York Teaching Hospital
NHS Foundation Trust

Board of Directors - Public

27 May 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

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 May 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 the first month of the 2020/21 financial year.

Executive Summary – Key Points

The Trust's income and expenditure positon is balanced for month 1 after including all NHSE/I funding.

Recommendation

The Board of Directors is asked to:

- Note the income and expenditure position for month 1 of the 2020/21 financial year
- Note the emergency financial regime implemented by the NHS for the period April to October 2020.
- Note the request made of internal audit to review the COVID-19 expenditure capture and authorisation processes.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: May 2020 (REVISED – Version 2 reflecting drug expenditure update)

1. COVID-19 Emergency Financial Regime

To support the NHS in its response to COVID-19 all normal financial arrangements have been suspended and a new national, temporary, emergency financial framework has been put in place. Initially, this was for the period April through to the end of July 2020 but the NHSE/I National Team have recently confirmed this arrangement will remain in place until at least 31 October 2020. Indications from the National Team are that this arrangement is most likely to continue for the full financial year, although no statement has been made to this effect.

The framework assesses the Trust's immediately pre-COVID monthly expenditure level and uses this as a baseline for funding. NHSE/I's initial assessment of this monthly value was £46.6m (including inflation for 2020/21 pay and price levels). We would recognise this value. The Trust receives £1.6m of funding from Health Education England (for training) and £0.4m from Local Authorities (for service provision) and so NHSE/I assess our monthly funding requirement as £44.6m, net of these two continuing payments. Again we would recognise these values.

In the first stage of NHSE/I emergency funding a payment has been made to each Trust on the basis of a block payment equal to 90% of the above value. For our Trust this is £40.1m. This payment was made on 1 April 2020 and is the April emergency payment. A second block payment, also of £40.1m, was made on 15 April 2020. This is the May block payment. On the 15 May we will receive June's payment, and so on. The idea behind the payments is to front load cash with the Trust having received £80m during April through this route. This significantly exceeds our in-month cash requirements.

There are then two top up payments that will be made by NHSE/I. The first top up will be to recognise an uplift from the 90% block to 100% funding, less an assumption for the continued receipt of other income sources. For the Trust this first top up amounts to a monthly payment of £1.3m. The NHSE/I model assumes the Trust continues to receive other income totaling £1.3m as well (comprising other patient care income, R&D and other operating income).

The table below summarises this emergency baseline funding position for the single month of April.

Income Plan for April	**£k**
NHS Block Income (at 90%)	40,080
LA Income	391
Other Patient Care Income	190
R&D	242
Education & Training Income	1,585
Other Operating Income	2,513
1st Top Income (90% to 100% funding)	1,345
Total Income	**46,346**

Note: NHSE/I made the original assumption that costs totaled £46.6m in their calculation of 90% funding. This has now been revised down to £46.3m as per the confirmed income plan in the table above.

Using the same principles as above NHSE/I has set the Trust's expenditure plan at pre-covid levels and applied appropriate inflation. This is summarised in the table below.

Expenditure Plan	£k
Employee Costs	31,319
Operating Costs (exc. employee)	14,465
Net Finance Costs	562
Total Income	**46,346**

This income and expenditure plan confirms that the Trust would break even. Note that all Provider Sustainability Funding has been suspended, with all income necessary to break even applied to the funding formula.

Clearly, on top of this base expenditure level is the revenue cost of the COVID-19 response effort. All organisations are required to track and report this on a monthly basis. The second top up process (known as the "trueing up" exercise) relates to COVID-19 emergency expenditure and is designed to uplift Trust funding by the necessary amount to deliver break even. This adjustment also recognises any short falls in income levels attributable to COVID-19, for example lost car parking revenue from moving to free staff parking. The trueing up exercise will only return an organisation to balance and cannot be used to generate a surplus.

NHSE/I require Trusts to declare the COVID-19 cost element of their trueing up requirement plus provide an analysis of any other variance the trueing up exercise is covering. This will be reviewed for its appropriateness under the COVID-19 response effort and must not include non-COVID revenue investments causing pressure against fixed funding levels, unless these have been pre-agreed with NHSE/I.

2. Month 1 Income and Expenditure Position

The emergency financial regime is designed to deliver income and expenditure balance to all organisations during the COVID-19 response period.

Prior to the trueing up exercise the Trust has a deficit against the NHSE/I plan of £1.4m. The Trust's trueing up request of NHSE/I is therefore £1.4m. The reported position, in line with the guidance, accrues for trueing up income of £1.4m and confirms income and expenditure balance.

There are 3 notable components to the trueing up request:

- COVID-19 expenditure for the month of April has been assessed as £1.8m
- Non-contracted activity (NCA) for March 2020 is £0.3m below the estimated position included at the year end. NCAs arise from patients accessing York and Scarborough services from other parts of the country, typically whilst on holiday or visiting the area. During March this activity significantly reduced but this information was not available until April coding work was complete. This loss of income is a clear consequence of COVID-19 and appropriate for the trueing up exercise.

- Other operating income is notably down on plan. Specific examples include car parking at £0.2m and catering income at £0.1m. R&D income is £0.2m down on plan due to a significant reduction in trial activity. Some of this income loss is compensated in spend reductions but a net trueing up top up of £0.2m is required to deliver income and expenditure balance.

From an expenditure perspective, during April the Trust spent £45.8m against NHSE/I's pre-COVID plan of £46.3m. Removing COVID-19 assessed expenditure of £1.8m suggests the underlying spend level was £44.0m, underspending against NHSE/I's plan by £2.3m. Significant underspends existed in pay (agency expenditure some £0.4m below plan) and on drugs (£0.8m). Income was down £1.9m from the NHSE/I plan of £46.3m due to major interruptions associated with COVID-19.

A submission will be made to NHSE/I highlighting these issues and payment of the trueing up top up is expected to be made in June.

This process will continue each month through to the end of October at the earliest. Arrangements post-October are not yet clear.

3. Other Financial Issues

The Board should be aware that as part of the emergency financial regime the delivery of the Trust's Cost Improvement Programme (CIP) has been suspended. No adjustment has been made to income levels for any implied efficiency requirement.

It is clear from discussions with the National Team that there is an expectation that productivity improvements and efficiency gains for the NHS will feature in the post-COVID recovery programme. To that end, whilst actual delivery of the CIP has been suspended, work continues with Care Groups and Directorates to prepare plans; including the continued review of model hospital opportunities, the development of regular efficiency opportunities and the capture of transformational changes to service delivery accelerated as part of the Trust's (and wider NHS) COVID-19 response effort.

In addition, this month NHSE/I require confirmation that arrangements have been made for internal audit to review the Trust's COVID-19 expenditure capture and authorisation processes. This has been actioned and the review will take place later in May/early June. The subsequent audit report will feature on the agenda of the next available Audit Committee. Confirmation will be provided to NHSE/I of this action.

4. Management of Suppliers

The emergency financial regime is designed to deliver two objectives. Firstly the process is designed to give income and expenditure balance to all organisations during the COVID-19 response period.

Secondly, the payment timetable is designed to ensure organisations have sufficient cash. This element of the regime has been designed with purpose; and that is to ensure that the NHS can act as a provider of cash to its commercial suppliers. NHSE/I have asked that

Trust's move towards payment of suppliers of goods and services within 7 days, irrespective of normal invoice payment terms. This is not a contractual requirement with no change to standard NHS contract terms. This is being actively encouraged.

This has been formally communicated to suppliers by NHSE/I.

There is considerable work to do to get to this point across the NHS. Many organisations do not use Purchase Order numbers (we do in the main), end user requisitioners do not prioritise receipt of goods (which is essential to release payment) and both requisitions and invoices often miss key information necessary to support prompt payment.

Work is now underway to support this initiative locally. Communications have been sent out to end user requisitioners to stress the importance of timely receipting of goods.

For the month of April the Trust achieved payment of 9% of invoices within 7 days. Compliance with the public sector better payments practice code was high with 93% of invoices paid within their standard 30 day terms.

5. Recommendation

The Board of Directors is asked to:

- Note the income and expenditure position for month 1 of the 2020/21 financial year
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- Note the request made of internal audit to review the COVID-19 expenditure capture and authorisation processes.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 May 2020
Complaints Annual Report 2019-20

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

- The NHS and Social Care Complaint Regulations 2009 require every NHS organisation to produce a complaints annual report
- Provide an overview of the complaints the Trust received in 2019-20

Executive Summary - Key Points

Key areas of achievement:
- Introduced on line complaints form
- Review of Concerns and Complaints Policy and Procedure, reflecting the changes resulting from the formation of care groups

Key area of concern:
- Although progress has been made, response times for complaints remains a concern (average 41% complaints met 30 working day target).

Recommendation

Committee asked to approve report.

Author: Justine Harle, Lead for Complaints & PALS

Director Sponsor: Heather McNair, Chief Nurse

Date: 4 May 2020

1. Introduction

The NHS and Social Care Complaint Regulations 2009 require every NHS organisation to produce a complaints annual report. The information set out below meets each requirement as set out in the regulations.

The Trust complaints function is overseen and monitored by the Chief Nurse. However, complaints and their prompt and effective management are everyone's responsibility. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in their absence, the Chief Nurse or an Executive Director designated signatory.

2. The number of complaints which the responsible body received and the number of complaints which the responsible body decided were well-founded

New complaints	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
York Hospital (including community)	72	76	94	73	**315**
Scarborough Hospital	47	54	35	32	**168**
Bridlington Hospital	2	6	7	4	**19**
Total	**121**	**136**	**136**	**109**	**502**

New complaints by Care Group	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
CG1: York Acute, Emergency, Elderly Medicine & Community	30	30	42	33	**135**
CG2: Scarborough Acute, Emergency & Elderly Medicine	18	28	17	16	**79**
CG3: Surgery	34	33	23	20	**110**
CG4: Cancer and Support Services	9	8	10	12	**39**
CG5: Family Health	16	15	17	12	**60**
CG6: Specialist Medicine	13	19	25	15	**72**
Corporate Services	1	3	2	1	**7**
Total	**121**	**136**	**136**	**109**	**502**

The Trust submits quarterly returns to NHS Digital (KO41a), which monitors written hospital and community health service complaints received by the NHS. 502 formal complaints were reported this year; an increase of 13% from 445 in 2018-19.This may be in part due to the year on year increase in Trust activity and the work that the Patient Experience team has undertaken to make it easy for people to provide feedback such as new online forms.

Most recent data from NHS Digital shows the Trust was below average for the number of complaints received and the number of closed cases upheld. However, there is not a standardised national approach to recording complaints. NHS Digital has notified NHS Trusts that returns for Q4 2019-20 and Q1 2020-21 will not be collected due to the impact of the Covid-19 pandemic.

In 2019-20, 66 cases were reopened for further local resolution, equating to 13% of complainants being dissatisfied with the response they received from the Trust. This

represents a 28% improvement from 92 in 2018-19 and illustrates the continuous effort to provide comprehensive responses.

Reopened (dissatisfied)	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
York Hospital (including community)	9	6	14	6	**35**
Scarborough Hospital	7	5	4	10	**26**
Bridlington Hospital	0	1	2	2	**5**
Total	**16**	**12**	**20**	**18**	**66**

Outcome data

The Trust is required under the complaints legislation to record whether or not the issues were considered to be substantiated following investigation. 531 complaints were closed this year, of which 34% were not upheld, 52% were partially upheld and 14% were upheld. These figures are comparable to 2018-19 (38% not upheld, 50% partially upheld and 12% upheld).

The table below shows the outcomes for cases closed in 2019-20

Outcomes	Not upheld	Partially upheld	Upheld	Total
York Hospital (including community)	121	155	45	**321**
Scarborough Hospital	56	108	25	**189**
Bridlington Hospital	5	11	5	**21**
Total	182	274	75	**531**

Parliamentary and Health Service Ombudsman (PHSO)

The Trust aims to remedy complaints locally through investigation and meetings, if appropriate. However, if the complainant remains dissatisfied they have the right to refer their complaint to the PHSO as the second and final stage of the complaints process.

This year the Trust had twelve complaints referred to the PHSO. Following a preliminary review of all the complaints the PHSO decided to investigate four cases (two relating to care at York Hospital and two relating to care at Scarborough Hospital).

The PHSO decided not to consider eight complaints either because they saw no evidence that the Trust had done anything wrong or they were assured that the Trust had conducted a thorough internal investigation and shared findings and learning with the complainant. The fact that the PHSO decided not to investigate 67% of the referred complaints provides assurance that the local complaints process is rigorous.

PHSO cases	15/16	16/17	17/18	18/19	19/20
Total	24	18	10	3	4

One PHSO investigation was concluded in 2019-20 (received in 2018-19 Q3) and not upheld.

3. The subject matter of complaints that the responsible body received

As in previous years, the top three themes for complaints were dissatisfaction with clinical treatment, patient care and communication, followed by issues relating to staff attitude and discharge arrangements.
The failure to properly involve patients in decisions about their care and treatment and to properly communicate with them can often be the main cause of complaint about clinical care. In many cases, investigations show that the care provided is satisfactory but there were short comings relating to communication and this was a specific theme in complaints about medical staff.

Patients told us they wanted to be treated as a person, not a number. Patients that complained did not always feel listened to and were not kept informed about their care. They wanted to be involved in decision making and to be able to ask questions.

Emerging trends or themes are monitored regularly as complaints are received, and any areas of concern are highlighted to the Care Group management teams. In addition, operational performance management reports are produced as well as quarterly reports for the Quality and Safety Committee.

The table below shows the number of complaints received by subject.

Subject	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
Clinical treatment	98	117	103	80	**398**
Patient care	63	60	79	60	**262**
Communication	62	80	67	52	**261**
Staff values and behaviours	40	53	69	37	**199**
Admissions, transfers and discharges	32	36	35	30	**133**
Appointments	18	14	9	18	**59**
Trust Admin/Policies/Procedures	15	21	13	8	**57**
Privacy, dignity and respect	8	13	9	8	**38**
Access to treatment or drugs	13	11	6	5	**35**
Waiting times	7	11	12	1	**31**
Prescribing	8	10	7	2	**27**
Facilities	3	4	8	1	**16**
End of Life care	2	4	6	2	**14**
Patient concerns	2	5	4	3	**14**
Staff numbers	1	0	6	0	**7**
Consent	0	1	4	2	**7**
Commissioning	2	0	1	0	**3**
Restraint	0	0	2	0	**2**
Total	**374**	**440**	**440**	**309**	**1563**

Please note that a complaint may have several subjects associated with it and this reflects the complexity of many complaints.

4. Any matters of general importance arising out of those complaints, or the way in which the complaints were handled

The Trust is committed to providing an open, honest and straightforward response, with robust complaint handling at a local level. On average 41% of closed cases (ranging from 27% in April to 47% in March) met the Trust's 30 day response target compared to 36% in 2018-19. This improvement is due to the targeted work that care groups have undertaken to address the timeliness of their complaint responses.

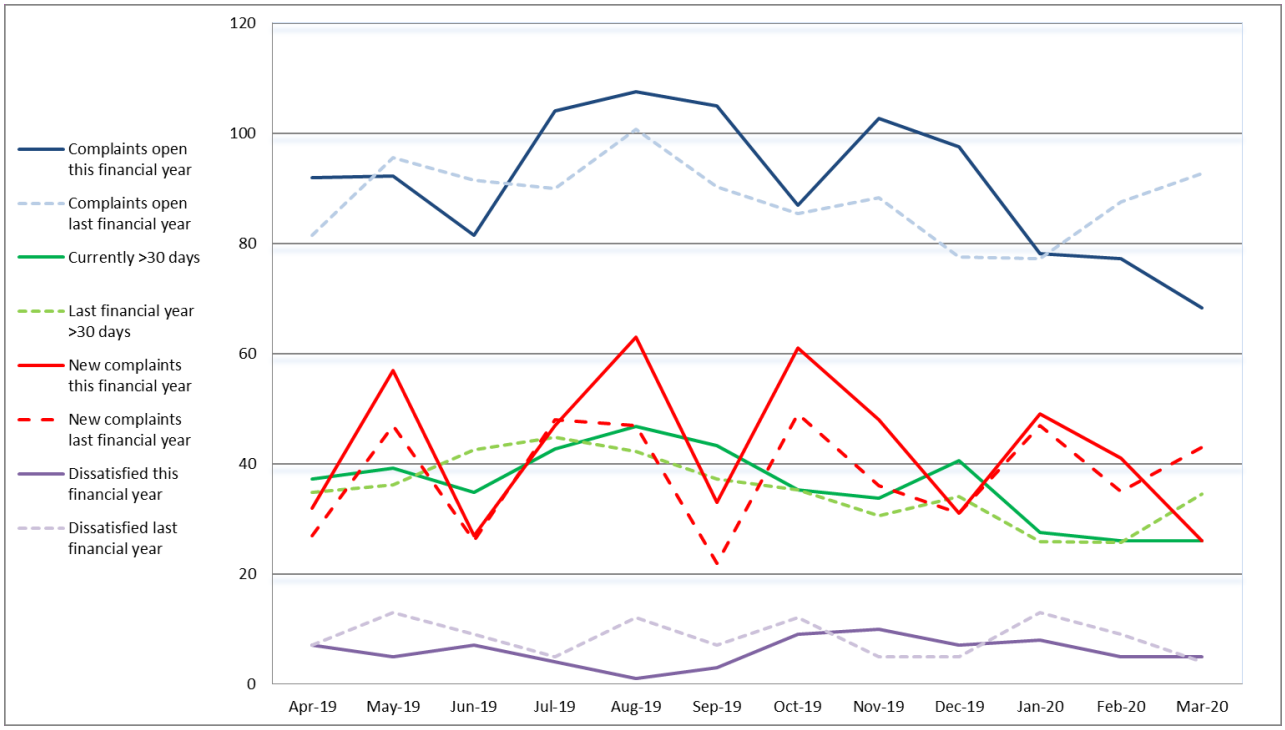
Responses within target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Number of cases closed	44	48	39	52	45	49	60	44	56	57	42	45
Closed within 30 working days	12	20	16	24	15	16	18	23	21	20	24	21
%	**27%**	**42%**	**41%**	**46%**	**33%**	**33%**	**35%**	**52%**	**38%**	**35%**	**57%**	**47%**

In addition, the Patient Experience team has developed a complaints training programme for investigators and managers across the Trust to assist in providing robust investigations and responses. The Patient Experience Team will continue to work with care group managers to improve response times.

As at 26 March 2020 41% of open complaints were over target compared to a low of 30% in July 2020. However, the number of complaints received in March 2020 has reduced dramatically, likely due to the impact of the Covid-19 pandemic, and there were only 66 cases open compared to a high of 117 in July 2020.

Care Group	<26 working days	26-29 working days	30-50 working days	51-100 working days	>100 working days	Total
CG1	9	2	4	8	1	**24**
CG2	7	1	1	1	0	**10**
CG3	8	0	6	2	0	**16**
CG4	3	0	1	0	0	**4**
CG5	3	0	0	0	0	**3**
CG6	6	0	2	1	0	**9**
Total	**36**	**3**	**14**	**12**	**1**	**66**

Complaint Performance



On behalf of the Trust, Patient Perspective sends out a survey at the end of the previous quarter, to all complainants whose complaint was closed during this period, unless they chose to opt out. Complainants are asked about their experience of accessing the complaints process and if they are happy with the handling and outcome of their complaint. The survey helps us to audit how complainants rate our complaints process.

404 complainants were sent a survey between April and December 2019. 88 complainants completed the survey, giving a response rate of 22%.

Complainants remained concerned that making a complaint would have a negative impact on care provision. Details on our website and leaflet give assurances that care will not be affected and this information is also included in the initial acknowledgement letter. However, the letter has been amended to make this point more noticeable. Investigating officers should also reiterate to all complainants that the complaints process will not have a negative effect on patient care when they first contact the complainant. This responsibility has been added to the Trust policy on complaints and concern management and is covered in the complaint management training programme.

Negative feedback was predominantly about the lack of communication with the investigating officer during the complaint process, unacceptable wait for a response, lack of evidence provided that real improvements had been made, lack of transparency and recognition of failings.

There has been an improvement in initial contact by the investigating officer with the complainant but communication is not consistently maintained and complainants are not always kept up to date with progress. Despite this, the majority of patients felt that they were taken seriously when they first raised their complaint and felt that their complaint was handled professionally. Over the period the number of complainants reporting a negative experience of their complaint handling has reduced.

What complainants told us about their experience:

- Cover up for doctors involved and fabricated statements.
- I was satisfied with the response which was timely, full and dealt with my complaint appropriately.
- Making a complaint was one of the worst experiences I've ever had - I was treated with real spite and the process was in no way fair or patient focused.
- Very happy with outcome, now understand re-order system and changes made to system as a result of my complaint.
- This was simply a tick box exercise but no one has really listened or cared.
- Very easy and handled professionally by the person who phoned me about the complaint.
- I was worried about complaining, but the PALS helpline were brilliant and put my mind at ease.

Complainant survey results will continue to be analysed to determine whether the training has an impact on the experience of making a complaint. Performance will be monitored by the Patient Experience Steering Group and at operational performance meetings.

5. Internal Audit Report: Concerns and Complaints Management YTH 20/07

The internal audit team conducted an audit in October 2019. The objective of the audit was to provide assurance that robust systems and processes are in place to encourage patient complaints and concerns and the Trust seeks to identify learning and continuous improvements to the quality and safety of services provided.

The audit concluded that the Patient Experience team has well controlled systems and processes are in place but that the Trust was not meeting completion timeframes. Weaknesses were also identified in relation to the identification of learning points and monitoring of outstanding actions in care groups.

The Patient Experience team produced new Datix dashboards to reflect the organisational changes and commencement of care groups. In addition, care group specific monthly reports were introduced this quarter to assist in highlighting areas for improvement. These reports complement the care group management dashboards and have been well received.

The Concerns and Complaints Policy has been reviewed this year, following the organisational restructure to ensure it is fit for purpose.

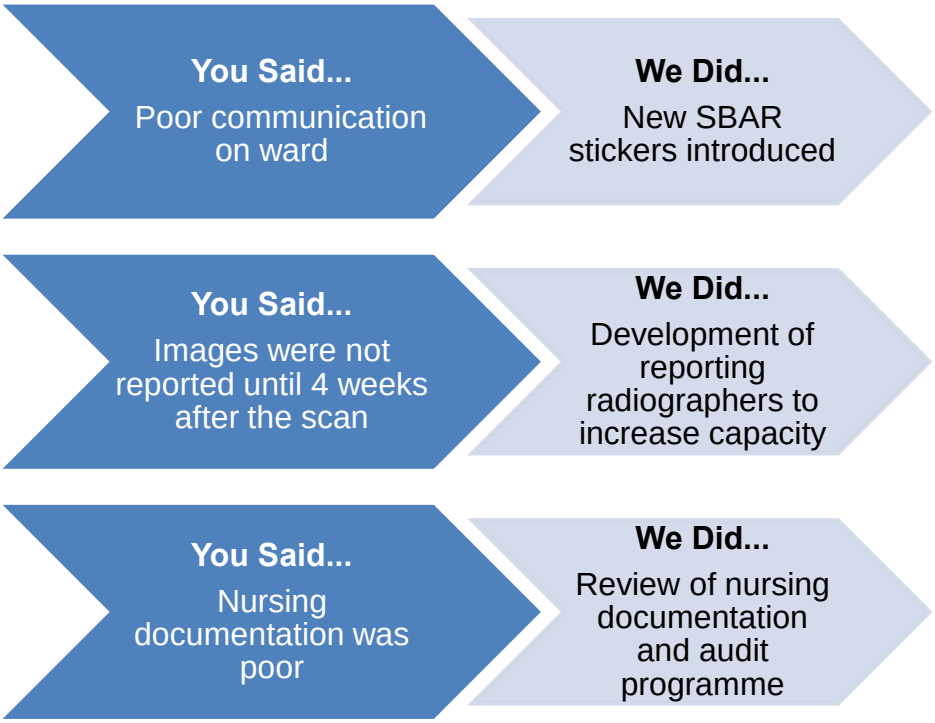
6. Any matters where action has been or is to be taken to improve services as a consequence of those complaints.

The Trust has made a number of changes and improvements in response to patient complaints. Listening to patient feedback and engaging with the experiences of patients through meetings, supports our staff to improve the standard of care and service provided.

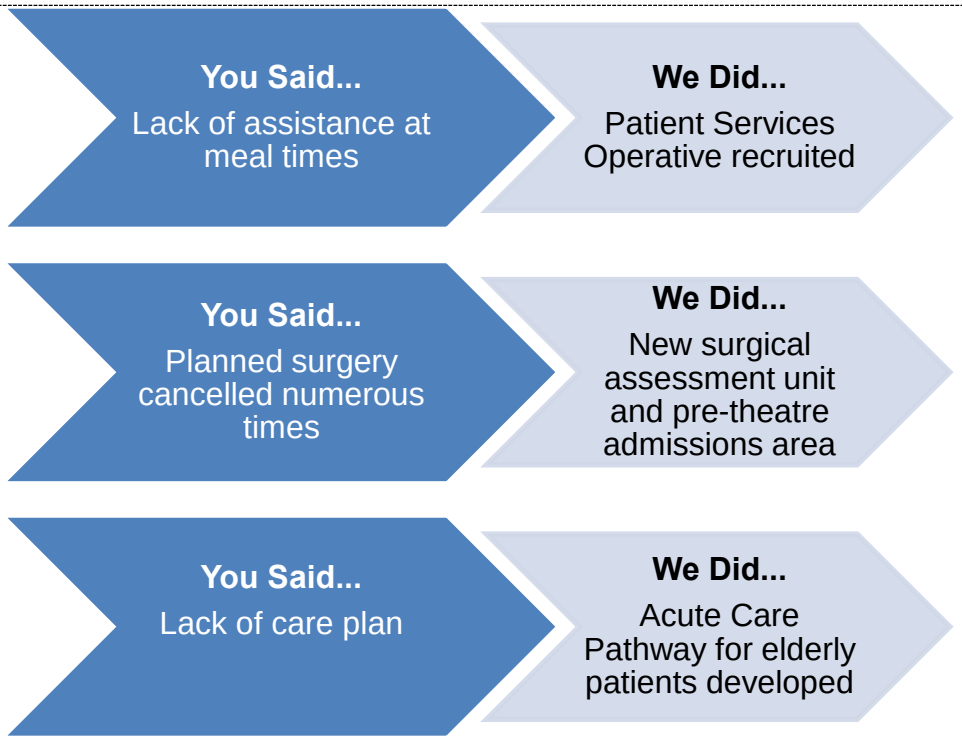
Throughout the year complaints have fed into staff education and learning, reflective practice across multi-disciplinary teams and changes to local practice and procedures where lessons have been learnt.

During 2019-20 the Trust provided patient experience training. Further focus on patient experience and complaint management will form part of the Trust's improvement work over the coming year.

Below are some examples of improvements that have been implemented by the care groups over the last financial year as a result of complaint investigations.



You Said...	We Did...
Inconsistent advice following a pulmonary embolism	New information leaflet
Lack of interpreting service	Introduced video remote interpreting (VRI)
Problem with catheter on ward	Introduced Stat Lock Foley Catheter Stabilisation Devices
Poor communication on wards	New 'nurse in charge' checklist developed
Lack of information for parents on Children's Assessment Unit	Information board created for parents
Delay in radiology administration process	Invested in a new radiology information system



7. Looking Ahead: Quality Priorities 2020-21

During the next year we will:

- Work with the new care group governance leads to ensure that care groups have mechanisms in place to monitor implementation of learning from complaints and any recommendations the Trust receives from the Parliamentary and Health Service Ombudsman
- Ensure learning is disseminated across care groups to promote Trust wide awareness and best practice
- Continue with the rolling programme of complaints training for current and new complaint investigators

We have set ambitious targets for 2020-21 in order to further improve the patient's experience by end of March 2021.

Our ambitions are to:

1. **Improve the timeliness & quality of complaint responses**

90% trajectory:
<10 days for PALS
<30 days complaints

2. **Reduce the number of reopened complaints**

8. Conclusion

During this year a great deal of work has taken place to improve the quality and timeliness of complaint responses; there has been an overall improvement as a result, however, there remains room for improvement.

Complaint timescales and progress of open complaints continue to be closely monitored. Each Care Group receives a monthly report which supports the information on the patient experience dashboards so that any areas of concern can be highlighted, and appropriate and immediate action taken.

We are always looking at ways to improve our complaints pathway for complainants. This year we have introduced an electronic complaint form to the complaints page on our website as an additional means of submitting a complaint to the Trust. The introduction of this form has reduced the number of email exchanges prior to a full investigation.

It is clear from the complaint feedback forms that improvements must be made in communicating with complainants both at the beginning and during the investigation process, where appropriate, to ensure they are kept fully informed of progress as per national guidelines. This is covered in the complaints training programme and will be reinforced.

In line with the Parliamentary and Health Service Ombudsman's "principles of good complaints handling", the Trust will continue to improve our handling of all complaints. We will continue to listen to people's concerns, address them and learn from them.

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York Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

Board Assurance Framework – At a glance

Strategic Goals

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

Goal	Strategic Risks	Original Risk Score	Residual Risk Score	Target Risk Score
Patient Care	1. Failure to maintain and improve patient safety and quality of care	**25**	**25 ↑**	**6**
Patient Care	2. Failure to maintain and transform services to ensure sustainability	**20**	**20 ↑**	**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**	**20 ↑**	**9**
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	**20**	**16 ↑**	**6↑**
Workforce	8. Failure to ensure there is engaged leadership and strong, effective succession planning systems in place	**16**	**12 ↔**	**1**
Finance	9. Failure to achieve the Trust's financial plan	**25**	**9 ↓**	**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**	**8 ↑**	**1**
Finance	12. Failure to achieve the System's financial plan	**25**	**9 ↓**	**6**

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.**

Temporary governance arrangements in relation to the Covid 19 pandemic which follow national guidance

- The Trust has introduced a bronze, silver and gold command structure to co-ordinate efforts for the pandemic – all decisions are logged
- Bronze, silver and gold meetings are held every day with a weekly gold group which has replaced the Executive Committee during this period – Executive Committee planned to restart in June
- The Board and sub-committees are following the 'reducing the burden' national guidance and meetings have been limited to a one hour meeting which discusses Covid issues and then there is a section for papers which are for information.
- Any documents still requiring approval of the Committees/Board are covered under any matters of urgency – due to large number of items for approval in March, this was done by email (all emails retained) a paper detailing the approvals was taken to the April Board.
- The Board is introducing a bi-monthly workshop which is longer in order to discuss Covid issues in more detail – this is initially planned until September 2020
- Board and Committee Action Logs dates continue to be scrutinised to ensure that elements are covered or reviewed periodically
- Audit Committee in May streamlined to focus on year-end only – the July time out meeting will now be a normal agenda incorporating the time out elements
- The Council of Governors has been stood down, but communications are still being sent from the Chair and FT Secretary – in May 2020 a plan was agreed to look at how technology could be used to get the governors around a virtual table.
- Covid capital and revenue spend processes have been put in place

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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, 11 – CN 2, 7, 8, 17, 20, 22, 23, 24, 25, 26 – COO 2, 3, 6, 7, 8, 17, 18, 19, 20 – HR 1a&b, 4, 9, 15, 18 – 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 = 5 Severity= 5 Score: 25	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure including o Assigned Director Portfolios, Structures & Teams o Ward to board nursing structures & teams o Patient Experience Steering Group o Safeguarding Children & Adults Teams & Internal & External Structures o Health & Safety Systems & Groups o Infection Prevention & Control meeting structures - Strategies, Policies & Procedures o Nursing and Midwifery Strategy, Patient Experience Strategy, Sign up to Safety Campaign pledges and Patient Safety Strategy. o Risk Management Framework o Performance Management Framework - Systems &Monitoring o Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities o CQUINs & contract monitoring o Recording of escalation systems NEWS etc o Medicines Management/EPMA implementation o National Surveys o NICE, NSF and Clinical Audit o Capital Programme o Maternity CNST	- External inspections including CQC Reports - Internal Audit Programme - CQC and Choices website feedback - SHMI - National Survey Action Plans, Friends & Family Test - Premises Assurance Model, PLACE/TAPE Reports - Patient Experience Work Plan & Quarterly Reports - Quarterly Pressure Ulcer & Falls Reports - Mortality Reports – Learning from Deaths - IPC Quarterly Report & Annual Report - Patient Safety, Quality, Workforce, Finance and Performance Report to Board/Committees - Annual Complaints Report to Board - Quality Report - Patient Safety Walk Rounds - NICE, NSF and Clinical Audits/Effectiveness Reports - Safeguarding Children & Adult Reports to Board - Maternity Reports - Staffing Reports - Learning Hub Data - Health & Safety Reporting - 7 day audit – 7 day task & finish group & plan - Integrated Board Report	- 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 - Surge plan if social distancing ineffective - Critical care capacity – establishment of Nightingale Y&H facility – transfer of care

○ 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 - Covid 19 command structure - Daily bronze, silver and gold meetings - Action Log and Loggists in place - Weekly gold strategic meeting chaired by CEO - HCV & North Yorks & York command structure in place - Processes, pathways and SOPs in place	- 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) - Daily and weekly Covid 19 actions logs - Review at weekly gold CEO led group - Covid 19 dashboard - Submission of required Covid 19 returns for assurance	- Access & maintenance of adequate oxygen supply - Access to appropriate supply & distribution of PPE - Increased risk of secondary deaths due to services not being accessed - Possible increased risk to children & adults in community due to social distancing - Possible increased risk that some routine elements may be negatively impacted due to reduced reporting or staff absence Actions (Identify plans to address gaps) - 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. - Safeguarding Team aware of risk to vulnerable adults & children – access to team for advice & support established during this period

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, 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 = 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 Directors Portfolios – Transformation Lead o Business case management system o System Transformation Board o Care Group Structure implemented - Strategies Policies & Procedures o Development of Trust Strategy and supporting strategies o Development of Care Group Service Plans and associated Business Cases - Partnership working o HCV HCP engagement o ECIST Support o McKinsey Engagement o Partnerships & Alliances o Health & Wellbeing Board & Place Based Boards o Peer Review	- Reports from E & Y – McKinsey Reports - HCV HCP Reports/Papers - External Review - Scarborough - Peer Review - External Benchmarking of systems and pathways - Executive/ Board Papers - Care Group Pathway Redesign - Performance data - Partnership & Alliance Reports	- Stakeholder Session to review Phase 2 of McKinsey Review due to be held on 31.01.20 - 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)

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
 	
Elements of assurance framework deferred ie: work plans, engagement with Internal Audit and 'routine' operational planning
In line with national guidance, usual reporting
	- 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
		- Due to pause in required reporting nationally during Covid, oversight of previous priorities may be lost.
		
		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

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arrangements have been suspended. Current reports as per national requirements but minimal.		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 - Work associated with realigning wards for Covid has meant some minor works have been deferred (although some work has taken place) - Some key projects aligned to the CQC plan have been put on hold ie ligature and childrens area in York ED - Assurance meetings associated with Estates & Health & Safety have been deferred due to delivery of Covid actions. **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

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		management system (Jul 19) – approved now being implemented – goes live (Apr 20) - CQC Plan areas ie: ligature and childrens area in York ED will be delivered immediately post Covid 19

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, 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
  ○ Senior Management team meetings
  ○ Project Management Group
  ○ Technical Steering Group
  ○ Security Focus Group
  ○ Change Board
  ○ Information Governance Executive Group
  ○ Named SIRO and Caldicott Guardian
  ○ Attendance at Operational meetings
  ○ Capital Programme Executive Group
  ○ Digital Strategy Group
- Systems
  ○ Capital Programme
  ○ Risk management
  ○ On-call Service
  ○ Internal monitoring/alerting systems
  ○ Third Party Monitoring
  ○ Ongoing User Awareness Programme
- External
  ○ DSP Toolkit
  ○ NHS Digital Cyber Security Support Model
  ○ Third party support & maintenance contracts
- Strategies, Policies & Procedures
  ○ Digital Strategy
  ○ 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
		- 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
		- greater demand on the team's time, IT infrastructure and network due to Covid 19
		- Opportunites for transformational working lost once the pandemic is over
		
		Actions
		
		(Identify plans to address gaps)
		
		- Lack of capital put on CRR, managed via CPEG
		- Resources Committee to oversee digital
		- Digital Strategy Group to meet monthly as par of Corporate Directors meeting (Jan 20)
		- CDIO appointment in progress (Apr 20)
		- Building a Digital Ready Workforce engagement ongoing (review tbc)
		- User feedback to be gained via a number of methods; surveys, email, roadshows, user training (ongoing, review Feb 20 inc. Clever Together feedback)
		- Cyber Essentials+ by June 2021

		- Staffing increased (May 20) - Infrastructure and networks adjustments being continually made (Jul 20) - Transformational working to be picked up by Digital Strategy Group and Care Group Leads to ensure opportunities are not lost (Oct 20)

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, 9, 15,187 – 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 = 5 Severity= 4 Score: 20	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	- 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	- 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 **Actions** (Identify plans to address gaps) - Workforce redesign in partnership with FE/HE (Sept 20) - Staff Survey Action Plan in place & being implemented (Jun 20) - Health & Wellbeing Initiatives being implemented (Sept 20)

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○ Development Opportunities ie: Leadership ○ Mentoring, Coaching/Mediation & training ○ Learning Management System development ○ Post & Undergraduate Medical Education ○ Medical library –Covid19 specifically Skills questionnaire circulated to clinical staff – collating responses to enable safe deployment of staff Training of non-stat and man stepped down; Retirees being contacted to facilitate returning Students (nursing – final year and medical 4th yr HYMS) being asked to volunteer Accommodation being sought for clinical staff whose families are in isolation Homeworking enabled where possible (max 250 if VPN token required)	- 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 - Covid 19 update Realtime sickness data being captured through central 'hub' Staff requiring isolation to be signed off via OH and placed on medical suspension	- Workforce Plan (Oct 20) - Apprenticeship Steering Group Outputs (Jul 20) - Implementation of e-Job Planning (Oct 20) - Continue to develop Bank (Dec 20) - HCV HCP Workforce Action Plan (Oct 20) - East Coast medical recruitment project (Dec 20) - NHSE response to pension tax (Apr 20) - International Nurse recruitment (Sept 20)

Strategic Goal: To support an engaged, healthy and resilient workforce **Principal Risk**: (7) Failure to ensure a healthy engaged and resilient workforce **CRR Ref**: HR 1a&b, 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 = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 2 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure o Occupational Health Service/EAP o Junior Doctor Forum o LNC/JNCC - Strategies, Policies & Procedures o Supportive polices and processes o Workforce & OD Strategy - Processes & Systems o Star Awards/Celebration of Achievement o Recruitment and Retention Processes o Workforce redesign including ACPs, Nurse Practitioners, Nursing Associates and Physicians Associates o Appraisal processes – Job Plans o Schwartz Rounds & RAFT o HYMS expansion o LIVEX - Statutory and Mandatory Training o Development Opportunities including Leadership o Mentoring, Coaching/Mediation & training Covid 19 update: Psychological support increased – drop in sessions (now virtual) for staff working in cohorted areas. Tailored Schwartz rounds Headspace app being pursued Clear daily communication updating staff	- 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 Covid 19 Real-time sickness data collated via central 'hub'.	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 Increased staff testing capacity for Covid 19 **Actions** (Identify plans to address gaps) Staff survey action plan in place & being implemented (Jun 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 (Sept 20) Staff testing capacity for Covid 19 to be increased (Apr 20)

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Staff testing for Covid 19 Helpline and support sessions staffed by Clinical Psychologists RAFT/TiPi Apps to support mental wellbeing (Headspace, unmind and Sleepio).		

