm data is subject to change. In exceptional cases, it may not be possible to provide letters to patients / relatives / carers, so percentage compliance is calculated on the number of incidents where the DoC process has been signed off signed as complete after discussion with Healthcare Governance, not the number of letters sent.

Claims	Sparkline / Previous Month	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
Number of Negligence Claims		15	11	19	11	19	20	18	17	16	13	7	20	8
Number of Claims settled per Month		3	6	3	5	4	3	3	5	2	4	3	3	1
Amount paid out per month		11,754,250	117,500	130,000	3,274,121	169,040	124,000	655,000	138,000	16,000	507,500	159,863	208,500	1,390,000
Reasons for the payment		Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability

Please note that damages data may be adjusted some time after a claim has been settled if there is a delay in agreeing a final settlement, hence data is subject to change.

Measures of Harm	Target	Sparkline / Previous Month	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
Incidents Reported			1,227	1,279	1,236	1,365	1,262	1,345	1,248	1,292	1,321	1,273	1,306	1,402	1,243
Incidents Awaiting Sign Off			889	894	905	811	843	792	841	950	793	727	844	767	902
Patient Falls			230	234	196	262	255	227	190	226	213	219	241	244	227
Pressure Ulcers - Newly Developed/Deteriorated **			114	129	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers - Transferred into our care			79	63	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers - Newly Developed Ulcer			2	4	90	87	78	76	73	97	92	84	130	109	100
Pressure Ulcers - Deterioration of Pressure Ulcer			1	2	21	9	9	16	14	10	16	6	11	18	13
Pressure Ulcers - Present on Admission			1	14	124	121	137	132	120	103	136	128	142	167	139
Degree of harm: serious or death			2	2	2	10	3	4	6	5	9	5	1	6	2
Medication Related Errors			122	121	111	133	120	141	140	135	152	136	119	156	135
VTE risk assessments	95%		97.1%	96.6%	97.5%	96.9%	96.7%	97.0%	96.3%	95.6%	96.3%	96.1%	96.8%	95.3%	95.2%
Never Events	0		2	0	0	0	0	0	1	0	1	1	0	0	0

** Revised pressure ulcer categorisation was introduced from 01/04/19 to reflect NHSI's new pressure ulcer reporting requirements. The Trust continues to validate all falls and pressure ulcer data, so this data is subject to change. Pressure ulcers reported prior to April 2019 may be recategorised according to the new categories after review, so data may appear in the new categories prior to April. Validation of harm for incidents of moderate harm and above is ongoing, so data is subject to change.

Assurance Framework
Responsive

Quality and Safety by Month – Trust level continued (ii)

Pressure Ulcers***	Sparkline / Previous Month	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
Number of Category 2	▼	66	74	67	62	53	54	56	70	61	48	85	66	56
Number of Category 3	▲	6	5	3	0	1	7	2	0	5	4	2	3	7
Number of Category 4	▼	0	0	2	2	0	0	4	1	1	0	1	1	0
Total no. developed/deteriorated while in our care (care of the org) - acute	▼	80	103	66	68	61	62	62	72	83	68	112	102	74
Total no. developed/deteriorated while in our care (care of the org) - community	▲	37	32	45	28	26	30	25	35	25	22	29	25	35

Falls****	Sparkline / Previous Month	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
Number of falls with moderate harm	▼	1	3	1	3	0	2	1	5	2	4	5	6	1
Number of falls with severe harm	▼	0	1	1	7	1	1	3	3	5	2	1	3	1
Number of falls resulting in death	◀▶	0	0	0	0	0	0	0	0	0	0	0	0	0

Note *** and **** - falls and pressure ulcers subject to validation. Falls resulting in deaths are investigated as Serious Incidents and the degree of harm will be confirmed upon completion of investigation.

All falls and pressure ulcer data is refreshed monthly to reflect ongoing monitoring and reporting of falls and pressure ulcers. Category 3 & 4 pressure ulcer data excludes Category 3 and 4 ulcers which are recorded as having developed within 72 hours of admission to inpatient care. The degrees of harm from falls and pressure ulcers are subject to further validation when investigations are completed, so harm data is subject to change.

Drug Administration	Target	Sparkline / Previous Month	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
Insulin Errors		▲	14	5	7	14	14	9	13	6	18	9	10	19	23
Prescribing Errors		▼	32	36	29	30	29	33	39	26	30	37	23	42	31
Preparation and Dispensing Errors		▼	10	8	12	9	6	14	10	12	17	14	6	12	9
Administrating and Supply Errrors		▼	55	50	51	55	53	69	64	65	69	59	57	69	60

Safeguarding	Sparkline / Previous Month	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
% of staff compliant with training (children)	◀▶	83%	84%	85%	85%	85%	86%	84%	83%	83%	84%	85%	86%	86%
% of staff compliant with training (adult)	◀▶	84%	85%	86%	86%	86%	88%	86%	85%	84%	85%	86%	88%	88%
% of staff working with children who have review DBS checks														

Patient Experience: Complaints, PALS and FFT	Target	Sparkline / Previous Month	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
New complaints this month		▼	35	44	36	51	36	47	56	31	56	48	36	43	42
% Complaint responses closed within target timescale	30 days	▲	44%	49%	27%	42%	41%	46%	33%	33%	35%	52%	38%	35%	57%
New PALS concerns this month		▼	174	180	188	220	175	205	181	191	184	192	120	168	151
% PALS responses closed within target timescale	10 days	▲	76%	76%	78%	75%	69%	69%	72%	73%	71%	73%	67%	74%	75%
FFT - York ED Recommend %	90%	▲	87.8%	82.7%	79.3%	84.0%	84.5%	69.5%	74.8%	70.7%	75.0%	74.9%	72.6%	77.8%	-
FFT - Scarborough ED Recommend %	90%	▼	90.9%	78.9%	88.2%	93.4%	88.7%	79.3%	82.4%	80.9%	86.2%	85.7%	92.3%	85.0%	-
FFT - Trust ED Recommend %	90%	▲	88.4%	82.1%	82.0%	87.0%	85.5%	71.4%	76.5%	74.2%	77.4%	76.9%	76.4%	78.8%	-
FFT - Trust Inpatient Recommend %	90%	▼	96.0%	97.3%	96.3%	97.4%	96.6%	97.0%	96.3%	96.4%	96.9%	96.5%	97.2%	96.8%	-
FFT - Trust Maternity Recommend %	90%	▲	98.0%	97.0%	98.6%	96.9%	98.1%	97.3%	97.5%	97.0%	98.3%	96.1%	97.3%	97.4%	-

Assurance Framework Responsive

Quality and Safety by Month – Trust level continued (iii)

Care of the Deteriorating Patient	Target	Sparkline / Previous Month	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
14 hour Post Take - York *	90%	▼	82%	78%	79%	79%	81%	82%	80%	80%	76%	76%	79%	82%	81%
14 hour Post Take - Scarborough *	90%	▲	71%	72%	70%	70%	72%	76%	71%	73%	74%	70%	74%	76%	77%
NEWS within 1 hour of prescribed time	90%	▲	90.1%	90.0%	90.1%	90.2%	90.6%	89.9%	89.9%	89.2%	89.6%	89.2%	89.6%	90.2%	90.7%
Elective admissions: EDD within 24 hours of admission	93%	▼	87.9%	90.8%	88.2%	88.6%	88.6%	87.3%	85.7%	87.8%	86.5%	88.1%	86.9%	94.0%	91.7%

* Data includes non-elective inpatients only, excludes Maternity, and excludes patients only admitted to the Patient Lounge. The numerator (those included as having had a Senior Review within 14hrs) includes any patient who has been marked on CPD as having had a Senior Review (post take still required) or Post Take Completed within 14 hours of admission time. It also includes any patients who have had a Length of Stay less than 14hrs.

Mortality Information	Target	Sparkline / Previous Month	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17	Jan 17 - Dec 17	Apr 17 - Mar 18	Jul 17 - Jun 18	Oct 17 - Sep 18	Jan 18 - Dec 18	Apr 18- Mar 19	Jul 18 - Jun 19	Oct 18 - Sep 19
Summary Hospital Level Mortality Indicator (SHMI)	100	▲	98	97	97	98	100	99	99	99	98	100	100	98	100

4AT Assessment			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
4AT Screening	90%		-	-	-	-	73.4%	69.9%	68.7%	69.7%	72.9%	82.2%	78.7%	79.8%	81.9%

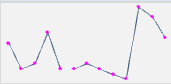
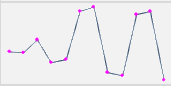
Infection Prevention	Target	Sparkline / Previous Month	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Clostridium Difficile - meeting the C.Diff objective		▼	3	6	14	11	15	10	15	9	9	11	12	13	10
Clostridium Difficile - meeting the C.Diff objective - cumulative	61 (year)		35	41	14	25	40	50	65	74	83	94	106	119	129
MRSA - meeting the MRSA objective	0	◆▶	0	0	0	0	0	2	0	0	0	0	0	0	0
MSSA			3	3	4	5	2	5	3	4	5	5	4	3	2
MSSA - cumulative	30 (year)		31	34	4	9	11	16	19	23	28	33	37	40	42
ECOLI		◆▶	5	8	7	6	5	5	8	2	5	6	7	6	6
ECOLI - cumulative	61 (year)		70	78	7	13	18	23	31	33	38	44	51	57	63
Klebsiella		▲	-	-	2	1	3	2	5	2	1	1	2	1	2
Klebsiella - cumulative			-	-	2	3	6	8	13	15	16	17	19	20	22
Pseudomonas		▼	-	-	2	1	2	4	2	1	2	1	3	3	1
Pseudomonas - cumulative			-	-	2	3	5	9	11	12	14	15	18	21	22
MRSA Screening - Elective	95%	▼	82.3%	85.6%	85.2%	79.4%	84.6%	89.8%	90.3%	90.0%	86.8%	88.4%	88.7%	88.6%	84.4%
MRSA Screening - Non Elective	95%	▼	88.7%	89.7%	88.3%	89.5%	89.6%	89.7%	89.5%	90.0%	90.8%	90.9%	89.0%	90.1%	90.0%

Stroke	Target	Sparkline / Previous Month	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
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	◆▶	100.0%	83.3%	92.8%	75.0%	73.3%	75.0%	100.0%	75.0%	100.0%	80.0%	100.0%	100.0%	-
Proportion of stroke patients with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation		◆▶	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
SSNAP Scores:			Apr- Jun 19			Jul- Sep 19			SSNAP Oct-Dec 20			Nov-19	Dec-19	Jan-20	Feb-20
Proportion of patients spending >90% of their time on stroke unit	85%	▲	89% (B)			87.4% (B)			89.9% (B)			90.5% (A)	88.1% (B)	85.4% (B)	81.4% (C)
Scanned within 1 hour of arrival	43%	▲	47.5% (B)			49.6%(A)			45.8%(B)			46.7% (B)	48.4% (A)	62.8% (A)	43.8% (B)
Scanned within 12 hours of arrival	90%	▲	97% (A)			94.4% (B)			95.6%(A)			97.3% (A)	97.8% (A)	97.4% (A)	92.2% (B)

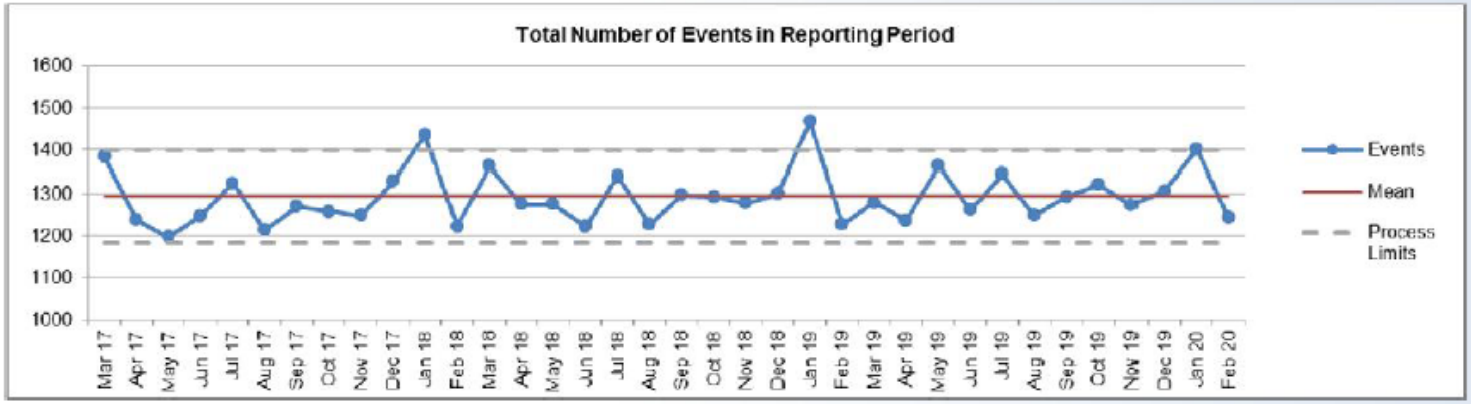
DoLS	Target	Sparkline / Previous Month	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Standard Authorisation Status Unknown: Local Authority not informed the Trust of outcome		▼	0	1	0	1	1	3	6	4	0	0	2	8	1
Standard Authorisation Not Required: Patient no longer in Trust's care and within 7 day self-authorisation		▼	11	13	17	9	14	14	16	10	19	1	19	29	21
Under Enquiry: Safeguarding Adults team reviewing progress of application with Local Authority or progress with ward		▼	17	9	12	20	9	21	15	19	15	14	15	24	14
Standard Authorisation Granted: Local Authority granted application		▲	1	0	0	0	0	0	0	0	0	2	0	0	1
Application Not Granted: Local Authority not granted application		▼	0	0	0	0	0	0	0	0	0	0	0	1	0
Application Unallocated as Given Local Authority Prioritisation: Local Authority confirmed receipt but not yet actioned application		◆▶	0	0	2	1	16	5	8	4	2	8	7	16	16
Safeguarding Adults concerns reported to the Local Authority against the Trust		▲	0	1	6	6	6	14	3	4	7	1	1	0	5
Application Withdrawn: Patient no longer in Trust's care within the Local Authority 8 week period for assessment		▲	5	0	0	0	1	1	0	0	1	5	4	8	14

Assurance Framework Responsive

Quality and Safety by Month – Trust level (iv) QUANTITATIVE TABLE

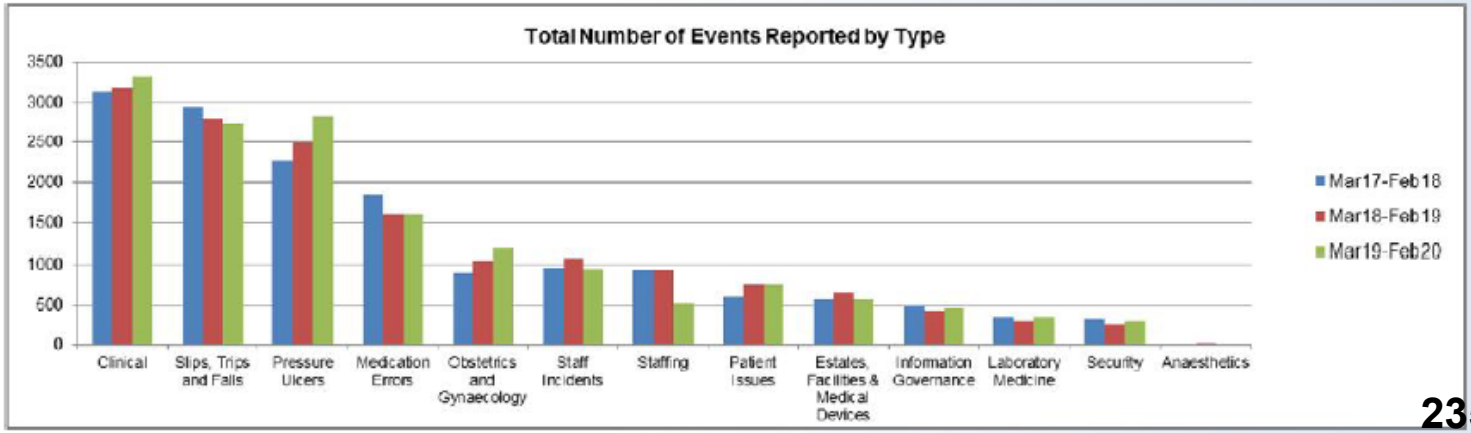
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Sparkline / Previous Month		Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Nov-19	Dec-19	Jan-20	Feb-20
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and re-scheduled episode of care	0		▼	16	18	10	15	0	14	12	8
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	0		◀▶	0	0	0	0	0	0	0	0
Sleeping Accommodation Breach	£250 per day per Service User affected	0		▲	0	0	0	0	0	0	0	4
% Compliance with WHO safer surgery checklist	No financial penalty	100.00%		◀▶	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	99.00%		▲	99.91%	99.71%	99.70%	-	99.81%	99.85%	-	-
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	95.00%		▲	98.96%	98.56%	98.16%	98.80%	98.90%	98.91%	99.11%	-
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%		▼	7.33%	8.40%	10.30%	9.73%	11.40%	11.61%	6.47%	-
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in Service Condition 3 and General Condition 9	Set baseline in Q1 and agree trajectory	Monthly Provider Report									
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	99.00%		▲	70.33%	52.08%	72.60%	66.67%	85.42%	71.64%	62.38%	83.17%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	As set out in Service Condition 3 and General Condition 9	Best Practice Standards	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced and tabled at sub CMB quarterly.									
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	90.00%		▼	94.41%	94.67%	93.21%	92.12%	92.76%	90.98%	89.46%	86.82%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	95.00%		◀▶	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All Red Drugs to be prescribed by provider effective from 01/04/15, subject to agreement on list	Recovery of costs for any breach to be agreed via medicines management committee	0	CCG to audit for breaches									
All Amber Drugs to be prescribed as per shared care guidelines from 01/04/15	Recovery of costs for any breach to be agreed via medicines management committee	0	CCG to audit for breaches									

Assurance Framework Responsive	# Event Reporting (March 2017 to February 2020)
Measure:	Number of Events Reported
Data Source:	Datix
Operational and Performance Update:	**Total Number of Events Reported**



The above table shows the total number of events reported on Datix between March 2017 and February 2020. The data includes events of all types so includes patient events, staff events and other events where individuals may not have been directly affected. Of particular note are the number of events reported in January each year, with in excess of 1400 events being reported. This is largely attributable to an increased number of patient falls and pressure ulcers being to the number of frail and elderly patients being admitted to our acute hospitals in these months.

Events by Type



235

Assurance Framework Responsive

Event Reporting (March 2017 to February 2020)

Measure: Number of Events Reported

Data Source: Datix

Operational and Performance Update:

Top 5 Event Types and Incidents by Site

The top 5 event types reported in this time period accounted for 73% of the total number of events reported, and are shown in the following table. Year on year, the most significant changes are a decrease in the number of medication events being reported, and an increase in the number of Obstetric and Gynaecology events (which in the last year was largely attributable to raising the awareness of the importance of incident reporting within the specialty). The number of pressure ulcers being reported has also seen an increase each year, and this can be associated with a number of initiatives to improve the management and reporting of pressure ulcers.

Top 5 Event Types	Mar17-Feb18	Mar18-Feb19	Mar19-Feb20	Total
Clinical	3134	3169	3318	**9621**
Slips, Trips and Falls	2949	2792	2734	**8475**
Pressure Ulcers	2280	2497	2820	**7597**
Medication Errors	1846	1611	1599	**5056**
Obstetrics and Gynaecology	893	1052	1181	**3126**
TOTAL	**11102**	**11121**	**11652**	**33875**

Between March 2019 and February 2020, 65% of the events reported occurred at York Hospital or in Community Services, compared with 69% in the previous 12 month period. Scarborough has seen an increase in event reporting, with 32% of the total events reported between March 2019 and February 2020 occurring in Scarborough, compared with 27% of the total events reported in the previous 12 month period. The percentage of events occurring in Bridlington remained the same at 3%.

Events Reported by Site	Mar17-Feb18	Mar18-Feb19	Mar19-Feb20	Total
York Hospital (Inc Comm since 2019)	8639	8813	10018	**27470**
Scarborough Hospital	4211	4242	4969	**13422**
Bridlington Hospital	538	531	463	**1532**
Community Services	1979	1976	122	**4077**
TOTAL	**15367**	**15562**	**15572**	**46501**

Top 5 Events Reported in February 2020

As February is a short month, the number of events reported in February decreased across most categories. However, the top 5 events reported remained the same as those reported in January 2020.

The number of clinical events reported decreased in February, with a decrease in events relating to admission, transfer and discharge being noted. At the time of reporting, one clinical event reported at the end of February was graded is currently graded serious harm and will be reviewed by the Quality and Safety Group to determine what further investigation or escalation is required.

The number of slips, trips and falls reported decreased from the previous month and was just above average for the 12 month period of March 2019 to February 2020. Falls of moderate harm or above continue to be reviewed by the Heads of Nursing via the 72 Hour Report process to determine if SI declaration is required. At the time of reporting, of the two falls of moderate or above harm reported Trust-wide in February, one has been declared an SI with the other awaiting Head of Nursing review.

The total number of pressure ulcers reported in February also decreased, although the number of pressure ulcers developing or deteriorating under our care remained largely the same. Category 3 and 4 pressure ulcers which develop or deteriorate under our care are also reviewed by the Heads of Nursing via the 72 Hour Report process to determine if SI declaration is required. At the time of reporting, of the seven Category 3 and 4 pressure ulcers reported as developing or deteriorating under our care, one has been declared an SI, two are awaiting TVN review, one is awaiting review by the ward sister prior to review by the Head of Nursing, and three are awaiting Head of Nursing Review.

The number of medication errors reported also decreased in February and was just above average for the period of March 2019 to February 2020. Of the medication errors reviewed to date, one administration error relating to a missed dose of insulin has been declared a Serious Incident.

The number of Obstetric and Gynaecology events reported showed a slight decrease in February, with no significant trends being noted. At the time of reporting, there were no events categorised as moderate or above harm.

Assurance Framework Responsive

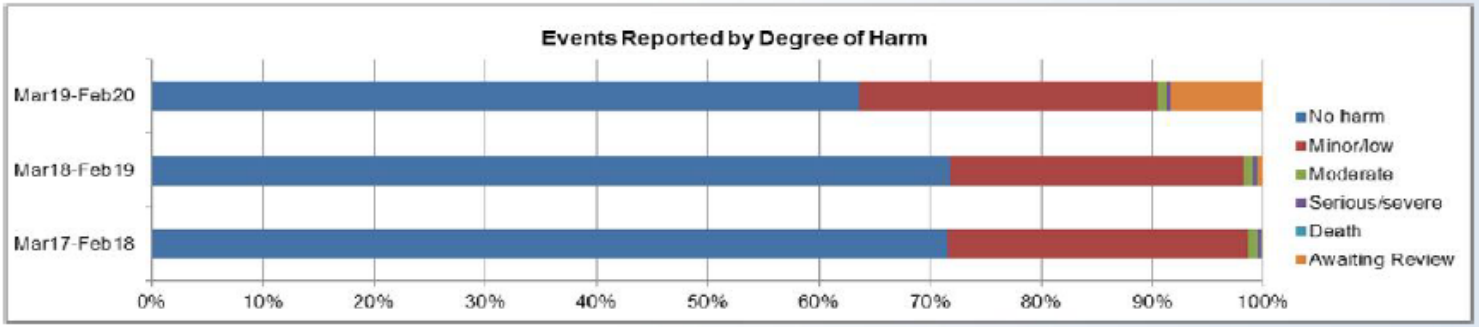
Degree of Harm

Measure: Degree of Harm from Event Reporting

Data Source: Datix

Operational and Performance Update:

Degree of Harm and Event Reviews



In the reporting periods March 2017 to February 2018 and March 2018 to February 2019, 98% of events reported resulted in no harm or minor/low harm. At the time of reporting, this figure is 91% for events reported between March 2019 and February 2020, but as the above table indicates, 8% of the events reported in this period are awaiting review and determination of the degree of harm, with 5.8% currently being overdue for review.

All incidents that are not subject to a more detailed investigation (for example serious incidents) should have their investigations completed with 14 days of the incident being reported. The number of incidents which are overdue for review is regularly monitored and escalated to senior colleagues for action where needed. The number of incidents awaiting review is also reported to Care Groups via the monthly Healthcare Governance Overview report and on Datix dashboards, so that the Care Group management teams can take remedial action.

Events of Moderate and Above Harm by Care Group

The following table shows the events resulting in moderate of above harm by the type of event and care group, for events reported since 1 April 2019.

32% of incidents resulting in moderate or above harm are patient falls occurring in Care Groups 1 and 2. Clinical incidents account for 21% of moderate and above harm events, and relate mostly to clinical assessment errors and treatment /procedure delays or errors.

The events resulting in moderate harm and above in Care Groups 1, 2 and 3 account for 83% of the total events resulting in moderate and above harm.

Event Type and Care Group	CG1	CG2	CG3	CG4	CG5	CG6	Corp	Total
Slips, Trips and Falls	35	20	3	0	0	0	0	58
Clinical	8	8	11	3	1	4	1	36
Pressure Ulcers	16	5	3	1	0	0	0	25
Medication Errors	4	5	6	0	1	1	0	17
Staff Incidents	0	2	5	4	0	0	4	15
Estates, Facilities & Medical Devices	1	0	3	1	0	0	1	6
Obstetrics and Gynaecology	0	0	2	0	4	0	0	6
Patient Issues	1	1	1	1	0	0	0	4
Security	0	1	0	0	0	0	1	2
Staffing	1	0	0	0	0	0	0	1
Information Governance	0	0	0	0	0	0	1	1
TOTAL	66	42	34	10	6	5	8	171

Assurance Framework Responsive	**Event Reporting (continued)**
Measure:	Event Reviews and Degree of Harm
Data Source:	Datix
Performance:	**Actions:** • Feedback from the recent online staff consultation and the results from the Staff Survey in relation to incident reporting continues to be addressed as part of the Staff Survey Action Plan and the Just Culture project • Automatic feedback to reporters when incident investigations are completed was launched on 6th January 2020. The Healthcare Governance Team have developed a staff guide for both reporters and incident reviewers to support this process. The Healthcare Governance Team continue to monitor the implementation of automatic feedback, but the initial feedback received to date has been positive. • Datix dashboards which give an overview of key trends and monitoring information in relation to incidents, claims, risks, and serious incidents are available to all Care Groups. • The Trust's falls and pressure ulcer project plans continue to be progressed and monitored via the respective steering groups. • Medication errors continue to be monitored by the Medication Errors Review Group, with remedial action being taken where incident trends or serious incidents are noted. • Obstetric incidents continue to be monitored at the weekly Maternity risk Meeting, with remedial action being taken where incident trends or serious incidents are noted. • Staff issues are investigated and managed by the Trust's Health and Safety team. • All incidents continue to be reviewed by Healthcare Governance on a daily basis, with potentially serious incidents or incident trends being escalated to the weekly Quality and Safety Briefing for discussion and further action as required.

Assurance Framework Responsive

Duty of Candour Compliance

Measure: Duty of Candour

Data Source: Datix

Performance:

Duty of Candour

Duty of Candour is applicable to all events where a patient suffers moderate or above harm through whatever medium the harm is identified – for example event reports, complaints, claims, or SJCRs. A verbal apology should be followed up with a written apology in all cases, except where there are exceptional circumstances which must be agreed with Healthcare Governance.

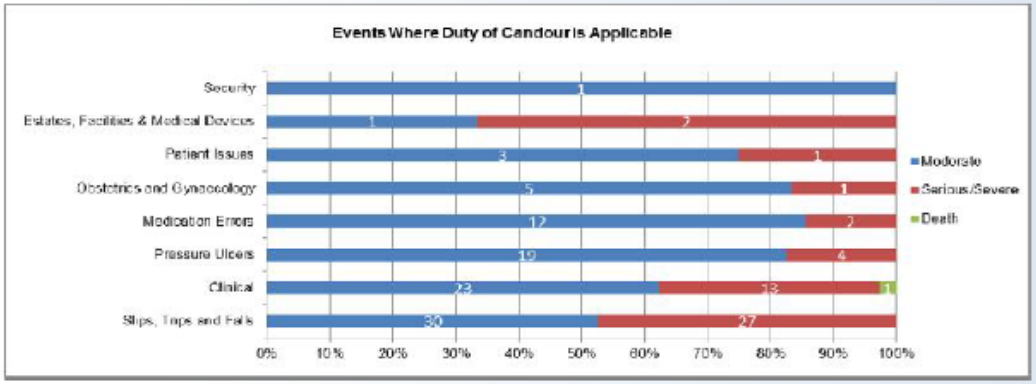
Compliance with Duty of Candour for events reported between 1st April 2019 and 16th February 2020 is 86.2% at the time of reporting. The following table shows a breakdown of compliance by Care Group.

Care Group	DoC Complete		Events Requiring DoC	% Compliance
	Yes	No		
CG1: Acute, Emergency, Elderly Medicine & Community Services - York	57	7	64	89.1
CG2 :Acute, Emergency & Elderly Medicine - SGH	31	6	37	83.8
CG3: Surgery	21	4	25	84.0
CG4: Cancer and Support Services	7	0	7	100.0
CG5: Family Health	6	0	6	100.0
CG6: Specialised Medicine	2	3	5	40.0
Corporate Services	1	0	1	100.0
TOTAL	**125**	**20**	**145**	**86.2**

Note: compliance is calculated from the number of events where Duty of Candour is marked as completed by the Healthcare Governance Unit.

Events Where Duty of Candour is Applicable

The following chart shows the events reported between 1st April and 16th February 2020 which resulted in moderate or above harm to patients, and for which Duty of Candour is applicable, by event type.



Actions

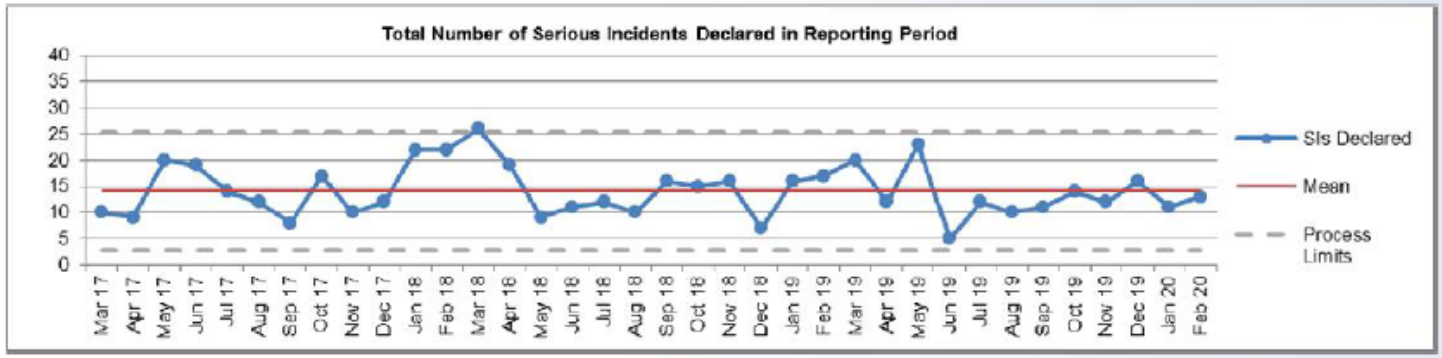
- The Deputy Director of Healthcare Governance continues to meet monthly with Care Group management teams to discuss care group governance, which includes compliance with Duty of Candour.
- Duty of Candour compliance is reported weekly to the Quality and Safety Briefing so that any areas of poor performance can be addressed by the Medical Director.
- Duty of Candour performance is reported to Care Groups via the Healthcare Governance Overview report .
- Datix dashboards showing overall compliance with Duty of Candour and showing incidents where Duty of Candour is outstanding have been published so that Care Group management teams can take remedial action where required.

Assurance Framework Responsive

Serious Incidents (Declared Between March 2017 and February 2020)

Operational Update

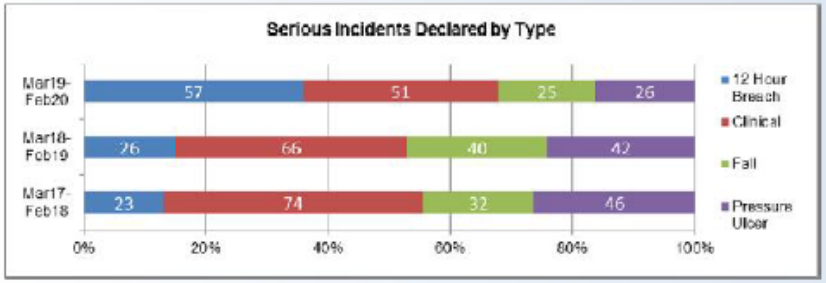
Serious Incident Overview



The above chart shows the total number of serious incidents (SIs) declared over the last 3 years and includes all types of SIs (clinical SIs, falls, pressure ulcers and 12 hour breaches.). The data reflects the date the incident was declared as serious incident rather than the date the incident occurred. It is important to note that some incidents which are declared as SIs may have occurred at an earlier date but are declared after the event if there has been a delay in identifying that an adverse event has occurred.

SIs Declared by Type

The following chart shows a breakdown of SIs declared by type and year. Of note is a significant increase in the number of 12 hour breaches declared between March 2019 and February 2020, with 95% of the 12 hour breaches occurring in Scarborough (see the analysis of 12 hour breaches later in the report for further information). The number of clinical SIs reported each year has decreased each year.



Also of note is a decrease in the number of falls and pressure ulcers declared as SIs in between March 2019 and February 2020. This is largely due to the introduction of the 72 Hour report system, where an early review by the Head of Nursing assists in identifying any lapses in care. The Head of Nursing can then determine if the incident requires local investigation, root cause analysis only or declaration as an SI, rather than declaring an SI which may then be delogged if no lapses in care are subsequently identified during an SI investigation.

Never Events

March 2019 to February 2020 saw an slight decrease in the number of Never Events being reported Of the three never events in this period, one occurred in York (a surgical procedure incident) and two occurred in Scarborough (a surgical procedure incident and a medication incident).

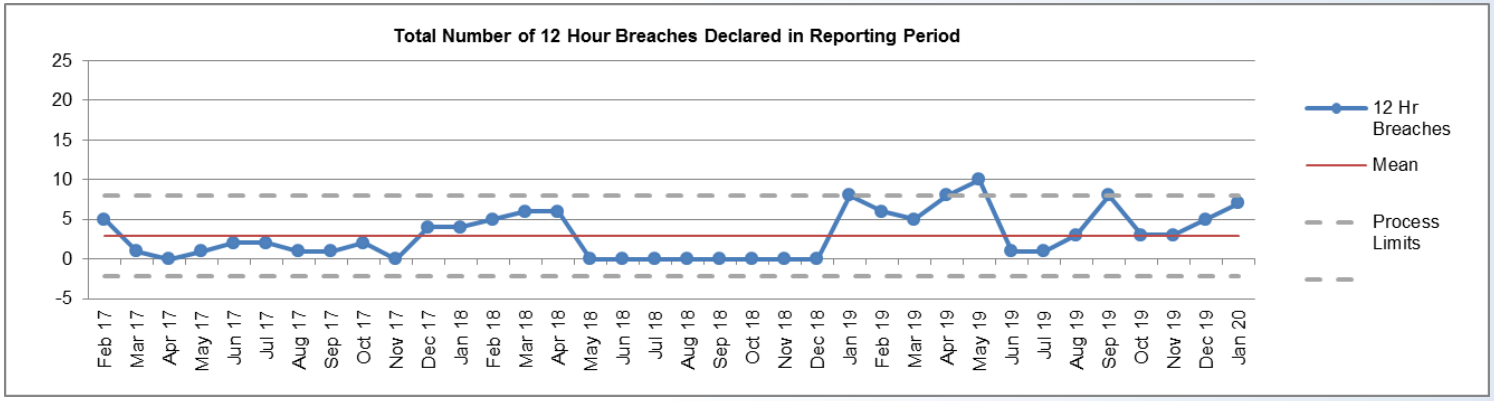
Never Event Type	Mar17-Feb18	Mar18-Feb19	Mar19-Feb20	TOTAL
Medical Equipment/Devices/Disposables Incident	0	1	0	1
Medication Incident - Never Event	0	1	1	2
Surgical/Invasive Procedure Incident	0	0	2	2
Wrong Implant/Prosthesis - Never Event	1	0	0	1
Wrong Site Surgery - Never Event	3	2	0	5
Total	**4**	**4**	**3**	**11**

Assurance Framework Responsive

Serious Incidents (Declared Between February 2017 and January 2020)

Performance:

12 Hour Breaches



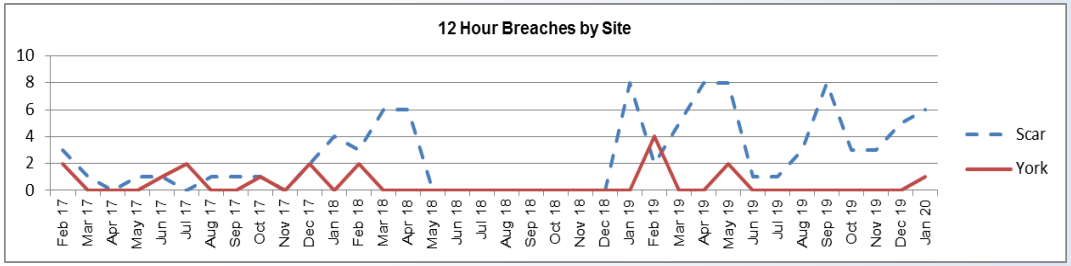
As previously noted, there was a significant increase in the number of 12 hour breaches reported in between February 2019 and January 2020 in comparison with the previous two years. Although 12 hour breaches are traditionally associated with winter pressures between December and February, the above chart indicates that in 2019, 12 hour breaches continued to occur between March and May, and again in September. The number of 12 hour breaches declared does not reflect the number of individual patients who experienced a 12 hour breach on that date, as in accordance with national guidelines, only one event per day per hospital site is declared, but each event may include multiple patients.

Analysis of 12 Hour Breaches by Site

The following chart shows the number of breaches occurring at Scarborough and York.

Over the 3 year period since February 2017, 16% of the 12 hour breaches occurred in York with 84 % occurring in Scarborough.

However, between February 2019 and January 2020, 12% of the breaches occurred in York, with 88% of the 12 hour breaches occurring in Scarborough.



Although 12 hour breaches do not usually result in any clinical harm to patients, the Quality and Safety Group continue to review and monitor the 48 Hour Reports produced for each patient who has experienced a 12 hour breach to identify any adverse outcomes or patient experience.

Assurance Framework Responsive

Serious Incidents (Declared Between February 2019 and January 2019)

Performance:

Themes from Clinical SIs

In the last year, the key themes and trends were as follows:

Treatment Delay – These relate to capacity and demand issues which result in patients waiting longer than they should have for treatment. Examples are long waits in Ophthalmology , which have resulted in either loss or partial loss of vision in one eye. Other delays in treatment are related to failure to deliver the Sepsis bundle , delays in radiology reporting and incorrect radiology reporting. An example of this was as a failure to follow-up on a nodule which was felt to be evident on a CT angiogram. Further issues identified related to medical outliers on non-medical wards , such as one medical outlier receiving delayed treatment for a high NEWS score. In this case it was felt that the current guidance for outliers was not effectively followed , as there was a lack of escalation to a senior decision maker and the patient was not transferred back to a medical ward. A further example of an SI declared in the past year related to delayed treatment following an adder bite, as there was a lack of understanding of who to contact for medication out of hours. Unclear documentation leading to delayed treatment was also identified in a SI relating to a patient developing a severe thumb infection leading to amputation.

Diagnostic Incident - Delay/Failure to Act on Test Results - SIs relating to diagnostic incidents have focussed on the incorrect interpretation of tests including radiological examinations or issues occurring during testing processes. SIs reported have related to the failure to identify a metastic lung cancer and metastic renal cancer. A further SI declared related to a delay in first trimester screening samples not arriving in the laboratory after been sent from the Trust. As the testing samples were over the testing guidance all samples had to be retested. The lack of any tracking in place between Trust and the testing laboratory was identified as a root cause for this incident. Delayed Diagnosis - SIs relating to delayed diagnosis have focused around the cancer pathway and either delays in radiology reporting, or incorrect radiology reporting. This included a delayed diagnosis of a patient with an acoustic neuroma, an obstructive colonic cancer and the diagnosis of a metastatic neuroendocrine carcinoma. Poor communication and appreciation of seriousness of the disease was identified as a cause in a SI where a patient developed an infection following a delayed diagnosis of septic arthritis of the left hip.

Surgical / Invasive Procedures - SIs identified as surgical invasive procedures have been linked to human error, procedures being undertaken without the required expertise and included SIs where items have been left within the patient following a procedure. This included a primary guidewire being left in place following insertion of a PICC line. These SIs have also related to procedures being undertaken which have not been felt to have been of an acceptable standard. One example of this related to treatment for a tibial plateau fracture where the patient was required to undergo further surgery and it was not felt that the surgeon who undertook this procedure had the specific skill/technique required. Human error was identified as a root cause in a SI where a single Hickman line was inserted where a patient had attended for a double Hickman line insertion.

Sub Optimal Care / Care of the Deteriorating Patient - Issues emerging from SI's that have a focus on sub-optimal Care and care of the deteriorating patient are often around communication, failure to escalate and handover. This is often when nursing staff have attempted to escalate but receive no response and they do not escalate further. In one SI , following a crash call a patient did not have any form of identification at their bedside and it was unclear if they had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. Other SIs relating to sub-optimal care also included a deteriorating patient who was not escalated to the Critical Care team or outreach for intervention within an appropriate time frame. There was also a patient with anaphylaxis where it was identified that there was need for staff to feel able to raise their concerns during an emergency. It was felt that this patient possibly underwent an unnecessary procedure resulting in a pneumothorax. In one SI, it was initially identified that a patient had developed an AKI which not fully recognised and not actively managed. There was also an SI were there was a failure to respond to changes in NEWS score.

Never Events

As previously noted, five Never Events were declared between February 2019 and January 2020. Three related to wrong site surgery (dermatology, incorrect removal of mole and theatres, stent placed in incorrect side) and the insertion of femoral nerve block on the incorrect leg. A further Never Event related to the wrong route administration of medication (oramorph) and a Never Event was also recently declared relating to a primary guidewire being left in place following insertion of a PICC line.

Assurance Framework Responsive

Serious Incidents (Declared Between February 2019 and January 2019)

Performance:

Falls and Pressure Ulcer SIs

Fall and Pressure Ulcer SIs continue to be reviewed by the Falls and Pressure Ulcer panel, with learning being identified and disseminated by the Patient Safety Team.

Actions:

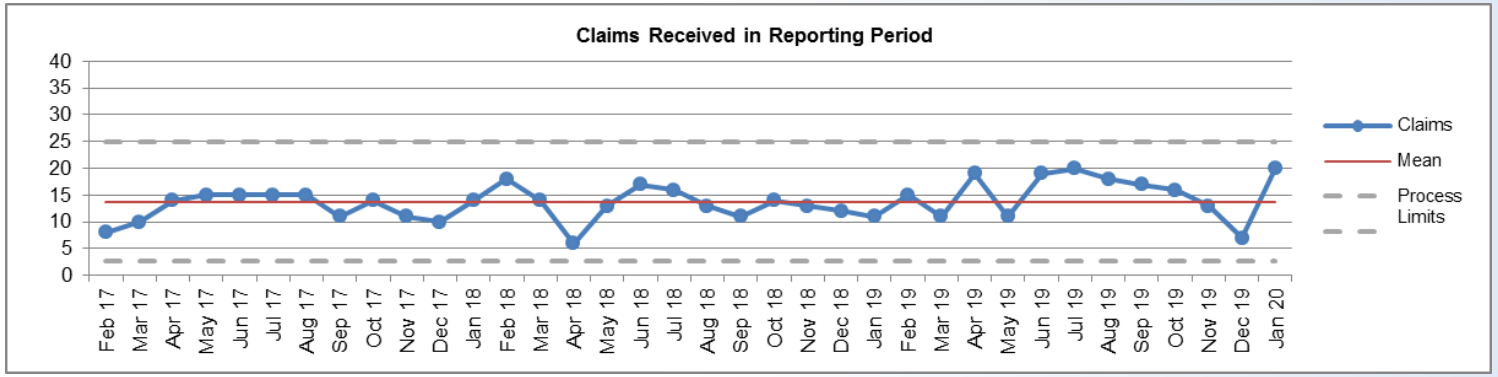
- Discussion on the degree of harm for each incident is a focus at SI Group , where degrees of harm for clinical serious incidents (SIs) are discussed and agreed to ensure senior review and group consensus of the level of harm. Not all incidents declared as serious incidents are graded as serious harm. For example, although 12 hour trolley waits are mandatory declarations, there is rarely any harm to patients as a result. If multiple patients are affected by a 12 hour trolley wait, the "worst" degree of harm is attributed to the incident. Category 3 pressure ulcers and fractures other than neck of femur are generally moderate harm, with Category 4 pressure ulcers and fractured necks of femur incidents being serious harm.
- Work continues to identify learning from SIs and how this can be best disseminated across the Trust

Assurance Framework Responsive

Clinical Negligence Claims (February 2017 to January 2020)

Operational Update

Clinical Negligence Claims Received



The above chart shows the number of clinical negligence claims received by the Trust over the last 3 years. It is important to note that the date a claim is received may not directly correlate with the event date (s) or time period of treatment that the claim relates to, due to the 3 year limitation period for raising a claim.

Top 5 Claims Types

496 clinical negligence claims were received in this period. The top 5 claim types accounted for 76% of the total number of claims received and are shown in the following table. Of note between February 2019 and January 2020, there was an increase in the number of claims relating to inadequate procedures, delays in treatment and lack of appropriate treatment.

Top 5 Claim Types	Feb17-Jan18	Feb18-Jan19	Feb19-Jan20	TOTAL
Failure to Diagnose/Delay in Diagnosis	36	54	52	**142**
Lack of Appropriate Treatment	31	32	37	**100**
Inadequate Surgery	20	19	17	**56**
Delay in Treatment	15	9	16	**40**
Inadequate Procedure	18	8	14	**40**
TOTAL	**120**	**122**	**136**	**378**

Claims by Site

In the reporting period, the number of clinical negligence claims received relating to treatment at York Hospital accounted for 61.9% pf the claims received. Claims relating to treatment at Scarborough accounted for 36.3% pf the claims, with Bridlington Hospital and Community Services accounting for 1.4% and 0.4% of the claims respectively.

Claims Received by Site	Feb17-Jan18	Feb18-Jan19	Feb19-Jan20	TOTAL
York Hospital	102	89	116	**307**
Scarborough Hospital	50	63	67	**180**
Bridlington Hospital	0	4	3	**7**
Community Services	0	2	0	**2**
TOTAL	**152**	**158**	**186**	**496**

Withdrawn Claims

It is also important to note that a significant number of claims received by the Trust do not proceed to settlement, as claims may be withdrawn after submission. Claims are usually withdrawn as the claimant has not been able to obtain supportive independent expert opinion. Of the claims received in the reporting period, 32% were withdrawn prior to settlement.

244

Assurance Framework Responsive

Clinical Negligence Claims

Operational Update

Ongoing Clinical Negligence Claims

Ongoing Claims	Year Claim Received											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
CG1: Acute, Emergency, Elderly Medicine & Community Services - York	0	0	0	0	0	1	2	7	13	26	2	51
CG2 :Acute, Emergency & Elderly Medicine - SGH	0	0	0	1	0	2	5	7	15	25	5	60
CG3: Surgery	0	1	0	0	1	2	8	8	26	43	5	94
CG4: Cancer and Support Services	0	0	0	0	1	0	3	2	5	12	1	24
CG5: Family Health	2	0	2	1	3	4	3	11	16	36	1	79
CG6: Specialised Medicine	0	0	0	0	0	0	0	6	8	16	5	35
TOTAL	**2**	**1**	**2**	**2**	**5**	**9**	**21**	**41**	**83**	**158**	**19**	**343**

The above table shows the number of ongoing clinical negligent claims by the care group which provided most or all of the care or treatment which the claim relates to, and the year the claim was received. Some claims, particulally relating to birth and children, can take a significant amount of time to conclude , as the clinical outcome for the patient may not be known for a number of years. Claims may take a significant time to conclude due to delays associated with obtaining expert opinion and timescales imposed by the Court.

Clinical Negligence Claims Settled Between February 2017 and January 2020

144 clinical claims were settled between February 2017 and January 2020. The top 5 claim by types settled in this time period accounted for 53% of the total number of claims received, and are shown in the following table. 60.4% of the total number of claims settled related to treatment in York, 35.4% related to Scarborough, with 2.1% relating to both Bridlington Hospital and Community Services.

Top 5 Claim Types (Settled)	Feb17-Jan18	Feb18-Jan19	Feb19-Jan20	Total
Failure to Diagnose/Delay in Diagnosis	10	16	6	**32**
Delay in Treatment	2	5	5	**12**
Failure to Adequately Interpret Radiology	6	2	3	**11**
Lack of Appropriate Treatment	2	2	7	**11**
Inadequate Surgery	3	3	5	**11**
TOTAL	**23**	**28**	**26**	**77**

Clinical Negligence Claims Settled Since April 2019 by Care Group

Care Group	Number of Claims and Month Settled										
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	TOTAL
CG1: Acute, Emergency, Elderly Medicine & Community Services - York	0	1	1	0	1	3	0	1	0	0	**7**
CG2 :Acute, Emergency & Elderly Medicine - SGH	0	1	1	0	0	0	0	0	1	0	**3**
CG3: Surgery	1	1	0	1	1	1	1	3	2	2	**13**
CG4: Cancer and Support Services	1	2	1	0	0	0	0	0	0	0	**4**
CG5: Family Health	0	0	0	1	1	1	1	0	0	0	**4**
CG6: Specialised Medicine	1	0	1	1	0	0	0	0	0	1	**4**
TOTAL	**3**	**5**	**4**	**3**	**3**	**5**	**2**	**4**	**3**	**3**	**35**

Care Group	Sum of Damages and Month Settled										
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	TOTAL
CG1: Acute, Emergency, Elderly Medicine & Community Services - York	0	37500	3000	0	5000	110500	0	220000	0	0	**376000**
CG2 :Acute, Emergency & Elderly Medicine - SGH	0	25566	25000	0	0	0	0	0	89863	0	**140430**
CG3: Surgery	5000	1161055	0	20000	100000	7500	12500	287500	70000	206500	**1870055**
CG4: Cancer and Support Services	15000	2050000	106040	0	0	0	0	0	0	0	**2171040**
CG5: Family Health	0	0	0	19000	550000	20000	3500	0	0	0	**592500**
CG6: Specialised Medicine	110000	0	35000	85000	0	0	0	0	0	2000	**232000**
TOTAL	**130000**	**3274121**	**169040**	**124000**	**655000**	**138000**	**16000**	**507500**	**159863**	**208500**	**5382025**

Assurance Framework Responsive

Clinical Negligence Claims and Inquests

Operational Update

Settled Clinical Negligence Claims Over £50,000 (January 2020)

One clinical negligence claim settled in January resulted in damages of over £50,000 being awarded.

Care Group 3 - Surgery - Inadequate Surgery - The Claimant alleges substandard surgery in respect of inguinal hernia repair. Significant pain was experienced post surgery and the patient was referred back to the Trust, where a diagnosis of neuropathic pain following hernia repair was made. The patient remained in pain and was dismissed from employment due to ill-health. A defence was filed denying breach of duty on the basis that appropriate steps were taken to ensure the nerves identified and preserved during surgery. However, there was vulnerability in respect of nerve damage sustained. Independent experts felt that the nerve most likely damaged was the ilio-inguinal nerve. If the Claimant's account that pain starting almost immediately after surgery was accepted by the Court, then it pointed to nerve damage during the operation. The risks identified meant that prospects of success at Court trial were poor. With clinician consent, a round table meeting took place and led to a reduced value settlement of the claim, on a no admissions basis. Damages of £200,000 were awarded.

Actions for All Claims:

- On receipt of a new clinical claim, clinicians are asked to review the case at an early stage to identify any immediate risks which may require action. On settlement of a claim, Care Groups are requested to ensure that any learning points are implemented with the relevant area .
- Work is ongoing to develop a mechanism for sharing the learning identified at Care Group level across the Trust.

Coroner's Inquests Concluded (February 2017 to January 2020)

The Legal Services Team continue to liaise with Coroners to support inquests where the Trust has been involved in a patient's care.

The outcome of most inquests result in no actions for the Trust, but work to provide further trend information and to improve the sharing of learning from clinical claims and inquests continues. The number of inquests concluded in the reporting period is shown in the following table.

Coroner's Conclusion and Inquest Date	Feb17-Jan18	Feb18-Jan19	Feb19-Jan20	Total
Accidental death	36	36	38	**110**
Narrative	14	12	31	**57**
Natural causes	11	12	6	**29**
Suicide	5	6	6	**17**
Misadventure	5	3	0	**8**
Industrial diseases	2	3	2	**7**
Open verdict	1	0	5	**6**
Road Traffic Collision	0	3	0	**3**
Accidental Overdose	0	1	0	**1**
TOTAL	**74**	**76**	**88**	**238**

Ongoing Inquests

The number of ongoing inquests by care group and the year the inquest was opened is shown in the following table.

Care Group and Year Inquest Opened	2017	2018	2019	2020	TOTAL
CG1: Acute, Emergency, Elderly Medicine & Comm Ser - York	0	2	25	5	**32**
CG2 :Acute, Emergency & Elderly Medicine - SGH	1	0	12	3	**16**
CG3: Surgery	0	1	9	4	**14**
CG4: Cancer and Support Services	0	0	2	0	**2**
CG6: Specialised Medicine	0	0	6	0	**6**
TOTAL	**1**	**3**	**54**	**12**	**70**

Assurance Framework Responsive

Clinical Effectiveness

Operational Update

National Audits

The Trust is currently participating in 47 NHSE Quality Account Audits and 24 national audits.

There were 32 Quality Account Audit National Reports received for the period ending January 2020. The Trust has been identified as an outlier in 3 of these published national reports, namely: the NJR National Joint Registry (2017/18 Data) and NEIAA National Early Inflammatory Arthritis Audit (2018/19 Data) and NBoCA National Bowel Cancer Audit (2017/18 Data)

The process for review is that local and national data is provided to the Audit Lead who then undertakes an analysis of findings and develops an action plan to address any identified issues.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

To date the Trust has submitted data for 2 NCEPOD studies. There are 67 open actions arising from NCEPOD studies which the Trust has participated in. 48 of these actions from NCEPOD studies are overdue and are being followed up.

Clinical Audit

For the 2019/2020 financial year, there are 373 Audits on the Annual Audit Programme which is comprised of 47 Quality Account, 24 National, 9 NICE Compliance, 4 NPSA, 1 New Procedure, 156 Local and 132 Re-Audits.

To date a total of 203 of the audits on the Annual Audit Programme have been registered and 28 of the audits have been completed.

NICE Guidance

There are 484 published NICE Guidance which are relevant to the Trust.

The Trust currently has a total of 21 pieces of NICE Guidance which are awaiting completion of a Trust baseline assessment, of which 11 are within the three month review period, the remaining 10 have not had baseline assessments completed within the required three month review period and are therefore overdue and have been escalated appropriately.

However despite escalation, there are 3 Baseline Assessments which are significantly overdue for completion, namely; PH048 Smoking: acute, maternity and mental health services (2013), NG056 Multimorbidity: clinical assessment and management (2016) and CG165 Hepatitis B (chronic): diagnosis and management (2017)

Assurance Framework Responsive

Patient Experience

Operational Update February 2020

New complaints and PALS cases by care group and site

Care Group	COMPLAINTS				PALS			
	York	Scarb	Brid	Total	York	Scarb	Brid	Total
CG1: York Acute, Emergency, Elderly Medicine & Community Services	10	0	0	**10**	30	0	0	**30**
CG2 : Scarborough Acute, Emergency & Elderly Medicine	0	5	1	**6**	0	17	1	**18**
CG3: Surgery	5	3	0	**8**	34	5	3	**42**
CG4: Cancer and Support Services	3	0	1	**4**	7	5	0	**12**
CG5: Family Health	1	2	0	**3**	5	2	0	**7**
CG6: Specialised Medicine	7	4	0	**11**	31	5	3	**39**
Corporate Services	0	0	0	**0**	3	0	0	**3**
Total	**26**	**14**	**2**	**42**	**110**	**34**	**7**	**151**

New (reopened) dissatisfied complaints

Reason Dissatisfied	Care Group			
	CG2	CG3	CG5	Total
Dissatisfied with findings	1	2	1	**4**
Further clarity/ questions	0	0	0	**0**
Complaint handling	0	0	0	**0**
Total	**1**	**2**	**1**	**4**

Top 5 sub-subjects

COMPLAINTS	York	Scarb	Brid	Total	PALS	York	Scarb	Brid	Total
Care needs not adequately met	8	6	0	**14**	Communication with patient	19	9	1	**29**
Delay or failure in treatment/procedure	8	1	2	**11**	Appointment availability	14	7	2	**23**
Communication with patient	4	5	0	**9**	Appointment cancellations	9	0	1	**10**
Communication with relatives/carers	6	1	0	**7**	Length of waiting list	10	0	0	**10**
Discharge arrangements	5	2	0	**7**	Access to services	5	4	0	**9**
Total	**31**	**15**	**2**	**48**	**Total**	**57**	**20**	**4**	**81**

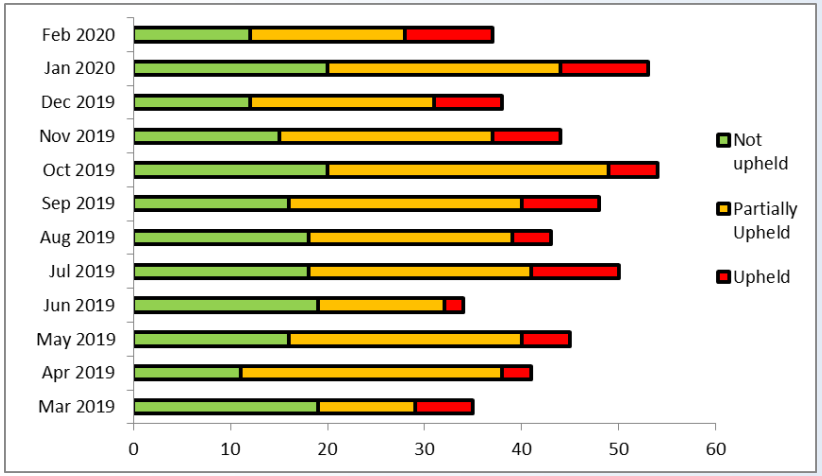
Formal compliments

Care Group	Feb-20
CG1	65
CG2	39
CG3	56
CG4	25
CG5	39
CG6	7
Total	**231**

Friends and Family Test

January 2020	% response rate	% recommend
Inpatient	23	97
Emergency	6	79
Maternity	47	97

Proportion of closed complaints by outcome



248

Assurance Framework Responsive

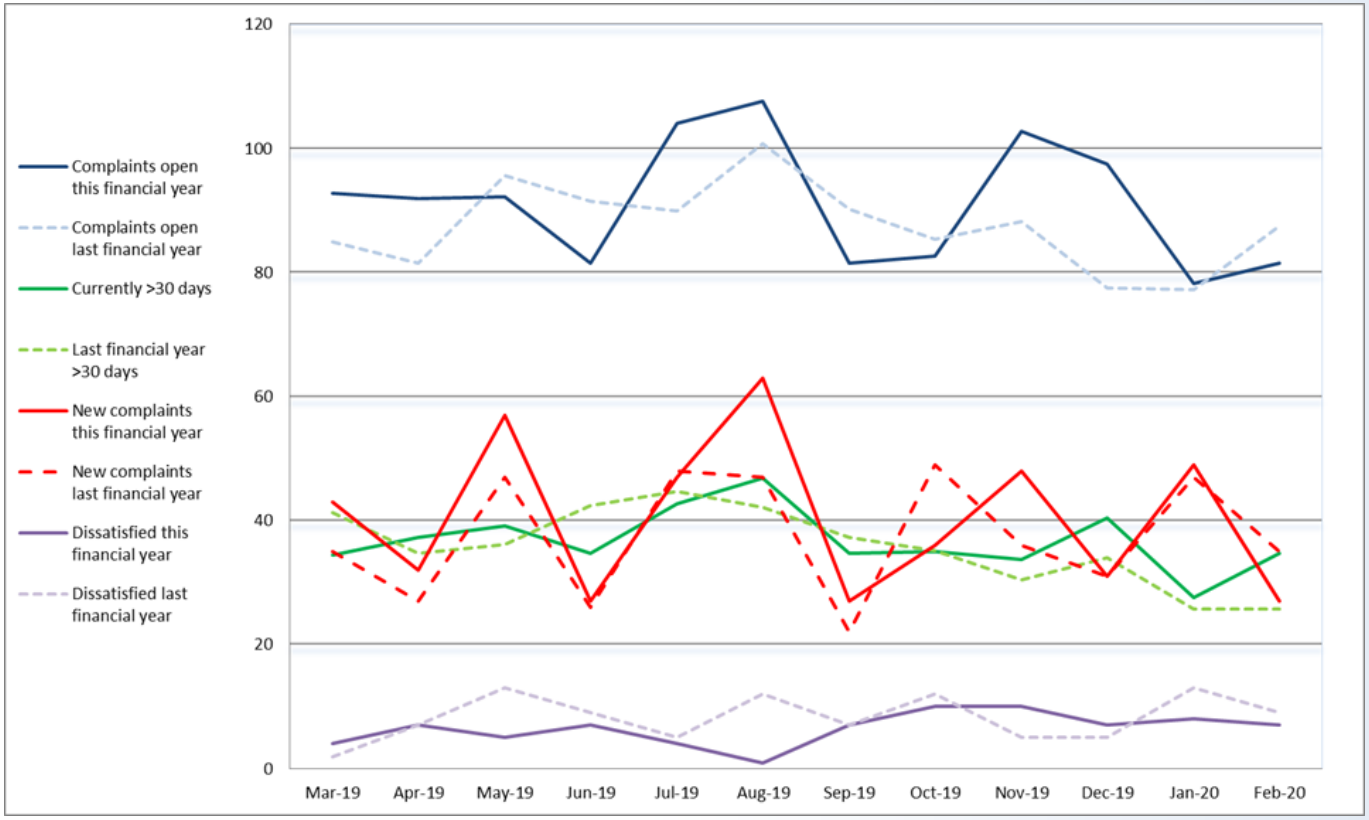
Patient Experience (continued)

Performance:

Closed complaint & PALS average response times

Complaints	Total Closed	Average no days	% Within Target	PALS	Total Closed	Average no days	% Within Target
CG1	7	33	29%	CG1	34	10	62%
CG2	10	40	50%	CG2	20	12	65%
CG3	8	37	50%	CG3	43	4	79%
CG4	5	22	80%	CG4	13	3	92%
CG5	8	15	88%	CG5	7	5	71%
CG6	4	23	50%	CG6	40	7	78%
Corporate Services	0	0	N/A	Corporate Services	4	4	100%
Total	**42**	**30**	**57%**	**Total**	**161**	**7**	**75%**

Complaint Performance Handling



Assurance Framework Responsive

Care of the Deteriorating Patient

Standard(s):

Senior review within 14 hours of arrival on Acute Medical Assessment Units – Royal College Standard and local targets
NEWS within 1 hour of prescribed time
14 hour Post Take data includes non-elective inpatients only, excludes Maternity, and excludes patients only admitted to the Patient Lounge. The numerator (those included as having had a Senior Review within 14hrs) includes any patient who has been marked on CPD as having had a Senior Review (post take still required) or Post Take Completed within 14 hours of admission time. It also includes any SDEC patients (having been admitted and discharged from an SDEC ward) who have had a Length of Stay less than 14hrs

Consequence of failure:

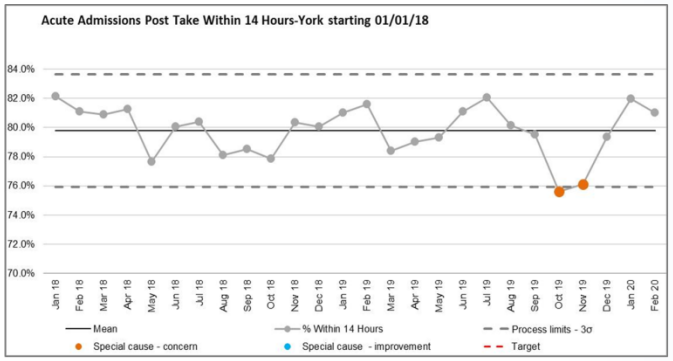
Patient experience, clinical outcomes, timely access to treatment

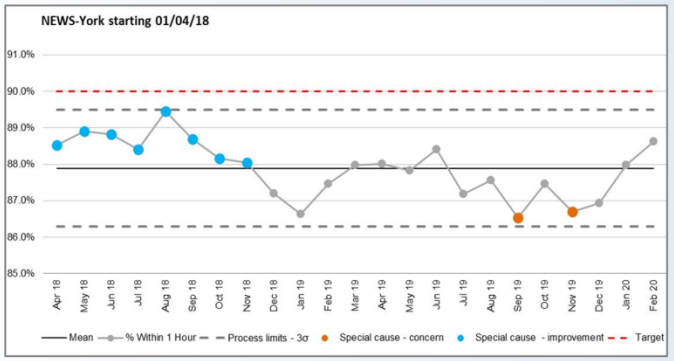
Operational Update:

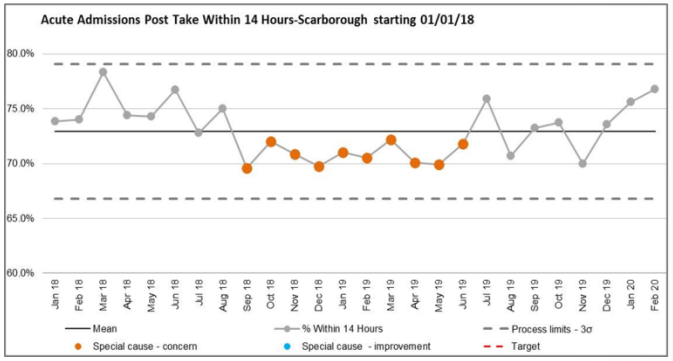
Compliance with NEWS within 1 hour of prescribed time met the target of 90% at Trust level. When broken down to hospital site, York hospital continues to be below this target, however improving trend over last 2 months. Compliance data is available to nursing teams to support improvement work.

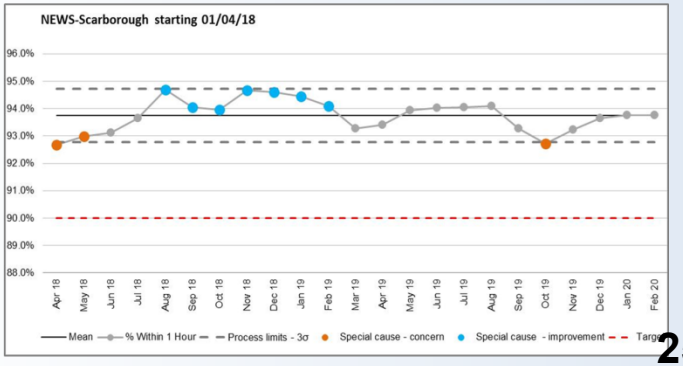
Work continues to ensure patients receive a senior review within 14 hours, specifically in relation to timetabling consultant presence on board and ward rounds, in addition to how daily senior review is recorded within CPD.

Performance:









Assurance Framework Responsive

Care of the Deteriorating Patient

Standard(s):

Senior review within 14 hours of arrival on Acute Medical Assessment Units – Royal College Standard and local targets
NEWS within 1 hour of prescribed time

Consequence of failure:

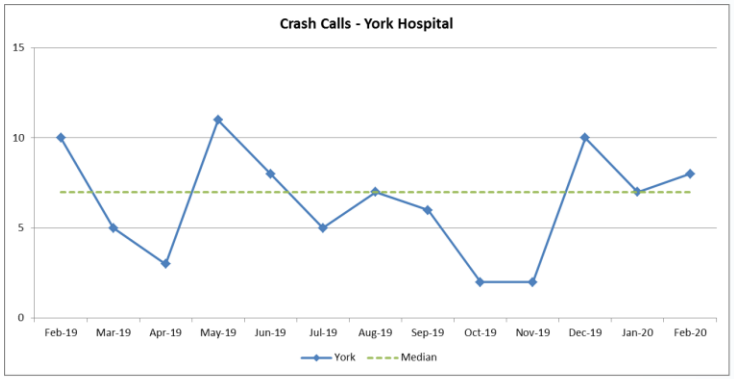
Patient experience, clinical outcomes, timely access to treatment

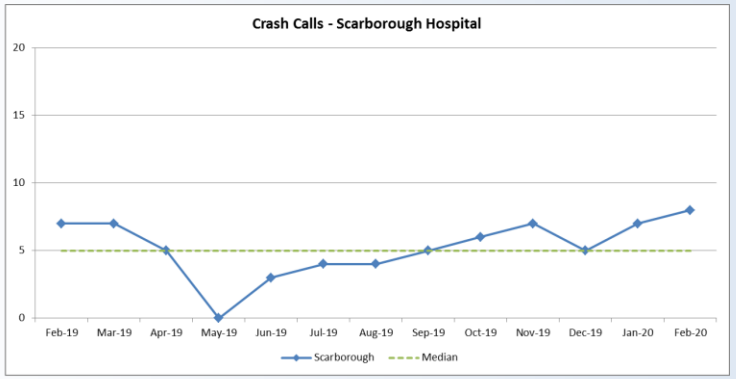
Operational Update:

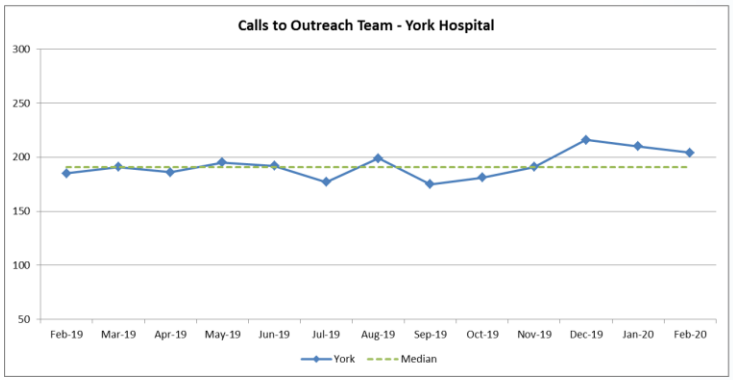
Both sites reported similar cardiac arrest numbers in February on each site. This data will be reviewed at the Deteriorating Patient Group and also DNACPR group to ensure learning points actioned.
At both sites there is a general trend towards increased referrals to Outreach .
The NEWS 2 rollout has gone to plan without issue. We still however are concerned about the new confusion assessment.

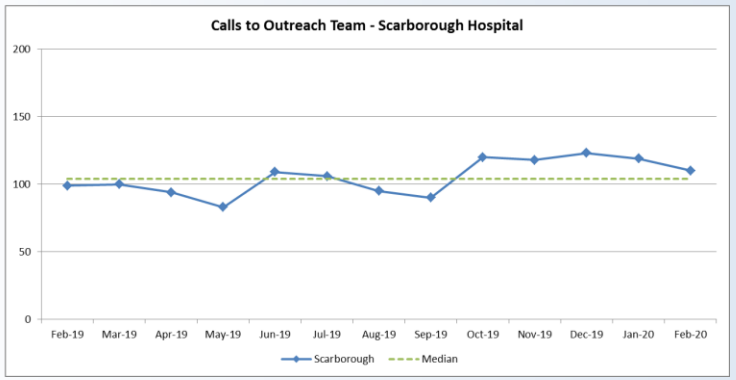
Work continues in relation to Hospital at Night; Outreach recruitment has been successful. The first CSW has started with positive feedback. There is a plan to trial the App at SGH in March. There has been some additional Registrar support during the weekend twilight shifts, this element remains a challenge.

Performance:









251

Assurance Framework Responsive

Medication Incidents

Measure: Insulin errors, prescribing errors, dispensing errors, administration errors

Data Source: DATIX

Operational Update:

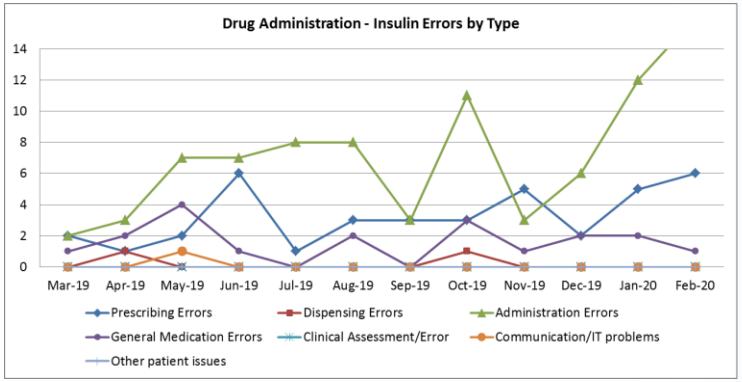
There were 142 medication incidents in February.

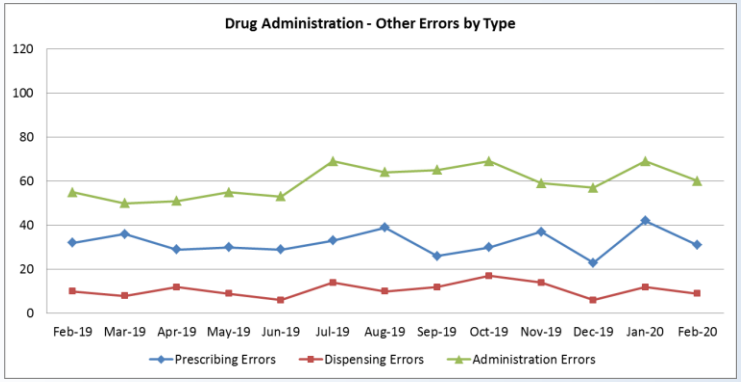
There was one incident which potentially caused moderate harm where a patients usual long term steroid was not prescribed during their admission and on discharge leading to a readmission with a COPD exacerbation.

There was an increase in the number of insulin incidents relating to both prescribing and administration of insulin. These include a number of incidents where the incorrect insulin has been prescribed and/or given due to similar sounding names e.g. Humalog and Humalog Mix 25. There have also been a number of incidents where insulin has been prescribed and/or given at an inappropriate time e.g. fast acting insulin which should be given with meals given at bedtime leading to hypoglycaemia. Finally there have been a number of cases in the community where insulin doses have been omitted due to scheduling issues with District Nurses worklists, one of which has been declared a SI.

The lead diabetes nurse has commenced a piece of work with community staff to review insulin administration. The Think Glucose team have developed an e-learning package on safe use of insulin for nurses and an educational update for doctors is planned for the March Clinical Governance meetings. The Trust Medication Safety Officer has commenced w QI project aiming to reduce medication related harms and Insulin will be one of the first work streams

Activity count:





Assurance Framework Responsive

Mortality – Learning from Deaths (LfD)

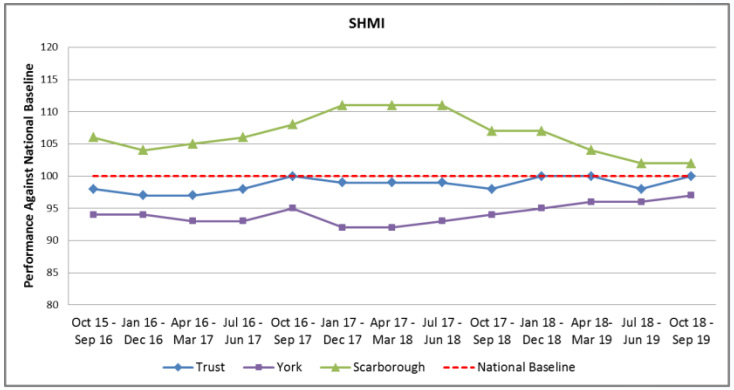
Operational Update

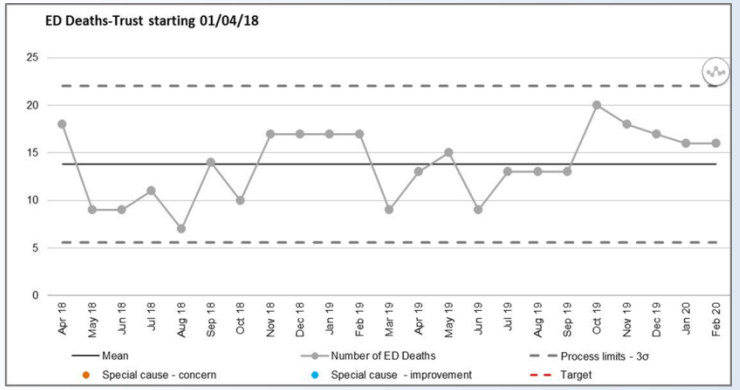
There were 189 deaths during February. All reported deaths were within the upper and lower control limits.

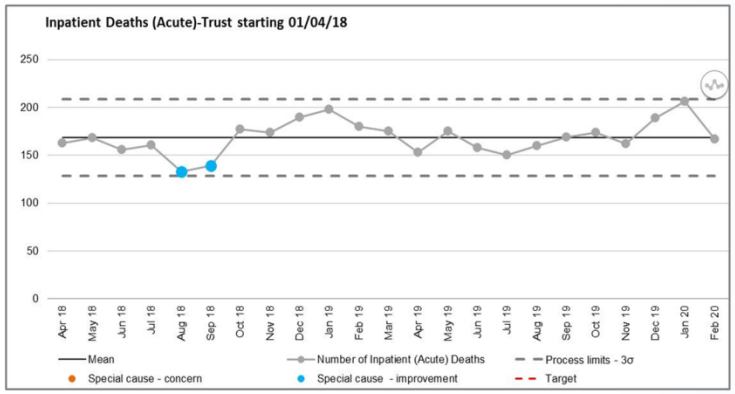
24% of the February mortality reviews have been completed at the time of reporting.

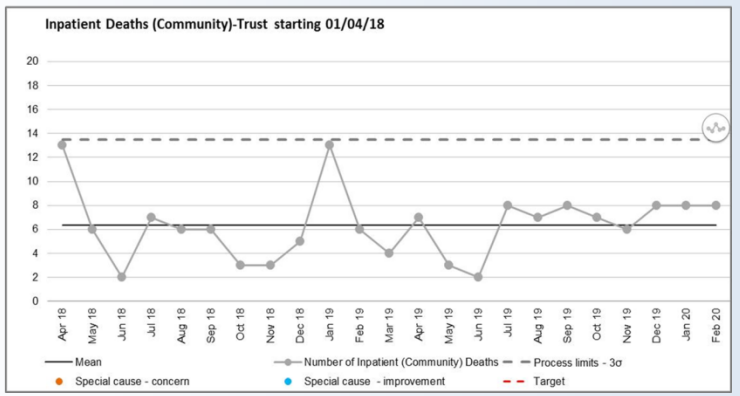
7 Structured Judgment Case Reviews (SJCRs) were commissioned during February; 1 of which has been completed at the time of reporting.
Of the 7 SJCRs, 3 were requested by the Quality and Safety meeting, 3 were requested following the Medical Examiners conversation with the family and 1 was requested following the initial review overall care score.
The Learning from deaths process is ever evolving. The Introduction of a Medical Examiner role from the 1st April 2019 has as expected seen an increase in the number of SJCR's commissioned from 130 April 2018-March 2019 to 196 from April 2019-March 2020,an increase of 34%.The learning from deaths process is managed within each of the care groups to ensure ownership following completion of the Structured Judgement Case Review (SJCR), the findings are discussed at their Governance Meetings and a Quarterly report submitted for discussion at the Mortality Steering Group. Governance meetings monitor completion of actions and ensure learning is shared.

Details:









Assurance Framework
Responsive

Maternity Dashboard - York

YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	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
Activity	Births	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	274	260	238	242	223	266	257	254	272	218	207	300	213
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	92.0%	92.3%	91.2%	95.5%	91.9%	89.8%	91.1%	94.5%	90.4%	85.3%	87.0%	90.7%	86.4%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10.1%-19.9%	>20%	2.9%	5.0%	2.5%	2.5%	4.9%	4.5%	3.5%	2.8%	4.0%	6.4%	3.9%	3.3%	4.2%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	75.0%	61.50%	50.00%	57.10%	45.50%	33.30%	66.70%	28.60%	18.20%	42.90%	25.00%	70.00%	88.90%
		Births	No. of babies	CPD	≤295	296-309	≥310	231	274	220	255	250	287	267	276	239	246	206	248	225
		No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311	226	273	216	250	246	285	261	270	233	242	203	245	222
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	1	0	0	0	1	0	0	0	0	0	0	0	0
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	1	0	0	0	2	0	0	0	0	0	0	0	0
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	4	1	1	1	0	2	1	5	0	2	0	1	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0	0	0	0	1	0	0
		SCBU at capacity	No of times	SCBU				5	9	7	0	0	2	0	0	0	5	0	4	0
		SCBU at capacity of intensive cots	No. of times	SCBU				2	10	2	2	3	4	8	8	0	3	0	1	0
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	1	3	2	0	0	0	2	0	1	1	0	0	0
Workforce	Staffing	MW to birth ratio	Ratio	Matron	≤29.5	29.6 - 30.9	>31	30	30	30	29	29	29	31	28	28	30	29	26	27
		1 to 1 care in Labour	CPD	CPD	100%	80% - 99.9%	≤79.9%	74.0%	79.9%	89.9%	93.0%	93.3%	97.1%	95.2%	90.2%	93.7%	95.9%	96.2%	94.9%	97.0%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	100%	80% - 99.9%	≤79.9%	73.0%	48.0%	100.0%	100.0%	100.0%	96.8%	98.0%	95.0%	97.0%	96.0%	100.0%	97.0%	91.0%
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10	4-9	≤3	10	10	10	10	10	10	10	10	10	10	10	10	10
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	54.5%	58.8%	61.5%	60.9%	64.1%	58.9%	59.7%	57.0%	57.0%	60.6%	61.0%	63.7%	61.4%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	12.8%	16.8%	17.1%	11.2%	15.9%	11.2%	12.3%	12.2%	15.5%	16.5%	13.3%	10.6%	9.5%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	32.7%	24.5%	20.8%	26.8%	19.5%	30.2%	28.4%	31.1%	27.5%	22.7%	24.6%	26.1%	28.4%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	1	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	0	1	1	0	2	3	1	1	0	0	3	0	1
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	17	16	15	10	15	22	17	16	21	22	17	17	12
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	3	5	0	1	5	5	1	1	4	4	2	2	3
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0	0	0
		NHS Resolution cases	No of cases		0	1	2 or more	0	0	0	0	0	0	0	0	0	1	0	0	0
	Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	1	0	0	0	0	0	0	0	0	1	1	1	0
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	0	0	0	0	0	1	0	0	0	1	0	1	1
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0	0
		Cold babies	No of babies admitted to SCBU cold (<36.5)		1 or less	2-3	4 or more								8	7	10	3	4	2
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	72.2%	73.7%	72.3%	71.0%	72.3%	71.0%	78.3%	73.8%	74.5%	72.7%	66.5%	69.6%	75.4%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	11.1%	11.4%	8.8%	10.8%	11.0%	11.9%	10.0%	7.0%	9.0%	9.9%	13.8%	13.5%	12.2%
		SI's	No. of SI's declared	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	1	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	5	11	8	8	8	15	10	7	12	11	6	12	11
		PPH > 1.5L as % of all women	% of births	CPD				2.2%	4.0%	3.6%	3.1%	3.2%	5.2%	3.7%	2.5%	5.0%	4.4%	2.9%	4.8%	4.8%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	4	2	4	7	3	4	1	1	0	2	2	5	2
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	0.0%	2.4%	0.0%	3.7%	2.5%	1.0%	2.6%	1.0%	3.4%	3.1%	2.5%	3.8%	0.6%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	1	3	2	1	0	2	5	1	1	1	1	5	1
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	1	4	2	1	2	3	4	0	3	2	0	1	0

Please note: Due to data cleansing that takes place, the data for the current quarter may be subject to change.

Assurance Framework
Responsive

Maternity Dashboard - Scarborough

SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	183	167	139	176	163	198	175	153	181	154	144	184	145
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	91.0%	89.2%	91.4%	91.5%	91.4%	90.4%	89.1%	87.6%	873.8%	91.6%	82.6%	88.0%	86.9%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	7.1%	8.4%	5.8%	5.7%	4.3%	4.5%	4.0%	7.2%	6.1%	2.6%	7.6%	7.6%	9.7%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	64%	79%	89%	70%	71%	44%	71%	73%	90.9%	100%	64%	64%	79%
		Births	No. of babies	CPD	≤170	171-189	≥190	109	126	98	118	114	141	121	122	113	107	109	120	110
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190	106	123	95	114	114	138	120	119	112	107	0	119	107
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	0	0	0	0	0	0	0	0	0	0
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0	0	0
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	1	4	0	1	0	3	2	2	0	0	0	0	2
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0	1
		SCBU at capacity	No of times	SCBU				0	2	22	15	9	14	0	0	15	11	13	2	0
		SCBU at capacity of intensive care cots	No. of times	SCBU				1	0	0	0	0	0	0	0	5	2	0	0	0
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	0	1	0	7	3	2	0	2	0	0	0	0	0
Workforce	Staffing	M/W to birth ratio	Ratio	Matron	≤29.5	29.6-30.9	>31	23.0	23	22	23	22	22	24	22	23	22	23	23	21
		1 to 1 care in Labour	CPD	CPD	≥100%	80% - 99.9%	≤79.9%	94.3%	95.7%	96.5%	96.2%	98.1%	95.0%	98.1%	98.1%	98.9%	94.7%	95.7%	96.4%	98.0%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%	80% - 99.9%	≤79.9%	75.0%	80.0%	100.0%	93.3%	100.0%	98.4%	97.0%	95.0%	97.0%	98.3%	91.9%	98.0%	96.6%
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	≥10	4-9	≤3	5	5	5	5	5	5	5	5	5	5	5	5	5
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	72.5%	66.9%	74.5%	63.6%	69.6%	64.3%	69.4%	70.5%	71.7%	56.0%	67.9%	73.8%	66.1%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	1.9%	10.6%	5.3%	9.6%	9.6%	7.2%	10.8%	4.2%	0.9%	8.4%	5.6%	5.0%	4.7%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	24.5%	22.0%	18.9%	27.2%	20.2%	26.8%	20.2%	26.1%	27.7%	34.6%	25.9%	18.5%	29.0%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	0	0	0	1	0	0	0	0	0	1	0	1	1
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	7	10	0	4	10	2	6	6	4	3	1	1	3
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	3	2	1	0	2	1	2	1	2	0	3	0	0
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0	0	0
		NHS Resolution cases	No of cases		0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0	0	0
	Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0	1
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	0	1	0	0	1	1	0	0	1	2	1	0	1
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	2	0	0	0	0	0	0	0	0	0	1	0
		Cold babies	No of babies admitted to SCBU	cold (<36.5)	1 or less	2-3	4 or more								2	0	0	3	2	0
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	67.9%	65.9%	61.2%	68.6%	55.8%	57.9%	53.7%	56.6%	59.8%	66.7%	64.8%	55.5%	65.1%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	18%	15%	15%	18%	25%	21%	16%	13%	21%	24%	19%	20%	19%
		SI's	No. of Si's declared	Risk Team	0		1 or more	0	1	0	0	0	0	1	0	0	0	0	1	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	3	6	1	2	0	1	4	2	2	2	3	1	3
		PPH > 1.5L as % of all women	% of births	CPD				2.8	4.7	1.0	1.7	0.0	0.7	3.3	2	1.8	2	0	0.8	2.7
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	2	1	1	2	1	1	2	1	0	2	3	0	3
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	2.5%	3.0%	0.0%	0.0%	0.0%	1.9%	3.1%	1.1%	2.4%	1.4%	2.5%	0.0%	1.3%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	1	0	1	0	0	1	1	1	0	0	1	0	2
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	0	1	0	1	0	0	1	1	1	0	0	0	0

Please note: Due to data cleansing that takes place, the data for the current quarter may be subject to change.

Please note a change in the NND figures for Scarborough for January. The cases identified were that of 21 week twins, the classification has been changed to 'late miscarriage' following further inspection of the case notes and clarity from the staff involved in the delivery.

255

Performance and Activity Report

February 2020 performance

Produced March 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

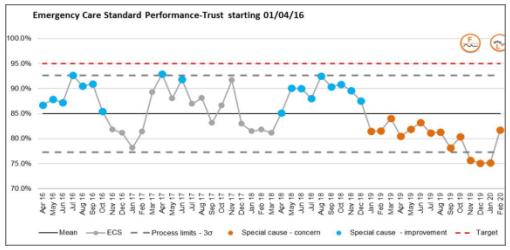
To ensure financial stability

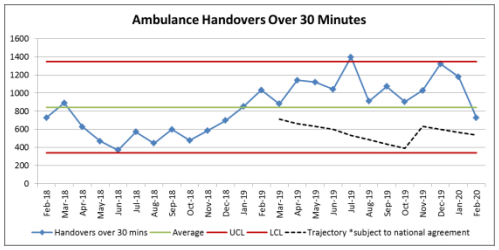
Assurance Framework Responsive

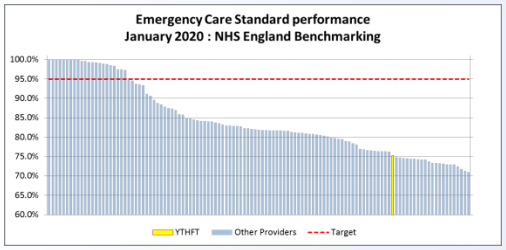
Key Performance Indicators – Trust level

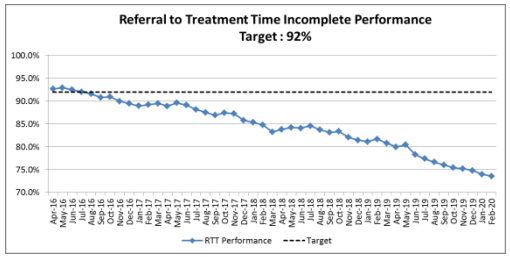
Operational Performance: Key Targets	Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Emergency Care Standard Performance	95%	81.5%	84.0%	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%	75.2%	81.7%
Ambulance handovers waiting 15-29 minutes	0	892	915	956	1072	978	988	983	969	1112	994	1068	1035	943
Ambulance handovers waiting 30-59 minutes	0	556	484	593	671	587	723	547	605	571	552	652	625	465
Ambulance handovers waiting >60 minutes	0	477	397	548	449	453	673	362	466	332	476	668	554	263
Stranded Patients at End of Month - York, Scarborough and Bridlington		386	442	422	406	397	394	409	397	363	363	377	384	342
Super Stranded Patients at End of Month - York, Scarborough and Bridlington		130	153	138	143	135	140	148	136	125	105	139	142	121
Diagnostics: Patients waiting <6 weeks from referral to test	99%	92.9%	93.0%	87.5%	86.4%	88.9%	87.5%	81.7%	82.4%	83.3%	85.0%	81.6%	81.1%	86.1%
RTT Incomplete Pathways	92%	81.7%	80.8%	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%	75.2%	74.8%	74.0%	73.6%
RTT Total Waiting List (RTT TWL)	26,303	27,144	27,536	28,344	28,809	28,724	28,394	29,252	29,771	29,442	28,775	30,187	29,583	29,534
RTT 52+ Week Waiters	0	0	3	0	0	3	0	1	1	0	0	0	1	0
Cancer 2 week (all cancers)	93%	95.7%	90.7%	88.3%	84.6%	81.5%	85.9%	89.9%	90.9%	94.0%	92.4%	94.8%	92.6%	-
Cancer 2 week (breast symptoms)	93%	93.2%	90.7%	79.6%	91.4%	93.8%	95.2%	97.1%	98.1%	98.0%	97.6%	98.4%	97.4%	-
Cancer 31 day wait from diagnosis to first treatment	96%	98.7%	96.9%	96.7%	98.3%	98.8%	99.1%	99.5%	97.5%	98.8%	96.4%	98.0%	96.7%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	92.3%	97.4%	94.3%	95.1%	96.9%	93.8%	84.4%	100.0%	97.2%	97.8%	87.2%	80.0%	-
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.8%	100.0%	100.0%	-
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	79.4%	83.5%	80.6%	79.5%	85.0%	79.8%	81.2%	80.2%	78.9%	75.9%	76.5%	76.8%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	89.1%	92.7%	100.0%	92.1%	100.0%	100.0%	90.6%	100.0%	98.0%	91.4%	86.4%	87.1%	-
Cancer 28 Day Wait - Faster Diagnosis Standard	TBC	69.6%	67.5%	67.4%	62.1%	66.8%	63.1%	60.2%	59.6%	64.9%	68.9%	70.7%	63.4%	-

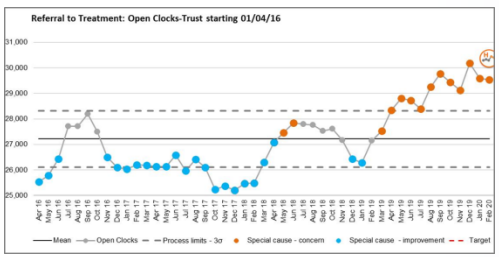
note: cancer one month behind due to national reporting timetable

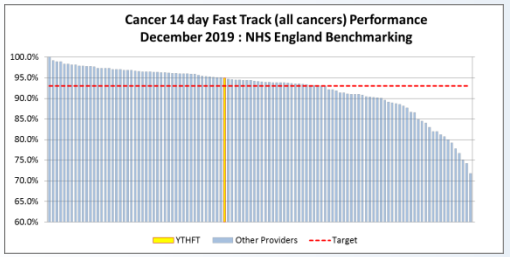


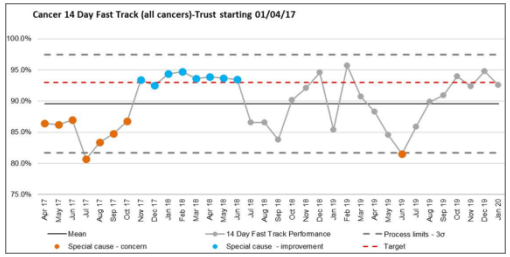


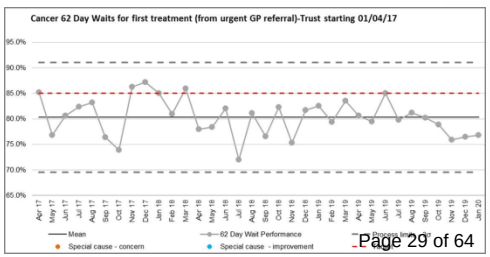


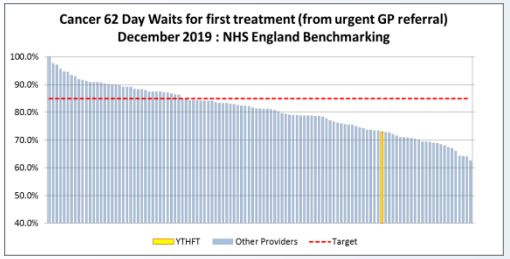












Assurance Framework Responsive

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

Operational Performance: Unplanned Care	Target	Sparkline / Previous Month	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
Emergency Care Attendances			15500	17489	18055	18270	18256	20101	19683	18486	18800	17848	17926	17169	16770
Emergency Care Breaches			2863	2791	3525	3310	3067	3785	3671	4043	3689	4337	4471	4257	3065
Emergency Care Standard Performance	95%		81.5%	84.0%	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%	75.2%	81.7%
ED Conversion Rate: Proportion of ED attendances subsequently admitted			38%	36%	36%	37%	38%	38%	38%	37%	30%	42%	42%	43%	44%
ED Total number of patients waiting over 8 hours in the departments			802	687	1007	972	799	1029	912	1275	817	1200	1499	1428	801
ED 12 hour trolley waits	0		8	28	24	26	2	1	7	32	16	9	15	28	4
ED: % of attendees assessed within 15 minutes of arrival			59%	63%	58%	59%	59%	53%	55%	54%	54%	51%	54%	58%	61%
ED: % of attendees seen by doctor within 60 minutes of arrival			40%	38%	37%	37%	36%	34%	33%	32%	32%	31%	32%	34%	38%
ED – Percentage of patients who Left Without Being Seen (LWBS)	5%		3.1%	3.2%	3.7%	4.0%	4.4%	4.8%	4.4%	4.6%	4.1%	3.0%	3.1%	3.0%	2.1%
ED - Median time between arrival and treatment (minutes)			192	190	205	197	196	201	206	219	202	223	226	222	194
Ambulance handovers waiting 15-29 minutes			892	915	956	1072	978	988	983	969	1112	994	1068	1035	943
Ambulance handovers waiting 15-29 minutes - improvement trajectory			-	846	829	812	795	778	761	744	727	710	694	685	681
Ambulance handovers waiting 30-59 minutes			556	484	593	671	587	723	547	605	571	552	652	625	465
Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	380	365	350	335	319	304	289	274	361	342	323	304
Ambulance handovers waiting >60 minutes			477	397	548	449	453	673	362	466	332	476	668	554	263
Ambulance handovers waiting >60 minutes - improvement trajectory			-	330	297	281	264	215	182	149	116	271	257	244	231
Non Elective Admissions (excl Paediatrics & Maternity)			4028	4578	4521	4733	4761	5070	4871	4553	5142	5048	5089	5167	4995
Non Elective Admissions - Paediatrics			865	891	745	729	711	808	658	790	944	1045	1011	839	806
Delayed Transfers of Care - Acute Hospitals			1067	1178	1456	1529	1486	1346	1325	1355	1215	1054	1183	1258	1233
Delayed Transfers of Care - Community Hospitals			295	377	277	303	352	235	333	335	342	182	249	408	271
Patients with LOS 0 Days (Elective & Non-Elective)			1278	1362	1241	1386	1550	1609	1472	1364	1663	1782	1691	1874	1807
Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)			991	1097	1102	1157	1076	1241	1115	1139	1116	1112	1191	1148	1119
Ward Transfers - Non clinical transfers after 10pm	100		71	94	87	87	76	87	72	89	104	99	123	127	91
Emergency readmissions within 30 days			741	876	925	912	941	1044	938	876	994	971	1030	-	-
Stranded Patients at End of Month - York, Scarborough and Bridlington			386	442	422	406	397	394	409	397	363	363	377	384	342
Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington			433	409	405	399	373	390	384	380	361	362	376	407	387
Super Stranded Patients at End of Month - York, Scarborough and Bridlington			130	153	138	143	135	140	148	136	125	105	139	142	121
Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington			166	143	147	134	141	138	134	138	129	109	118	145	133

Operational Performance: Planned Care	Target	Sparkline / Previous Month	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
Outpatients: All Referral Types			19500	19105	18848	19697	19164	20503	18446	18954	20357	18743	17432	20522	18079
Outpatients: GP Referrals			10458	9835	9580	9841	9560	10133	9405	9518	10158	9270	8593	10009	8772
Outpatients: Consultant to Consultant Referrals			2234	2282	2200	2397	2244	2329	2101	2239	2389	2258	2029	2317	1953
Outpatients: Other Referrals			6808	6988	7068	7459	7360	8041	6940	7197	7810	7215	6810	8196	7354
Outpatients: 1st Attendances			9005	9315	8605	9212	9208	9879	8308	8732	9876	9192	7935	9518	8719
Outpatients: Follow Up Attendances			15415	16441	15046	16385	15098	16842	14098	14872	16982	16466	13105	16806	14482
Outpatients: 1st to FU Ratio			1.71	1.77	1.75	1.78	1.64	1.70	1.70	1.70	1.72	1.79	1.65	1.77	1.66
Outpatients: DNA rates			5.7%	5.5%	5.9%	6.1%	5.9%	6.3%	6.0%	6.0%	5.9%	6.0%	5.8%	6.2%	6.0%
Outpatients: Cancelled Clinics with less than 14 days notice	180		193	209	180	179	198	243	240	232	270	213	164	219	250
Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons			803	979	993	945	883	987	1214	1316	1474	1076	1303	1158	978
Diagnostics: Patients waiting <6 weeks from referral to test	99%		92.9%	93.0%	87.5%	86.4%	88.9%	81.7%	81.7%	82.4%	83.3%	85.2%	81.6%	81.1%	86.1%
Elective Admissions			554	687	649	682	724	692	579	685	762	753	520	671	583
Day Case Admissions			5868	6082	5843	6061	5879	6232	5901	6135	6684	6411	5637	6572	6060
Cancelled Operations within 48 hours - Bed shortages			10	17	32	66	59	32	13	60	26	41	48	42	10
Cancelled Operations within 48 hours - Non clinical reasons			90	141	130	147	194	229	85	173	148	173	152	142	89
Theatres: Utilisation of planned sessions			87%	90%	92%	86%	89%	89%	91%	91%	95%	91%	88%	86%	89%
Theatres: number of sessions held			506	576	576	602	609	712	501	588	640	561	498	591	542
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)			89	108	99	43	83	104	92	48	66	52	70	31	17

Assurance Framework Responsive

Performance Summary by Month – Trust level continued

18 Weeks Referral To Treatment	Target	Sparkline / Previous Month	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
Incomplete Pathways	92%	▼	81.7%	80.8%	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%	75.2%	74.8%	74.0%	73.6%
Waits over 52 weeks for incomplete pathways	0	▼	0	3	0	0	3	0	1	1	0	0	0	1	0
Waits over 26 weeks for incomplete pathways	0	▼	2066	2220	2468	2657	2558	2735	3239	3595	3508	3526	3929	3917	3866
Waits over 36 weeks for incomplete pathways	0	▲	530	606	669	632	660	632	868	887	1076	1168	1292	1306	1311
RTT Total Waiting List (RTT TWL)	26,303	▼	27144	27536	28344	28809	28724	28394	29252	29771	29442	29123	30187	29583	29534
Number of patients on Admitted Backlog (18+ weeks)		▲	2470	2738	2850	2877	2847	3338	3543	3639	3686	3711	3919	4005	4075
Number of patients on Non Admitted Backlog (18+ weeks)		▲	2505	2556	2825	2769	3391	3079	3283	3445	3554	3512	3694	3687	3727
Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)	8.5	▼	-	-	-	-	-	-	-	-	12	12.0	12.1	12.1	12.0

Cancer (one month behind due to national reporting timetable)	Target	Sparkline / Previous Month	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
Cancer 2 week (all cancers)	93%	▼	95.7%	90.7%	88.3%	84.6%	81.3%	85.9%	89.9%	90.9%	94.0%	92.4%	94.8%	92.6%	-
Cancer 2 week (breast symptoms)	93%	▼	93.2%	90.7%	79.6%	91.4%	93.8%	95.2%	97.1%	98.1%	98.0%	97.6%	98.4%	97.4%	-
Cancer 31 day wait from diagnosis to first treatment	96%	▼	98.7%	96.9%	96.7%	98.3%	98.8%	99.1%	99.5%	97.5%	98.8%	96.4%	98.0%	96.7%	-
Cancer 31 day wait for second or subsequent treatment - surgery	94%	▼	92.3%	97.4%	94.3%	95.1%	96.9%	93.8%	84.4%	100.0%	97.2%	97.8%	87.2%	80.0%	-
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	◀▶	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.8%	100.0%	100.0%	-
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▲	79.4%	83.5%	80.6%	79.5%	85.0%	79.8%	81.2%	80.2%	78.9%	75.9%	76.5%	76.8%	-
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	▲	89.1%	92.7%	100.0%	92.1%	100.0%	100.0%	90.6%	100.0%	98.0%	91.4%	86.4%	87.1%	-
Cancer 28 Day Wait - Faster Diagnosis Standard	TBC	▼	69.6%	67.5%	67.4%	62.1%	66.8%	63.1%	60.2%	59.6%	64.9%	68.9%	70.7%	63.4%	-

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 81.7% in February, a 6.5% improvement on the January position. The latest published data saw the Trust perform below the national position for January (81.7%). The Trust ranked 80th nationally out of 132 providers. In January, only one Trust achieved the ECS; Sheffield Children's NHS Foundation Trust. February data is not available at the time of this report. Unplanned care demand continues to be challenging, with type 1, 2 and 3 attendances up 7% for the year to date on the same period in 2018/19. In total an extra 13,746 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 7,014 patients; a rise of 6%.