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 = 3 Severity= 3 Score: 9	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) - COVID-19 Exceptional Measures o Temporary suspension of PbR with nationally set block contracts recognising cost of	- 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 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.

services. ○ COVID-19 claims process for exceptional capital and revenue. ○ National cash process paying on 1 Apr and 15 Apr to ensure strong cash position for all providers. - Temporary suspension of efficiency requirements		

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
  ○ York/Harrogate Alliance
  ○ HCV HCP Executive Group and subsidiary working groups
  ○ HCV HCP Place Based Boards
  ○ HCV HCP Cancer Alliance Board and subsidiary working groups
  ○ York Primary Care Home Steering Group and subsidiary working groups
  ○ HCV HCP Hospital Partnership Group
  ○ SGH Acute Service Review Steering Group
  ○ Health & Wellbeing Board
  ○ East Coast Strategic Review Group
  ○ Systems Transformation Board
  ○ OHC Services Strategy
  ○ HCV HCP Strategy & Place Based Plans
  ○ Complex Discharge Steering Group
- Strategies, Policies & Procedures
  ○ Refreshed Trust & Clinical Strategies
- HCV & NY & Y Covid 19 command & control structure in place to ensure all partners understand role & responsibilities during Covid 19 crisis - YTHFT engaged in all working groups.
	- CQC System Report
	- Agendas, minutes and papers of the various HCV HCP and partnership groups
	- HCV Executive Group – CEO attendance
	- Hull/York Partnership Board
	- Harrogate/York Partnership meetings
	- Quarterly System Finance Meetings
	
	- OHC Services Reports
	- NHSI Action Plan
		- Place Based Plans
		- System governance arrangements that describe approach to delivery of the system transformation programme
		
		Actions
		
		(Identify plans to address gaps)
		
		- Development of system plan
		- Proposal that sets out future 'system' governance, currently being developed by system partners
		- Clinical reference group (sponsored by Trust MD & CCGs Clinical Chairs)
		- Quarterly System Finance Meetings

	Assurance Level		
Strategic Goal: To ensure financial stability **Principal Risk**: (11) Failure to develop a trust wide environmental sustainability agenda **CRR Ref**: DOF 1, 3, 4, 8, 9, 11 – HR 1a&b, 4, 15, 18 – DE1, 2 **Lead Committee:** Board (last formal review – Jan 20)(Mar 20 – Resources) **Director Lead:** Director of Estates and Facilities (reviewed Oct 2018)	Original Risk Score RAG Rating – 5x5 Likelihood = 5 Severity= 4 Score: 20	Residual Risk Score RAG Rating – 5x5 Likelihood = 4 Severity= 2 Score: 8	Target Risk Score RAG Rating – 5x5 Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)

- Trust Committee/Governance Structure
  - Trust Sustainable Development Management Group
  ○ 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 including Senior Management trust wide
		- 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 and draft NHS Standard Contract 2020-21
		- New risks highlighted from the introduction of the above which have yet to be addressed
		
		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)
		- Review of SD/Green plan including risks being conducted against Long Term Plan targets and NHS Standard Contract 2020-21

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 = 3 Severity= 3 Score: 9	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) - COVID-19 Exceptional Measures o Temporary suspension of PbR with nationally set block contracts recognising cost of	- 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. - Performance recovery plans developed as necessary. - System partner Board to Board meetings arranged to discuss financial issues.

services. ○ Commissioner allocations adjusted to reflect increased provider funding. ○ COVID-19 claims process for exceptional capital and revenue. ○ National cash process paying on 1 Apr and 15 Apr to ensure strong cash position for all providers. ○ Temporary suspension of efficiency requirements		

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 - May 2020

York Teaching Hospital NHS
NHS Foundation Trust

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	16/06/2020	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 appointing a lead to work on the delivery of a Clinical Strategy.	Chief Executive	16/06/2020	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	16/06/2020	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. In addition the Trust has now appointed a Director of Digital.	Chief Executive	16/06/2020	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	16/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Eliminate

Corporate Risk Register - May 2020

York Teaching Hospital NHS
NHS Foundation Trust

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: 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. We are awaiting the trajectories for 2020/2021.	Chief Nurse	14/06/2020	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 71 international recruits now working as B5 nurses (43 in York and 28 in Scarborough). We have 4 currently in training but whose OSCE have been cancelled due to Covid-19. 3 are based at Scarborough and 1 in York. Prior to the COVID-19 outbreak the Board had approved a further 60 international recruits; this project will begin once social distancing and travel restrictions have been lifted. We are awaiting confirmation from the NMC that these staff have been added to the temporary register and that they can then work as Band 5 nurses for the duration of the Covid-19 outbreak. The Board have approved a further 60 international recruits. Action to recruit RSCN's is nearing completion with interviews taking place w/c 11/5/2020.	Chief Nurse	14/06/2020	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. HPV activity has increased as a result of reduced clinical activity during the pandemic. The LLP is leading on a project to reinstigate side rooms currently used as offices in clinical areas.	Chief Nurse	14/06/2020	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	14/06/2020	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	14/06/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	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	14/06/2020	5 - Catastrophic Harm	3 - Possible	15	Eliminate

Corporate Risk Register - May 2020

York Teaching Hospital NHS
NHS Foundation Trust

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?
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. This issue should resolve post pandemic when a number of staff currently 'shielding' return to work	Chief Nurse	14/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
CN25	30/01/2020	Organisational	Regulatory Intervention	Current - Internal & External Risk	There is a risk that systems for recording clinical information, risk assessments and care plans are not used in a consistent way across York emergency department and the medical wards at Scarborough hospital to ensure safe care and treatment for patients. This may result in potential patient harm. The CQC have issued a Regulation 29A Warning Notice in relation to this standard.	As part of the CQC Summary Improvement Plan actions are being taken to address issues surrounding documentation. This will involve an interim solution for nursing documentation until a permanent electronic solution has been achieved. The revised documentation is currently being printed and will be implemented from June 2020. An fully electronic solution will be developed and implemented by January 2021.	Chief Nurse	14/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce
CN26	02/03/2020	Preparedness & Resilience	Service Provision	Current - Internal & External Risk	There is a risk to patient, visitor, staff safety and core hospital business resulting from the COVID-19 virus. This has the potential to result in disruption to hospital services (cancellation on non urgent operations, reduced staffing should staff become affected)	Significant preparation is currently underway to ensure that the organisation is able to respond to pressures . This includes the establishment of PODs, fit testing of staff engaged in swabbing, identification of equipment, kit and potential co-hort wards. The organisation has established internal preparedness meetings and is participating in system wide meetings. There 5/6 wards on each side dedicated to Covid negative and positive, including ICU's.		14/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce

Corporate Risk Register - May 2020

York Teaching Hospital NHS
NHS Foundation Trust

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: 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. These approaches have been maintained through the Covid-19 pandemic. 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. Additional operational management out of hours has been stood up over April to support the Covid-19 response. 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. Continuing joint working with Yorkshire Ambulance Service to improve timely escalation of handover delays with established warning and trigger responses. The Trust has reconfigured both hospital sites to provide urgent care pathways for covid and non-covid patients to reduce the risk of transmission while retaining emergency care services. The Trust has seen rapid improvements in the ECS standard due to a reduction in attendances. The risk remains should previous levels of attendees return.	Chief Operating Officer	14/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	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 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. 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. Cancer Delivery Board is focussed on the maintenance of Cancer Services and access to complex treatment through the Pandemic	Chief Operating Officer	14/06/2020	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. Application of the national ambulance timed pathways.	Chief Operating Officer	14/06/2020	3 - Moderate Harm	4 - Somewhat Likely	12	Reduce

Corporate Risk Register - May 2020

York Teaching Hospital NHS
NHS Foundation Trust

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?
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 regulatory 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 from each occurrence. The group has agreed some additional parameters that need to be included in the reviews, for example, diabetic patients experiencing hypoglycemic episodes whilst delayed in ED. Care Group Heads of Nursing will assume responsibility for reviewing all 12 hour breach reports. In addition to those patients experiencing a 12 hour breach, it is recognised that other patients experience long delays in ED but do not breach 12 hours. In order to provide assurance on the care of these patients, an audit is to be undertaken on a sample of patients who have waited longer than 8 hours in ED and who were subsequently admitted to understand if patients delayed in ED are coming to harm. The methodology of this is has been agreed with Heads of Nursing and a dashboard of all patients with a stay in ED of 8 hours or more, subsequently admitted, is being developed to support future reviews/audit. At the present time April has seen on long waits in either ED. The risk remains if the number of pre-covid attendees return.	Chief Operating Officer	14/06/2020	4 - Severe Harm	3 - Possible	12	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 work will be completed by the end of March 2020. There are further difficulties with the cancellation of routine outpatient appointments due to the Covid-19 pandemic. Where possible outpatient consultations are taking place by Skype. There is likely to be a greater backlog longer term.	Chief Operating Officer	14/06/2020	4 - Severe Harm	5 - Very Likely	20	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 accreditation 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. This risk has been realised - JAG accreditation has not been achieved and an action plan is in development	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	14/06/2020	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	14/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Eliminate

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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	14/06/2020	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	14/06/2020	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 April was 22.6%	• 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 number of recovery actions have been identified: o Clinical Validation; Royal College Best Practice Guidance changed in October 2019 and as a result of the change in guidance fewer patients will require follow up surveillance endoscopy. Initial validation has resulted in a discharge rate of 60%. o Opening Room 5; equipment has already been procured, recruitment completed in December 2019 and Room 5 will be operational from the 3rd of February. o Opening Room 6; Finance Director confirming business case requirement for equipment to support room 6 opening and Endoscopy management commence the recruitment of staff to support opening room 6. o Seven day working Nurse Endoscopists; a consultation process to be undertaken with the Nurse Endoscopists in early 2020 to move towards seven day working in 2020 so that Saturday lists can be provided consistently. • £209,700 additional monies secured from NHSE&I for Endoscopy and MRI. Will be used to tackle the endoscopy backlog and to maintain the low numbers of MRI waiters. The diagnostic target has been severely affected by the stand-down of routine endoscopy and routine elective work.	Chief Operating Officer	14/06/2020	4 - Severe Harm	5 - Very Likely	20	Reduce
COO21	04/05/2020	Preparedness & Resilience	Service Provision	Current - Internal Risk	The Trust has mitigated the plan to respond to either a Critical or Major Incident with the appointment of an Emergency Planning Manager and the establishment of Incident Response Plans. The activation of the Incident Response Plan will impact on service delivery and specifically elective activity.	Incident Response Plans include the establishment of a Recovery Working Group at the earliest opportunity in the response. The scale and complexity of the incident will determine the length of time any service delivery will be affected i.e. a mass casualty incident may require 2 - 4 days of response and a return to normal service delivery within 72 hours whereas a Pandemic Flu response may require a response over a number of months with a resulting impact on service delivery. Restoration and reset of service delivery to be managed in Working Group.	Chief Operating Officer	14/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Tolerate
COO22	04/05/2020	Preparedness & Resilience	Service Provision	Current - Internal Risk	The Trust has begun the process of restoring and resetting service provision to address the inactivity in elective activity during the Covid response. National lifting of lockdown strategies may result in subsequent peaks of Covid admissions and a requirement to return the response phase.	Subsequent peaks of Covid admissions may require adjstment to the scale and timelines of the restoration and reset objectives. Robust clinical triage will be required to ensure that urgent and acute cases continue to be seen whilst service delivery priorty reverts to response to Covid.	Chief Operating Officer	14/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Tolerate

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COO23	04/05/2020	Patient Safety	Service Provision	Current - Internal Risk	Cancer; FT referrals down 70% against average. and ceasing of non-urgent endoscopy. Diagnostics; in line with JAG and the BSG letter dated 24th March 2020 and the NHSE/I Clinical Guide for the management of patients requiring endoscopy during the coronavirus pandemic, published on the 3rd April 2020 all non-emergency endoscopy has ceased. RTT and Outpatient FUs; Trust received National guidance on the 17th March to postpone all non-urgent elective operations for a period of at least three months, this resulted in 32 patients waiting 52 weeks or longer at the end of March 2020. This number will rise month on month. Outpatient appointments have been cancelled due to COVID by both the Trust and by patients. Process required to ensure that patients aren't 'lost' and their future care is managed safely.	Cancer; SOP created to provide an outline of the actions taken and tumour site surge plans to optimise the management of cancer patients during the COVID 19 Pandemic. The SOP allows the Trust to adhere to national guidance that "Essential and urgent cancer treatment must continue. Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time.". Urgent surgery has been moved to Nuffield Hospital site. Cancer governance structure and meetings remain in place. Diagnostics: Endoscopy Service provision during initial COVID 19 Response: • All non-emergency referrals cancelled on the 24 March 2020 • All referrals to be clinically triaged by a consultant and telephone consultations should take place with patients and appropriate safety netting in place for patients whose symptoms worsen. • All referrals are held on the provider waiting list • All external providers (the endoscopy group) lists cancelled as of the 24 March 2020 • All training lists are stood down as of the 24 March 2020 • Continued clinical validation of surveillance patients by nurse endoscopists and consultants. RTT and Outpatients; Longest RTT waiters are being risk stratified fortnightly by Care Groups to ensure waiting for treatment is not causing harm. To date 1,803 elective inpatient or Day Case TCIs and 40,891 outpatient appointments have been cancelled by the Trust. In addition 3,633 outpatient appointments have been cancelled by patients due to concerns around attending hospital. In order that these patients who have cancelled their appointments are not 'lost' those with no future booked activity are being reviewed by clinicians using the NOTIFY process on CPD. Notify allows clinicians to access all areas of CPD to decide on the next stage of a patients care. To mitigate against the loss of routine capacity the Trust has accelerated its outpatient transformation project with increased numbers of patients being seen via online consultations and telephone clinics; for April to date a third of all attendances have been non face-to-face (4,700 attendances). Where patients have to be seen in a face-to-face environment the Trust has moved activity to non-acute site clinics where possible. Where high-risk patients have had to attend the York site, areas such as the Neurosciences department have been used. These areas have a separate entrance and therefore the footfall and risk to patients and staff can be minimised. Care Group clinicians are working with Patient Access to review via NOTIFY a rolling four weeks of future booked outpatient appointments. The following options are available to clinicians when reviewing: • Discharge • Defer - Timescale can be entered, clinic type, instructions and additional selections. • Add to Waiting List • Convert to Phone / Video using existing or new appointment time and date	Chief Operating Officer	14/06/2020	4 - Severe Harm	5 - Very Likely	20	Reduce
COO24	04/05/2020	Patient Access & Performance	National Targets		Trust received National guidance on the 17th March to postpone all non-urgent elective operations for a period of at least three months, this resulted in 32 patients waiting 52 weeks or longer at the end of March 2020. This number will rise month on month. Referrals into the Trust have reduced negatively impacting performance against the RTT 92% target. Diagnostics; in line with JAG and the BSG letter dated 24th March 2020 and the NHSE/I Clinical Guide for the management of patients requiring endoscopy during the coronavirus pandemic, published on the 3rd April 2020 all non-emergency endoscopy has ceased. Cancer; impacted by reduction in FT referrals and ceasing of non-urgent endoscopy.	Restoration of Services cell has been established as part of the bronze level of the Trust's Incident response Command and Control structure. Discussions have started with Humber, Coast and Vale partners. Work Completed to date: ToR Established Bronze recovery cell Data and baseline Capacity assessment commenced Clinical Risk Management processes for high risk services Phase 1 response to end of May 2020; Mitigation of impact and clinical risk; Capacity: Assessment: Prioritisation: Maximisation; Planning: 'Blue, Green, Yellow' zones, scenario modelling and identification of transformational change to maintain. System opportunities being explored with Humber, Coast and Vale partners.	Chief Operating Officer	14/06/2020	4 - Severe Harm	5 - Very Likely	20	Reduce

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Manager: Executive, Deputy Chief												
DCE00	22/08/2018				NO OTHER CORPORATE RISKS AT PRESENT		Deputy Chief Executive					

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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	16/06/2020	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	16/06/2020	5 - Catastrophic Harm	4 - Somewhat Likely	20	Reduce

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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. The programme has been temporarily suspended due to the national covid response but planning for restart continues.	Director of Finance	14/10/2020	3 - Moderate Harm	3 - Possible	9	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	07/06/2020	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. This risk is temporarily suspended given the national covid response and the new provider funding at cost regime.	Director of Finance	14/10/2020	3 - Moderate Harm	3 - Possible	9	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. Temporarily suspended as part of the national covid response.	Director of Finance	14/10/2020	3 - Moderate Harm	3 - Possible	9	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	07/06/2020	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. This risk has been temporarily suspended with the national covid response but will need to restart at the end of the pandemic.	Director of Finance	14/10/2020	3 - Moderate Harm	3 - Possible	9	Reduce

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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	12/06/2020	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	12/06/2020	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 10.6% 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	12/06/2020	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	12/06/2020	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	12/06/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce
HR18	03/03/2020	Staffing & Human Resources	Sickness Absence	Current - Internal & External Risk	Patient safety and service delivery compromised due to high absenteeism of staff due to Covid-19 outbreak	Close monitoring of absence levels, reporting through Bronze, Silver and Gold commands	Director of Workforce & OD	12/06/2020	4 - Severe Harm	5 - Very Likely	20	Eliminate

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Manager: SNS, Director												
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	07/06/2020	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 Digital Strategy Group 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	07/06/2020	4 - Severe Harm	5 - Very Likely	20	Reduce

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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	16/06/2020	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 Histopathology.	Medical Director	16/06/2020	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	16/06/2020	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	16/06/2020	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. This is likely to be exacerbated by the current cancellation of routine outpatient appointment due to Covid-19.	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	16/06/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce

Corporate Risk Register - May 2020

York Teaching Hospital NHS
NHS Foundation Trust

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?
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 Steps continue as per the action plan for the section 29a although footfall has reduced as a result of the current Covid-19 Pandemic .	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. A review of the integrated discharge approach on the acute floor is underway to bring together DLT, Social Workers, CRT, RATS and the therapists to better support the acute teams with discharges. A significant number of patients appear to be admitted with low level mental health needs. ECIST will support a mental health mini-MADE event and the outcomes of this will be shared with partners to generate discussion about next steps. The Winter plan 19/20 for YFT & system partners incorporates; (1) high impact schemes embedded from 18/19, (2) Winter Pressure Grant schemes & (3) the additional system & locality specific actions mobilised across both sites by Chief Officers following the ECS Risk Summit. These are captured in a single system workplan held by the A&E Delivery Board & System Resilience Group, with ECIST supporting all in-hospital actions. For YTHFT these include: communication plans and learning from stakeholder engagement; increased bed capacity; increased decision making capacity; and temporary changes to the function of some wards.	Medical Director	16/06/2020	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. Steps continue as per the action plan for the section 29a although footfall has reduced as a result of the current Covid-19 Pandemic	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. A review of the integrated discharge approach on the acute floor is underway to bring together DLT, Social Workers, CRT, RATS and the therapists to better support the acute teams with discharges. A significant number of patients appear to be admitted with low level mental health needs. ECIST will support a mental health mini-MADE event and the outcomes of this will be shared with partners to generate discussion about next steps. The Winter plan 19/20 for YFT & system partners incorporates; (1) high impact schemes embedded from 18/19, (2) Winter Pressure Grant schemes & (3) the additional system & locality specific actions mobilised across both sites by Chief Officers following the ECS Risk Summit. These are captured in a single system workplan held by the A&E Delivery Board & System Resilience Group, with ECIST supporting all in-hospital actions. For YTHFT these include: communication plans and learning from stakeholder engagement; increased bed capacity; increased decision making capacity; and temporary changes to the function of some wards.	Medical Director	16/06/2020	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	16/06/2020	5 - Catastrophic Harm	3 - Possible	15	Reduce

Corporate Risk Register - May 2020

York Teaching Hospital NHS
NHS Foundation Trust

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?
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.	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 being provided by Everlight, and will be more permanently resolved when the new Radiologist on-call rota comes into effect. A mobile CT scanner is on site 2 days per fortnight along with internally staffed evening sessions when required to manage capacity issues. Installation of 2nd CT is progressing well. Evaluation of scanners underway. Aiming for installation Autumn 2019. Update - although business case for 2nd scanner is approved, capital not available this financial year.To be reviewed within the current financial year	Medical Director	16/06/2020	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	16/06/2020	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 some patients are having to wait a significant amount of time to receive support from the MH Trust. 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. A number of pathways have now been developed with the assistance of TEWV and the next stage is to implement and then audit their success in Q4 2020/21	Medical Director	16/06/2020	4 - Severe Harm	4 - Somewhat Likely	16	Reduce

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Quality and Safety, Workforce, Finance, Research and Development and Operational Performance Integrated Report

April-2020

Produced May 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

Report produced by:

Information Team

Integrated Performance Report : April-2020

Understanding the Report

1. Operational Performance Summary

This section provides a summary of key performance targets for NHSI, Quality, Workforce and Finance, plus activity data. The target is either the monthly standard and performance is coloured according to achievement. This should be read in conjunction with overall trends and not taken in isolation. The table will show performance for a 13 month rolling period, which is also displayed in the snapshot overview. Change from previous month is displayed using arrow, but again this must be read in conjunction with trend analysis.

Indicator

target if applicable

change from previous month

monthly performance or activity level

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.01	Emergency Care Attendances		▼	18055	18270	18256	20101	19683	18486	18800	17848	17926	17169	16770	13034	7755
1.02	Emergency Care Breaches		▼	3525	3310	3067	3785	3671	4043	3689	4337	4471	4257	3065	2131	490
1.03	Emergency Care Standard Performance	95%	▲	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%	75.2%	81.7%	83.7%	93.7%

trend of 13 month rolling period

2. Focus Sections

This section provides a summary of key performance targets for NHSI, Quality, Workforce and Finance, plus activity data. The target is either the monthly standard and performance is coloured according to achievement. This should be read in conjunction with overall trends and not taken in isolation. The table will show performance for a 13 month rolling period, which is also displayed in the snapshot overview. Change from previous month is displayed using arrow, but again this must be read in conjunction with trend analysis.

monthly performance

change from previous month

SPC for 13 month period

SPC triggers can be 1 or all of

93.7%

1.03
Emergency Care Standard Performance

95.0%

10.0%

↑

target if applicable

Special cause triggers within data

- 7 Consecutive points above the mean
- 7 Consecutive points in one direction
- Special cause outside UCL/LCL

- 7 Consecutive points above the mean
- 7 Consecutive points in one direction
- Special cause outside UCL/LCL

QUALITY AND SAFETY REPORT

April-2020

Produced May 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

Report produced by:

Information Team

Quality and Safety Report: April 2020

Executive Summary

Trust Strategic Goals:

- [X] to deliver safe and high quality patient care as part of an integrated system
- [X] to support an engaged, healthy and resilient workforce
- [X] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of Quality and Safety indicators within the Trust

Executive Summary:

Key discussion points for the Board are:

Event Reporting

Of particular note is a continued reduction in the number of events being reported since the start of the Coronavirus pandemic due to the reduction in clinical activity across all specialties and all patient attendance types. In April 2020, all event types saw a decrease in the number of events being reported.

34 events reported in April indicated that either Coronavirus or COVID-19 were a factor in the event being reported. Although it should be noted that many of these events continue to be multifactorial and that categorisation of the main event type varies, COVID-19 incidents recently reviewed by the Quality and Safety Briefing Team relate to incorrect use of PPE or faulty PPE (one split face mask), a member of staff contracting the virus in shared accommodation, a member of staff wearing their uniform outside of work and equipment issues regarding the accuracy of thermometers.

To Note:

Radiology testing during the pandemic

Currently all essential/ urgent/ fast track patients where the benefit of the scan outweighs the risk are invited to attend for a scan. There have been several patients who have refused because of the pandemic; however a clear process has been put in place.

Medicines management with CoVID-19

COVID-19 has given rise to shortages of several groups of medicines. Due to the increased utilisation of ICU capacity there has been shortages of several critical care medicines such as: sedatives, muscle relaxants, and vasopressors. (see Medical Directors report)

Mortality

The percentage of deaths as a proportion of discharges does show a spike from mid-March, but this should be read in line with the number of admissions which has shown a planned reduction with the suspension of elective activity

Looking specifically at the period from 1st February until 10th May 2020, there has been no statistical change in the number of inpatient deaths at York and Scarborough Hospitals. Deaths as a proportion is above the average, but this is in line with the reduced number of admissions

Recommendation:

The Board is asked to receive the report and note any actions being taken.

Author(s): Helen Noble, Head of Patient Safety
Jo Nelson-Smith, Compliance Manager

Director Sponsor: James Taylor, Medical Director
Heather McNair, Chief Nurse

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY SUMMARY: (i)

REF	SERIOUS INCIDENTS (data is based on SI declaration Date)	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.01	Number of SI's reported	▼	12	23	5	12	10	11	14	12	16	11	13	9	4
1.02	% 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*:														
1.03	-Invitation to be involved in Investigation	▼	0	1	1	3	4	1	2	1	2	0	2	2	0
1.04	-Given Final Report (If Requested)	▼	2	5	3	1	1	1	3	2	2	1	2	1	0

* Duty of Candour reporting has been revised to report from the beginning of the 2019-20 financial year.

REF	DUTY OF CANDOUR (All Incidents - data is based on the incident date) *	Target	Sparkline / Previous Month	TOTAL
1.10	Incident Graded Moderate or Above			153
1.11	Verbal Apology Given			107
1.12	Written Apology Given			114
1.13	Duty of Candour Complete			133
1.14	% Compliiance with Duty of Candour			86.9%

*** For Incidents Reported Between 01/05/19 and 19/04/20**

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.

REF	CLAIMS	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.20	Number of Negligence Claims	▼	19	11	19	20	18	17	16	13	7	20	8	12	3
1.21	Number of Claims settled per Month	▼	2	5	4	3	3	5	2	4	3	3	2	7	5
1.22	Amount paid out per month	▲	115,000	3,274,121	169,040	124,000	655,000	138,000	16,000	507,500	159,863	208,500	1,400,000	189,000	530,000
1.23	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.

REF	MEASURES OF HARM	Target	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.30	Incidents Reported		▼	1,236	1,365	1,262	1,345	1,248	1,293	1,320	1,271	1,307	1,407	1,279	1,036	792
1.31	Incidents Awaiting Sign Off		▼	905	811	843	792	841	950	793	727	844	767	902	871	500
1.32	Patient Falls		▼	196	262	255	227	190	226	212	219	241	244	225	143	141
1.33	Pressure Ulcers - Newly Developed Ulcer		▼	90	87	78	76	73	97	92	84	130	110	97	109	94
1.34	Pressure Ulcers - Deterioration of Pressure Ulcer		▼	21	9	9	16	14	10	16	6	10	18	14	11	10
1.35	Pressure Ulcers - Present on Admission		▼	124	121	137	132	120	103	135	128	140	166	133	137	106
1.36	Degree of harm: serious or death		▼	2	10	3	4	6	4	9	4	0	5	3	1	0
1.37	Medication Related Errors		▼	111	133	120	141	140	135	152	134	120	155	143	100	61
1.38	VTE risk assessments	95%	▼	97.5%	96.9%	96.7%	97.0%	96.3%	95.6%	96.3%	96.1%	96.8%	95.3%	95.2%	96.3%	93.1%
1.39	Never Events	0	▲	0	0	0	0	1	0	1	1	0	0	0	0	2

There has been a decrease in the numbers of incidents being reported since the outbreak of the Coronavirus due to a decrease in hospital activity. The Trust continues to validate falls and pressure ulcer data, so this data is subject to change. Validation of harm for incidents of moderate harm and above is ongoing, so data is subject to change.

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY SUMMARY: (ii)

REF	PRESSURE ULCERS***	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.40	Number of Category 2	▼	67	62	53	54	56	70	61	48	87	67	60	67	66
1.41	Number of Category 3	▼	3	0	1	7	2	0	5	4	3	3	6	5	0
1.42	Number of Category 4	▲	2	2	0	0	4	1	1	1	1	1	0	0	1
1.43	Total no. developed/deteriorated while in our care (care of the org) - acute	▼	67	69	61	62	64	74	83	69	116	105	77	94	83
1.44	Total no. developed/deteriorated while in our care (care of the org) - community	▼	44	27	26	30	23	33	25	21	24	23	34	26	21

REF	FALLS****	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.50	Number of falls with moderate harm	▼	1	3	0	2	1	6	2	4	5	5	2	1	0
1.51	Number of falls with severe harm	▼	1	7	1	1	3	2	5	2	0	2	2	1	0
1.52	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. 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.

REF	DRUG ADMINISTRATION	Target	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.60	Insulin Errors		▼	7	13	14	9	13	6	18	9	10	19	24	8	4
1.61	Prescribing Errors		▼	29	30	29	33	39	26	31	37	24	45	35	17	11
1.62	Preparation and Dispensing Errors		▼	12	9	6	14	10	12	17	12	6	11	10	6	4
1.63	Administrating and Supply Errrors		▼	51	55	53	69	64	65	68	60	57	68	67	53	33

REF	SAFEGUARDING	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.70	% of staff compliant with training (children)	◀▶	85%	85%	85%	86%	84%	83%	83%	84%	85%	86%	86%	86%	86%
1.71	% of staff compliant with training (adult)	◀▶	86%	86%	86%	88%	86%	85%	84%	85%	86%	88%	88%	88%	88%
1.72	% of staff working with children who have review DBS checks														

REF	PATIENT EXPERIENCE: COMPLAINTS, PALS AND FFT	Target	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
2.01	New complaints this month		▼	36	51	36	51	59	31	56	48	36	43	42	26	9
2.02	% Complaint responses closed within target timescale	30 days	▼	27%	42%	41%	46%	33%	33%	35%	52%	38%	35%	57%	47%	33%
2.03	New PALS concerns this month		▼	188	160	135	139	141	142	143	135	86	168	151	87	57
2.04	% PALS responses closed within target timescale	10 days	▼	78%	75%	69%	69%	72%	73%	71%	73%	67%	74%	75%	70%	69%
2.05	FFT - York ED Recommend %	90%	▲	79.3%	84.0%	84.5%	69.5%	74.8%	70.7%	75.0%	74.9%	72.6%	77.8%	76.8%	96.2%	-
2.06	FFT - Scarborough ED Recommend %	90%	▲	88.2%	93.4%	88.7%	79.3%	82.4%	80.9%	86.2%	85.7%	92.3%	85.0%	85.9%	88.9%	-
2.07	FFT - Trust ED Recommend %	90%	▲	82.0%	87.0%	85.5%	71.4%	76.5%	74.2%	77.4%	76.9%	76.4%	78.8%	78.7%	94.9%	-
2.08	FFT - Trust Inpatient Recommend %	90%	▲	96.3%	97.4%	96.6%	97.0%	96.3%	96.4%	96.9%	96.5%	97.2%	96.8%	96.9%	97.3%	-
2.09	FFT - Trust Maternity Recommend %	90%	▲	98.6%	96.9%	98.1%	97.3%	97.5%	97.0%	98.3%	96.1%	97.3%	97.4%	97.7%	97.9%	-

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY SUMMARY: (iii)

REF	CARE OF THE DETERIORATING PATIENT	Target	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
3.01	14 hour Post Take - York *	90%		79%	79%	81%	82%	80%	80%	76%	76%	79%	82%	81%	83%	84%
3.02	14 hour Post Take - Scarborough *	90%		70%	70%	72%	76%	71%	73%	74%	70%	74%	76%	77%	77%	68%
3.03	NEWS within 1 hour of prescribed time	90%		90.1%	90.2%	90.6%	89.9%	89.9%	89.2%	89.6%	89.2%	89.6%	90.2%	90.7%	90.1%	90.3%
3.04	Elective admissions: EDD within 24 hours of admission	93%		88.2%	88.6%	88.6%	87.3%	85.7%	87.8%	86.5%	88.1%	86.9%	94.0%	91.7%	89.4%	91.5%

* 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.

REF	MORTALITY INFORMATION	Target	Sparkline / Previous Month	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	Jan 19 - Dec 19
4.01	Summary Hospital Level Mortality Indicator (SHMI)	100		97	97	98	100	99	99	99	98	100	100	98	100	99

REF	4AT ASSESSMENT		Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
5.01	4AT Screening	90%		-	-	73.4%	69.9%	68.7%	69.7%	72.9%	82.2%	78.7%	79.8%	81.9%	75.8%	72.5%

REF	INFECTION PREVENTION	Target*	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
6.01	Clostridium Difficile - meeting the C.Diff objective			14	11	15	10	15	9	9	11	12	13	10	7	7
6.02	Clostridium Difficile - meeting the C.Diff objective - cumulative	61 (year)		14	25	40	50	65	74	83	94	106	119	129	136	7
6.03	MRSA - meeting the MRSA objective	0		0	0	0	2	0	0	0	0	0	0	0	0	0
6.04	MSSA			4	5	2	5	3	4	5	5	4	3	2	5	5
6.05	MSSA - cumulative	30 (year)		4	9	11	16	19	23	28	33	37	40	42	47	5
6.06	ECOLI			7	6	5	5	8	2	5	6	7	6	6	8	14
6.07	ECOLI - cumulative	61 (year)		7	13	18	23	31	33	38	44	51	57	63	71	14
6.08	Klebsiella			2	1	3	2	5	2	1	1	2	1	2	1	1
6.09	Klebsiella - cumulative			2	3	6	8	13	15	16	17	19	20	22	23	1
6.10	Pseudomonas			2	1	2	4	2	1	2	1	3	3	1	1	4
6.11	Pseudomonas - cumulative			2	3	5	9	11	12	14	15	18	21	22	23	4
6.12	MRSA Screening - Elective	95%		85.17%	79.38%	84.62%	89.81%	90.31%	89.96%	86.75%	88.40%	88.69%	88.61%	84.41%	90.23%	74.47%
6.13	MRSA Screening - Non Elective	95%		88.25%	89.52%	89.63%	89.71%	89.54%	89.98%	90.83%	90.95%	88.98%	90.13%	90.01%	86.54%	88.42%

* Thresholds to be confirmed for 2020-21 for MSSA, ECOLI and C-DIFF

REF	STROKE	Target	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
7.01	Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%		92.8%	75.0%	73.3%	75.0%	100.0%	75.0%	100.0%	80.0%	100.0%	100.0%	100.0%	-	-
7.02	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			Oct-Dec 20			Jan-20	Feb-20	Mar-20	Apr-20*
7.03	Proportion of patients spending >90% of their time on stroke unit	85%		89% (B)			87.4% (B)			89.9% (B)			86.4% (A)	82.6% (C)	87.3% (B)	73.4% (E)
7.04	Scanned within 1 hour of arrival	43%		47.5% (B)			49.6%(A)			45.8%(B)			63.7% (A)	46.4% (B)	64.9% (A)	67.2% (A)
7.05	Scanned within 12 hours of arrival	90%		97% (A)			94.4% (B)			95.6%(A)			97.8% (A)	92.8% (B)	99% (A)	93.4% (B)

*April 20 SSNAP scores based on local data only. The 90% proportion time in Stroke services is low, however this only relates to 49 discharged stroke patients out of 61 admitted and may change once the other patients admitted in April have also been discharged.
Of those patients who have been discharged/died, eight were diagnosed with COVID 19 at some point during their hospital admission so spent time on COVID positive wards/ICU outside of stroke services.

REF	DOLS	Target	Sparkline / Previous Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
8.01	Standard Authorisation Status Unknown: Local Authority not informed the Trust of outcome			0	1	1	3	6	4	0	0	2	8	1	8	2
8.02	Standard Authorisation Not Required: Patient no longer in Trust's care and within 7 day self-authorisation			17	9	14	14	16	10	19	1	19	29	21	22	12
8.03	Under Enquiry: Safeguarding Adults team reviewing progress of application with Local Authority or progress with ward			12	20	9	21	15	19	15	14	15	24	14	1	2
8.04	Standard Authorisation Granted: Local Authority granted application			0	0	0	0	0	0	0	2	0	0	1	0	0
8.05	Application Not Granted: Local Authority not granted application			0	0	0	0	0	0	0	0	0	1	0	0	1
8.06	Application Unallocated as Given Local Authority Prioritisation: Local Authority confirmed receipt but not yet actioned application			2	1	16	5	8	4	2	8	7	16	16	18	9
8.07	Safeguarding Adults concerns reported to the Local Authority against the Trust			6	6	6	14	3	4	7	1	1	0	5	3	3
8.08	Application Withdrawn: Patient no longer in Trust's care within the Local Authority 8 week period for assessment			0	0	1	1	0	0	1	5	4	8	14	0	1

TRUST BOARD REPORT : April-2020

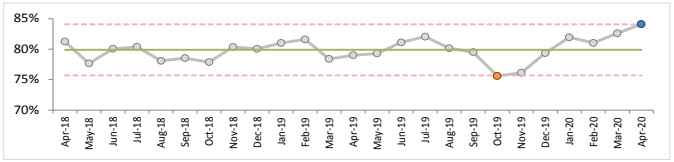
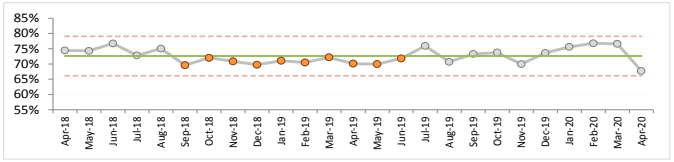
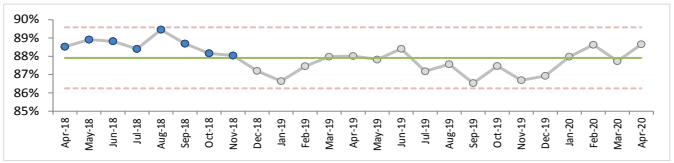
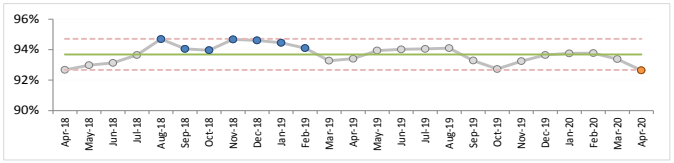
QUALITY AND SAFETY SUMMARY: (iv) QUANTITATIVE TABLE

REF	Indicator	Consequence of Breach	Threshold	Sparkline / Previous Month	Q2 19/20	Q3 19/20	Q3 19/20	Q4 19/20	Jan-20	Feb-20	Mar-20	Apr-20
9.01	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	 ◀▶	18	10	15	20	12	8	-	-
9.02	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	-	-
9.03	Sleeping Accommodation Breach	£250 per day per Service User affected	0	 ▼	0	0	0	7	0	4	3	0
9.04	% 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%
9.05	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%	 ▼	99.71%	99.70%	99.81%	99.89%	99.89%	99.86%	99.93%	-
9.06	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%	 ▲	98.56%	98.16%	98.80%	99.21%	99.11%	99.26%	99.27%	-
9.07	Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	>4% slot unavailability if	 ▲	8.40%	10.30%	9.73%	8.17%	6.47%	9.21%	9.32%	-
	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								
9.08	Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	99.00%	 ▼	52.08%	72.60%	66.67%	76.72%	62.38%	83.17%	82.67%	53.57%
	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.								
9.09	Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	90.00%	 ▼	94.67%	93.21%	92.12%	91.06%	90.51%	92.28%	90.02%	89.00%
9.10	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								

*QMCO and Monthly Sitrep Return suspended due to Covid-19

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY: CARE OF DETERIORATING PATIENT

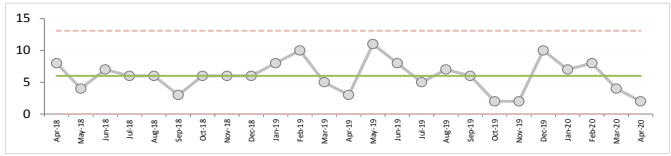
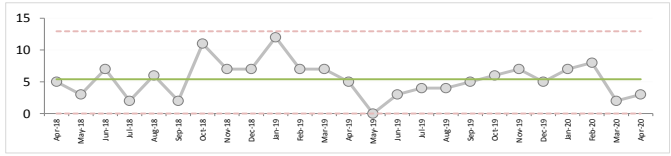
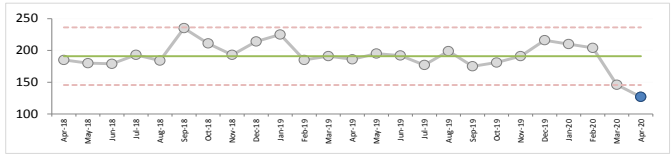
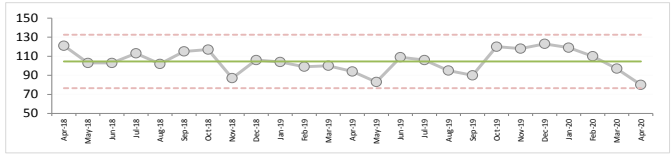
Apr-20	METRIC :	TARGET :	vs LM :	
84.1%	**3.01** 14 hour Post Take - York	90.0%	1.5% ↑	
67.7%	**3.02** 14 hour Post Take - Scarborough	90.0%	-8.9% ↓	
88.7%	**10.01** NEWS within 1 hour (York)	90.0%	0.9% ↑	
92.6%	**10.02** NEWS within 1 hour (Scarb)	90.0%	-0.7% ↓	

HIGHLIGHTS FOR BOARD TO NOTE :

NEWS within 1 hour at Scarborough remains in target range and York improvement from March.

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY: CARE OF DETERIORATING PATIENT

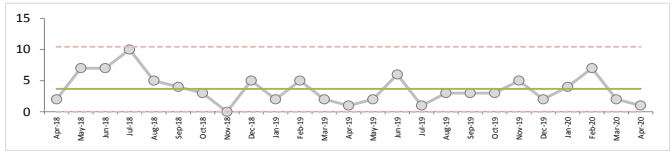
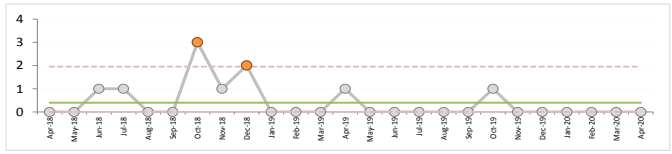
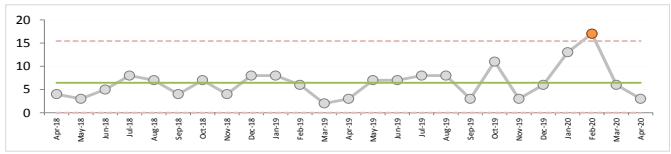
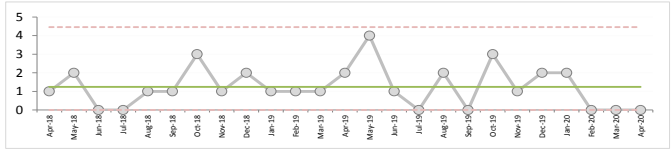
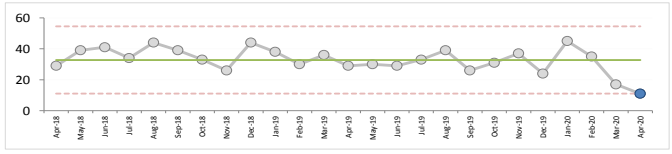
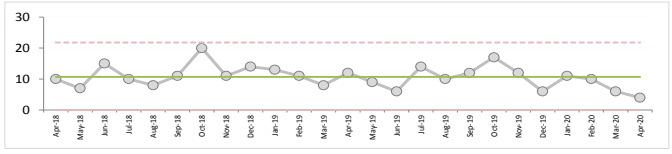
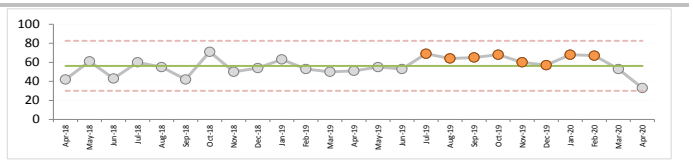
Apr-20	METRIC :	TARGET :	vs LM :	
2	**10.10** Crash Calls (York)	-	-2 ↓	
3	**10.12** Crash Calls (Scarb)	-	1 ↑	
127	**10.13** Calls to Outreach Team (York)	-	-19 ↓	
80	**10.14** Calls to Outreach Team (Scarb)	-	-17 ↓	

HIGHLIGHTS FOR BOARD TO NOTE :

Reduced calls to Critical Care Outreach teams at both Scarborough and York in April representative of fewer patients admitted into hospital in the Green/Cold side. Improved number of ceiling of care decisions and again reduced admissions highlighted in low cardiac arrest calls.

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY: MEDICATION INCIDENTS

Apr-20	METRIC :	TARGET :	vs LM :	
1	**10.20** Prescribing Errors (Insulin)	0	-1 ↓	
0	**10.21** Dispensing Errors (Insulin)	0	0	
3	**10.22** Administration Errors (Insulin)	0	-3 ↓	
0	**10.23** General Medication Errors (Insulin)	0	0	
11	**1.61** Prescribing Errors	0	-6 ↓	
4	**1.62** Preparation and Dispensing Errors	0	-2 ↓	
33	**1.63** Administrating and Supply Errrors	0	-20 ↓	

HIGHLIGHTS FOR BOARD TO NOTE :

The number of reported medication incidents has decreased this month, probably due to decreased reporting due to Covid 19.

There have been 2 medication related never events this month

1. Patient connected to an air port rather than an oxygen port. This was quickly recognised and no harm occurred to the patient. However, this is the third occurrence of this type of never event within the Trust and consideration must be given to removing piped medical air at the York site and moving to compressors as is the practice at SGH.

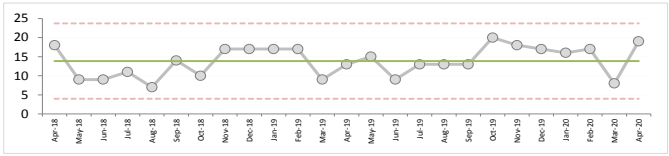
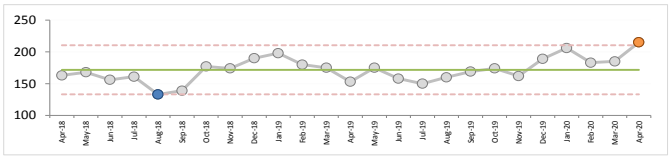
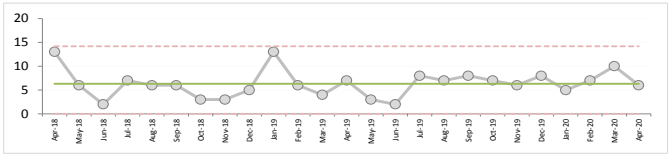
2. A patient who received an incorrect dose of Methotrexate on discharge. The patient received one dose of 40mg instead of the intended 10mg. No harm came to the patient

Of the administration errors, 5 of these relate to patients been discharged with incorrect or missing medicines. This has previously been escalated to the Patient Safety Team and a small group is to be established to review the discharge process.

Of the insulin administration errors, 2 of the 3 related to missed visits by the Community Nursing team. This issue is been investigated as part of a SI investigation.

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY : MORTALITY

Apr-20	METRIC :	TARGET :	vs LM :	
19	**10.30** ED Deaths	0	11 ↑	
215	**10.31** Inpatient Deaths (Acute)	0	30 ↑	
6	**10.32** Inpatient Deaths (Community)	0	-4 ↓	

HIGHLIGHTS FOR BOARD TO NOTE :

Total numbers of deaths within the trust have shown no statistical change however, death rates based on inpatient numbers have shown a large increase (4.5% April 2019, 13% April 2020).

The current number of inpatients are significantly reduced (3144 April 2019, 1477 April 2020) with a large proportion of these patients those that would have been elective admissions .

47% of deaths recorded in April 2020 were attributed to CoVID-19 positive patients. Nationally, the last week in April showed 37% of all deaths were attributed to CoVID-19.