Four twelve-hour trolley breaches were reported in February 2020, all 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 have been one hundred and sixty-four twelve hour trolley breaches declared during 2019/20 (Scarborough 161, York 3). Sixty-five were declared in 2018/19.

High levels of Ambulance arrivals continue to impact the two main EDs, up 2% overall on 2018/19, a rise of 829 ambulances YTD. There was slightly more ambulances in February compared to February 2019 (4,038 from 4,004) and this continued high demand contributed to 728 ambulances being delayed by over 30 minutes, this is above the revised improvement trajectory* of 535 submitted to NHS England and NHS Improvement. However for the first time in thirteen months the number of ambulances being delayed by over 30 mins was below the two-year average.

The Trust continues to experience bed pressures, with Scarborough Hospital experiencing bed occupancy of above 90% at midnight on 22 days during the month. York Hospital had above 90% bed occupancy for 27 days during the month. The acute Delayed Transfers of Care (DToC) position in February was 2% down on the end of January. 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.

Coronavirus – COVID 19; following national guidance we have put in place NHS 111 pods at our emergency departments, so that anyone attending hospital with symptoms of the virus can be kept isolated from other patients and avoid causing unnecessary pressure in A&E. We have also set up a 'drive through' service to make sure people in our community can get safe, convenient and quick checks for coronavirus, as part of NHS efforts to keep everyone safe.

*Trajectory subject to national agreement.

Targeted actions

- **Same Day Emergency Care (SDEC)** - Service expansion to a full 7 day SDEC service, on both York and Scarborough sites, agreed. Test of workforce models for 12 hour opening on York site of Medical SDEC and Surgical Assessment unit at weekends begun, to complete mid-March. Scarborough site – new Home First Unit demonstrating considerable impact upon number of over 65s attending ED and turned around within 24 hours, and admissions of over 65s to inpatient wards. Bed occupancy by medical over 65s has also reduced significantly. York site have planned a further test of change from 9 March in ED, for Medical SDEC patient selection method, to try to further reduce admissions to inpatient wards.
- **Site Management and Operational Escalation** - Staff engagement undertaken to listen to concerns and plan improvements to formalise all roles and responsibilities contributing to efficient site management. Bed management team testing new roles and revised rota to improve continuity. Operational escalation protocol being revised for York's Care Group 1 to improve effectiveness of escalation measures. Trust internal and external ambulance divert process revised.
- **ED Systems & Processes** - York site plans now in place to improve the medical and nursing workforce model and improve effectiveness of clinical and operational processes including surge escalation. Scarborough site plans in place to strengthen partnership working internally and externally. York and Scarborough EDs have introduced paediatric nurse in ED, ED paediatric doctor on every shift, and a newly dedicated paediatric assessment room, with strong links to Children's Assessment Unit and Ward 17, for children needing further assessment or admission. York and Scarborough EDs have designated a mental health assessment room to ensure that there is a place in ED suitable for undertaking mental health assessment.
- **Hospital out of Hours & Seven Day Working** - Work continues to deliver safe care out of hours by investment on York site in medical emergency response tea, critical care outreach team, and team huddles during the night on Scarborough site. SNS development team will provide bleep filtering App by March 2020.
- **SAFER** - Weekly Long Lengths of Stay reviews ongoing on both sites and Medical definitions of 'Expected Date of Discharge' under discussion, to improve engagement with discharge planning based on EDD.
- The **Winter Plan 19/20** for YFT & system partners mobilised on the 1st of December 2019 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 February 2020 was 82.5%.

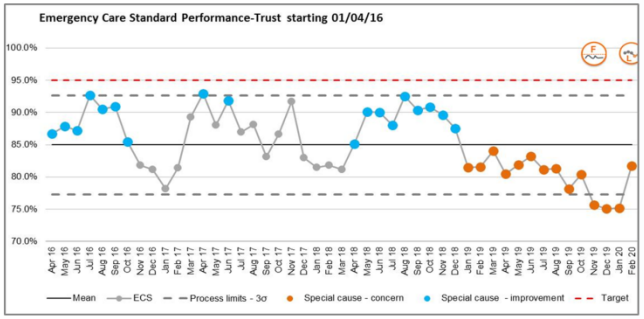
Consequence of under-achievement

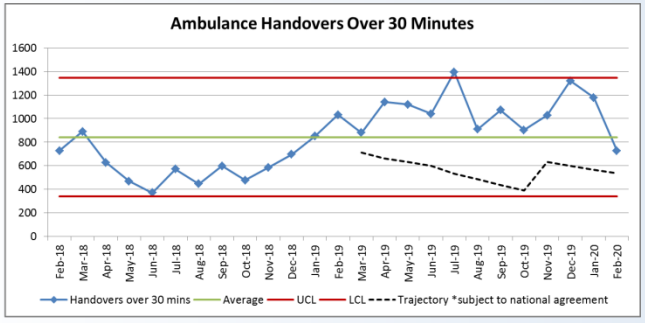
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

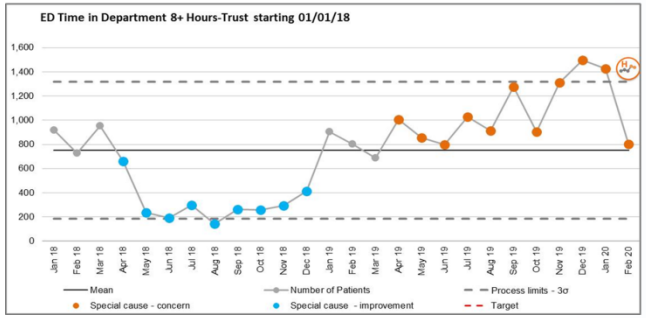
Performance Update:

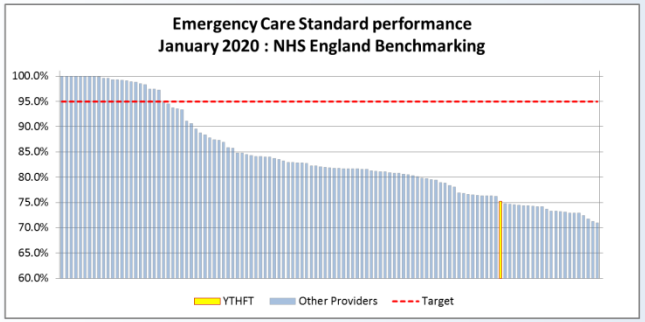
- The Trust achieved 81.7% in February 2020.
- Unplanned care demand continues to be challenging, with type 1, 2 and 3 attendances up 7% for the year to date on the same period in 2018/19. In total an extra 13,746 patients have attended the main EDs, UCCs and MIUs compared to the same period last year, with the main EDs (type 1) seeing and treating an additional 7,014 patients; a rise of 6%.
- Scarborough ED has been under significant pressure, up 9% year to date compared to 2018/19.
- The number of patients waiting over 8 hours fell to the lowest level this financial year; 801 compared to 1,428 in January.
- Four twelve-hour trolley breaches were reported in February 2020, all at Scarborough Hospital.
- The number of ambulances being delayed by over 30 minutes were below the two-year average for the first time in thirteen months.

Performance:









261

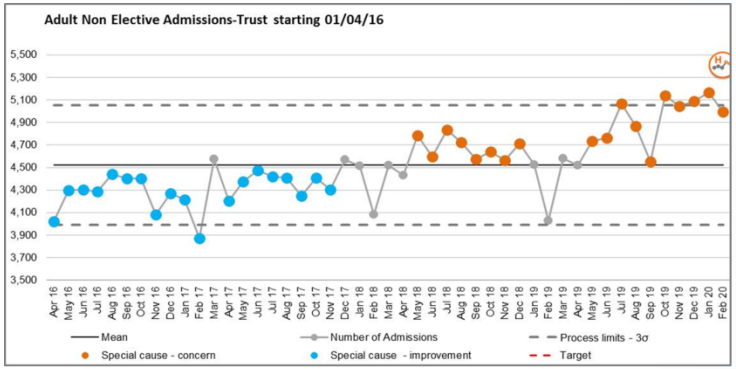
Assurance Framework Responsive

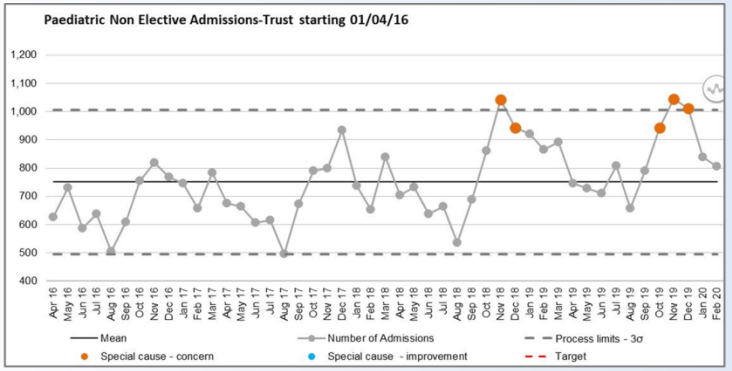
Unplanned Care

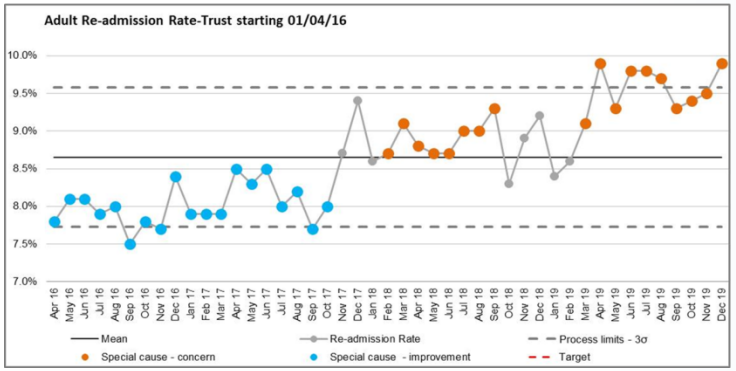
Performance Update:

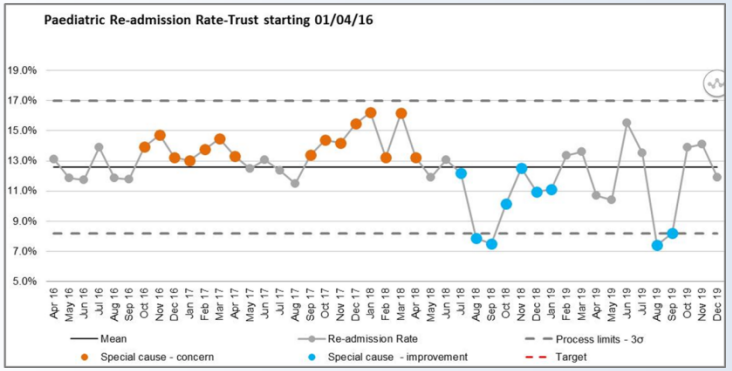
- The number of adult non-elective admissions for the year to date has increased by 7% in 2019/20 compared to 2018/19 (+3,536). For twenty of the past twenty-two months adult admissions have been above the four year average.
- Paediatric non-elective admissions have been above the four year average for the past four months and are 6% up YTD compared to 2018/19 (+492). The rise in paediatric admissions has been seen in children with respiratory conditions.

Performance:









Assurance Framework Responsive

Cancer Waiting Times

(Reported a month in arrears)

Operational Context

Overall, the Trust achieved 92.6% against the 14 day Fast Track referral from GP standard in January. National January performance is not available at the time of this report, the latest published figures for December saw the Trust outperform the national position (91.8%) for the third consecutive month.

The Trust continues to experience high numbers of Cancer Fast Track (FT) referrals, with a 5% increase in FT referrals (+846) received to the end of January compared to 2018/19. Due to this continued rise in referrals, the Trust is undertaking more urgent suspected 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 76.8% in January. National performance for December was 78.0% , the second time in the last 12 months that the Trust has not outperformed the national position (National January performance is not available at the time of this report). The Trust's performance equated to 142.5 accountable patients treated in January, with 33 accountable breaches (43 patients). The breaches were spread across a range of tumour pathways, with the highest number of breaches seen in Colorectal and Lung cancers. Of the reported patient breaches, 5% relate to delays for medical reasons, 51% due to delays to diagnostic tests or treatment plans/lack of capacity, 28% relate to complex or inconclusive diagnostics and 16% due to patient delay. Delays in sub-contracted histopathology during late 2019 especially in Skin is likely to impact 62 Day performance in February.

Progress towards the April 2020 target to diagnose patients within 28 days continues, with improving performance of 63.4% in January. Performance is currently being shadow reported with the target of 70% coming into force from April 2020.

Targeted actions

- **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.
- **Rapid Diagnostic Centre (RDC)** for patients with vague symptoms and Upper GI referrals. The Rapid Diagnostics Centre for Serious nonspecific symptoms is an early diagnosis initiative to support NHS England's national strategy for earlier and faster cancer diagnosis (28 day Faster Diagnosis Standard). It is envisaged patients coming through the new pathway will experience a rapid diagnostic one stop clinic approach involving a CT TAP and TNE scope and a results consultation all on the same day. A phased roll out of the new pathway and service has commenced across York and Scarborough and Ryedale with recent patients referred from general practice and diagnosed in secondary care between 3 and 5 days. Next step is phase 2 rollout to the York Priory Medical Group PCN, which involves 58,000 patients which commenced on the 9th March (all 9 practices).
- **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.

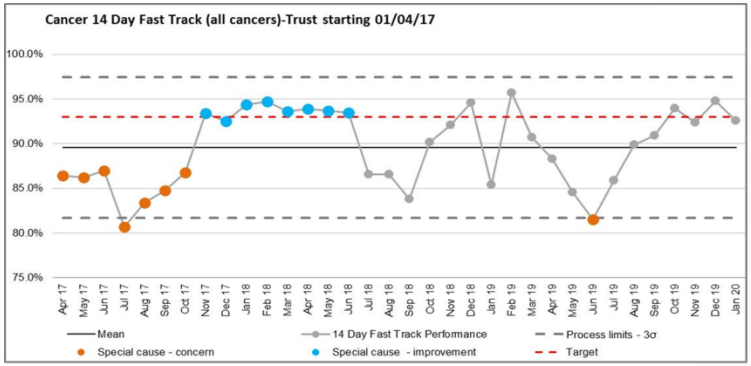
Consequence of under-achievement:

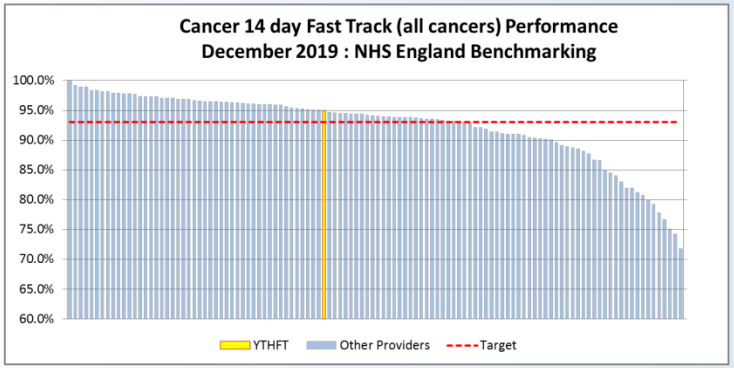
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

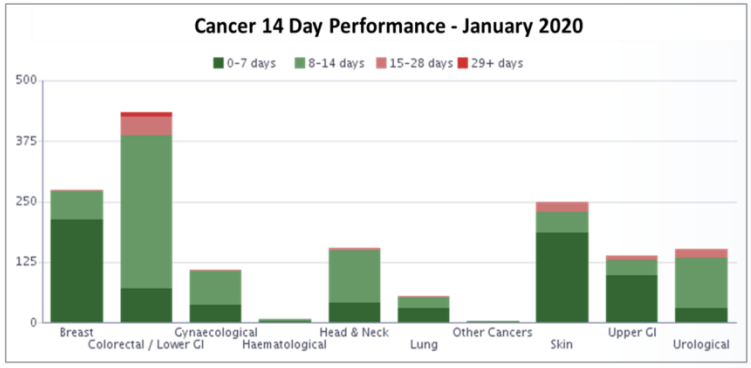
Performance Update:

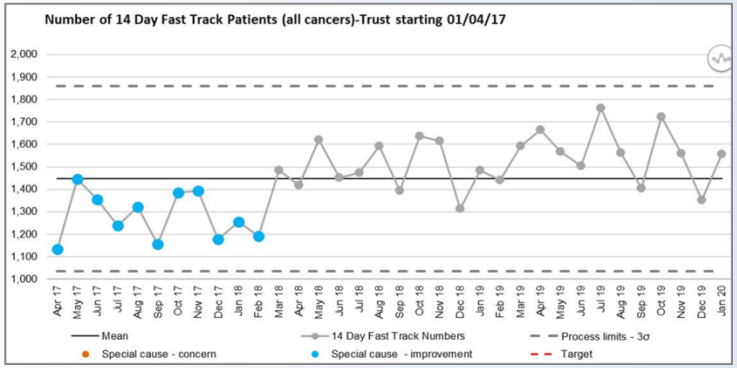
- Overall, the Trust achieved 92.6% against the 14 day Fast Track referral from GP standard in January.
- The Trust continues to experience high numbers of Cancer Fast Track (FT) referrals, with a 5% increase in FT referrals received April 2019 to January 2020 compared to 2018-19.

Performance:









264

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.

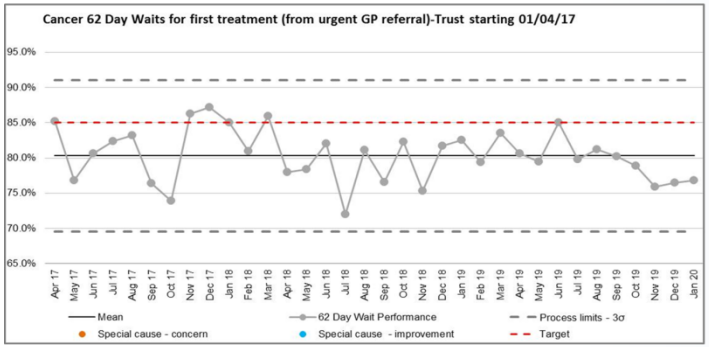
Consequence of under-achievement:

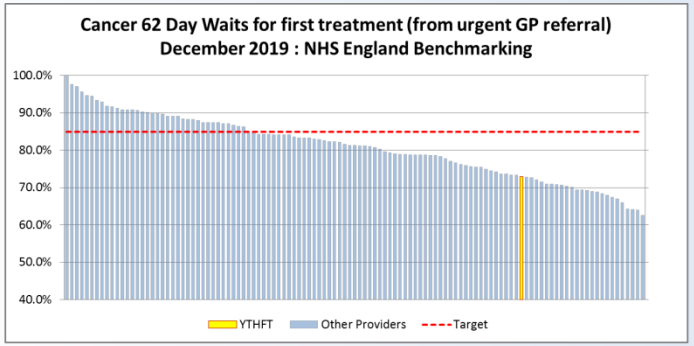
Patient experience, clinical outcomes and potential impact on timely access to treatment.

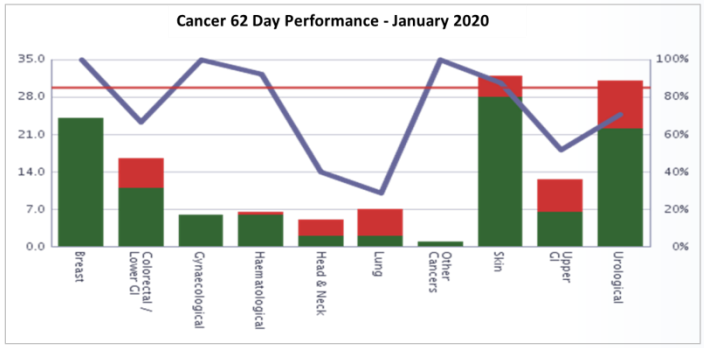
Performance Update:

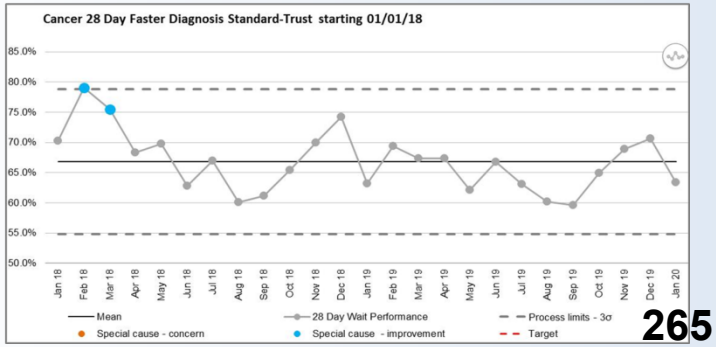
- Performance against the 62 day target from referral to treatment was 76.8% in January.
- The Trust's performance equated to 142.5 accountable patients treated in January, with 33 accountable breaches (43 patients). The breaches were spread across a range of tumour pathways, with the highest number of breaches seen in Colorectal, Lung and Urological cancers.
- Of the reported patient breaches, 5% relate to delays for medical reasons, 51% due to delays to diagnostic tests or treatment plans/lack of capacity, 28% relate to complex or inconclusive diagnostics and 16% due to patient delay.

Performance:









Assurance Framework Responsive

Planned Care

Operational Context

The provisional total incomplete Referral to Treatment (RTT) waiting list (TWL) stood at 29,534 at the end of February, down 49 clocks on the end of January position. This is above the target of 26,303 open clocks (March 2018 position) by the end of March 2020 and the trajectory of 28,558 submitted to NHS England and NHS Improvement.

GP referrals received by the Trust in February were below the four year average for the seventh time in the previous nine months month, the number received for the year to date is a 5% 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. Overall referrals from all sources are down by 0.4% (-943) compared to 2018-19.

Outpatient capacity has been impacted by the continuing delay in the opening of the Community Stadium, particularly affecting areas such as Ophthalmology and Sleep. It is now envisaged that the Trust will not be in a position to undertake patient activity at the Stadium until July 2020 at the earliest.

The Trust's provisional RTT position for February 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 110 (1%).

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 from Q2 2020-21, the Trust along with Commissioners are in dialogue with NHS England and NHS Improvement as to system requirements. At the end of February there were 3,866 patients waiting 26 weeks or over; a reduction of 51 on the end of January position. The number of long wait patients (those waiting more than 36 weeks) increased by 5 at the end of February. 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 February.

The Trust has seen a 5% improvement against the national 6 weeks diagnostic target in February, with performance of 86.1% against the standard of 99% (January 2020 – 81.1%). The latest published National performance for December was 95.8%. 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 Trust is working with the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services with a programme of work started 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.
- 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). This work will be completed by the end of March 2020.
- £209,700 additional monies secured from NHSE&I for Endoscopy and MRI. This is being used to tackle the endoscopy backlog and to maintain the low numbers of MRI waiters. This work will be completed by the end of March 2020.

Assurance Framework Responsive

18 Weeks Referral to Treatment

Standard(s):

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

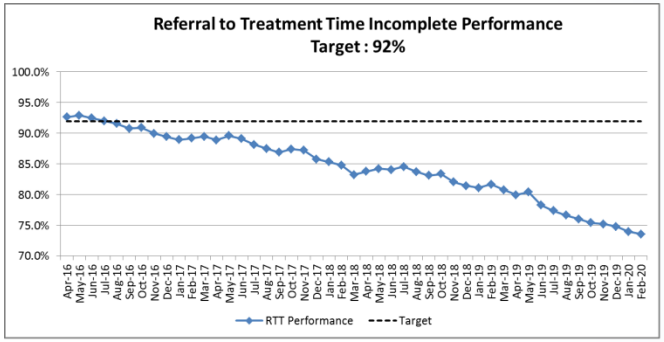
Consequence of under-achievement:

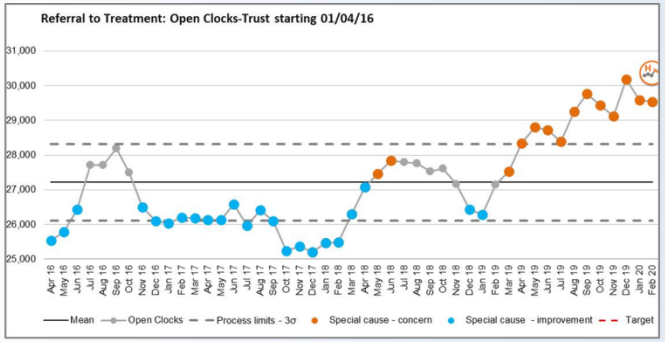
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

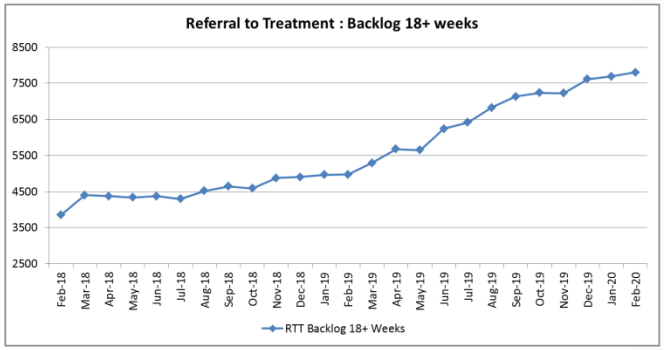
Performance Update:

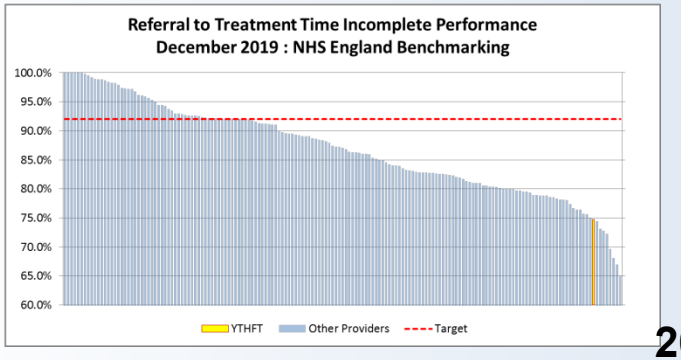
- The provisional total incomplete Referral to Treatment (RTT) waiting list (TWL) stood at 29,534 at the end of February, down 49 clocks on the end of January position.
- The Trust achieved 73.6% RTT at the end of February, below the 80.0% trajectory submitted to NHS England and NHS Improvement.
- The Trust's 'Did Not Attend/Was Not Brought' (DNA) rate decreased to 6% in February, performance has now remained below the two-year average for fourteen 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:









267

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.

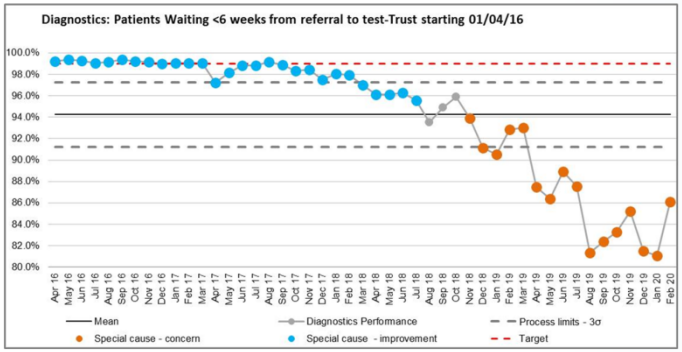
Consequence of under-achievement:

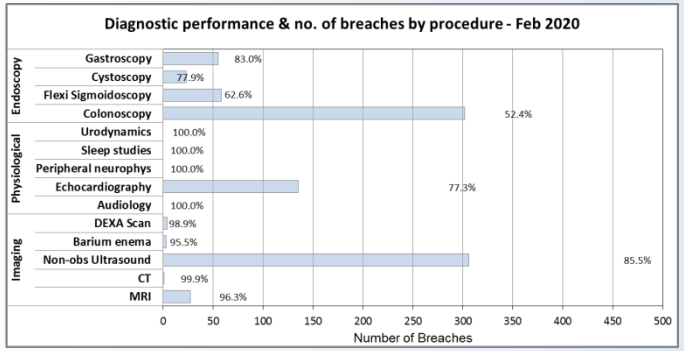
Patient experience, clinical outcomes, timely access to treatment and regulatory action.

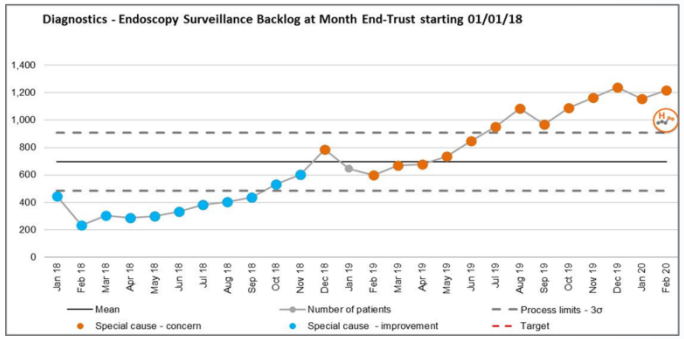
Performance Update:

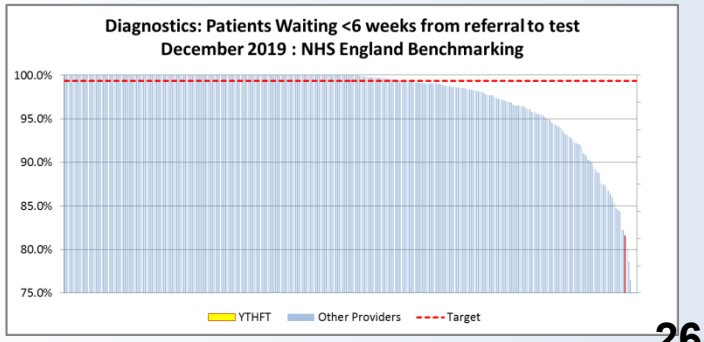
- The Trust has seen a 5% improvement against the national 6 weeks diagnostic target in February compared to January, with performance of 86.1% against the standard of 99%.
- Support from the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services. Programmes of work have been started; 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:









268

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 Outcome	Quarter 4 RAG & Risks
CCG1a: Antimicrobial Resistance; Urinary Tract Infections	James Taylor	Rachel Davidson	**Achieved**	**Achieved**	**Achieved**	**Green Project on track**
CCG1b: Antimicrobial Resistance; Colorectal Surgery	James Taylor	Michael Lim	**Achieved**	**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 Current performance 71%**	
CCG7: Three high impact actions to prevent Hospital Falls	Heather McNair	Rebecca Hoskins	**Achieved**	**Achieved**	**Amber – CCG response awaited**	**Amber – difficulties in capturing medication review element. Discussion with CCG ongoing.**
CCG9: Six Month Reviews for Stroke Survivors	Wendy Scott	Gemma Ellison	**Achieved**	**Achieved**	**Achieved**	**Amber – Latest Performance below trajectory Q3 Performance 36% against Q4 target of 55%**
CCG11: Same Day Emergency Care; Pulmonary Embolus, Tachycardia with Atrial Fibrillation and Community Acquired Pneumonia	Wendy Scott	David Thomas and Gemma Ellison	**Achieved**	**Achieved**	**Achieved**	**Green Project on track**
PSS3: Cystic Fibrosis Supporting Self-Management	Wendy Scott	Eleanor King	**Achieved**	**Achieved**	**Achieved**	**Green Project on track**

Finance Performance Report

February 2020

Produced March 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

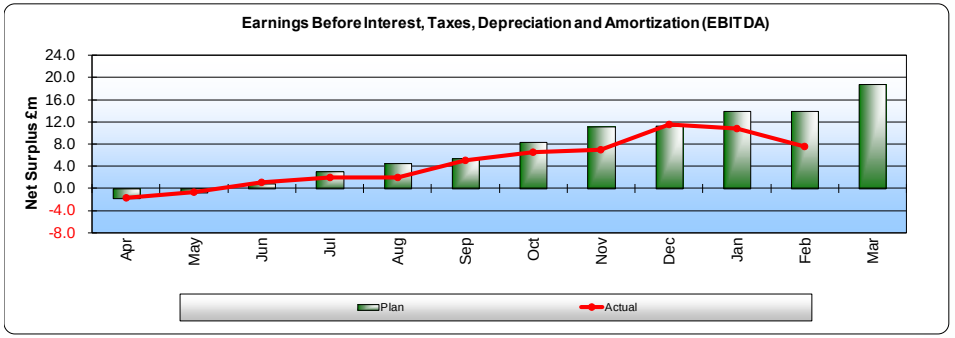
To ensure financial stability

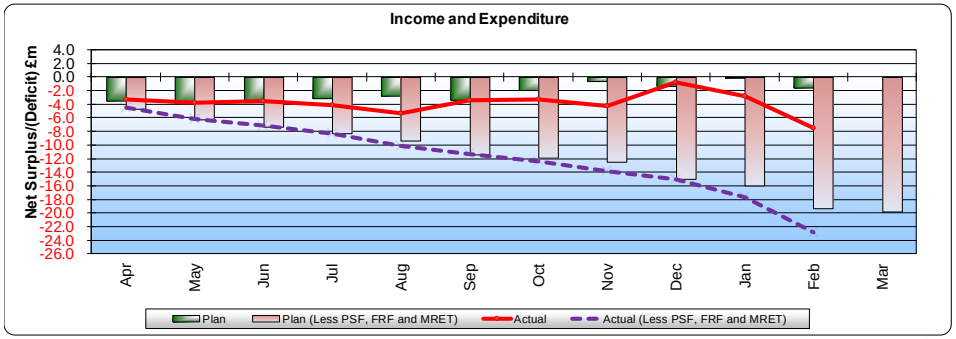
Summary Income and Expenditure Position
Month 11 - The Period 1st April 2019 to 29th February 2020

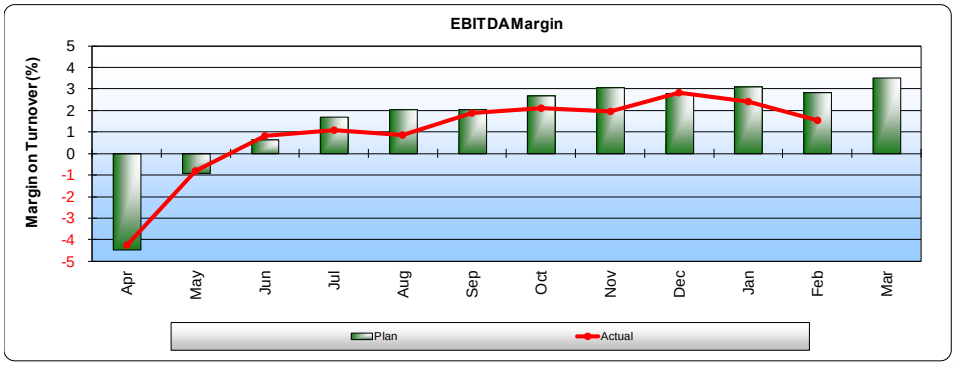
NHS
York Teaching Hospital
NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £7.4m, placing it £5.9m behind the operational plan.
* Income is £2m behind plan, with NHS clinical income being £2m behind plan.
* Operational expenditure is £4.3m ahead of the operational plan, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £7.5m (1.5%) compared to plan of £13.9m (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	23,444	23,156	-288	24,138	-467
Planned same day (Day cases)	40,791	38,798	37,973	-825	40,161	-630
Non-Elective Income	140,704	128,542	128,395	-147	141,110	406
Outpatients	64,943	60,283	58,359	-1,924	62,922	-2,021
A&E	20,491	18,784	18,911	127	20,703	212
Community	20,169	18,488	18,492	4	20,173	4
Other	108,018	99,482	100,209	727	107,724	-294
Pass-through excluded drugs expenditure	44,685	41,205	41,571	366	45,586	901
	464,406	**429,027**	**427,066**	**-1,961**	**462,517**	**-1,889**
Non-NHS Clinical Income						
Private Patient Income	1,105	1,012	1,085	72	1,218	113
Other Non-protected Clinical Income	1,863	1,721	1,854	133	2,033	169
	2,968	**2,733**	**2,938**	**205**	**3,250**	**282**
Other Income						
Education & Training	17,365	15,918	17,772	1,853	19,043	1,678
Research & Development	2,425	2,223	2,972	750	3,230	806
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	623	571	537	-34	577	-46
Other Income	27,460	24,886	24,580	-306	24,460	-400
PSF, FRF and MRET	19,814	17,720	15,178	-2,542	15,716	-4,098
	67,686	**61,318**	**61,039**	**-279**	**65,627**	**-2,059**
Total Income	**535,060**	**493,078**	**491,043**	**-2,035**	**531,394**	**-3,666**
Expenditure						
Pay costs	-358,381	-329,743	-334,012	-4,270	-363,955	-5,573
Pass-through excluded drugs expenditure	-44,685	-41,205	-41,837	-632	-45,586	-901
PbR Drugs	-8,907	-8,282	-8,327	-45	-8,081	826
Clinical Supplies & Services	-52,020	-48,048	-46,133	1,915	-48,091	3,930
Other costs (excluding Depreciation)	-54,267	-50,986	-53,150	-2,164	-57,230	-2,963
Restructuring Costs	0	0	0	0	0	0
CIP	349	-939	0	939	0	-349
Total Expenditure	**-517,912**	**-479,202**	**-483,459**	**-4,256**	**-522,943**	**-5,031**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**17,149**	**13,875**	**7,584**	**-6,291**	**8,452**	**-8,697**
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	-9,167	-8,800	367	-9,600	400
Depreciation - donated/granted assets	-400	-367	-367	0	-400	0
Interest Receivable/ Payable	130	119	175	56	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	-858	-861	-3	-926	10
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	0	0	-19	-19
PDC Dividend	-5,641	-5,171	-5,171	0	-5,641	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**2**	**-1,568**	**-7,439**	**-5,871**	**-8,227**	**-8,228**

271

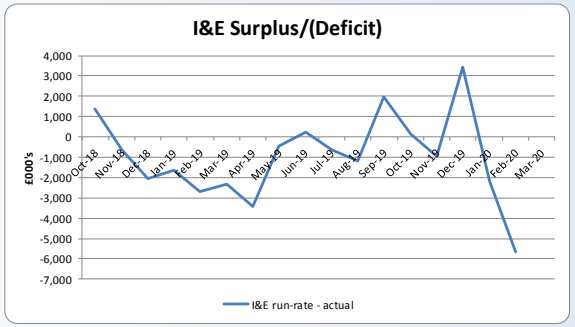
Summary Trust Run Rate Analysis

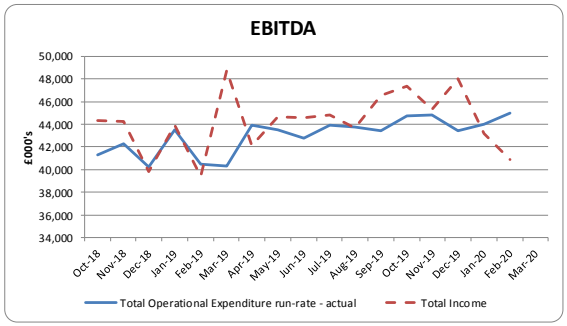
Month 11 - The Period 1st April 2019 to 29th February 2020

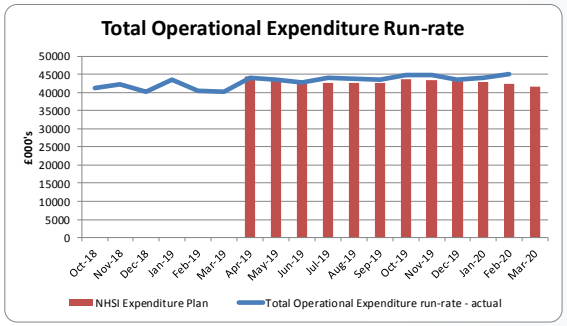
Key Messages:

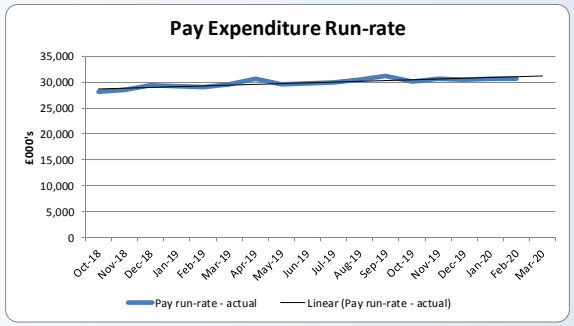
* The total operational expenditure in February was £45.0m. The average total operational expenditure in the previous sixteen months was £42.9m. Resulting in an adverse variance of £2.1m.

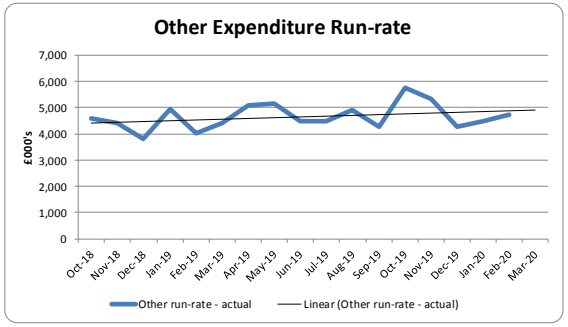
* In month operational expenditure exceeded income by £4.1m, resulting in a negative EBITDA for the month.