TRUST BOARD REPORT : April-2020

PATIENT EXPERIENCE: NEW COMPLAINTS AND PALS CASES

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	2	0	0	**2**	13	0	0	**13**
CG2 : Scarborough Acute, Emergency & Elderly Medicine	0	1	0	**1**	0	13	0	**13**
CG3: Surgery	3	0	0	**3**	10	2	0	**12**
CG4: Cancer and Support Services	0	0	0	**0**	4	1	1	**6**
CG5: Family Health	0	3	0	**3**	2	0	0	**2**
CG6: Specialised Medicine	0	0	0	**0**	6	1	1	**8**
Corporate Services	0	0	0	**0**	3	0	0	**3**
Total	**5**	**4**	**0**	**9**	**38**	**17**	**2**	**57**

New reopened complaints

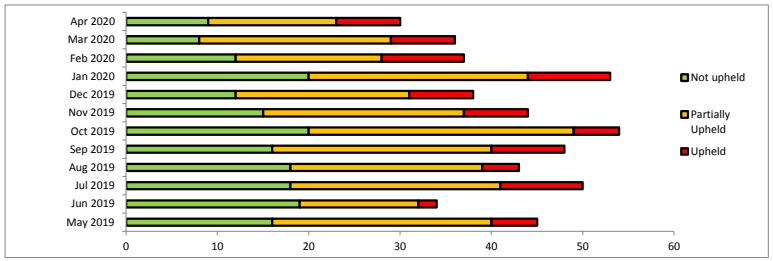
Reason reopened	CG1	Total
Dissatisfied with findings	1	**1**
Total	**1**	**0**

Top 5 sub-subjects

COMPLAINTS	York	Scarb	Brid	Total	PALS	York	Scarb	Brid	Total
Delay or failure in arranging tests	3	0	0	**3**	Communication with relatives/carers	8	3	0	**11**
Delay or failure to diagnose	3	0	0	**3**	Communication - Clinical Advice	6	4	0	**10**
Discharge arrangements	1	2	0	**3**	Attitude of nursing staff/midwives	3	4	0	**7**
Delay or failure in treatment/procedure	2	1	0	**3**	Communication with patient	5	0	0	**5**
Attitude of nursing staff/midwives	1	1	0	**2**	Care needs not adequately met	3	2	0	**5**
Total	**10**	**4**	**0**	**14**	**Total**	**25**	**13**	**0**	**38**

PATIENT EXPERIENCE: CLOSED CASES

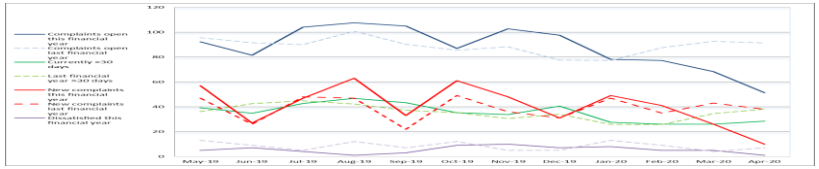
Proportion of closed complaints by outcome



Closed complaint & PALS average response times

Complaints	Total Closed	Total average no of days	% within target	PALS	Total Closed	Total average no of days	% within target
CG1	11	72	18%	CG1	16	27	69%
CG2	4	35	25%	CG2	9	6	78%
CG3	7	30	43%	CG3	14	7	79%
CG4	2	32	0%	CG4	5	6	60%
CG5	4	19	100%	CG5	4	6	75%
CG6	5	43	20%	CG6	9	5	78%
Corporate Services	0	0	N/A	Corporate Services	7	23	29%
Total	**33**	**45**	33%	**Total**	**64**	**13**	69%

PATIENT EXPERIENCE: COMPLAINT PERFORMANCE HANDLING



HIGHLIGHTS FOR BOARD TO NOTE :

Care groups have undertaken targeted work to address overdue complaints in recent months. In addition, the number of complaints that the Trust has received during the Covid-19 pandemic has been very low. As at 07/05/20 there were a total of 36 open complaints compared to a high of 117 in July 2020.

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY: MATERNITY (YORK)

YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Activity	Births	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	238	242	223	266	257	254	272	218	207	301	291	308	271
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	91.2%	95.5%	91.9%	89.8%	91.1%	94.5%	90.4%	85.3%	87.0%	92.0%	93.8%	91.6%	89.7%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10.1%-19.9%	>20%	2.5%	2.5%	4.9%	4.5%	3.5%	2.8%	4.0%	6.4%	3.9%	3.7%	3.1%	4.2%	3.0%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	50.0%	57.10%	45.50%	33.30%	66.70%	28.60%	18.20%	42.90%	25.00%	72.70%	88.90%	76.90%	100.00%
		Births	No. of babies	CPD	≤295	296-309	≥310	220	255	250	287	267	276	239	246	206	248	225	257	230
		No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311	216	250	246	285	261	270	233	242	203	245	222	253	225
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	1	0	0	0	0	0	0	0	0	13	26
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	2	0	0	0	0	0	0	0	0	0	4
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	1	1	0	2	1	5	0	2	0	1	0	1	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0	0	1	0	0	0	0
		SCBU at capacity	No of times	SCBU				7	0	0	2	0	0	0	5	0	4	0	7	0
		SCBU at capacity of intensive cots	No. of times	SCBU				2	2	3	4	8	8	0	3	0	1	0	0	1
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	2	0	0	0	2	0	1	1	0	0	0	0	0
Workforce	Staffing	MW to birth ratio	Ratio	Matron	≤29.5	29.6 - 30.9	>31	30	29	29	29	31	28	28	30	29	26	27	29	29
		1 to 1 care in Labour	CPD	CPD	100%	80% - 99.9%	≤79.9%	89.9%	93.0%	93.3%	97.1%	95.2%	90.2%	93.7%	95.9%	96.2%	94.9%	97.0%	97.8%	97.5%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	100%	80% - 99.9%	≤79.9%	100.0%	100.0%	100.0%	96.8%	98.0%	95.0%	97.0%	96.0%	100.0%	97.0%	91.0%	98.0%	100.0%
		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%	61.5%	60.9%	64.1%	58.9%	59.7%	57.0%	57.0%	60.6%	61.0%	63.7%	61.4%	57.3%	53.9%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	17.1%	11.2%	15.9%	11.2%	12.3%	12.2%	15.5%	16.5%	13.3%	10.6%	9.5%	15.4%	17.8%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	20.8%	26.8%	19.5%	30.2%	28.4%	31.1%	27.5%	22.7%	24.6%	26.1%	28.4%	26.9%	28.4%
		Eclampsia	No. of women	CPD	0		1 or more	0	1	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	1	0	2	3	1	1	0	0	3	0	1	1	0
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	15	10	15	22	17	16	21	22	17	17	12	12	24
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	0	1	5	5	1	1	4	4	2	2	3	3	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	1	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	1	1	1	0	1	0
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	0	0	0	1	0	0	0	1	0	1	1	1	0
		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	1	0	0
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	72.3%	71.0%	72.3%	71.0%	78.3%	73.8%	74.5%	72.7%	66.5%	69.6%	75.9%	72.7%	73.8%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	8.8%	10.8%	11.0%	11.9%	10.0%	7.0%	9.0%	9.9%	13.8%	13.5%	12.2%	11.1%	11.1%
		SI's	No. of Si's declared	Risk Team	0		1 or more	0	0	0	0	0	0	0	1	0	0	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	8	8	8	15	10	7	12	11	6	12	11	6	11
		PPH > 1.5L as % of all women	% of births	CPD				3.6%	3.1%	3.2%	5.2%	3.7%	2.5%	5.0%	4.4%	2.9%	4.8%	4.8%	2.3%	4.7%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	4	7	3	4	1	1	0	2	2	5	1	2	0
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	0.0%	3.7%	2.5%	1.0%	2.6%	1.0%	3.4%	3.1%	2.5%	3.8%	0.6%	2.1%	1.2%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	2	1	0	2	5	1	1	1	1	5	1	1	0
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	2	1	2	3	4	0	3	2	0	1	0	0	0

Please note: Due to data cleansing that takes place, the data for the current quarter may be subject to change.

TRUST BOARD REPORT : April-2020

QUALITY AND SAFETY: MATERNITY (SCARBOROUGH)

SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	139	176	163	198	175	153	181	154	144	184	151	163	174
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	91.4%	91.5%	91.4%	90.4%	89.1%	87.6%	873.8%	91.6%	82.6%	88.0%	90.7%	87.7%	86.2%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	5.8%	5.7%	4.3%	4.5%	4.0%	7.2%	6.1%	2.6%	7.6%	7.6%	8.6%	7.4%	9.2%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	89%	70%	71%	44%	71%	73%	91%	100%	63.6%	79%	85%	83%	69%
		Births	No. of babies	CPD	≤170	171-189	≥190	98	118	114	141	121	122	113	107	109	120	110	117	101
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190	95	114	114	138	120	119	112	107	0	119	107	117	101
	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	13	26
		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	1
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	0	1	0	3	2	2	0	0	0	0	2	0	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				22	15	9	14	0	0	15	11	13	2	0	1	3
		SCBU at capacity of intensive care cots	No. of times	SCBU				0	0	0	0	0	0	5	2	0	0	0	0	0
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	0	7	3	2	0	2	0	0	0	0	0	0	0
Workforce	Staffing	M/W to birth ratio	Ratio	Matron	≤29.5	29.6-30.9	>31	22.0	23	22	22	24	22	23	22	23	23	21	21	22
		1 to 1 care in Labour	CPD	CPD	≥100%	80% - 99.9%	≤79.9%	96.5%	96.2%	98.1%	95.0%	98.1%	98.1%	98.9%	94.7%	95.7%	96.4%	98.0%	99.0%	98.9%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%	80% - 99.9%	≤79.9%	100.0%	93.3%	100.0%	98.4%	97.0%	95.0%	97.0%	98.3%	91.9%	98.0%	96.6%	96.7%	100.0%
		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%	74.5%	63.6%	69.6%	64.3%	69.4%	70.5%	71.7%	56.0%	67.9%	73.8%	66.1%	68.6%	73.5%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	5.3%	9.6%	9.6%	7.2%	10.8%	4.2%	0.9%	8.4%	5.6%	5.0%	4.7%	2.6%	6.9%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	18.9%	27.2%	20.2%	26.8%	20.2%	26.1%	27.7%	34.6%	25.9%	18.5%	29.0%	28.2%	18.8%
		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	1	0	0	0	0	0	1	0	1	1	1	0
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	0	4	10	2	6	6	4	3	1	1	3	4	2
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	1	0	2	1	2	1	2	0	3	0	0	1	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	1	0	0
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	0	0	1	1	0	0	1	2	1	0	1	0	0
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	1	0	0	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	4	5
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	61.2%	68.6%	55.8%	57.9%	53.7%	56.6%	59.8%	66.7%	64.8%	55.5%	65.1%	61.5%	56.4%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	15%	18%	25%	21%	16%	13%	21%	24%	19%	20%	19%	14%	21%
		SI's	No. of Si's declared	Risk Team	0		1 or more	0	0	0	0	1	0	0	0	0	1	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	1	2	0	1	4	2	2	2	3	1	3	3	1
		PPH > 1.5L as % of all women	% of births	CPD				1.0	1.7	0.0	0.7	3.3	1.6	1.8	2	0.0	1	3	2.5	1.0
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	1	2	1	1	2	1	0	2	3	0	3	0	2
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	0.0%	0.0%	0.0%	1.9%	3.1%	1.1%	2.4%	1.4%	2.5%	0.0%	1.3%	0.0%	0.0%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	1	0	0	1	1	1	0	0	1	0	2	0	1
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	0	1	0	0	1	1	1	0	0	0	0	2	1

Please note: Due to data cleansing that takes place, the data for the current quarter may be subject to change.

WORKFORCE PERFORMANCE REPORT

April-2020

Produced May 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

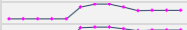
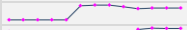
Report produced by:

Information Team

TRUST BOARD REPORT : April-2020

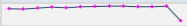
WORKFORCE

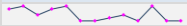
STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

REF	Vacancies	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.01	Trust vacancy factor			8.7%	10.2%	10.2%	10.0%	10.0%	9.4%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
1.02	LLP vacancy factor			13.8%	13.9%	14.1%	13.7%	13.7%	13.6%	13.0%	13.0%	11.0%	10.0%	8.0%	9.0%	9.0%
1.03	Nursing and Midwifery vacancy rate - Trust			16.5%	17.5%	16.4%	11.2%	11.2%	10.1%	11.7%	11.7%	9.8%	7.6%	8.1%	8.1%	8.1%
1.04	Nursing and Midwifery vacancy rate - York			-	-	-	-	-	6.9%	8.7%	8.7%	7.0%	4.9%	5.1%	5.1%	5.1%
1.05	Nursing and Midwifery staff group vacancy rate - Scarborough			-	-	-	-	-	17.5%	18.5%	18.5%	16.3%	13.9%	14.8%	14.8%	14.8%
1.06	Medical and Dental vacancy rate - Trust			9.7%	8.4%	7.9%	7.9%	9.0%	7.8%	7.8%	8.2%	6.8%	10.3%	10.7%	10.6%	10.6%
1.07	Medical and Dental vacancy rate - York			7.2%	6.8%	6.7%	6.7%	7.6%	7.0%	7.0%	7.8%	6.1%	10.1%	10.7%	10.7%	10.7%
1.08	Medical and Dental vacancy rate - Scarborough			15.5%	12.2%	10.8%	10.8%	12.2%	9.8%	9.8%	9.2%	8.4%	10.6%	10.9%	10.6%	10.6%

REF	Recruitment	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
2.01	New appointments (Permanent and Temporary) - Trust			80	68	77	106	74	204	137	96	88	132	82	84	91
2.02	Number of new appointments from outside the Trust			32	32	37	55	25	114	82	50	39	70	45	35	20
2.03	Number of new appointments that are medical and dental staff			-	-	-	-	-	28	9	3	3	3	4	5	0
2.04	Number of new appointments that are bank staff			10	11	21	25	10	20	10	17	14	24	16	2	27

REF	Temporary Workforce	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
3.01	Total FTE Medical and Dental roles covered by bank and agency			115.9	120.7	120.7	123.5	127.1	116.2	116.5	103.6	105.1	110.2	99.4	117.4	116.0
3.02	Temporary medical and dental bank fill rate (%)			36.0%	37.0%	37.0%	41.0%	42.0%	40.0%	43.0%	40.0%	46.0%	50.0%	56.0%	60.0%	58.0%
3.03	Temporary medical and dental agency fill rate (%)			64.0%	63.0%	63.0%	59.0%	58.0%	60.0%	57.0%	60.0%	54.0%	50.0%	44.0%	40.0%	42.0%
3.05	Temporary nurse staffing bank filled (FTE)			260.4	283.2	278.6	308.3	314.4	311.0	293.3	282.7	260.7	307.9	311.1	320.6	299.8
3.06	Temporary nurse staffing agency filled (FTE)			111.3	123.1	114.2	141.9	172.6	163.8	162.0	129.8	121.7	127.9	127.9	120.4	68.7
3.11	Pay Expenditure - Total (£000)			£30,555	£29,489	£29,679	£29,896	£30,285	£31,142	£29,737	£30,888	£30,038	£30,542	£30,450	£30,715	£30,698
3.12	Pay Expenditure - Contracted (£000)			£24,861	£23,915	£24,046	£24,012	£23,910	£24,822	£24,438	£24,611	£24,509	£24,445	£24,745	£24,379	£25,456
3.13	Pay Expenditure - Locums (£000)			£230	£179	£212	£204	£219	£203	£215	£264	£203	£359	£182	£206	£203
3.14	Pay Expenditure - Bank (£000)			£917	£975	£785	£1,060	£1,146	£1,096	£1,104	£1,131	£1,293	£1,752	£1,754	£2,033	£1,592
3.15	Pay Expenditure - Agency (£000)			£1,612	£1,500	£1,685	£1,624	£2,175	£2,057	£1,323	£2,177	£1,557	£1,503	£1,371	£1,641	£1,168
3.16	Pay Expenditure - Additional Hours (£000)			£2,710	£2,770	£2,791	£2,817	£2,658	£2,795	£2,457	£2,506	£2,275	£2,319	£2,238	£2,265	£1,993
3.17	Pay Expenditure - Overtime (£000)			£225	£150	£161	£179	£177	£169	£200	£199	£200	£164	£161	£191	£286

REF	Absence Management	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
4.01	Absence Rate Trust (excluding LLP)			3.8%	3.7%	4.0%	4.3%	4.1%	4.4%	4.5%	4.6%	4.6%	4.4%	4.3%	4.6%	-
4.02	Absence Rate LLP			6.4%	6.2%	7.0%	7.3%	7.3%	7.2%	7.0%	6.5%	7.5%	7.1%	6.6%	7.4%	-

REF	Disciplinary and Grievance	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
5.01	Live disciplinary or bullying and harassment cases (Including investigations)			6	7	4	6	7	2	2	3	4	2	7	2	2
5.02	Live grievance cases			7	12	11	10	11	6	6	9	8	5	7	1	1

TRUST BOARD REPORT : April-2020

WORKFORCE

STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

REF	Learning and Organisational Development	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
6.01	Trust Stat & Mand Training compliance		▲	84.0%	85.0%	85.0%	86.0%	85.0%	82.0%	83.0%	83.0%	84.0%	86.0%	85.0%	86.0%	87.0%
6.02	Trust Corporate Induction Compliance		▼	96.0%	96.0%	96.0%	96.0%	96.0%	95.0%	94.0%	95.0%	95.0%	95.0%	96.0%	95.0%	94.0%
6.03	Non-medical staff core training compliance		◀▶	84.0%	84.0%	85.0%	85.0%	84.0%	86.0%	86.0%	87.0%	87.0%	88.0%	88.0%	88.0%	88.0%
6.04	Non-medical staff essential skills compliance		◀▶	85.0%	86.0%	87.0%	87.0%	87.0%	82.0%	83.0%	84.0%	85.0%	87.0%	88.0%	88.0%	90.0%
6.05	Non-medical staff corporate induction compliance		◀▶	-	-	-	-	-	96.0%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	94.0%
6.06	Medical staff core training compliance		▲	-	-	-	-	-	60.0%	64.0%	65.0%	66.0%	69.0%	69.0%	70.0%	71.0%
6.07	Medical staff essential skills compliance		◀▶	-	-	-	-	-	67.0%	71.0%	72.0%	73.0%	76.0%	88.0%	88.0%	86.0%
6.08	Medical staff corporate induction compliance		▼	-	-	-	-	-	91.0%	90.0%	90.0%	90.0%	92.0%	93.0%	92.0%	93.0%

REF	Research	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
7.01	Year to date accural		▼	325	586	851	1102	1358	1662	2079	2489	3128	3566	3983	4272	513
7.02	Open studies - Trust		▼	9	9	117	219	230	186	-	117	117	-	117	117	42
7.03	Trust place nationally for open studies (out of 450 trusts)		▲	-	-	48	-	-	-	-	48	48	-	48	48	-
7.04	Patients recruited into clinical trials		▼	-	-	4906	-	-	-	-	-	-	-	4906	4906	513
7.05	Trust place nationally for patients recruited into clinical trials (out of 450 trusts)		◀▶	-	-	33	-	-	-	-	-	-	-	33	-	-

Note: The Trust has suspended the majority of clinical trials due to the current pandemic. Support is now focused on Covid 19 trials that have been badged as an Urgent Public Health Need by the Department of Health. As a result, as opposed to supporting around 150 clinical trials at any one time, the Trust is currently supporting just 6 trials. 513 patients have been recruited into our April research. The Trust was the first site in the region to recruit to the complex drug and plasma trial, and we are the largest recruiter in the region to the recovery trial.

REF	Appraisal Compliance	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
8.01	Trust (excluding medical and dental)		▲	74.7%	75.7%	74.0%	73.6%	72.7%	72.4%	71.5%	74.0%	75.4%	75.0%	74.7%	1.8%	3.7%
8.02	Medical and Dental		▼	90.0%	89.0%	89.0%	90.0%	90.0%	88.0%	88.0%	87.0%	91.0%	90.0%	90.0%	91.0%	89.0%

REF	Sickness absence	TARGET	SPARKLINE / PREVIOUS WEEK	27-Mar	03-Apr	10-Apr	17-Apr	24-Apr	01-May	08-May
9.01	All absence		▼	365	530	698	756	669	831	759
9.02	COVID-19 related absence		▼	73	447	540	571	490	506	481

TRUST BOARD REPORT : April-2020

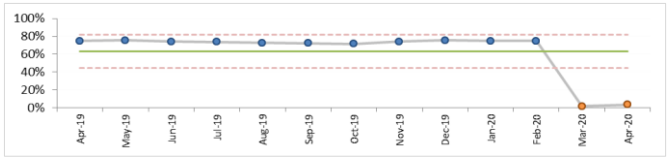
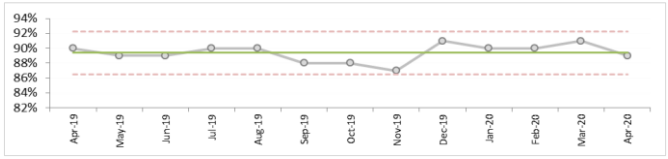
WORKFORCE

STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

REF	COVID Support Staff	TARGET	SPARKLINE / PREVIOUS WEEK	27-Mar	03-Apr	10-Apr	17-Apr	24-Apr	01-May	08-May
10.01	In recruitment stage - Total		▼	-	-	-	344	248	191	135
10.02	Ready to start - Total		▲	-	-	-	55	36	70	82
10.03	Started - Total		▲	-	-	-	155	193	232	289
10.04	In recruitment stage - Nurses		▼	-	-	-	81	69	49	25
10.05	In recruitment stage - HCA		▼	-	-	-	178	166	127	99
10.06	In recruitment stage - Midwives		▲	-	-	-	5	4	5	6
10.07	In recruitment stage - Paramedics		▼	-	-	-	2	2	3	2
10.08	In recruitment stage - Rediology		◀▶	-	-	-	0	0	0	0
10.09	In recruitment stage - AHP		▼	-	-	-	5	3	5	1
10.10	In recruitment stage - Pharmacy		◀▶	-	-	-	4	2	0	0
10.11	In recruitment stage - Clinical Support Roles		◀▶	-	-	-	1	0	0	0
10.12	In recruitment stage - LLP		◀▶	-	-	-	64	0	0	0
10.13	In recruitment stage - Admin		◀▶	-	-	-	0	0	0	0
10.14	In recruitment stage - Chaplain		◀▶	-	-	-	0	0	0	0
10.15	In recruitment stage - Phlebotomist		◀▶	-	-	-	0	0	0	0
10.16	In recruitment stage - Labatory Medicine		◀▶	-	-	-	4	2	2	2
10.17	Ready to start - Nurses		▼	-	-	-	40	26	31	23
10.18	Ready to start - HCA		▼	-	-	-	8	6	36	31
10.19	Ready to start - Midwives		▲	-	-	-	3	0	0	22
10.20	Ready to start - Paramedics		◀▶	-	-	-	0	0	0	0
10.21	Ready to start - Rediology		◀▶	-	-	-	0	0	0	0
10.22	Ready to start - AHP		▲	-	-	-	4	3	2	5
10.23	Ready to start - Pharmacy		◀▶	-	-	-	0	0	0	0
10.24	Ready to start - Clinical Support Roles		◀▶	-	-	-	0	0	0	0
10.25	Ready to start - LLP		◀▶	-	-	-	0	0	0	0
10.26	Ready to start - Admin		◀▶	-	-	-	0	0	0	0
10.27	Ready to start - Chaplain		◀▶	-	-	-	0	0	0	0
10.28	Ready to start - Phlebotomist		◀▶	-	-	-	0	0	0	0
10.29	Ready to start - Labatory Medicine		◀▶	-	-	-	0	1	1	1
10.30	Started - Nurses		▲	-	-	-	15	46	66	91
10.31	Started - HCA		▲	-	-	-	25	20	35	65
10.32	Started - Midwives		◀▶	-	-	-	0	3	3	3
10.33	Started - Paramedics		▲	-	-	-	1	1	1	2
10.34	Started - Rediology		◀▶	-	-	-	2	2	2	2
10.35	Started - AHP		▲	-	-	-	5	8	9	10
10.36	Started - Pharmacy		◀▶	-	-	-	3	4	6	6
10.37	Started - Clinical Support Roles		◀▶	-	-	-	2	3	3	3
10.38	Started - LLP		◀▶	-	-	-	100	0	0	0
10.39	Started - Admin		◀▶	-	-	-	1	3	3	3
10.40	Started - Chaplain		◀▶	-	-	-	0	1	1	1
10.41	Started - Phlebotomist		◀▶	-	-	-	0	1	1	1
10.42	Started - Labatory Medicine		◀▶	-	-	-	1	2	2	2

TRUST BOARD REPORT : April-2020

WORKFORCE : APPRAISAL COMPLIANCE

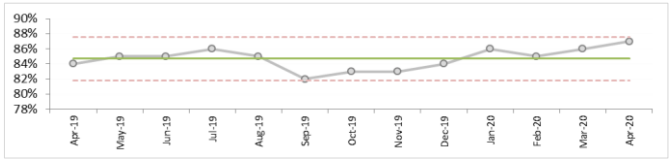
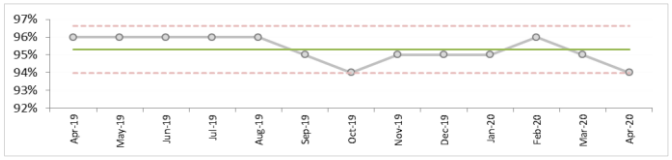
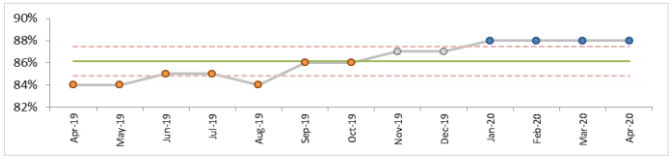
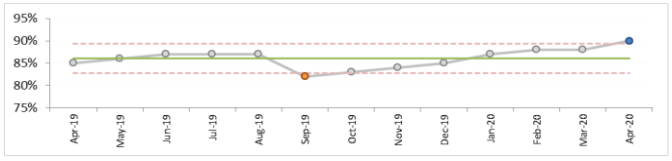
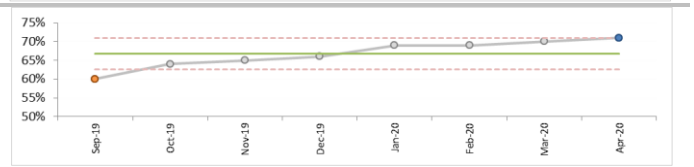
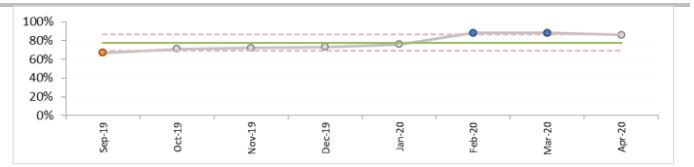
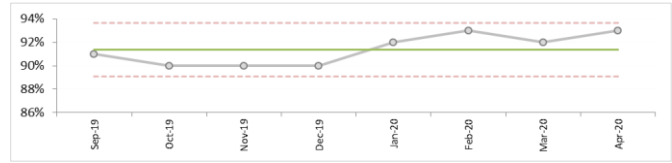
Apr-20	METRIC :	TARGET :	vs LM :	
3.7%	**8.01** Trust (excluding medical and dental)	-	1.9% ↑	
89.0%	**8.02** Medical and Dental	-	-2.0% ↓	

HIGHLIGHTS FOR BOARD TO NOTE :

The appraisal data produced now just looks at two figures – the appraisal activity of all Trust staff (excluding M&D). The Trust's new appraisal window came into effect from March 2020. The data represented for non-medical staff has commenced from scratch due to the implementation of a new appraisal window. The appraisal window will run up to and including September this year. The appraisal and revalidation process for medical and dental staff will remain unchanged.

TRUST BOARD REPORT : April-2020

WORKFORCE : STATUTORY AND MANDATORY TRAINING COMPLIANCE

Apr-20	METRIC :	TARGET :	vs LM :	
87.0%	**6.01** Trust Stat & Mand Training compliance	-	1.0% ↑	
94.0%	**6.02** Trust Corporate Induction Compliance	-	-1.0% ↓	
88.0%	**6.03** Non-medical staff core training compliance	-	0.0% ↑	
90.0%	**6.04** Non-medical staff essential skills compliance	-	2.0% ↑	
94.0%	**6.05** Non-medical staff corporate induction compliance	-	-2.0% ↓	
71.0%	**6.06** Medical staff core training compliance	-	1.0% ↑	
86.0%	**6.07** Medical staff essential skills compliance	-	-2.0% ↓	
93.0%	**6.08** Medical staff corporate induction compliance	-	1.0% ↑	

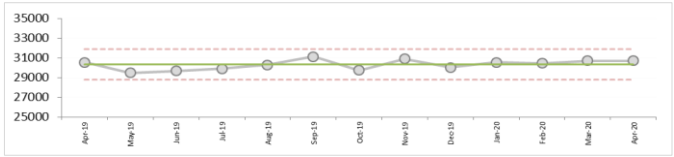
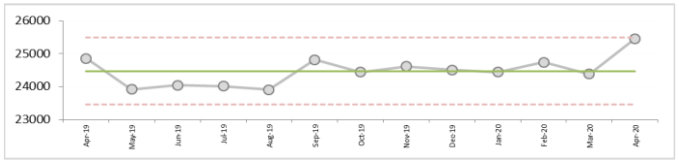
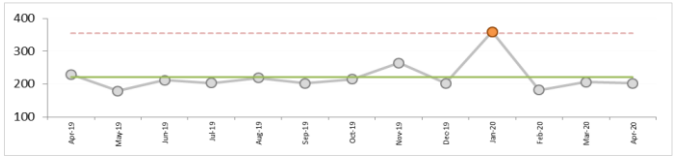
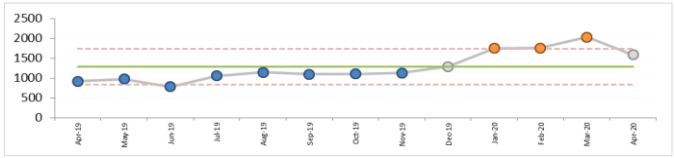
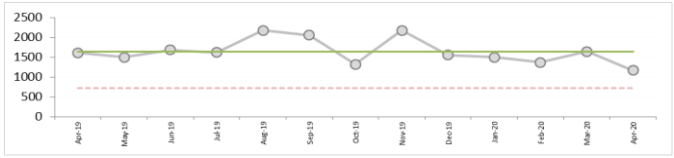
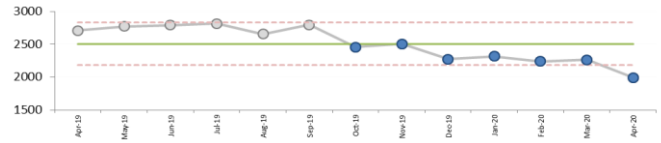
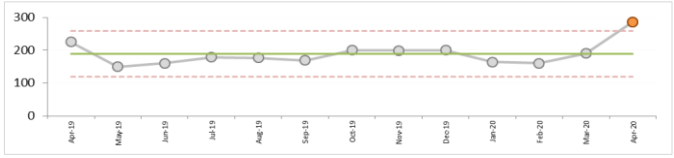
HIGHLIGHTS FOR BOARD TO NOTE :

Alongside individual and team support for staff across the organisation during the Covid-19 crisis, the ODIL team are working in collaboration with colleagues from workforce and other health and wellbeing services in supporting staff. This work has included a number of resources for line managers around support and softer skills involved in managing and supporting remote teams.

The team is working with key contacts within the Care Groups in preparation to support the Restore and Reset programme of work and the ongoing care group development work. The team is also supporting the Clever Together platform and staff engagement work in collaboration with the workforce team.

TRUST BOARD REPORT : April-2020

WORKFORCE : PAY EXPENDITURE (£000)

Apr-20	METRIC :	TARGET :	vs LM :	
£30,698	**3.11** Pay Expenditure - Total (£000)	-	-0.1% ↓	
£25,456	**3.12** Pay Expenditure - Contracted (£000)	-	4.4% ↑	
£203	**3.13** Pay Expenditure - Locums (£000)	-	-1.5% ↓	
£1,592	**3.14** Pay Expenditure - Bank (£000)	-	-21.7% ↓	
£1,168	**3.15** Pay Expenditure - Agency (£000)	-	-28.8% ↓	
£1,993	**3.16** Pay Expenditure - Additional Hours (£000)	-	-12.0% ↓	
£286	**3.17** Pay Expenditure - Overtime (£000)	-	49.7% ↑	

FINANCE PERFORMANCE REPORT

April-2020

Produced May 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

TRUST BOARD REPORT : April-2020

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

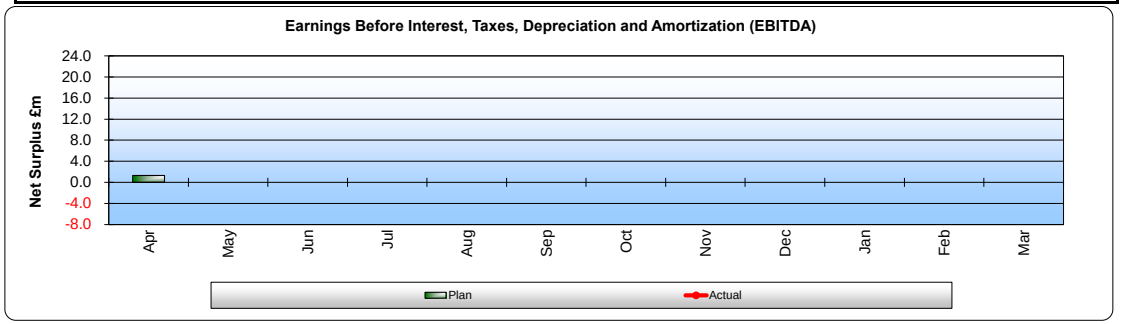
Summary Position:

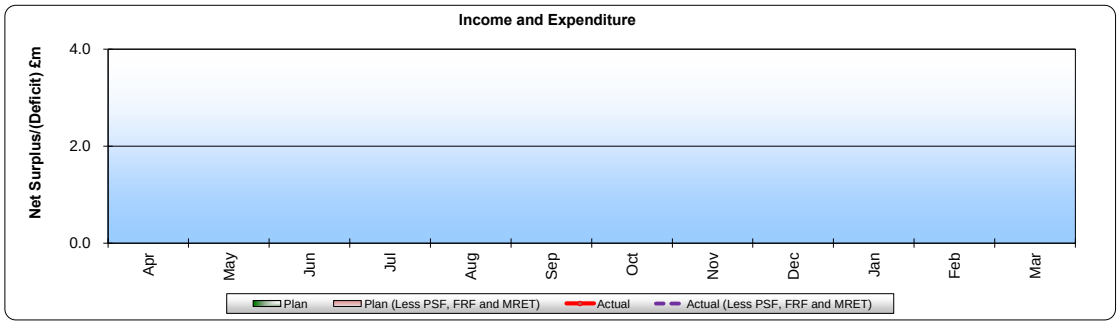
* The Trust is reporting a balanced I&E position.

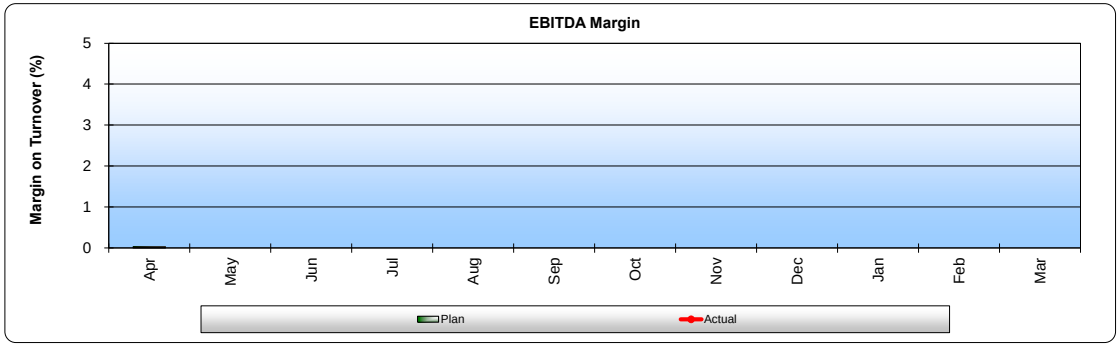
* Income is £0.5m behind plan, with NHS clinical income being £0.3m behind plan.

* Operational expenditure is £0.7m behindthe NHSI plan, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £1.4m (3.09%) compared to plan of £1.3m (2.78%), and is reflective of the reported net I&E performance.







	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date
	£000	£000	£000
NHS Clinical Income			
NHSE & I	5,462	5,469	7
CCGs	34,618	34,356	-262
Local Authorities	391	362	-29
	40,471	**40,187**	**-284**
Non-NHS Clinical Income			
Private Patient Income	97	29	-68
Other Non-protected Clinical Income	93	119	26
	190	**148**	**-42**
Other Income			
Education & Training	1,648	1,655	7
Research & Development	242	21	-221
Donations & Grants received (Assets)	0	0	0
Donations & Grants received (cash to buy Assets)	18	38	20
Other Income	3,778	3,807	-1,394
PSF, FRF and MRET	0	0	0
	5,686	**5,521**	**-165**
Total Income	**46,347**	**45,855**	**-492**
Expenditure			
Pay costs	-31,336	-30,961	375
Pass-through excluded drugs expenditure	0	0	0
PbR Drugs	-4,668	-3,897	771
Clinical Supplies & Services	-3,833	-3,868	-35
Other costs (excluding Depreciation)	-5,220	-5,680	-460
Restructuring Costs	0	0	0
Total Expenditure	**-45,057**	**-44,406**	**651**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**1,290**	**1,449**	**159**
Profit/ Loss on Asset Disposals	0	0	0
Fixed Asset Impairments	0	0	0
Depreciation - purchased/constructed assets	-728	-840	-112
Depreciation - donated/granted assets	0	-31	-31
Interest Receivable/ Payable	17	-9	-26
Interest Expense on Overdrafts and WCF	0	0	0
Interest Expense on Bridging loans	0	0	0
Interest Expense on Non-commercial borrowings	0	-43	-43
Interest Expense on Commercial borrowings	-27	-40	-13
Interest Expense on Finance leases (non-PFI)	0	0	0
Other Finance costs	0	-2	-2
PDC Dividend	-552	-477	75
Taxation Payable	0	0	0
NET SURPLUS/ DEFICIT	**0**	**7**	**7**

TRUST BOARD REPORT : April-2020

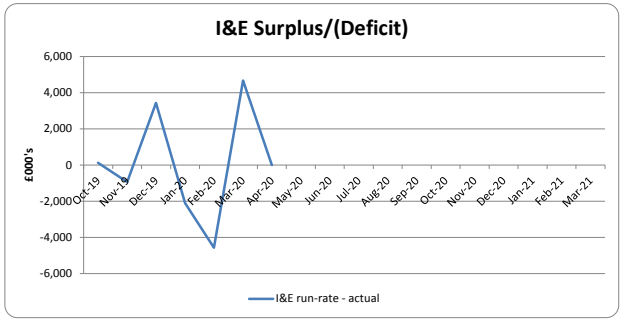
RUN RATE ANALYSIS

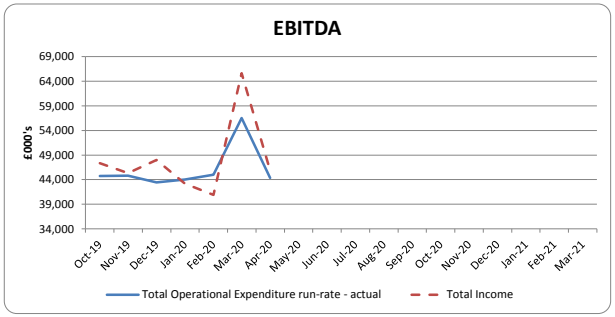
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

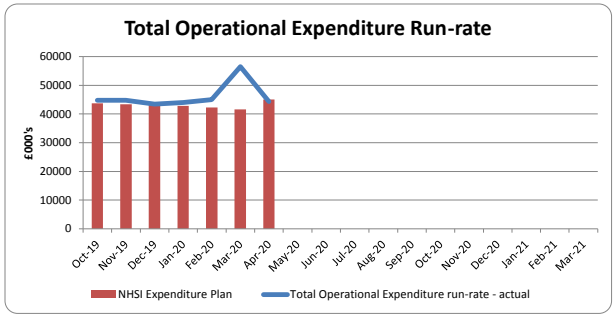
Key Messages:

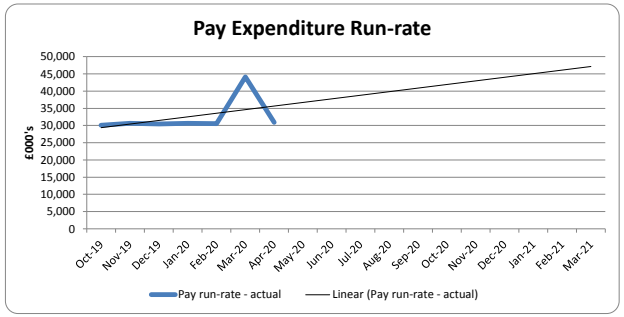
* The total operational expenditure in April was £44.4m. The average total operational expenditure in the previous six months was £46.4m. Resulting in an favourable variance of £2.1m.

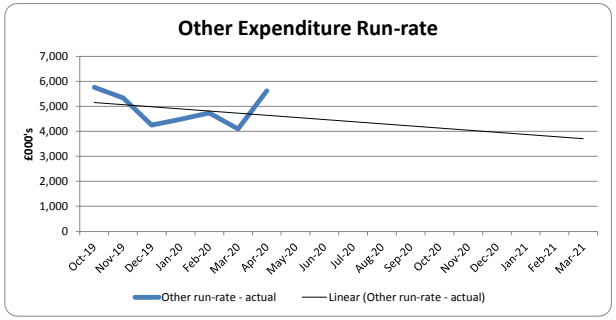
* In month operational income exceeded expenditure by £1.5m, resulting in a positive EBITDA for the month.

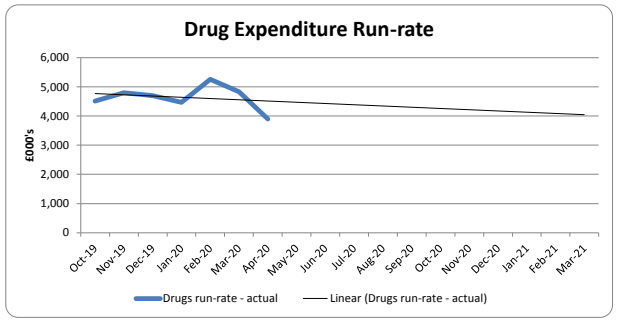


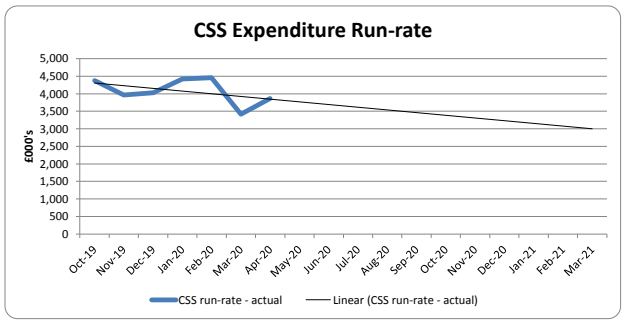












	Monthly Spend																			
	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Monthly Ave	Variance
Total Income	47,330	45,327	47,985	43,205	40,871	65,612	45,855	0	0	0	0	0	0	0	0	0	0	0	48,388	-2,533
Pay Expenditure	-30,100	-30,690	-30,469	-30,655	-30,567	-44,148	-30,961	0	0	0	0	0	0	0	0	0	0	0	-32,771	1,810
Drug Expenditure	-4,513	-4,793	-4,704	-4,469	-5,260	-4,835	-3,897	0	0	0	0	0	0	0	0	0	0	0	-4,762	865
CSS Expenditure	-4,377	-3,963	-4,028	-4,425	-4,454	-3,420	-3,868	0	0	0	0	0	0	0	0	0	0	0	-4,111	243
Other Expenditure	-5,759	-5,341	-4,251	-4,483	-4,737	-4,101	-5,623	0	0	0	0	0	0	0	0	0	0	0	-4,779	-844
EBITDA	2,581	540	4,533	-827	-4,147	9,108	1,506	0	0	0	0	0	0	0	0	0	0	0	1,965	-459

TRUST BOARD REPORT : April-2020

AGENCY ANALYSIS

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Key Messages:

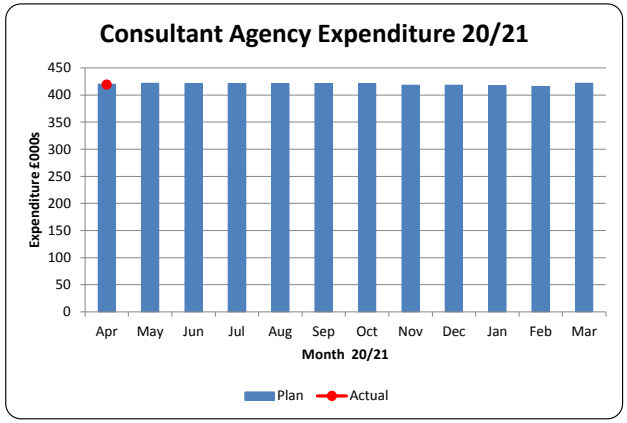
* Total agency spend year to date of £1.2m, compared to the NHSI agency ceiling of £1.6m.