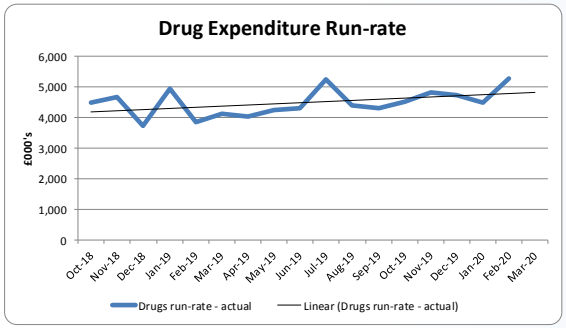


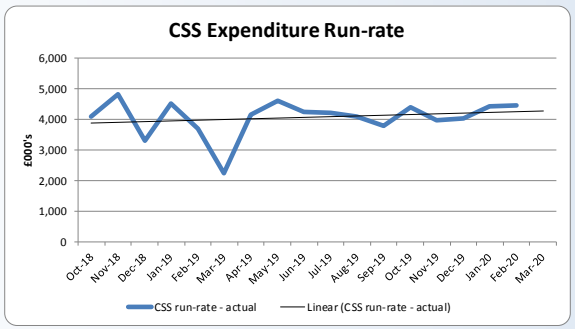












	Monthly Spend																	Monthly Ave	Variance
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		
Total Income	44,347	44,277	39,808	43,908	39,422	48,743	42,117	44,632	44,555	44,837	43,700	46,556	47,330	45,327	47,985	43,205	40,871	0	44,422	-3,551
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	-30,655	-30,567	0	-29,823	-744
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	-4,469	-5,260	0	-4,414	-846
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	-4,425	-4,454	0	-4,026	-428
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	-4,483	-4,737	0	-4,649	-88
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	-827	-4,147	0	1,511	-5,658

Contract Performance

Month 11 - The Period 1st April 2019 to 29th February 2020

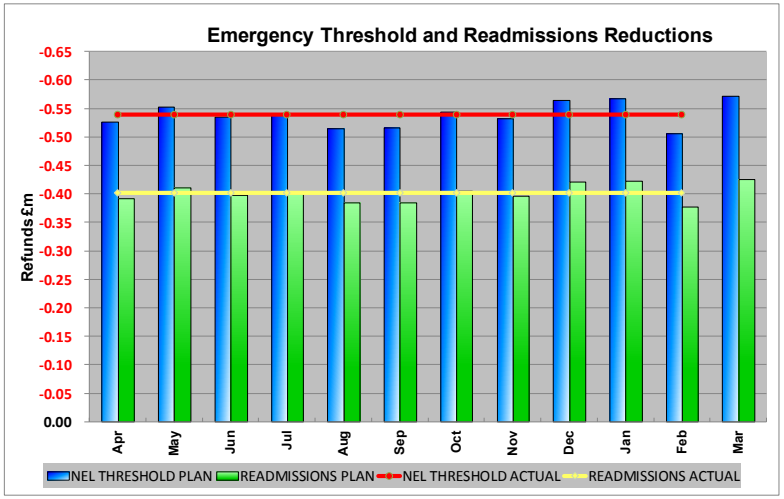
York Teaching Hospital NHS Foundation Trust

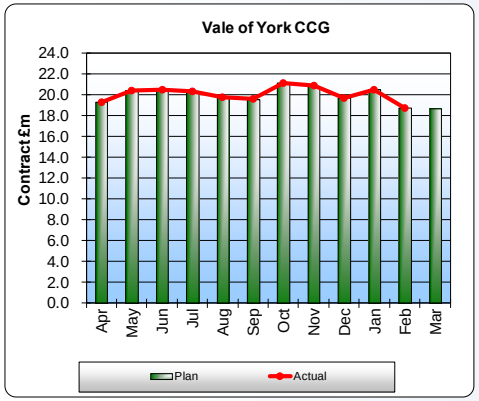
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	239,634	220,949	220,949	0
Scarborough & Ryedale CCG	84,719	79,414	79,414	0
East Riding CCG	47,538	43,615	43,615	0
Other Contracted CCGs	18,675	17,075	17,148	73
NHSE - Specialised Commissioning	47,216	43,128	42,382	-746
NHSE - Direct Commissioning	15,115	13,775	12,738	-1,037
Local Authorities	4,347	3,985	3,986	1
Total NHS Contract Clinical Income	**457,244**	**421,941**	**420,232**	**-1,709**

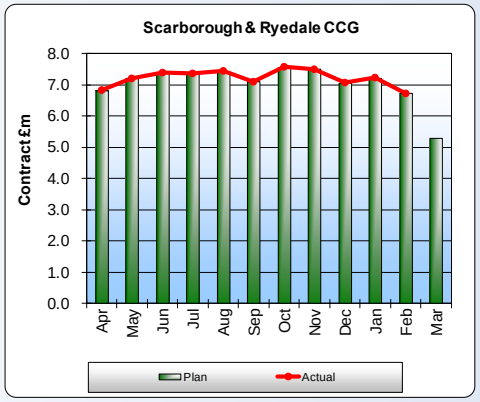
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	5,932	5,958	6,834	876
Risk Income	1,230	1,128	0	-1,128
Total Other NHS Clinical Income	**7,162**	**7,086**	**6,834**	**-252**

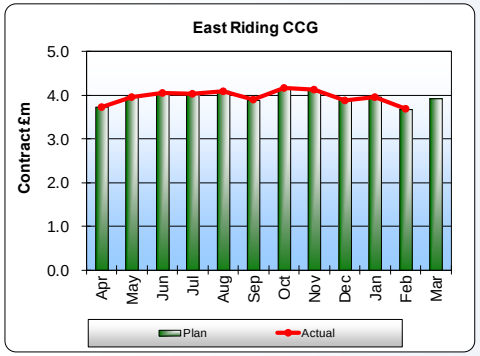
Total NHS Clinical Income	**464,406**	**429,027**	**427,066**	**-1,961**

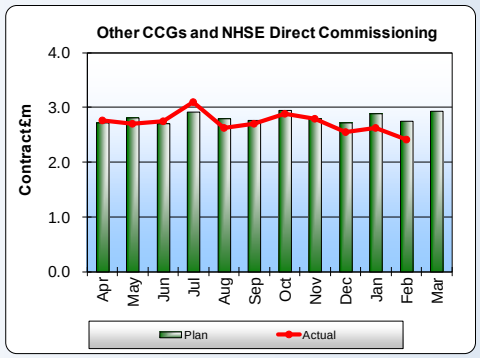
Activity data for February is partially coded (59%) and January data is 94% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

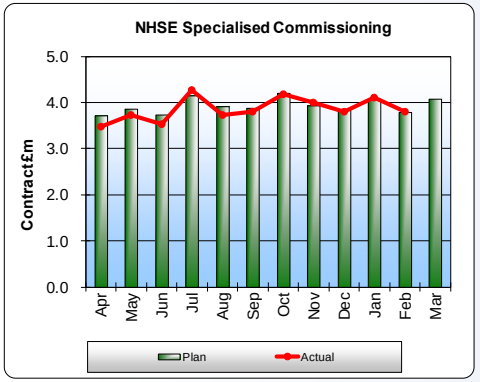


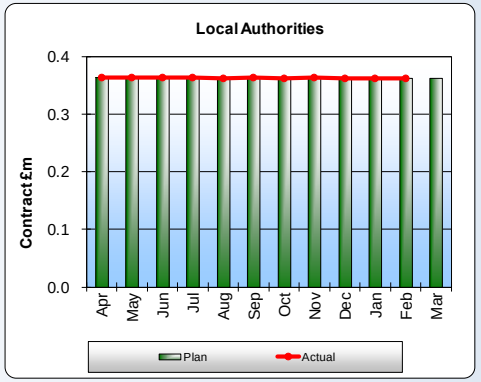












273

Agency Expenditure Analysis

Month 11 - The Period 1st April 2019 to 29th February 2020

York Teaching Hospital NHS Foundation Trust

Key Messages:

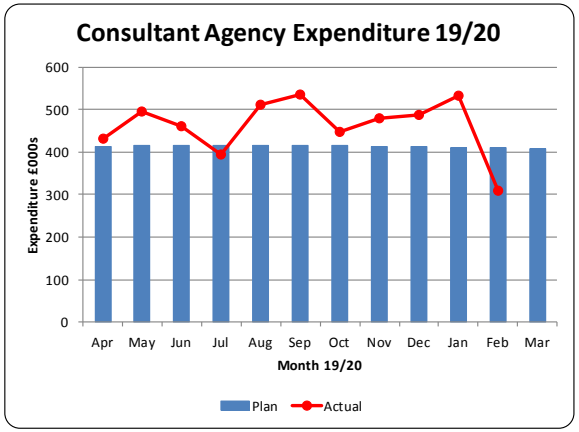
* Total agency spend year to date of £18.6m, compared to the NHSI agency ceiling of £14m.

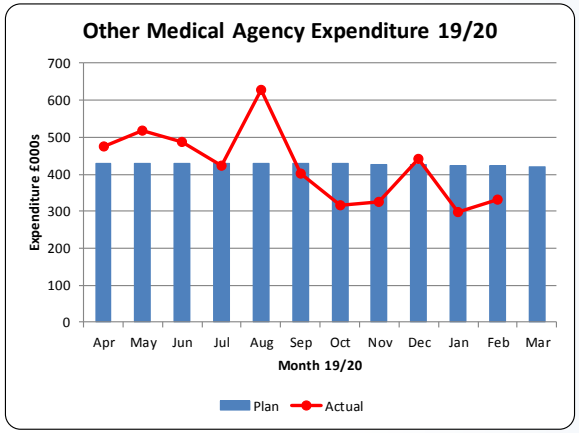
* Consultant Agency spend is £0.5m ahead of plan.

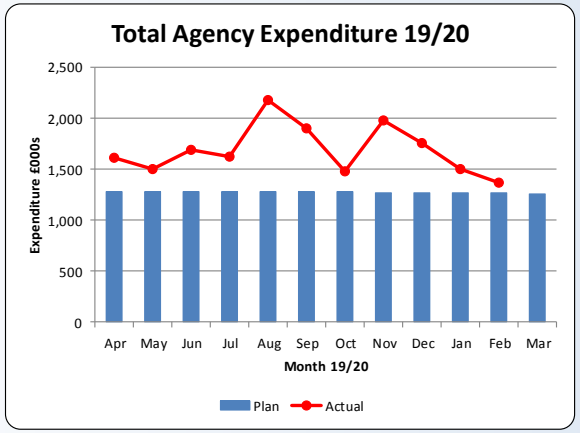
* Nursing Agency is £4.1m ahead of plan.

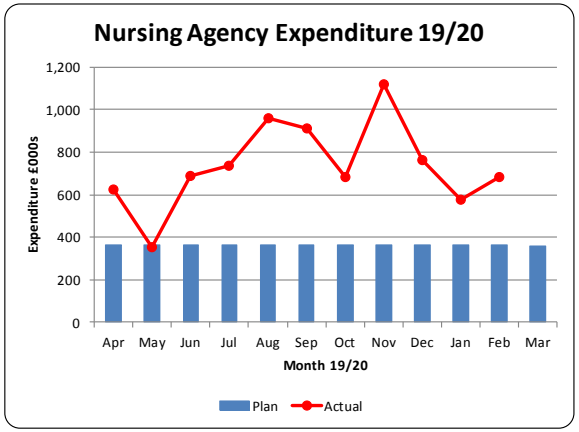
* Other Medical Agency spend is on plan.

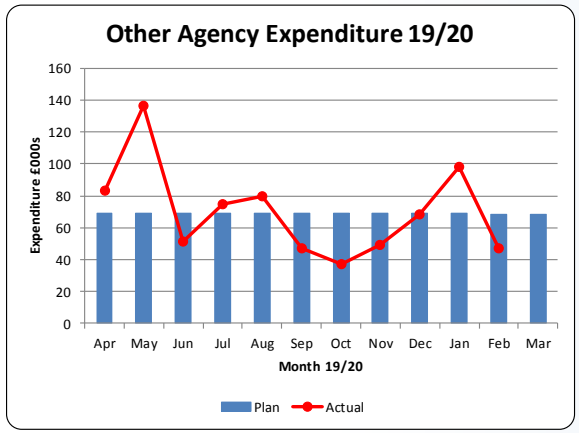
* Other Agency spend is broadly on plan.

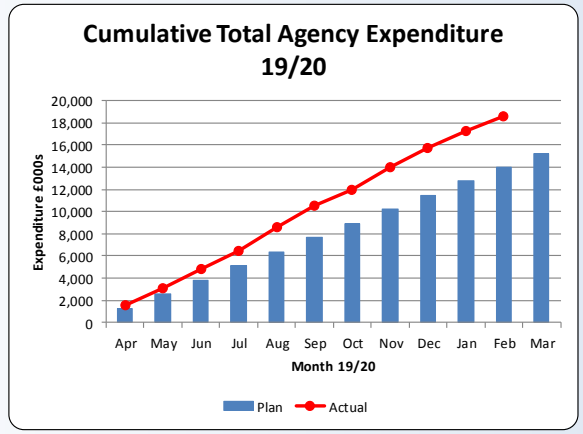












274

Expenditure Analysis

Month 11 - The Period 1st April 2019 to 29th February 2020

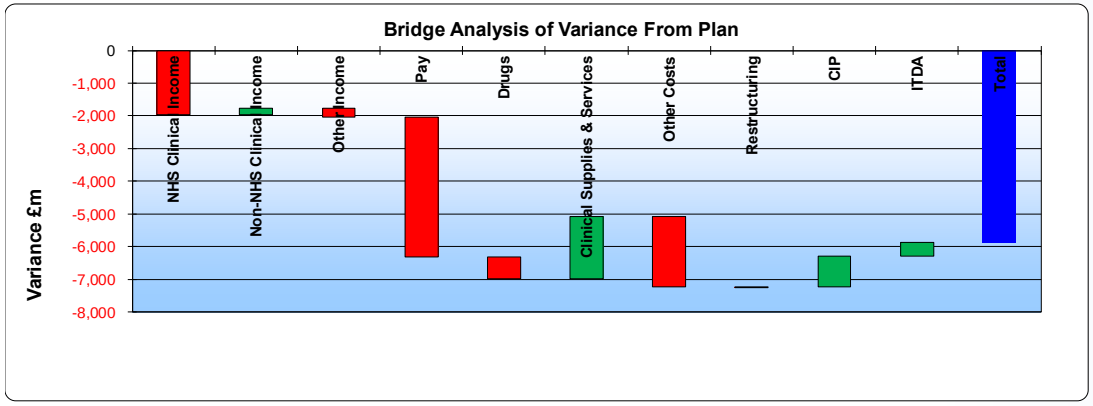
York Teaching Hospital NHS Foundation Trust

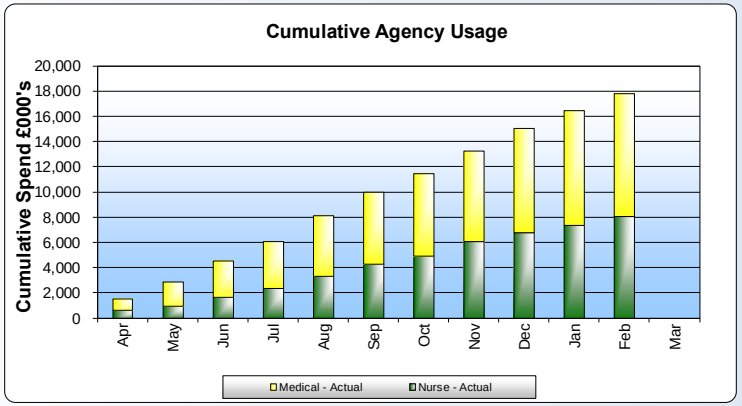
Key Messages:

There is an adverse expenditure variance of £4.3m at the end of February 2020. This comprises:

* Pay expenditure is £4.3m ahead of plan.
* Drugs expenditure is £0.7m ahead of plan.
* CIP achievement is £0.9m 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	62,528	57,196	50,418	0	1,280	0	5,084	56,782	414	0	
Medical and Dental	36,197	33,120	36,706	0	216	0	4,641	41,563	-8,443	0	
Nursing	93,492	85,794	73,501	482	147	11,107	8,080	93,317	-7,523	0	
Healthcare Scientists	11,694	10,728	11,367	20	18	17	140	11,563	-834	0	
Scientific, Therapeutic and technical	16,479	15,091	14,304	73	5	34	50	14,467	624	0	
Allied Health Professionals	24,615	22,519	21,362	184	224	0	77	21,848	671	0	
HCAs and Support Staff	50,073	45,910	42,579	756	71	47	375	43,828	2,082	0	
Chairman and Non Executives	198	181	167	0	0	0	0	167	14	0	
Exec Board and Senior managers	15,194	13,904	13,000	7	0	0	0	13,007	897	0	
Admin & Clerical	40,489	37,127	36,022	8	1	0	128	36,160	968	0	
Pay Reserves	6,231	7,080	0	0	0	0	0	0	7,080	0	
Apprenticeship Levy	1,192	1,093	1,312	0	0	0	0	1,312	-219	0	
TOTAL	**358,381**	**329,743**	**300,738**	**1,530**	**1,963**	**11,206**	**18,576**	**334,012**	**-4,270**	**0**	





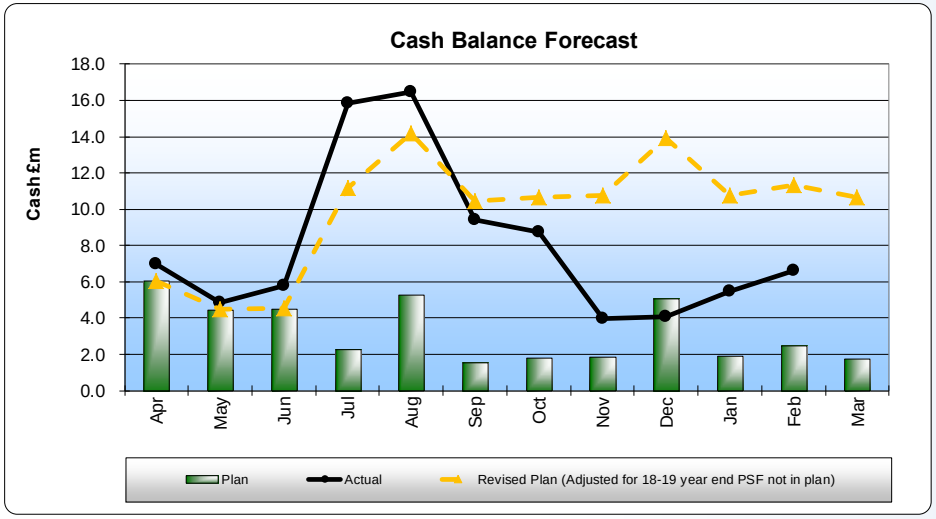
Cash Flow Management

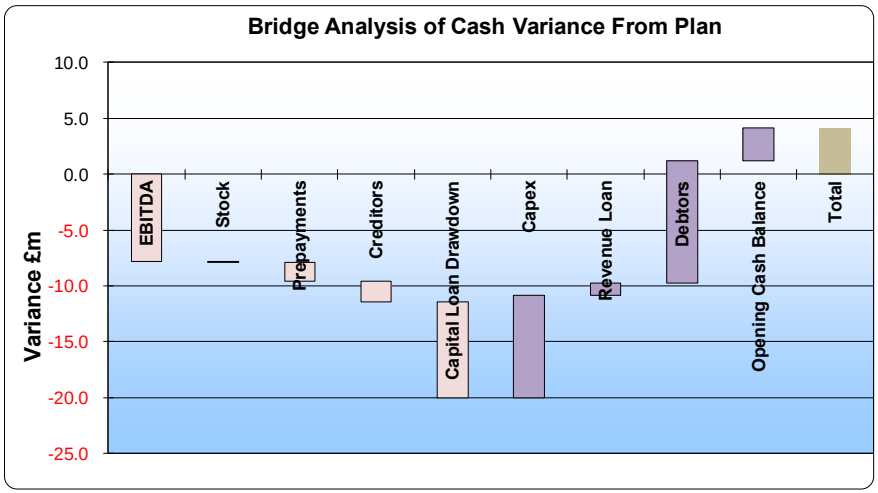
Month 11 - The Period 1st April 2019 to 29th February 2020

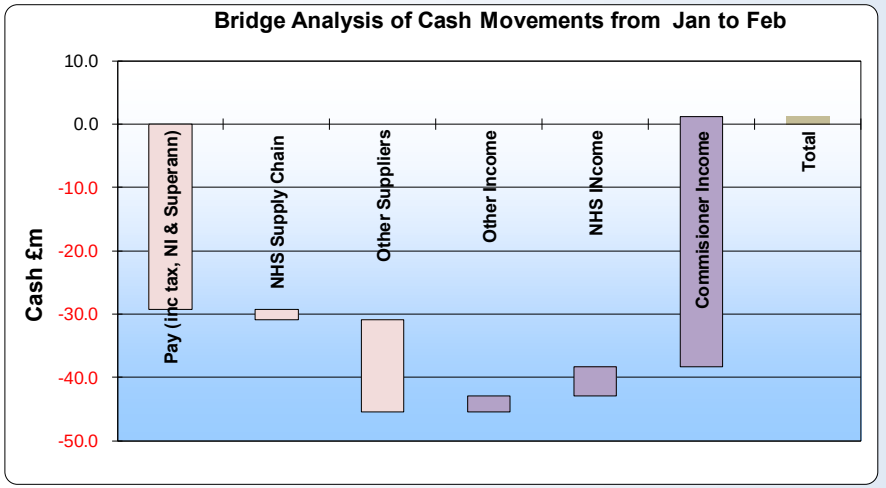
York Teaching Hospital NHS Foundation Trust

Key Messages

* The cash position at the end of February was £6.6m, which is £4.5m below the revised profile following receipt of the extra PSF in connection with 18-19.
* This is mainly due to the £6.3m deficit negative variance from plan but is offset with debtors remaining positively £2.6m below plan.
* The remaining movement is due to the timing of other working capital movements.







276

Cash Flow Management

Month 11 - The Period 1st April 2019 to 29th February 2020

York Teaching Hospital NHS Foundation Trust

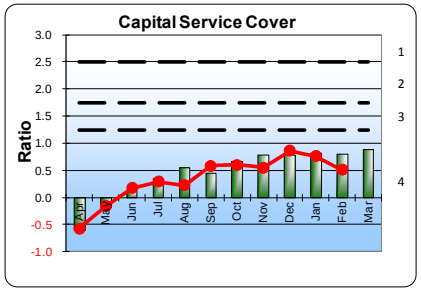
Key Messages:

* The receivables balance at the end of February was £8.4m, which is below plan.
* The payables balance at the end of February was £14m, which is slightly below plan.
* The Use of Resources Rating is assessed is a score of 4 in February, and is reflective of the I&E position.

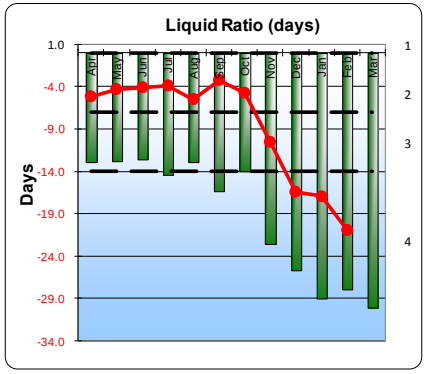
Significant Aged Debtors (Invoices Over 90 Days)

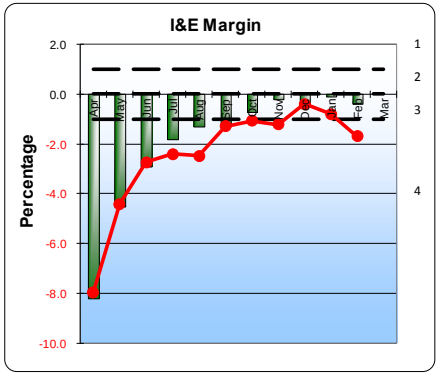
Harrogate & District NHS Foundation Trust	**£452K**
Vocare	**£411K**
Hull University Teaching Hospitals NHS Trust	**£410K**
Tees, Esk And Wear Valleys NHS Foundation Trust	**£394K**
Humber NHS Foundation Trust	**£335K**
NHS Property Services	**£257K**

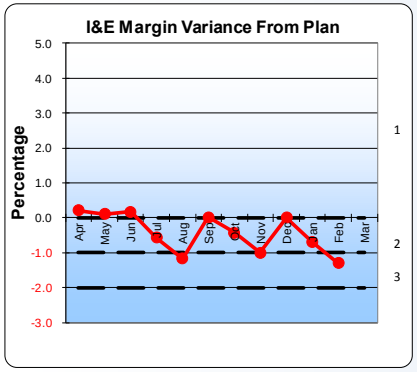
	Current	1-30 days	31-60 days	Over 60 days	Total
	£m	£m	£m	£m	£m
Payables	5.41	2.81	1.13	4.64	13.98
Receivables	2.66	1.00	0.94	3.79	8.39

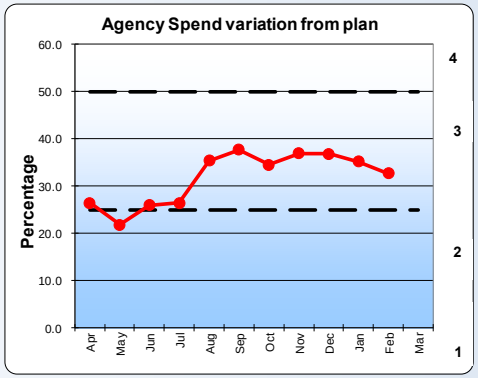


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Capital Service Cover (20%)	4	4	4	4
Liquidity (20%)	4	4	4	4
I&E Margin (20%)	2	3	4	4
I&E Margin Variance From Plan (20%)	1	1	3	3
Agency variation from Plan (20%)	1	1	3	3
Overall Use of Resources Rating	**3**	**3**	**4**	**4**









277

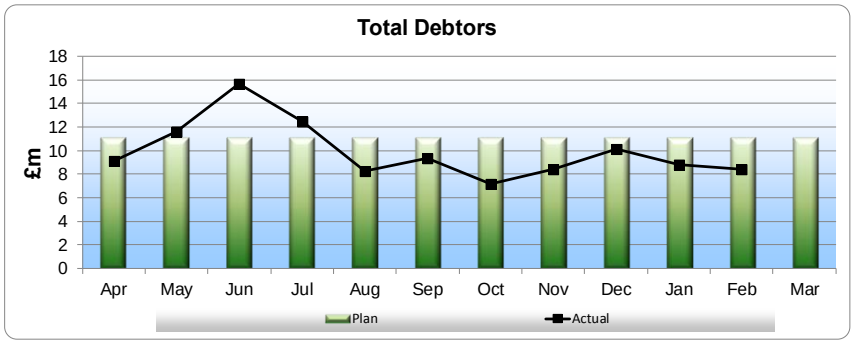
Debtor Analysis

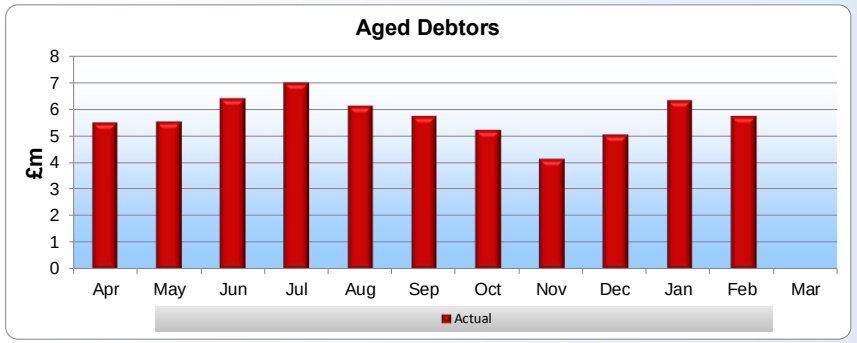
Month 11 - The Period 1st April 2019 to 29th February 2020

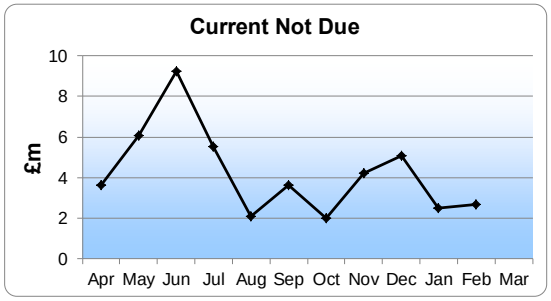
York Teaching Hospital NHS Foundation Trust

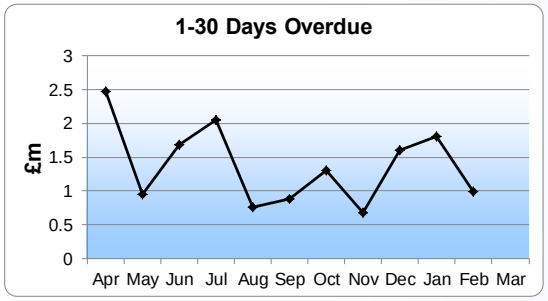
Key Messages

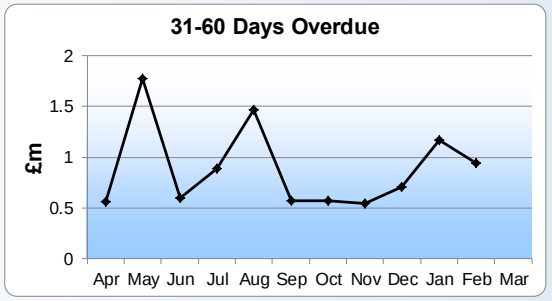
* At the end of February the total debtor balance was £8.5m, which is below plan, mainly due to increased focus on cash collection.
* £2.7m of the total debtor balance relates to 'current' invoices not due for payment. Aged debt totalled £5.7m.
* Aged debt has decreased from the January position by £0.5m and £0.3m less than the prior year comparator for February.
* Long term debtors (Over 90 Days) have increased slightly on the January position by £0.3m and continues to be a focus area for the Trust.
* Accrued income remaing below plan, mainly linked to reduction in Q4 PSF and a continued focus ensuring that invoices are raised in a timely manner to maintain cash flow.

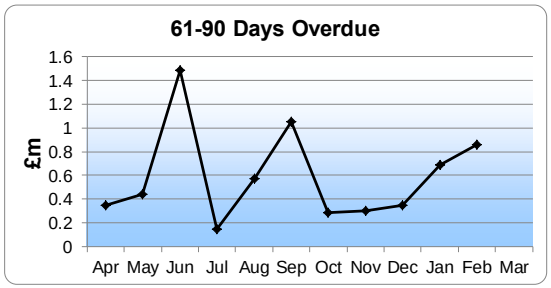


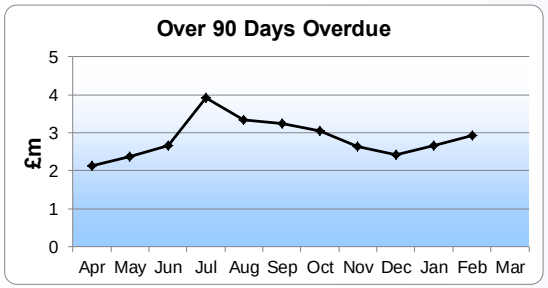


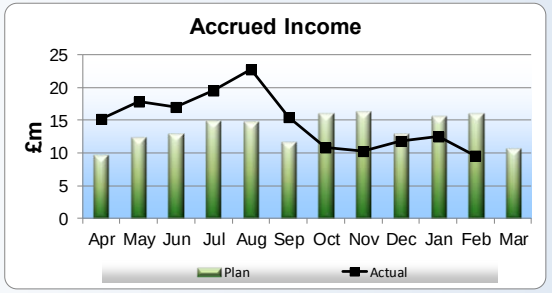












278

Capital Programme
Month 11 - The Period 1st April 2019 to 29th February 2020

York Teaching Hospital NHS Foundation Trust

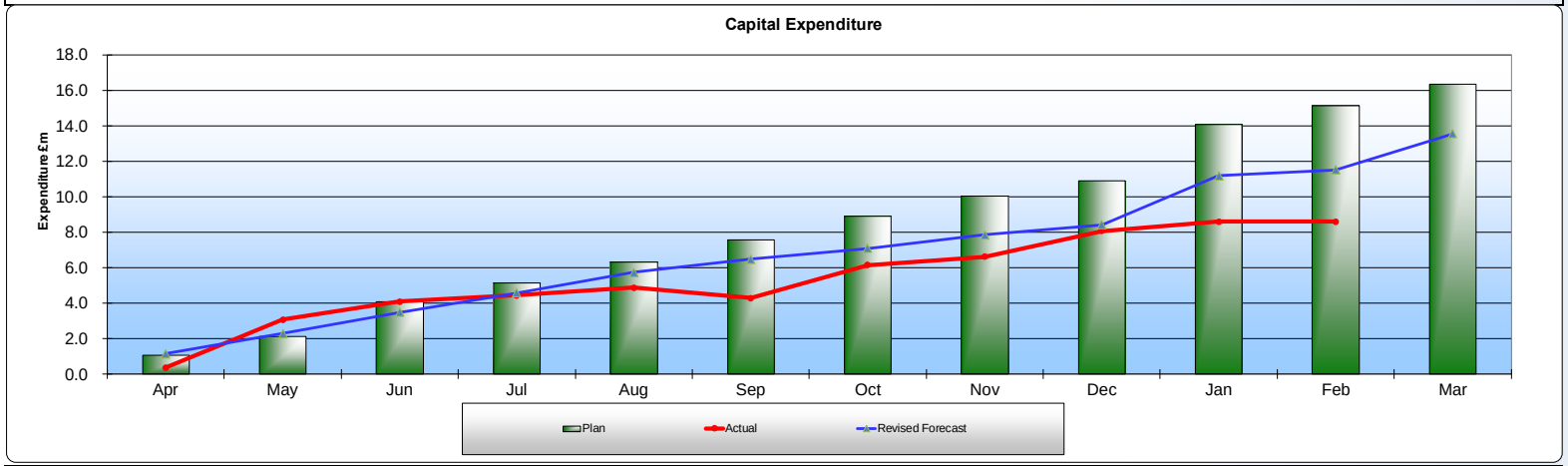
Key Messages:

* The original NHSE&I plan submitted in April showed a capital programme of £22.15m, at the request of NHSE&I this was resubmitted to a reduced figure of £16.360m in July, with a revised forecast outturn of £13.54m notified to NHSE&I in Jan 20

* 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	2019-20 Plan as per NHSE&I	Revised in-year Expenditure	Year-to-date Expenditure	Year to date Forecast Expenditure	Variance Forecast v Actual	Comments
	£000	£000	£000	£000	£000	
Community Stadium	2,201	1,845	44	1,845	1,801	
York Electrical Infrastructure	1,415	500	29	300	271	
Fire Alarm System SGH	820	820	600	820	220	
Other Capital Schemes	700	1,563	-18	103	121	
SGH Estates Backlog Maintenance	1,014	800	918	800	- 118	
York Estates Backlog Maintenance - York	1,013	800	294	800	506	
Cardiac/VIU Extention	1,585	700	753	600	- 153	
Medical Equipment	200	580	737	905	168	
SNS Capital Programme	1,800	1,450	1,276	1,500	224	
Capital Programme Management	1,055	1,320	1,473	1,106	- 367	
Endoscopy Development	3,000	2,408	1,882	2,145	263	
Charitable funded schemes	624	577	513	572	59	
Wave 4 STP Fees	933	180	86	0	- 86	
Slippage	0	0	0	0	-	
TOTAL CAPITAL PROGRAMME	**16,360**	**13,543**	**8,587**	**11,496**	**2,909**	

This Years Capital Programme Funding is made up of:-	Total Approved Funding	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£000	£000	£000	£000		
Depreciation	11,400	8,673	4,819	6,974	2,155	
In Year Loan Repayments	-3,047	0	0	0	0	
Loan Funding	6,000	3,913	2,969	3,750	781	
Charitable Funding	624	577	513	572	59	
Finance Lease funding	450	0	0	0	0	
PDC funding	933	380	286	200	-86	
TOTAL FUNDING	**16,360**	**13,543**	**8,587**	**11,496**	**2,909**	

Key Messages:

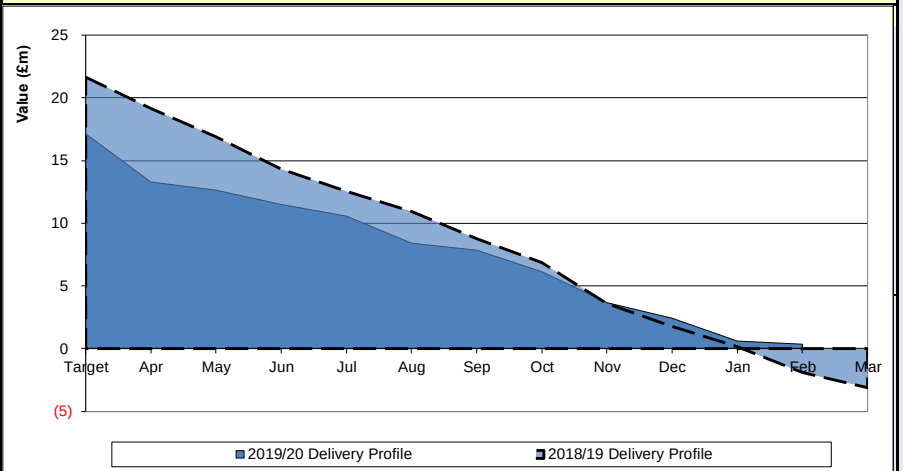
* Delivery - £16.8m has been delivered against the Trust annual target of £17.1m, giving a gap of £0.3m.
* Part year NHSI variance - The part year NHSI variance is £0.7m.
* Four year planning - The four year planning surplus is £1.0m.
* Recurrent delivery is £9.8m in-year, which is 57% of the 2019/20 CIP target.

Efficiency - Total CIP

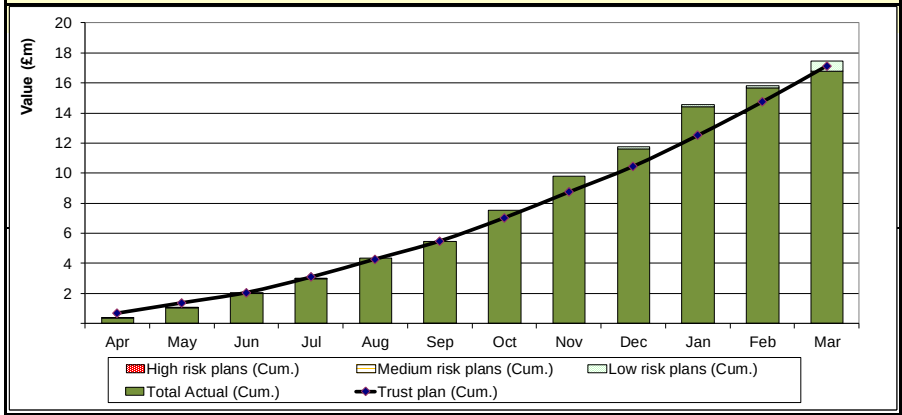
Executive Summary

	£m
2019/20 CIP Target	**£17.1**
In Year Delivery	
NHSI YTD Target at Month 11	£14.7
Actual Delivery at Month 11	£15.7
NHSI Variance Month 11	**£0.9**
Recurrent Delivery	£9.8
Non Recurrent Delivery	£7.0
Total Delivery	**£16.8**
In Year (Gap)/Surplus to Delivery	**-£0.3**
In Year Planning	
Forecasted Delivery	£17.3
Forecasted Planning (Gap)/Surplus	**£0.2**
Long Term Planning	
4 Year CIP Target (19/20 to 22/23)	**£42.8**
4 Year Plans	£43.8
4 Year Planning (Gap)/Surplus	**£1.0**

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	390
Total Number of Assessed Schemes - Directorate	243
Total Number of Assessed Schemes - Signed Off	229

Probability/ Likelihood	Negligable - None				Catastrophic/death
Almost Certain	0		1		
	0				
	0	4	2		
	4	4	2		
Rare	198	25	3	0	

Consequence/Severity

Key Messages:
* Transactional CIP schemes represent £14.1m of the £17.1m Efficiency Target.
* Total delivery at Month 11 is £14.2m of which £7.9m is recurrent.

Efficiency - Transactional CIP

Executive Summary

	£m
2019/20 Transactional CIP Target	**£14.1**
In Year Delivery	
NHSI YTD Target at Month 11	£11.9
Actual Delivery at Month 11	£13.3
NHSI Variance Month 11	**£1.3**
Recurrent Delivery	£7.9
Non Recurrent Delivery	£6.3
Total Delivery	**£14.2**
In Year (Gap)/Surplus to Delivery	**£0.1**
In Year Planning	
Forecasted Delivery	£14.3
Forecasted Planning (Gap)/Surplus	**£0.2**
Long Term Planning	
4 Year Transactional CIP Target (19/20 to 22/23)	**£36.3**
4 Year Plans	£37.3
4 Year Planning (Gap)/Surplus	**£1.0**

Governance Risk Heat Map

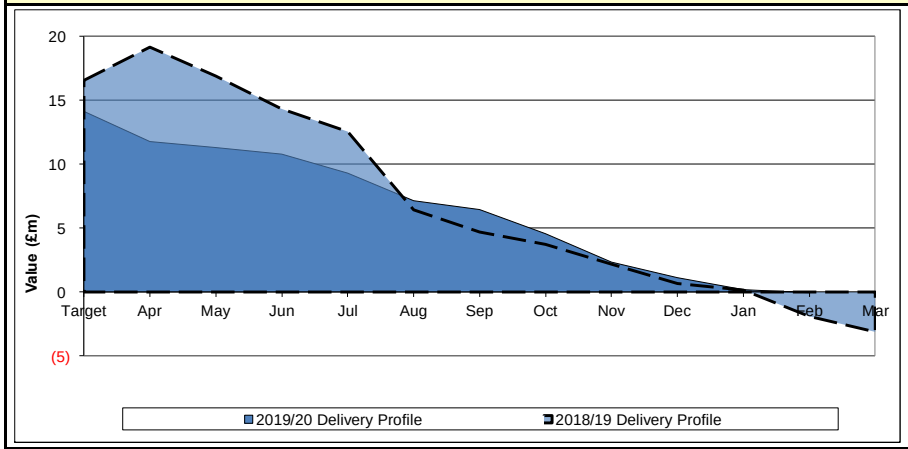
Total Number of Schemes	360
Total Number of Assessed Schemes - Directorate	215
Total Number of Assessed Schemes - Signed Off	208

Probability/ Likelihood	Negligable - None				Catastrophic/death
Almost Certain	0	0	1	0	0
	0	0	0	0	0
	0	1	0	0	0
	4	3	1	0	0
Rare	179	23	3	0	0

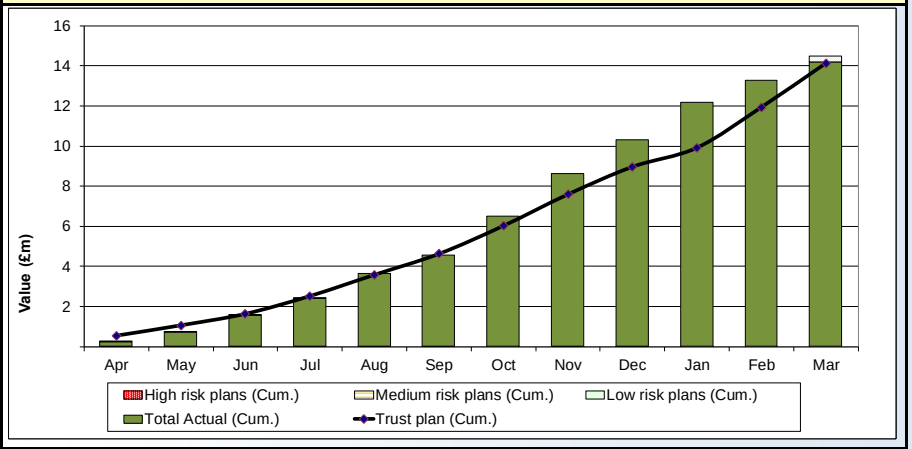
Consequence/Severity

Moderate Risk Plans:

Gap to delivery - 2019/20



In Year CIP Delivery and Future Plans by Risk



Key Messages:

* 5 Transformational schemes represent £3m of the £17.1m Efficiency Target.
* Delivery at Month 11 is £2.6m, of which £1.8m is recurrent.

Efficiency - Transformation Programme

Executive Summary

	£m
2019/20 Transformation CIP Target	**£3.0**
In Year Delivery	
NHSI YTD Target at Month 11	£2.8
Actual Delivery at Month 11	£2.4
NHSI Variance Month 11	**-£0.4**
Recurrent Delivery	£1.8
Non Recurrent Delivery	£0.7
Total Delivery	**£2.6**
In Year (Gap)/Surplus to Delivery	**-£0.4**
In Year Planning	
Forecasted Delivery	£3.0
Forecasted Planning (Gap)/Surplus	**£0.0**
Long Term Planning	
4 Year Transformation CIP Target	**£6.5**
4 Year Plans	£6.5
4 Year Planning (Gap)/Surplus	**£0.0**

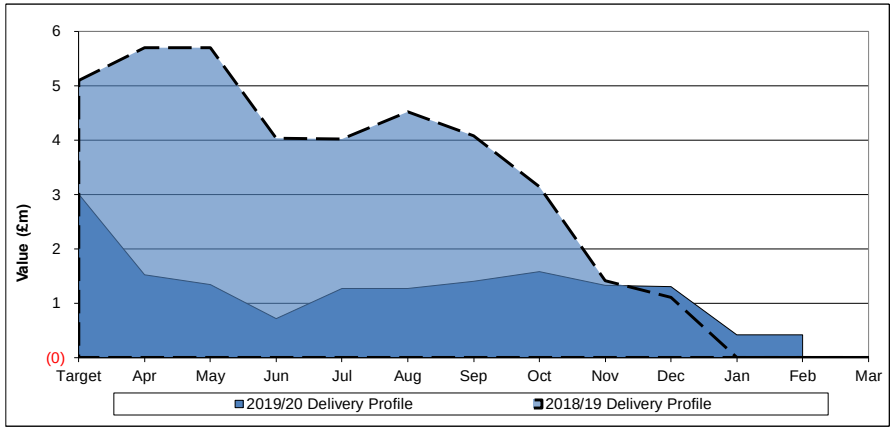
Governance Risk Heat Map

Total Number of Schemes	30
Total Number of Assessed Schemes - Directorate	28
Total Number of Assessed Schemes - Signed Off	21

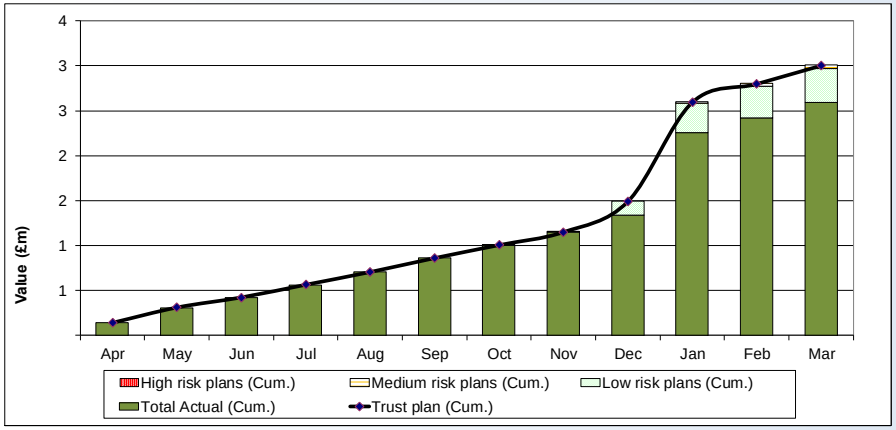
Probability/ Likelihood	Negligible - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	3	2	0	0
	0	1	1	0	0
Rare	19	2	0	0	0

Consequence/Severity

Gap to delivery - 2019/20



In Year CIP Delivery and Future Plans by Risk



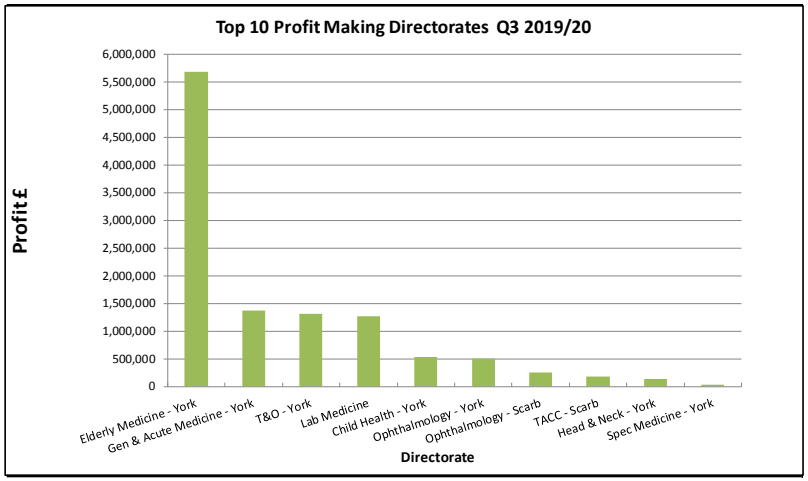
282

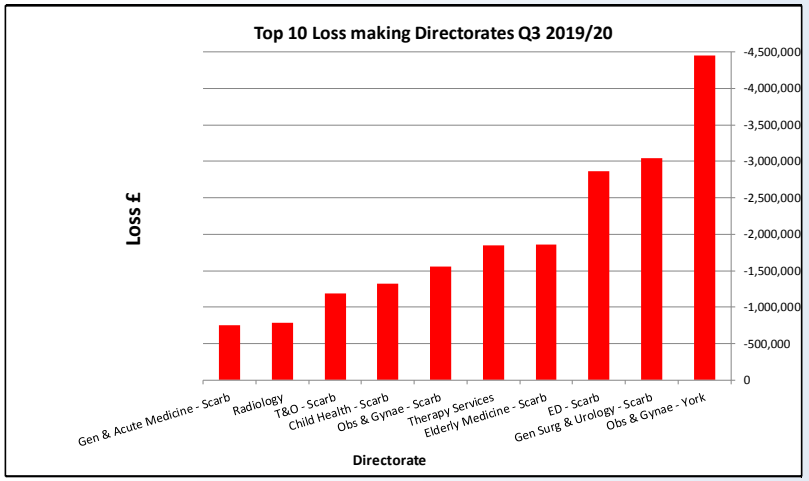
Service Line Reporting
Month 11 - The Period 1st April 2019 to 29th February 2020

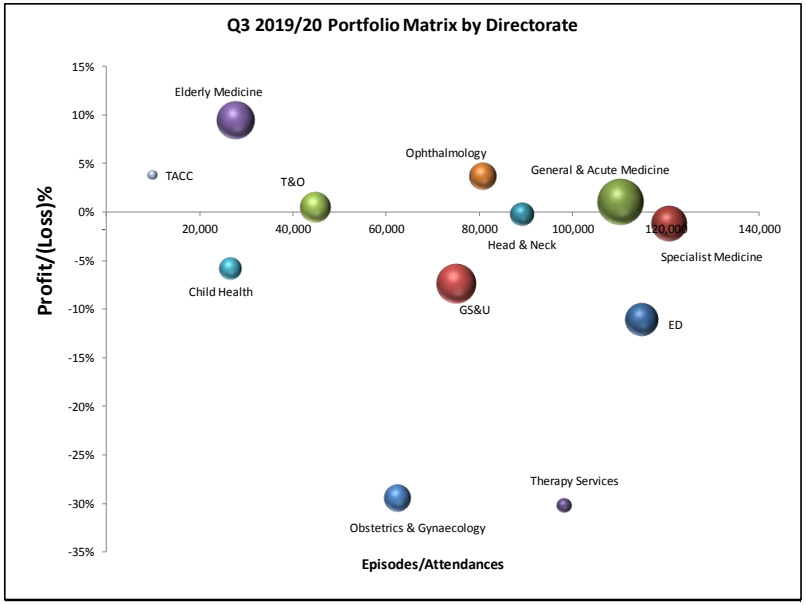
York Teaching Hospital NHS Foundation Trust

Key Messages:

* Current data is based on Q3 2019/20
* The 2018/19 mandatory NHS Improvement National Cost Collection was successfully submitted in August 2019
* Q4 2019/20 SLR / PLICS reports and the National Cost Collection to NHS Improvement 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	Q3 2019/20
CURRENT WORK	*The Q4 2019/20 SLR / PLICS reports are now the key focus for the team. * The National Cost Collection to NHS Improvement is also a key focus and work will run concurrently with Q4. * 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**

283

Workforce Performance Report

February 2020

Produced March 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

Workforce Summary

Operational Update:

Vacancies

The current establishment reports show an 8% vacancy factor across the Trust, and a vacancy factor of 8% within the LLP at the end of February 2020.

The current vacancy rate for the trained Nursing and Midwifery staff group was 8.07%. By site, this was 5.10% in York and 14.81% in Scarborough.

The medical and dental overall Trust vacancies rate was 10.7%. Vacancy rates by site were 10.9% at Scarborough and 10.7% at York.

Temporary Staffing

In February 2020, 99.36 FTE Medical & Dental roles were covered by a combination of bank (56%) and agency workers (44%). Bank fill-rates are showing an approximate 10% increase since the Trust began trialling the Patchwork app for locum shifts.

Total demand for temporary nurse staffing (registered nurses and HCAs) in February equated to 573.36 FTE. Of this demand, 54.26% was covered by bank and 22.30% by agency, leaving an unfilled rate of 23.44%.

Recruitment

The Trust recorded 82 new appointments (temporary and permanent) commencing in February 2020; 45 from outside the Trust; 4 of them Medical and Dental staff. Additionally, there were 16 new starters on the Bank.

Retention

In the year to the end of February 2020, the retention rate for the Trust was 87.82%. This shows an increase on last month's figure by 0.39%.

Absence Management

The monthly absence rate in January 2020 (excluding the LLP) was 4.40%.

The monthly absence rate in January for the LLP was 7.14%.

Disciplinary and Grievance

For all staff (i.e. medical and non-medical), there are 7 live disciplinary or bullying and harassment cases (including investigations), and 7 live grievance cases.

Learning and Organisational Development

Overall Stat & Mand Training compliance = 85%
Corporate Induction Compliance = 96%

Non-medical staff	Medical staff
Stat Mand Core training = 88%	Stat Mand Core training = 69%
Stat Mand Essential skills = 88%	Stat Mand Essential skills = 88%
Corporate Induction = 96%	Corporate Induction = 93%

ODIL are working with our partners in the Clever Together team to support and implement the outcomes from the "Our Voice, Our Future" conversations.

There have been 64 nurses through the OSCE programme, with a further 23 confirmed to start before April. A successful business case has been agreed for an additional 60 nurses for 2020 - 2021. Currently 60 HCA learners are on Care Certificate Training, which is being monitored by CWBL.

There are 35 student nurses completing BSc Nursing from the September 2019 cohort, with an aim to increase placement capacity on the East Coast. The bidding for the tender of the Registered Nurse Degree apprenticeship will take place on 27th March.

There has been an active focus on available apprenticeships to improve awareness and uptake and registration on courses.

Research

Year to date accruals are 3983. The Trust has achieved and surpassed its target of 3800.

The Trust has been shortlisted for a major research award with the University of York. If successful, this will be collaboration between our renal Consultant and R&D with the York Centre for Hyperpolarisation in Magnetic Resonance.

The Trust had 117 open studies, a drop of 10.7% from the previous year. This puts the Trust 48th (out of c. 450 Trusts nationally). This was an expected drop given the significant period we have devoted to teams on cleaning up the Trust's portfolio of studies.

The Trust had a total of 4906 patients recruited into clinical trials, a rise of 27.7% in comparison to the previous year. This places the Trust 33rd nationally (out of c. 450 Trusts). This is a great achievement and demonstrates the Trust's efficiency and positive outcome from being more selective on the studies undertaken.

Assurance Framework Responsive

Sickness Absence

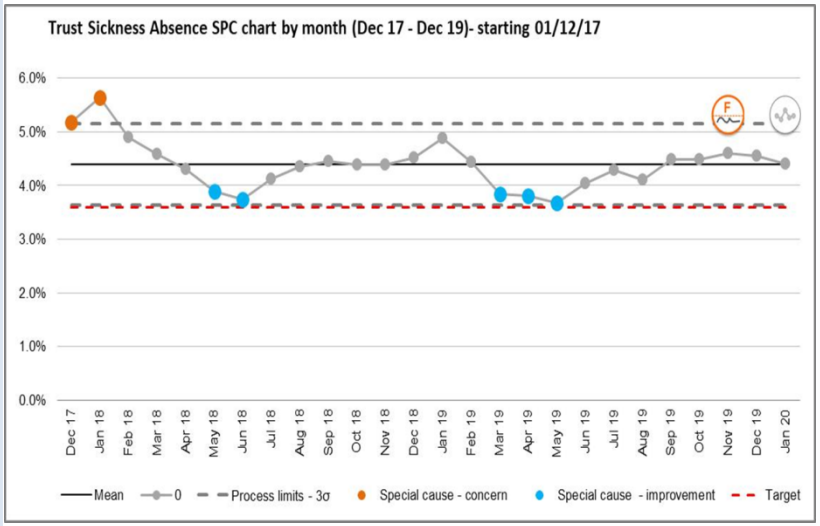
Operational Update:

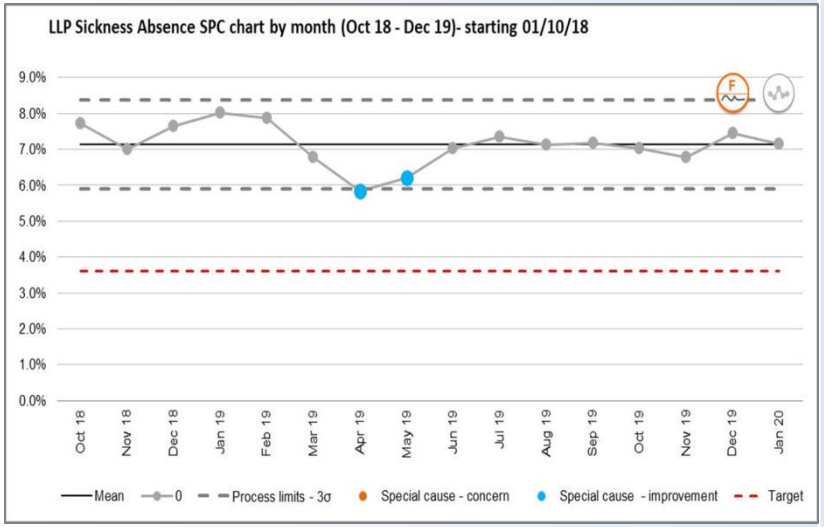
The monthly absence rate in January 2020 for the Trust was 4.40% , which shows a slight decrease in comparison to the previous month by 0.16%. The data shown for the Trust has not returned any cause for concern since January 2018. The grey coloured fluctuations are common variations, which are normally present in this type of data set. There have been five instances where the Trust has seen improvement on sickness ratings, with May 2019 returning the closest absence rate to the sickness absence target of 3.6%.

For York Teaching Hospital Facilities Management, the monthly absence rate in January 2020 was 7.14%. This shows a decrease from December's absence rate but the data is still within the limits of the common variations.

Performance:

	Threshold	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
Sickness - YTHFT (Monthly)	**3.6%**	5.1%	4.7%	4.1%	4.0%	3.9%	4.3%	4.6%	4.4%	4.8%	4.7%	4.6%	4.6%	4.4%
Sickness - YTH Facilities Management (Monthly)	**3.6%**	8.0%	7.8%	6.9%	6.0%	6.2%	7.0%	7.4%	7.2%	7.2%	7.0%	6.5%	7.5%	7.1%





286

Assurance Framework Responsive

Retention Rate

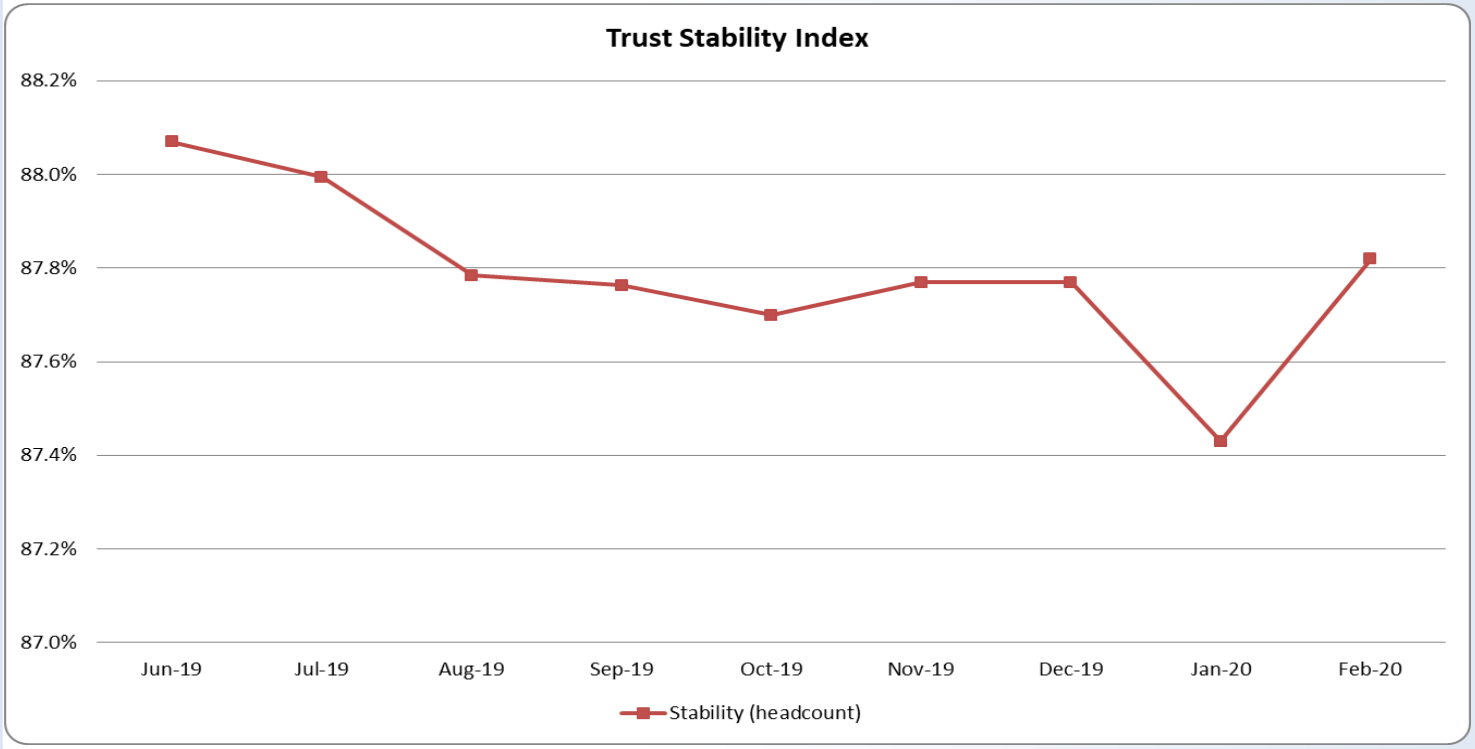
Operational Update:

Workforce Performance Reports have historically reported labour turnover rates. However, NHSI/E's Model Hospital tool uses the retention rate (also known as stability index) to measure organisations against their peers and therefore this measure will now be presented in this report. The data below relates to the trust and excludes York Teaching Hospital Facilities Management and is based solely on permanent members of staff.

Stability index compares a count of employees at the start and end date of a period (typically a 12 month period). A higher stability rate indicates a higher retention rate. In the year to the end of February 2020, the stability index was 87.82%. At the start of the period (1st March 2019) there were 8,008 permanent staff in post, of which there were 7,033 remaining at the end (29th February 2020). The stability rate has revealed a high of 88.07% and a low of 87.43% since June 2019.

Performance:

	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Stability (headcount)	88.07%	87.99%	87.78%	87.76%	87.70%	87.77%	87.77%	87.43%	87.82%



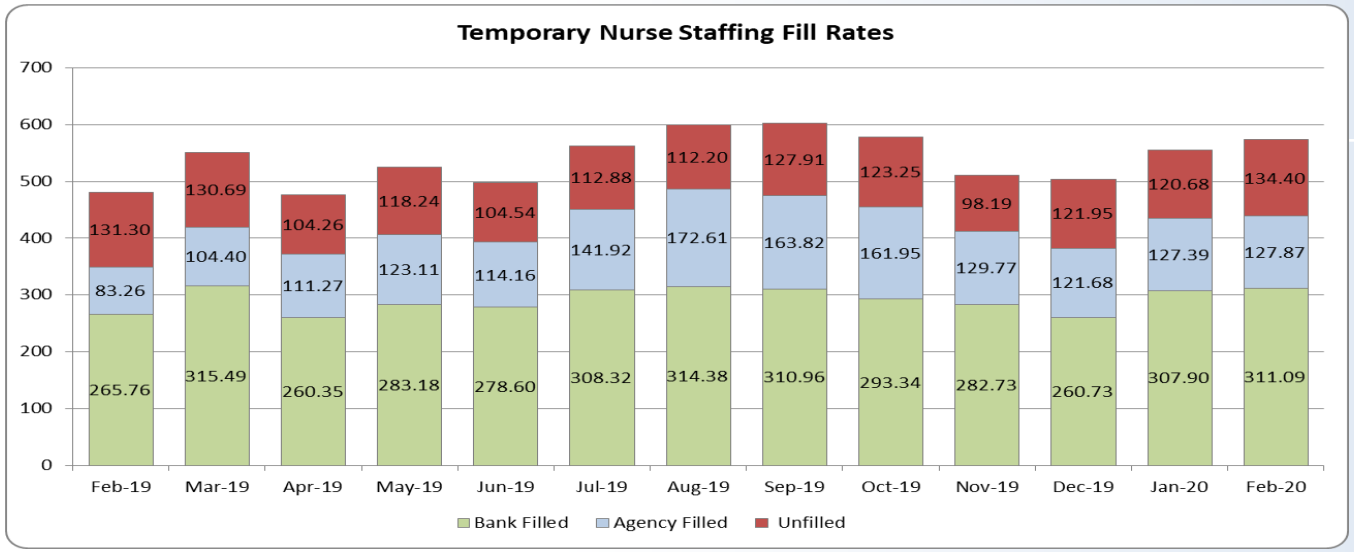
Assurance Framework Responsive

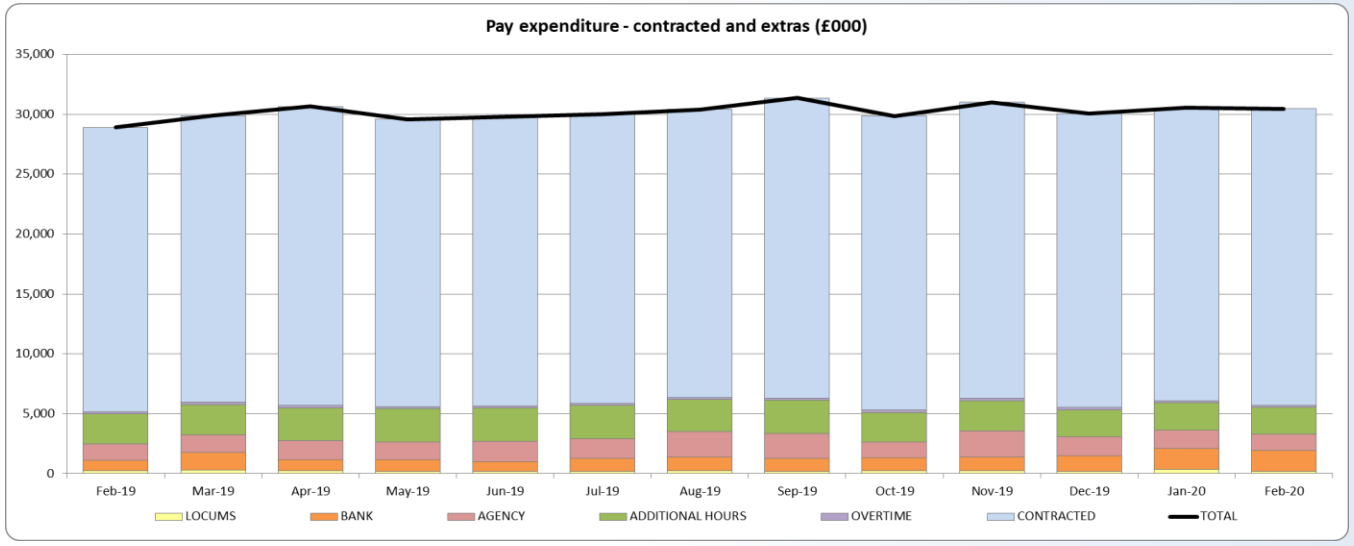
Temporary Workforce Spend

Operational Update:

54.26% of all nursing shifts requested in February 2020 were filled by the internal bank, whilst 22.30% were filled by agency. This left 23.44% of shift requests unfilled, which was an increase on the unfilled percentage rate of 21.71% seen in the previous month.

Performance:





Assurance Framework Responsive

Appraisal Activity

Operational Update:

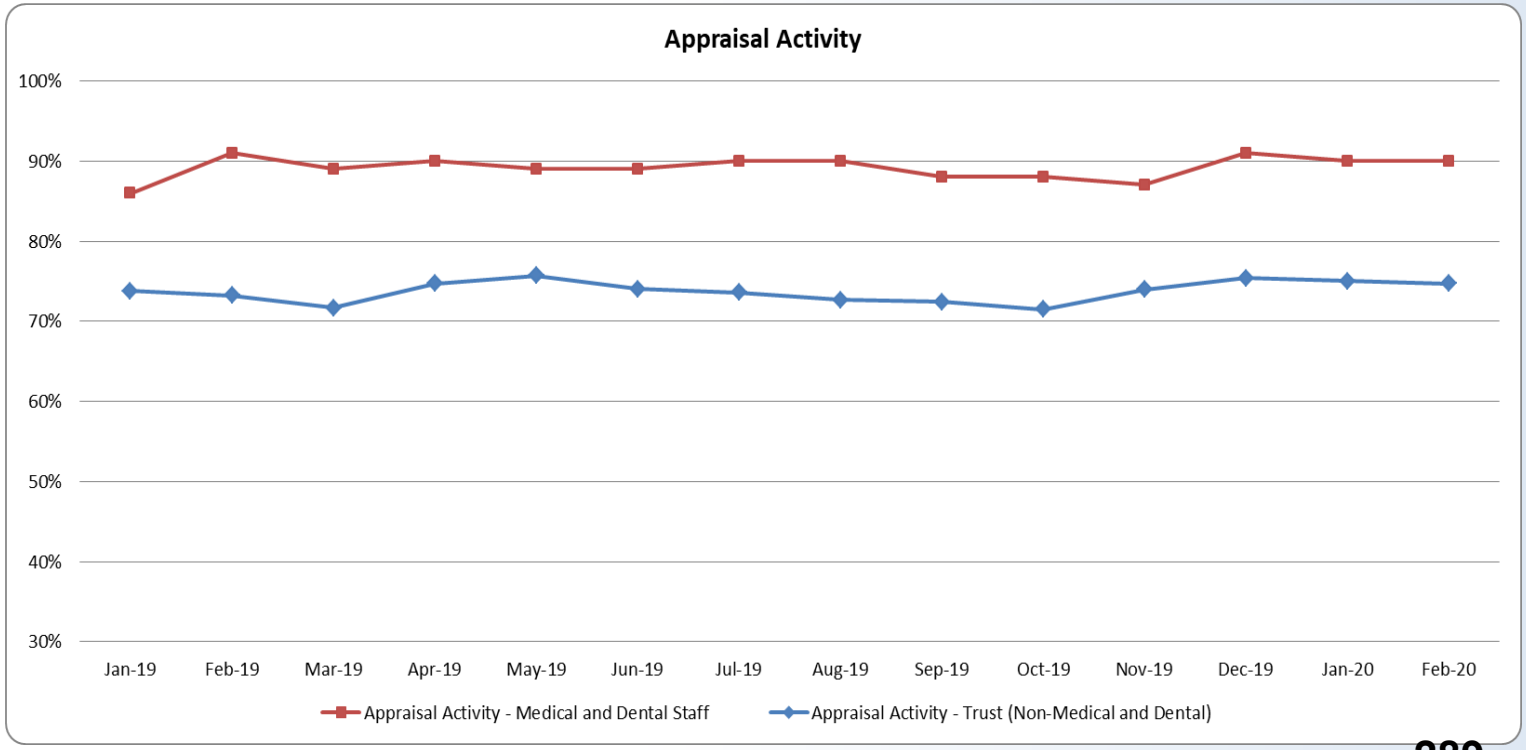
Since April 2018, appraisal rate compliance is reported directly from the Learning Hub, for non-medical staff. For medical staff, appraisal rates are reported from PreP. As a result, adjustments have been made to the reporting criteria (appraisal compliancy is now reported over a 12 month period, as opposed to what was previously a 14 month period).

The data produced now just looks at two figures – the appraisal activity of all Trust staff (excluding M&D), and the appraisal data for M&D staff. The overall compliancy rate for the Trust in February 2020 was 74.7% . The compliancy rate for medical and dental staff for February is currently at 90%.

The Trust will move to a four month appraisal window that will run each year from March, up to and including June. The recent introduction of an appraisal timeline will only concern non-medical staff. The current appraisal and revalidation process for medical and dental staff will remain unchanged.

Performance:

	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
Appraisal Activity - Trust (Non-Medical and Dental)	73.8%	73.2%	71.7%	74.7%	75.7%	74.0%	73.6%	72.7%	72.4%	71.5%	74.0%	75.4%	75.0%	74.7%
Appraisal Activity - Medical and Dental Staff	86.0%	91.0%	89.0%	90.0%	89.0%	89.0%	90.0%	90.0%	88.0%	88.0%	87.0%	91.0%	90.0%	90.0%



289

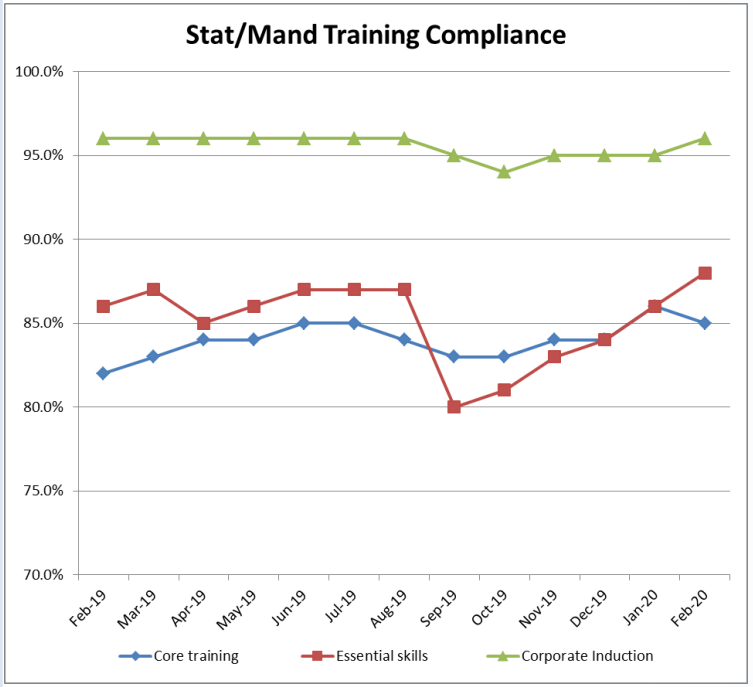
Assurance Framework Responsive

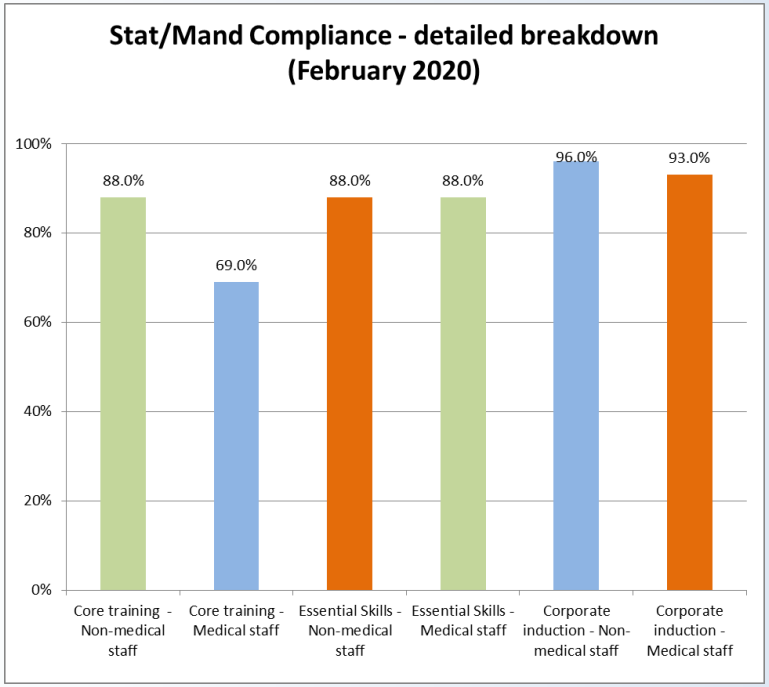
Statutory & Mandatory training compliance

Operational Update:

Corporate Induction compliance has increased to 96%. This is the first increase we have seen since October 2019. Compliancy ratings for Essential Skills training have also increased since last month. The percentage rate for Core Training has decreased slightly by 1% and currently sits at 85%. The information below details a breakdown for non-medical staff, and for medical and dental staff.

Performance:





290

Research and Development Performance Report

February 2020

Produced March 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

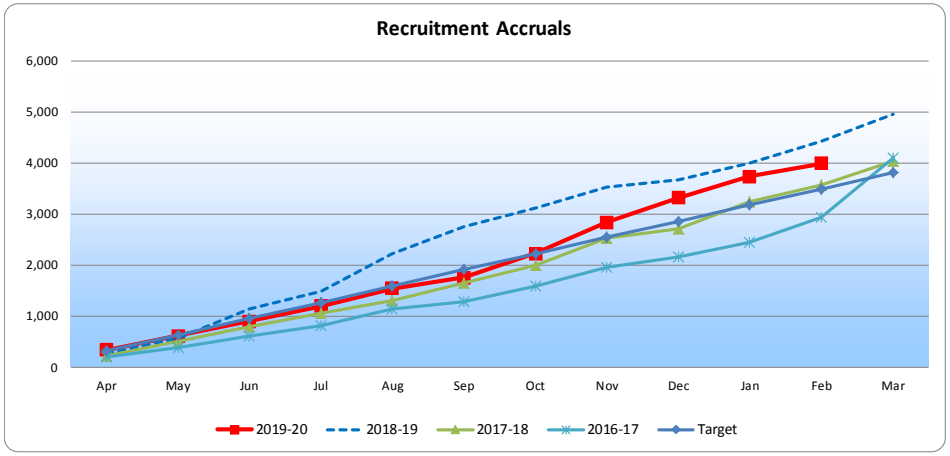
To ensure financial stability

Clinical Research Performance Report

York Teaching Hospital NHS Foundation Trust

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	334	275	284	297	345	218	466	615	475	425	249		3983
2018-19	249	322	562	354	731	531	365	408	145	319	442	512	4940
2017-18	222	280	291	262	244	340	358	535	167	546	311	483	4039
2016-17	204	176	217	215	316	152	294	378	207	275	497	1156	4087



Breakdown (as of the end of Q3 19/20)

Directorate	Accruals Running Total 18/19	Target	%
Anaesthetics	187	253	74
Cardiology	90	197	46
Dermatology	10	53	19
Diabetes	15	16	95
ED	0	0	0
Gastro	1672	1770	94.5
Generic - Scarborough	39	129	30.5
Generic - York	48	12	100
Haematology	23	20	100
Obstetrics	52	19	100
Scarborough	262	145	100
Oncology-York	206	78	100
Ophthalmology	216	361	60
Paediatrics	2	13	7
Renal	144	212	68
Rheumatology	7	100	7
Sexual Health	57	5	100
Stroke	9	50	18
Orthopaedics & Physio	6	0	100
ENT	0	0	0
Respiratory	30	60	50
Neurology	0	0	0
Elderly Medicine	17	0	100
Microbiology	36	0	100
General Surgery (tallied within the above Generics York & Oncology totals)	27	0	100

Recruitment Target for Y	3800
Open Trials	102
Total Due to Close 19/20	14

Commercial	12%
Non-Commercial	88%
Interventional	50%
Observational	49%
I & O	1%

Accruals to date this year are 3983, so we have achieved our target of 3800 accruals with one month to go- well done everyone

League Table Performance 2018/2019

All Trusts are measured on two key metrics:
1. Number of studies open for recruitment

This year the Trust had 117 open studies last year - a drop of 10.7% from the previous year, this puts the Trust 48th (out of approx 450 Trusts) in the country – last year's position was 42nd. This drop was expected as we have spent a significant amount time working with teams on cleaning up our portfolio of studies, and we are being more selective on what studies we take on.

2. Number of patients recruited to clinical trials

The Trust had a total of 4906 patients recruited into clinical trials last year (NIHR exclude commercial accruals) – a rise of 27.7 % from the previous year, this puts the Trust at 33rd in the country (out of approx 450) - last year it was 44th. The is a great achievement and further demonstrates how being more efficient and selective on what studies we take on benefits our Trust

The NIHR annual league tables for research active trusts can be viewed below:
https://www.nihr.ac.uk/research-and-impact/nhs-research-performance/league-tables/

292

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 March 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 11 of the 2019/20 financial year.

Executive Summary – Key Points

The income and expenditure position for month 11 of the 2019/20 financial year confirms the Trust has not met its pre-PSF control total. It is therefore not appropriate to apply PSF and FRF for the month 11 position. This position is subject to the usual quarterly assessment process and there is time to recover the position.

For the period April to February the Trust's pre-PSF control total was a deficit of £19.5m. The actual reported deficit is £22.8m placing the Trust £3.3m adrift of plan. After applying the relevant sustainability funding for the period April through to December the Trust is reporting a deficit of £7.4m against a planned deficit of £1.5m, therefore reporting an adverse variance to plan of £5.9m.

Recommendation

The Board of Directors is asked to:

- Note the month 11 financial position
- Continue to support the mitigating intervention to reduce the impact of the current forecast outturn.

Author & Director Sponsor: Andrew Bertram, Finance Director

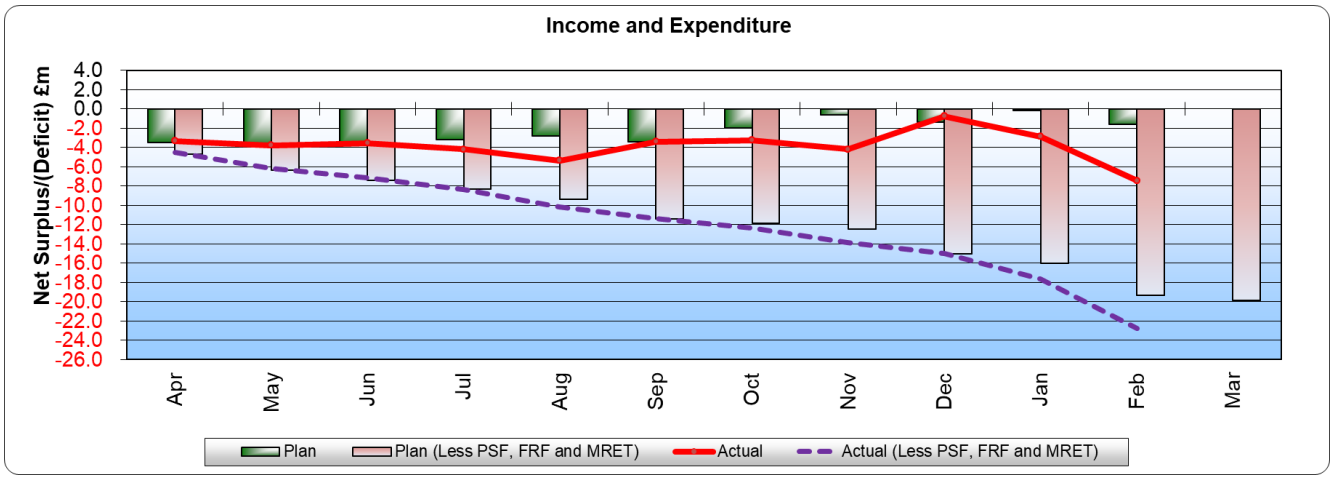
Date: March 2020

1. Year to date Summary Financial Position

The income and expenditure position for month 11 of the 2019/20 financial year confirms the Trust has not met its pre-PSF control total. It is therefore not appropriate to apply PSF and FRF for the month 11 position. This position is subject to the usual quarterly assessment process and there is time to recover the position.

For the period April to February the Trust's pre-PSF control total was a deficit of £19.5m. The actual reported deficit is £22.8m placing the Trust £3.3m adrift of plan. After applying the relevant sustainability funding for the period April through to December the Trust is reporting a deficit of £7.4m against a planned deficit of £1.5m, therefore reporting an adverse variance to plan of £5.9m.

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 position at month 11 and 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. Mitigating action is now in place in an attempt to recover the position.

2. Summary Financial Commentary

NHS Clinical Income remains behind plan by £2.0 and relates to continued underperformance against activity plans. This position is compensated partially by non-NHS clinical income positive variances but significantly by additional to plan education and training income and R&D income. Total income, from all sources, is showing an adverse variance to plan of £2.0m after including the net loss of sustainability funding of £2.5m.

The operational expenditure variance to plan has deteriorated significantly from £2.2m at month 10 to £4.3m at month 11. Around £0.8m of this relates to high cost drug expenditure with a corresponding positive income variance of £0.5m neutralising most of the pressure. The CIP plan profile technically impacts by a further £1.0m on the position

and the balance relates to a number of low level miscellaneous expenditure pressures. There are no material cost pressures, other than those previously reported, that are impacting on our position.

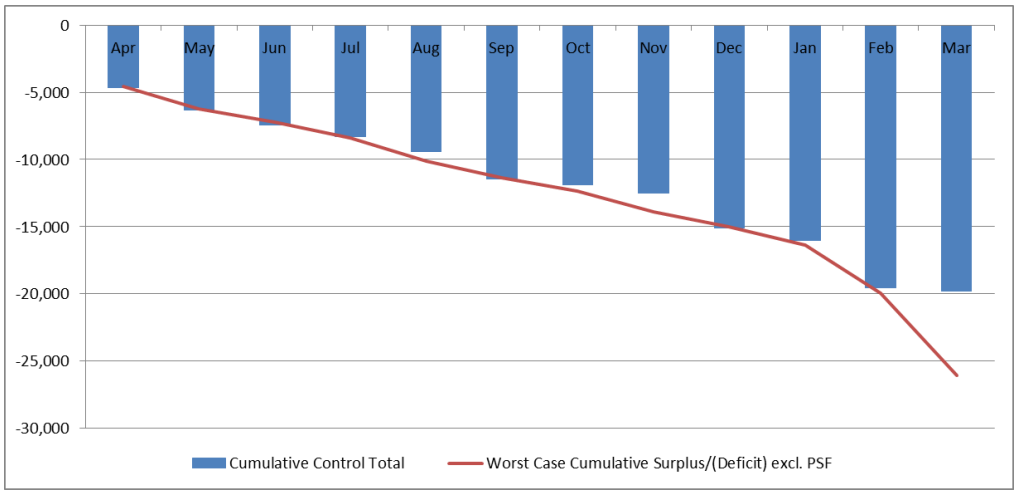
The spend pressure areas remain those reported to the Board in recent months.

Notwithstanding the vacancy position in terms of medical and nurse staffing the Trust continues to materially breach its agency expenditure cap. Spend to month 11 (£18.6m) 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 February has moved delivery to £16.8m of the £17.1m target. Recurrent delivery stands at £9.8m. Continued focus and energy is required to ensure delivery of the programme. Plans continue to match the programme target and no difficulties are anticipated in delivering the requirement.

3. Forecast Outturn

The forecast outturn reported last month remains in situ. This is summarised in the chart below.



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 11 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.

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 month of the financial year is now necessary. Discussions with NHSE/I have commenced and advanced 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 months.

5. Update on Working Capital Loans

The Board is aware that in recent years, particularly during the significant deficit of 2018/19, the Trust has needed working capital support in order to maintain salary and supplier payments. In more recent times, working capital has been drawn as an advance against Provider Sustainability Funding and a repayment has subsequently been made.

The total working capital loan value currently stands at £32.0m (including £4.5m drawn in March 2020 following the February Board resolution).

Under the terms of access to working capital, £17.9m is repayable in 2020/21. This is based on standard working capital loan terms of repayment in year three. This repayment does not feature in our current operational plan as clearly this is unaffordable to the Trust.

There are currently several billion pounds of repayable working capital loans on the NHS balance sheet.

Working with the Treasury, the DHSC are exploring a revision to the working capital regime that will include the treatment and management of historic debt. If approved this will most likely see this removed and converted to Public Dividend Capital. In the meantime, Trusts with maturing working capital loans are effectively refinancing these through the DHSC. This is the standard NHS approach and is in widespread use. This will be the route the Trust takes should this be necessary in year.

6. Recommendation

The Board of Directors is asked to:

- Note the month 11 financial position
- Continue to support the mitigating intervention to reduce the impact of the current forecast outturn.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 March 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 all low risk.
Full year delivery as at February 2020 is £16.8m.

The key risks to the programme are:

2019/20 - recurrent delivery £9.8m.
2020/21 – fully planned with medium risk plans of £5m
2021-24 - planning gap of £32m.

Recommendation

The Board of Directors is asked to note the February 2020 CIP position.

Author: Wendy Pollard, Deputy Head of Resource Management

Director Sponsor: Andrew Bertram, Finance Director

Date: March 2020

1. Summary reported position for February 2020

1.1 Current position – highlights

Delivery – Full year Delivery is £16.8m as at February 2020 which is (98%) of the target and has improved in month by £0.3m with the balance of £0.3m to be delivered over the final 1 month. This position compares to a delivery position of £23.6m in February 2019.

Part year delivery is £0.9m ahead of the profiled plan submitted to NHSI.

In year planning – At February 2020 the target of £17.1m is 100% planned all Low Risk.

Five year planning – Five year planning (19/20 – 23/24) shows a gap of £31m.

Recurrent vs. Non recurrent – Of the £16.8m full year delivery, £9.8m has been delivered recurrently which is 57% of the overall target for 2019/20, an improvement of £0.3m in month. Recurrent delivery at February 2019 was £13.4m.

Risk **– Appendix 1 – Risk Scores** provides an overview of the Risk associated with the Efficiency Programme. This is viewed over a 4 year period and takes into consideration in-year and 4 year planning, in year delivery and recurrent delivery and governance risk.

1.2 Overview

Delivery Performance
Delivery across Care Groups has improved in Month 11 with delivery of £0.2m. **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 £0.3m. Transformation schemes account for 18% of Plans with no change in Month 11. At month 11 there has been no movement with the ADM which is £0.2m behind plan.

Appendix 3 – **Summary of Schemes by Category** summarises the year to date and full year delivery position.

To meet the planned rollover position we require £1m recurrent delivery in March. We will be reviewing non-recurrent delivery with a view to making recurrent.

Model Hospital
The Model Hospital has been refreshed with 2018/19 reference costing/PLICS data and this indicates an overall improvement for the Trust when compared to Peers and the National Median.

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	11,669	2,030	923	905
Medium Risk	5,049	2,986	2,941	2,643
High Risk	0	850	56	0
Total Plans	**16,718**	**5,866**	**3,920**	**3,548**
Shortfall against Target	**710**	**-10,287**	**-10,576**	**-10,999**

Get It Right First Time (GIRFT)

Litigation Review Process & Shared Learning – we continue to work with the Trust's legal team to review completed legal claims and identify common themes that can be shared across the Care Groups via the Learning Hub and via local clinical governance meetings.

There is now a dedicated area within the Learning Hub where common themes emerging from the litigation review process can be shared.

NHS resolution are providing further advice and guidance to our internal legal team as part of the GIRFT review process with a planned visit to the Trust in the near future.

Data Submissions to National Teams – we have made submissions to the national project teams as follows:

- Paediatric Trauma & Orthopaedics
- Acute and General Medicine
- Emergency Medicine

Network Meetings – we have attended the regional Neonatology network meeting where the national team presented a regional picture as how the service is delivered in this region. Specific site visits will be scheduled in the near future.

We are in the process of planning a GIRFT led Pathology network meeting.

Review Meetings – we have met with the Max Fax team to review the national GIRFT report to review the 15 national recommendations and discuss potential opportunities to make service improvements. This work continues.

Further review meetings to discuss national report recommendations are scheduled with the ENT and Ophthalmology teams.

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 February.

Table 2 – QIA Performance

QIA 2019-20								
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Total No of schemes	270	280	306	315	342	333	386	390
Extreme	0	0	0	1	1	1	1	1
High	0	0	0	0	0	0	2	2
Moderate	15	9	6	6	6	6	10	10
Low	109	79	96	134	133	205	226	230
To be assessed	146	192	204	174	202	121	147	147

Face to face meetings have been held with Care Groups with some schemes being reassessed and the risk downgraded. These changes will be reflected in the Month 12 position. An overview of the schemes are summarised in **Appendix 4 – 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.

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	59%	HIGH	55%	HIGH	44%	HIGH	52%	HIGH	12	HIGH	50%	MEDIUM
CG2. Acute, Emergency and Elderly Scarborough	2,107	4,992	31%	HIGH	31%	HIGH	18%	HIGH	43%	HIGH	12	HIGH	100%	LOW
CG3. Surgery	3,278	9,133	85%	HIGH	76%	HIGH	27%	HIGH	51%	HIGH	12	HIGH	90%	LOW
CG4. Cancer and Support Services	3,176	8,139	57%	HIGH	53%	HIGH	33%	HIGH	74%	HIGH	12	HIGH	44%	HIGH
CG5. Family Health	2,180	5,243	47%	HIGH	44%	HIGH	14%	HIGH	27%	HIGH	12	HIGH	35%	HIGH
CG6. Specialised Medicine	3,428	8,885	98%	HIGH	81%	HIGH	42%	HIGH	70%	HIGH	12	HIGH	66%	MEDIUM
Corporate Functions														
Chief Nurse Team	275	441	96%	HIGH	17%	HIGH	0%	HIGH	60%	HIGH	12	HIGH	33%	HIGH
Chairman and CEO	165	316	282%	LOW	251%	LOW	2%	HIGH	147%	LOW	6	LOW	0%	HIGH
SNS	215	431	55%	HIGH	55%	HIGH	17%	HIGH	35%	HIGH	12	HIGH	22%	HIGH
Ops Management	928	2,221	55%	HIGH	55%	HIGH	17%	HIGH	35%	HIGH	12	HIGH	0%	HIGH
Medical Governance	1,149	2,560	99%	HIGH	99%	MEDIUM	6%	HIGH	55%	HIGH	11	HIGH	0%	HIGH
Finance	1,211	3,240	232%	LOW	232%	LOW	105%	LOW	111%	LOW	4	LOW	91%	LOW
Workforce and Organisational Development	54	98	262%	LOW	151%	LOW	4%	HIGH	196%	LOW	6	LOW	100%	LOW
Estates and Facilities	294	704	135%	LOW	91%	HIGH	91%	LOW	89%	HIGH	8	MEDIUM	95%	LOW
TRUST SCORE	**17,137**	**42,831**	**101%**	**HIGH**	**98%**	**HIGH**	**57%**	**HIGH**	**102%**	**HIGH**	**12**	**LOW**	62%	**MEDIUM**

Appendix 2 - Care Group and Directorate Performance

Sum of Total 2019/20

		January			February			In Month Delivery		
Care Group	**Directorate**	**R**	**NR**	**Total**	**R**	**NR**	**Total**	**R**	**NR**	**Total**
1. Acute, Emergency and Elderly Medicine (York)	Community	198809	3170	201979	250089	3170	253259	51280	0	51280
	ED York	236172	0	236172	238287	0	238287	2115	0	2115
	General Medicine York	486275	290679	776954	489015	290679	779694	2740	0	2740
	Medicine for the Elderly York	162666	0	162666	169737	0	169737	7071	0	7071
1. Acute, Emergency and Elderly Medicine (York) Total		**1,083,922.00**	**293,849.00**	**1,377,771.00**	**1,147,128.00**	**293,849.00**	**1,440,977.00**	**63,206.00**	**-**	**63,206.00**
2. Acute, Emergency and Elderly Medicine (Scarborough)		358036	263888	621924	370219	273388	643607	12183	9500	21683
2. Acute, Emergency and Elderly Medicine (Scarborough) Total		**358,036.00**	**263,888.00**	**621,924.00**	**370,219.00**	**273,388.00**	**643,607.00**	**12,183.00**	**9,500.00**	**21,683.00**
3. Surgery	GS&U	514797	354705	869502	534899	354705	889604	20102	0	20102
	Head and Neck	142689	186895	329584	150085	186895	336980	7396	0	7396
	TACC	163969	1091733	1255702	189577	1061733	1251310	25608	-30000	-4392
3. Surgery Total		**821,455.00**	**1,633,333.00**	**2,454,788.00**	**874,561.00**	**1,603,333.00**	**2,477,894.00**	**53,106.00**	**- 30,000.00**	**23,106.00**
4. Cancer and Support Services	Cancer	9961	120000	129961	10599	120000	130599	638	0	638
	Endoscopy	40963	125000	165963	41013	125000	166013	50	0	50
	Lab Medicine	300420	155366	455786	300420	155366	455786	0	0	0
	Pharmacy	426583	0	426583	464641	0	464641	38058	0	38058
	Radiology	238291	218883	457174	238291	218883	457174	0	0	0
4. Cancer and Support Services Total		**1,016,218.00**	**619,249.00**	**1,635,467.00**	**1,054,964.00**	**619,249.00**	**1,674,213.00**	**38,746.00**	**-**	**38,746.00**
5. Family Health	Child Health	194885	339950	534835	195007	339950	534957	122	0	122
	Sexual Health	19113	207677	226790	19113	227677	246790	0	20000	20000
	Womens Health	88908	97164	186072	89142	97164	186306	234	0	234
5. Family Health Total		**302,906.00**	**644,791.00**	**947,697.00**	**303,262.00**	**664,791.00**	**968,053.00**	**356.00**	**20,000.00**	**20,356.00**
6. Specialised Medicine	Ophthalmology	24270	188000	212270	20661	188000	208661	-3609	0	-3609
	Orthopaedics	433634	212153	645787	493826	157294	651120	60192	-54859	5333
	Specialist Medicine	918906	982979	1901885	920254	982979	1903233	1348	0	1348
6. Specialised Medicine Total		**1,376,810.00**	**1,383,132.00**	**2,759,942.00**	**1,434,741.00**	**1,328,273.00**	**2,763,014.00**	**57,931.00**	**- 54,859.00**	**3,072.00**
7. Corporate Functions	Chief Exec	3208	410325	413533	3208	410325	413533	0	0	0
	Chief Nurse Team	0	48000	48000	0	48000	48000	0	0	0
	CIP Reserve	3546328	659078	4205406	3546328	674845	4221173	0	15767	15767
	Estates and Facilities	584687	0	584687	584687	60000	644687	0	60000	60000
	Finance	302163	372782	674945	309179	372782	681961	7016	0	7016
	Medical Governance	3195	50487	53682	3195	51487	54682	0	1000	1000
	Ops Management	31077	67668	98745	31077	67668	98745	0	0	0
	SNS	86450	240000	326450	86450	240000	326450	0	0	0
	Workforce & organisational development	8512	322551	331063	7090	322551	329641	-1422	0	-1422
7. Corporate Functions Total		**4,565,620.00**	**2,170,891.00**	**6,736,511.00**	**4,571,214.00**	**2,247,658.00**	**6,818,872.00**	**5,594.00**	**76,767.00**	**82,361.00**
Grand Total		**9,524,967.00**	**7,009,133.00**	**16,534,100.00**	**9,756,089.00**	**7,030,541.00**	**16,786,630.00**	**231,122.00**	**21,408.00**	**252,530.00**

Appendix 3 - Summary of Efficiency Programme by Category

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

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

Table 1: Efficiency Programme Summary

Programme Category	Annual Plan £'m	Full Year Delivery £'m	Full Year Recurrent Delivery £'m	Full Year Non Recurrent Delivery £'m	NHSI Plan YTD £'m	Total Delivery YTD £'m
Transactional	£14.1	£ 14.2	£ 7.9	£ 6.3	£ 11.9	£ 13.3
Transformational	£ 3.0	£ 2.6	£ 1.8	£ 0.7	£ 2.8	£ 2.4
Total Programme	**£17.1**	**£ 16.8**	**£ 9.8**	**£ 7.0**	**£ 14.7**	**£ 15.7**

Table 2: Transformational Scheme Summary

Transformational Scheme	Annual Plan £'m	Full Year Delivery £'m	Full Year Recurrent Delivery £'m	Full Year Non Recurrent Delivery £'m	NHSI Plan YTD £'m	Total Delivery YTD £'m
Theatre Productivity	£ 0.8	£ 0.8	£ 0.0	£ 0.8	£ 0.8	£ 0.8
Outpatients	£ -	£ -	£ -	£ -	£	£ -
ADM	£ 0.6	£ 0.4	£ 0.4	£ 0.0	£ 0.6	£ 0.4
Pharmacy	£ 1.3	£ 1.3	£ 1.3	£ 0.0	£ 1.2	£ 1.2
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	£ 0.2	£ 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	**£ 3.0**	**£ 2.6**	**£ 1.8**	**£ 0.7**	**£ 2.8**	**£ 2.4**

Table 3: Efficiency Programme by Carter Category						
Carter Category	**NHSI Annual Plan £'m**	**Full Year Delivery £'m**	**Full Year Recurrent Delivery £'m**	**Full Year Non Recurrent Delivery £'m**	**NHSI Plan YTD £'m**	**Total Delivery YTD £'m**
Carter W/force (Medical)	£2.0	£1.1	£0.6	£0.4	£ 1.5	£ 1.0
Carter W/force (Nursing)	£1.4	£1.4	£0.8	£0.6	£ 1.2	£ 1.4
Carter W/force (AHP)	£0.2	£0.4	£0.3	£0.1	£ 0.2	£ 0.4
Carter W/force (Other)	£1.8	£2.2	£0.1	£2.2	£ 1.6	£ 2.2
Carter Procurement	£3.2	£3.5	£2.2	£1.4	£ 2.9	£ 3.2
Carter Hospital Medicine & Pharmacy	£2.0	£1.8	£1.8	£0.0	£ 1.8	£ 1.6
Carter Corporate & Admin	£0.5	£3.9	£2.4	£1.5	£ 0.5	£ 3.6
Carter Estates & Facilities	£1.0	£0.9	£0.8	£0.0	£ 0.9	£ 0.8
Carter Imaging	£0.5	£0.4	£0.2	£0.1	£ 0.4	£ 0.4
Carter Pathology	£0.6	£0.4	£0.3	£0.2	£ 0.5	£ 0.4
Other Savings Plans/Unidentified	£3.9	£0.8	£0.3	£0.5	£ 3.2	£ 0.8
Total Programme by Carter Category	**£17.1**	**£16.8**	**£9.8**	**£7.0**	**£14.7**	**£15.7**

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

2019/20 Directorate QIA Assessment

Care Group	Directorate	Scheme Ref	Scheme Name	Description of risk	Potential Clinical Impact	Impact on Service	Possible mitigation	Date Assessed	Probability / likelihood	Consequence/ Severity	Residual Risk Rating	Residual Risk Acceptability	Value of scheme 2019/20 £'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. Care Group to amend risk
CG 2	Care Group 2		SIP 2.12 SAFER - TRANSFORMATION 5 CARDIOLOGY	Regents Park funding used by other care Groups for Services in York	Patients will need to travel - Service will not be local - Patient expereince	Will affect ability to provide local services	DGCM emailing CG 1 mgr to explain that funding shouldn't be used as it is in CG2.	14/01/2020	3	3	9	High Risk	0	
CG 2	Care Group 2		SIP 2.1 - AMBULANCE HANDOVER	Incorrect patients identified for self-handover.	Unwell patients are included in the Minor stream incorrectly resulting in poor patient outcomes.	Build up of incorrect patients in the waiting room.	Surveillance of the waiting room by streaming nurse and reception team.	06/01/2020	2	2	4	Moderate Risk	0	
CG 2	Care Group 2		SIP 2.8 AUTOMATIC REFERRAL	Acutely unwell patients are not discussed with the on call (take) team.	On call team are unaware of patients that have been referred under their care.	Could lead to delay to post-take review, longer length of stay and poor patient outcomes.	Adherence to auto referral protocol.	06/01/2020	3	2	6	Moderate Risk	3	
CG 2	Care Group 2		SIP 2.9 SINGLE CLERKING	Clerking patinets in in ED could add delays to patient journey if not sufficient recourse available to meet demand.	Longer waits in ED	Higher number of breaches and poor outcomes	Dedciated clerking team to enable ED doctors to see & treat.	06/01/2020	3	3	9	High Risk	0	
CG 2	Care Group 2		SIP 2.15 BRIDLINGTON	Incorrect patients are transferred to Johnson	Acutely unwell pateints will need to be transferred back to Scarborough	High volume of patients transferred.	Strict adherence to Trusted Assessor SOP.	06/01/2020	3	2	6	Moderate Risk	0	
CG 2	Care Group 2		SIP 2.30 UTC - IMPROVE STREAMING	Incorrect patients are streamed to UTC	Acutely unwell patients are seen in the wrong location; UTC staff unable to deal with higher acuity.	UTC overwhemed with incorrect patients.	Adherence to streaming guidance; co-loation of UTC; joint working to ensure patient safety maintained.	06/01/2020	2	3	6	Moderate Risk	0	
CG 2	Care Group 2	CIP1920-248	ENABLER WORKFORCE REVIEW (SK)	Removal of site manager at Brid reduces senior presence overnight and dilutes ALS capability. Removal of night shifts for bed managers on nights only contracts may trigger resignations.	Onsite response to deteriorating patients.	Loss of experienced staff as a result of the re-organisation.	On site RMO provides cover for deteriorating patients.	06/01/2020	3	3	9	High Risk	0	
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	0	
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	0	
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	7	
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	155	

Corporate Efficiency Team Sign Off (Please return with electronic	
Name:	
Signature	
Assistant Medical Director Sign Off (Please return with electronic	
Name:	
Signature	
Assistant Chief Nurse Sign Off (Please return with electronic	
Name:	
Signature	

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 March 2020
Approval of the Private Patient Policy

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 attached draft of the private patient policy was presented for comment to the February and March meetings of the Executive Committee meeting and the only comment received has been incorporated into the policy.