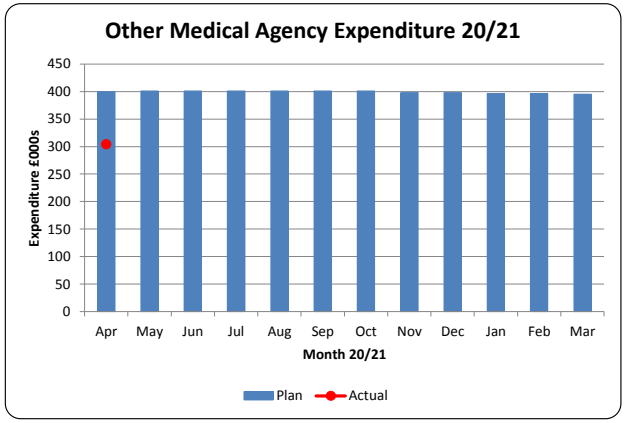
* Consultant Agency spend is on plan.

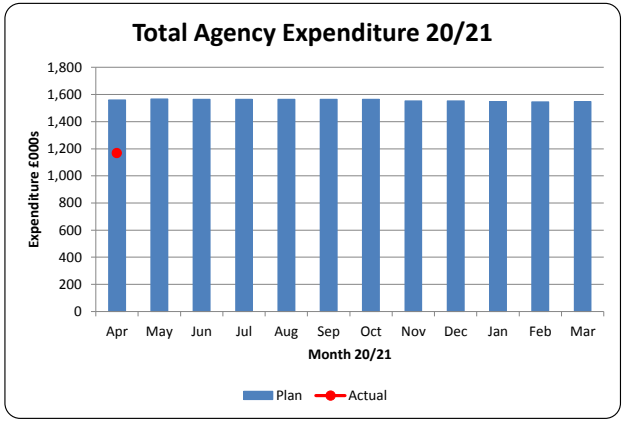
* Nursing Agency is £0.3m behind plan.

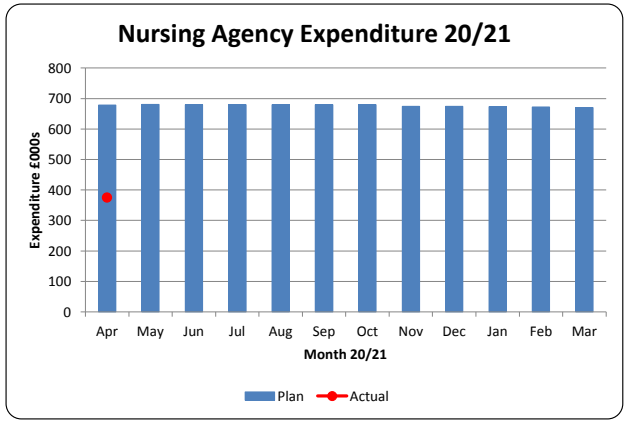
* Other Medical Agency spend is £0.1m behind plan.

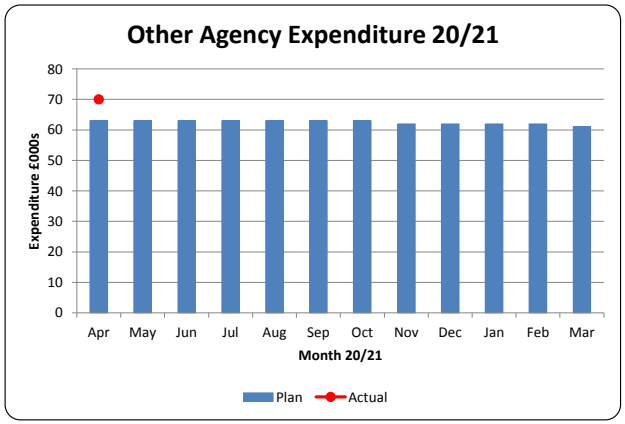
* Other Agency spend is broadly on plan.

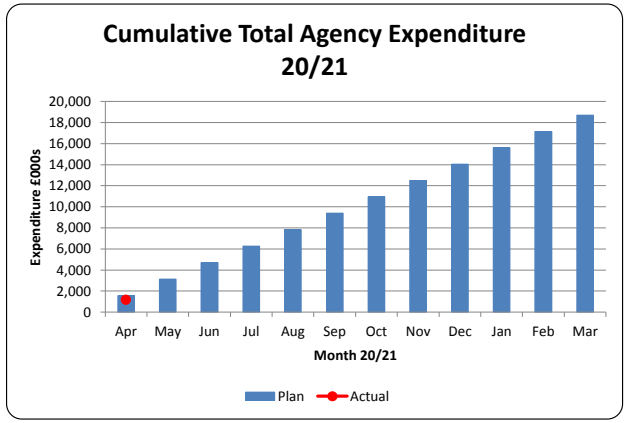












TRUST BOARD REPORT : April-2020

EXPENDITURE ANALYSIS

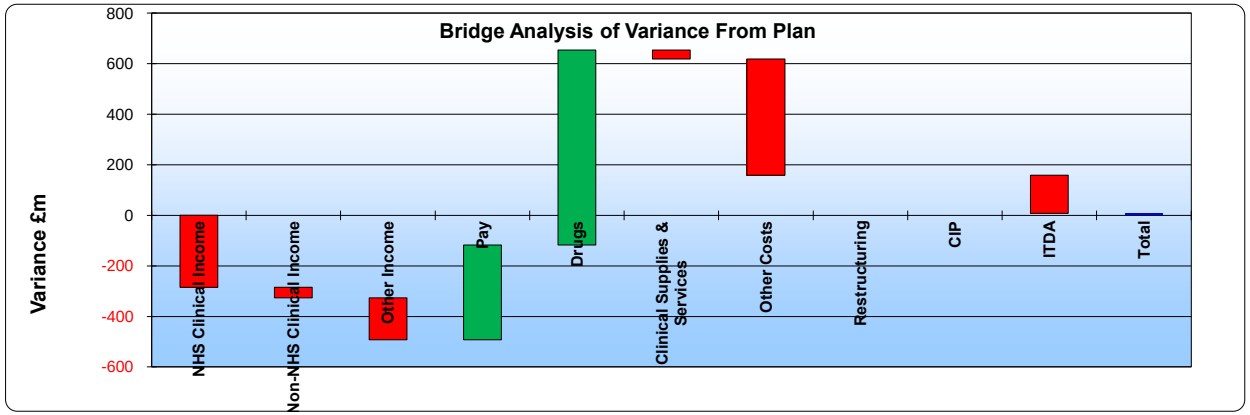
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

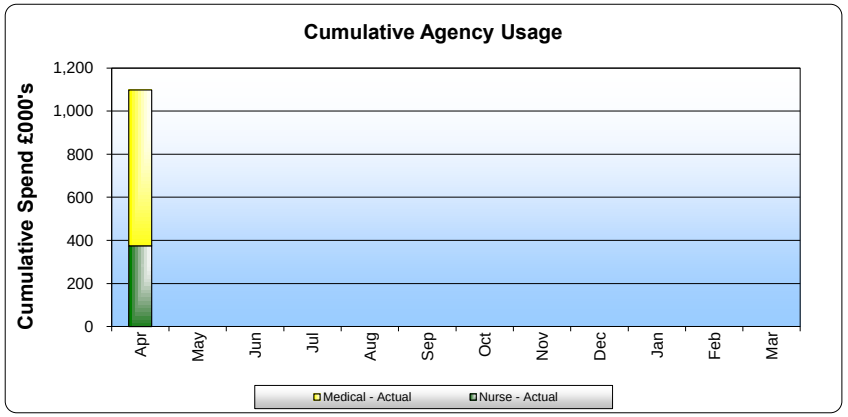
Key Messages:

There is a favourable expenditure variance of £0.7m at the end of April 2020. This comprises:

* Pay expenditure is £0.4m behind plan.
* Drugs expenditure is £0.8m behind plan.
* Other expenditure is £0.5m ahead of plan.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	63,922	5,192	4,619	0	-30	0	419	5,009	183	0	
Medical and Dental	35,837	3,900	3,763	0	10	0	304	4,077	-177	0	
Nursing	95,586	8,371	7,022	70	15	892	375	8,373	-2	0	
Healthcare Scientists	12,348	836	1,063	1	1	-6	2	1,061	-226	0	
Scientific, Therapeutic and technical	16,821	1,146	1,319	8	1	3	0	1,331	-184	0	
Allied Health Professionals	24,989	1,689	2,002	22	16	0	24	2,064	-375	0	
HCAs and Support Staff	52,113	5,217	4,151	120	6	4	10	4,291	926	0	
Chairman and Non Executives	203	17	15	0	0	0	0	15	2	0	
Exec Board and Senior managers	15,599	1,303	1,209	0	0	0	0	1,209	93	0	
Admin & Clerical	42,543	3,550	3,384	0	0	0	34	3,419	131	0	
Pay Reserves	20,007	0	0	0	0	0	0	0	0	0	
Apprenticeship Levy	1,192	115	113	0	0	0	0	113	2	0	
TOTAL	**381,159**	**31,336**	**28,659**	**221**	**19**	**893**	**1,168**	**30,961**	**375**	**0**	





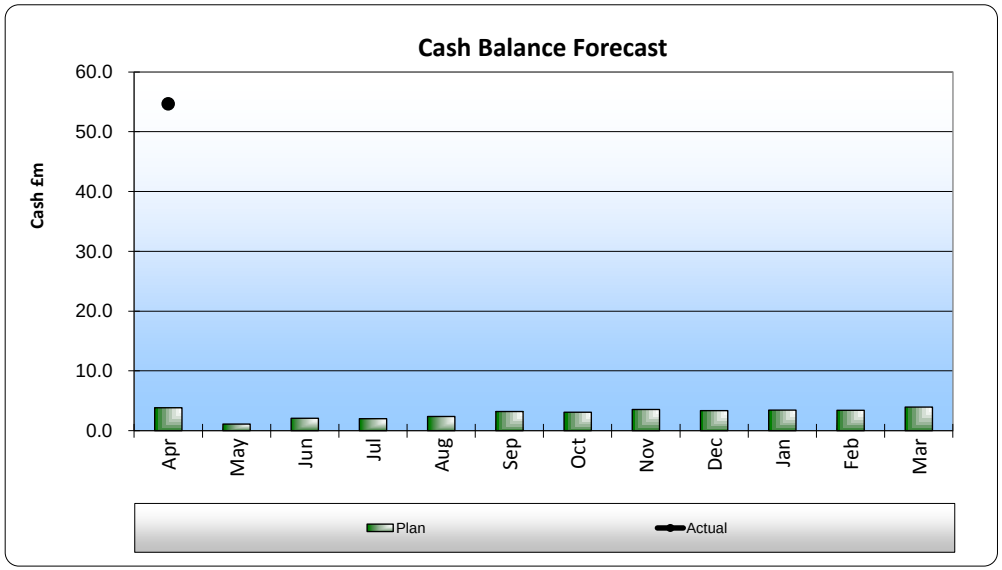
TRUST BOARD REPORT : April-2020

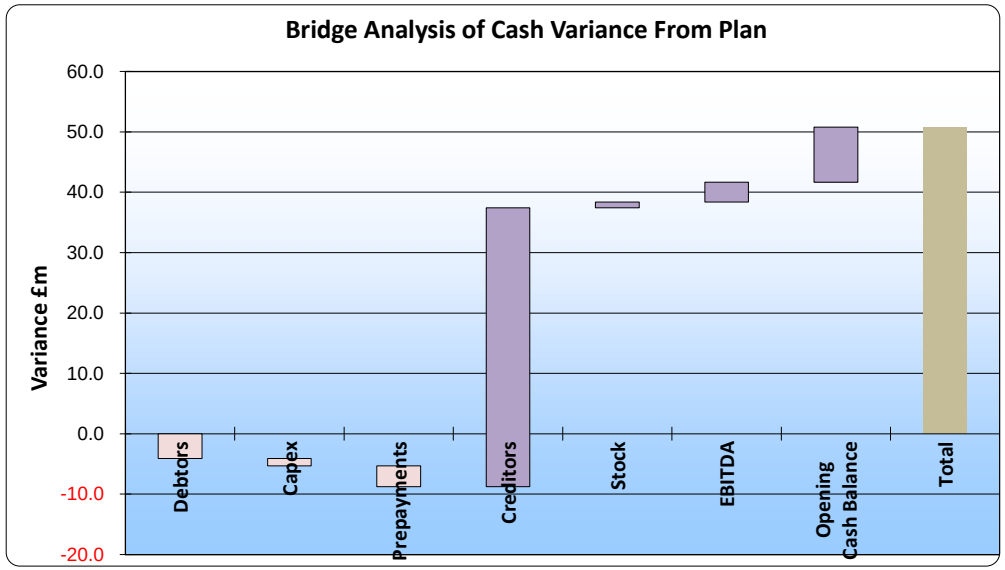
CASH FLOW MANAGEMENT

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Key Messages

* The cash position at the end of April was £54.6m, which is £50m above plan.
* The 20/21 opening cash balance was £9m above plan. This is because the draft plan was based on the M9 FOT position when the Trust was forecasting an £8m year end deficit position.
* Delivery of the 19/20 I&E position resulted in the gain to the Trust's year end cash balance.
* The remaining £41m variance is due to receipt of May income in advance, in line with the current funding guidance during the Covid Pandemic. This is shown in the creditors line on the graph below.





Significant Aged Debtors (Invoices Over 90 Days)

Hull University Teaching Hospitals NHS Trust	£443K
Harrogate & District NHS Foundation Trust	£425K
Tees, Esk And Wear Valleys NHS Foundation Trust	£396K
Humber NHS Foundation Trust	£351K
Vocare Group	£282K
NHS Property Services	£257K

Significant Aged Creditors (Invoices Over 90 Days)

Hull University Teaching Hospitals NHS Trust	£834K
Harrogate And District Nhs Foundation Trust	£753K
Nhs Property Services Ltd	£736K
Northumbria Healthcare Facilities Management Ltd	£153K
Tees Esk And Wear Valleys Nhs Foundation Trust	£109K
Northumbria Healthcare Nhs Foundation Trust	£104K

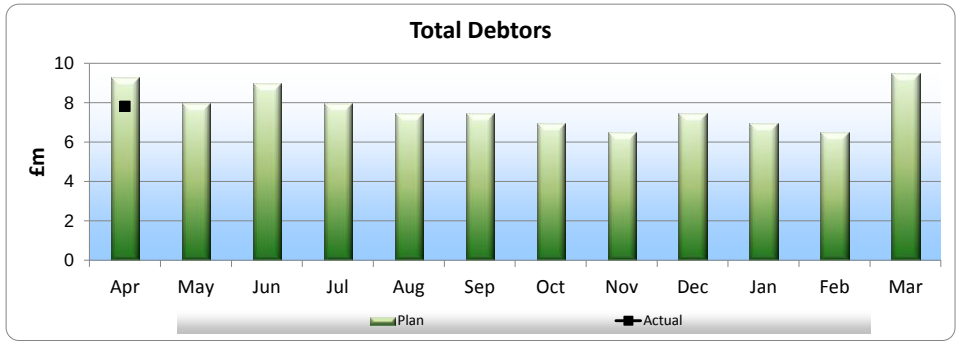
TRUST BOARD REPORT : April-2020

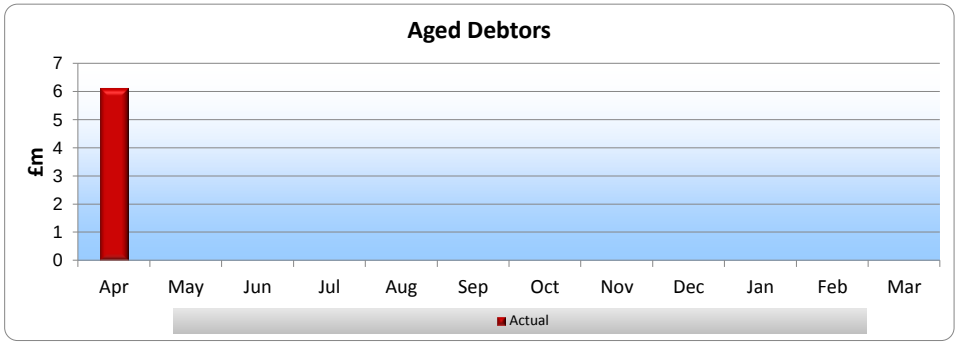
DEBTOR ANALYSIS

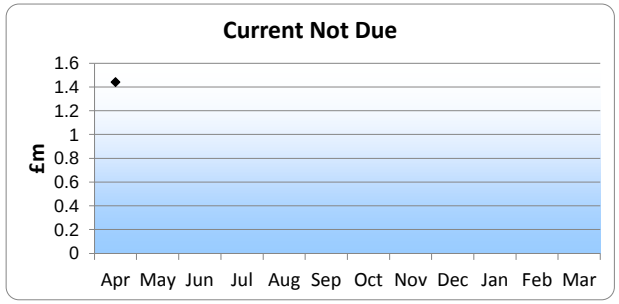
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

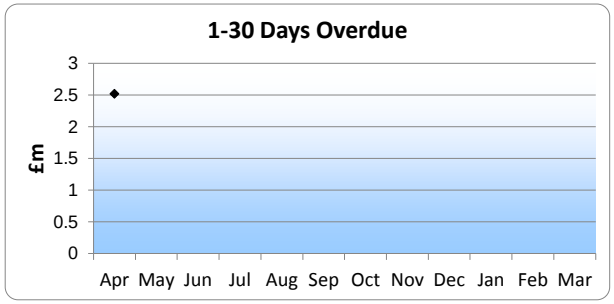
Key Messages

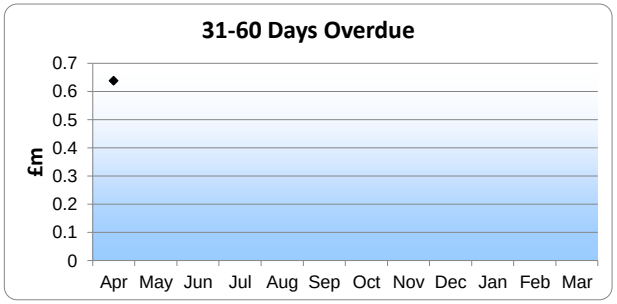
* At the end of April the total debtor balance was £7.8m, which is below plan, mainly due to increased focus on cash collection.
* £1.4m of the total debtor balance relates to 'current' invoices not due for payment. Aged debt totalled £6.4m. Key aged debtors are outlined in the cash flow management section.
* Aged debt has increased from the March position by £0.8m and is broadly in line with the prior year comparator for April 19.
* Long term debtors (Over 90 Days) in April has remained in line with the March position at £2.9m and continues to be a focus area for the Trust.
* Accrued income is slightly above plan but no major issues to report.

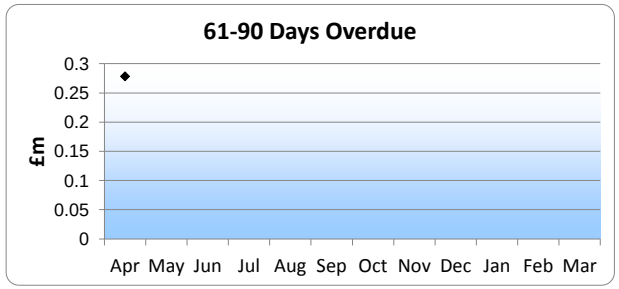


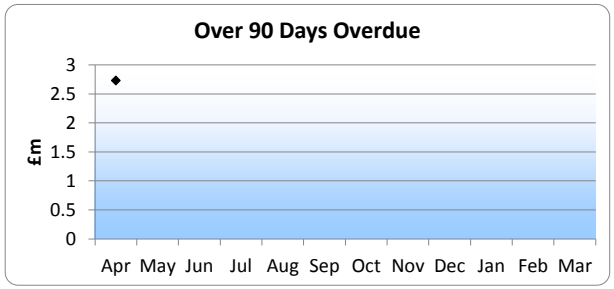


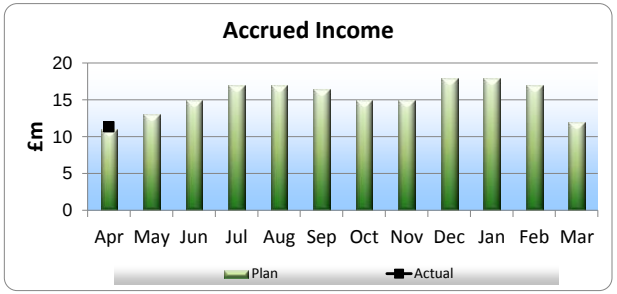












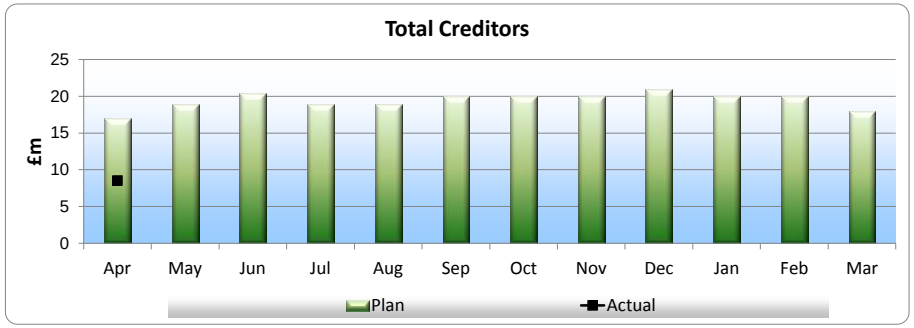
TRUST BOARD REPORT : April-2020

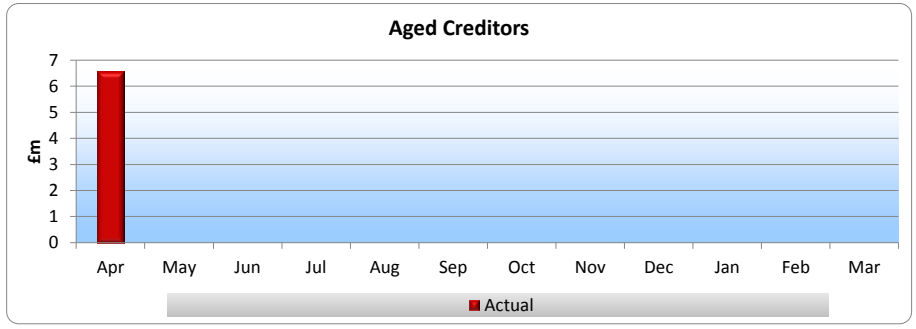
CREDITOR ANALYSIS

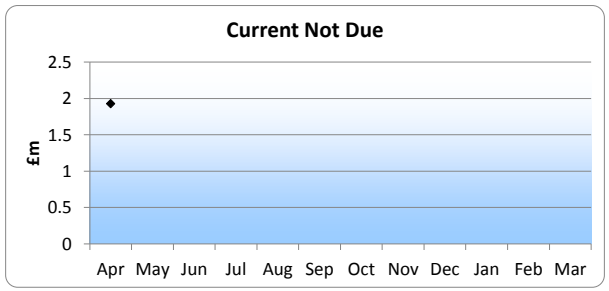
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

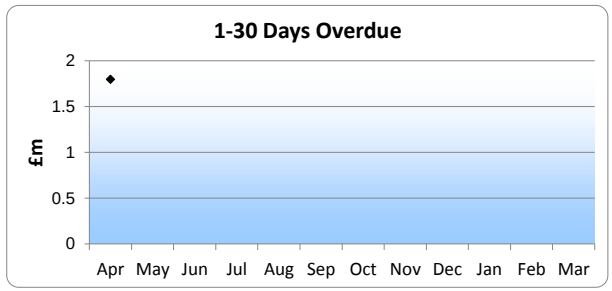
Key Messages

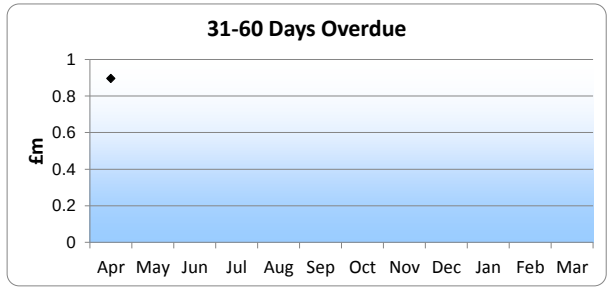
* At the end of April the total creditor balance was £8.5m, which is significantly below the plan of £17m. This is mainly linked to the delay in invoices flowing in to the organisation in the current pandemic.
* Aged creditors in April are £6.6m - Key aged creditors are outlined in the cash flow management section.
* Accrued expenditure is above plan at £19.1m. This is linked to the creditor balance explained above and is expected as the team accrue for invoices to ensure the expenditure position is correctly stated.
* The Better Payments Practice Code (BPPC) table details the number of invoices paid in each category. The current direction is to pay suppliers within 7 days during the Covid pandemic.
* To improve performance in this area, work is underway to educate the organisation to ensure PO's are receipted as soon as goods are received so that invoices can be released for payment.

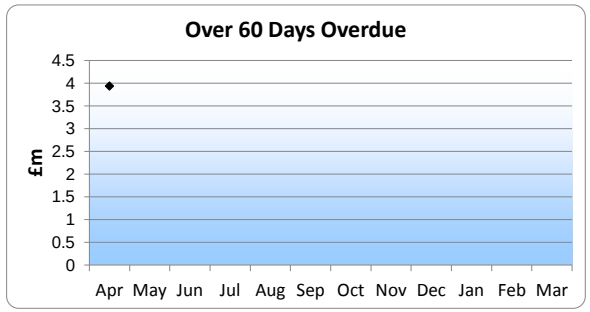






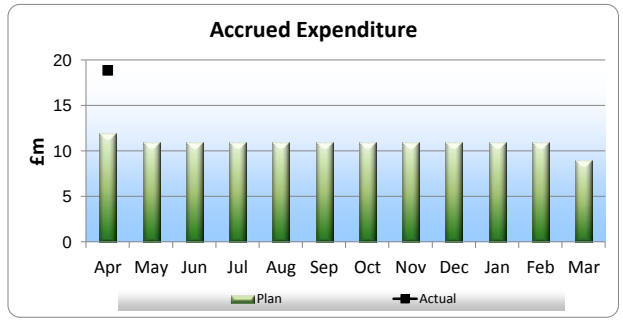






Better Payments Practice Code (BPPC):

In Month Payments Paid Within:	Number of Invoices			% of Total
	NHS	Non-NHS	Total	
7 Days	38	761	799	9%
10 Days	33	566	599	7%
20 Days	73	1,353	1,426	16%
30 Days	131	5,305	5,436	61%
Over 30 days	93	538	631	7%
Total	**368**	**8,523**	**8,891**	**100%**



TRUST BOARD REPORT : April-2020

CAPITAL PROGRAMME

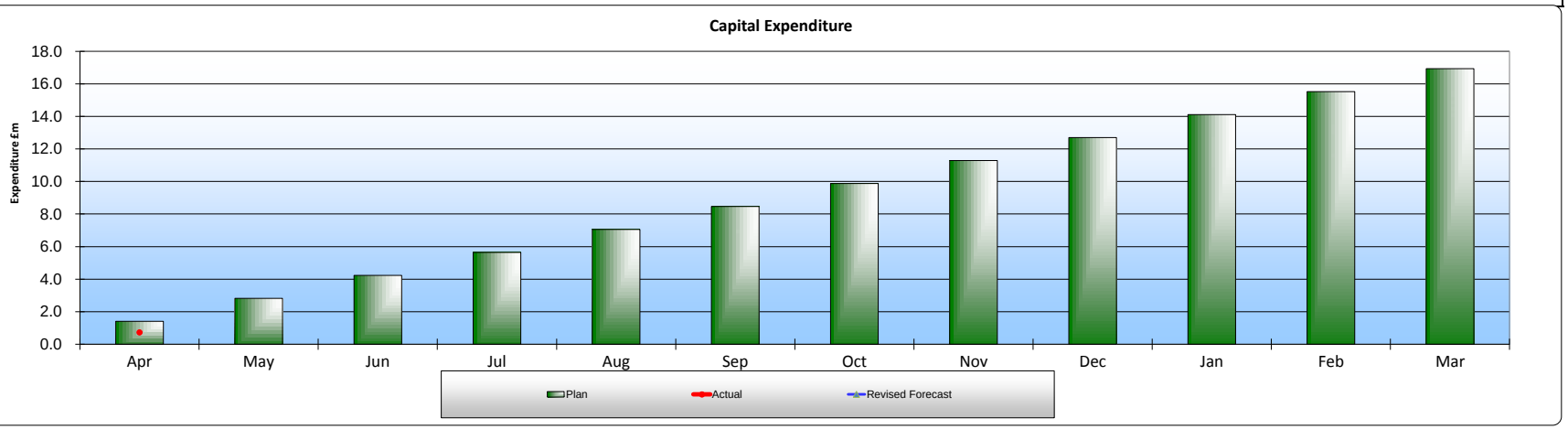
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Key Messages:

* The approved capital programme for 2020-21 is £16.937m , Actual spend at month 1 is £734k, this is £677k behind plan and relates to disruption to the availability of contractors due to the Covid-19 lockdown.

* This consists of the construction of the VIU extension and the Community Stadium. Due to current circumstances the Community Stadium project is on hold and therefore the completion date of this project cannot as yet be confirmed.

* Work will be completed on the SGH fire alarm and the transfer and refurbishment of the Endoscopy decontamination unit.



Scheme	2020-21 Plan as per NHSE&I	2020-21 Plan including over commitment	Year-to-date Expenditure	Year to date Forecast Expenditure	Variance Forecast v Actual	Comments
	£000	£000	£000	£000	£000	
Community Stadium	2,214	2,214	1	185	-184	
York Electrical Infrastructure	1,200	1,200	12	100	-88	
Fire Alarm System SGH	100	100	11	8	3	
Other Capital Schemes	410	410	194	34	160	
SGH Estates Backlog Maintenance	300	300	58	25	33	
York Estates Backlog Maintenance - York	300	300	4	25	-21	
Cardiac/VIU Extention	5,300	5,300	1	442	-441	
Medical Equipment	350	350	44	29	15	
SNS Capital Programme	2,600	2,600	203	217	-14	
Capital Programme Management	1,640	1,640	168	137	31	
Charitable funded schemes	450	450	38	38	1	
Wave 4 STP Fees	963	963	-	80	-80	
Ward Refurbishment	400	400	-	33	-33	
Contingency	710	710	-	59	-59	
Estimated In year work in progress	-	-	-	-	-	
TOTAL CAPITAL PROGRAMME	**16,937**	**16,937**	**734**	**1,411**	**-677**	

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	10,450	10,450	683	619	-64	
Loan Funding Repayments	-3,026	-3,026	-	-	-	
Loan Funding	6,500	6,500	13	542	529	
Charitable Funding	450	450	38	38	-1	
Finance lease repayments	-	-	-	-	-	
PDC funding	2,563	2,563	-	214	214	
TOTAL FUNDING	**16,937**	**16,937**	**734**	**1,411**	**677**	

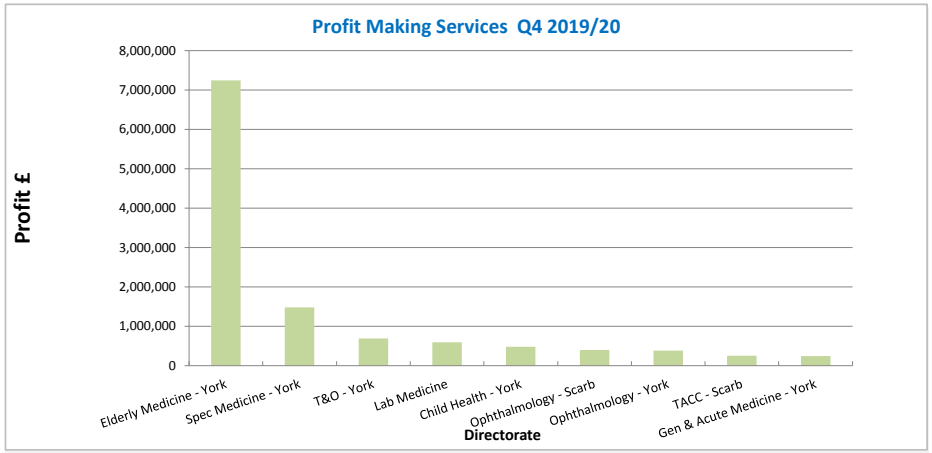
TRUST BOARD REPORT : May-2020

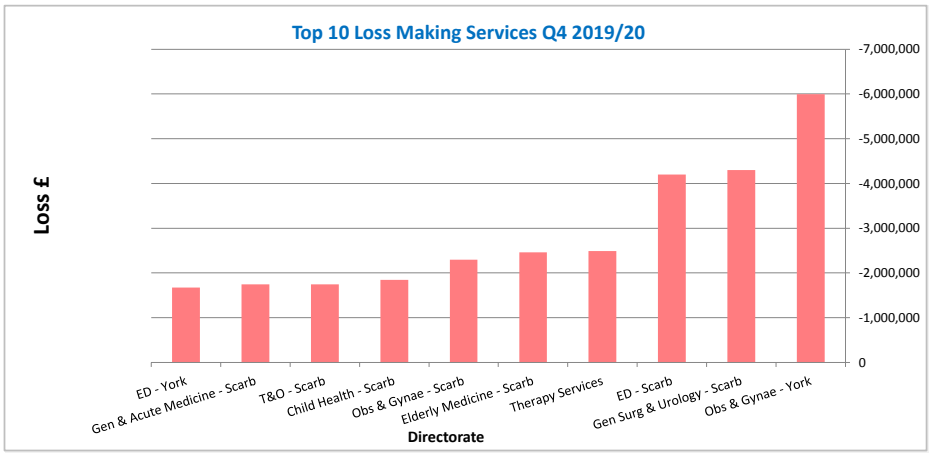
SERVICE LINE REPORTING

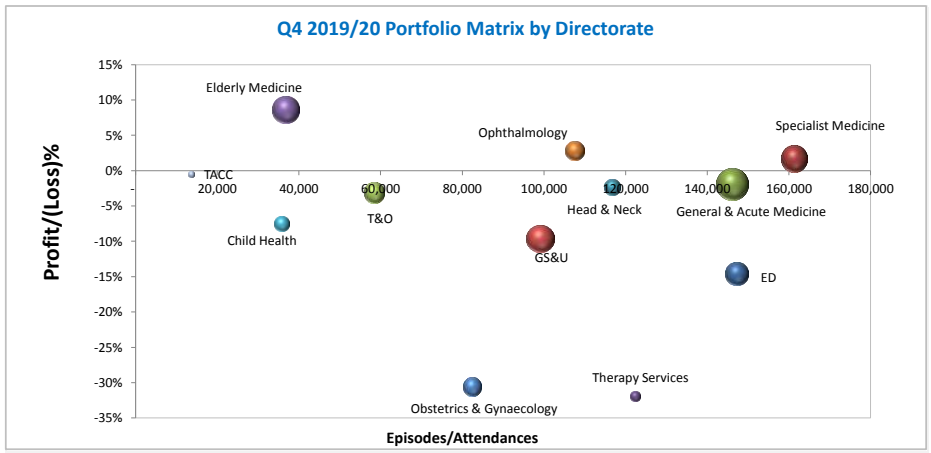
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

HIGHLIGHTS FOR BOARD TO NOTE :

* Current data is based on Q4 2019/20.
* The 2019/20 National Cost Collection submission to NHS Improvement is now the key focus for the team.
* The 2019/20 National Cost Collection submission window has been delayed by NHS Improvement.
* The SLR system configuration is on-going to ensure the year 2 NHS Improvement Costing Transformation Programme requirements are achieved.







DATA PERIOD	Q4 2019/20
CURRENT WORK	* The 2019/20 National Cost Collection submission to NHS Improvement is now the key focus for the team. * The new National Cost Collection window for 2019/20 has not yet been announced by NHS Improvement. * 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 being developed to allow the SLR / PLICS data to be more easily interpreted and understood. * System configuration for the NHS Improvement National Cost Collection PLICS submission is planned to run throughout 2019/20.

FINANCIAL BENEFITS SINCE SYSTEM INTRODUCTION	£3.73m

RESEARCH AND DEVELOPMENT REPORT

April-2020

Produced May 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

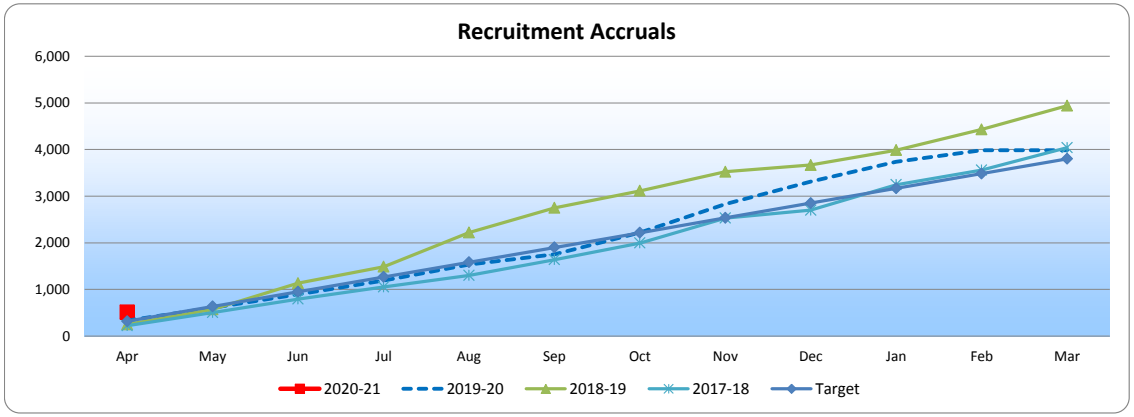
To ensure financial stability

TRUST BOARD REPORT : April-2020

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2020-21	513												513
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



We have had to suspend most of the clinical trials were supporting due to the current crisis, and we are now supporting the Covid 19 trials that have been badged an Urgent Public Health Need by the Department of Health. So instead of supporting around 150 clinical trials at any one time we are currently only supporting 6 trials. Despite this we have still recruited 513 patients into our research which is an fantastic achievement

Care Group Breakdown will be calculated at end Q1 20/21

Directorate	Accruals Running Total 18/19	Target	%
Anaesthetics	0	0	0
Cardiology	0	0	0
Dermatology	0	0	0
Diabetes	0	0	0
ED	0	0	0
Gastro	0	0	0
Generic - Scarborough	0	0	0
Generic - York	0	0	0
Haematology	0	0	0
Obstetrics	0	0	0
Scarborough	0	0	0
Oncology-York	0	0	0
Ophthalmology	0	0	0
Paediatrics	0	0	0
Renal	0	0	0
Rheumatology	0	0	0
Sexual Health	0	0	0
Stroke	0	0	0
Orthopaedics & Physio	0	0	0
ENT	0	0	0
Respiratory	0	0	0
Neurology	0	0	0
Elderly Medicine	0	0	0
Microbiology	0	0	0
General Surgery (tallied within the above Generics York & Oncology totals)	**0**	**0**	**0**

Recruitment Target for Year	3800
Open Trials	42
Total Due to Close 19/20	14

Commercial	2%
Non-Commercial	98%
Interventional	70%
Observational	30%
I & O	0%

OPERATIONAL PERFORMANCE REPORT

April-2020

Produced May 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

Report produced by:

Information Team

Operational Performance Report: April-2020

Executive Summary

Trust Strategic Goals:

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

Purpose of the Report:

To provide the Board with an integrated overview of performance within the Trust.

Executive Summary:

Key discussion points for the Board are:

The Trust's COVID-19 Command and Control structure is in place with the COVID-19 Incident Coordination Centre (ICC) operational since the week commencing 2nd March 2020. The period since the 31st of January, when the first reported case occurred in York, has been a very challenging period with significant upheaval and changes in staffing, estate configuration and provision of services.

As at the 10th May 5,435 patients have been tested for COVID-19 with 1,056 (19%) testing positive. 612 patients have been admitted with confirmed COVID-19; unfortunately 152 patients who were COVID-19 positive have died; 337 have been discharged home.

The impact on routine performance has been substantial, resulting in considerable deterioration across the Trust's access targets for routine care (Referral to Treatment times and Diagnostic Waiting Times). This has been in the context of suppressed referrals to the Trust. Of notable concern are:

- The 152 52 week wait patients declared for April. The high levels of 36 week waiters is expected to result in further increases to the Trust's 52 week position.
- Impact of the stand-down on non-emergency endoscopy, resulting in significant delays in the Diagnostic targets and also affecting the time to diagnosis on the Colorectal and Upper GI Cancer pathways.

The Trust achieved compliance against 5 out of 7 cancer standards in March 2020, partially due to the current COVID-19 situation; all pathways are being tracked and monitored in line with national guidance. There has been some deterioration in the 28 Faster Diagnosis Standard position during March 2020 (69.4% from 72.3% in February).

The 'Restoration of Services and Operational Reset' programme of work has commenced, with an immediate focus on Cancer Fast Track and Urgent patients. The Trust has worked to rapidly return to a level of endoscopy from Mid-May and review of all opportunity to provide elective services.

There has been a significant improvement across in ECS performance the position. April 2020 performance (93.7%) was the highest monthly performance since May 2014. The Trust performance was 28th nationally (out of 113) and 6th in the North East and Yorkshire for April. This performance constitutes an improvement on March 2020 (83.7%) and April 2019 (80.5%). The Trust has seen low levels of delayed patients across Trust and Community sites, supporting lower bed occupancy levels on each site, as part of the requirement to protect 'surge' capacity for COVID-19 patients. The reduction in Type 1 attendances across our Emergency Departments and the low level of paediatric admissions (a reduction of 59% compared to 19/20 monthly average) is being targeted by local and national communications to encourage patients to access health care services.

Recommendation:

The Board is asked to receive the report and note the impact on the Trust KPIs and the actions being taken to address the significant performance challenges.