The policy is now presented to the Board of Directors for approval. If this is given then the policy will be incorporated into the Trust's policy formatl.

Executive Summary – Key Points

The Trust's Private Patient Office, working with NHS Elect and a selection of Trust consultant staff, has produced the first draft private patient policy. The policy is designed to signal a positive commitment to private patient activity within the Trust and to provide a broad framework for individuals to work within when managing private activity within the Trust. The policy is not a standard operating procedure covering all eventualities. One of the actions within the policy is the creation of a medical advisory committee who will be tasked with overseeing some of the more detailed aspects of arranging and developing private activity.

Recommendation

The Board of Directors is asked to approve the Private Patient Policy.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: March 2020

DRAFT PRIVATE PATIENTS POLICY

Version	Version 2 updated draft 5 Feb 2020
Name of responsible (ratifying) committee	
Date ratified	
Document Manager (job title)	
Date issued	
Review date	
Electronic location	
Related Procedural Documents	
Key Words (to aid with searching)	

Version Tracking

Version	Date Ratified	Brief Summary of Changes	Author
2	*5 Feb 2020*	First working draft for review	J Sykes/A Bertram

CONTENTS

This policy must be followed in full when developing or reviewing and amending Trust procedural documents.

For quick reference the guide below is a summary of actions required. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy.

1. The Private Patient Policy sets out the basic standards for financial management and financial control to be followed within the Trust with regards to private practice

2. The policy sets out the management processes of private patients throughout the Trust to ensure that the correct regulations and guidance is applied when treating private patients.

3. The policy should be read in conjunction with other Trust policies and procedures related to patient care, management and financial standings

4. All managers and staff working directly or indirectly for the Trust must comply with the policy in relation to the care and management of private patients.

1. INTRODUCTION

The aim of the Trust is to provide high quality, clinically appropriate, value for money care for patients. The Trust recognises and welcomes private patients where their treatment may be funded by health insurers, sponsored by international bodies or patients' own funds and therefore that private practice is an integral part of the business of the Trust. The delivery by the Trust of an effective and efficient mixed business model that appeals to NHS and private patients offers the best opportunities for the organisation to secure its' financial future whilst at the same time providing an appealing career move for consultant staff looking to join the Trust, for whom private work opportunity is a key recruitment factor.

This policy should be used in conjunction with other Trust policies relating to the admission, treatment and discharge of patients, as well as the Private Patients Procedures. The Trust has a Private Patient Office with responsibility for the management and administration of all private patient activity irrelevant of site.

The Trust is keen to maximise external income through private patient activity, the profits of which will be reinvested into the Trust for the benefit of all of our patient services. The purpose of this policy is to provide clear guidelines to staff for the management of private patients within the Trust, to ensure that working in partnership with Consultant Medical colleagues to ensure that their private practice can thrive within the Trust and to ensure that NHS patients are not disadvantaged.

The aim of this policy is to**:**

- Ensure that patients receive safe and coordinated care.
- Ensure that private care as a treatment choice is understood and supported.
- Identify and Promote services provided to private patients.
- Ensure that the boundaries between NHS work and private practice at the Trust are clear, transparent and understood so that the Trust can maximise private patient income by actively promoting service delivery, championing best practice and celebrating clinical excellence, subject to no adverse impact on mainstream NHS activities.
- Ensure that the service has controls in place to capture all chargeable patients so that the service can be audited to demonstrate that the Trust accurately captures income for investigations and treatments.
- Ensure that there are processes in place to minimise the non-recovery of charges and that discourage bad debt

2. PURPOSE

This policy on private patient services is required to provide clear guidance to staff on the management of private patients. This will ensure that income generated from this source is done so within the terms of the Trust's authorisation and in accordance with national guidance; that there are

processes to ensure that NHS patients are not disadvantaged and controls are in place to ensure the private income is collected and no losses are incurred.

The private patient policy for the Trust has been based on:

- The NHS Executive handbook 'A Guide to Management of Private Practice in the Health Service Hospitals in England and Wales' issued in September 1995
- The Department of Health document 'A Code of Conduct for Private Practice – Guidance for NHS Medical Staff' issued April 2003
- The Department of Health Guidance on NHS patients who wish to pay for additional Private Care 2009, and
- Best practice learned from other NHS Trusts and across the independent health care industry.

The NHS Executive handbook sets out the statutory framework and the key principles which govern private practice in the NHS and which has been agreed with the medical profession nationally. It also gives guidance on the organisation and management of private practice and provides a general guide to good practice.

The Department of Health document sets standards for NHS medical practitioners about their conduct in relation to private practice. It ensures that clear standards are in place for managing the relationship between NHS work and private practice. The document provides the local policy and procedure that the Trust will expect for the management of private practice within its own organisation. Consultants work as an independent contractor and not as an employee, agent or servant of the Trust. Consultants must maintain adequate indemnity cover for the duration of their private practice.

Private medical practice by medical and dental staff in NHS hospitals has been a part of the NHS since 1948. Private practice generates valuable income for improving services for all patients by using resources, which from time to time, are not needed for treating patients receiving NHS treatment.

Within the statutory framework, the Trust can decide the extent of the provision of private facilities.

The main principle is that private practice must not interfere with the performance of an NHS Trust or its obligations under the NHS contract. The provision of services for private patients must not prejudice non-paying patients.

Private patient activities must provide a level of income that exceeds total costs and should not run at a loss. Charges should be set at a commercial rate and financial systems must ensure there is no subsidisation of private patient activity by the NHS.

To ensure capacity and resources are used effectively, wherever possible, private patients must be seen separately from scheduled NHS patients, for example in designated outpatient or diagnostic sessions. However, clinical need and also effective use of capacity may also lead to integrated patient scheduling, for example theatre lists or diagnostic imaging, when managed within the guidance set out in this Policy.

Standards of clinical care should be the same for all patients. Normally, access to diagnostic and treatment facilities must be governed by clinical consideration and generally, early private consultations must not lead to earlier NHS admission.

3. SCOPE

This document applies to all Consultant Staff undertaking private work. Junior Doctors and other Trust staff have a responsibility to all Trust Patients whether NHS or Private.

'In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety'

4. PRINCIPLES OF CONDUCT

Six principles govern the use of NHS facilities for private patients. These principles have been agreed by the Executive Board and the Board of Directors. Private Practice throughout the NHS should follow these principles in full.

1. The provision of accommodation and services for private patients should not prejudice non-paying patients. (This is a reiteration of the intention behind the statutory requirements).

2. Subject to clinical considerations, private consultation should not lead to earlier NHS admission or to earlier access to NHS diagnostic procedures.

3. Common waiting lists must be used for urgent and seriously ill patients, and for highly specialised diagnosis and treatment. The same criteria must be used for categorising the priority of paying and non-paying patients.

4. After admission, access by all patients to diagnostic and treatment facilities must be governed by clinical considerations. This does not exclude earlier access by private patients to facilities especially arranged for them, if these are provided without prejudice to NHS patients and without extra expense to the NHS.

5. Standards of clinical care and services provided by the hospital must be the same for all patients. This does not affect the provision, on separate payment, of extra amenities, or the custom of day-to-day care of private patients usually being undertaken by the Consultant engaged by them.

6. If required for NHS use, single rooms must not be held vacant for potential private use longer than the usual time between NHS patient admissions.

5. MEDICAL PRACTITIONERS' RESPONSIBILITIES (Management of potential conflict with NHS care)

5.1 Governance

To achieve an effective and efficient mixed business model within the Trust requires clear governance for the way in which both private practice and NHS commitments are managed.

Consultants undertaking private practice within the Trust must register an interest with the Private Patient Office and will be required to provide evidence of suitable indemnity cover and other details. Failure to provide such evidence may result in private practice privileges being withdrawn. Leadership of private practice within the Trust will be provided by the Medical Advisory Committee (MAC) Chair who will hold the effective role of clinical director for private practice. It will be the MAC Chair's role to represent private practice interests to Trust management, but also to ensure that medical practitioners adhere to the required terms.

This policy should be read in conjunction with the Standards of Business Conduct Policy which also requires any staff undertaking private practice to register this with the private patients office.

5.2 Scheduling of work and job planning

Recognising that private patients are treated in the Trust, the following "time shifting" system has been agreed to enable a more flexible approach for consultants undertaking private practice activity whilst still meeting the demands of the NHS Obligations.

Monitoring and reviewing of NHS duties and private practice will take place at the annual job plan discussions with the relevant clinical directors.

Where there would otherwise be a conflict or potential conflict of interests, Trust commitments must take precedence over private work,

Medical practitioners should ensure that they have arrangements in place such that there is no significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late, or to be cancelled.

5.3 Unscheduled care

- Medical practitioners engaging in private practice are expected to provide emergency treatment for their NHS patients, should the need arise.
- Circumstances may also arise in which medical practitioners need to provide emergency treatment for private patients during times when they are scheduled to be working for the NHS.
- **If identified in an individual's job plan and on average amounts to less than 2 hours** per week, then by agreement with the Medical Director and the Care Group Director this activity can be allowed to take place during the NHS week in recognition that individuals should be able to time shift this degree of NHS activity to another part of the week without any corresponding reduction in the value of the NHS activity. This principle is supported in the full expectation that any time taken from NHS commitments is re-provided back to the NHS. Time shifting in this way must re-provide like for like lost time; that is to say if NHS direct clinical care is compromised by unscheduled private care then NHS direct clinical care must be re-provided. It is

not acceptable to re-provide lost NHS direct clinical care with NHS supporting professional activity time.

- If the hours per week are in excess of 2 hours or are not part of an agreed job plan then this must be discussed with the Medical Director and Care Group Director. A clear audit trail of hours must be maintained by the individual consultant.
- The volume of unscheduled care and time shifting will be monitored and discussed at the MAC meetings.

Where there is a necessary change to the scheduling of Trust work, this must be repaid to the Trust within a period of one month.

5.4 On-call

Consultants must **not** schedule private commitments that would prevent them from being able to attend an emergency while they are on call for the NHS or attend for predictable emergency NHS activity.

5.5 Theatre

Elective private commitments must not be routinely planned during times at which the Clinician is scheduled to be working for the NHS.

If the procedure is required to be done as a part of the NHS session due to clinical reasons i.e. **complex surgery** involving more than one surgeon or due to the length of the operation, prior agreement must be obtained via email from the clinical director and Care Group Manager. The impact on the NHS list must be discussed and use agreed by the Care Group Manager and the Clinical Director for the related specialty that the NHS list can be utilised for a private patient without compromising NHS patients. The Trust recognises that a flexible approach is required that supports both NHS and private patient activity.

Emergency private care - the Trust recognises the need to treat trauma and emergency patients in accordance with clinical priority and that in doing so circumstances may arise in which clinicians need to provide emergency treatment for private patients during the time they are scheduled to be working for the NHS. A clear email audit trail must be maintained to facilitate any necessary time shifting and details should be sent to the Clinical Director, MAC chair and Private Patient Manager

- Private Emergency activity must be listed according to clinical priority. Where this is undertaken on the CEPOD / Trauma list time, it would be subject to time shifting for which a clear audit trail will need to be maintained.

Non urgent private commitments (scheduled emergencies) – this private activity should be booked outside of planned NHS lists in the same way as elective private commitments

- can be booked as early starts / late finishes / bookable private patient lists

Where a medical practitioner is asked to provide emergency cover for a colleague at short notice and the medical practitioner has previously arranged private commitments, the medical practitioner should

only agree to do so if these commitments would not prevent them from returning at short notice to attend an emergency.

5.6 Anaesthetic Services

The Private Patient Office is responsible for booking an anaesthetist who carries out private patient services and holds appropriate professional indemnification. The Anaesthetic Co coordinator will be informed of the requirement and will view the rota and identify either a member of the Anaesthetic Service or an independent Trust private anaesthetist. For some insurance companies it is essential that there is an approved consultant in which case the Private Patient Office and the Anaesthetic Co-coordinator will seek to seek to find a solution by making changes to the rota if appropriate. For dedicated private patient sessions this is not an issue as a private anaesthetist is allocated automatically.

5.7 Patient enquiries about private treatment

Medical practitioners must not, in the course of their NHS duties and responsibilities, make arrangements to provide private services elsewhere, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient in the NHS facility concerned.

Where, in the course of their duties, a medical practitioner is approached by a patient and asked about the provision of private services, the practitioner must direct the enquirer to the Private Patient Office.

5.8 Promotion of private services by medical practitioners

In the course of their NHS duties and responsibilities medical practitioners must not initiate discussions about providing private neither services for NHS patients, nor ask other NHS staff to initiate such discussion on their behalf.

Medical practitioners must not use Trust headed stationery to advertise their services, unless agreement is received from the Private Patients Office, and then permission will only be granted to group practice rather than single named medical practitioners.

NHS staff must all be familiar and understand that the Trust supports patients that choose to have private care and to direct any enquirer to the Private Patient Office who will then follow up any enquiry.

NHS staff may promote that the trust welcomes private patients and must direct all enquiries to the Private Patient Office.

6. PRIVATE PATIENTS IN NHS FACILITIES

Except in urgent/out of hours and non-elective cases, medical practitioners must not provide private patient services that will involve the use of NHS facilities, equipment, consumable stock or involve access to an NHS funded MDT unless a “Undertaking to Pay” agreement has been issued to the patient and signed by the patient (or on behalf of the patient) and returned to the Private Patient

Office and with the correct authorisation from the insurance company. In the case of a self-funding patient a deposit paid based against the full estimated cost identified, prior to consultation, test, diagnosis or treatment.

Practitioners must notify the Private Patient Office of any interaction with a private patient that involves NHS funded resources. This includes (but it not limited to) premises, consumable stock, equipment, staff, drugs, dressings, supporting patient literature and access to MDT resources for patient discussion.

Private patients must be seen separately from scheduled Trust patients. Under no circumstances will a practitioner cancel a Trust NHS patient's appointment to make way for a private patient. Private patients, as with NHS patients, will however need to be scheduled according to clinical urgency. Where the Trust agreed NHS job plan requirements will still be fulfilled, medical practitioners may treat private patients within core hours. In most cases this will mean that private patients can only be added to routine outpatient and inpatient/day case lists where there is sufficient spare capacity that cannot ordinarily be filled by an NHS patient or a reciprocal arrangement is made to list NHS patients on additional lists on a like for like basis. The Medical Director, through the relevant Clinical Director will require evidence that the medical practitioner can demonstrate maintenance of job plan requirements, including achievement of NHS activity and quality targets, where such instances may occur.

7. OTHER STAFF WORKING ARRANGEMENTS

The Trust fully supports staff to provide care and treatment to private patients, where the revenue is sourced must not influence the care provided. Consultants must not under any circumstances ask staff members to work additional hours to help with a private patient in return for an additional payment or gift outside of agreed staff contracted Terms and Conditions of Employment. This practice is strictly prohibited by the Trust as it is putting both the staff members and the Trust at risk. In this situation the Trust is also exposed to risk as it has a medical/legal duty to keep detailed records for all patients who have received services in the Trust, including recording of the patient on CPD.

- All staff must be made aware that they are only covered by the Trusts vicarious liability insurance if working for the Trust. In a situation where a consultant has not been given authorisation by the Trust, the staff members are working for the Consultant and not the Trust and are therefore not insured by the Trust and will not be paid by the Trust.

- **Junior Doctor arrangements** –The Trust recognises that any patient regardless of status is entitled to the best clinical care and therefore the Trust NHS Indemnity covers Private patients that are managed under the care of the Trust. Therefore, all staff treating private patients within the course of their normal duties, including Junior Doctors, is covered by NHS Indemnity.

8. IDENTIFICATION OF PRIVATE PATIENTS

A key to success and creating a seamless pathway for the consultant and the patient is the early and easy identification of private patients. All hospital consultants, including Honorary Consultants, have a personal obligation to ensure that Private Patients are identified as "private" and that the Private Patient Office is aware of ALL such patients prior to any consultation, investigation or treatment (unless in an emergency/unscheduled/out of hours situation). The Private Patient Office will maintain a database of consultants, specialities and treatments.

The Consultant is responsible for notifying the Private Patient Office as soon as they become aware of a private patient's requirements to receive Trust services privately and for filling in and providing the required private patient booking forms. Consultants must also inform their Private Patients that

the charges levied by them exclude all charges from the hospital, which will be billed separately to the patient.

Failure to notify the Private Patient Office of private patient activity is a serious matter and failure to identify/notify to the Trust of a private patient episode at the outset will potentially result in the failure to recover the fee owed to the Trust and make the consultant concerned potentially liable for the cost of NHS facilities used during the private patient episode. All occurrences will be reported to the Medical Director and MAC Chair and could also trigger disciplinary action against the individual concerned.

- Outpatients – Notification must be provided to the Private Patient Office of the intention to see a private patient in outpatients.

- Diagnostics & Prescription Forms – All request forms must clearly indicate the patients 'private' status

- GP to Consultant Admissions – The patient will be booked through the private patient administration team into a bed according to availability. The accepting Consultant must be available to assess and admit the patient and determine the treatment plan at the time of admission

- Other Hospital to Consultant - The patient will be booked through the private patient team into a bed according to availability. The accepting Consultant must be available to assess the patient and determine the treatment plan at the time of admission

- Planned Admissions - A booking form should be completed and forwarded directly to the private patient administration team.

- Paediatric Admissions - All children admitted for inpatient private treatment under the age of 16 years must be cared for on the children's unit. Adolescents between the ages of 16 to 18 years can be accommodated by agreement in general facilities. The surgical management of children must be in accordance with the Trusts policy and the Trust's safe guarding guidance must be followed for all young people under the age of 18years. The same booking process as for adults are followed with pre-assessment being arranged through the Paediatric team to ensure that the standards for Paediatric care is met.

- For current NHS admission – Patients that identify during the course of their admission that they either have private healthcare insurance or wish to self-fund their admission as a private patient – a consultant must be identified who will take the responsibility for the patient privately, if this is not the current consultant then the Private Patient Office will help identify an appropriate Consultant, the patient must be advised to contact their insurance provider and gain authorisation. Non urgent patients 7 day rule applies and for urgent patients ASAP.

9. CLINICAL SUPPORT CENTRES RESPONSIBILITIES

Private patients bring additional income to the Trust and the individual Care Groups. Simple but robust systems must be in place at directorate level to enable consultants to see and treat private patients in a timely manner, in an appropriate environment and with appropriate support.

- Care Group Manager's must have a clear view of how they see private patient activity covering costs and contributing to their income and contribution plans and this view should be communicated in their business plan, within the Care Group and to the Private Patient Manager.

- Executive teams/operational teams/Care Group Directors/Care Group Managers/Heads of Nursing/business managers/Matrons , all senior managers ,should ensure that staff understand that private patients are not seen instead of NHS patients but as well as and that the income generated benefits the Care Group, the Trust as a whole and reduces the NHS waiting times.

- Care Group Managers must with guidance and support from HR, ensure that non consultant staff involved in the delivery of private patient activity outside their normal working hours are paid appropriately. This will normally be through overtime at Agenda for Change rates or through bank/agency. Care Group Managers must ensure staff are aware that they should not accept payment from consultants for supporting private activity carried out during their contracted hours.

- Where the provision of treatment, care or other services to private patients falls within normal contracted hours of employment, then there will be no additional payment made to employees for such activity in order to avoid a 'double payment'. In these circumstances Agenda for Change remuneration terms will apply, as set out in their terms and conditions of employment.

- Care Groups should not make any additional payment to consultants or any other staff for private work undertaken in contracted hours as this would constitute 'double payment'. Where a consultant sees private patients during core hours, this must be in alignment with fulfilment of NHS job plan requirements and with the knowledge of the Clinical Director and Medical Director and with transparent and documented arrangements in place to pay back time (time shift) as necessary.

Where junior medical staff, nurses or members of professions allied to medicine are involved in the care of a private patient in the Trust, they will normally be doing so as part of their NHS contract and will therefore be covered by NHS Indemnity.

10. CHANGE OF PATIENT STATUS

10.1 Patients transferring from the Private Sector to the NHS

If a patient wishes to change their status from private to NHS care, or from NHS care to private care with the NHS facilities, then the overarching principle is that any switch between a private provider and the NHS must not advantage or disadvantage the individual concerned when compared to a patient who has remained within the NHS for all their pathway of care.

In the case of any change of status of a patient from private to NHS the lead consultant must inform the Private Patient Office, and provide an overview of the patient's clinical priority to treatment, as an NHS patient. Clinical priority must be the sole criteria for access to NHS facilities. The Private Patient Office must be informed at once of any change of status. It must be noted that consultants cannot make routine onward referrals from the private sector to the Trust either to themselves or to other consultants for conditions not related to the original consultation. This does not apply to urgent or fast track conditions or where there are defined clinical pathways, for example radiotherapy following surgery. All such requests must be directed to and coordinated via the patients' NHS General Practitioner.

Patients can choose to convert between the private sector and the NHS at any point during their treatment without prejudice. All patients wishing to transfer from the private service to the NHS must be returned to their GP to be offered choice and onward referral to an NHS provider.

For patients who have been seen privately but then transfer to the NHS, the referral to treatment clock should start at the point at which clinical responsibility for the patient's care transfers to the

NHS, i.e. the date when the Trust accepts the referral for the patient. Patients who are referred to the Trust should not be able to access procedures or treatments that are not commissioned locally. It should be noted that any drug therapy commenced in the private sector will only be continued if it is a locally commissioned pathway or drug.

10.2 Inpatients

A private in-patient can only opt to change their status to NHS during the course of their stay in a NHS hospital when a significant and unforeseen change in circumstances arises, e.g. when they enter hospital for a minor operation and a more serious complaint is found. At this stage the Consultant must complete and ask the patient to sign the relevant documentation.

Where a person is receiving treatment in a NHS or private hospital as a private patient and they or their representative seek to change their status to that of a NHS patient; the insurance company (if one is involved), lead Consultant and hospital facility, all have a joint duty to ensure that the patient receives seamless care and that arrangements are made with the NHS for such a change to occur in a planned and orderly manner.

If continuing in-patient care is required, then the normal procedure for advising the NHS (as well as a patient's GP) of an emergency admission should be followed.

Where a patient is referred from a Private Hospital to an NHS Hospital because of enhanced facilities and is not admitted through Accident and Emergency, then the episode of care is deemed continuous and private patient status will be effective immediately at point of entry to the NHS establishment. The Private Patient office must be notified of the potential admission so that the health insurance cover can be authorised for the transfer or an agreement made with the patient to self-fund the episode and set out what the costs might be.

10.3 Outpatients

A patient who sees a Consultant privately in an outpatient setting who then opts to seek treatment under the NHS may do so without prejudice. The patient does not have to be referred back to their GP for a subsequent referral, provided the condition is related to the original consultation, but will join the waiting list at the same point as if the consultation had taken place as a NHS patient. This does not apply to urgent or fast track conditions or where there are defined clinical pathways, for example radiotherapy following surgery.

An outpatient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a health service hospital. This means, for instance, that diagnostic or other tests requested at a private outpatient visit must also be carried out on a private basis as well, and this will include follow up appointments within the episode of care. Patients who are referred to the Trust should not be able to access procedures or treatments that are not commissioned locally. It should be noted that any drug therapy commenced in the private sector will only be continued if it is a locally commissioned pathway or drug.

A private out-patient at an NHS hospital is none the less legally entitled to change their status at a subsequent visit and seek treatment under the NHS. **A patient can move from private to NHS treatment within a single episode but MUST then remain an NHS patient for the duration of that treatment.**

10.4 Patients transferring from the NHS to the private sector

NHS Patients already on NHS waiting lists opting to have a private procedure must be removed from the NHS waiting list and the referral to treatment clock stops on the date that the patient informs the provider of this decision. A new referral must be created to the provider of choice.

Where a patient requests to attend a private consultation with their NHS consultant in an NHS Hospital only, in order to gain more information about their condition, but wishes to remain on the NHS waiting list, this is acceptable and does not stop the referral to treatment clock. Where there is no clarity the default position should be to discharge the patient back to the patient's NHS GP or the consultant should discuss the case with the GP.

Patients that are currently admitted as an NHS patient that express a wish to change status to private and identify during the course of their admission/stay that they either have private healthcare insurance or wish to self-fund their admission as a private patient the following must take place before the patients status can be changed:

- A consultant must be identified who will take the responsibility for the patient privately, if this is not the current consultant then the consultant will have to nominate another appropriate colleague.

- There will need to be a clear treatment plan in place, without this the insurance company are unlikely to authorise the episode.

- The patient or a delegated family member must be advised to contact their insurance provider and gain authorisation.

- For patients wishing to self-fund the consultant will need to provide a plan so that an estimate of the potential costs can be developed and a deposit of this amount gained from the patient or family representative either prior to or at the point of transfer.

- Until both of these have been completed the patient cannot be accepted as a private patient.

11. MARKETING AND PROMOTION OF SERVICES TO PRIVATE PATIENTS

The Private Patient Team and the Trust will work with the Consultants to develop new markets to help grow new revenue streams for mutual benefit. The Trust believes that by investing in the Private Patient Services and other resources including marketing it can provide an environment in which Consultants will use as an additional facility for managing and developing their private practice and provide a facility of choice for patients requiring complex treatment or treatments not locally provided for.

The income generated from private practice will then be used for the benefit of all patients within the Trust.

All staff with the exception of consultants that offer private practice may promote that the Trust supports private patients.

In order to maximise the opportunity to generate income from patients opting to have private care at the Trust, business plans by each Care Group should include a reference to Private Patient activity – established and potential growth areas.

Patients who wish to receive private care should be given the opportunity and support to do so. Advice should be available on how to elect to receive such care. This advice will be promoted by the Private Patient Services through a variety of mediums such as a dedicated webpages, linked directly to the Trust, social media platforms such as Twitter and Facebook, posters and banners located strategically around the Trust, leaflets and advertisements in Trust joint marketing materials such as League of Friends patient bedside brochure, advertisements on TV boards within the Trust. The Private Patient team will seek appropriate external marketing sources such as GP appointment cards, relevant healthcare marketing leaflets etc.

12. FINANCE

12.1. Private Patient Office

The Private Patients Office consists of a dedicated team of staff with responsibility for managing and supporting all private patient activity across the Trust irrelevant of site. The Office is led by a Nurse Manager and is based in the dedicated office located at Scarborough Hospital

The Private Patients Office is pivotal to ensuring that private patient activity is effectively managed and administered across the Trust as well as ensuring fees are recovered. Consultants undertaking private patient activity are obliged to notify the Private Patients Office of all private patients seen and investigated or treated, whether inpatient or outpatient.

12.2 General Payment Information

Private Patient charges consist of the following:

a) Consultant fees, anaesthetists fees (invoiced by the individuals)

b) Hospital Services, which are billed by the hospital, and cover:

- All other treatment – staff costs (e.g. Nursing, Paramedical support, medical excluding Consultants)
- Diagnostic and Testing Service Costs (e.g. X-ray, CT, Laboratory Services)
- Non Staff Treatment Costs e.g. drugs, dressings, consumables, medical equipment)
- Accommodation Services (e.g. catering, cleaning and laundry);
- Overhead costs (e.g. heat, water, electricity, capital costs; Administration)
- Any additional services provided in excess of that for NHS/private patients

All private patients must sign an “Undertaking to Pay” form prior to the receipt of services. By signing the form, the patient confirms that they take ultimate responsibility for the hospital charges, whether they are insured, sponsored or self-funding.

All self-funding patients (those without medical/health insurance or those choosing not to use it) will be required to pay the full estimated amount due before treatment, which in some cases may be required *at least 5 working days before the day of admission*. Failure to do so may result in the service or treatment being cancelled or deferred. Following discharge an invoice will be raised that will include any additional charges incurred that had not been planned for including any additional nights, conversely of the patients stay is shorter and incurred less tests and/or procedures the patient will be credited any amount owing from the original payment.

All insured patients need to provide the name of their health insurance provider and an authorisation code on or before the day of the procedure or treatment. No procedure will take place without an insurance authorisation code and the patient may be charged a cancellation fee and/or for consumables ordered in context with the procedure.

It is the patient's responsibility to verify with their insurers that the condition to be treated is covered by their insurance and that cover is adequate to pay for the treatment to be provided. The Trust is also responsible for cross checking and verifying this episode of care and obtaining pre-authorisation.

The Private Patient Office will seek authorisation from the health insurance provider prior to the date of admission that they will cover the full cost of treatment relevant to the Trust's charges. Any known excess or shortfall in the estimated cost of treatment is the responsibility of the patient and payment will be taken prior to admission. Failure to comply could result in admission being refused.

The cost of treatment will be charged as stipulated in the Trust's Private Patients' Tariff as agreed under contract with an individual insurer, or as published for self-paying patients.

Patients who do not attend for their appointments/procedures may be charged the full cost of their treatment as if it had occurred. A notice or letter will be sent to the patient informing them of their obligations.

It is imperative that the patient checks the detail in their individual policy as charges that are not met by their health insurer become the patients' responsibility. Any shortfall in invoices raised is the responsibility of the patient and the Trust expect payment to be made within 28 days of the date of issue of the invoice.

Any and all costs associated with recovery of amounts due will be charged to patients and the outstanding debt will be subject to interest charges from the date of invoice.

12. 3. International Insurance

It is Trust policy not to deal direct with insurance companies based abroad, if patients are insured by an overseas company, they will be expected to pay the estimated cost of their treatment in full in advance. The Trust may require further payments on account should the treatment and/or length of stay be longer than anticipated.

12. 4. Sponsored Patients

Any sponsored patient will be treated as a self-funding patient, and an estimate of the total cost of care will be given prior to admission. This estimated cost must be paid either by the patient or by the sponsor *in full at least 5 working days prior to admission if possible unless in the case of an urgent/unplanned admission where this will be required to be paid on admission.* The Trust may require further payments on account should the treatment and/or length of stay be longer than anticipated.

A letter of guarantee must be obtained from the sponsor, if this has not been received before treatment starts, the patient will provide payment which can be refunded when the letter of guarantee has been received and verified by the Private Patient that it covers the full costs of the treatment.

12. 5. Outpatients & Diagnostic Services

Payment for outpatient services must be paid in full on the day of treatment or prior to the day of treatment.

A patient referred to the Trust for diagnostic testing from a private consultation either at the hospital or elsewhere (e.g. at a private hospital or at the request of their GP) will be considered to be a private patient, liable to pay the full cost of any tests undertaken.

An outpatient cannot be both a private and an NHS patient for the treatment of one condition during a single visit at an NHS hospital. Private patients are normally expected to remain private throughout their whole treatment episode and should not transfer to the NHS unless there is a significant and unforeseen change in circumstances.

The outpatient private patient form must be completed at the time of the appointment, signed by the patient and returned to the Private Patient Office.

12. 6. Financial Control Requirements

The Private Patient Office will manage the financial control requirements on a day to day basis to ensure that:

- Systems and procedures are in place to identify all private patients to whom direct charges are applied, and to ensure that all charges that are applicable to private patient episodes are accounted for.

- Private Patient Tariffs are constructed and reviewed on a regular basis to ensure that private patient activity makes an agreed and appropriate contribution to the Trust's overheads and local budgets.

- Patients are aware on admission and/or during the episode of care, of the scope and quantum of the Trust's fees for being treated as a private patient and their responsibility to settle Trust fees as well as medical practitioner's/ Consultants fees.

- All private patients have completed, signed and returned an 'Undertaking to Pay' form prior to or on the day of admission.

The Private Patient Office opening times are Monday to Friday 8.00 am to 5.00 pm. A credit/debit swipe machine is available in the Cashiers Office, as well as the Private Patient Office. Credit/debit card payments can also be taken over the phone. Cash payments can be made at the cashier's office.

If a private patient is admitted as an emergency, the accepting Consultant must advise the Private Patients Office as a matter of urgency, and an 'Undertaking to Pay' form must be completed, signed and returned as soon as possible so that arrangements can be made to capture payment. Copies of the Undertaking to pay agreement are kept in the Private Patient Office. A patient must not be accepted for private care unless there is a named consultant and an agreement has been complete, until that time the patient remains under the care of the NHS.

12. 7. Internal management accounting

The Private Patient Office will work with Finance to ensure that income is correctly coded against the appropriate cost centre. This is to ensure that reports are produced to allow management to monitor income and recovery, and to ensure that the contribution of private patient revenues to the overall Trust financial position is known.

All private patient revenues, costs and services provided to a third party commercially will be coded into divisional and directorate accounts, consistent with service line reporting.

12. 8. Private Patient Charges

The Private Patient Manager, in conjunction with the finance team, will ensure that private patient charges are reviewed regularly, and these reviews take place at least annually.

The Trust will conduct negotiations annually with private medical insurers in order to reach agreement on pricing and network status.

Pricing must at least recover full costs, including overheads, depreciation of assets and appropriate return on capital employed.

12. 9. Record Keeping

Records will be maintained by the Private Patients' Office in such a way that the following information can be accessed quickly and accurately:

- Patient's name, address and telephone number.
- Completed 'Undertaking to Pay' agreement.
- Health insurance details for insured patients.
- Name of Consultant.
- Details of all treatment received, admission and discharge dates.
- Invoices raised and settlement dates. This is maintained by income section, Finance based at Tribune House.

The Private Patients Office, in conjunction with the Finance Manager and care group Managers will maintain a record of all activity by Consultant, including In-Patient, Out-Patient and day case episodes, together with income generated for the Trust by each Consultant and produce regular reports for submission to the Director of Finance.

The Private Patient team must ensure that the CPD name is accurate showing the correct status of the patient and that all private patients are entered on the system for every visit they make to the Trust.

The Private Patient Office reviews CPD on a regular basis to check for any Private Patients that may have been admitted that they are not aware of, so that the finance of these patients can be accurately captured. Therefore is it vital that all administration staff throughout the Trust must ensure that they accurately record the patients status on CPD for each admission, the default entry is NHS.

12.10 Consultant Fees

The Trust Private Patient Office will under some agreed circumstances collect private patient fees on behalf of consultants. On receipt, the Private Patient Office will enable prompt payment of these fees, usually within 14 days. The Private Patient Office will actively manage bad debt risks, and share bad debt information with the MAC and individual consultants as required. Periodically the Trust may be required to retrospectively apportion nett bad debt with consultants on an agreed basis.

From time to time insurance companies may request medical reports in order to process a claim. A claim may remain unpaid in whole or in part until the report has been received and assessed. It is therefore important that Consultants provide any requested reports to the insurer in the required time frame.

13. REFERENCES AND ASSOCIATED DOCUMENTATION

This policy is to be read in conjunction with;

- The Department of Health & Social Security Management of Private Practice in Health Service Hospitals in England & Wales 'Green Book' 1986

- The Department of Health (DOH) 'A Code of Conduct for Private Practice' Recommended Standards of Practice for NHS Consultants 2004
- Data Protection Act 1998
- The Health and Social Care Act 2008.
- The Department of Health Guidance on NHS patients who wish to pay for additional Private Care 2009
- GMC – Good Medical Practice Guide 2013

14. EQUALITY IMPACT STATEMENT

To be completed

15. MONITORING COMPLIANCE WITH PROCEDURAL DOCUMENTS

To be completed

This document will be monitored to ensure it is effective and to assurance compliance.

Term	Description
"Consultant"	A registered medical or dental practitioner who is deemed eligible to have user rights at a hospital.
"Day-case"	Treatment, which is not received as an In-patient but which nevertheless, necessitates the pre-arranged occupation of a bed or comparable hospital facility for treatment in a hospital.
"Emergency treatment"	Immediate lifesaving treatment, resuscitation simultaneous with surgical treatment. Operation usually within 1 hour.
"Episode"	The total treatment of either an In-patient or Day-case patient from diagnosis through to discharge.
"GP referral"	Referral from a GP, optician or dentist, excludes other health service professionals such as physiotherapists.
"In-patient"	A person, who, on the instruction of a Consultant, is admitted to a hospital for treatment or examination, is receiving nursing care and, on the Consultant's instruction, is occupying a bed in the hospital at midnight.
"Intensive therapy" / "Critical care"	Any treatment in an intensive care, Intensive Therapy, progressive care, cardiac care or high dependency facility of a hospital.
"Medical case"	A person undergoing In-patient or day-case examination or treatment not included within the definition of a surgical case, and defined as a medical case by insurance companies.
"Out-patient"	A person who attends a hospital or consulting room on the instructions of a Consultant for examination, testing or treatment and who does not require a period of recovery under medical supervision.
"Private patient"	An individual who has chosen to pay for services provided by the Trust or has private healthcare insurance that will meet the costs of treatment.

“Private patient income”	Private patient income is defined as income arising from and receivable by an NHS Trust in respect of goods and services provided by the NHS FT directly or indirectly to patients other than for the purposes of the National Health Service.
“PPO”	Private Patient Office – the Trust department that is tasked with collecting the income due to the Trust from private patient activity.
“Private practice”	The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under section 65(2) of the National Health Service Act 1977), excluding fee paying services as described in Schedule 10 of the Terms and Conditions. Work in the general medical, dental or ophthalmic services under Part II of the National Health Service Act 1977 (except in respect of patients for whom a hospital medical officer is allowed a limited "list", e.g. members of the hospital staff).
“Procedure”	Surgical treatment, excluding diagnostic radiology, pathology and nuclear medicine.
“Services”	Procedures, treatment, intensive therapy, emergency treatment, radiology, pathology, imaging, pharmacy.
“Treatment”	Services which prevent or diagnose illness, includes services needed by pregnant women.

York Teaching Hospital
NHS Foundation Trust

Board of Directors - 25 March 2020
Workforce Report – March 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 of Directors with an overview of work being undertaken to address current and future workforce challenges.

Executive Summary – Key Points

- The work taking place across the Trust to support and reassure staff in response to the Covid-19 outbreak;
- The development of a new framework of values and behaviours in response to the 'Our Voice, Our Future' workshops;
- The review by Mike Wright of governance surrounding Nurse Staffing levels in the Trust, leading to new recommendations for Board Reporting, and a plan to review nursing establishments.

Recommendation

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

Author: Will Thornton, Head of Resourcing

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

Date: March 2020

1. Introduction and Background

March's Workforce Report sets out work that has taken place during the previous month, including planning for the spread of Covid-19 in the UK, work to support the development of a new values and behaviours framework for the Trust, and actions to support governance of Nurse Staffing levels.

2. Health and Wellbeing

Covid-19 preparations

In recent weeks, the UK has been dominated by preparations for a Covid-19 outbreak. The implications for all of our staff are significant. There has been and continues to be a need to provide assurance that the Trust is doing everything possible to support their wellbeing; while at the same time the Trust is having to think differently about how staff might be deployed to maintain services if the infection reaches epidemic levels.

The Trust has taken a number of steps to increase the level of support for staff. Any member of staff who is required to self-isolate following a conversation with NHS 111 and Occupational Health will be medically suspended on full pay. Self-isolation will not impact on their attendance record. In addition, staff attached to the Trust's Bank, or working for the Trust through a sub-contractor will be paid an average of earnings in the previous 12-weeks during their period of self-isolation.

The Infection Prevention Team has been at the forefront of the operation to ensure that frontline staff have the Personal Protective Equipment needed to safeguard against infection when dealing with suspected or positive Covid-19 cases. The Clinical Skills Team have supported this work by putting in place training for teams to ensure they are appropriately trained in donning and doffing. A comprehensive fit-testing programme is also in operation, co-ordinated by the Chief Nurse Team.

Occupational Health have developed a questionnaire for staff who have certain underlying medical conditions, and who are known to be at increased risk of developing more serious illness and/or complications from Covid-19. The information provided by staff, together with assessments from Occupational Health, will help inform decisions about deployment and offer protection for our most at risk staff wherever possible. Meanwhile staff working in high-risk areas, such as our Emergency Departments and Intensive Care Units, will be able to access support from staff in our Psychological Medicine team in their area of work.

The Trust is also temporarily reviewing its policies to offer easements for maintaining services. Staff are being permitted to carry five days' annual leave into the new financial year in order to increase the level of rota coverage in March. The Trust is also actively looking to redefine its position on flexible, agile and home working to enable more staff to work remotely should the need arise. In addition, staff are being asked via a questionnaire to provide information on any extended skills or experience that could help maintain services in the event of staff shortages.

Work will continue throughout the coming months to develop these arrangements in response to the changing picture in the UK.

Smoke-free

In February, Corporate Directors approved the plan for all Trust sites to become smoke-free from 1 July 2020. This is in response to the Next Steps on the NHS Five Year Forward View document published in 2017, which stated that all NHS estates would be smoke-free by 2019-20. Following consideration, the Trust will continue to permit the use of vaping and e-cigarettes as measures which support smoking cessation. A communication strategy will be developed to support this change, with a strong focus on how we manage the change for patients and visitors.

Flu

The 2019-20 vaccination campaign has now completed with the Trust having vaccinated 71% of front-line staff. This is the same level as 2018-19, and falls short of the increased target of 80% set by NHS England.

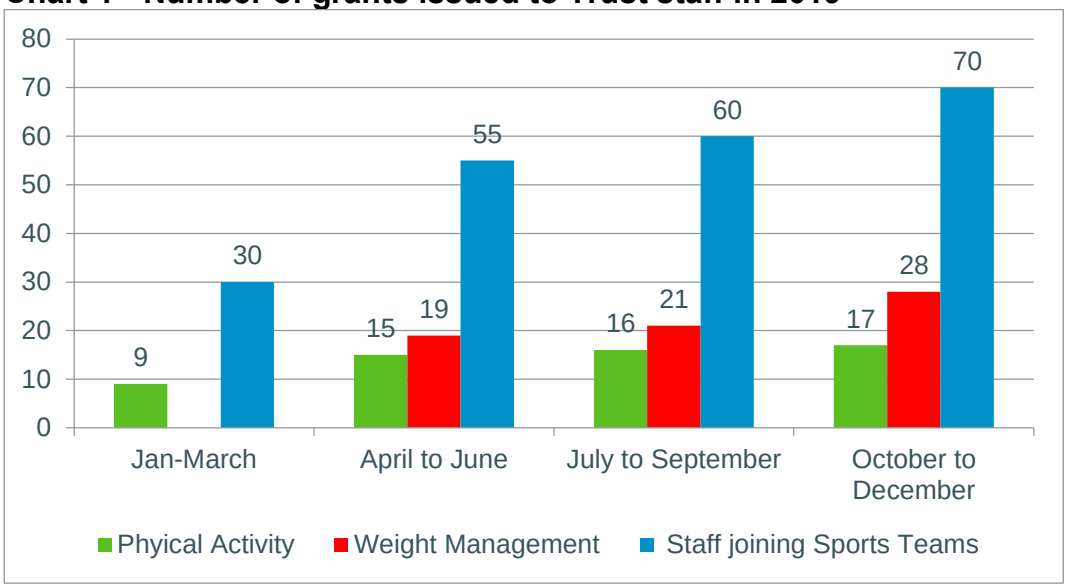
In 2020-21, the CQUIN target is 90%. The Trust is beginning to plan for increasing vaccination levels, particularly with utilisation of Peer Vaccinators. Peer vaccination proved to be very effective in 2019-20: more than 1,000 staff received the vaccination via this programme. An increase in the number of Peer Vaccinators would assist with achieving the 90% target, but would involve mandating the role (for example, this could be performed by every Ward Manager) or expanding the team of Vaccinators to include unregistered nursing staff. A recommendation will be made to Executive Board in April.

Grants towards physical activities, weight management courses and team sports

Over the past 12-months, the Trust's Staff Benefits Team has recorded a significant increase in the number of staff applying for grants towards physical activities, weight management courses and team sports.

These three types of grant are funded by the Staff Lottery and can be used by staff as contributions towards membership, course or club booking fees. They are available annually and worth up to £150 in total. During the 2019 calendar year, £3,825 was paid to staff through these schemes (340 applications).

Chart 1 - Number of grants issued to Trust staff in 2019



3. Our Voice Our Future

The Trust has now closed the second Our Voice Our Future online workshop run by Clever Together. This workshop was used to validate Clever Together's analysis of ideas put forward by staff through the initial workshop. Collectively across the two workshops, staff have shared more than 25,500 ideas and insights. Clever Together met with the Board of Directors in February to present their findings. As a result, it has been agreed that the Trust will change its values to:

- We are KIND
- We are OPEN
- We pursue EXCELLENCE

These values are underpinned by behaviours:

We are KIND, this means we:
- RESPECT and value each other;
- Treat each other FAIRLY;
- Are HELPFUL, and seek help when we need it.

We are OPEN, this means we:
- LISTEN, making sure we truly understand the point of view of others;
- Work COLLABORATIVELY, to deliver the best possible outcomes;
- Are INCLUSIVE, demonstrating everyone's voice matters.

We pursue EXCELLENCE, this means we:
- Are PROFESSIONAL and take pride in our work, always seeking to do our best;
- Demonstrate high INTEGRITY, always seeking to do the right thing;
- Are AMBITIOUS, we suggest new ideas and find ways to take them forward, and we support others to do the same.

Work is now ongoing corporately and within the care groups to review the ideas put forward through the 'fix the basics' workshop to create action plans. These action plans will also include actions as a result of the feedback received through the 2019 Staff Survey.

4. Talent management

The Trust is in the process of developing a new Talent Management Framework. The Framework is being developed to provide managers with a structured approach for developing employees' potential in line with organisational and individual needs, and retaining talent within the Trust. The Framework will become a fundamental part of the workforce planning process and will enable the Trust to adopt a clear and transparent approach to succession planning and recruitment.

To support the Framework, an appraisal and talent window has been launched and will run annually from 1 March to 30 June. The purpose of the window is to ensure that agreed shared objectives transcend individuals and departments, and flow from the Board to all employees.

The appraisal and talent conversation will consist of two parts: a conversation looking back on the previous year's performance, taking into account the Trust's new behavioural framework. This section will also involve objective setting. The second part will then focus on the employee's future aspirations, readiness and development needs.

Following the window there will be a review period where the data from all the appraisal and talent conversations is collated at team, directorate and care group level, mapping individuals and their aspirations alongside the learning and development requirements. This will ultimately feed into an overall Trust matrix to identify the talent pipeline and future leaders of the Trust.

5. Safer Staffing

During January, the Trust commissioned Mike Wright, previously Chief Nurse at Hull University Teaching Hospital NHS Trust, to independently review the organisation's governance and reporting of Nurse Staffing Levels. As part of this work, Mike visited York Hospital twice to speak with a number of Nursing, Workforce and Finance Managers, while also undertaking a review of organisational policies and reports against regulatory requirements. These include Board reporting and the regular review of nursing establishments to support quality and outcomes.

Mike has now issued the findings of his review. These include recommendations to adjust monthly reports submitted to Board on Safe Staffing so that they provide a clearer link to key patient care standards and outcome measures. The report also identifies the need to operationalise the process of reviewing nursing, midwifery and care staffing establishments every six-months. This is to ensure that staffing levels are budgeted appropriately in comparison with the levels of demand and acuity on wards. This type of review is overdue in the Trust, and therefore the Chief Nurse Team will undertake a piece of work, supported by a stakeholder team during the coming months. The initial review will consider workforce plans for other clinical staff groups so that it is fully integrated into the Trust's overall workforce plan.

6. Recruitment update

In recent weeks, the Trust has completed the recruitment process for a number of key roles within the organisation. In February, the process to appoint a new Managing Director for York Teaching Hospital Facilities Management was concluded, and Delroy Beverley will take up the appointment in April, succeeding Brian Golding following his retirement. Meanwhile, Lucy Brown has been appointed as Director of Communications following a competitive recruitment process. The Trust has also completed recruitment to the Freedom to Speak Up Guardian and Guardian of Safer Working roles previously held as a single assignment by Lisa Smith. Stefanie Greenwood will take up the Freedom to Speak Up role, while Ruwani Rupesinghe has been appointed to the Safer Working role.

The latest appointments are just four of 1,339 made at the Trust during the past 12-months, including 656 from outside of the Trust.

International recruitment

At the end of February, the number of nurses recruited via the Trust's international nurse recruitment programme stood at 71 (43 arrivals in York and 28 in Scarborough in the last 9-months); with a further 41 arrivals planned between March and July 2020 (7 in York and 34 in Scarborough).

At the beginning of March, the Trust's registered nursing and midwifery vacancy rate stood at 8.07% (5.10% in York and 14.86% on the East Coast). To assist the Trust in reducing vacancy levels over the next 12-months, the Executive Board have provided support to extend the programme to recruit an additional 60 nurses (20 in York and 40 in Scarborough) from overseas between August 2020 and March 2021.

7. Changes to the immigration system

In February, the Government published a policy statement describing its intentions for the immigration system, which will take effect from January 2021. From this date, the new system will apply to all applicants from outside the UK. It will continue to operate as a points-based system, but will involve a number of changes from the current system which was designed specifically to support employment of workers from outside of the EU. Changes include:

- The removal of the resident labour market test;
- There will be no cap on the number of Tier 2 visas;
- Individuals will acquire points for three mandatory factors: a job offer, meets the skill level and English language requirements;
- Additional points can then be obtained for salary, whether the role is included in the shortage list or requires a very high level of academic qualification, e.g. PhD;
- The qualification range for the skilled route will start at level 3, A-level or equivalent (the current system starts at graduate, level 6);
- The salary threshold will be £25,600 per annum, although a lower salary can be considered for roles included on the shortage occupation list.

In practice, this means most registered healthcare professionals will meet the criteria for a visa, either through salary or because they are included on the shortage list. The Migration Advisory Committee review of the shortage list over the next few months will also consider whether any roles at bands 3 and above should be recognised as shortage. At present, there is concern about the lack of an obvious route for the employment of care workers, and the potential risk to social care providers.

8. Conclusion

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

York Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

Board Assurance Framework – At a glance

Strategic Goals

- **To deliver safe and high quality patient care as part of an integrated system**
- **To support an engaged, healthy and resilient workforce**
- **To ensure financial stability**

Goal	Strategic Risks	Original Risk Score	Residual Risk Score	Target Risk Score
Patient Care	1. Failure to maintain and improve patient safety and quality of care	**25**	**16 ↑**	**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**	**20↑**	**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↓**	**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**	**20↑**	**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**

Revised BAF approved in Aug 18 – current version 0.18 (Feb 20)

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, 13, 17, 18, 19, 20 – HR 1a&b, 4, 15 – CE 5a&b, 9 – DE1, 2 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – 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 = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure including o Assigned Director Portfolios, Structures & Teams o Ward to board nursing structures & teams o Patient Experience Steering Group o Safeguarding Children & Adults Teams & Internal & External Structures o Health & Safety Systems & Groups o Infection Prevention & Control meeting structures - Strategies, Policies & Procedures o Nursing and Midwifery Strategy, Patient Experience Strategy, Sign up to Safety Campaign pledges and Patient Safety Strategy. o Risk Management Framework o Performance Management Framework - Systems &Monitoring o Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities o CQUINs & contract monitoring o Recording of escalation systems NEWS etc o Medicines Management/EPMA implementation o National Surveys	- External inspections including CQC Reports - Internal Audit Programme - CQC and Choices website feedback - SHMI - National Survey Action Plans, Friends & Family Test - Premises Assurance Model, PLACE/TAPE Reports - Patient Experience Work Plan & Quarterly Reports - Quarterly Pressure Ulcer & Falls Reports - Mortality Reports – Learning from Deaths - IPC Quarterly Report & Annual Report - Patient Safety, Quality, Workforce, Finance and Performance Report to Board/Committees - Annual Complaints Report to Board - Quality Report - Patient Safety Walk Rounds - NICE, NSF and Clinical Audits/Effectiveness Reports - Safeguarding Children & Adult Reports to Board - Maternity Reports - Staffing Reports - Learning Hub Data	- 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 - The potential risk of harm to patients in light of the issues raised by the CQC report/letters Actions (Identify plans to address gaps)

○ NICE, NSF and Clinical Audit ○ Capital Programme ○ Maternity CNST ○ 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	- 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 - 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) - CQC Unannounced visit & Well Led responses and action plans (monthly monitoring at Board & Quality Committee) - MCA/DoLS action plans/reaudit- took place in Nov 19 with action plans now in place & no significant concern raised.

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, 9 – COO 2, 3, 6, 7, 8, 13, 17, 18, 19, 20 – DE1, 2 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – 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
  ○ Directors Portfolios – Transformation Lead
  ○ Business case management system
  ○ System Transformation Board
  ○ Care Group Structure implemented
- Strategies Policies & Procedures
  ○ Development of Trust Strategy and supporting strategies
  ○ Development of Care Group Service Plans and associated Business Cases
- Partnership working
  ○ HCV HCP engagement
  ○ ECIST Support
  ○ McKinsey Engagement
  ○ Partnerships & Alliances
  ○ Health & Wellbeing Board & Place Based Boards
  ○ 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
		- 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
		- Clinical senate review document to Board (Feb 20)

Revised BAF approved in Aug 18 – current version 0.18 (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, 13, 17, 18, 19, 20 – CE 8 – MD 6a&b, 7, 8, 10 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – 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 = 5 Severity= 4 Score: 20	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
  ○ Corporate Performance Team
  ○ Integrated Acute & Planned Care Board (York & SGH)
  ○ Care Group Structure implemented
- Partnership Working
  ○ Ernst & Young Diagnostic Work
  ○ ECIST engagement
  ○ YAS engagement
  ○ Health & Care Resilience Board
  ○ HCV HCP Cancer Alliance Board
  ○ Complex Discharge Working Group
  ○ System Planned Care Steering Group
- Strategies, Policies & Procedures
  ○ Trust Strategy, Clinical Strategy and Care Group Strategies
  ○ Policies & Procedures/Standard Operating Procedures
  ○ Performance Recovery Initiatives
  ○ Winter Planning/System Resilience/Winter Plan
  ○ Trust Operational Plan
- Training & Development
	- E & Y Reports
	- External Benchmarking of systems and pathways
	- Internal Audit Programme
	
	- Performance Reports
	- Operational Performance Recovery Plan
	- Winter Plan/System Resilience Plan
	- SAFER Local Delivery Plan
	- Planned Care Transformation Plan
	- Validation
	- Operational Plan
	- Learning Hub Data
		- Continued challenges around achieving the ECS on a sustainable basis
		- Need to develop primary care and community services – East Coast Review – to include a system plan for out of hospital services.
		- Recruitment
		- Robust process required to identify harm
		
		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)
		- Recruitment - Initiatives linked to strategic staffing risk
		- Single integrated improvement plans being developed with regular monitoring via PAMs (from 1.8.19 onwards)
		- Daily reporting of ECS performance & ED breach analysis – identification of learning or areas for improvement (new format from Jul 19) – continues to be refined with support from ECIST)
		- Development of an ECS recovery plan for both sites – which continues to be refined with weekly monitoring by COO
		- 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 – Jan 20)(Jan 20 – 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 20)

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (5) Failure to develop, maintain/replace and secure digital systems impacting on security, functionality and clinical care **CRR Ref**: SNS 1, 55, 74, DE2 **Lead Committee:** Board (last formal review – Jan 20)(Resources – Jan 20) **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)
		- Board lead for digital under discussion (in progress)
		- Digital maturity to be scored via EMR Adoption Model (EMRAM) (Mar 20)
		- User feedback to be gained via a number of methods; surveys, email, roadshows, user training

Revised BAF approved in Aug 18 – current version 0.18 (Feb 20)

		(ongoing, review Feb 20 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, 17 – CN 2, 24 - MD 2a&b, 8 – CE3, 5a&b, 9 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – 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) - 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 (Feb 20) - Health & Wellbeing Initiatives being implemented (Sept 20) - Workforce Plan (Oct 20) - Apprenticeship Steering Group Outputs (Apr 20) - Implementation of e-Job Planning (May 20) - Continue to develop Bank (Apr 20 - HCV HCP Workforce Action Plan (Oct 20) - East Coast medical recruitment project (Jan 20) - Recruitment Initiatives (Mar 20) - NHSE response to pension tax

Revised BAF approved in Aug 18 – current version 0.18 (Feb 20)

		- 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, 4, 15 – CE8, 9 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – 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 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)
- 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 (Nov20) Implementation of Health & Well being Strategy (Dec 20) Workforce Plan implementation (Oct 20) Flu Vaccinations (Feb 20) Safer Working Group Feedback initiatives (continuous) Line Manager Competency Training (Oct 20) Clever Together Programme (Jun 20)

Strategic Goal: To support an engaged, healthy and resilient workforce **Principal Risk**: (8) Failure to ensure there is engaged leadership and strong, effective succession planning **CRR Ref**: CE3, 8, 9 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – 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) 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)

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 – Jan 20)(Jan 20 – 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 = 5 Severity= 4 Score: 20	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 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 financial pressure on the system partners and the Trust through the shared risk contract. - System affordability issues in relation to delivery of constitutional standards - Uncertainty around availability of cash should the Trust fail to meet Q4 targets and not receive PSF **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).

Revised BAF approved in Aug 18 – current version 0.18 (Feb 20)

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, 7, 8 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – 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

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, 15 – DE1, 2 **Lead Committee:** Board (last formal review – Jan 20)(Jan 20 – Resources) **Director Lead:** Director of Estates and Facilities (reviewed Oct 2018)	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 2 Severity= 2 Score: 4	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)

- Trust Committee/Governance Structure
  - Trust Sustainable Development Management Group
  ○ Board Commitment
  - Travel and Transport Group
  - Head of Sustainability
- Processes & Systems
  ○ Good Corporate Citizen/ Sustainability Development Assessment Tool
  ○ 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) to include Climate Change Act targets
		- Sustainable Development Assessment Tool Action Plan (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)

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 – Jan 20)(Jan 20 – 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 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 financial pressure on 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.

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.

Corporate Risk Register - Current Risks (Print Version)

Risk No.	Opened	Risk Type	Risk Subtype	Current or Potential Risk Status	Description	Current Mitigation	Responsible Person	Next Review Date	Severity (Current)	Likelihood (current)	Rating (current)	Eliminate Reduce or Tolerate?
Manager: Executive, Chief												
CE3	20/08/2018	Organisational	Reputation	Current - External Risk, Current - Internal Risk	There will always be a potential risk in a lack of confidence in the organisation, which might be caused by multi factoral issues, ie loss of public confidence in service delivery, loss of partner confidence, loss of staff confidence in the leadership of the organisation or a loss of confidence in the organisation by our regulators resulting from reviews or this may result in reputational damage to the organisation.	There are various mechanisms in place to ensure that risks that might impact on the organisations reputation are managed and identified. For example, the Trust has a programme of staff and partner engagement that extends to team brief, and has launched an internal programme of Staff Engagement (Clever Together) that has resulted in a summit 'Our Voice , Our Future' held in Nov 2019. Council of Governor meetings, Public Board Meetings. Meetings with CCGs and other Strategic Partners, Council Overview and Scrutiny Panels, Engagement meetings with the CQC and other system partners.	Chief Executive	14/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
CE5A	01/11/2018	Organisational	Sustainability of Service Delivery	Current - External Risk, Current - Internal Risk	There is a current risk to the delivery of some services on the Trust East Coast Sites. This is caused by nursing and medical staffing vacancies, significant demand for acute services underpinned by local demographic issues. This has the potential to influence our ability to deliver some services safely.	There are many mitigations currently being undertaken to manage the various risks articulated in various parts of the Corporate Risk Register. (Ie developments in nurse staffing recruitment, introduction of AHPs to aid senior decision making. Where possible there is cross working between sites to ensure that safe delivery and continuity of service. The Trust is developing a Clinical Strategy due for completion in April 2020	Chief Executive	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
CE5B	05/03/2019	Organisational	Reputation	Current - Internal & External Risk	There is a current risk to the organisation which is caused by adverse media and social media CQC report published in Oct 19 reflected a rating of inadequate for Safety which may further cause a damage to reputation and lack of public and staff confidence.	Action has been taken to meet with key stakeholders to allay concerns over the purpose and potential outcomes of the East Coast Review. MckInsey are due to report to the organisation by the end of 2018 , after which key stakeholders will consider suggested options. A York and Scarborough Quality Improvement Board which includes key stakeholders has been established from November 2019. A new QIB Board has been established which includes the participation of all stakeholders, CQC, NHSI/E and Commissioners.	Chief Executive	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
CE8	17/05/2019	Organisational	Sustainability of Service Delivery	Current - Internal & External Risk	There is a potential risk to the ability of the Executive Team to provide the leadership required in a rapidly changing environment/organisation. This is caused by the significant demands of regulatory and commissioning bodies, the change from being an autonomous organisation to whole system working and the impact on an Executive Team with current vacancies. This may result in insufficient capacity to undertake day to day leadership and sub optimal preparation for other key activities.	This is being mitigated by the prioritization of demands as they arise and appropriate delegation to other senior managers	Chief Executive	14/04/2020	4 - Severe Harm	5 - Very Likely	20	Reduce

CE9	13/01/2020	Organisational	Regulatory Intervention	Current - Internal & External Risk	The CQC have issued Section 31 Enforcement Action and a Section 29a Warning notice which require the organisation to take immediate action on a number of issues. This is a consequence a recent un-announced inspection of Emergency Care and Medical Services at Scarborough Site, and the Emergency Care on the York site. Such action will potentially have an increased risk of patient harm and will attract negative media coverage.	In terms of mitigation, a comprehensive action plan has been developed and is being reviewed on a fortnightly basis. The action plan details strategies for the improvement of staffing, recruitment and retention and those issues that have an impact from low level staffing such as low appraisal and statutory/mandatory training rates. Work is being undertaken to review the Facing the Future Standards for Children in Emergency Settings assessments undertaken in 2019. Work is on-going to establish an Anti-ligature room in Scarborough ED, alongside work being undertaken on access and flow. System wide partnership meetings are in place that have a focus on this issue. Action continues to be taken with a factual accuracy response sent to the CQC on 4th Feb 2020. Meetings have taken place to ensure priority actions are taken. Action plans are taking place for the Section 29a's which require a formal response on 21/4/2020	Chief Executive	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Eliminate

Manager: Nurse, Chief											
CN7	20/08/2018	Patient Safety	Infection Control	Current - Internal Risk	There is a risk to patient safety caused by hospital acquired infections, particularly with Cdiff caused through several contributory factors, environmental issues. Domestic vacancies failure to adhere to isolation protocols. All may result in patient harm and poor patient experience.	Monitoring of current performance is being undertaken on a weekly basis via Q&S and Corporate Directors. Post infection reviews take place . The findings are reviewed and disseminated for learning, e.g. through PNLF, patient safety initiatives, the IPC website. MSSA bacteraemia cases are reviewed by ward staff and infection control, though this process is for review, aiming to introduce a more robust method. Reporting monthly to the Board on all infections also takes place. The Cdiff outbreak at Scarborough has now officially ended. The trust is currently over trajectory on Cdiff with 109 cases against a trajectory of 61.	Chief Nurse	11/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
CN2	20/08/2018	Patient Safety	Nurse Staffing	Current - Internal & External Risk	There is a risk to patient safety which is caused by difficulties in recruitment resulting from a national shortage of nursing staff, including Registered Sick Children's Nurses. This is across both York and Scarborough sites, but with Scarborough experiencing greater difficulties. This has the potential to result in patient harm. This has resulted in the CQC issuing a Regulation 29a Warning Notice	The Trust has a multi faceted approach to mitigating this issue. This includes the training of AHP's, the Coventry University undergraduate programme,recruitment days and the Matron of the day taking the lead on staffing. In addition we have 49 international recruits now working as B5 nurses (37 in York and 12 in Scarborough). We have 16 currently in training who undertook their OSCE on the 5th February (awaiting results) and who will be based at Scarborough, 10 of whom are part of the HEE Global Learners Programme). We welcomed g a further 6 nurses to York on the 17th February and a further 15 join us in Scarborough on the 30th March. . We also have 2 existing members of staff who will undertake their OSCE in the next couple of months having been supported by the International Nurse Project. The Board have approved a further 60 international recruits.	Chief Nurse	11/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
CN8	20/08/2018	Patient Safety	Infection Control	Current - Internal Risk, Potential - Internal Risk	There is a risk of contagious infection outbreaks resulting from insufficient specialist and standard isolation capacity which may result in patient harm. A large proportion of current isolation capacity does not have on suite facilities which further increases the risk.	Action is being taken to mitigate by ensuring that patients with contagious infection are a priority for side rooms. Ward 25 has been HPV'd at York and there have been some ward bays in Scarborough HPV'd. A business case to enhance the existing HPV service was presented to Business Case Panel on 9 Dec 2019 and will require some further work. The LLP is leading on a project to reinstigate side rooms currently used as offices in clinical areas.	Chief Nurse	11/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
CN17	20/08/2018	Patient Safety	Infection Control	Current - Internal Risk	There is a risk of transmission of infection on the 3 Nightingale wards in Scarborough (Ann Wright, Duke of Kent and Graham Ward). This can lead to prolonged outbreaks of (ie norovirus, influenza) with associated patient morbidity and sometimes mortality (2018,2019). However, reduction of bed base would generate other risks which may outweigh the Infection prevention risk.	All precautions are taken to avoid the placement of patients with contagious infection on a Nightingale Ward, although there is a risk both at times of operational pressure, and a diagnosis of infection (ie Cdiff, FLU) post admission to a ward of infection being spread between patients. Estates, Ops and IPC are working collaboratively to identify solutions.	Chief Nurse	11/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
CN20	20/08/2018	Patient Safety	Infection Control	Current - Internal Risk	There is a potential risk to patient safety caused by a current lack of decant facilities at Scarborough Hospital to enable refurbishment or deep cleaning of ward environments.	Minor works are done around patients, or bay by bay decants, in some circumstances. Issues around domestic vacancies have been raised with the Director of Estates and Facilities.	Chief Nurse	11/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce

CN22	05/03/2019	Patient Safety	Safeguarding Children	Current - Internal Risk	There is a potential risk to patient safety caused by a current lack of a safeguarding children's doctor on the Scarborough site due to the post holder's maternity leave. This may result in difficulties in accessing a named doctor and potential patient harm and a failure to identify safeguarding concerns.	In terms of mitigation Dr L Baker will be acting as named Doctor support for the Scarborough site as cover for maternity leave. However due to the significant children's safeguarding issues in Scarborough it is not always possible to provide the support needed. However all consultant paediatricians are trained to level 3 safeguarding. This risk should be eliminated from April 2020	Chief Nurse	11/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
CN23	15/03/2019	Patient Safety	Infection Control	Current - Internal Risk	There is a risk to patient safety caused by periodic MRSA colonisation of babies in SCBU at York which is in part due to the ageing environment and an inability to deep clean effectively. This has the potential to result in patient harm.	In terms of mitigation babies and staff have been swabbed. Staff swabs are all negative, but rybotyping indicates it is the same strain as experienced in 2017. PHE are attending to look at the environment and undertake testing. PHE indicating that the source is now likely to be traced to an individual. PHE undertook a review in September 2019 with the support of some dedicated IPC time. The report has not yet been received.	Chief Nurse	11/04/2020	5 - Catastrophic Harm	3 - Possible	15	Eliminate
CN24	16/04/2019	Staffing & Human Resources	Nurse Staffing	Current - Internal Risk	There is a potential risk to patient safety caused by recruitment and retention difficulties in SCBU on the Scarborough site. This has the potential to result in patient and reputational harm.	The Royal College of Paediatrics and Child Health have recently published a report on the York and Scarborough Paediatric Service. It has suggested that on the Scarborough site we enhance the service with transitional care cots and consider alternative staffing models. In the meantime the unit gestation age will remain at taking babies at 34 weeks and above only, with a temporary cot restriction of 4. We continue to use agency locum paediatricians and midwives are rotating through SCBU to support nurse staffing (although this should improve from September as a result of successful recruitment). Once substantive staffing is in place, discussion will take place in the senior team and with Neonatal Network regarding reverting to usual gestational age criteria of 32-34 weeks and cot capacity of 8.	Chief Nurse	11/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce

Manager: Operating Officer, Chief												
COO2	22/08/2018	Patient Access & Performance	Emergency Care Standard (ECS)	Current - Internal & External Risk	There is a significant and material risk of failing to deliver contractual requirements relating to the achievement of the ECS, which is caused by: - increased non-elective admissions, exacerbated by an ageing population with significant co-morbidities - bed capacity and high levels of bed occupancy (severity "exit block") - workforce challenges - inability to successfully discharge due to a lack of external support and community services, all of which negatively impact on patient experience. This has the potential to result in patient harm through delays in treatment. This has resulted in the issue of a Section 29 A warning notice.	Same Day Emergency Care (SDEC) - Service expansion to a full 7 day SDEC service, on both York and Scarborough sites, agreed. Test of workforce models for 12 hour opening on York site of Medical SDEC and Surgical Assessment unit at weekends begun, to complete mid-March. Scarborough site – new Home First Unit demonstrating considerable impact upon number of over 65s attending ED and turned around within 24 hours, and admissions of over 65s to inpatient wards. Bed occupancy by medical over 65s has also reduced significantly. York site have planned a further test of change from 9 March in ED, for Medical SDEC patient selection method, to try to further reduce admissions to inpatient wards.Site Management and Operational Escalation - Staff engagement undertaken to listen to concerns and plan improvements to formalise all roles and responsibilities contributing to efficient site management. Bed management team testing new roles and revised rota to improve continuity. Operational escalation protocol being revised for York's Care Group 1 to improve effectiveness of escalation measures. Trust internal and external ambulance divert process revised.ED Systems & Processes - York	Chief Operating Officer	14/04/2020	4 - Severe Harm	5 - Very Likely	20	Reduce
COO3	22/08/2018	Patient Access & Performance	Cancer Targets - 62 Days	Current - Internal & External Risk	There is a risk of failing to deliver the 62 day GP referral pathway, affected by patient choice, diagnostic access, tertiary capacity and growth in referrals for specific specialties. This has the potential to result in patient harm through delays in treatment and risks regulatory intervention. Where a patient's care is shared between the Trust and another provider, new national rules introduced from April 2019 mean that if a patient first seen at the Trust isn't transferred to the second provider by day 38, York NHSFT will be fully accountable for any subsequent breach. This is having a detrimental impact on the Trust's performance against the 62 day standard.	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. Rapid Diagnostic Centre (RDC) for patients with vague symptoms and Upper GI referrals. The Rapid Diagnostics Centre for Serious nonspecific symptoms is an early diagnosis initiative to support NHS England's national strategy for earlier and faster cancer diagnosis (28 day Faster Diagnosis Standard). It is envisaged patients coming through the new pathway will experience a rapid diagnostic one stop clinic approach involving a CT TAP and TNE scope and	Chief Operating Officer	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
COO6	22/08/2018	Patient Access & Performance	Ambulance Handover Times	Current - External Risk, Current - Internal Risk	There is a risk to failing to deliver the commitment to minimize delays to ambulance handover. This is caused by issues of patient flow as detailed above (COO2).	Mitigating actions are as detailed in COO2 above. This includes a Concordat Agreement with the Yorkshire Ambulance Service and commissioners in order to reduce avoidable delays in hand-overs. This encompasses self-handover of clinically appropriate patients.First Assessment Area opened in Scarborough. Ambulance queue nurse available 24/7.	Chief Operating Officer	14/04/2020	3 - Moderate Harm	5 - Very Likely	15	Reduce

COO7	22/08/2018	Patient Access & Performance	Long Waits in ED (8-12 hrs)	Current - Internal Risk	There is a risk of failing to deliver the requirement that no patient should experience a 12 hour trolley wait and the commitment to reducing the number of 8 hour waits. This may happen should the process of improvement fail to deliver the expected outcome. This may result in potential patient harm, poor patient experience, contractual and has resulted in regulatory Section 29 A intervention.	Mitigating actions are as detailed in C002 above.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	Chief Operating Officer	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Eliminate
COO8	22/08/2018	Patient Access & Performance	RTT	Current - Internal Risk	The Trust is not forecasting to meet the RTT standard in 2019/20, and ensuring the total waiting list (TWL) size at the end of March 2020 is lower than it was at the end of March 2018 will be challenging. Failure to achieve trajectories will result in patients waiting longer for treatment and will (especially for the TWL measure) result in regulatory intervention.	Robust demand and capacity modelling used to inform 2019/20 activity plans.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. 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). This	Chief Operating Officer	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
COO17	01/08/2017	Patient Access & Performance	National Targets	Current - Internal Risk	There is a risk to the JAG accreditation of the Endoscopy Units. This risk has been realised with JAG Accreditation lost at York. Scarborough's accrediation remains in place.This is because the Trust is not compliant with the National Endoscopy Database (NED) and there is a backlog of surveillance patients.There is a risk to the JAG accreditation of the Endoscopy Units. This is because the Trust is not compliant with the National Endoscopy Database (NED) and there is a backlog of surveillance patients.	Executive Committee have requested that CG4 create an Action Plan to regain JAG Accreditation on the York site. CPD development to ensure compliance with the NED has not been completed and there is no timescale for completion set at the moment. The care group is outsourcing a number of procedures to be compliant with timeliness requirements by Q4 19/20.	Chief Operating Officer	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Eliminate

COO18	01/04/2017	Patient Safety	Service Provision	Current - Internal Risk	There is no access to a Nurse Enhanced Unit (Level 1 facility) for vascular patients at York. This was highlighted in the vascular GIRFT visit in 2016 as a significant risk and means that vascular patients in York have a longer than average length of stay.	Corporate Directors approved a business case to create a Level 1 Nursing facility on the vascular ward (ward 11). The Director of Finance is leading discussions on how to progress the case with commissioners.	Chief Operating Officer	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Eliminate
COO19	08/05/2019	Patient Access & Performance	Capacity	Current - Internal & External Risk	The Trust is experiencing delays in the time taken to report imaging. This may result in poor patient care and outcomes. The biggest contributory factors to reporting delays are the consultant workforce and the current inability to carry out meaningful demand and capacity analysis.	Reporting turnaround times are now reducing as a result of recruitment, the use of an outsourced reporting radiographer company to report current plain film backlog and insourced capacity provided by an existing consultant.Involvement in the Humber Coast and Vale Reporting Hub solution to provide increased expert capacity for reporting images of patients in cancer pathways.Business case has been approved and the care group is currently in the process of procuring a Radiology Information System which will be installed by July 2020. KPIs for reporting turnaround times have been developed.	Chief Operating Officer	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
COO20	15/08/2019	Patient Access & Performance	National Targets	Current - Internal Risk	The Trust has not met the 99% diagnostics waiting time standard since August 2017. Failing to carry out diagnostic tests within 6 weeks of a referral can lead to poor patient experience and is likely to negatively impact on achievement of other standards such as RTT and cancer waiting times.	See COO13 and COO8	Chief Operating Officer	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
COO13	14/10/2019	Patient Access & Performance	Capacity	Current - Internal Risk	The diagnostic target has not been met, performance for February was 86.1%	Review of patient pathways involving Radiology. MSK Radiologist • 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.o 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	Chief Operating Officer	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce

Manager: Executive, Deputy Chief												
DCE00	22/08/2018				NO OTHER CORPORATE RISKS AT PRESENT		Deputy Chief Executive					
Manager: Estates and Facilties, Director												
DE01	21/08/2018	Estates & Facilities	Capital	Potential - Internal Risk	There is a material and significant risk in being unable to achieve required compliance with Trust estate plans, due to insufficient capital available to deliver the Trusts Estate Strategy. There is a plan for the re-build of Scarborough ED by 2024 and there are issues with nightingale wards in Scarbrough that require capital funding. This could result in adverse publicity or potential intervention by other NHS authorities or regulators.	This is currently being managed by the prioritisation and investigation of capital funding strategies year on year. Specific risk controls and mitigation in place to manage corporate/capital specific risk areas. It is identified there are existing significant risk outstanding to be addressed at main sites, with lower level risk at other sites, no funding currently identified to date, on these sites the risk is being managed at site level by local estates teams on risk specific case by case basis. The CQC have identified that mitigations need to be in place for Scarborough ED given that the new build is not due until 2024.	Director of Estates & Facilities	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
DE02	21/08/2018	Estates & Facilities	Equipment	Potential - Internal Risk	There is a significant risk in being unable to maintain the Trust estate due to insufficient funds being available for estate / equipment repair, replacement or to address any significant critical event or failure. There are pressures on both ED's and nightingale wards in Scarborough. This could potentially result in inability to deliver clinical services, loss of reputation and potential for regulatory intervention.	Budgets are calculated on historic and plan estates activity. The Trust has in place contingency for limited unexpected events or failure of estates and equipment. Condition survey has been completed 2018 and included in estates business planning. The current Trust financial situation requires close management and prioritisation of the capital and revenue spent.	Head of Capital Projects	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce

Manager: Finance, Director												
DOF1	21/08/2018	Finance	Corporate Efficiency	Current - Internal Risk	There is a risk of there being a failure to deliver current and future CIP requirements due to pressures within the organisation that could attract scrutiny of our FT license.	Extensive monitoring of plans and delivery through efficiency meetings, PAMs, Executive Board, Finance and Performance Committee and Board of Directors. The oversight of the programme is by the new Efficiency Delivery Group. An engagement programme has been implemented with the NHSI Operational Productivity Team to focus on key efficiency areas and to provide access to national subject matter experts.	Director of Finance	14/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
DOF3	21/08/2018	Finance	Corporate Financial Services - Cash Flow	Current - Internal Risk	There is a risk of there being a failure to manage organisational expenditure plans therefore impacting on the organisations ability to deliver its financial plan which may result in regulatory intervention.	Extensive monitoring of plans and delivery through Care Group Meetings, OPAMs, Executive Board, Finance and Performance Committee and Board of Directors. Experience has been gained as to the Distressed Cash Regime and daily cash flow monitoring and forecasting now routinely takes place.	Director of Finance	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
DOF4	21/08/2018	Finance	Corporate Financial Services - Cash Flow	Current - External Risk	There is a system affordability risk with the prevailing activity levels and available commissioner allocation share. Under the new combined NHSE/I regime this risk is expressed as a system risk under which the current levels of activity cannot continue.	Continued liaison and discussion with DH, NHSE, NHSI, STP and CCGs is underway to prepare a system cost reduction plan to ensure the system can live within its available resource. Detailed contract monitoring arrangements in place supported by STB and the AIC Management Group. Full participation by the Trust in the system-wide open book approach to contract planning and system costing.	Director of Finance	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
DOF8	21/08/2018	Finance	Corporate Financial Services - Cash Flow	Current - Internal Risk	There is a risk that the Trust fails to meet the terms associated with receipt of the Provider Sustainability Funding, Financial Recovery Fund and MRET allocations totalling £20m for 2019/20.	Continued liaison and discussion with DH, NHS England and NHSI. Detailed monitoring arrangements are in place for the Exec Board, Resources Committee and Board of Directors.	Director of Finance	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
DOF9	21/08/2018	Finance	Corporate Financial Services - Cash Flow	Current - Internal Risk	There is a risk that the Trust fails to manage agency expenditure within the NHSI prescribed cap of £15m. This will compromise delivery of the financial plan, receipt of the sustainability funding and may result in NHSI intervention.	Enhanced agency controls and actions remain in place to manage nursing and medical costs. Continued liaison and discussion with NHS England and NHSI. Detailed monitoring arrangements are in place for Corporate Directors, the Exec Board, Resources Committee and Board of Directors.	Director of Finance	14/04/2020	5 - Catastrophic Harm	5 - Very Likely	25	Reduce
DOF11	21/08/2018	Finance	Corporate Financial Services - Cash Flow	Current - Internal Risk	There is a risk that the system will not be able to identify and deliver sufficient cost reducing QIPP to return the system to financial balance.	This is a maximum score risk. The STB has been established to manage this risk and the Trust is fully engaged in this process. Detailed monitoring of the system gap is in place through the STB. Planned and unplanned care QIPP groups have been established and work programmes have been agreed and new initiatives continue to be developed.	Director of Finance	14/04/2020	5 - Catastrophic Harm	5 - Very Likely	25	Reduce

Manager: Workforce & Organisational Development, Director											
HR15	22/08/2018	Staffing & Human Resources	Sickness Absence	Current - Internal Risk	Risk to quality of patient care due to increased staff sickness absence. Specifically Additional Clinical Services and Estates and Ancillary. Increase relates primarily to increase in long term sickness relating to Stress, Anxiety and/or Depression.	Range of measures including revised sickness management policy; revised health and wellbeing strategy and obtaining further support from the communications Team to reach wider audience.	Director of Workforce & OD	07/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
HR1a	01/11/2018	Staffing & Human Resources	Medical Staffing	Current - Internal Risk, Potential - Internal Risk	There is a risk to how the organisation manages medical/surgical services across the trust both in and out of hours, resulting from recruitment difficulties that are being experienced nationally. This may potentially result in patient harm, regulatory intervention and loss of license in additional to increased agency usage / costs causing inconsistent delivery of care to patients and adversely impacts the financial viability of the Trust.	The organisation has had to take steps to base some specialist services on one site (ie Breast, vascular, stroke and dermatology) in order to provide a safe and quality service to patients. New workforce models are being developed. In addition short-term actions to offer recruitment incentives such as RRP / more interesting and attractive job roles. Medium term developing the middle grades to offer an attractive career with development and appropriate remuneration / Development of ACPs / PAs and more Associate Specialists. Long term - improved workforce planning and communication with STP Workforce Board and HEE to ensure appropriate numbers of trainee places are commissioned. Continue to review skill mix and role profiles.	Director of Workforce & OD / Medical Director	07/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
HR1b	01/11/2018	Staffing & Human Resources	Medical Staffing	Current - Internal Risk, Potential - Internal Risk	There is an increased risk to patient safety on the Scarborough site which experiences particular difficulties in recruiting medical staff. We currently have a vacancy rate of 19% which may impact on patient experience and care.	Consideration is being given to how and where services can be provided and also to oversees recruitment. The organisation now has a rota that includes intensivist presence at our Scarborough site and we have introduced the Acute Medical Model at Scarborough	Director of Workforce & OD / Medical Director	07/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
HR4	01/11/2018	Staffing & Human Resources	Medical Staffing	Current - Internal Risk	Risk to the delivery of safe and effective care at the weekends due to the lack of senior medical input. This may result in patient harm, delays in treatment and review, delayed diagnosis, and delayed transfers of care. The national contract (Schedule 3, para 6) prevents enforcement of weekend working for non-emergency care. This results in an inconsistent patient flow throughout seven days which causes breaches to Trust Targets and financial penalties.	National negotiations through NHS Employers regarding key aspects (schedule 3, 8 and 12) which have come to a halt. Regular communication regionally and nationally on the need for greater flexibility. Progress is slow with the BMA specifically. Local Seven Day Services Task and Finish Group established to locally negotiate (within the current national contract) for flexibilities. Reviewed the job planning principles to ensure the Trust maximises direct clinical care capacity.	Director of Workforce & OD / Medical Director	07/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
HR9	06/01/2020	Staffing & Human Resources	IT Infrastructure	Current - Internal Risk	Lack of electronic rostering solution for medical staff, stipulated within the 2016 junior doctor contract. Part of NHS Improvement's Levels of Attainment for providing assurance around organisational grip and control on workforce deployment. Impacts safe working and coverage of medical rotas on all sites. This may potentially result in patient harm, regulatory intervention and loss of license in additional to increased agency usage / costs causing inconsistent delivery of care to patients and adversely impacts the financial viability of the Trust.	Procurement of DRS Real Time in 2016. System does not fulfil all of Trust's requirements. Increase in coverage of centralised medical rostering.	Director of Workforce & OD	07/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce

Manager: SNS, Director											
SNS55	21/08/2018	IT	Infrastructure	Current - Internal Risk	In September 2017 HPE advised that the Trust needed to undertake a firmware upgrade to the HP X20000 storage array. The upgrade reduced the level at which a disk could be classified as failing, this has the potential to increase the likelihood of system failure if multiple disks fail at the same time. The Laboratory system, Telepath, is using the HP XP20000 as data storage. This could result in significant downtime and potential data loss. As of June 2018 only Telepath data now remains on the XP20000. The operating system (AIX) running on the Telepath servers went end of support April 2017 and must be upgraded prior to any move of data. If this did not happen then there would be a risk of no support should there be any issues when moving the data.	This work has now been completed and the risk now eliminated. Recommended for removal from the CRR	Head of IT Infrastructure	17/03/2020	5 - Catastrophic Harm	3 - Possible	15	Eliminate
SNS1	01/11/2018	IT	System Security	Current - Internal Risk, Potential - Internal Risk	Trust services could be impacted by malicious software such as a computer virus or malware. In addition Trust services and data could be compromised by the execution of unauthorised code on Trust systems.	1. Anti-Malware products are maintained via the McAfee EPO service 2. There is a process for reviewing and actioning security alerts from trusted sources including Carecert, USCert and vendors such as Cisco and HPE. 3. CareCert updates and supplier bulletins are reviewed as they are released to maintain awareness of new threats 4. Independent vulnerability scans are performed and associated action plans for closing gaps identified 5. Anti-malware is installed and proactively managed on Microsoft Servers and PCs 6. Use of NHS mail relay service for the removal of insecure email attachments 7. Web proxy in place for managing access to third party websites and scanning downloads for threats 8. Security gateways in place denying external access to services by default 9. Robust certificate access policy in place for wireless networks	Head of IT Infrastructure	14/04/2020	5 - Catastrophic Harm	3 - Possible	15	Tolerate
SNS74	21/05/2019	IT	Capital	Potential - Internal Risk	There is a significant risk in being unable to maintain the Trust SNS infrastructure due to insufficient funds being available for equipment repair and replacement. This could potentially result in an inability to deliver clinical services or result in poor system performance to the detriment of the organisation.	The current Trust financial situation requires close management and prioritisation of the capital spend. The prioritisation of the SNS capital budget is to be done in conjunction with the Operations team and monitored via the Capital Programme Exec Group. Specific risk controls and mitigation are in place to manage specific risk areas.	Head of IT Infrastructure	14/04/2020	3 - Moderate Harm	5 - Very Likely	15	Reduce

Manager: Director, Medical											
MD2a	20/08/2018	Patient Safety	Medical Staffing	Current - External Risk	There is a risk to how the organisation manages clinical services across the trust both in and out of hours, resulting from national recruitment difficulties that are being experienced nationally. This may potentially result in a poor quality unsafe service, potential patient harm, regulatory intervention and loss of license.	The organisation has taken steps to ensure active recruitment and retention and the use of locum staff to deliver safe quality services into hub and spoke models that include travel for some patients. steps to improve quality service to patients. The Trust is now reporting a medical vacancy figure below 10% on each of its main hospital sites. The level of improvement on the East Coast is such that there are only seven vacancies outside of Consultant and SAS Grades which the Trust is now seeking to fill. There have been 81 new starters across all medical grades Aug- Nov (which includes September and October changeover). At Consultant level, the Trust has welcomed four new Upper GI Surgeons (including one Locum Consultant), three Anaesthetists and two Gastroenterologists in York.	Medical Director	14/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
MD2b	20/08/2018	Patient Safety	Medical Staffing	Current - External Risk	There is an increased risk to patient safety on the Scarbrough site which experiences particular difficulties in recruiting medical staff and radiology staff. We currently have an vacancy rate of 10.3% which may impact on patient experience and care. The CQC have issued a Regulation 29A around staffing on the medical wards and ED at Scarborough.	There is active recruitment that is being driven by the appointment of a Senior Medical Staffing Officer at Scarborough. There is now an integrated model for surgery, paediatrics and obstetrics. The CQC have raised concerns particularly over the core medical service and staffing has been improved as a result of a better intake of juniors from HEE. The Trust is now reporting a medical vacancy figure of 10.3% across its main hospital sites. International recruitment continues to deliver quality appointments, most recently in Radiology, Gastroenterology and Histopathologyt.	Medical Director	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce
MD3	20/08/2018	Information Governance	Confidentiality	Current - Internal Risk	There is a risk of inappropriate disclosure of patient and staff confidential information which is caused by individuals failure to comply with trust policy. This may result in regulatory intervention, patient/staff dissatisfaction and a greater risk of fines by the Office of the Information Commissioner.	Staff are constantly reminded of their responsibilities and the potential action for any failure to follow policy re confidentiality. A new staff guide has been produced to make staff aware of the implications of breaches of confidentiality under the GDPR. Reported IG incidents are reviewed at the Information Governance Executive Group. We continue to provide specialist training sessions for specific groups and regularly review IG compliance in clinical areas.	Medical Director	14/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
MD4	20/08/2018	Patient Safety	Deteriorating Patients	Current - Internal Risk, Potential - Internal Risk	There is a risk of failure to always identify and escalate the deteriorating patient which is largely caused by patient flow issues and as a result of a failure to act on results which could result in serious harm or death.	The Implementation of NEWS2 and the Escalation Policy will aid the identification and escalation of the deteriorating patient. Issues are considered at operational and directorate level with specific work streams in place that are monitored through the Quality Committee. A business case has been approved to support the review of the deteriorating patient pathway with an aim of delivering an improved quality of care.	Medical Director	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce

MD5	20/08/2018	Patient Safety	Delayed Follow Up	Current - Internal Risk	There is a risk of patient harm caused by avoidable delays in follow up appointments owing to capacity issues. This is particularly in Ophthalmology where there is the potential to result in loss of patient sight, and regulatory intervention and patient dissatisfaction with treatment received. There are also similar emergent risks in Radiology services around reporting.	There have been some recommendations investigated incidents that are currently in the process of being implemented, however we continue to experience some levels of harm caused by capacity issues in the glaucoma service. Action is being taken to address this on a short, medium and long term basis through the Outpatient Transformation Programme. As part of our CQC action plan the Trust is to risk assess those patients waiting longer than the due appointment timeframe. Dr Quinn attending a workshop run by NLAG who have experience of this work.	Medical Director	14/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
MD6a	20/08/2018	Patient Safety	Delay in Treatment	Current - Internal Risk	There is a risk of failing to deliver contractual requirements relating to the delivery of emergency care in York. This has multi faceted causation, which includes increasing patient attendances, workforce and environmental issues etc. This may result in a delay in treatment, failure of ED targets, commissioner fines and regulatory intervention.The CQC has now issues a Regulation 29A Warning Notice in relation to this standard	A detailed Emergency Care Recovery Plan has been developed in conjunction with the Health and Care Partnership and regulators. Progress against the plan is being monitored with care groups on a weekly basis. An ECS 'task force' meeting also takes place each week at the Scarborough and York sites led by the Deputy Medical Director and the Chief Operating Officer. An internal Acute Board, chaired by the Trust CEO meets monthly, where key actions, issues and progress against improvement plans are discussed. The Trust and wider York and Scarborough system has been identified as needing support in order to address performance challenges, resulting in the Emergency Care Intensive Support Team (ECIST) working alongside Care Group teams to observe, advise and facilitate change. Focused work underway to help 'unlock' the acute pathway, reduce overcrowding in ED and promote better flow through the hospitals – SDEC and SAFER. SAFER to be relaunched and reframed as a safety tool, sponsored by the Medical Director and Chief Nurse.	Medical Director	14/04/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce

MD6b	20/08/2018	Patient Safety	Delay in Treatment	Current - Internal Risk	There is a risk of failing to deliver contractual requirements relating to the delivery of emergency care in Scarborough. This may result in a delay in treatment, failure of ED targets, commissioner and fines . The CQC has now issues a Regulation 29A Warning Notice in relation to this standard.	A detailed Emergency Care Recovery Plan has been developed in conjunction with the Health and Care Partnership and regulators. Progress against the plan is being monitored with care groups on a weekly basis. An ECS 'task force' meeting also takes place each week at the Scarborough and York sites led by the Deputy Medical Director and the Chief Operating Officer. An internal Acute Board, chaired by the Trust CEO meets monthly, where key actions, issues and progress against improvement plans are discussed. The Trust and wider York and Scarborough system has been identified as needing support in order to address performance challenges, resulting in the Emergency Care Intensive Support Team (ECIST) working alongside Care Group teams to observe, advise and facilitate change. Focused work underway to help 'unlock' the acute pathway, reduce overcrowding in ED and promote better flow through the hospitals – SDEC and SAFER. SAFER to be relaunched and reframed as a safety tool, sponsored by the Medical Director and Chief Nurse.	Medical Director	14/04/2020	4 - Severe Harm	5 - Very Likely	20	Reduce
MD7	20/08/2018	Patient Safety	Critical Care Capacity	Current - Internal Risk	There is a potential risk to patient safety caused by the lack of capacity of ICU beds at both Scarborough and York. This may result in the non clinical transfers of patients to other ICU units to ensure the safety of the patient.	1 additional bed has been established at York and Scarborough and a clinical educator has been appointed at Scarborough. McKinsey will consider ICU provision on the East Coast as part of their review. However the number of non clinical transfers has reduced.	Medical Director	14/04/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
MD8	20/08/2018	Patient Safety	Resilience	Current - Internal Risk	Significant and material risk to continuity of service due to increased demand on capacity, along with critical staffing levels for CT radiographers, who have to cover in hours, on-call and extra sessions. Additionally, there are a limited number of radiologists to provide an on-call service (currently 1 in 4), which may result in delays to patient care, failure to adhere to national targets, financial fines and regulatory intervention.	Provision of a staffed mobile scanner to relieve pressure on existing service. There are plans to implement outsourcing for radiology reporting (similar to York model), but lack of CT radiographic staff is preventing this. Process is underway for business case for static 2nd CT scanner. Outsourcing done. Approved business case for 2nd static CT scanner. ETA for installation Autumn 2018. January 2018. Additional pressure currently on service, as no access to mobile CT scanner whilst MRI unit is being refurbished (as static MRI scanner on site). April 2018 - CT radiographers now working shifts which means that someone is resident. Still struggling with capacity & getting WLI sessions covered. July 2018 - MRI refurbishment due for completion November 2018. This will have a continued impact for CT provision (as well as putting an additional cost pressure on the Trust for continuing to provide a mobile MRI scanner). There is currently no estimated start time for the 2nd CT scanner. October 2018 - position unchanged March 2019 - cover for Radiologist on-call is	Medical Director	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce

MD10	20/08/2018	Patient Safety	Service Provision	Current - Internal Risk	There is a risk to patient safety caused by the organisations failure to deliver 7 day services. This may result in patient harm, delays in treatment and review, delayed diagnosis, and delayed transfers of care.	In terms of 7 day services, a task and finish group has been established in response to the last audit and an SOP and dashboard of outstanding 14 hour reviews has been developed. The next self assessment is due in June 2020. Current activity is that we are working on a system to record daily senior review within CPD and we are also articulating expectations of Board Rounds, this includes attendance, time at Ward level.	Medical Director	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
MD11	30/01/2020	Patient Safety	Service Provision	Current - Internal Risk	There is a risk that patients who present at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services). As a result the CQC have issued a Regulation 29 A warning notice.	Work is being undertaken to ensure that steps are taken to ensure that Scarborough ED is compliant with the requirements of the RCEM Guidance. Work is taking place with TEWV and our Commissioners.	Medical Director	14/04/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 March 2020
Standards of Business Conduct

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 approve the amended version of the Standards of Business Conduct Policy.