Author(s): Andrew Hurren, Deputy Head of Operational Planning and Performance
Lynette Smith, Head of Operational Planning and Performance

Director Sponsor: Wendy Scott, Chief Operating Officer
Date: May 2020

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE SUMMARY

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.01	Emergency Care Attendances		▼	18055	18270	18256	20101	19683	18486	18800	17848	17926	17169	16770	13034	7755
1.02	Emergency Care Breaches		▼	3525	3310	3067	3785	3671	4043	3689	4337	4471	4257	3065	2131	490
1.03	Emergency Care Standard Performance	95%	▲	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%	75.2%	81.7%	83.7%	93.7%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▲	36%	37%	38%	38%	38%	37%	30%	42%	42%	43%	44%	42%	43%
1.05	ED Total number of patients waiting over 8 hours in the departments		▼	1007	972	799	1029	912	1275	817	1200	1499	1428	801	468	55
1.06	ED 12 hour trolley waits	0	◀▶	24	26	2	1	7	32	16	9	15	28	4	0	0
1.07	ED: % of attendees assessed within 15 minutes of arrival		▲	58%	59%	59%	53%	55%	54%	54%	51%	54%	58%	61%	64%	71%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▲	37%	37%	36%	34%	33%	32%	32%	31%	32%	34%	38%	48%	88%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▼	3.7%	4.0%	4.4%	4.8%	4.4%	4.6%	4.1%	3.0%	3.1%	3.0%	2.1%	2.4%	0.8%
1.10	ED - Median time between arrival and treatment (minutes)			205	197	196	201	206	219	202	223	226	222	194	183	145
1.11	Ambulance handovers waiting 15-29 minutes		▼	956	1072	978	988	983	969	1112	994	1068	1035	943	799	477
1.12	Ambulance handovers waiting 15-29 minutes - improvement trajectory			829	812	795	778	761	744	727	710	694	685	681	677	-
1.13	Ambulance handovers waiting 30-59 minutes		▼	593	671	587	723	547	605	571	552	652	625	465	324	113
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			365	350	335	319	304	289	274	361	342	323	304	285	-
1.15	Ambulance handovers waiting >60 minutes		▼	548	449	453	673	362	466	332	476	668	554	263	176	6
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			297	281	264	215	182	149	116	271	257	244	231	215	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	4521	4733	4761	5070	4871	4553	5142	5048	5089	5166	4993	3951	2922
2.02	Non Elective Admissions - Paediatrics		▼	745	729	711	808	658	790	944	1045	1011	839	806	611	330
2.03	Delayed Transfers of Care - Acute Hospitals		▲	1178	1529	1486	1346	1325	1355	1215	1054	1183	1258	1233	775	-
2.04	Delayed Transfers of Care - Community Hospitals		▼	277	303	352	235	333	335	342	182	249	408	271	256	34
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▼	1241	1386	1550	1609	1472	1364	1663	1782	1691	1881	1822	1424	856
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	1102	1157	1076	1241	1115	1139	1116	1112	1191	1147	1122	818	694
2.07	Ward Transfers - Non clinical transfers after 10pm	100	▲	87	87	76	87	72	89	104	99	123	127	91	51	65
2.08	Emergency readmissions within 30 days		▼	925	912	941	1044	938	876	994	971	1030	989	939	-	-
2.09	Stranded Patients at End of Month - York, Scarborough and Bridlington		▲	422	406	397	394	409	397	363	363	377	384	342	147	176
2.10	Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▼	405	399	373	390	384	380	361	362	376	407	387	311	144
2.12	Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	138	143	135	140	148	136	125	105	139	142	121	55	38
2.13	Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▼	147	134	141	138	134	138	129	109	118	145	133	98	39

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
3.01	Outpatients: All Referral Types		▼	18857	19704	19180	20521	18458	18964	20372	18759	17484	20598	18726	14955	7146
3.02	Outpatients: GP Referrals		▼	9580	9846	9558	10142	9399	9521	10162	9278	8617	10023	9020	7360	2039
3.03	Outpatients: Consultant to Consultant Referrals		▼	2201	2396	2243	2328	2101	2238	2395	2260	2035	2329	2036	1689	847
3.04	Outpatients: Other Referrals		▼	7076	7462	7379	8051	6958	7205	7815	7221	6832	8246	7670	5906	4260
3.05	Outpatients: 1st Attendances		▼	8605	9212	9208	9880	8309	8733	9877	9191	7937	9520	8701	7581	3895
3.06	Outpatients: Follow Up Attendances		▼	15046	16385	15098	16841	14098	14870	16982	16463	13107	16839	14518	13577	8298
3.07	Outpatients: 1st to FU Ratio		▲	1.75	1.78	1.64	1.70	1.70	1.70	1.72	1.79	1.65	1.77	1.67	1.79	2.13
3.08	Outpatients: DNA rates		▼	5.9%	6.1%	5.9%	6.3%	6.0%	6.0%	5.9%	6.0%	5.8%	6.2%	6.0%	5.5%	3.9%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	180	▲	180	179	198	243	240	232	270	213	164	219	250	751	1331
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	993	945	883	987	1214	1316	1474	1076	1303	1158	978	2070	3855
3.11	Outpatients: Follow-up Partial Booking (FUPB) Overdue			11483	11594	12358	12383	12189	12035	11505	12156	12879	12953	12971	14468	17165
3.12	Diagnostics: Patients waiting <6 weeks from referral to test	99%	▼	87.5%	86.4%	88.9%	81.7%	81.7%	82.4%	83.3%	85.2%	81.6%	81.1%	86.1%	75.1%	22.6%
4.01	Elective Admissions		▼	649	682	724	692	579	685	762	753	520	653	576	410	94
4.02	Day Case Admissions		▼	5843	6061	5879	6232	5901	6135	6684	6411	5637	6590	6068	4781	1830
4.03	Cancelled Operations within 48 hours - Bed shortages		▼	32	66	59	32	13	60	26	41	48	42	10	333	14
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▼	130	147	194	229	85	173	148	173	152	142	89	408	21
4.05	Theatres: Utilisation of planned sessions		▼	92%	86%	89%	89%	91%	91%	95%	91%	88%	86%	89%	87%	61%
4.06	Theatres: number of sessions held		▼	576	602	609	712	501	588	640	561	498	591	542	369	54
4.07	Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		▲	99	43	83	104	92	48	66	52	70	31	17	230	379

TRUST BOARD REPORT: April-2020

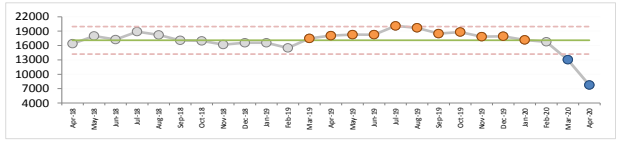
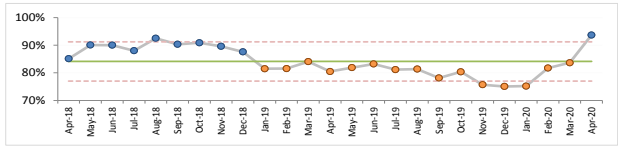
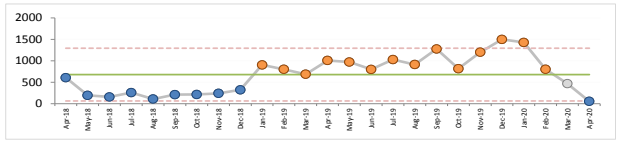
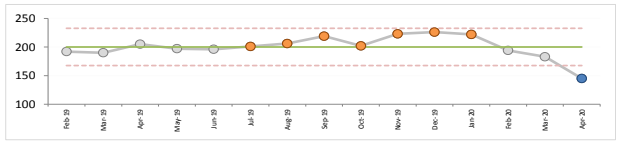
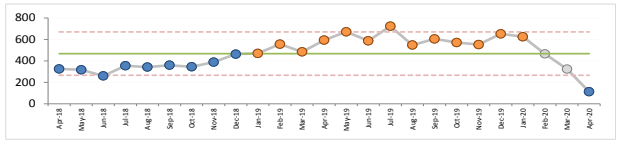
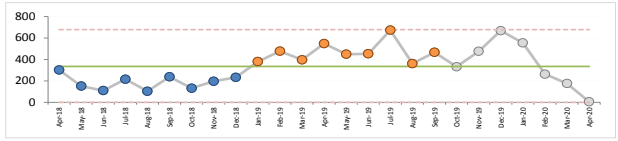
OPERATIONAL PERFORMANCE SUMMARY

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
5.01	RTT Percentage of incomplete pathways within 18wks	92%	▼	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%	75.2%	74.8%	74.0%	73.6%	69.7%	58.7%
5.02	RTT Waits over 52 weeks for incomplete pathways	0	▲	0	0	3	0	1	1	0	0	0	1	0	32	158
5.03	RTT Waits over 26 weeks for incomplete pathways	0	▲	2468	2657	2558	2735	3239	3595	3508	3526	3929	3917	3866	4413	5734
5.04	RTT Waits over 36 weeks for incomplete pathways	0	▲	669	632	660	632	868	887	1076	1168	1292	1306	1311	1681	2474
5.05	RTT Total Waiting List	29,583	▼	28344	28809	28724	28394	29252	29771	29442	29123	30187	29583	29534	28508	24947
5.06	Number of RTT patients on Admitted Backlog (18+ weeks)		▲	2850	2877	2847	3338	3543	3639	3686	3711	3919	4005	4075	4540	5506
5.07	Number of RTT patients on Non Admitted Backlog (18+ weeks)		▲	2825	2769	3391	3079	3283	3445	3554	3512	3694	3687	3727	4085	4797
5.08	RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)	8.5	▲	-	-	-	-	-	-	11.6	12.0	12.1	12.1	12.0	13.7	17.7

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
6.01	Cancer 2 week (all cancers)	93%	▼	88.3%	84.6%	81.3%	85.9%	89.9%	90.9%	94.0%	92.4%	94.8%	92.6%	94.4%	90.8%	-
6.02	Cancer 2 week (breast symptoms)	93%	▼	79.6%	91.4%	93.8%	95.2%	97.1%	98.1%	98.0%	97.6%	98.4%	97.4%	99.1%	95.3%	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	▼	96.7%	98.3%	98.8%	99.1%	99.5%	97.5%	98.8%	96.4%	98.0%	96.7%	100.0%	96.8%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▲	94.3%	95.1%	96.9%	93.8%	84.4%	100.0%	97.2%	97.8%	87.2%	80.0%	91.1%	94.4%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	◀▶	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.8%	100.0%	100.0%	100.0%	100.0%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▲	80.6%	79.5%	85.0%	79.8%	81.2%	80.2%	78.9%	75.9%	76.5%	76.8%	73.3%	83.9%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	▼	100.0%	92.1%	100.0%	100.0%	90.6%	100.0%	98.0%	91.4%	86.4%	87.1%	96.8%	95.6%	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▼	67.4%	62.1%	66.8%	63.1%	60.2%	59.6%	64.9%	68.9%	70.7%	63.4%	72.3%	69.4%	-

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE: ED

Apr-20	METRIC :	TARGET :	vs LM :	
7,755	**1.01** Emergency Care Attendances	-	-5,279 ↓	
93.7%	**1.03** Emergency Care Standard Performance	95.0%	10.0% ↑	
55	**1.05** ED Total number of patients waiting over 8 hours in the departments	-	-413 ↓	
145	**1.10** ED - Median time between arrival and treatment (minutes)	-	-38 ↓	
113	**1.13** Ambulance handovers waiting 30-59 minutes	0	-211 ↓	
6	**1.15** Ambulance handovers waiting >60 minutes	0	-170 ↓	

HIGHLIGHTS FOR BOARD TO NOTE:

Performance against the urgent care standards has improved across the range of metrics. Emergency Care Standard (ECS) performance of 93.7% was the highest monthly performance since May 2014. This constitutes a significant improvement on March 2020 (83.7%) and April 2019 (80.5%). Root cause analysis of all ECS breaches continues at both sites to inform improvement and learning.

The improved performance has been facilitated by a reduction in attendances due to the national lockdown in April and reduced levels of bed occupancy. Overall attendances at all sites were down 10,300 (-57%) compared to April 2019. The number of Type 1 attendances at our main EDs were down by 47%; 5,116 attendances compared to the same period last year.

To address the concerning drop in Type 1 attendances, national and local communications have commenced to encourage patients to access emergency care. The Trust has seen some increases in the daily average of attendances recently, with the last seven days averaging 218 (Type 1) and 73 (Type 3) from an average of 183 (Type 1) and 58 (Type 3) in the period since lockdown started.

Trust Performance in April 2020 was 93.7% for Type 1, 2 & 3 attendances, compared to National Performance of 90.4%. Nationally the Trust was ranked 28 out of 118 Trusts, an improved position when compared against last month (86th out of 118). Only 20 Trusts achieved the 95% standard nationally in April 2020.

There were zero twelve hour trolley waits in April 2020.

Both sites have been operating the re-configured urgent care pathways. Each site has created a 'COVID' and 'non-COVID' emergency department space, with wards re-designated to reduce the risk of transmission for all patients. Protected escalation capacity is in place on both sites.

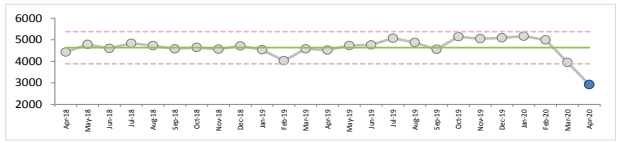
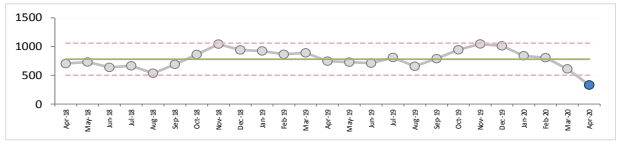
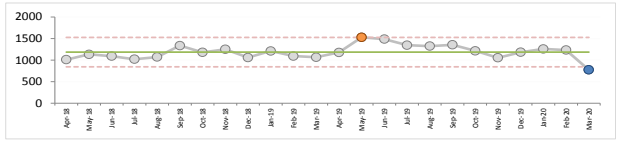
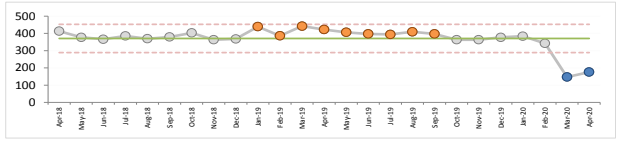
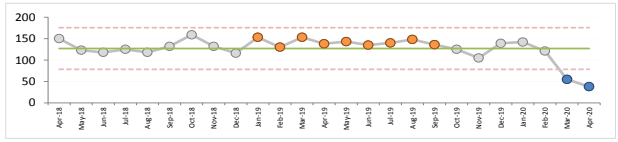
The national and local response to manage delayed transfers of care (DToC) via discharge hubs has had a significant impact on the Trust performance supporting bed occupancy levels.

While the Trust remains in 'response' phase of the COVID-19 incident both Care Groups responsible for Urgent Care have started evaluating the change in processes to capture learning and best practice to ensure it is 'locked in'.

A bid has been submitted to NHSE/I against the National Intensive Support Programme Budget to support the following three priorities:
1. Clinical transformation to enhance delivery of safe and effective care, drive engagement and create a culture of continuous improvement across the system.
2. Governance: delivery of a clearly articulated digital framework in line with well led domain that is used in a systematic way and drives a culture of learning.
3. Leadership development: deliver a leadership and team development programme that focusses on delivering a compassionate and inclusive approach and embeds a culture of ownership and accountability.

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE: NON-ELECTIVE INPATIENTS

Apr-20	METRIC :	TARGET :	vs LM :	
2,922	**2.01** Non Elective Admissions (excl Paediatrics & Maternity)	-	-1,029 ↓	
330	**2.02** Non Elective Admissions - Paediatrics	-	-281 ↓	
Unavailable -	**2.03** Delayed Transfers of Care - Acute Hospitals	-	Prov. 755	
176	**2.09** Stranded Patients at End of Month - York, Scarborough and Bridlington	-	29 ↑	
38	**2.12** Super Stranded Patients at End of Month - York, Scarborough and Bridlington	-	-17 ↓	

HIGHLIGHTS FOR BOARD TO NOTE:

Both sites have undertaken re-organisation of patient flows and re-designation of ward areas to minimise the risk of transmission between patients with suspected or confirmed COVID-19 and 'non-COVID' patients. This has required the development of a range of standard operating procedures (SOPS) on the placement, testing and discharge of patients.

As expected with the reduction of attendances, adult non-elective admissions in April 2020 were 35% down on the same period last year (-1,599 admissions). York Hospital saw a reduction of 1,244 admissions (-40%) with Scarborough seeing a reduction of 355 (26%).

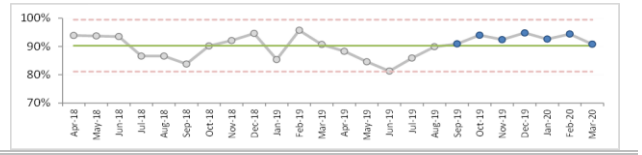
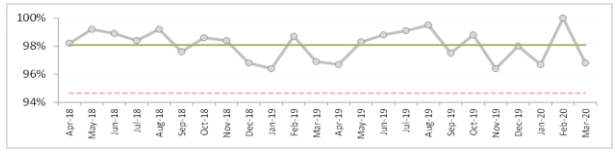
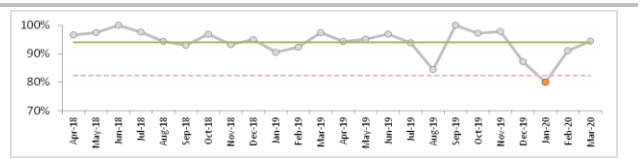
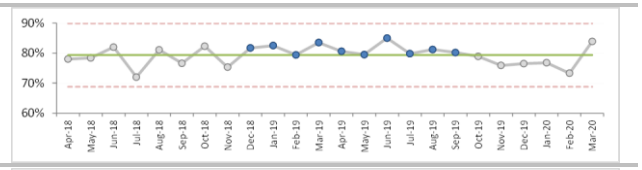
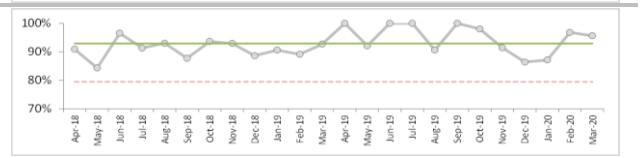
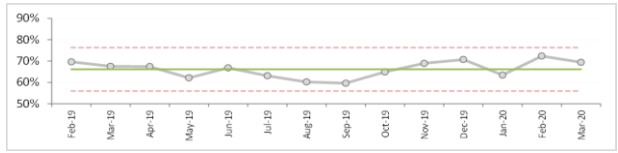
Paediatric admissions in April were the lowest since the July 2013, down to 330. This was 478 below the average monthly admissions in 2019/20, a reduction of 59%. The significant decrease is an area of concern. National and local communications have commenced to encourage parents to seek medical care for their children.

Super-Stranded (Lenght of Stay 21+ Days) patients at the end of April 2020 were at the lowest level in the last two years. The low level of delays to transfer from Acute and Community setting and long Length of Stay (LoS) inpatients has been significantly influenced by national guidance received on the 17th March 2020 that instructed Trusts to urgently discharge all hospital inpatients who are medically fit to leave. Emergency legislation was passed by Parliament in March to ensure that eligibility assessments do not delay discharge. In addition new government funding for discharge packages and to support the supply and resilience of out-of-hospital care more broadly is being made available.

This has significantly contributed to the bed occupancy levels at both main hospitals, and created the protected capacity in the case of a second 'surge' of COVID 19 patients.

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE: CANCER

Mar-20	METRIC :	TARGET :	vs LM :	
90.8%	**6.01** Cancer 2 week (all cancers)	93.0%	-3.6% ↓	
96.8%	**6.03** Cancer 31 day wait from diagnosis to first treatment	96.0%	-3.2% ↓	
94.4%	**6.04** Cancer 31 day wait for second or subsequent treatment - surgery	94.0%	3.3% ↑	
83.9%	**6.06** Cancer 62 Day Waits for first treatment (from urgent GP referral)	85.0%	10.6% ↑	
95.6%	**6.07** Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90.0%	-1.2% ↓	
69.4%	**6.08** Cancer 28 Day Wait - Faster Diagnosis Standard	75.0%	-2.9% ↓	

HIGHLIGHTS FOR BOARD TO NOTE:

The number of cancer fast track referrals received in the six weeks from Monday 16th March was 1,041. This is approximately 1,350 fewer referrals than the Trust would have expected to receive over that period. This reduction could be due to patients not presenting at their GPs, the reduction in routine GP appointments, which identify the possibility of cancer, difficulties in access or GPs (following a discussion with the patient) have made a decision not to refer. In these circumstances the GP is expected to 'safety net' the patient and review on a regular basis. Joint communications have been sent out by the Trust and CCGs encouraging patients to contact their GPs if they are experiencing symptoms.

There has been some deterioration in the 28 Day Faster Diagnosis Standard position during March 2020 (69.4% from 72.3% in February). Although this target is new and came into effect from the beginning of April 2020, guidance has been received that states it "will not be subject to formal performance management" until further notice. The Trust has shadow reported during 2019/20.

Radiology referrals are being clinically triaged by consultant radiologists and managed as 'Essential' or 'Not Essential'. 'Essential' referrals such as Cancer fast track or 'Urgents' are being booked and seen.

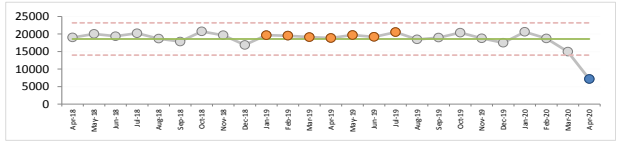
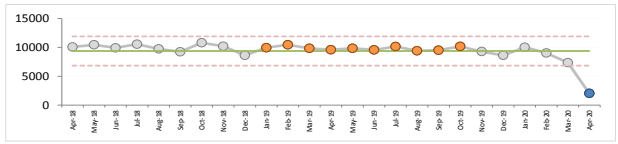
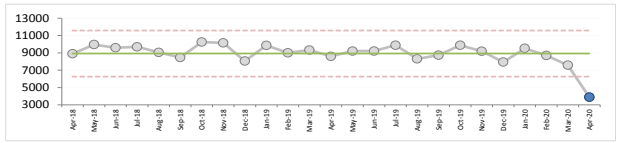
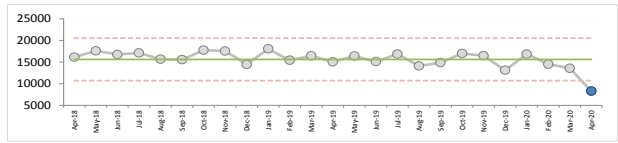
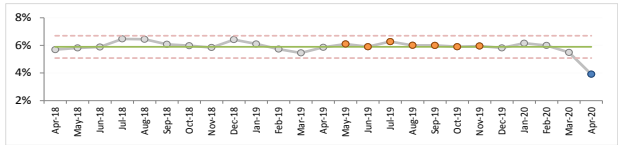
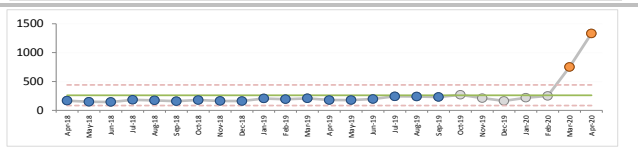
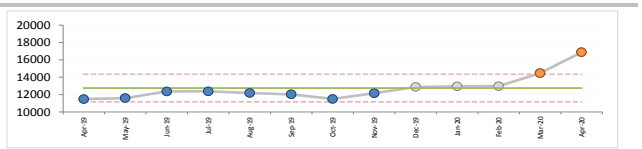
The Trust has continued to provide a level of cancer surgery across all tumour sites, but comp[ared to the same period last year has very limited capacity to undertake complex cases requiring critical care. These have been prioritised through the establishment of a Trust-Level Multi-Disciplinary Team (MDT) process. The Trust has also worked with neighbouring providers where possible. The clinical teams have documented any changes to expected first-line treatments during the pandemic to assess future impact.

The Colorectal pathway has been significantly affected by the stand-down of diagnostic endoscopy, however from the 18th of May endoscopy colonoscopies will recommence at reduced capacity on our York and Bridlington sites. Week commencing 25th May the service will look to recommence gastroscopies on the York and Scarborough sites, again at a much reduced rate.

The Trust is working with the Humber Coast and Vale Cancer Alliance to maintain and share best practice, establish clinical risk prioritisation frameworks and work to embed optimal pathways. A HCV oversight and Assurance 'Cancer deep dive' workshop was held on the 13th May.

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE: OUTPATIENTS

Apr-20	METRIC :	TARGET :	vs LM :	
7,146	**3.01** Outpatients: All Referral Types	-	-7,809 ↓	
2039	**3.02** Outpatients: GP Referrals	-	-5321 ↓	
3895	**3.05** Outpatients: 1st Attendances	-	-3686 ↓	
8298	**3.06** Outpatients: Follow Up Attendances	-	-5279 ↓	
3.9%	**3.08** Outpatients: DNA rates	-	-1.6% ↓	
1331	**3.09** Outpatients: Cancelled Clinics with less than 14 days notice	120	580 ↑	
16876	**3.11** Outpatients: Follow-up Partial Booking (FUPB) Overdue	0	2408 ↑	

HIGHLIGHTS FOR BOARD TO NOTE:

National guidance received on the 17th March instructed Trusts to postpone all non-urgent elective operations for a period of at least three months. To date 44,477 outpatient appointments have been cancelled by the Trust. The Trust implemented a 'safety netting' approach, with all outpatient appointments receiving a clinical review to determine if they could be reprovided virtually, over the telephone, Patient-Initated Follow Up or safely discharged to primary care.

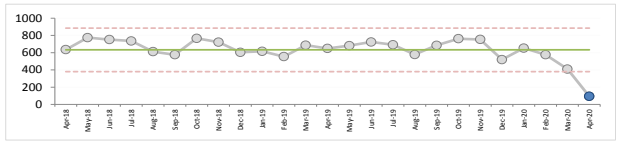
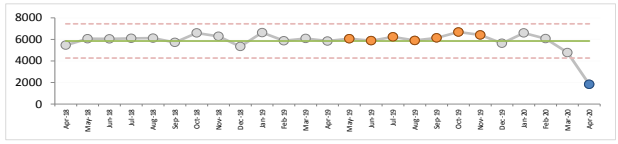
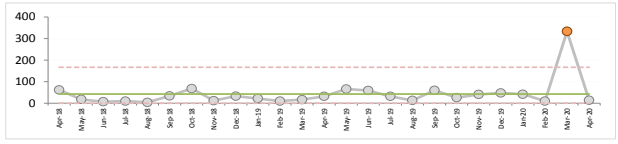
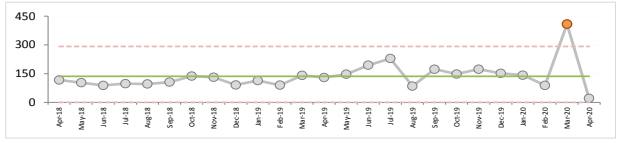
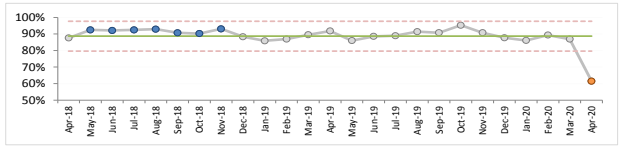
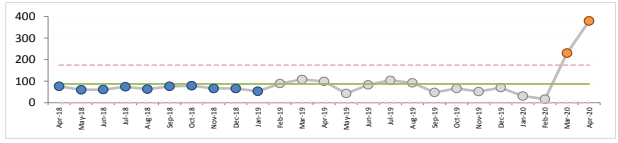
In addition 3,759 outpatient appointments have been cancelled by patients due to concerns around attending hospital. In order that these patients who have cancelled their appointments are not 'lost' those with no future booked activity are being reviewed by clinicians using the NOTIFY module on CPD. Notify allows clinicians to access all areas of CPD to decide on the next stage of a patients care.

To mitigate against the loss of routine capacity the Trust has accelerated its outpatient transformation project with increased numbers of patients being seen via online consultations and telephone clinics; for April a third of all attendances have been non face-to-face. Where patients have to be seen in a face-to-face environment the Trust has moved activity to non-acute site clinics where possible. Where high-risk patients have had to attend the York site, areas such as the Neurosciences department have been used. These areas have a separate entrance and therefore the footfall and risk to patients and staff can be minimised.

Care Group clinicians are working with Patient Access to review via NOTIFY a rolling four weeks of future booked outpatient appointments. This process is being closely monitored with a standard operating procedure in place to provide a robust method for reviewing patients awaiting an outpatient attendance. A working group with representation from all Care Groups is meeting regularly to ensure governance of the process and that all patients whose appointments have/will have their appointment cancelled are managed safely. GP referrals are down 78.7% (7541) compared to April 19, and all referrals are down 62% (11,711) compared to April 2019. This has resulted in a reduction in our total waiting list (TWL). The Trust is working through the York and North Yorkshire Joint Planned Care Board to determine how innovation is maintained and joint planning as primary care continue the restoration of their services. The Trust 'switched' back on routine referrals from GPs on the 8th May.

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE: ORDINARY ELECTIVE INPATIENTS

Apr-20	METRIC :	TARGET :	vs LM :	
94	**4.01** Elective Admissions	-	-316 ↓	
1830	**4.02** Day Case Admissions	-	-2951 ↓	
14	**4.03** Cancelled Operations within 48 hours - Bed shortages	-	-319 ↓	
21	**4.04** Cancelled Operations within 48 hours - Non clinical reasons	-	-387 ↓	
61.5%	**4.05** Theatres: Utilisation of planned sessions	-	-25.4% ↓	
379	**4.07** Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)	-	149 ↑	

HIGHLIGHTS FOR BOARD TO NOTE:

National guidance received on the 17th March instructed Trusts to postpone all non-urgent elective operations for a period of at least three months. To date 1,804 elective inpatient or Day Case TCIs have been cancelled by the Trust.

In terms of impact of COVID on activity, the weekly average for Quarter one saw the Trust treat 149 ordinary and 1,404 day case (including endoscopy etc.), the weekly average in April 2020 was 19 ordinary electives (a reduction of 87%) and 66 day cases (down 95%).

There is reduced on-site theatre capacity; urgent and complex cancer patient lists are in place for four hours per day Monday to Friday at York Hospital. Trauma Lists are provided each day at both York and Scarborough sites. Cancer surgery across the Trust has been consolidated at the Nuffield Hospital at York.

Lists are being provided across breast, GI, Colorectal, Plastics, MaxFax, Gynaecology, Urology, Ocuplastics and Vascular at the Nuffield Hospital (cold site) in York; currently two General Anaesthetic list (72hrs across Monday to Friday) and, one Local Anaesthetic list (Monday to Friday).

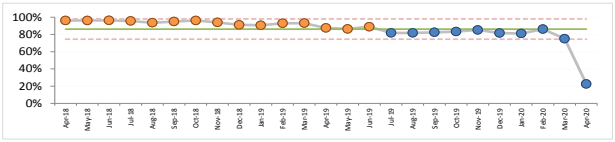
In addition the Trust is providing Oncology, Phlebotomy, MES from the Nuffield Hospital.

The Trust is working to determine our ability to increase elective capacity to ensure all Urgent and Fast Track work can be undertaken, and then to consider how routine electives can be provided. This work is being undertaken through 'Restoration of Services and Operational Reset'.

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE: DIAGNOSTICS

Apr-20	METRIC :	TARGET :	vs LM :
22.6%	**3.12** Diagnostics: Patients waiting <6 weeks from referral to test	99%	-52.5% ↓



HIGHLIGHTS FOR BOARD TO NOTE:

The diagnostic target has been particularly affected by the COVID Pandemic, due to the stand-down of some routine diagnostics, including endoscopy. At the end of April there were 4,732 patients waiting six weeks or more for their diagnostic test.

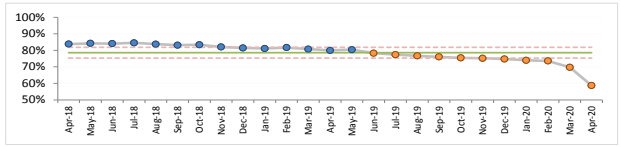
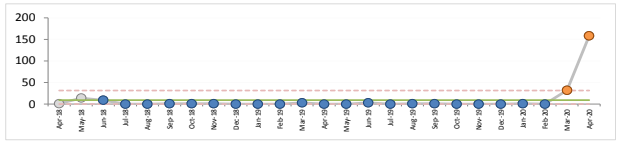
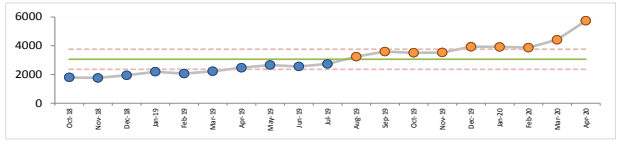
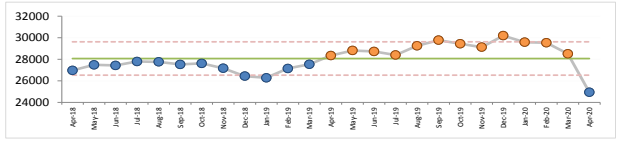
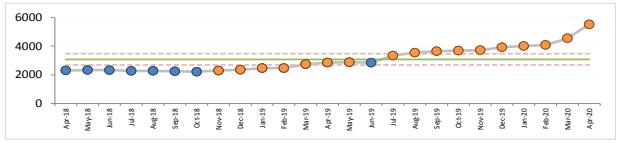
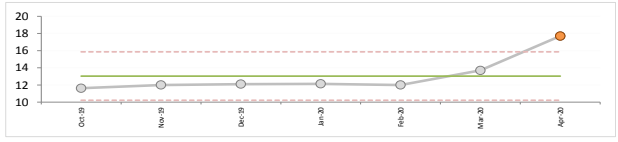
In line with COVID-19 guidance all non-emergency endoscopy has ceased. At the end of April the endoscopy element of the diagnostic target was 36.7% with 999 patients waiting six weeks or over.

Radiology has also been affected; referrals are being clinically triaged by consultant radiologists and managed as 'Essential' or 'Not Essential'. 'Essential' referrals such as Cancer fast track or 'Urgent' are being booked and seen. 'Not Essential' referrals are being placed into two sub categories; 'Defer' or 'Return'. Those classed as 'Defer' are being retained by the service with a letter sent to the referrer and the patient advising that there may be a significant delay. Scans will be prioritised when routine service provision commences. Those classed as 'Return' are being returned to the referrer and should only be re-requested if needed. To ensure the governance of the process and safety of patients those classed as 'Deferred' or 'Returned' are 'double vetted', so that two clinicians agree on the action. At the end of April radiology diagnostics performance was 19% with 3,086 patients waiting six weeks or over.

Audiology services stopped seeing patients on the 14th March with guidance received on the 19th March from NHSE/I that all Audiology services except new-born screening within maternity units should cease until at least the 31st July. Performance for Audiology diagnostics has therefore fallen to 9% having achieved the 99% target for eleven of the previous twelve months.

TRUST BOARD REPORT: April-2020

OPERATIONAL PERFORMANCE: REFERRAL TO TREATMENT (RTT)

Apr-20	METRIC :	TARGET :	vs LM :	
58.7%	**5.01** RTT Percentage of incomplete pathways within 18wks	92.0%	-11.0% ↓	
158	**5.02** RTT Waits over 52 weeks for incomplete pathways	0	126 ↑	
5734	**5.03** RTT Waits over 26 weeks for incomplete pathways	-	1321 ↑	
24947	**5.05** RTT Total Waiting List	29583	-3561 ↓	
5506	**5.06** Number of RTT patients on Admitted Backlog (18+ weeks)	-	966 ↑	
17.7	**5.08** RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)	-	4.0 ↑	

HIGHLIGHTS FOR BOARD TO NOTE :

The planned care targets (Referral to Treatment Times and Diagnostic waiting times) have continued to be impacted by the reduction in routine activity. The Trust was mandated to postpone all non-urgent elective operations for a period of at least three months in National guidance received on the 17th March. April therefore saw a significant reduction in the RTT Total Waiting List (TWL) with the Trust not receiving as many routine referrals due to the COVID-19 pandemic.

Referrals received reduced to 7,146 in April 2020, down from 18,857 in April 2019 (-1,711, -62%) with referrals from GPs falling to 2,039, a reduction of 77% (-6,998) compared to the 2019/20 monthly average. The reduction in referrals has seen the TWL reduce from 28,508 open clocks at the end of March to 24,947 at the end of April (-3,558, -12.5%). As a result the Trust is 4,636 open clocks below the 2020/21 requirement to have fewer than 29,583 open clocks at the end of March 2021.

The decrease in new RTT clocks has negatively impacted on the percentage of waiting under 18 weeks which has fallen to 58.7% (March 2020; 69.7%). A drop in RTT performance is anticipated nationally.

The Trust had maintained a relentless focus on long wait patients and preventing patients waiting more than 52 weeks for treatment, projecting a reduction from 30 patients in 2018/19, to a predicted 7 patients for 2019-20. The existing pressure in the system, combined with the stand-down of routine elective surgery has resulted in the Trust having 158 patients waiting 52 weeks or longer at the end of April 2020. These include a substantial proportion of dental patients, which due to the nature of the surgery may continue to be suspended. Given the numbers of patients currently waiting over 40 weeks (1,857), Board is asked to note that with the stand down of routine surgery that the number of 52 week waiters will continue to rise significantly.

The Trust is engaged with the Humber Coast and Vale to develop clinical risk assessment and prioritisation to understand and mitigate where possible clinical risk for these patients. Our regulators are briefed on this and we have been advised that our situation mirrors other providers.

Identifying how the Trust can re-provide services for long wait patients is a core element of the work on the Restoration of Services. The scale of issues faced by providers is recognised by NHSE/I locally. NHSE/I are planning to facilitate a workstream to forecast anticipated long waits to year-end.

TRUST BOARD REPORT : April-2020

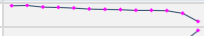
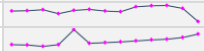
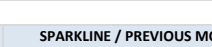
OPERATIONAL PERFORMANCE SUMMARY - SCARBOROUGH

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.01	Locality Emergency Care Attendances		▼	8644	8606	8564	9738	9650	8676	8616	7939	8385	8019	7775	6068	3395
1.02	Locality Emergency Care Breaches		▼	1670	1456	1431	1769	1396	1772	1653	1809	2138	1790	1138	828	322
1.03	Locality Emergency Care Standard Performance	95%	▲	80.7%	83.1%	83.3%	81.8%	85.5%	79.6%	80.8%	77.2%	74.5%	77.7%	85.4%	86.4%	90.5%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	48%	51%	54%	53%	52%	64%	57%	57%	54%	58%	61%	56%	52%
1.05	ED Total number of patients waiting over 8 hours in the departments		▼	546	412	378	555	496	721	499	571	871	662	291	172	37
1.06	ED 12 hour trolley waits	0	◀▶	24	24	2	1	7	32	16	9	15	27	4	0	0
1.07	ED: % of attendees assessed within 15 minutes of arrival		▼	42%	41%	44%	37%	42%	37%	37%	39%	35%	43%	45%	48%	38%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▲	24%	25%	28%	23%	26%	20%	20%	19%	17%	24%	30%	42%	86%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▼	2.3%	2.0%	2.1%	3.4%	3.8%	3.8%	1.9%	2.5%	4.6%	3.0%	1.7%	2.2%	0.9%
1.10	ED - Median time between arrival and treatment (minutes)			257	237	234	238	226	274	239	285	330	282	217	207	179
1.11	Ambulance handovers waiting 15-29 minutes		▼	446	470	450	473	453	427	507	412	484	517	450	393	290
1.13	Ambulance handovers waiting 30-59 minutes		▼	379	381	352	449	290	357	328	283	385	352	265	166	80
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			221	213	204	194	185	177	168	250	250	240	220	210	-
1.15	Ambulance handovers waiting >60 minutes		▼	350	268	309	401	138	252	200	223	388	255	105	60	5
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			205	196	187	145	120	94	69	141	147	134	131	130	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	1383	1550	1644	1790	1690	1525	1778	1662	1648	1808	1759	1425	1028
2.02	Non Elective Admissions - Paediatrics		▼	294	311	296	347	264	302	340	343	381	295	318	235	119
2.03	Delayed Transfers of Care - Acute Hospitals		▲	423	532	609	421	372	482	426	405	527	418	510	335	-
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▼	243	340	486	509	459	355	498	474	419	595	600	411	239
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	423	463	429	501	431	463	458	440	471	458	411	316	250
2.07	Ward Transfers - Non clinical transfers after 10pm	33	▲	25	31	32	27	27	33	47	38	52	39	30	25	31
2.08	Emergency readmissions within 30 days		▼	290	308	318	383	327	307	329	312	352	350	336	-	-
2.09	Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	136	129	136	137	132	124	121	126	120	114	98	59	58
2.10	Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▼	130	126	123	125	127	126	112	121	126	125	123	98	53
2.12	Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▲	28	43	37	40	38	34	27	29	35	37	29	13	14
2.13	Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▼	37	32	38	35	36	37	30	27	30	34	35	25	12

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
3.01	Outpatients: All Referral Types		▼	6140	6460	6389	6800	6080	6159	6737	6250	5706	6850	6293	5168	2237
3.02	Outpatients: GP Referrals		▼	3421	3543	3564	3574	3397	3342	3578	3435	3129	3751	3367	2789	821
3.03	Outpatients: Consultant to Consultant Referrals		▼	731	799	751	827	692	723	755	681	621	708	682	584	241
3.04	Outpatients: Other Referrals		▼	1988	2118	2074	2399	1991	2094	2404	2134	1956	2391	2244	1795	1175
3.05	Outpatients: 1st Attendances		▼	3106	3477	3228	3704	2878	3258	3664	3326	2865	3480	3174	2788	1318
3.06	Outpatients: Follow Up Attendances		▼	5195	5841	5118	5913	4699	5127	6012	5735	4602	5880	5225	4729	2822
3.07	Outpatients: 1st to FU Ratio		▲	1.67	1.68	1.59	1.60	1.63	1.57	1.64	1.72	1.61	1.69	1.65	1.70	2.14
3.08	Outpatients: DNA rates		▼	7.0%	7.0%	7.0%	7.3%	7.0%	6.9%	7.1%	7.3%	6.9%	7.5%	7.1%	6.6%	4.8%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	60	▲	68	72	83	114	92	101	108	96	71	94	121	248	434
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	432	362	328	358	474	580	460	374	495	467	362	701	1234
4.01	Elective Admissions		▼	196	195	206	182	148	185	213	176	125	189	158	121	13
4.02	Day Case Admissions		▼	1752	1762	1759	1922	1852	1876	1976	1737	1590	1899	1696	1323	625
4.03	Cancelled Operations within 48 hours - Bed shortages		▼	15	6	22	23	8	37	11	21	24	9	2	21	5
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▼	34	30	50	97	27	81	53	59	56	35	25	107	8
4.05	Theatres: Utilisation of planned sessions		▼	87%	77%	84%	80%	90%	84%	93%	85%	85%	82%	84%	75%	30%
4.06	Theatres: number of sessions held		▼	170	167	169	189	136	151	171	131	112	140	134	108	20
4.07	Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		▲	3	0	1	2	0	0	3	0	0	0	0	9	37

TRUST BOARD REPORT : April-2020

OPERATIONAL PERFORMANCE SUMMARY - SCARBOROUGH

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
5.01	Incomplete Pathways		 ▼	83.6%	84.4%	82.0%	81.6%	80.8%	79.5%	78.7%	78.3%	77.3%	77.4%	77.3%	73.4%	62.4%
5.02	Waits over 52 weeks for incomplete pathways		 ▲	0	0	0	0	0	0	0	0	0	0	0	13	54
5.03	Waits over 26 weeks for incomplete pathways		▲	610	603	599	610	726	824	803	845	1048	1087	1049	1205	1580
5.04	Waits over 36 weeks for incomplete pathways		 ▲	160	138	131	133	178	178	211	227	282	346	357	452	620
5.05	RTT Total Waiting List (RTT TWL)		▼	9048	9074	9176	8739	9134	9233	9055	8968	9536	9633	9693	9347	7856
5.06	Number of patients on Admitted Backlog (18+ weeks)		 ▲	499	464	353	504	1758	607	674	716	798	889	943	1089	1362
5.07	Number of patients on Non Admitted Backlog (18+ weeks)		 ▲	986	954	1286	1104	1098	1289	1252	1229	1362	1287	1261	1398	1590
5.08	Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)		▲	-	-	-	-	-	-	10.5	10.8	11.3	11.1	11.1	12.7	16.8

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
6.01	Cancer 2 week (all cancers)	93%	 ▲	83.4%	83.9%	78.0%	76.8%	78.1%	84.8%	87.8%	86.9%	92.1%	85.7%	90.4%	90.9%	-
6.02	Cancer 2 week (breast symptoms)	93%	 ◀▶	79.6%	91.4%	97.6%	95.2%	100.0%	100.0%	98.0%	97.6%	98.4%	-	-	-	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	 ▼	94.0%	100.0%	98.1%	100.0%	100.0%	90.7%	98.4%	97.0%	97.9%	90.3%	100.0%	95.4%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▲	100.0%	80.0%	100.0%	100.0%	55.6%	100.0%	75.0%	100.0%	100.0%	-	0.0%	66.7%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	 ◀▶	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▲	69.2%	74.2%	76.6%	61.4%	79.4%	69.8%	78.1%	70.7%	66.7%	68.8%	66.0%	79.7%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	 ▼	-	-	-	-	-	-	-	-	-	-	-	0.0%	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▼	57.1%	47.5%	53.8%	50.2%	48.8%	50.3%	50.5%	59.1%	55.8%	53.6%	66.0%	55.7%	-

TRUST BOARD REPORT : April-2020

OPERATIONAL PERFORMANCE SUMMARY - YORK

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.01	Locality Emergency Care Attendances		▼	9411	9664	9692	10363	10033	9810	10184	9909	9541	9150	8995	6966	4360
1.02	Locality Emergency Care Breaches		▼	1855	1854	1636	2016	2275	2271	2036	2528	2333	2467	1927	1303	168
1.03	Locality Emergency Care Standard Performance	95%	▲	80.3%	80.8%	83.1%	80.6%	77.3%	76.9%	80.0%	74.5%	75.6%	73.0%	78.6%	81.3%	96.2%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▲	31%	31%	30%	30%	31%	31%	32%	35%	37%	36%	36%	34%	38%
1.05	ED Total number of patients waiting over 8 hours in the departments		▼	461	442	316	369	416	554	318	629	628	766	510	296	18
1.06	ED 12 hour trolley waits	0	◀▶	0	2	0	0	0	0	0	0	0	1	0	0	0
1.07	ED: % of attendees assessed within 15 minutes of arrival		▲	66%	68%	65%	61%	60%	61%	61%	57%	63%	65%	68%	72%	91%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▲	43%	43%	40%	39%	37%	37%	37%	36%	39%	39%	42%	52%	89%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▼	4.3%	4.9%	5.5%	5.6%	6.8%	6.7%	4.2%	3.3%	2.3%	3.0%	2.2%	2.5%	0.8%
1.10	ED - Median time between arrival and treatment (minutes)			181	179	180	180	194	197	185	201	196	201	182	169	123
1.11	Ambulance handovers waiting 15-29 minutes		▼	510	584	528	515	530	542	605	582	584	518	493	406	187
1.13	Ambulance handovers waiting 30-59 minutes		▼	214	290	235	274	257	248	243	269	267	273	200	158	33
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			144	138	131	125	119	113	106	111	92	83	84	75	-
1.15	Ambulance handovers waiting >60 minutes		▼	198	181	144	272	224	214	132	253	280	299	158	116	1
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			93	85	78	70	63	55	48	130	110	110	100	85	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	3138	3183	3117	3280	3181	3028	3364	3386	3441	3358	3234	2526	1894
2.02	Non Elective Admissions - Paediatrics		▼	451	418	415	461	394	488	604	702	630	544	488	376	211
2.03	Delayed Transfers of Care - Acute Hospitals		▲	1033	997	877	925	953	873	789	649	656	840	723	440	-
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▼	998	1046	1064	1100	1013	1009	1165	1308	1272	1286	1222	1013	617
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	679	694	647	740	684	676	658	672	720	689	711	502	444
2.07	Ward Transfers - Non clinical transfers after 10pm	67	▲	62	56	44	60	45	56	57	61	71	88	61	26	34
2.08	Emergency readmissions within 30 days		▼	635	604	623	661	609	569	662	634	678	639	603	-	-
2.09	Stranded Patients at End of Month - York, Scarborough and Bridlington		▲	259	251	233	233	250	252	216	213	231	247	220	77	118
2.10	Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▼	249	247	223	239	231	229	224	219	226	257	241	191	87
2.12	Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	92	82	77	82	92	92	86	61	86	94	76	36	24
2.13	Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▼	92	83	84	87	84	87	87	69	73	95	87	62	24

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
3.01	Outpatients: All Referral Types		▼	12717	13244	12791	13721	12378	12805	13635	12509	11778	13748	12433	9787	4909
3.02	Outpatients: GP Referrals		▼	6159	6303	5994	6568	6002	6179	6584	5843	5488	6272	5653	4571	1218
3.03	Outpatients: Consultant to Consultant Referrals		▼	1470	1597	1492	1501	1409	1515	1640	1579	1414	1621	1354	1105	606
3.04	Outpatients: Other Referrals		▼	5088	5344	5305	5652	4967	5111	5411	5087	4876	5855	5426	4111	3085
3.05	Outpatients: 1st Attendances		▼	5499	5735	5980	6176	5431	5475	6213	5865	5072	6040	5527	4793	2577
3.06	Outpatients: Follow Up Attendances		▼	9851	10544	9980	10928	9399	9743	10970	10728	8505	10959	9293	8848	5476
3.07	Outpatients: 1st to FU Ratio		▲	1.79	1.84	1.67	1.77	1.73	1.78	1.77	1.83	1.68	1.81	1.68	1.85	2.12
3.08	Outpatients: DNA rates		▼	5.4%	5.7%	5.5%	5.9%	5.6%	5.6%	5.4%	5.4%	5.4%	5.6%	5.5%	5.1%	3.6%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	120	▲	112	107	115	129	148	131	162	117	93	125	129	503	897
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	561	583	555	629	740	736	1014	702	808	691	616	1369	2621
4.01	Elective Admissions		▼	453	487	518	510	431	500	549	577	395	464	418	289	81
4.02	Day Case Admissions		▼	4091	4299	4120	4310	4049	4259	4708	4674	4047	4691	4372	3458	1205
4.03	Cancelled Operations within 48 hours - Bed shortages		▼	17	62	37	9	5	23	15	20	24	33	8	65	9
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▼	96	122	148	132	58	92	95	114	96	107	64	301	13
4.05	Theatres: Utilisation of planned sessions		▼	94%	89%	90%	92%	92%	93%	96%	92%	88%	87%	91%	92%	80%
4.06	Theatres: number of sessions held		▼	406	435	440	523	365	437	469	430	386	451	408	261	34
4.07	Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		▲	96	43	82	102	92	48	63	52	70	31	17	221	342

TRUST BOARD REPORT : April-2020

OPERATIONAL PERFORMANCE SUMMARY - YORK

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
5.01	Incomplete Pathways		▼	78.3%	78.6%	76.6%	75.5%	74.8%	74.5%	73.9%	73.2%	73.6%	72.4%	71.8%	68.0%	57.0%
5.02	Waits over 52 weeks for incomplete pathways		▲	0	0	3	0	1	1	0	0	0	1	0	19	104
5.03	Waits over 26 weeks for incomplete pathways		▲	1858	2054	1959	2125	2513	2771	2705	2694	2881	2830	2817	3208	4154
5.04	Waits over 36 weeks for incomplete pathways		▲	509	494	529	499	690	709	865	948	1010	960	954	1229	1854
5.05	RTT Total Waiting List (RTT TWL)		▼	19296	19735	19948	19655	20118	20538	20387	19807	20651	19950	19841	19161	17091
5.06	Number of patients on Admitted Backlog (18+ weeks)		▲	2351	2413	2494	2834	2883	3032	3012	3057	3121	3116	3132	3451	4144
5.07	Number of patients on Non Admitted Backlog (18+ weeks)		▲	1839	1815	2105	1975	2185	2206	2302	2246	2332	2400	2466	2687	3207
5.08	Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)		▲	-	-	-	-	-	-	12.1	12.5	12.5	12.6	12.5	14.2	18.1

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
6.01	Cancer 2 week (all cancers)	93%	▼	90.0%	84.9%	82.7%	88.8%	94.1%	93.1%	95.7%	94.5%	95.6%	95.1%	96.1%	90.7%	-
6.02	Cancer 2 week (breast symptoms)	93%	▼	79.6%	84.9%	97.6%	95.2%	98.9%	98.1%	98.0%	97.6%	98.4%	97.4%	99.1%	95.3%	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	▼	97.8%	98.0%	98.5%	98.9%	99.4%	99.5%	99.0%	96.3%	97.5%	99.0%	100.0%	97.4%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▲	93.8%	91.7%	88.5%	93.5%	86.4%	100.0%	96.6%	97.6%	83.9%	80.0%	93.2%	97.0%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	◀▶	100.0%	98.5%	100.0%	100.0%	100.0%	100.0%	98.8%	98.6%	100.0%	100.0%	100.0%	100.0%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▲	87.6%	84.4%	87.0%	84.6%	81.2%	83.3%	79.1%	78.4%	82.6%	80.0%	75.1%	84.5%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	▼	100.0%	92.3%	100.0%	100.0%	91.8%	100.0%	98.0%	96.9%	86.4%	87.1%	96.8%	96.6%	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▼	70.1%	66.1%	69.3%	65.5%	62.4%	61.7%	67.6%	70.1%	73.4%	65.0%	74.3%	71.5%	-

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Resources Committee – 19 May 2020
Resources Committee Minutes – 21 April 2020

Attendance: Jennie Adams (JA) (Chair), Lynne Mellor (LM), Jim Dillon (JD), Andrew Bertram (AB), Kevin Beatson (KB), Polly McMeekin (PM), Delroy Beverley (DB), Andrew Bennett (Abe), Lynda Provins (LP) (minute taker).

The following staff were stood down from attending due to the Covid 19 situation: Graham Lamb, Adrian Shakeshaft, Steven Kitching

Apologies for Absence:

1. Welcome

JA welcomed everyone including Delroy Beverley, the new Managing Director of York Teaching Hospital Facilities Management LLP and declared the meeting quorate. The meeting was shortened and the attendance was slimmed down to key personnel.

2. Declaration of Interests

There were no new / changes to the declarations.

3. Minutes of the meeting held on 17 March 2020

The minutes of the meeting held on 17 March 2020 were approved as a correct record subject to the following amendment:

Page 11 - Digital Non Covid Report - LM suggested that it would be worth exploring the possibility of becoming part of this programme. AS explained that KB had examined the Programme and that the decision was not to take it forward but agreed that this should be explored further – should read:

LM suggested that it would be worth exploring the possibility of becoming part of this programme. AS explained that the digital aspirants were chosen centrally.

4. Matter Arising/Action Log

JA noted that actions will be reassessed following the end of the pandemic.

DB noted that he and his staff will still be working towards the due dates in the action log.

Any matters arising would be picked up during the meeting.

5. COVID 19 Updates

Workforce

Staff Absence – PM provided some headline figures:

- Staff absence in February was 4.3%
- 750 individuals off sick, 570 relating to Covid which is just over 8% mark (7 April)
- Staff testing is ahead of other Trusts in the area with capacity for approximately 64 tests per day which will increase to 96 by the end of April However, there is a process bottleneck which is being dealt with. The majority tested were able to be brought back to work initially.

Wellbeing – PM noted the following:

- Support sessions are being provided by clinical psychologists;
- Staff are reporting that webex sessions are not working well and that they prefer face to face;
- Risk assessment following trauma (RAFT) circa 115 sessions provided last year - 20 provided this year;
- Time in Post Incident (TiPi) – pause at the end of the shift has been introduced which supports the identification of stress;
- Both RAFT and TiPi provide a shortened route into Occupational Health;
- Resilience coaching being provided;
- Free car parking and pack lunches being provided for staff;
- Free accommodation for staff which has been taken up on 65 occasions.

Recruitment – PM stated the headlines are:

- 427 applications are being processed, 141 in facilities;
- The BBS (Bring Back to Service) Staff return rates have been disappointing as individuals are being prescriptive about what they are willing to do – currently the Trust has taken on 6 nurses and 5 doctors. Experience of this facility is consistent across the region. ;
- 90 students are being taken on, 64 3rd year nursing students and 18 final year medical students.

Personal Protective Equipment (PPE) – PM reported that this is a significant challenge for the Trust, but a delivery of 1000 category 2 items was expected today.

AB stated that at York a discrete swipe access PPE store room has been set up, which during the day 2 individuals are monitoring and coordinating deliveries from. Out of hours arrangements are also in place. At Scarborough similar arrangements have been put in place uning the main stores function. He noted the Trust was unable to order any PPE as this was all being handled nationally. The Trust has to report daily and this is assessed nationally and stock pushed out to Trusts. AB stressed that at no point had the Trust run out of stock, but currently some stocks are low and an example of this today would be plastic aprons. The Trust currently holds 15 rolls (200 per roll) which will be used up today, however, a delivery of approximately 400 rolls of these is expected later today, but there is no guarantee. AB stated that as a backup, Nestle have been contacted and a small team is trawling the Trust for any stocks held elsewhere in the Trust. The Trust currently has 3 to 4 days worth of gowns and 2 days worth of level 2 masks.

JA was concerned that the Board did not have sight of these stock levels and asked how the Board could be provided with this information. AB responded that the position can change by the hour and this would represent a huge amount of information which would fill inboxes. AB will look at what can be provided. JA asked if the data being provided nationally could be sent to the Board to avoid duplication of effort.

Action: AB to look at what PPE stock level information could be provided.

JD highlighted a personal contact in Hong Kong who is setting up to make 30,000 masks and who wants them to go to Trusts in this region. It was noted that he has been put in contact with the Head of Procurement.

LM stated that she was reassured by the report and it was great to see initiatives like wobble rooms being set up as mental health issues had been highlighted at the last meeting. LM noted the fantastic donations being made by GCHQ and the University of York and asked if there was anything else the Trust needed. PM responded that the biggest concern remained the lack of PPE which was a national Issue.

JA stated that it was a great report and she was really pleased about all the staff welfare initiatives, however, she was concerned about the lack of data in the report such as staff sickness and how it was moving over time. She stated that she had seen various detail in various reports and asked for this to be pulled together. PM stated that the monthly report provides the data, but that data collection needed to catch up and that it would be better next month.

JA asked if the amount of temporary staff being brought in was necessary. PM stated that absenteeism is double what it usually is so temporary staff are off setting this. She also noted that there is a huge amount of guidance which is changing all the time eg: the changes to those staff that are pregnant and now need to be deployed away from front line care.

JA also asked about staff with health issues and whether these are being taken into account. PM noted that approximately 600 clinical staff moves have been made and approximately 30 administration and back office staff. She stated that medical staff redeployment was always difficult and 2 individuals had been taken on as part of the Medical Director's team to look at this.

JA thanked PM for the changes to the BAF; however, she noted that there did not seem to be many changes to the CRR, but also noted that it would be discussed at the Board.

LM asked for the staff testing for Covid 19 to be added to BAF risk 7 – Failure to ensure a healthy, engaged and resilient workforce.

Action: PM to add staff testing to BAF risk 7.

<u>Digital</u>

KB stated that home working had doubled to 2000 since the start of the pandemic, which had placed stress on the support team so some extra staff had been taken on. The moves to the Nuffield and Ramsay sites had been partially done, but there was still more to do. He noted that the ICU had gone very quickly from paper based to digital systems which

had made a massive difference and that they were seeing quite a lot of appetite for digital working so the team were trying to support this. Video consultation now had 30 teams set up and has received positive feedback from both patients and clinicians, however, not everyone wants to be seen this way. KB stated that there are no statistics available yet, but they will be shared once available. KB also noted lots of small moves are being made to support service reconfiguration together with lots of PC and network changes. The team is trying to support colleagues the best they can.

JD stated that he was reassured by the amount of work being done especially in relation to home working. LM echoed this and thanked the team for the work they are doing.

LM hoped to see this work carry on and that technological changes would be adopted much quicker. KB stated that everything is changing and that the Trust cannot go backwards now. Things that the Trust has been asked to do nationally are now the norm and the advantages of having a digital record are being made obvious. He stated that the pace staff are accepting change is staggering.

LM asked how these transformations can be translated so that the business benefit can be seen but also sustained. AB stated that he has asked the Corporate Efficiency Team to capture and map out what has changed with regards to volume and productivity. He also noted that there is a broader transformation piece for the CCGs to pick up. His example was around diabetes and that patients are massively complying with their insulin regimes and diet so as not to be admitted which is a huge benefit to primary and secondary care.

KB noted that the substance of the BAF detail had changed, but the score had been kept the same.

JA asked whether everyone who wanted to work from home could do it. KB stated that some staff were making do (with their own equipment), but a further 100 laptops were due from the MOD so that his staff were contacting staff to see who would benefit from more help or just to see how they were doing.

JA also asked about what was happening to projects that were not related to Covid 19. KB stated that some projects have had to be delayed, but that this had been balanced by the number of projects which have been accelerated and that the Trust would come out of this situation better than it went in. He also noted that the team were involved in managing risk in patient pathways so that the massive changes can be done safely without introducing more risk.

LM stated that the greater demand on the team's time, IT infrastructure and network needed to be expressed as part of risk 5 on the BAF together with the opportunity risk for the future.

Action: KB to update BAF risk 5.

Finance Report

AB stated that the report stated that the Trust was £180k the right side of the pre-PSF position, but he noted that due to technical moves involving PDC valuations, since the paper was written, the position had further improved to £220k. AB noted that the Covid situation had been a significant contributing factor to this. The paper stated that the Trust

were in the process of claiming £2.5m which had now been confirmed and had been the only outstanding risk area.

In relation to cash, due to the emergency finance regime which had been implemented, the Trust had £90m cash in the bank which was unprecedented and was the result of two months worth of payments being received. Payments to Trusts had been made to ensure that Trusts can pay suppliers many of whom are currently reliant on Trusts as their only source of income. Trusts had been instructed to pay suppliers within 7 days where possible. Staff were being encouraged to make this happen, but currently the Trust was achieving less than 20% and this needed to increase. Communication has been sent out to all end user requisitioners to advise of this initiative and to impress the importance of receipting goods and services in a timely way.

In relation to month 1, AB stated that the Trust had been funded at cost so the expectation at the centre is that Trusts will achieve balance and there should not be any material variation. AB stated that he had also noted the working capital loan position in the paper and updated his BAF and CRR especially the scores which reflected the new funding regime.

LM thanked AB for the positive news on what had been a very challenging position previously. She wanted to know how the Trust could keep the temporary staff taken on in order to reduce agency spend. PM stated that her team will endeavor to maintain the staff, but many are just seeking to help out during the pandemic. AB stated that the NHS was experiencing a hero-like status during the pandemic and it was about continuing to use that wealth of good feeling. PM noted the huge response to the Harrogate Nightingale Hospital, but she was concerned that social care was missing out.

JD asked if another silver lining would be a change to the attitude in relation to NHS finance and whether the current finance regime would continue. AB stated that this was unknown and the plan currently was to return back to the original financial plan in August. He did note a national task and finish group that had been set up to look at the funding regime and that any benefit of the working capital debt being written off would be lost if the previous finance regime was brought back in.

JA expressed her concern at the massive swing in the Trust's finances and she asked for further assurance about the big movements in the position. AB stated that these were all listed in the report noting that £4m had been secured from NHSE linked to specialist commissioning, a third of a million from the CCGs, £2.5m from Covid payments and the pension payment of £13m had a neutral impact as the included expenditure was matched with corresponding income. AB stated that the Trust had been able to negotiate a better year-end position than originally predicted.

JA asked AB if he was happy that there was a robust system in place regarding the capture of Covid expenditure. AB stated that he was assured about the systems in place as a scheme of delegation had been created for revenue spend together with dedicated Covid cost centres which Care Group Managers and LLP staff were authorised to use. In relation to capital an A4 proforma was in use which included tests specified by NHSE/I so that spend could be attributed to Covid and all these were authorised by AB. Scheme by scheme monitoring had been put in place.

AB stated that the main worry for him was in relation to PPE. JA asked about the use of different masks as she was aware these needed fit testing. AB stated that the Trust was using its preferred masks first and holding any others for use if stocks run low.

YTHFM LLP

DB paid tribute to all colleagues saying that he had been made very welcome in the LLP and Trust. He stated that he was overwhelmed by the contribution the Trust and LLP were making during the pandemic situation and he wished to put this on record as well as his thanks for HR and OD colleagues who were supported the LLP recruitment of bank staff. Finally, DB wished to thank Andrew Bennett who had pulled together the paper which set out the current position in relation to the LLP and its client, the Trust.

DB highlighted the following elements:

- 2.1.1 set out some of the challenges in relation to medical oxygen. He noted that this was an issue nationally related to the demand organisations are facing during the Covid situation. He provided his assurance that the LLP will maintain the position and will notify the Trust of any changes;
- DB stated that stellar work was being done by the facilities element of the LLP which included services like domestics;
- 2.1.2 the relationship with HR and OD had worked seamlessly and absence recording was being done both daily and weekly;
- 2.1.3 medical engineering dovetails with 2.1.1 medical oxygen;
- 2.1.4 detailed a resource plan which included critical operating levels.

DB stated that from a Managing Director perspective things were being managed according to the situation. He noted that he will be asking some challenging questions and stress testing the business to see how responsive it was in order to set out business continuity plans which were underpinned by scenario planning. DB stated that workforce planning needed to be better.

JA stated that she had enjoyed reading the report. JD was also pleased with the report and extended a welcome to DB. LM echoed the welcome and thanked DB for the report and overview especially the fact that stress testing will be performed which she found reassuring.

DB stated that it was very useful for him to see how the LLP performed in a crisis and he commended the outstanding work by the team; however, he wished to be more assured and work through every element of the business. DB noted that KPIs will be developed to respond to the client's needs.

JA asked which were the worst affected areas in terms of sickness and whether DB was happy with the backfill. DB stated that areas of sickness absence do require better management and that the culture needed to be responsive to the needs of the staff and in his opinion there were issues around short term absence which created pressure. He assured the committee that there were some things that he would immediately start to work on.

JA asked if Covid systems in the LLP were robust as previous internal audits had shown some challenges. DB noted that revenue was authorized by himself and ABe. He noted that there were areas for improvement and work to be done to ensure elements were fit for purpose, but it was work in progress.

DB stated that he commended the work done previously, but that he would take the LLP from good to great and that risk understanding and other tools would add value.

JA thanked both DB and ABe for joining the meeting.

6. Any other business

JA noted the amendments that had been made to the Resources sections of the BAF to reflect the new circumstances - and the suggestions made by LM for consideration by Execs.

She noted that the CRR did not appear to have been amended in the same way and asked that this be brought to the attention of the Board. The committee had felt at the previous meeting that it might be better to capture all Covid risks in one place within the CRR.

7. Items for Board

PPE stock levels
Year end finances
New finance regime
Robustness of financial systems and process for covid expenses
Staff absence and wellbeing measures
Digital response
Longer term strategic lessons and opportunities

8. Time and Date of next meeting

The next meeting will be held on 19 May 2020 at 9am by teleconference. Dial in details will follow.

ACTION LOG

Meeting Date	Action	Owner	Due Date
29.05.19	Highlight new limited assurance audits in their report to the Committee.	Executives	Monthly
30.01.20 25.10.19	Provide update on GIRFT	AB	Mar 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.	DB	May/ Jun
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.	DB	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.	DB	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
17.03.20	Notes and action log of the Operational Pandemic Group (and other key groups) to be provided to Board as a form of assurance on Trust COVID response	LP	April 2020
17.03.20	LP to ensure the Contract Management Group Terms of Reference are amended.	LP	Next meeting
17.03.20	LP to discuss with Jane Money / update BAF Risk on sustainability	LP	Next meeting
17.03.20	Detailed PLACE report and action plan to be received at the next meeting.	YTHFM	Next meeting
17.03.20	Committee members to feedback suggestions for digital metrics for inclusion in IBR	All	
21.04.20	AB to look at what PPE stock level information could be provided.	AB	Completed
21.04.20	PM to add staff testing to BAF risk 7.	PM	Completed
21.04.20	KB to update BAF risk 5.	KB	Completed

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 May 2020
Quality Committee Minutes – 21 April 2020

Attendance: Lorraine Boyd (LB) (Chair), Lynda Provins (LP), James Taylor (JT), Heather McNair (HM), Jenny McAleese (JM), Wendy Scott (WS), Lucy Turner (LT), Stephen Holmberg (SH), Donald Richardson (DR) (observation), Rhiannon Heraty (RH) (minutes)

Apologies for Absence: Lynette Smith (LS)

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 17 March

LP said she would email out the March minutes for comment following the meeting and action log from 17 March to confirm accuracy and update actions due to shortened meeting time.

4. Matters arising from the minutes

No matters discussed as LP agreed to email minutes and action log out for comment following the meeting. JM said that the action log will be crucial once things return to normal.

5. COVID-19 Update

WS gave an overview of attached reports for information and assurance and discussed the impact of Covid-19 on performance. Paper B also included performance information for year to date re coronavirus and the impact on ED and business as usual. WS advised that Paper C was based on capacity and demand modelling and how to respond to the surge in activity. WS said that LT has done a lot of work around this and it has been submitted to NHSE. LT said the Surge Plan has three stages and that we have been in Surge 2 for a number of weeks. WS said there is a body of work around cancer services and that there

is a lot of national guidance around how to manage cancer services in both primary and secondary care. WS acknowledged this as an area of concern. SH asked WS about the number of cancer patients that aren't being referred and WS said the two week wait referrals are down by 70%. WS said that if a patient presents in primary care, it is the GP responsibility to talk to the patient and decide whether or not to delay referral (also known as 'safety netting'). WS said there are some concerns around the reduction in referrals as a result and said she has spoken to HCV about the message being sent to the public but still needs to seek further advice. LT added that screening programmes are being stepped down and that may result in delayed diagnosis. SH said we may be faced with a large number of delayed referrals as well as a backlog of patients that were already on the waiting list but had been delayed once things return to normal and asked how this will be handled. WS said there is internal work on a recovery plan in progress but the timeline cannot be confirmed as we are currently mandated to lockdown in line with national guidance. JT said that in terms of fast-track pathways, 95% or more of referrals are negative. LB asked if patients were referring themselves to GPs and added that GPs should be risk managing the situation. JM said it is a delicate subject and acknowledged the good work being done, and asked about the economic position re whether people and resources are being fully utilised. LT said we are continuing as much cancer work as possible and confirmed Nuffield as a cold site until the end of June with the possibility of Ramsay Health for orthopaedics, but added that there is still no official national 'go-ahead ' for business as usual.

HM said she is mindful of staffing and that if we need to open up more capacity then more nurses are needed. HM said that we may be underestimating the stress of the current situation on nurses and asked how we can give the nurses on Covid wards a break. JM acknowledged this as a fair point and added that the plateau is likely to go on for a long time. LB said the main assurance is that conversations are taking place and that these concerns are not going unnoticed. WS said that part of the recovery plan is around what can be done now and recognizing the step-down process in case of a surge and said she will be happy to share this plan at the next Committee meeting. JT said that there are caveats to add, such as PPE risk, and confirmed that there are daily checks on this. JT added that if surgery provision is to be increased, we will need more consumables, which is a risk and requires thoughtfulness. JT said there are medical staff available but that other staff such as anaesthetists will need to be redeployed, which will increase the pressure on and challenges for staff. JT said there are some false assurances around cold wards, which do still have outbreaks in both staff and patients. WS said she would be happy to take any questions outside of the Committee meeting. LB acknowledged that the situation is more complex than was initially thought and that it is important to balance all our resources.

JM asked about PPE and JT confirmed that it was checked this morning (21 April) and we had run out of aprons (PPE2) but that 30 mins before Quality Committee commenced there was a delivery of 11,000 aprons. JT said we are working day to day and that there can be shortages, but that we do not know what will arrive until it is delivered. JT added that we have not yet run out of any critical kit so staff have remained compliant with guidance, but that the new national guidance around face masks is a concern. HM said that we have been very resourceful – JT found 2,600 washable gowns, which have gone to ICU and ED, as well as additional gowns of the right material that are being adapted by the York Sewing Circle. HM added that we are in a better position than some organisations and that we may need to offer mutual aid. WS added that we have received a lot of PPE from the private sector as well as offers from local companies. HM said that Colin

Weatherill has been sourcing and issuing respiratory masks and agreed with JT that the national debate around wearing masks in public may cause additional pressure. JM asked about other consumables such as oxygen and drugs and JT confirmed we have a daily oxygen order with a maximum capacity of 1800 litres per minute. JT added that we could exceed capacity if there are a lot of patients. The capacity is the same across sites but there are currently more patients on York site than on Scarborough site. SH asked about the new Nightingale Hospital in Harrogate and HM said there has been a lot of activity in the last fortnight around pulling together cohorts of staff. HM said that HCV are identifying staff for 60 beds and that 22x WTE staff have been identified and completed their training on Wednesday/Thursday last week, and were signed off by NHSE on Friday. Final sign-off confirming as fit-for-purpose was completed yesterday. HM said there is also a conversation around how they can be utilised once things return to normal.

LB asked about testing and JT confirmed that there is reasonable local capacity for testing as well as a plan to open a local testing centre in York on the A19 junction at McArthur Glen shopping centre. JT said we will be able to test staff or relatives on 14-day isolation as well as some symptomatic staff and added that McArthur Glen should be ready before the end of April. JT confirmed capacity in both Scarborough and York for swabbing/testing and said that just over 50% of staff have been able to return to work earlier than their isolation period. HM discussed staffing challenges and confirmed that Scarborough has seen a lot of sickness – at one point half of ward sisters from non-Covid wards were all off at the same time, confirming that there is still risk of transmission on cold wards. HM said that sickness will likely continue for a long time and this needs consideration. HM said that there have been anecdotes from nursing staff around how traumatic it is to be with dying patients on a regular basis without any relatives present, and that more patients are dying. LB asked if there is short-term support and HM confirmed yes but that more is needed and this must be picked up when things return to normal. JT shared mortality rates with the Committee that concentrated around Covid and non-Covid cases.

JM asked JT, WS and HM what they were most concerned about. JT said his main concern was staffing and how to get them through the pandemic and then tackle the huge amount of work waiting once things return to normal. JM agreed that staff were already under pressure before the pandemic. JT said that ED and medical staff are all working night shifts and all wearing PPE, which puts a physical and mental strain on them. SH asked if anyone is looking at changes in practice as a result of Covid-19 and how practice can be driven by these changes post-pandemic, such as virtual meetings. JT said a good number of medical staff are recording ‘lessons learned ’during the pandemic. HM said that Simon Morritt had asked Lucy Brown to gather focused feedback from staff to use for ‘Clever Together’.

Action: WS to share recovery plan at next Committee meeting

The Committee

- **received and discussed COO, MD & CN updates**
- **noted the IP activity associated with the CV19 pandemic and were assured by progress to support this activity outlined to date**
- **received and discussed the Surge Plan, gaining assurance from the efficacy demonstrated by triangulation with daily sitrep data received**

- **noted the reduction in A/E attendances and associated gaps in assurance around the potential safety impact of this reduction. Assurance gained by the ongoing work to clarify and mitigate this risk.**
- **gained assurance from the Trust response to the national directives to stand down routine planned care and processes put in place to minimise clinical risk and ensure good communication and support to patients**
- **commend the acceleration of the outpatient transformation project and increased availability of technology based consulting techniques**
- **received the Independent Sector Utilisation paper**
- **gained assurance from the collaborative working with primary care and the independent sector**
- **received and discussed Cancer Management During Pandemic paper**
- **were assured by the ongoing focus on emergency care and cancer care**
- **noted the increase in long waits for treatment and likelihood of further deterioration in this metric as a result of stand down of elective surgery aligned with NHSE/I directives**
- **noted the deterioration in RTT, as anticipated**
- **noted concerns re reduction in referrals, including suspected cancer (TWW) referrals, leading to reduced total waiting list and gaps in assurance around the clinical risks associated with this**
- **were assured that processes to identify and minimise patient harms as a result of changes in capacity and delivery models are clinically focussed and clinically led**
- **support the clinically driven approach to prioritisation of resource including theatre utilisation**
- **noted concerns re staff wellbeing. Metrics do not fully reflect the pressures they are working under. Gained assurance that support available in the immediate and planned to increase going forward.**

Escalation to the Board

- **ensure Board fully sighted on the complexity and scale of the challenges ahead as suspended activities are stood back up. Staff wellbeing and resilience are of particular concern, as well as balancing of resources, while continuing to maintain safe service**

6. Any matters of urgency

CQC Action Plan - HM confirmed that we have made significant progress against the CQC Section 29 breaches and that this was submitted today. HM added that although routine inspections are suspended, the CQC can still visit if they suspect patients are not being kept safe but HM is confident that enough has been done to satisfy in the short term and lift breaches. SH asked if we can evidence enough structural change re ED department to ensure we are in a better position - HM said that we are in a different position because ED has fundamentally changed in response to Covid and that CQC are sympathetic to this.

The Committee

- **received and discussed the CQC Action Plan**

IPC Report - HM confirmed that she would send IPC report following Committee meeting and said that Covid is the new focus of the report. There was a norovirus outbreak that was closed quickly. HM confirmed that two 8a posts have been filled for IPC – one in York and one in Scarborough – and are due to start in July. SH asked about C.diff and asked if there is any opportunity given the low bed occupancy to do more work and HM confirmed that empty wards are being HPV'd and remedial work is being done.

The Committee

- **received the IPC Report electronically following the meeting**

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

JM said that staffing and support needs to be escalated – WS and HM agreed and said that apart from staff health and wellbeing, the recovery plan is dependent on staff and capacity. HM said that returning to normal is a concern.

Items for information:

8. Corporate Risk Register & Board Assurance Framework

LB said that most of the additional Covid issues are being addressed and that there are no changes to be made.

9. Health & Safety

This item was for information only and no further discussion by Committee was required.

10. Any other business

JM, SH and LB thanked all staff for facing enormous pressure and danger. SH asked if any staff had been very ill or died – HM confirmed that one paramedic has died in Scarborough ICU and noted that he was older with underlying comorbidities, and that one pregnant staff nurse became ill but is now recovering. LB asked if there was a system in place to record these cases and Committee confirmed yes. JT added that mortality work is still being addressed as normal.

11. Time and Date of next meeting

The next meeting will be held on 19 May 2020 by teleconference. Dial-in details will follow.

Action Log

Date of Meeting	Item No.	Action	Owner	Due Date
25/9/19	1.	Progress report on 14 hour consultant review	JT	Ongoing
31/7/19	2.	Provide more assurance around outputs & triangulation with numbers - **We have now purchased the Perfect ward and will launch in the first quarter - The nursing dash board will be in use along side**	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	Completed
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	Completed
27/11/19	6.	HM, JT & LB to agree changes to structure and content of meeting	HM, JT LB	~~Mar 20~~ Sept 20
27/11/19	7.	LB & HM to discuss inviting knowledgeable staff to meeting	LB HM	~~Mar 20~~ Sept 20
21.01.20	8.	FJ to provide Duty of Candour update at Feb meeting - **Completed - in the Performance Pack and FJ attended March Audit Cttee to give and update**	FJ	Completed
21.01.20	9.	LP to look at agenda and work programmes going forward	LP	~~Feb 20~~ Sept 20
21.01.20	10.	LP to invite Care Group Quality chairs to March meeting	LP	~~March 20~~ Sept 20
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	Completed
17.02.20	17.	FJ to provide an update to Audit Committee at March meeting – **Completed - FJ attended Audit Cttee and provided and update**	FJ	Completed
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	Completed
17.02.20	19.	HH to speak to RC re an IPC secondment placement from barracks	HH	Mar 20
17.03.20	20.	LR to obtain Nursing shift areas of concern from Non-Executive Director Jennie Adams for HM to investigate and report back.	LP	Completed
17.03.20	21.	JT to provide an update report on the plans to imbed the internal audit consent into the clinical audit care groups.	JT	Sep 20
17.03.20	22.	JT to provide update in 3 or 6 months on NICE Action Plans which were due in March 2020	JT	June 20 or Sep 20
17.03.20	23.	JT to report on three baseline assessments on NICE guidelines	JT	June 20
21.04.20	24.	WS to share Trust Covid-19 recovery plan at next Committee meeting	WS	May 20

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York Teaching Hospital
NHS Foundation Trust

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

Committee/Group: Resources	Date: 19.05.20	Chair: Jennie Adams

Agenda Item	Issue and Lead Officer	Receiving Body	For Recommendation or Assurance to the receiving body
Finance Report	**Month 1 position and looking ahead.** The Covid financial regime has been extended until end October and likely for the full year. The formula for payment ensures a breakeven I&E position. The Trust claimed additional covid revenue expenses of £1.4m – as a % of income this is in line with the national average of 4-5%. With the CiP programme currently suspended, the efficiency team are working with Care Groups to embed transformational programmes that have accelerated due to new ways of working during the pandemic. **Covid Capital:**The committee noted that around £2.3m of capital spending had been approved and deployed under the Covid capital regime. This had "liberated" the Trust to make some key changes to IT and physical infrastructure precipitated by the covid reconfiguration. A number of these investments will continue to be of value after the pandemic. E.g, improved capacity for mobile working and video consultation; separation of hot and cold patient pathways. Lessons have been learned around streamlining approval processes for priority capital projects going forward. **Systems and Processes** NHSE/I have requested that Internal Audit verify systems and processes in place for authorising and claiming Covid expenses.	Board	**Assurance** : Finance Team achieved accreditation by Future Focus Finance programme of NHS Leadership Academy. Covid regime ensures breakeven during the crisis. IA audit will add independent assurance to covid claims process. PPE – not at crisis level and actively monitored. Trust is front loaded with cash from centre **Gaps/concerns** How to keep hold of positive changes from Covid experience locally and nationally. Need to become slicker at paying suppliers in timely way (ie within 7 days under new regime) -requires rapid confirmation of delivery. The Committee remains very concerned about small capital allocation for backlog maintenance in capital spending plans for current year. Work continues on scoping the scale and risk of this backlog**.**
LLP Report	Committee received a report detailing **current capacity to deliver key services** during the crisis – showing that staffing , whilst a challenge, is adequate and above critical levels. Additional staff have been recruited to bolster catering and domestic areas – where establishments are most stretched.	Board	**Assurance:** Temporary workforce in-fill is progressing well. No pressing supply/equipment issues of note LLP liaising with partners in the Trust and externally re

	Supply of medical equipment and key consumables is being maintained. Oxygen supplies are significantly above demand and plant is receiving special attention. **Site reconfiguration** work has been successful and is ongoing. **Staff sickness absence** is down slightly and Trust OH swabbing service had worked well. The committee noted the **absence of KPI data** around areas of concern in the past (catering hygiene and cleanliness audits).New cleaning products are being trialled in Covid wards.		"stepping back up" facilities. EPAM meetings have resumed. **Gaps/Concerns**: Absence of KPI data especially on areas of past concern. Some variation in cleaning standards between sites was a concern. Challenge around ventilation/cooling in Summer for staff and patients. Committee queried enhanced roles for Brid & Stadium
Workforce Report	**Staff absence** remains an issue with around 463 of the 736 staff off due to covid/family covid. Includes 112 shielded staff (plus 68 in LLP). Current 7.2% sickness rate in Trust.vs 8% last month. – with caveat this data is taken from sitreps not normal ESR. Not all covid absence captured due to inability to code for covid specific stress. **Staff testing** bottlenecks have been resolved. 24 hr turnaround on both sites. More staff testing will be required – asymptomatic/non typical staff may be added soon. Negative test results for staff are rising – this week 72% . **Mental health support** and staff benefits continue to expand and get positive feedback. **Issue of protection of BAME frontline** staff is challenging given high % within medical workforce – especially at SGH. Some support is being offered but referrals to OH for anxiety within this group is growing. Need to support staff and managers to **adapt to home working** mentally. Committee queried measures to ensure staff safety now and **in step up.**	Board/ Quality Committee	**Assurance:** Evidence of staff support, staff testing and sickness levels peaking. Stat/Mand training compliance for some key areas improving (life support, DNACPR) – a CQC request. Task and Finish group to explore adjustments to environment and practice to enable step up **Gaps/Concerns** Data within new IBR on unfilled nursing shifts was a concern and needs to be checked for accuracy. BAME staff – a concern about how to balance needs of the service with risk to the physical and mental health of these staff. Stress/anxiety support for longer term effects Capacity and support for home working not yet optimal
Digital Report	**Capacity for remote working** has been dramatically increased, but more requests are outstanding and team are continuing to add to capacity. **Increased capacity for video consultations** made available with 400 interactions so far – need to increase both capacity and usage where appropriate... Some projects now slipping due to Covid priority. Conversion to **Windows 10** only 30% - must reach 100% by October. **Covid capital** has enabled significant advance in some digital projects.	Board	**Assurance:** Actions to increase mobile working capacity, video consultations, patient tablets and other operating/governance systems **Gaps/concerns** Need for the business to drive transformation begun by covid – will require support of key senior leaders. Slippage on some key projects. Board support to shift culture to new ways of working.