Executive Summary – Key Points

The Standards of Business Conduct Policy has been reviewed and amended in light of an Internal Audit Report which asked for some minor adjustments to be made. The policy does conform to the requirements of NHSE to ensure that conflicts of interest are managed and declarations are open and honest.

The two biggest differences are as follows:

- The declaration of private practice by consultants which has seen two requirements brought together. Consultants are now asked to only submit a return to the Private Patient Unit instead of completing a form as well.
- Declarations will be published on the website.

The policy was approved by the Executive Committee at their February 2020 meeting.

Following approval of the policy, an awareness campaign using Staff Matters and Team Brief will take place.

Recommendation

The Board of Directors is asked to approve the Standards of Business Conduct Policy.

Author: Lynda Provins, Foundation Trust Secretary

Executive sponsor: Simon Morritt, Chief Executive

Date: March 2020

York Teaching Hospital NHS
NHS Foundation Trust

NHS
York Teaching Hospital
Facilities Management

Standards of Business Conduct Policy

Author:	Foundation Trust Secretary
Owner:	Chief Executive
Publisher:	Healthcare Governance Unit
Date of first issue:	June 2005
Version:	V9.008.01
Date of version issue:	
Approved by:	Trust Board
Date approved:	31 January 2018
Review date:	5 years
Target audience:	All Trust staff
Relevant Regulations and Standards	See Policy
Links to Organisational/Service Objectives, business plans or strategies	Personal Responsibility Framework Our shared commitment

Executive Summary

This policy describes the expectations of the Trust and methods to be used to declare any conflicts of interest, secondary employment, financial interest, and sponsorship.

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

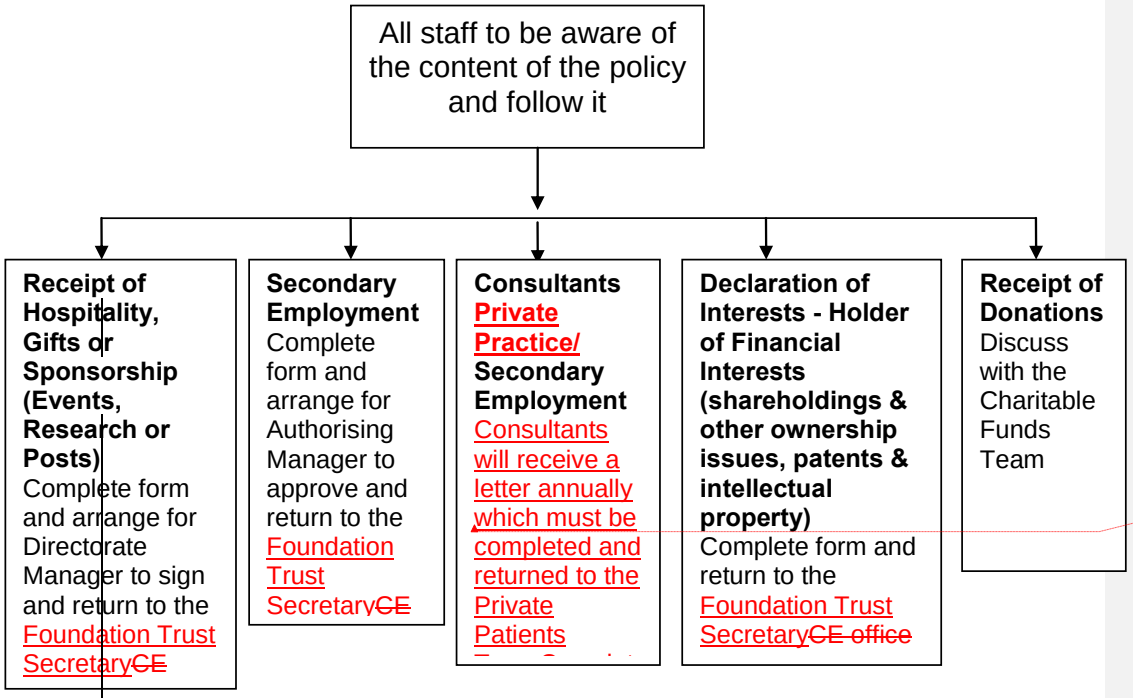
consider the resource and environmental implications before printing this document.

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

Version	Date Approved	Version Author	Status & location	Details of significant changes
7		Anna Pridmore		Re draft of whole policy
8		Lynda Provins		Revision – New NHSE Managing Conflicts of Interest in the NHS Guidance
8.01	31.01.18	Lynda Provins	Final Intranet	Revision – comments received
9.00		Lynda Provins		Revised to ensure compliance with guidance

Contents

Process flowchart



Formatted: Underline

All staff should use common sense and judgement to consider whether the interests you have and declare these as they arise. If in doubt, declare.

Staff should regularly consider what interests you have and declare these as they arise. If in doubt, declare.

Staff should **not** misuse your position to further your own interests or those close to you.

Staff should **not** be influenced, or give the impression that you have influenced by outside interests.

Staff should **not** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers money.

Queries on any areas of this policy should be referred to the Foundation Trust Secretary in the first instance.

If any clarification is required please talk to your Line Manager or the Foundation Trust Secretary.

All completed forms should be returned to the Foundation Trust Secretary with the exception of the Consultants Private Patients letter which must be returned

to the Private Patients Team.

1 Introduction & Scope

The Trust has in place a framework for personal responsibility and living our values. This framework focuses on promoting personal responsibility through how individuals act within the organisation in relation to the roles, the teams and the behaviours displayed on a daily basis. The impact of these values is felt by everyone who comes into contact with our services. The framework is supported by the Trust's document called *Our shared commitment*.

Following on from the guidance on Standards of Business Conduct in HSG (93)5, legislation has been introduced specifically to address issues of bribery and commercial sponsorship through the Bribery Act 2010. Further guidance has been issued by NHS England on Managing Conflicts of Interest in the NHS in 2017. NHS Foundation Trusts must also comply with the 'NHS Foundation Trust Code of Governance' issued by NHSI, the sector regulator.

The Trust's Constitution and Standing Orders requires conflicts of interest to be declared and a register of interests to be maintained. The requirement to abide by the Trust's Standard of Business Conduct Policy is incorporated into every individual's contract of employment. This policy is designed to guide and protect individual employees in their normal day to day dealings with regard to the acceptance of gifts, hospitality, honaria, charitable donations, financial interests, sponsorship and the award of contracts for goods and/or services.

The principles and conduct of the NHS are summarised as follows:

NHS staff are expected to:

- Ensure that the interest of patients remains paramount at all times;
- Be impartial and honest in the conduct of their official business;
- Use the public funds entrusted to them wisely and to the best advantage of the service, always ensuring value for money.

The Code of Conduct/ Code of Accountability emphasises three crucial public service values which must underpin the work of the health service staff at all times:

Accountability – Everything that is done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity – There should be an absolute standard of honesty in dealing with the assets of the NHS; integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and any news or information acquired in the course of NHS duties.

Openness – There should be sufficient transparency about NHS activities to promote confidence between the NHS Authority or Trust and its staff, patients and the public.

2 Definitions / Terms used in policy

There are a number of elements that should be taken into account around standards of business conduct. They include:

Financial Interests – where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.

Non-financial professional interests – where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

Non-financial person interests – Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

Indirect interests – Where an individual has a close association with another individual who has a financial interest or a non-financial interest and could stand to benefit from a decision they are involved in making.

For the purpose of this policy this includes, but is not restricted to:

- Interest in a company by the employee, their partner/ spouse or children which the Trust has commercial dealings with, or whose principal business is healthcare or an allied business associated to healthcare;
- Significant financial or controlling interests or ownership by the employee or a member of their family, of a company which the Trust has a business relationship with. Family members include siblings, direct descendants or ancestors, and their partners/ spouse;
- Secondary employment including the formation of a company that is in the healthcare or healthcare related field;
- Unpaid advisory work for organisations where the Trust has a contractual relationship or is within the healthcare environment.

Sponsorship including commercial sponsorship – Defined as NHS funding from an external source, including funding of all or part of the costs of member(s) of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.

Commercial sponsorship of posts may be offered by companies (for example pharmaceutical or orthopaedic companies). This may be on the basis of whole or partial funding.

Gifts, honoraria and charitable donations – This is defined as something (of value) given voluntarily (for which payment has not been made) from an individual or company to another individual or organisation (the Trust) to mark an occasion, make a gesture and/or as a token of gratitude. The policy does not expect staff to record and report every gift offered, declined or received. If the gift is of a 'low intrinsic value' (below £6) such as calendars, mugs, pens, diaries, note pads, mouse mats, confectionery, etc. it does not need to be declared.

Conflicts of Interest – a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. It may be:

- **Actual** – there is a material conflict between one or more interests;
- **Potential** – there is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Bribery Act 2010 responsibilities – It defines bribery as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. This includes seeking to influence a decision-maker by giving some kind of 'gift' to that decision maker rather than buy what can legitimately be offered as part of a tender process. This is a criminal offence, punishable by up to 10 years imprisonment and an unlimited fine. Further information can be found at Attachment A.

Hospitality – Hospitality is often offered by suppliers of goods and services and partner organisations and includes such things as business breakfasts/lunches, educational seminars, travel, overnight accommodation and corporate networking events.

Trust Staff – All individuals who are employed by the Trust including those on permanent, temporary and bank contracts along with agency and locum workers. It also includes those who hold honorary contracts, secondees to the Trust and contractors. Employment means receiving remuneration for hours worked in the Trust.

Decision Making Staff – Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. Staff should be familiar with the Trust's Reservation of Powers and Scheme of Delegation and the knowledge of what their limits are. These staff are:

- Executive, Non-executive and Corporate Directors or equivalent roles;
- Members of advisory groups which contribute to direct or delegated decision making;
- Those at Agenda for Change band 8d and above;
- Administrative and clinical staff who have the power to enter into contracts on behalf of the organisation;
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.

3 Policy Statement

The Trust has an obligation to ensure that all employees are able to perform their duties safely and to protect its business interests. Therefore, you may not engage in any employment outside of the Trust and/or any additional secondary employment with the Trust (paid, unpaid or voluntary), without having obtained the prior approval of your manager. Additionally, you must not engage in any employment which may conflict with your Trust employment or be detrimental to it, e.g. private work, or that which may be detrimental to the interests or image of the Trust. In accordance with this policy you must tell your line manager if you think you may be risking a conflict of interest in this area.

General principles of the policy are that all staff working for the Trust under NHS terms and conditions are covered by the policy. The policy applies equally to exchequer and charitable sources of funding. All employees have a responsibility for ensuring that they are not placed in a position, which risks – or appears to risk – a conflict between their private interests and their NHS duties.

4 Identification, Declaration and Review of Interests

4.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any

doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).
- Individuals that are part of a tender evaluation panel should complete a declaration of interest document as required by the tendering checklist.

Declaration forms can be found at Attachment B of this document.

Declarations should be completed, approved by the authorising manager and sent to the Foundation Trust Secretary~~Chief Executive's Office~~.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a record of historic interests will be retained for a minimum of 6 years.

4.2 Proactive review of interests

The Trust will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

5 Records and publication

5.1 Maintenance

The Trust will maintain the following registers:

- Register of Secondary Employment;
- Register of Pecuniary (Financial) Interests;
- Register of Hospitality, Gifts or Sponsorship.

All declared interests that are material will be promptly transferred to the register by administrative staff in the Chief Executive's Office.

5.2 Publication

The Trust will:

- Publish the interests declared by decision making staff in
    - Register of Secondary Employment;
    - Register of Pecuniary (Financial) Interests;
    - Register of Hospitality, Gifts or Sponsorship.

- Refresh this information annually;
- Make this information available on the Trust's website.

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Foundation Trust Secretary to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

5.3 Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare, and encourages staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website: http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

6 Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making;
- removing staff from the whole decision making process;
- removing staff responsibility for an entire area of work;
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

7 Management of Interests – Common Situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

7.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.

- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6[1] in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust and information about how such gifts should be received e.g. payment into any charitable fund in existence not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

7.1.1 What should be declared

- Staff name and their role with the organisation;
- A description of the nature and value of the gift, including its source;
- Date of receipt;
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy);

7.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement;

[1] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event;
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared;
- Of a value between £25 and £75[2] - may be accepted and must be declared;
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept;
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate);

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared;
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel)
  - offers of foreign travel and accommodation.

7.2.1 What should be declared

- Staff name and their role with the organisation;

[2] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- The nature and value of the hospitality including the circumstances;
- Date of receipt;
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.3 Outside Employment

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises;
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks;
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

7.3.1 What should be declared

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation;
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks;

- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

7.4.1 What should be declared

- Staff name and their role with the organisation;
- Nature of the shareholdings/other ownership interest;
- Relevant dates;
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy);

7.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are on-going, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation;
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property;
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

7.5.1 What should be declared

- Staff name and their role with the organisation;
- A description of the patent;
- Relevant dates;
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role;
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money;
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners;
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

7.6.1 What should be declared

- Staff name and their role with the organisation;
- Nature of the loyalty interest;
- Relevant dates;
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.7 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and dealt with through the Fundraising Team only. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value;
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the

organisation's own registered charity or other charitable body and is not for their own personal gain;
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own;
- Donations, when received, should be made to York Teaching Hospital Charity fund (never to an individual) and a receipt should be issued by the cashiers office or general office (please see the Charity Fundraising Policy and Procedure). All donations over £5 should receive an official acknowledgement in the form of a thank you letter from the Fundraising Team;
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

7.7.1 What should be declared

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

7.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS;
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they

should not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event should always be clearly identified;
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event;
- Staff arranging sponsored events must declare this to the organisation.

7.8.1 What should be declared

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

7.9 Sponsored research

- Funding sources for research purposes must be transparent;
- Any proposed research must go through the relevant health research authority or other approvals process;
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services;
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service;
- Staff should declare involvement with sponsored research to the organisation.

7.9.1 What should be declared

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
    - their name and their role with the organisation.
    - Nature of their involvement in the sponsored research.
    - relevant dates.

- Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.10 Sponsored posts

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

7.10.1 What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

7.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[3] to the Private Patient Team including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment) and if this is in NHS contracted hours then prior approval should be sought from the Medical Director.

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[4]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

7.11.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.

---

[3] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[4] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Consultant staff must complete the Consultant Declaration of Intent Re: Private Patients/Secondary Employment which is sent out annually by the Private Patient Team.

8 Management of interests – advice in specific contexts

8.1 Strategic decision making groups

In common with other NHS bodies York Teaching Hospital NHS Foundation Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are: Board of Directors, Council of Governors and Executive Board

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

8.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with the Trust's Procurement Policy and procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

9 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate

actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

9.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to their manager.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised see the Raising Concerns and Whistleblowing Policy and Fraud, Bribery and Corruption Policy or contact the Trust's Freedom to Speak Up Guardian.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

9.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
    - Informal action (such as reprimand, or signposting to training and/or guidance).
    - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

9.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Trust's Audit Committee annually.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and made available for inspection by the public upon request.

10 Associated documentation

Freedom of Information Act 2000
ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)
Trust's Charity Fundraising Policy and Procedure
Procurement Policy
Reservation of Powers and Scheme of Delegation

11 Impact Upon Individuals with Protected Characteristics

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

12 Accountability

Operational implementation, delivery and monitoring of the policy reside with:

The Trust

The Chief Executive is responsible for ensuring that this policy is brought to the attention of all employees, also that machinery is put in place for ensuring that they are effectively implemented and monitored including periodic examination of the 'gifts and hospitality' registers and declaration of interests register maintained within the directorates or by the Foundation Trust Secretary.

Foundation Trust Secretary

The Foundation Trust Secretary is responsible for the upkeep of the corporate registers and for compiling an annual report which is presented to the Audit Committee.

Directorate Managers/Clinical Directors

The Directorate Managers/Clinical Directors are responsible for ensuring all staff are aware of the policy and for approving/escalating any forms received.

Trust Staff

It is the responsibility of all Trust staff to ensure that they are not placed in a position which risks, or may risk, conflict between their private interests and their NHS duties.

It is the responsibility of all Trust staff to declare the information requested by this policy. Failure to do so may result in disciplinary procedures against individual members of staff.

Attachment A – Bribery Act 2010

The Bribery Act 2010 replaced offences in common law and under the Public Bodies Corrupt Practices Act 1889, the Prevention of Corruption Act 1906 and 1916.

The Act brings into force a new consolidated scheme of bribery offences including:

- Two general offences covering offering, promising or giving an advantage, and the requesting, agreeing to receive or accepting of an advantage
- A discrete offence of bribery of a foreign public official to obtain or retain business or an advantage in the conduct of business;
- A new offence of failure by a commercial organisation to prevent a bribe being paid for or on its behalf. It will be a defence if the organisation has ' adequate procedures' in place to prevent bribery
- A maximum penalty of 10 years imprisonment for all offences and unlimited fines
- Extra-territorial jurisdiction to prosecute bribery committed abroad by persons ordinarily resident in the UK as well as UK national and UK corporate bodies

The Trust is committed to eliminating all level of fraud and corruption within the Trust and the NHS. It is an offence under the Bribery Act 2010 for anyone to receive, be offered or to offer any financial or other advantage to another person in order to induce a person to perform improperly or reward any person for improper performance of a function or activity. The Trust is committed to carry out business fairly, honestly and openly and is committed to a zero tolerance of bribery.

Any staff concerned or requiring further clarification should contact the Foundation Trust Secretary or Head of Procurement.

If you believe any bribery offence has taken place, please report to Steve Moss, Counter Fraud Specialist.

Attachment B – documents and forms

York Teaching Hospital NHS
NHS Foundation Trust

Declaration of interest form – Financial Interest

Name:

Position held in the Trust:

Date Detail when the interest arose and if relevant when it ceased.

Formatted: Font: 11 pt

The Code of Business Conduct requires staff to declare, on an annual basis, when they or their close relatives/associates have any interests, as detailed in the sections below, in an organisation, activity or pursuit which may compete for an NHS contract to supply either goods or services to the Trust:

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS.

(c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

(d) A position of Authority in a charity or voluntary organisation in the field of health and social care.

(e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

(f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

If at any time your declaration changes and you are affected by one or more of the above you must complete this form at that time, and in any instance that you feel appropriate.

Description of Interest: Provide a description of the interest that is being declared. That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest

Types of interest:

Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making

Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career

Non-financial personal interests - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career

Indirect interests - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making

A benefit may arise from both a gain or avoidance of a loss.

~~**Business interests relevant to the work of the organisation**~~

~~Please give details of any relevant business interests held by you or your associates:~~

Name of organisation: ..……..……..……

Relationship/role: ……..……..……,

~~When did business interest begin? ……..~~

How is this relevant to the work of the organisation?
……..……..……
…..……..……
……..……
……

Declaration:

I have read and understood the Standard of Business Conduct Policy as it relates to conflicts of interest, and declare that the information I have provided on this form is correct and complete. I understand that failure to abide by the code will render me liable for disciplinary action and civil recovery procedures, including termination of employment, and potentially liable to prosecution for any fraudulent actions. I consent to the information on this form being used for the prevention, detection and investigation of fraud.

I do/do not (delete as appropriate) give my consent for this information to be published on the registers held by the Trust. If consent is not given please state why,

Signature……..……..

Print name: ……Date: …….. …….

Line manager to complete:

Declaration is Acceptable/Unacceptable (please delete as appropriate)
Comments:
……
……

Signature:……..……

Print name: ……Date: ……..……..

Please return completed forms to the Foundation Trust Secretary.

York Teaching Hospital NHS
NHS Foundation Trust

Secondary or outside employment

This form is for use during the financial year to advise if you have started any secondary or outside employment

Name……

Position held in the Trust……

Date……..

The Code of Business Conduct requires staff to declare, on an annual basis, when they are undertaking secondary or outside employment

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises;
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks;
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

What should be declared

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Name of secondary or outside employer……

Your post with secondary or outside employer……

Date employment began……..

Hours and time worked……

Declaration:
I have read and understood the Standard of Business Conduct as it relates to secondary or outside employment and I declare that the information I have provided on this form is correct and complete. I understand that failure to abide by the code will render me liable for disciplinary action and civil recovery procedures, including termination of employment, and potentially liable to prosecution for any fraudulent actions. I consent to the information on this form being used for the prevention, detection and investigation of fraud.

I do/do not (delete as appropriate) give my consent for this information to be published on the registers held by the Trust. If consent is not given please state why,

Signature……

Print name……

Line Manager to complete

Declaration is acceptable/ unacceptable (please delete as appropriate)

Comment……
……

Signature …….

Print Name…….Date……..

Please return completed forms to the Foundation Trust Secretary.

For Consultants and other practitioners with other interests and employment

This form is for use during the financial year to advise if you have started any secondary or outside employment including private practice and category 2 work.

Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[5] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[6]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

The form contains a couple of examples of the type of declaration expected.

Name……

[5] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical-advice-at-work/contracts/consultanttermsandconditions.pdf

[6] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical-advice-at-work/contracts/consultanttermsandconditions.pdf)

Position held in the Trust……

Date declared	Organisation where interest held	Nature of interest
Example	Smith Pharmaceuticals	Advisor Clinical Trials Lecture fees
Example	Smith Surgery Partnership LLP	Contracted NHS work Partner
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

Declaration:
I have read and understood the Standards of Business Conduct as it relates to secondary or outside employment including private practice and category 2 work and I declare that the information I have provided on this form is correct and complete. I understand that failure to abide by the code will render me liable for disciplinary action and civil recovery procedures, including termination of employment, and potentially liable to prosecution for any fraudulent actions. I consent to the information on this form being used for the prevention, detection and investigation of fraud.

Signature……

Print name……

CONSULTANTS DECLARATION OF INTENT PRIVATE PATIENTS

I, declare to the best of my knowledge, **I will / I will not see private patients (**please delete as appropriate) within the York Teaching Hospitals NHS Foundation Trust (including any of its premises or facilities) during the period April 2020 to March 2021.

I therefore agree I will only see private patients outside of my NHS contracted hours. If private patients are seen in NHS contracted hours this will only be with prior approval from the Medical Director.

I declare that should I see, treat or admit any patient on a private basis I will notify the Private Patient Team in advance of my intention to do so (tel. 01723 385382). Arrangements to recover any necessary hospital fees on behalf of the Trust will then be made.

I will ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[7]

If your private patients are seen by other NHS Trust staff this must be notified to the Trust, agreed in advance and not impact on NHS work.

The Consultant, or their nominated deputy, have the prime responsibility of informing the Private Patient Team of any costs associated with the private episode of care and also for ensuring that the private status of any patient admitted by them to any site or premises of York Teaching Hospitals NHS Foundation Trust is accurately recorded and that the Trust's capacity and resources are effectively used.

NHS facilities, staff and services must only be used for private practice with the agreement of the Trust.

I declare that if I treat or admit Private Patients to York Teaching Hospitals NHS Foundation Trust premises or facilities, I have the necessary personal insurance cover required.

I declare that I am also aware that the Trust cannot be held responsible for any errors regarding information given to private patients and that use of the Trust's headed notepaper is not permitted in these circumstances.

I declare that I will also inform the Trust through the Overseas Visitor Officer of any person who may be deemed an Overseas Visitor.

Room Rent

In line with present arrangements Consultants will be charged directly for the use of consulting rooms. Outstanding invoices should be settled in line with payment of instruction (within 28 days). Otherwise the trust reserve the right to deduct the outstanding amount from the individuals salary.

PHIN

I declare I accept responsibility for adherence, compliance and processes necessary to comply with PHIN and will act upon PHIN updates as required.

Non NHS work (Category II)

In line with the Private Patient Policy and audit recommendations any non NHS work i.e. DVLA, solicitor or medico-legal work. Trust headed notepaper

[7] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

must not be used and any work must be declared and notified to Private Patient Team, (telephone: 01723 385382) in the first instance.

Please declare if you employ any NHS Trust staff i.e. secretary, technician, nurse for any element of your private work.

I do/ I do not (delete as appropriate) employ NHS Trust staff details below:
Staff member name ……
Department……
Position……..

Your co-operation in completing this form is very much appreciated.

Print Name……

Speciality/Hospital Site……

The form contains a couple of examples of the type of declaration expected.

Date declared	**Organisation where interest held**	**Nature of interest**
Example	Smith Pharmaceuticals	Advisor Clinical Trials Lecture fees
Example	Smith Surgery Partnership LLP	Contracted NHS work Partner

Declaration: I have read and understood the Standards of Business Conduct as it relates to secondary or outside employment including private practice and category 2 work and I declare that the information I have provided on this form is correct and complete. I understand that failure to abide by the code will render me liable for disciplinary action and civil recovery procedures, including termination of employment, and potentially liable to prosecution for any fraudulent actions. I consent to the information on this form being used for the prevention, detection and investigation of fraud.

I do/do not (delete as appropriate) give my consent for this information to be published on the registers held by the Trust. If consent is not given please state why.

Signed……
Date……
…
Please complete this form by no later than **Friday 29th May 2020** and return to Private Patient's Team, Private Patient Unit, Scarborough Hospital.

- ❖ Please be aware this information will also be used to update the Trust's secondary employment register.

Appendix A – covers the relevant section of the Standards of Business Conduct Policy.

Appendix A – Standards of Business Conduct Policy

7.11 Clinical Private Practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[8] to the Private Patient Team including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment) and if this is in NHS contracted hours then prior approval should be sought from the Medical Director.

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[9]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

7.11.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).

[8] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[9] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Consultant staff must complete the Consultant Declaration of Intent Re: Private Patients/Secondary Employment which is sent out annually by the Private Patient Team.

York Teaching Hospital NHS
NHS Foundation Trust

York Teaching Hospital NHS Foundation Trust – Register of Hospitality, Gifts or Sponsorship

The Standards of Business Conduct Policy requires staff to declare; gifts, benefits, hospitality or sponsorship, which are relevant and material to the Trust. All staff are required to comply with all Trust policies and procedures for procurement.

Please complete the declaration below if your situation satisfies any of the following criteria:

1. **Hospitality over the value of £50**

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement;
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event;
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:
- Under a value of £25 - may be accepted and need not be declared;
- Of a value between £25 and £75[10] - may be accepted and must be declared;
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept;
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate);

Travel and accommodation:
- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared;
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
    - offers of business class or first class travel and accommodation (including domestic travel)
    - offers of foreign travel and accommodation.

[10] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

What should be declared

- Staff name and their role with the organisation;
- The nature and value of the hospitality including the circumstances;
- Date of receipt;
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

2. Gifts

Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6[11] in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust and information about how such gifts should be received e.g. payment into any charitable fund in existence not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

What should be declared

- Staff name and their role with the organisation;
- A description of the nature and value of the gift, including its source;
- Date of receipt;
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy);

3. Commercial Sponsorship for Attendance at Courses and Conferences including fees and travel (over the value of £50)

The policy defines commercial sponsorship as including:

[11] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

'NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises'.

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS;
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event should always be clearly identified;
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event;
- Staff arranging sponsored events must declare this to the organisation.

What should be declared

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

In all cases, the Directors or Governors of York Teaching Hospital NHS Foundation Trust must publicly declare sponsorship or any commercial relationship linked to the supply of goods or services and be prepared to be held to account for it.

Declarations must be made to the Chief Executive who has overall responsibility for the Public register relating to 'Declaration of Interests and Sponsorship'.

Sponsored research

- Funding sources for research purposes must be transparent;
- Any proposed research must go through the relevant health research authority or other approvals process;
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services;
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service;
- Staff should declare involvement with sponsored research to the organisation.

What should be declared

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
    - their name and their role with the organisation.
    - Nature of their involvement in the sponsored research.
    - relevant dates.
    - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Sponsored posts

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

Name……

Position held in the Trust……

Date……

Is this:

Hospitality
A gift
Commercial sponsorship

Nature of hospitality, gift or sponsorship……..

By whom……

Total value £……..

Travel £ ……..

Accommodation £…….

Other £ …….. (please specify)

Location of hospitality/ sponsorship if not provided in the Trust premises

……

Declaration

I have read and understood the Standards of Business Conduct Policy as it relates to conflicts of interest, personal activities and hospitality and declare that the information I have provided on this form is correct and complete. I understand that failure to abide by the policy will render me liable for disciplinary action and civil recovery procedures, including termination of employment, and potentially liable to prosecution for any fraudulent actions. I consent to the information on this form being used for the prevention, detection and investigation of fraud.

I do/do not (delete as appropriate) give my consent for this information to be published on the registers held by the Trust. If consent is not given please state why,

Signature:……..……

Print name: ……..…..…

Date: ……...……

Line manager to complete:

Declaration is Acceptable/Unacceptable (please delete as appropriate)

Comments:
……
……
……
……
……

Signature:……..……
……

Print name: ……..…..…

Date: ……..……

Approval by Chief Pharmacist required when the declaration is related to pharmaceuticals

Approval by Chief Pharmacist …….

Date…….

NOTES REGARDING THE USE OF THIS INFORMATION

The information you have provided on this form will be recorded in the Trust's Register of Gifts and Hospitality, which will be available to the public, Monitor and will be made available to the Audit Committee on an annual basis.

The Register is held by the Chief Executive and maintained by the Foundation Trust Secretary. Information should be supplied to the Foundation Trust Secretary.

Please return completed forms to the Foundation Trust Secretary.

Appendix 1 Equality Analysis

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

Name of Policy	**Standards of Business Conduct Policy**	
1.	**What are the intended outcomes of this work?** **That Staff have clear guidance and understanding of the acceptable standards of business conduct in the Trust**	
2	**Who will be affected? Staff**	
3	**What evidence have you considered?** **Legislation** **National guidance**	
a	**Disability**	
b	**Sex**	
c	**Race**	
d	**Age** .	
e	**Gender Reassignment**	
f	**Sexual Orientation**	
g	**Religion or Belief**	
h	**Pregnancy and Maternity**.	
i	**Carers**	
j	**Other Identified Groups**	
4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	Yes
b.	How have you engaged stakeholders in constructing the policy	Yes
c.	If so, how have you engaged stakeholders in constructing the policy	A number of stakeholders have been asked to comment on the draft policy
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs Corporate Directors Counter Fraud/ Internal Audit	

	Heads of Service Staff side JNMC	
5.	**Consultation Outcome** *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	**Not applicable**
b	Advance Equality of Opportunity	Not applicable
c	Promote Good Relations Between Groups	Not applicable
d	What is the overall impact?	None
	Name of the Person who carried out this assessment: Foundation Trust Secretary	
	Date Assessment Completed	
	Name of responsible Director **Patrick Crowley**	

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

Appendix 2 Policy Management

1 Consultation, Assurance and Approval Process

Consultation Process

The policy is based on legislation and guidance supplied by the NHS. Those members of staff involved in interpreting the legislation and guidance along with the Executive Directors of the Trust have been invited to comment on the policy. The Trust will involve stakeholders and service users in the development of its policies.

Quality Assurance Process

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

- Counter Fraud/ Internal Audit
- Procurement
- Finance
- Corporate Directors
- Staff side
- JNMC

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

Approval Process

The approval process for this policy complies with that detailed in section 3.3 of the Policy Development Guideline. The approving body for this policy Executive Board.

2 Review and Revision Arrangements

The Foundation Trust Secretary will be responsible for review of this policy in line with the timeline details on the front cover.

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

3 Dissemination and Implementation

Dissemination

Once approved, this policy will be brought to the attention of all relevant staff working at and for York Teaching Hospital NHS Foundation Trust via the Staff Matters and Team Brief and by publishing on the Policies and Procedures section of the Staff Room.

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

Implementation of Policies

This policy will be implemented throughout the Trust by the Foundation Trust Secretary annual basis. Staff can access the policy on staffroom and the policy will be publicised through payslip messages.

In addition to this the Policy Author will collate the following evidence to demonstrate compliance with this policy:

- Annual report
- Register of gifts and hospitality
- Register of secondary employment
- Register of declaration of interest
- Annual Report for the Audit Committee

Document Control including Archiving Arrangements

Register/Library of Policies

All corporate and clinical documents will be logged on Q-Pulse, the Trust's document management system and made accessible via Staff Room using the portal's search facility. The register of documents will be maintained by the Healthcare Governance Directorate.

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

Archiving Arrangements

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

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

Process for Retrieving Archived Policies

To retrieve a former version of this policy from Q-Pulse, the Policy Manager should be contacted.

Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements as laid out on page 44.

4 Standards/Key Performance Indicators

Any theoretical training requirements identified within this policy are outlined within the mandatory training profiles accessed via the Statutory & Mandatory Training Link that can be found on the home page of Horizon or on Q:\York Hospitals Trust\Mandatory Training. You will be required to create your own mandatory training profile using the tool and support materials available in these areas and agree your uptake of this training with your line manager. The training identification policy and procedure document describes the processes related to the review, delivery and monitoring of mandatory training, including non-attendance. See section 11 of the Policy for Development and Management of Policies for details of the statutory and mandatory training arrangements.

Process for Monitoring Compliance and Effectiveness

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

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. Completion of an Annual Report	Production of the report	Audit Committee	Annual	Audit Committee	Foundation Trust Secretary	Audit Committee
b. Production of the registers & breach log	Register updates	Audit Committee	Annual	Audit Committee	Foundation Trust Secretary	Audit Committee
c. Review of the system	Audit undertaken by Internal Audit	Audit Committee	According to the annual risk assessment as part of the annual audit plan preparation, but at least once every three years	Audit Committee	Foundation Trust Secretary	Audit Committee

5 Training

Training requirements should be identified during the development stage.

Any training requirements identified within this policy that are of a Corporate Statutory or Mandatory nature will be outlined in the Statutory/Mandatory Training Brochure. This can be accessed via the link on StaffRoom, the Q:\York Hospital Trust\Mandatory Training or the organisation's online learning platform.

If this training is deemed to be statutory or mandatory and is not identified within the Statutory/Mandatory Training Brochure then application must be made by the Policy Author to the Corporate Learning and Development Team to have it added.

These training requirements are used to develop the customised profiles that can be viewed by learners when they access their personal online learning account. It is then the learner's responsibility to undertake this learning with the support of their line manager and the line manager's responsibility to review this at annual KSF appraisal.

The Corporate Statutory and Mandatory Training Identification Policy and Procedure document describes the processes relating to the identification, review, delivery and monitoring of statutory and mandatory training including non-attendance.

6 Trust Associated Documentation

- Fraud, Bribery and Corruption Policy
- Procurement Policy
- Tender Checklist
- Standing Orders
- Standing Financial Instructions
- Raising Concerns and Whistleblowing Policy

7 External References

- Code of Conduct code of accountability - http://www.nhsbsa.nhs.uk/Documents/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf
- Code of Governance - http://www.monitor-nhsft.gov.uk/sites/default/files/Code%20of%20Governance_WEB%20(2).pdf
- Bribery Act 2010 - http://www.legislation.gov.uk/ukpga/2010/23/contents
- HSG (93)5 - http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4065045.pdf
- Managing Conflicts of Interest in the NHS – http://www.england.nhs.uk/ourwork/coi

Appendix 3 Plan for the dissemination of a policy

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

Title of document:	**Standards of Business Conduct Policy**
Date finalised:	
Previous document in use?	**Yes**
Dissemination lead	**Foundation Trust Secretary**
Which Strategy does it relate to?	**Corporate Governance**
If yes, in what format and where?	
Proposed action to retrieve out of date copies of the document:	**Healthcare Governance Directorate will hold archive**

To be disseminated to:	**1)**	**2)**
Method of dissemination	**Electronic**	
who will do it?		
and when?	**Immediate**	
Format (i.e. paper or electronic)	**Electronic**	

Dissemination Record

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

Blank page

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 March 2020
Group Modern Slavery and Human Trafficking Act 2015

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

The Board is asked to approve the declaration and the agreed statement should be signed by the Chair and the Chief Executive and placed on the website.

Executive Summary – Key Points

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act.

The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking, and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36 million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors and LLP Management Group.

The aim of the statement is to encourage transparency within organisations, although it is possible to comply with the provision by simply stating that no steps have been taken during the financial year to ensure that the business and supply chain is modern slavery

free. It should be noted that although this may be an acceptable approach for the first year's statement, there is an expectation that further work will be undertaken to provide these assurances. There are potential consequences for those organisations that do not appear to make progress in this area; especially for those that are funded wholly, or in part, by public money.

This year's statement has been prepared on a Group basis.

On-going assurance

The Trust will be required to review and /or prepare a similar statement on an annual basis. Plans are in place to raise awareness of modern slavery through Staff Matters, policies and training.

Recommendation

It is recommended that the Board of Directors approve the statement for signature by the Chair and Chief Executive.

Author: Lynda Provins, Foundation Trust Secretary

Director Sponsor: Simon Morritt, Chief Executive

Date: March 2020

Modern Slavery and Human Trafficking Act 2015

Annual Statement 2020

York Teaching Hospital NHS Foundation Trust and York Teaching Hospital Facilities Management LLP offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chain.

The Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

York Teaching Hospital NHS Foundation Trust and York Teaching Hospital Facilities Management LLP provide a comprehensive range of acute hospital and specialist healthcare services for approximately **800,000** people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering **3,400 square miles.** The annual turnover is approximately **£0.5bn.** We manage 8 hospital sites**, 1,127 beds** (including day-case beds) and have a workforce of over **9,000 staff** working across our hospitals and in the community.

The Group have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. There are robust recruitment policies and processes in place, including conducting eligibility to work in the UK checks for all directly employed staff and agencies on approved frameworks.

There are a range of equal opportunities controls in place to protect staff such as a Freedom to Speak Up Guardian, Fairness Champions and a Raising Concerns and Whistleblowing Policy.

The Group has in place a Standards of Business Conduct Policy which covers the way in which the organisation and staff behave.

The Procurement Department's senior team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPs code of professional conduct. The intranet includes a link to an ethical procurement training module which is available to all members of staff. Competency assessments are currently being developed for all bands in the department some of which will include requirements around modern slavery.

The top 50% of suppliers nationally, affirm their own compliance with the modern slavery and human trafficking act within their own organisation, sub-contracting arrangements and supply chain. The Group has written to its top supplier requesting them to affirm their compliance with the legislation.

Modern Slavery is referenced in the Safeguarding Adults Policy and features as part of the safeguarding adults training following the changes in the Care Act. The Safeguarding Adults Staff intranet resource includes signposting to help and advice for patient's affected by Modern Slavery. In addition the safeguarding adults team has a delegated Modern Slavery Lead to ensure that all relevant national, regional and local context is embedded in processes in a timely manner.

The Group has evaluated the principle risks related to slavery and human trafficking and identify them as:

- Reputational
- Lack of assurances from suppliers
- Lack of anti–slavery clauses in contracts
- Training staff to maintain the Group's position around anti-slavery and human trafficking.

Aim

The aim of this statement is to demonstrate the Group follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

……
Susan Symington
Chair

……
Simon Morritt
Chief Executive

25 March 2020

……
Mike Keaney
Chair

……..
Brian Golding
Managing Director

23 March 2020

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 March 2020
Executive Committee Terms of Reference

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 approve the latest version of the Executive Committee terms of reference which has been altered to reflect comments received following review at the Executive Committee in February.

Executive Summary – Key Points

The Executive Committee and is the senior operational committee reporting to the Board of Directors.

Committee members were asked to provide any comments following the Executive Committee February meeting and these have been incorporated into the latest version, which is attached.

Recommendation

The Board of Directors is asked to approve the terms of reference.

Author: Lynda Provins, Foundation Trust Secretary

Executive sponsor: Simon Morritt, Chief Executive

Date: March 2020

York Teaching Hospital
NHS Foundation Trust

Executive Committee: Summary of Governance

Version 0.0~~8~~6
March~~December~~ 20~~19~~20

York Teaching Hospital NHS Foundation Trust

Executive Committee:
Summary of Governance

Table of Contents

Executive Committee

Terms of Reference

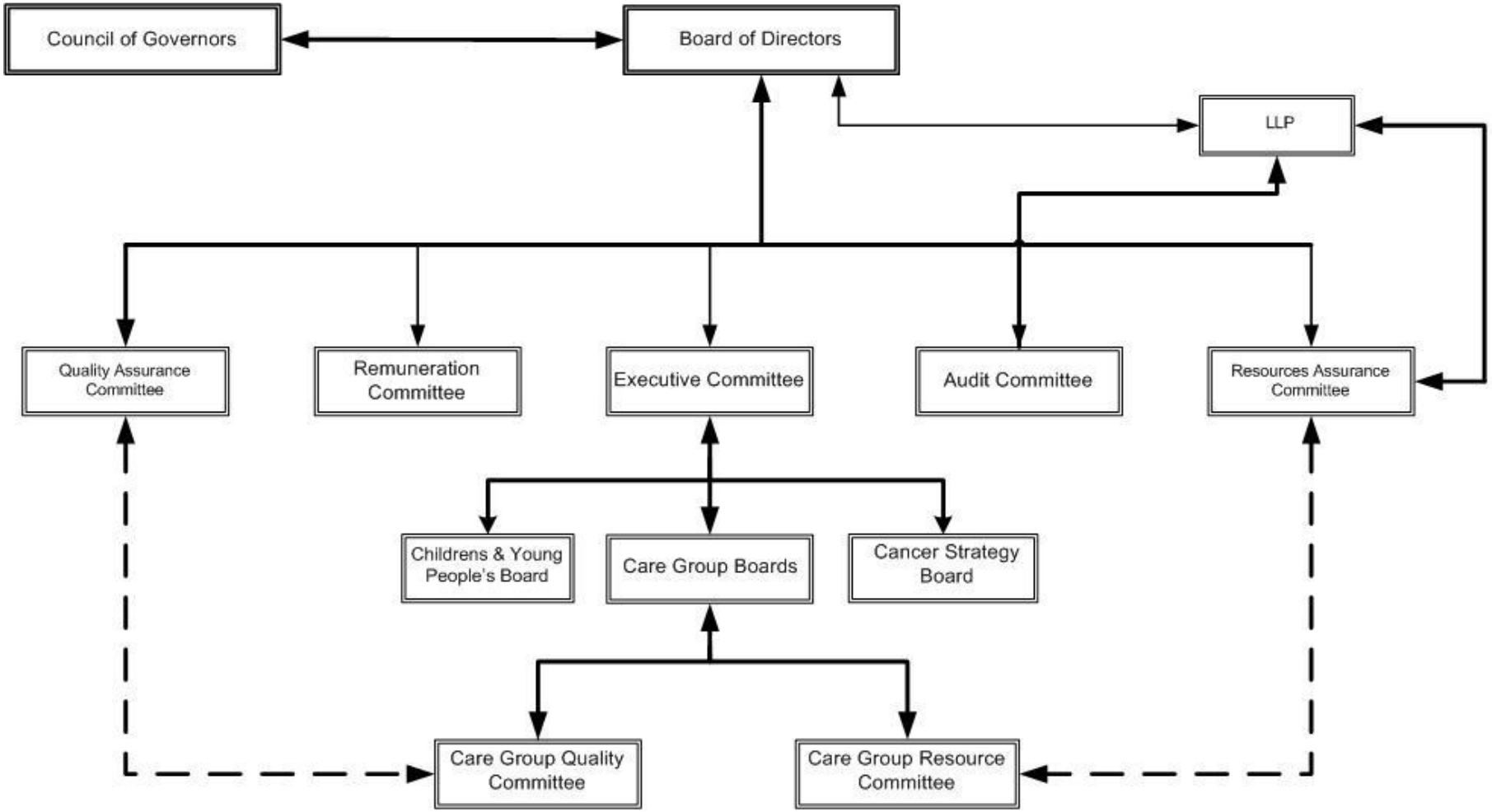
1 **Status**	
1.1	The Executive Committee (the Committee) is a Committee of the Board of Directors.
2 **Purpose of the Committee**	
2.1	The Executive Committee provides assurance to the Board of Directors around patient safety and putting the best interests of patients first in relation to the Trust's development and implementation of strategy. The Executive Committee is responsible for making recommendations to the Board of Directors regarding the Trusts strategy, implementing the agreed strategy as directed by the Board and providing oversight on Trust-wide governance, risk, operations and performance.
3 **Authority**	
3.1	The Executive Committee is given delegated authority by the Board of Directors to act. The Trust's Reservations of Powers and Scheme of Delegation document provides the Executive Committee with authority to approve aspects of business cases up to a value of £1m. The Executive Committee is accountable to the Board of Directors for any decisions made. Decisions on business cases and overarching Trust strategies proceeding to the Board of Directors for approval must be considered by the Executive Committee in the first instance.
4 **Legal requirements of the committee**	
4.1	There are no specific legal requirements attached to the functioning of the Executive Committee. The Executive Committee will however be made aware of any legal requirements the Trust is expected to fulfil relating to quality and safety.
5 **Roles and functions**	
5.1	The Executive Committee will consider proposed investments up to a limit of £1m.
5.2	The Executive Committee is responsible for making recommendations to the Board of Directors regarding Trust strategies.
5.3	The Executive Committee will provide advice and comment, where required, to other Groups, Committees and the Board of Directors within the governance structure.
5.4	The Executive Committee will consider the monthly performance data of the whole Trust and consider areas of adjustment that may need to be made to improve performance. The performance data will include, but is not limited to the metrics

	from the operational activity along with the financial metrics, workforce metrics and compliance information.
	The Executive Committee will receive regular reports from each Care Group.
5.5	The Executive Committee has the authority through the Reservations of Powers and Scheme of Delegation to consider and approve the appointment of consultants where it is a replacement post on behalf of the Board.
5.6	The Executive Committee will regularly review the Corporate Risk Register and Board Assurance Framework to gain assurance that risks are being managed and scored appropriately..
5.7	To escalate any other areas of concern/risk identified to the Board of Directors for further discussion and resolution.
	The Executive Committee
6	**Membership**
6.1	The membership will comprise: • Chief Executive (Chief Executive to Chair) • Executive and Corporate Directors (Finance Director to deputise for the Chief Executive) • Clinical Chief Information officer • Chief Pharmacist • Care Group Directors • Foundation Trust Secretary
7	**Quoracy**
7.1	The Executive Committee will be quorate if 10 members attend. The Deputy Chair will preside over the meeting if the Chair is unable to attend.
8	**Meeting arrangements**
8.1	The Executive Committee will meet at least 10 times per year and all supporting papers will be circulated 5 working days in advance of the meeting. Copies of all agendas and supplementary papers will be retained by the Foundation Trust Secretary in accordance with the Trust's requirements for the retention of documents.
8.2	The Chair of the Executive Committee has the right to convene additional meetings should the need arise and in the event of a request being received from at least 2 members of the group.
8.3	Where members of the Executive Committee are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the group. Deputies should ~~only~~ be provided, but ~~in exceptional circumstances when agreed with the Chair and~~ would not form part of the quoracy.

9	**Review and monitoring**
9.1	The Executive Committee will maintain a register of attendance at the meeting. Attendance of less than 75% will be brought to the attention of the Chair of the Committee to consider the appropriate action to be taken.
9.2	The terms of reference will be reviewed every two years.

Author	Foundation Trust Secretary
Owner	Chief Executive
Date of Issue	
Version #	V0.0~~6~~8
Approved by	Board of Directors
Review date	

Executive Committee Structure



V.0.01 Jan 2020 Executive Committee Structure

Executive Committee Work Programme

Standard Agenda Items:

Chief Executives Briefing
Business Case Review – Approval
Patient Safety – Medical Directors Report – Chief Nurse Report
Finance Report
Operational Performance Report
Care Group Summary Reports
Any regulatory action plan monitoring ie: CQC
Policies for Approval

Other Items:

January	**May** CRR/BAF Review	**September** Winter Planning Discussion Cancer Board Review Annual Library Report Safer Working Guardian – Freedom to Speak Up Report - Quarterly
February Cancer Board Review CRR/BAF Review Draft Operation/Financial Plan Free of Charge Drug Schemes Research Update	**June** Safer Working Guardian – Freedom to Speak Up Report - Quarterly	**October** Winter Planning – Prior to Board
March Safer Working Guardian – Freedom to Speak Up Report - Quarterly	**July**	**November** CRR/BAF Review
April Winter Review Children & YP Board Report	**August** CRR/BAF Review Free of Charge Drug Schemes	**December** Safer Working Guardian – Freedom to Speak Up Report - Quarterly

	Research Update	