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

Committee/Group: Quality	Date: 19.05.20	Chair: Lorraine Boyd

Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	For Recommendation or Assurance to the receiving body
5	Significant impacts of Covid19 on KPIs, as anticipated, discussed. Planned care has been suspended through April in line with national guidance, resulting in a rise in waiting times and an expectation that this will deteriorate further. Plans to address the reset and restoration of services are being developed in collaboration with primary care. Cancer activity has been prioritised and significant challenges identified. These are being mitigated by clinical prioritisation, site reconfiguration and utilisation of private sector and system partner assets. ECS not an issue currently but as normal activity resumes it may become so again. There is concern about the unmet, hidden need that will reemerge in the coming weeks and months. Fast track and urgent care remain the priority	Board	For assurance: the Board to be fully sighted on the significant impact of Covid19

5	Operation Reset and Restore was presented and discussed. The magnitude of the task to restore services and the lengthy timescale required was evident. A three phased approach is being followed and is underpinned by six core principles. We remain in the response phase, moving towards the recovery phase. There is significant work being undertaken to identify the risks and limitations to operational capacity. The focus of planning activity will evolve over the coming weeks as the immediate pandemic needs recede	Board	Recommendation: further discussion as planned through Board workshop Assurance: continued development of clinical risk assessments to inform prioritisation of treatments Assurance: collaborative work with HCV to ensure consistency in approach and mutual support Assurance: TOR and governance structure to support Operation Restore and Reset Risk: second wave of pandemic Risk: availability of resources e.g. PPE, drugs, supplies Risk: workforce Risk: infection risk management Risk: patient support and engagement
6	CQC Action Plan 1. Good progress being made on mental health risk assessments on both sites although progress in Scarborough relies on review of commissioned services from TEWV. 2.Access and flow improved but sustainability of improvement post Covid remains unknown 3. Staffing across children's services in Scarborough remains challenging. CQC are fully aware of these issues, some of which are national and not unique to the Trust, and there is ongoing dialogue red solutions. 4. Nurse documentation has been updated and reverted to paper recording whilst awaiting digitalisation, anticipated to be January 2021. 5. Datix reporting actions completed 6. Staffing of medical wards at Scarborough currently compliant but sustainability post Covid remains an unknown	Board	Assurance: ongoing focus on CQC Action Plan Assurance: ongoing constructive dialogue with CQC Risk: uncertainty on how the process will be monitored and managed in the coming months in the light of the national pandemic response Risk: mental health support in A/E requires commissioner action Risk: availability of suitably trained staff nationally

6	IPC update report was discussed. The operational capacity of the team is stretched. There is an increase in outstanding Post Infection Reviews, which the Trust have elected to continue with, although CCG has suspended them. PHE have issued an IPC BAF which is not currently mandated. Will be completed and brought to Board for discussion. IPC risk register being currently reviewed and a number of adjustments are anticipated	Board	Assurance: continued focus on IPC as a priority Assurance: no immediate areas of concern identified against PHE Covid19 related IP&C guidance Risk: impact of Covid 19 on operational capacity of IPC Team
6	Adult Safeguarding Annual Report was discussed. The national replacement of Deprivation off Liberty Safeguards with Liberty Protection Safeguarding remains outstanding and the timeframe for introduction is uncertain. The interim period is being overseen by the Safeguarding Adults Strategic Group to ensure a safe system in the interim period. Impacts of Covid19 were outlined, specifically increase demand, and potential missed safeguarding opportunities, risk to compliance with staff training and external delays in completion of LeDeR reviews	Board	Recommendation: Board to approve report Recommendation: Board to approve sharing of progress externally to specific bodies and the public under the Safeguarding Adults Multi-agency processes Assurance: oversight by Safeguarding Adults Strategic Group Assurance: systems in place to manage risk of increased demand and missed opportunities Assurance: multi agency working to support the recovery period Risk: uncertainty of introduction of LPS replacing DoLs Risk: operational capacity Risk: limitation of progress against CQC MD11 and SD43

6	Safeguarding Children & Children Looked After Annual Report was discussed. There has been a rise in activity and a reduction in operational capacity just prior to and during the pandemic period, leading in particular to pressure on timely delivery of Initial Health Assessments and their quality assurance. There has been legislative changes, strengthening responsibilities towards children at risk during the pandemic and adaptations have been made within the Trust team to continue offer the majority of services. The Trust is no longer a provider of Child Sexual Assault Assessment Service	Board	Recommendation: Board to approve report Recommendation: Board to approve sharing of progress externally to specific bodies and the public Assurance: Trust representative at all levels of local Safeguarding governance Assurance: adaptations within Trust teams in response to legislative change Risk: operational capacity Risk: timely delivery and quality assurance of Initial Health Assessments
6	Nurse Staffing Report discussed. The report highlighted the Trust response to the capacity demands and flexible skills required to manage the Covid19 pandemic , continued work on safe staffing, particularly in relation to Scarborough Hospital Medical Wards and RSCN cover in both EDs and continued focus on Nurse training and recruitment processes Formal national nurse staffing reporting is suspended but assurance given that this continues to be a focus internally.	Board	Assurance: continued constructive engagement with CQC re safe staffing concerns Assurance: continued focus on Nurse training and recruitment
6	Complaints Annual Report was discussed. Continued concern was expressed re timeline of response to complaints, which is being addressed through targeted work with Care Groups IA found robust processes were in place to manage complaints but weakness was identify re learning and tracking actions. This is being addressed by the development of dashboard at Care Group level.	Board	Recommendation: Board to approve report. Assurance: IA report on complaints process Assurance gap: learning and tracking actions Assurance gap: timelines of response to complaints
6	Quality Priorities for 2020/21 were discussed. They were broadly agreed but it was acknowledged that in the light of the pandemic that there was greater uncertainty around what our priorities for the year should be as this has been such a catalyst for change in every respect and that we must be willing to be more flexible to ensure use of our resources to best effect as the future emerges.	Board	Assurance: further review to ensure priorities reflect post Covid world

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 May 2020
Medical Director's Report – Public Meeting

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 report

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

Executive Summary -Key Points

NICE Guidance
For information – we have received new NICE guidance related to Covid 19 the specialties have received an action on this. See Appendix A

Sepsis
Screening and antibiotics within the hour has improved in our EDs.
Screening in the in-patient wards has decreased slightly but antibiotics within the hour has improved. A report is attached see Appendix B

Ceiling of Care
Ceiling of Care has improved. Further improvement has been requested. A report is attached see Appendix C

Medicines management with CoVID-19
A report is attached on management of Covid related medicine shortages for assurance. See Appendix D

Recommendation

Board of Directors are asked to note the Medical Directors Report for May 2020.

Author: Mrs. Helen Noble, Head of Patient Safety

Director sponsor: Mr. James Taylor, Medical Director

Date: May 2020

1. Introduction and Background

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

2.1 Consistency of Care

2.1.1 Clinical Audit

There have been no National/ Quality Account Audit reports issued since the beginning of April, and it has been indicated that no further reports will be published for the foreseeable future.
Data Collection on National/ Quality Account Audits has been suspended nationally for all current audits, with the exception of SNAP.

2.2 Early Detection & Treatment

2.2.1. Sepsis

A sepsis report is attached for information. See Appendix B

2.2.2 Ceiling of Care

A Ceiling of Care report is attached for information. See Appendix C

2.2.3 Medicines management with CoVID-19

A medicines management report is attached for information. See Appendix D

2.3 Learning from Death

Mortality – a verbal update will be given at Board

3. Recommendations

Board of Directors are asked to note the Medical Directors Report for May 2020.

York Teaching Hospital
NHS Foundation Trust

Appendix A

Board of Directors – 27 May 2020
NICE Guidelines

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 a summary on the current situation for decisions around NICE Guidelines in York Teaching Hospital Trust.

Executive Summary – Key Points

14 new or updated COVID NICE Guides have been issued during April 2020

Recommendation

Quality Committee is asked to note the Medical Directors Report for May 2020.

Author: Fiona Jamieson, Deputy Director of Healthcare Governance

Director Sponsor: Mr. James Taylor, Medical Director

Date: 19th May 2020

1. Introduction and Background

14 new or updated COVID NICE Guides have been issued during April 2020 and distributed to medical specialties for appropriate action.

Ref no	Title	New?	Status
MTG048	PneuX to prevent ventilator-associated pneumonia	New	Not Relevant
NG172	COVID-19 rapid guideline: gastrointestinal and liver conditions treated with drugs affecting the immune response	New	Circulated to Care Groups
NG171	COVID-19 rapid guideline: acute myocardial injury	New	Circulated to Care Groups
NG170	COVID-19 rapid guideline: cystic fibrosis	New	Circulated to Care Groups
NG169	COVID-19 rapid guideline: dermatological conditions treated with drugs affecting the immune response	New	Circulated to Care Groups
NG168	COVID-19 rapid guideline: community-based care of patients with chronic obstructive pulmonary disease (COPD)	New	Circulated to Care Groups
NG167	COVID-19 rapid guideline: rheumatological autoimmune, inflammatory and metabolic bone disorders	New	Circulated to Care Groups
NG166	COVID-19 rapid guideline severe asthma	New	Circulated to Care Groups
NG165	COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community	New	Circulated to Care Groups
NG164	COVID-19 rapid guideline: haematopoietic stem cell transplantation	New	Circulated to Care Groups
NG163	COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community	New	Circulated to Care Groups
NG161	COVID-19 rapid guideline: delivery of systemic anticancer treatments	Update	Circulated to Care Groups
NG160	COVID-19 rapid guideline: dialysis service delivery	Update	Circulated to Care Groups
NG159	COVID-19 rapid guideline: critical care	Update	Circulated to Care Groups

APPENDIX B

York Teaching Hospital NHS Foundation Trust

Board of Directors – 27 May 2020
Quarter 4 Summary Sepsis Report

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

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

Executive Summary – Key Points

- National Contract Audit commenced in August 2019
- The results of the quarterly audit is fed back through the Sepsis Steering Group

Highlights:

- Compliance with sepsis screening patient in the Emergency Departments has improved from 92% to 97% and the administration of antibiotics within the hour has improved from 56% to 61%
- Compliance with sepsis screening in the in-patient wards has decreased from 71% to 68% but the administration of antibiotics within the hour has improved from 57% to 59%

This is a summary report. The full report has been presented at sepsis steering group and shared with the care groups and Yorkshire Ambulance Service.

Recommendation

Quality Committee is asked to note performance in the screening and treatment of Sepsis.

Author: Clare O'Brien, Lead Nurse for Patient Safety

Director Sponsor: Mr James Taylor, Medical Director

Date: May 2020

1. Introduction and Background

The National Contract kept the same parameters as the previous CQUIN and requires Trusts to audit 50 inpatients, and 50 Emergency Department patients per quarter. Identification of patients with sepsis is closely linked to the introduction of NEWS2. For the purpose of improved learning more cases than the required 50 were audited.

Whilst the national guidance states time zero is when the diagnosis of sepsis is made, it was agreed that in the patients best interests the Trust would use "time zero" as being the time of the first NEWS of 5 or above.

2. Audit

The new Sepsis screening tool was introduced across the Trust on 7 August 2019 using the internationally agreed definitions for sepsis and red flags.

Both the inpatient and ED audits were carried out by clinical staff, able to exclude patients who had clear causes for the high NEWS other than sepsis. Cases in which sepsis was considered but there was a clear emergency which needed to be managed with prior to antibiotic administration have been excluded e.g. emergency airway management.

2.1 Emergency Department audit

363 cases were retrospectively audited which identified 125 patients eligible for the audit. This audit includes:

- Patients that have an arrival NEWS of ≥5 and have red flags for sepsis
- Patients that on arrival do not have a NEWS of ≥5 but that deteriorate whilst in the Emergency Department. In these cases time zero is the time of the first NEWS ≥5

% of patients that met criteria and were screened		
	2019/20 Q3	**2019 Q4**
TRUST	92%	95% ↑
Scarborough ED	95%	95% =
York ED	63%	95% ↑

% of patients that were screened & received IV antibiotics within the hour		
	2019/20 Q3	**2019/20 Q4**
TRUST	56%	61% ↑
Scarborough ED	63%	56% ↓
York ED	50%	66% ↑

In the interest of improved learning a more in-depth audit was carried out in both ED's during February 2020. This audit included recording/ recognition of the NEWS score calculated by Yorkshire Ambulance Service, timeliness of sepsis screening, administration of appropriate fluid boluses, insertion of catheters and correctly completed ED discharge letters. This data has been fed back to the Emergency Departments and to the Yorkshire Ambulance Service to assist improvement planning.

2.2 Inpatient audit:

132 cases were highlighted from Systems and networks as having a NEWS ≥5
32 of these met criteria for inclusion i.e. had red flags for sepsis
Therefore, the audit methodology of 50 patients has not been met. This fits with national statistics

	2019/20 Q3	**2019/20 Q4**
TRUST (inc. community inpatient units)	71%	68% ↓
Scarborough	100%*	85% ↓
York	60%	64% ↑

*this was based on auditing of 50 patients but did not adequately reflect the true picture

This audit information is taken from CPD and it is accepted that there may be further information in the paper notes that show that screening has been considered.

% of patients that were screened, met criteria for treatment and received IV antibiotics within the hour			
	2019/20 Q2	**2019/20 Q3**	**2019/20 Q4**
TRUST (inc. community inpatient units)	43%	57%	59%↑
Scarborough	33%	50%	66%↑
York	38%	100%*	56%↓

*this was based on auditing of 50 patients but did not adequately reflect the true picture

3. Learning and action from audit

3.1 Emergency department

3.1.2 There is a discrepancy between the number of patients receiving screening & antibiotics and those that have a suspicion of sepsis recorded in the notes. Some patients were found to have been screened but with no indication of why, whilst others had sepsis documented as a differential diagnosis but were not screened and did not receive antibiotics.

Action: this is being further investigation to better understand why this happens in order to focus improvement.

3.1.3 There remains a delay in patients receiving IV antibiotics within an hour of trigger for sepsis. Speaking to staff and observation shows some consistent themes:

- Staff report difficulty in finding a nurse to second check IV medication after it has been prescribed.
  Action: a reminder has been sent to all staff that doctors and ACP's can be second checkers
- IV antibiotics are often administered as an infusion which requires IV pumps, however most IV antibiotics can be administered as a bolus.
  Action: Information has been provided by pharmacy about administering antibiotics as boluses

3.1.4 Audit results showed that the ED discharge letters that are sent to the patient's GP does not always contain the same information as the notes that are handwritten at the time of assessment. Discussion with clinical staff and observation of the process revealed that often the letters are not written by the clinician that sees the patient. The author of the letter uses the handwritten notes as a guide, however the system consists of drop down options which do not always match the handwritten diagnosis/ treatment therefore the closest diagnosis is used. This creates a potential patient safety risk as incorrect information and/ or delayed information is shared with primary care teams. Review has been carried out in conjunction with systems and network support (SNS) into the process required to populate an ED discharge letter which is time consuming and requires inputting of large amounts of data that are already in CPD.
Action: SNS are reviewing the process to simplify it and set CPD to automatically populate some for the letter from data already entered.

3.2 In-patient audit

Anecdotal evidence suggests that it is often documented in paper medical notes that sepsis has been considered but excluded. This is not captured in the audit. Compliance with administration of antibiotics within the hour remains varied. Work is ongoing to educate staff about the importance of timely administration. An area that has been identified for more work is: lack of communication from the Medical team informing nursing staff that stat medication has been prescribed.
Action: This has been escalated to Care Group Directors for dissemination to the medical teams.

4. Quality Improvement

4.1 Sepsis Screening Tools

4.1.1 A maternity screening tool has been developed and is going through the approval process.

4.1.2 Following consideration of different paediatric screening tools the paediatric team have chosen to use the age specific sepsis screening tools from the UK Sepsis Trust. This will be presented at the Sepsis Steering Group in April 2020 for approval.

4.1.3 The Sepsis screening tool adapted for use in the Easingwold renal dialysis unit has been approved by Renal development group and Sepsis steering group. If the trial at Easingwold is successful it will be introduced to the other dialysis units in the Trust.

4.1.4 A group of medical students from HYMS have been carrying out a project looking at the understanding of the use of lactate results as indicators of successful treatment versus deterioration. This project has been put on hold since the start of the Covid pandemic.

4.2 Sepsis Emergency Department Operational Groups

4.2.1 Both Emergency departments have active operational groups which are implementing learning from the audits.

4.2.2 A working group has been formed, with representation from the Yorkshire Ambulance Service, to look at why there is such variance in the cases that are pre-alerted to ED and to review how the ED staff use the information from the ambulance crew. The first meeting of the group has been postponed due to the current situation.

4.3 Community Sepsis Collaborative

The community sepsis collaborative is on hold due to lack of attendance. The CCG have taken over chair of the group and are reviewing the terms of reference and the members of the group.

5. Paediatrics

Following a complaint received by the Trust about sepsis in a child and enquiries from CQC a snapshot audit was carried out reviewing 106 paediatric patients admitted through the Emergency Department with possible Sepsis.

Of these, 13 children were coded as sepsis or suspected sepsis.

Review of the ED records of these 13 children, 10 had no triggers indicating a need for urgent treatment for sepsis.
2 of the patients that did meet criteria for urgent sepsis management had screening and treatment started within an hour or presentation.
The remaining patient had a slight delay in receiving IV antibiotics due to also having another medical emergency which needed stabilizing prior to sepsis treatment.

6. CQC action plan

All actions in the CQC action plan have been implemented and are being monitored as part of the audit.

7. Next Steps

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

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

8. Recommendation

Quality Committee is asked to note performance in the screening & treatment of Sepsis and the action being implemented to improve them.

York Teaching Hospital
NHS Foundation Trust

APPENDIX C

Board of Directors – 27 May 2020
Ceiling of Care

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 a summary on the current situation for decisions around Ceiling of Care (CoC) for inpatients in York Teaching Hospital Trust.

Executive Summary – Key Points

Elderly and general medicine in YH have significantly improved in management of CoC. Surgery across both sites require QI on CoC.

Recommendation

Quality Committee is asked to note the Medical Directors Report for May 2020.

Author: Dr Alexandra Ward, Clinical Leadership Fellow

Director Sponsor: Mr. James Taylor, Medical Director

Date: 19th May 2020

1. Introduction and Background

Current Trust policy is to document all Ceiling of Care (CoC) decisions on CPD for inpatients within York Trust. CoC refers to the highest level of medical intervention deemed appropriate by the responsible team with regard to the patient's wishes. DNACPR decisions must be documented on the appropriate form with the correct sign off and recorded on CPD. Once documented this information is then included in printouts of doctors and nurses handovers. There are also identified areas on paper clerking documents for surgical and medical acute admissions, for any decisions made in post take ward rounds to be documented.

Elderly care regularly records a CoC decision at both sites and general medicine in YH also commonly performs well. Surgical specialities across both sites routinely have low percentages of completed CoC for their inpatients. It must be noted however that some of the surgical data includes acute admission beds, so some patients may have only been an inpatient for a short period of time and not yet been reviewed by a senior/consultant.

1.1 Cardiac arrest rates

There has been a definite improvement in rates of cardiac arrest calls since the function to record CoC was introduced. In 2016 pre electronic recording there were 137 cardiac arrests in the Trust. This number has reduced to 77 arrests in 2019. However there are still cardiac arrests happening in patients who had no CoC recorded, and inappropriate CPR could have been avoided in a few of these patients.

2. Themes in Cardiac arrests calls

Themes that have been identified:

- **were failure to follow deteriorating patient and sepsis protocols**
- **failure to make good decisions around advance care planning.**

3. Actions

A QI project to improve decision making and recording CoC on CPD was commenced in October 2019. A small selection of wards were identified at York and Scarborough. The intention being that improving CoC documentation will reduce the amount of inappropriate cardiac arrest calls and outreach visits. Patients who deteriorate out of hours will also have a clearer plan which makes it easier for on call staff, and in turn will hopefully improve patient and family experience and satisfaction. As of March 2020 there has only been a statistically significant improvement on one ward in percentage of patients with a CoC completed. Further PDSA cycles are planned post- Covid.

Deteriorating patient workshops have been run for staff including guidance on DNACPR decisions, which will hopefully encourage staff to prompt doctors to have discussions and make CoC decisions for more patients.

4. Impact from CoVID-19

Since mid-March there have been significant changes in the Trust related to CoVID -19. This included number of inpatients, type of inpatient, where these patients are nursed, and who is responsible for them. Senior review and involvement has been much greater, and there has been a big drive to think about CoC for all patients on admission and document this decision. As a consequence of this CoC for the Trust currently sits at 79%, and had been above 70% for the whole of April. Some of the confirmed CoVID-19 positive wards have had weeks with 100% completion. The wards that have lower rates of completion continue to be the acute surgical and orthopaedic wards. It is not possible however to give an accurate breakdown for each specialty at one time, due to recent frequent ward changes and reassignments. The Care Group Directors responsible for Surgery and Orthopaedics have been informed of their CoC data and action requested.
Since the increase in CoC recording we have seen a decrease in the number of cardiac arrest calls, although this must be interpreted in the context of fewer total numbers of inpatients.

5. Recommendations

Recent results show that is it possible to achieve high numbers of patients with a CoC recorded. This is of benefit to clinical staff and patients when communicated effectively. This improvement must be continued when the pandemic is over and further QI work will deliver further improvements in surgery.

York Teaching Hospital
NHS Foundation Trust

APPENDIX D

Board of Directors – 27 May 2020
COVID-19 related medicines issues

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 a summary on the current situation for Covid-19 related medicines issues in York Teaching Hospital Trust.

Executive Summary – Key Points

COVID-19 has given rise to shortages of several groups of medicines. The reasons for these shortages are multi-factorial but largely due to increased demand. Medicines supplies to the Trust have been well managed as a result of a structured National approach, in addition to tight management within the Trust from pharmacy and clinical teams. Up to the current point in time there has not been any patient harm as a result of medicines shortages.

Recommendation

Quality Committee is asked to note the Medical Directors Report for May 2020.

Author: Stuart Parkes, Deputy Chief Pharmacist

Director Sponsor: Mr. James Taylor, Medical Director

Date: May 2020

1. Introduction and Background

- To outline the issues that have arisen relating to medicines-related shortages due to COVID-19 and the mitigations that has been put in place to safeguard patients and Trust business.
- To provide the Board assurance that medicine supplies are being well managed.

COVID-19 has given rise to shortages of several groups of medicines. The reasons for these shortages are multi-factorial but largely due to increased demand. Medicines supplies to the Trust have been well managed as a result of a structured National approach, in addition to tight management within the Trust from pharmacy and clinical teams. Up to the current point in time there has not been any patient harm as a result of medicines shortages.

2. Supplies of critical care medicines

Due to the increased utilisation of ICU capacity there has been shortages of several critical care medicines such as: sedatives, muscle relaxants, and vasopressors. Trusts have been placed on a quota system by NHS England in conjunction with regional procurement colleagues, and stock has been allocated dependent on current stock holding and number of ventilated critical care patients. A data capture system called EXEND is used so that regional procurement can monitor Trust medicines stock holdings centrally. There hasn't been any impact on medicines supplies due to the Nightingale Hospital in Harrogate, who are now only stocking minimal levels of medicines.

In the Trust, colleagues in pharmacy and critical care have tightly managed stock and patient requirements on a daily basis, and have been resilient in switching to different strength products or alternatives in the same class to provide continuity of supplies.

The pharmacy aseptic unit has been used to prepare pre-filled infusions of critical medicines. This has enabled vials to be shared to reduce the wastage of medicines, and has helped nursing colleagues in providing medicines in a ready to use form. Guidance has been issued for nursing staff on sharing of vials for critical care medicines to reduce wastage.

3. Antimicrobials

As a Trust we have tried to move to antibiotics for COVID-19 related pneumonia that are given less frequently, in order to reduce exposure to nursing staff and reduce time spent preparing IV medicines. However, there have been shortages of several commonly used once daily antibiotics.

The Antimicrobial Stewardship Team and pharmacy teams have worked with clinicians to ensure that COVID-19 patients without bacterial infection are not started on antibiotics. The pharmacy aseptic unit has been utilised to prepare 24 hour infusors of benzylpenicillin in order to reduce the doses administered each day from 4 to one, this has reduced potential exposure and released time to care for nursing staff.

4. Renal replacement fluid

COVID-19 patients ventilated on ICU have been more likely to develop acute kidney injury and require renal replacement therapy.

Nationally there has been a policy and process developed to maintain supplies of fluids and consumables related to renal replacement therapy. This is been closely managed by pharmacy in conjunction with Trust procurement and ICU teams. On occasions stock has been shared around Trusts in Yorkshire and Humber to maintain supply continuity.

5. Medical gases

Medical gas cylinders and piped (VIE) oxygen supplies are being monitored nationally in conjunction with the main suppliers, estates and pharmacy teams. The VIEs are monitored remotely by suppliers, for COVID-19 the thresholds for ordering have been increased in order to maximise the amount of oxygen available on site. Cylinder orders are going through a national approval process and are being monitored closely on site by dispatchers and pharmacy.

6. Governance

There has been guidance from national bodies and the MHRA highlighting acceptable derogations to normal governance processes. These have enabled innovative practice, such as batch production in aseptics and vial sharing to preserve stock on the wards. They have also been used to redesign some of the medicines processes on COVID wards. These derogations have been documented and gone through an approval process through the Chief Pharmacist.

7. Recommendation

The Board accepts this report as assurance that medicines shortages are being appropriately managed.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 May 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, Deputy Chief Nurse

Director Sponsor: Heather McNair, Chief Nurse

Date: 11.05.20

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 May 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 Clostridium difficile infection.

Since the last reported position dated 17/04/20 there has been: x1 further case of Clostridium difficile toxin at York Hospital and x3 further cases at Scarborough Hospital; there have been x2 further cases of MSSA bacteraemia at York Hospital; there have been a further x5 cases of E Coli bacteraemia at York hospital and x3 further cases at Scarborough Hospital; x2 further cases of Pseudomonas bacteraemia at York Hospital and x2 further cases at Scarborough Hospital. The number of MRSA bacteremia remains at zero.

As reported in April the algorithm for the attribution of bacteraemia has changed for the year ahead and we continue to await confirmation of Trust thresholds for 2020-2021.

Please see attached Infection Prevention Weekly Update dated 07/05/20 (Appendix 1)

2. Detail of Report and Assurance

a. Key Risks

Last month the committee was made aware of the impact on the IPC team in relation to increased operational pressure related to COVID-19. The team is extraordinarily busy and is concerned that they continue to lack sufficient capacity to manage important routine IPC business including Post Infection Reviews (PIRs). The purpose of the PIRs is to identify how a case occurred and to identify actions that will prevent similar cases reoccurring in the future.To date there is x25 Post Infection Reviews at Scarborough Hospital and x20 at York Hospital that have not yet been initiated which has a potential to have an adverse impact on patient safety and quality of care.

b. Novel Coronavirus (COVID-19)

The most recently published weekly Covid-19 bulletin is dated week ending 03/05/20 and is attached at Appendix 2 for information. This bulletin is sent to the IPC team, DIPC, Chairman and Chief Executives Office, Medical Director and Deputy Chief Nurse team.

c. Infection Prevention and Control Board Assurance Framework

NHS England and NHS Improvement have developed a board assurance framework to support healthcare providers to effectively self-assess their compliance with Public Health England Covid-19 related infection prevention and control guidance and to identify any risks. The framework was published on 04/05/20 and can be used as a source of internal assurance that quality standards are being maintained and/or identify any areas of risk and show corrective actions taken in response. Although, the document states the framework is not compulsory, there is a view that it would be something that commissioners and regulators are likely to ask to be used in the future.

An initial review of the document indicates that our practice is in line with national guidelines and there are no immediate areas of concern evident. The IPC team will work through the framework and the completed document will be provided to the next Quality Committee meeting in June 2020. The framework is attached at Appendix 3 for information.

d. Outbreaks

Current outbreaks are all related to COVID-19. A summary of the most recent outbreak data and subsequent ward closure can be seen in the table below:

Date Closed	Ward	Hospital	Bay	Reason Closed	Date of Next Review by IPN	Date of Opening
06/05/2020	11	YH	3	? COVID-19	08/05/2020	-
06/05/2020	16	YH	5	? COVID-19	08/05/2020	-
07/05/2020	All	St Helen's	All	? COVID-19	09/05/2020	-
07/05/2020	16A	YH	4	? COVID-19	08/05/2020	-
07/05/2020	ESA	YH	4	COVID-19	08/05/2020	-
22/04/2020	33	YH	5	? COVID-19	-	18:26 06/05/2020
05/05/2020	11	YH	1	? COVID-19	-	16:15 07/05/2020

The Trust guidance for infection prevention and control advice for inpatient management for possible and confirmed cases of COVID-19 in York NHS Trust is updated regularly to reflect current evidence based practice and is now on version11.

Future Workplan

The future workplan includes the following:

- Completion of the new NHSE/I Board Assurance Framework

- Developing the IPC Annual Report 2019-20

3. Detailed Recommendation

The Board is asked to note this report.

APPENDIX 1

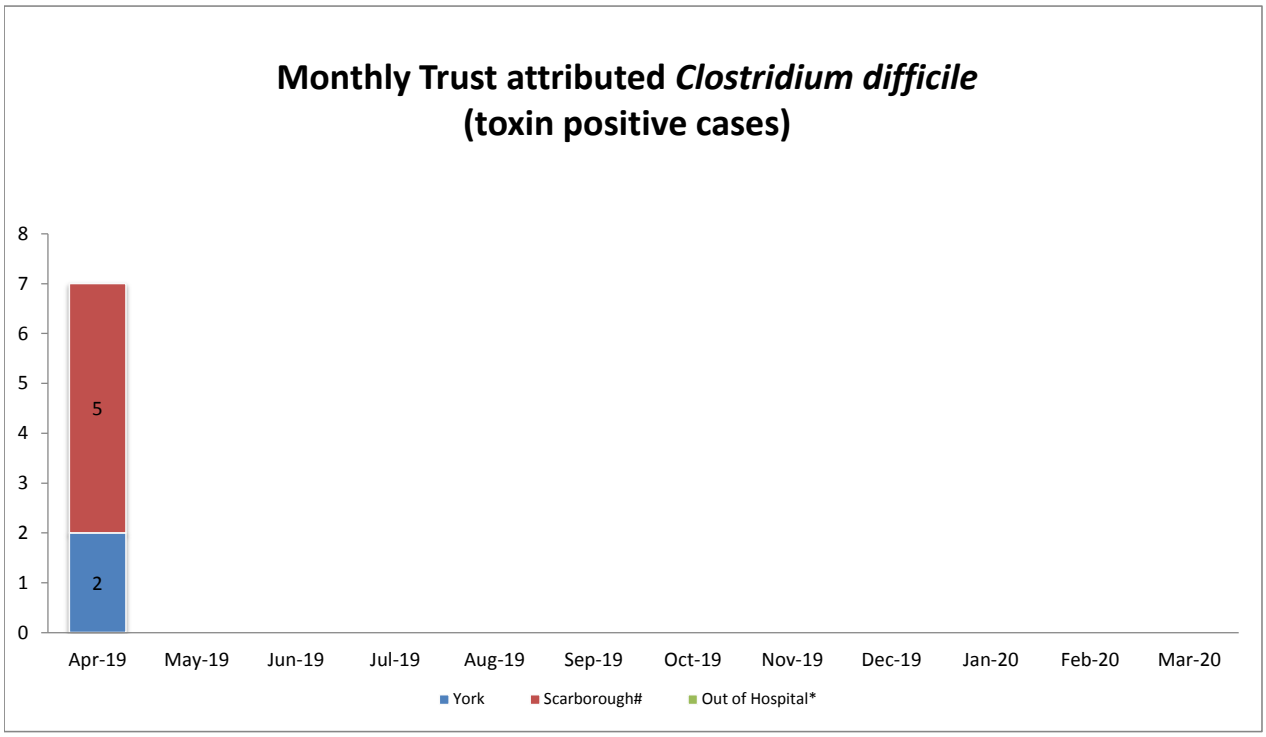
York Teaching Hospital NHS
NHS Foundation Trust

Infection Prevention Health Care Acquired Infection incidence

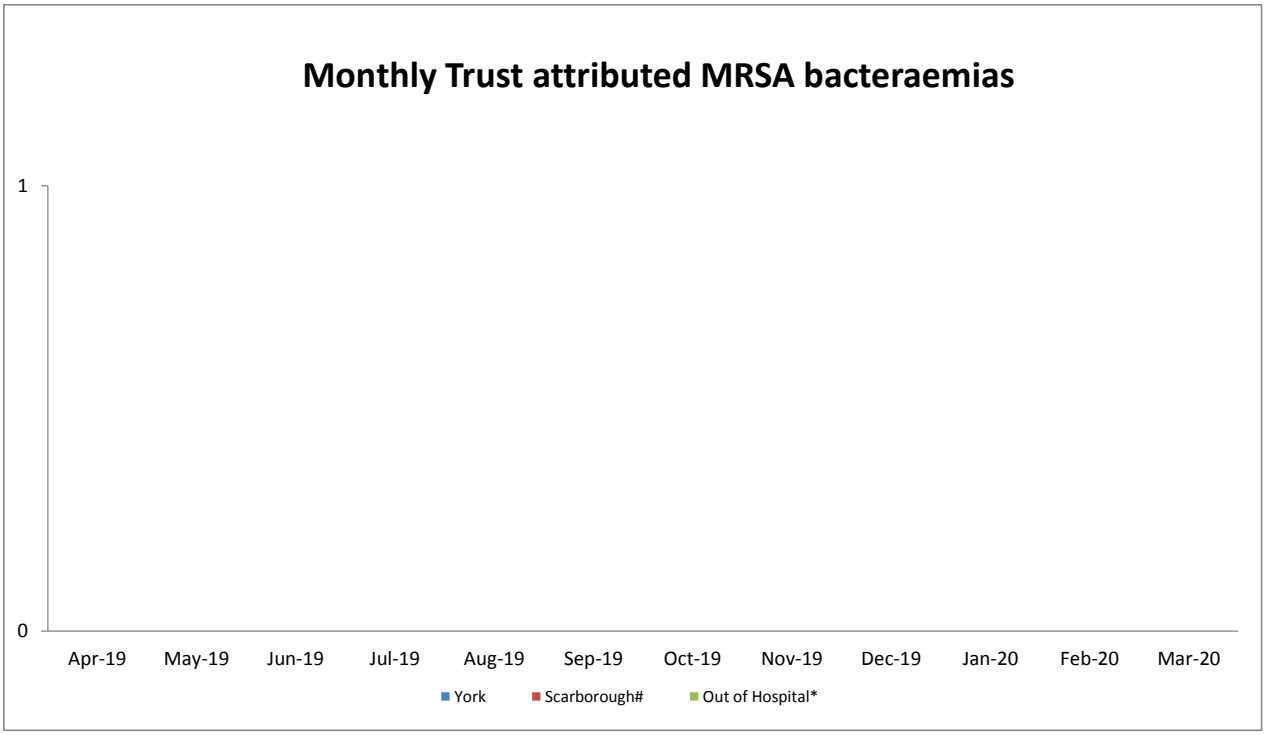
#Scarborough includes Bridlington
*Out of hospital includes Selby, St Monicas and Rehabilitation units

Clostridium difficile toxin			Days since last case on 07/05/2020		
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
24/04/2020	13	28/04/2020	9	24/01/2020	104

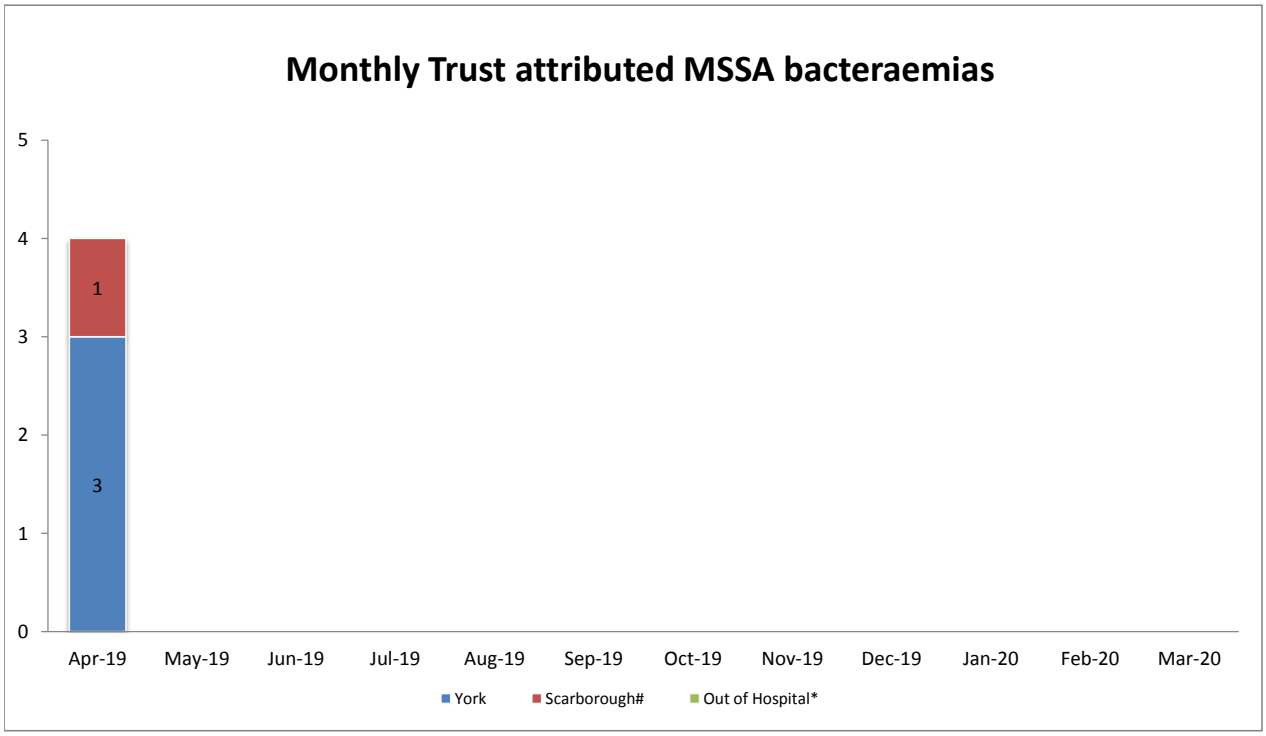
Clostridium difficile toxin	York	Scarborough#	Out of Hospital*	Total	Accumulated total	Accumulated threshold
Apr 20 to date	2	5	0	7	7	
May-20	0	0	0	0	7	
Jun-20	0	0	0	0	7	
Jul-20	0	0	0	0	7	
Aug-20	0	0	0	0	7	
Sep-20	0	0	0	0	7	
Oct-20	0	0	0	0	7	
Nov-20	0	0	0	0	7	
Dec-20	0	0	0	0	7	
Jan-21	0	0	0	0	7	
Feb-21	0	0	0	0	7	
Mar-21	0	0	0	0	7	
Total	**2**	**5**	**0**	**7**		



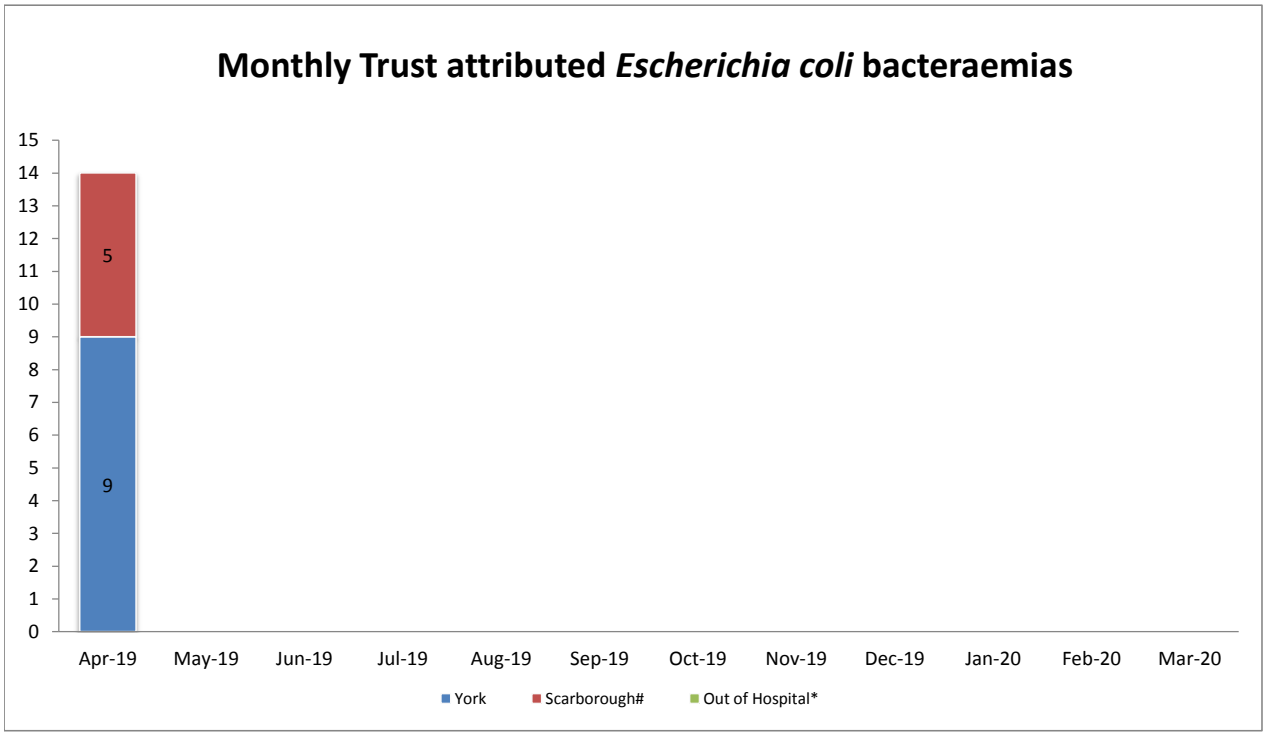
MRSA bacteraemia			Days since last case on 07/05/2020			
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
22/07/2019	290	11/07/2019	301	07/10/2016	1308	
MRSA bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumulated total**	**Accumulated threshold**
Apr 20 to date	0	0	0	0	0	**Threshold = zero tolerance**
May-20	0	0	0	0	0	
Jun-20	0	0	0	0	0	
Jul-20	0	0	0	0	0	
Aug-20	0	0	0	0	0	
Sep-20	0	0	0	0	0	
Oct-20	0	0	0	0	0	
Nov-20	0	0	0	0	0	
Dec-20	0	0	0	0	0	
Jan-21	0	0	0	0	0	
Feb-21	0	0	0	0	0	
Mar-21	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**		



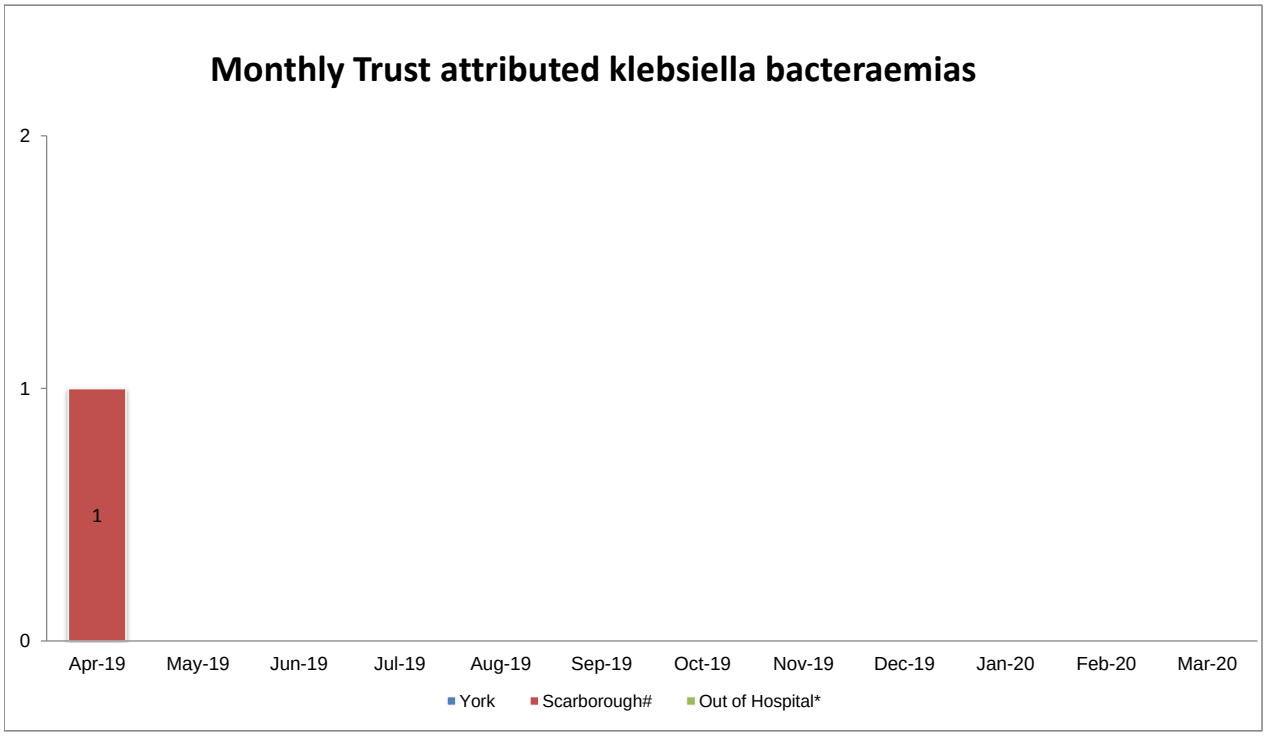
MSSA bacteraemia				Days since last case on 07/05/2020		
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
26/04/2020	11	14/04/2020	23	26/11/2019	163	
MSSA bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumulated total**	**Accumulated threshold**
Apr 20 to date	3	1	0	4	4	
May-20	0	0	0	0	4	
Jun-20	0	0	0	0	4	
Jul-20	0	0	0	0	4	
Aug-20	0	0	0	0	4	
Sep-20	0	0	0	0	4	
Oct-20	0	0	0	0	4	
Nov-20	0	0	0	0	4	
Dec-20	0	0	0	0	4	
Jan-21	0	0	0	0	4	
Feb-21	0	0	0	0	4	
Mar-21	0	0	0	0	4	
Total	**3**	**1**	**0**	**4**		



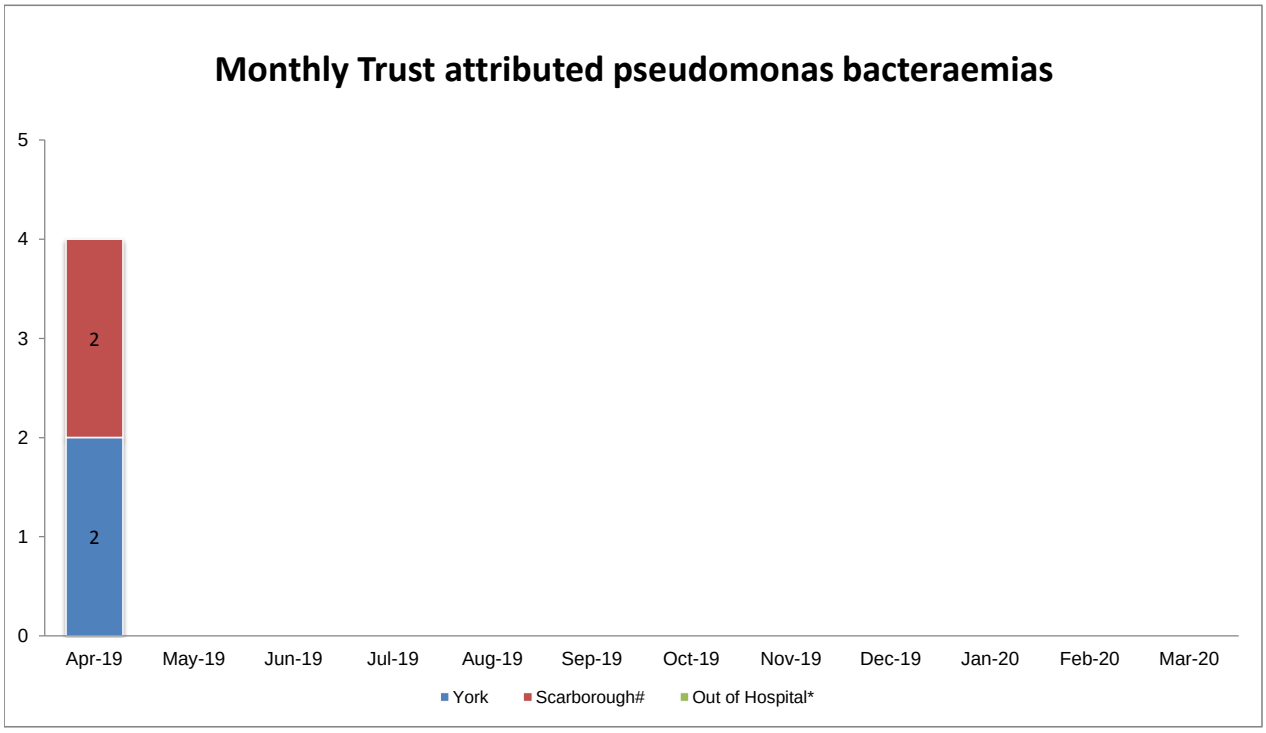
E Coli bacteraemia				Days since last case on 07/05/2020		
York		Scarborough		Out of hospital		
Date of last case	Days since last case	Date of last case	Days since last case	Date of last case	Days since last case	
27/04/2020	10	23/04/2020	14	24/01/2019	469	
E coli bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumulated total**	**Accumulated threshold**
Apr 20 to date	9	5	0	14	14	
May-20	0	0	0	0	14	
Jun-20	0	0	0	0	14	
Jul-20	0	0	0	0	14	
Aug-20	0	0	0	0	14	
Sep-20	0	0	0	0	14	
Oct-20	0	0	0	0	14	
Nov-20	0	0	0	0	14	
Dec-20	0	0	0	0	14	
Jan-21	0	0	0	0	14	
Feb-21	0	0	0	0	14	
Mar-21	0	0	0	0	14	
Total	**9**	**5**	**0**	**14**		



Klebsiella species bacteraemia				Days since last case on 07/05/2020		
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	90	07/04/2020	30	12/02/2019	450	
Klebsiella bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumulated total**	**Accumulated threshold**
Apr 20 to date	0	1	0	1	1	
May-20	0	0	0	0	1	
Jun-20	0	0	0	0	1	
Jul-20	0	0	0	0	1	
Aug-20	0	0	0	0	1	
Sep-20	0	0	0	0	1	
Oct-20	0	0	0	0	1	
Nov-20	0	0	0	0	1	
Dec-20	0	0	0	0	1	
Jan-21	0	0	0	0	1	
Feb-21	0	0	0	0	1	
Mar-21	0	0	0	0	1	
Total	**0**	**1**	**0**	**1**		



Pseudomonas bacteraemia				Days since last case on 07/05/2020		
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	
30/04/2020	7	15/04/2020	22	26/10/2019	194	
Pseudomonas bacteraemia	**York**	**Scarborough#**	**Out of Hospital***	**Total**	**Accumulated total**	**Accumulated threshold**
Apr 20 to date	2	2	0	4	4	
May-20	0	0	0	0	4	
Jun-20	0	0	0	0	4	
Jul-20	0	0	0	0	4	
Aug-20	0	0	0	0	4	
Sep-20	0	0	0	0	4	
Oct-20	0	0	0	0	4	
Nov-20	0	0	0	0	4	
Dec-20	0	0	0	0	4	
Jan-21	0	0	0	0	4	
Feb-21	0	0	0	0	4	
Mar-21	0	0	0	0	4	
Total	**2**	**2**	**0**	**4**		



Appendix 2 – Covid-19 Weekly Report week ending 03/05/20

COVID-19 WEEKLY REPORT

NHS
York Teaching Hospital
NHS Foundation Trust

Summary for week ending 03/05/20

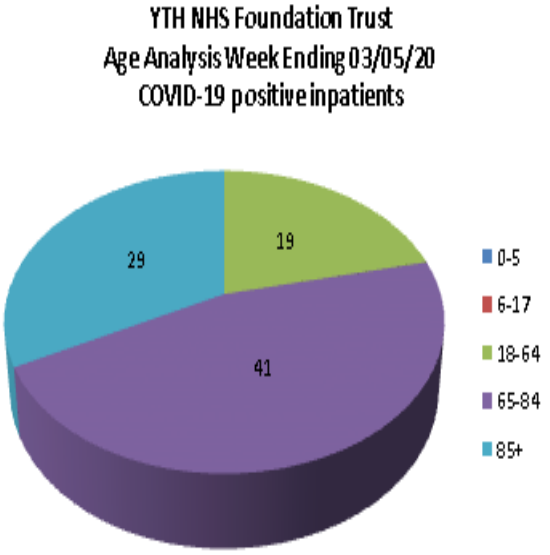
Similar number of COVID inpatient cases this week compared with last week.

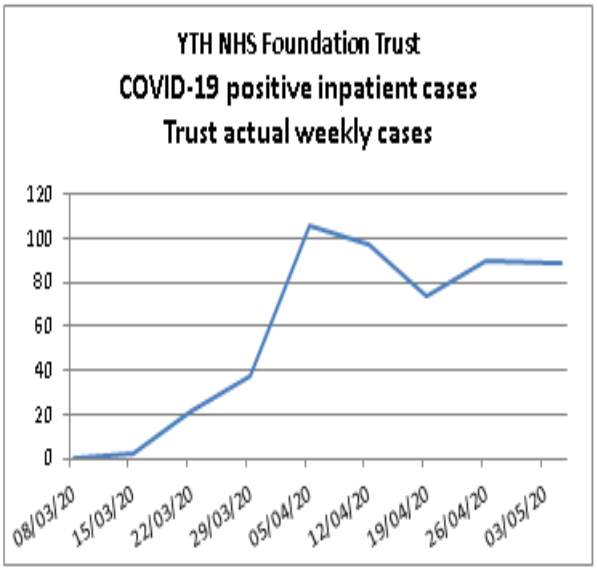
The number of COVID tests performed increased from 722 to 1265

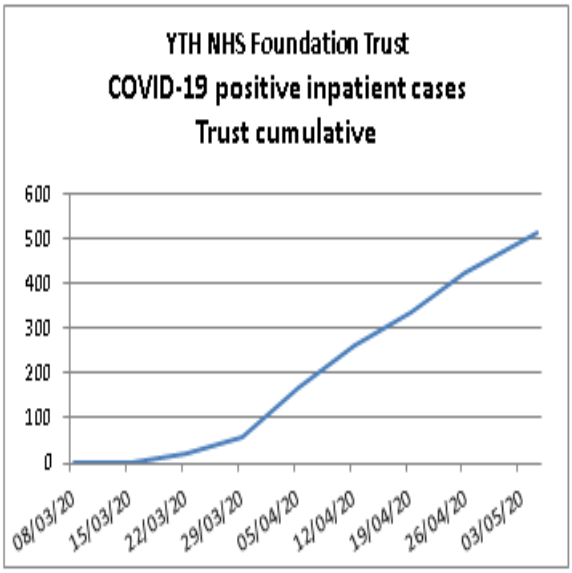
To date 156 COVID-positive inpatients have died.

COVID-19 Laboratory Tests

Total number of laboratory tests =	1265
Positive test rate =	**12%**







Publications approval reference: 001559

Infection prevention and control board assurance framework

4 May 2020, Version 1

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated appropriately.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission • compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance • national IPC PHE guidance is regularly checked for updates and any changes are			

effectively communicated to staff in a timely way • changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use			

of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance • linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE national policy			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight			
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and			

where appropriate with restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved			
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly			

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately			
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it			

• a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their			

household display any of the symptoms.			
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement			
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance • screening for other potential infections takes place			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected			

COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing			

• staff that test positive have adequate information and support to aid their recovery and return to work.			

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 May 2020
Progress Against Section 29 A Actions

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 of Directors will be aware that the CQC require a response to the Section 29A Warning Notice issued to the Trust on the 21st January 2020. This paper provides the response that is to be made.

Executive Summary – Key Points

Members of the Board of Directors are asked to note that the response has been drafted to reflect the exact requirements of the CQC, it details how the trust has responded, the supporting evidence and any mitigations that are in place.

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

Recommendation

Members of the Board of Directors are asked to note and discuss the progress made in response the Section 29a Warning Notices issues by the CQC on 21st January 2020.

Author: Fiona Jamieson, Deputy Director of Healthcare Governance

Director Sponsor: Heather McNair, Chief Nurse

Date: May 2020V1

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.

The Trust responded to the CQC providing an update on the areas for immediate improvement on 21 April 2020 and the Trust received a letter of response from the CQC on the 5th May 2020 seeking further assurance on a number of issues pertaining to Mental Health, Pediatrics ,Documentation and Staffing to be delivered by 13th May 2020. The updated Action Plan incorporates the most up to date position that informed our response.

2. Detail of Report and Assurance

Members of the Board of Directors are asked to note the actions taken and supporting evidence made against each requirement for improvement detailed in the Section 29A.

1. **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.

1.1 '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)'

A review of the RCEM standards has been undertaken and has identified the actions required. Work has been undertaken in partnership with Tees, Esk and Wear Valley MH NHS Foundation Trust, (TEWV) in the review of pathways. The Trust has written to the Scarborough Ryedale CCG about the inadequacy of the level of cover provided in the support service that they commission from TEWV.

Current Risk Rating: Amber:

1.2. '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'.

Significant work has been undertaken on access and flow at site management and scheme level to address the issues raised by the CQC; it is too early to fully assess the impact of the schemes, particularly in the light of the current pandemic. Schemes will be evaluated in Q4 of 2020-2021.

Current Risk Rating: Green:

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

Appendix A details the work undertaken to address the requirements of meeting the standards for facing the future, standards for children in emergency settings. Pathways are in the process of being implemented and will require audit in Q4 2020/21. The CQC have in their letter of 5th May 2020 have requested further assurance on our progress to appointing Registered Children's Nurses to the Emergency Departments. We have provided assurance that these posts have been funded and interviews took place week commencing 11/5/2020. In addition there is an issue about the lack of a Consultant with the requisite Paediatric Emergency Medicine qualification in Scarborough. There are four Consultants in York ED with the qualification and we are implementing a system of rotation from the York site to support Scarborough ED.

Current Risk Rating: Amber

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

Work has been undertaken to develop a nursing documentation bundle. The documentation is currently being printed and will be rolled out with supporting education in June. An electronic solution will be developed and implemented from January 2021.

Current Risk Rating: Amber

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

Response was made to the CQC on 7/2/2020.

1.6 There were not sufficient numbers of suitably qualified skilled, competent and experienced clinical staff at all times to meet the needs of patients within the medical wards at Scarborough and both emergency departments.

The organization can demonstrate that it has taken steps to improve the numbers of sufficiently qualified skilled, competent and experienced clinical staff. The current medical vacancy rate at Scarborough is 10.9%. Appendix A details all of the actions undertaken.

Current Risk Rating: Green:

Section 31 Actions

Members will see from the Action Plan that the actions pertaining to the Section 31 require the same evidence base as those for the Section 29A's. However for completeness the actions are reflected on the refreshed Action Plan. Of note, the CQC have requested the provision of staffing information to be provided on a monthly basis for the Scarborough medical wards and for Registered Children's nurses in both ED's.

3. Next Steps

The continued monitoring and review of actions.

4. Detailed Recommendation

The Board of Directors are asked to note the progress of the actions associated with the Section 29A Warning Notice and the Section 31 Enforcement Action.

CQC Action Plan York Teaching Hospital NHS Foundation Trust

May-20

Issue Number	Executive Lead/ Assurance Committee	CQC Recommendation	Care Group (CG1, CG2 CG3 CG5 CG6) Site (SGH BH, YORK)	Action	Responsible Officer	Completion Date	Evidence of Completion	Narrative Update	Nextsteps/ timescales
Section 29A requirements									
1. Patients who presented at the emergency departments with mental health needs were not cared for safely in line with national guidance (RCEM guidance and Psychiatric Liaison Accreditation									
Links to MD 7 and SD 6	Medical Director	The environments within the ED's at York Hospital and Scarborough Hospital were not in line with RCEM guidance or Psychiatric Liaison Accreditation Network (PLAN)	CG1, CG2 & CG5 SGH and York	Assessment to be undertaken against the standards and an action plan to be implemented to ensure standards are met	ED Clinical Lead	31.03.20	For the environment to be in line with the guidance	An assessment has been undertaken against the RCEM guidance and the PLAN Quality Standards for Liaison Psychiatry regarding environment. Awaiting post COVID 19 to finish the designated cubicles. Work ongoing with CCG and MH providers regarding a robust SLA	Cubicles to be completed once the architecture of the layout of the ED can be safely updated and contractors can come onto site. Timescale to be determined.
Links to SD 6		There was a capital strategic outline business case that included a planned refurbishment/rebuild of the emergency department at Scarborough Hospital however, this was not due for completion until 2024 and there was no effective interim measures identified to keep patients safe in the current environment	CG2 SGH	Development and implementation of a risk document for both adults and children attending with MH issues. Development and implementation of a SOP for environment risk assessment. Identification of a designated room on an interim basis prior to new build	Heads of Nursing	28.02.2020	Risk assessment SOP	Risk assessment implemented from 21.01.2020 and SOP implemented in Scarborought ED from 22.04.20. At York ED the MH assessment was implemented from 04.05.20 and the SOP has yet to be adopted and implemented. Room identified at both sites but but awaiting doors due to current pandemic. Audit shows that MH risk assessment is consistently being completed in order to safely care for patients.	Environmental risk assessment of the York site undertaken with Tees Esk & Wear Valley NHS Trust (MH provider) on 11.05.20 to ensure that the SOP is fit for purpose for YDH ED. SOP to be slightly amended and will be implemented w/c 18.05.2020

Links to MD 7 and 10	Medical Director	Our review of records and interviews with staff on the 13 and 14 January 2020 showed there were delays with OOH provision for patients presenting with mental health needs at the ED's. We asked for further information from staff about how this was being monitored and reviewed; however they were unable to provide this.	CG1, CG2 & CG5 SGH and York	To undertake partnership work with the CCG and mental health providers to ensure that there is a robust SLA in place to deliver a MH liaison service. To encourage all staff to report delays via the DATIX reporting system	Heads of Nursing		DATIX submitted SLA in place and being monitored Ongoing audit	SLA work ongoing with all partners. Review undertaken on both sites to regarding length of wait to better understand performance and risk and to share with partner. Review of SGH length of time to review shared with the CCG by the Care Group 2 CD.	Regular quarterly review to be undertaken to ensure monitoring. To continue to work with the CCG to ensure a robust SLA with KPI's that meet national standards.
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.									
Links to MD 9 & SD 10	Chief Operating Officer	During the inspection of the emergency departments of York Hospital and Scarborough Hospital patients were found to be waiting for long periods.	CG1 and CG2 SGH and York	To undertake a review of patient flow systems and processes implementing new processes as identified in the review.	Care Group Managers	31.03.2020	New systems and processes in place and being monitored	A review has been undertaken and new systems and processes including roles and responsibilities are being implemented.	Ongoing monitoring

Links to MD 9 & SD 10	Chief Nurse	Patients who were waiting in the department were not always cared for in suitable environments; • Including patients waiting handover from ambulance crews to emergency staff at York Hospital in a corridor remote from the main emergency department with no access to emergency equipment in this corridor. • It was common practice for patients to be cared for on trolleys at Scarborough Hospital emergency department; both awaiting a cubicle on arrival by ambulance and those awaiting admission.	CG1 and CG2 SGH and York	To undertake a review of the environment for ambulance handovers and make safe fro patients and staff. Review the way patients are cared for at SGH	Heads of Nursing	31.03.2020	New systems and processes in place and being monitored	There is now designated nurse for ambulance handover and YAS also have staff on site to assist. Extra crash trolley in place to ensure access to emergency equipment. Currently no queue due to low attendance and splitting of department. No incidents recorded. There has been a review of the trolleys at SGH to ensure that appropriate equipment is used.	Ongoing monitoring
	Medical Director	Of the 22 staff we spoke with at York Hospital ED, 9 told us that they had raised concerns about patient safety in the department	CG1 York	To ensure that all staff are aware of how to raise concerns through both the incident reporting system and other means such as the Freedom to Speak Up Guardian. To encourage ED staff to become involved in the Future Together work in trust. To develop and implement robust actions in response to the staff survey.	CG1 management team		Patient safety concerns being reported through the appropriate channels and staff getting the feedback. Longer term staff survey results		

Links to MD 9 & SD 10	Chief Operating Officer	Evidence from the trust indicated that there were significant delays in discharging patients which was impacting on flow through the hospital at both sites.	CG1 and CG2 SGH and York	To undertake a review of the systems and processes for discharge, update and implement new procedures as appropriate.	CG1 and CG2 management team	31.03.2020	Appropriate systems and processes in place to ensure patients are discharged in a timely manner.	New SAFER bundles have been implemented in the Discharge Lounge, flow matron team and bed management team. Home first has recently been implemented in the trust and is becoming embedded.	Ongoing monitoring
Links to MD 9 & SD 10	Chief Operating Officer	The trust was not meeting the national standards for emergency care.	CG1 and CG2 SGH and York	Actions as outlined above as well as work undertaken with ECIST with monitoring through the Acute Programme Board and the Trust Board	CG1 and CG2 management team	31.03.2020	Reporting and close monitoring of the trust standards	Improvement has been made against the target.	Ongoing monitoring
3. Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings									
Links to MD 4 & 7	Medical Director	We reviewed ten child records in Scarborough emergency department. In two records there was no evidence of the children being streamed on initial attendance and there was a significant delay until seen by a clinician in other records.	CG2 SGH	To review the pathways for paediatrics at both York and SGH sites and develop and implement new ones as appropriate	CG2 Head of Nursing	30.04.2020	Development of new pathways as required	New pathways and SOP's have been developed but are currently being implemented.	To undertake audit of the new pathways once embedded commencing in September 2020 Audit to be undertaken of the triage times and recommendations to be made regarding findings.
Links to MD 4	Chief Nurse	No nursing documentation had been completed in the 5 child records reviewed including pain scores at York emergency department.	CG2 SGH	To ensure that documentation is completed as per trust standards	CG2 Head of Nursing	30.04.2020	Education and training as appropriate and further audit	Further audit to be undertaken in Quarter 4. Audit undertaken which shows good complaince with documentation however not so compliant with pain score recording. Action plan developed to ensure compliance.	To undertake further audit in Quarter 4 2020/21 once actions have been delivered.

	Chief Nurse	The environment at both departments was not designed to accommodate the needs of children and those accompanying parents, carers and siblings.	CG1 and CG2 SGH and York	To ensure that the environment within the departments are suitable for the needs of children	CG1 & CG2 Heads of Nursing	30.09.2020	Suitable environment for children and their families	Areas identified for the development of a paediatric environment awaiting works to be undertaken following pandemic	Awaiting the change in ED following pandemic to complete the works required.
	Medical Director	At Scarborough Hospital ED there was no Paediatric emergency medicine trained doctor.	CG2 SGH	To ensure that there is appropriate support for paediatrics in the ED from a clinical perspective	CG2 Clinical Director	31.03.2020	Appropriate clinical support in place	Scarborough ED now has an identified ED doctor for the paediatric stream each shift. This person is known to the paediatric nurse within the ED and is their direct point of contact for medical review and intervention.	To review further the medical provision at Scarborough ED. Awaiting further guidance from CQC Engagement Officer.
4. Systems for recording clinical information, risk assessments and care plans were not used in a consistent way across York emergency department and the medical wards at Scarborough hospital to ensure safe									
	Chief Nurse	a) During inspection of medical wards in Scarborough Hospital it was found that the systems for documentation were different on each ward. b) This was a risk because, due to the low staffing levels, nursing staff were moved between wards based on patient acuity so were not always familiar with the processes for each ward, In addition, there was high use of agency staff to fill shifts across the medical wards so these staff would not always be familiar with the processes for each ward.	Corporate	To ensure that there is a consistent approach to care planning across the trust.	Deputy Director of Nursing	30.06.20	Care plan agreed, rolled out trust wide and audited. Education and training delivered to staff on SCH site in August 2019 regarding record keeping.	Care plans developed awaiting printing.	To undertake a print run which will be delivered at the end of May. Roll out of the new documentation to be comenced 4 June 2020. Trust has agreed to fund the development of a digital nursing record to be implemented January 2021

	Chief Nurse	During the inspection we reviewed five records from across the medical wards which showed gaps in care and escalation.	CG1 and CG2 SGH and York	For patients records to be updated contemporaneously	Head of Nursing CG 1 & 2	31.03.20	Audit showing improvement in record keeping	A rolling programme of eductaion and training was underaken across all in patient areas at SGH in August 2019 to ensure all staff were refreshed regardng the requirements for documentation. An ongoing process of audit of compliance with record keeping standards has been implemented by the matrons and results/action plans are reported through the Care Group Quality Committee.	Documentation to revert to paper and rolled out across the trust from June 2020. Ongoing audit of this will be via the Perfect Ward system commencing September 2020.
	Chief Nurse	Of the 26 patients we reviewed where a decision to admit had been made in York Hospital ED, 11 did not have appropriate risk assessments completed.	CG1, CG2 & CG5 SGH and York	For patients to have the appropriate risk assessments undertaken and care planned accordingly	Head of Nursing CG 1, 2 & 5 and Deputy Director of Nursing	30.04.20	Appropriate risk assessments in place. Audit showing improvement in risk assessments being undertaken.	The trust has a risk assessment checklist in place in the York Hospital ED. This is used on an hourly basis and is a prompt for staff to undertake the appropriate risk assessments.	Work on going to review the current way that risk assessments are undertaken in the ED and to align documentation on both sites by 31.12.2020 The Deputy Chief Nurse is leading a piece of work to review the trust policy and risk assessment regarding the prevention of pressure ulcers which will include ED. This will be undertaken by 30.09.2020.

6. There were not sufficient numbers of suitably qualified skilled, competent and experienced clinical staff at all times to meet the needs of patients within the medical wards at Scarborough and both emergency departments.									
	Chief Nurse	The staffing on the medical wards at Scarborough was significantly below expected.	CG2 SGH	For staffing levels to be at the expected levels	Head of Nursing CG 2	31.01.20	Staffing establishments and rota's show adequate nurse staffing levels.	Staffing was immediately increased on Beech Ward and CCU post inspection in June 2019. Skill mix review has been completed with the business case for the permanent uplift in establishment approved. The trust continues to undertake international recruitment and has just approved a further wave of recruitment of 60 nurses in 20/21. An external review of nurse staffing was commissioned by the Chief Nurse and the recommendations of this are being reviewed and worked through including the development of risk based board reporting. The trust has commissioned	Monthly submission of staffing data to the CQC. Process for undertaking establishment reviews beign reviewed.
	Medical Director	b) During the inspection it was found that: There were 3 WTE consultant vacancies at York Hospital ED	CG1 York	For staffing levels to be at the expected levels	Clinical Director CG1	31.03.20	Vacancies filled	The Consultant posts have been recruited to.	

	Chief Nurse	There were gaps in the RN rota at York Hospital ED.	CG1 York	For staffing levels to be at the expected levels	Head of Nursing CG1	31.03.20	Gaps in rota's to be filled	Work has been undertaken with ECIST (Richard Brownhill) following use of the BEST tool. The advice form ECIST is not to use BEST but to use the ED SNCT and they are supporting this The ECIST advice is to realign the model based on streaming data and demand. However with the current architecture of the ED being split into hot and cold this will need further review.	Further work to be undertaken with ECIST once able to attend the trust again.
	Director of HR and Organisational Development	Scarborough Hospital indicated that 33% of nursing staff had done PILS	CG2 SGH	For PILS training to be at the trust defined level for mandatory training of 85%	Head of Nursing CG2	31.03.20	For staff to be trained	Further PILS training has been undertaken and Scarborough Hospital ED is currently at 94%	Ongoing monitoring
	Director of HR and Organisational Development	At Scarborough Hospital emergency department 21 out of 58 staff had done bespoke paediatric training run by the Yorkshire and Humber critical care network.	CG2 SGH	For further staff to undertake training as available	Head of Nursing CG2	31.03.21	For staff to be trained	Eight places have been requested for the sick children in ED course at York University	Awaiting confirmation of the places via HEE once Universities are able to commence courses.

Section 31 requirements									
1&2 The registered provider must with immediate effect implement and effective system to identify, mitigate and manage risks to patients at York and Scarborough Hospitals who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines									
	Medical Director	1) At York and Scarborough Hospitals, patients were at risk of being able to further self harm as there were ligature risks and other fixtures and fittings that were likely to cause harm to themselves or others	CG1 York CG2 SGH	1. Establishment of antiligature rooms in the York and Scarborough ED departments. 2) Development of an Environmental SOP for MH patients in ED's	1) Head of Estates and Faciliities 2) Heads of Nursing CG1 and CG2	31.3.20	For the environment to be in line with the guidance	An assessment has been undertaken against the RCEM guidance and the PLAN Quality Standards for Liaison Psychiatry regarding environment. Awaiting post COVID 19 to finish the designated cubicles. Work ongoing with CCG and MH providers regarding a robust SLA. Environmentla SOP developed and being implemented.	Cubicles to be completed once the architecture of the layout of the ED can be safely updated and contractors can come onto site. Timescale to be determined.
	Medical Director	2)Out of hours support for patients presenting with mental health needs at the ED was provided by a crisis team from a MH NHS Trust, however this could take long periods of time and we were not assured that this was being monitored or risks being mitigated while patients were in ED	CG1 York CG2 SGH	To undertake partnership work with the CCG and mental health providers to ensure that there is a robust SLA in place to deliver a MH liaison service. To encourage all staff to report delays via the DATIX reporting system	Heads of Nursing CG1 and CG2		DATIX submitted SLA in place and being monitored	SLA work ongoing with all partners. Review undertaken on both sites to regarding length of wait to better understand performance and risk and to share with partner. Review of SGH length of time to review shared with the CCG by the Care Group 2 CD.	Regular quarterly review to be undertaken to ensure monitoring.

	Medical Director	3) Consultants and senior nurses and nursing staff from Scarborough ED were unable to describe how they would assess and safely care for patients presenting with mental health needs when waiting for support from MH NHS Trust	CG2 SGH	To develop and implement a MH Assessment that identifies any risks that need to be mitigated whilst awaiting support from the MH NHS Trust.	Head of Nursing CG2		Staff are aware and able to describle how they would assess and safely care for patients presenting with MH needs when waiting for support from a MH NHS Trust	Risk assessment implemented from 21.01.2020 and SOP implemented in Scarborought ED from 22.04.20. At York ED the MH assessment was implemented from 04.05.20 and the SOP has yet to be adopted and implemented. Room identified at both sites but but awaiting doors due to current pandemic. Audit shows that MH risk assessment is consistently being completed in order to safely care for patients.	Regular quarterly review to be undertaken to ensure monitoring. To continue to work with the CCG to ensure a robust SLA with KPI's that meet national standards.
3. Paediatric nurse staffing was not in line with national guidance in the emergency department (York and Scarborough)									
	Chief Nurse	At York Hospital ED there were only two registered children's nurse in the staffing establishment. One of which was a Band 7, this meant that the trust was unable to meet the national standard for having two registered children's nurses on every shift was not met	CG1 York	1) Immediate action taken to use Agency staff where necessary to fill shifts 2) Mitigations established for when RSCN unavailable to fill shifts 3)Board have approved funding for the recruitment of 16.8wte RSCN	Heads of Nursing CG1 and CG2	1) 31/1/2020 2) 31/1/2020 3) Vacancies are filled	That the number of children's nurses meets the requirement of national guidance	Agency staff utilised when available. In reach system from the ward used to support times when paediatric staffing is below planned. Recruitment commenced.	Interviews being undertaken w/c 11.05.2020 with a high level of interest. Student nurses redeployed from University as part of the pandemic planning include RSCN. Monthly reporting to the CQC

	Chief Nurse	At the Scarborough Emergency Department there were no registered children's nurse in the staffing establishment: this meant that the Trust was unable to meet the national standard for having two registered children's nurses on every shift was not met	CG2 SGH	1) Immediate action taken to use Agency staff where necessary to fill shifts 2) Mitigations established for when RSCN unavailable to fill shifts 3)Board have approved funding for the recruitment of 16.8 RSCN	Heads of Nursing CG1 and CG2	1) 31/1/2020 2) 31/1/2020 3) anticipated start date of new recruits?	That the number of children's nurses meets the requirement of national guidance	Agency staff utilised when available. In reach system from the ward used to support times when paediatric staffing is below planned. Recruitment commenced.	Interviews being undertaken w/c 11.05.2020 with a high level of interest. Student nurses redeployed from University as part of the pandemic planning include RSCN. Monthly reporting to the CQC
4. There was an insufficient number of nursing staff to meet patient needs on medical wards in Scarborough Hospital									
	Chief Nurse	There was an insufficient number of nursing staff to meet patient needs on medical wards	CG2 SGH	For staffing levels to be at the expected levels	Head of Nursing CG 2	31.01.20	Staffing was immediately increased on Beech Ward and CCU post inspection in June 2019. Skill mix review has been completed with the business case for the permanent uplift in establishment approved. The trust continues to undertake international recruitment and has just approved a further wave of recruitment of 60 nurses in 20/21. An external review of nurse staffing was commissioned by the Chief Nurse and the recommendations of this are being reviewed and worked through including the development of risk based board reporting. The trust has commissioned	Wards have been moved around to facilitate the national requirements for COVID 19 pandemic.Staff have been deployed through the national campaigns including third year student nurses and returning nurses.	Monthly submission of staffing data to the CQC. Process for undertaking establishment reviews beign reviewed.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 May 2020
Workforce Report – May 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 committee with an overview of work being undertaken to support the workforce in response to the Covid-19 pandemic; and update on training compliance as part of the CQC Action Plan.

Executive Summary – Key Points

- The staff absence rate for April 2020 was 7.27%, with Covid-19 absences accounting for 72% of all absences. Work continues to proactively support staff health and wellbeing in order to reduce absences wherever possible;
- To 3rd May, 940 staff and members of their household had been tested for Covid-19. 649 of the results (69%) were negative, allowing staff to return to work;
- A piece of work has been commissioned for managers to have a sensitive and comprehensive one-to-one conversation with all of the BAME members of their teams to ensure they are being supported;
- Resuscitation training compliance levels have improved since January 2020, though compliance rates in four of the six subjects are still below the Trust's 85% target.

Recommendation

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

Author: Will Thornton, Head of Resourcing

Director Sponsor: Polly McMeekin, Executive Director of Workforce & OD

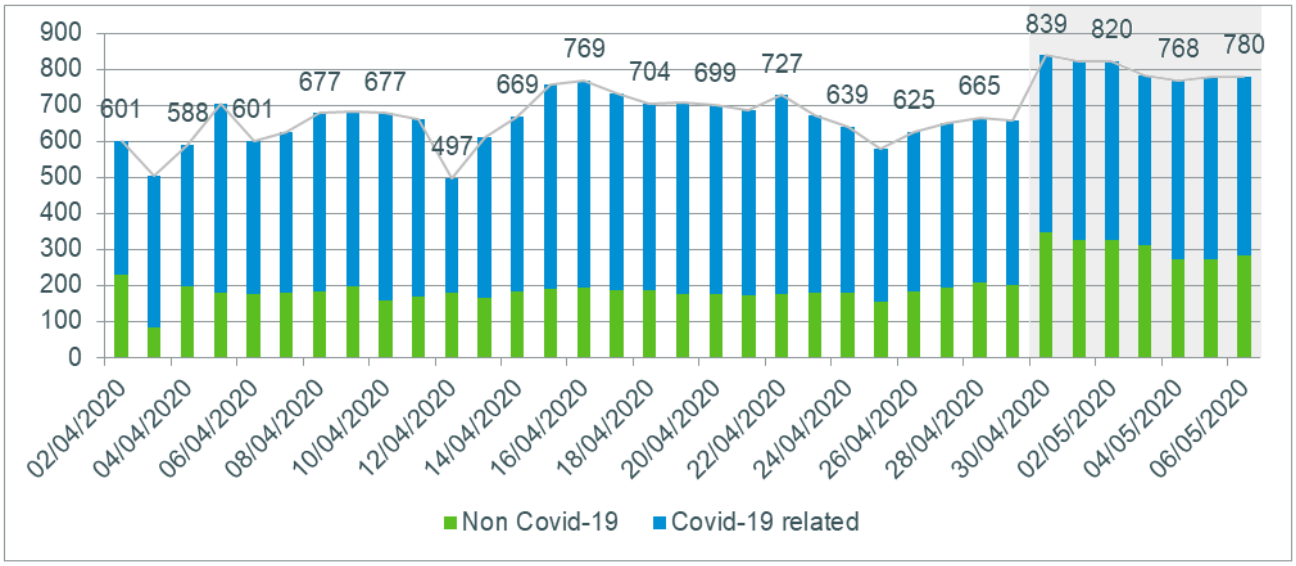
Date: May 2020

1. Introduction

May's Workforce Report focuses on work being undertaken to support the workforce in response to the Covid-19 pandemic; and an update on training compliance as part of the CQC Action Plan.

2. Staff absence rates

Chart 1 – Staff sickness absence, 2 April to 6 May 2020 (new reporting system from 30 April – shaded area of chart). Data for the Trust and York Teaching Hospital Facilities Management combined.



Source: Trust absence logs, 02/04/2020 – 06/05/2020.

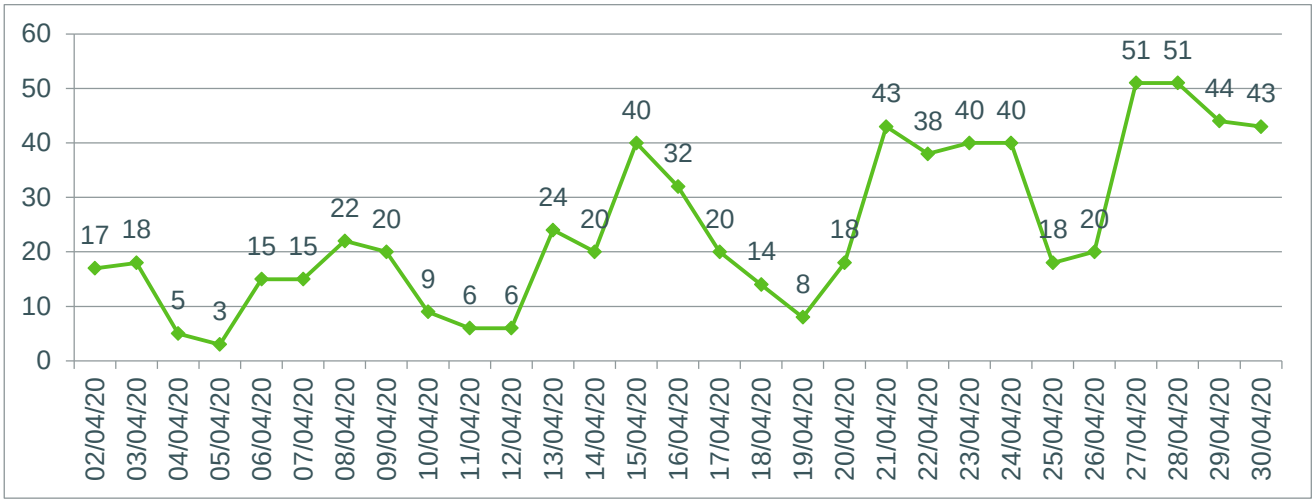
During April 2020, the Trust and YTHFM recorded an overall sickness absence rate of 7.27% (calculation based on headcount). Chart 1 shows a spike in absence at 30 April; however, this is artificial as this marks the first date on which data was taken from departments where previously the information was compiled based on staff calls made to a central phone line. Comparison with dates earlier than 30 April is difficult.

It is worth noting the absence rate for March 2020 was 4.91%, although this does come with the caveat that the figures for each month have been produced using different systems.

Covid-19 absences accounted for 72% of all absences recorded within the Trust during April. These include absences where staff have been medically suspended because they are deemed 'extremely vulnerable' (there are 198 'shielding' cases across the Trust and YTHFM) or have been required to observe the 14-day rule around household isolation. Covid-19 absences do not include instances where the disease is not the direct cause of absence; for example where someone is experiencing stress and anxiety due to worrying about Covid-19, the absence is recorded as Non-Covid-19, in line with national reporting guidelines.

3. Staff testing

Chart 2 – Number of staff (and household members of staff) tested for Covid-19, 2 to 30 April 2020



Source: Occupational Health

Since the end of March, the Trust has been providing testing for staff and their family members in order to support people to safely return to work. The trigger for testing is a high temperature and/or new persistent cough in line with Public Health England guidelines. Up to 3 May, a total of 940 tests for staff and family members had been undertaken. The following results were recorded:

- 649 negative tests (69%)
- 251 positive tests (27%)
- 40 results pending (4%)

93% of referrals in York were turned-around within 24-hours. In Scarborough, this was 95%.

4. Staff welfare

Black, Asian and Minority Ethnic (BAME) staff

Emerging UK and international data suggests that people from Black, Asian and Minority Ethnic (BAME) backgrounds are disproportionately affected by Covid-19. National guidance recommends employers should ensure that line managers are supported to have sensitive and comprehensive conversations with their BAME staff. They should identify any existing underlying health conditions that may increase the risks for them in undertaking their frontline roles.

9.1% of all staff in the Trust and YTHFM are BAME including 33.8% of doctors and 11% of nurses.

Managers in the Trust are being supported to have a sensitive and comprehensive conversation with all of the BAME members of their teams on a one-to-one basis. The conversations follow a standard format which covers a number of areas, including wellbeing and personal circumstances. There is a checklist for managers to assess which precautionary measures have been adopted to reduce the individual's risk of exposure.

Where a staff member has unresolved concerns, these are escalated through the appropriate management team.

Managers are keeping a list of staff with whom a documented conversation has taken place. These lists will be cross-checked against staff records held on the Payroll system to ensure that a conversation has taken place with all BAME colleagues.

Personal Protective Equipment (PPE)

The provision of Personal Protective Equipment (PPE) continues to be the Trust's highest priority for staff welfare. Throughout the pandemic, the Trust has maintained stock at a sufficient level to meet demand. This has involved constantly reviewing items in stores and on wards, working closely with national and regional providers to ensure a clear understanding of available equipment, and where necessary accessing and providing mutual aid from and to neighbouring trusts to ensure the distribution of items within the region are prioritised according to where there is greatest need. The Trust is following Public Health England guidance on sessional use of PPE to build an extensive supply of reusable gowns which can be safely laundered and re-used, and this will buttress existing stock.

Health and wellbeing offer

Beyond PPE, the Trust has continued to develop its health and wellbeing offer for staff during the pandemic. New developments since the April 2020 Workforce Report include:

- The creation of Calm Spaces in York, Scarborough and Bridlington Hospitals;
- The development of regular 'Drop In' Psychology sessions, staffed by one of the Trust's Clinical Psychologists;
- Chaplaincy team giving staff the opportunity to talk to them, and offering calm, quiet spaces for reflection and candle-lighting;
- Guidance has been produced to provide line managers with advice in supporting the emotional wellbeing of their staff, including those who are shielding or have been off work in isolation or with sickness absence and who are anxious about returning to the workplace;
- Refreshed communications across the Trust encouraging staff to take annual leave at regular intervals.

5. Learning and Development Update

The Trust has maintained its focus on staff learning and development throughout the pandemic, including areas that feature in its CQC Action Plan. Improving compliance rates for Resuscitation training has been a priority. The target compliance rate for each subject area under the Resuscitation umbrella is 85% of eligible staff. Current Trust-level compliance rates are provided below, alongside January's compliance levels for comparison:

Table 1 – Staff resuscitation training compliance levels

Subject	Compliance in January 2020	Compliance in April 2020	Change in compliance
Basic / Immediate Life Support	89.3%	89.6%	0.3%
Advanced Life Support	48.0%	59.1%	11.1%
Adult Do Not Attempt CPR	79.0%	82.0%	3.0%
Paediatric Basic / Immediate Life Support	71.7%	81.5%	9.8%
European Paediatric Advanced Life Support	53.0%	57.0%	4.0%
Paediatric Do Not Attempt CPR	56.0%	87.0%	31.0%

The Trust is continuing to engage with staff who are not compliant to book them onto refresher training. This is challenging in the present circumstances as class sizes have been reduced to allow for physical distancing and the number of staff not attending their pre-booked training has also increased marginally.

Additionally during this period, the Trust has provided a suite of training to support the response to Covid-19 including: training in donning and doffing Personal Protective Equipment (nearly 2,000 staff trained); Covid Basic Life Support Simulation (840 staff trained); clinical skills refresher training (250 staff trained); and deteriorating/acutely unwell patient revision sessions (106 doctors trained).

6. Conclusion

The committee is asked to read the report and discuss.

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Nominations Booklet
May 2020

Cath Speechley Therapies Team Leader **Community Services** **Nominated by A colleague**

Cath shows an unwavering commitment to both patients in the community and those who work for her. She leads with compassion, warmth, integrity and cares about the well-being of her team. She is fiercely loyal and is always looking for ways to improve the working lives of her colleagues. She is always looking to develop our skill base both individually and collectively. She shows a strong wish for each member of our team to be the best they possibly can be at their job. When times have been more difficult Cath is always the first to step forward to support us as a team, to keep us motivated and to help us to work through challenges and learn from them. As a manager she is innovative, her experience and wish for patients to receive the best possible experience means that she is always looking for new initiatives and is keen also to learn from her team. She will often work beyond her hours to help with service development. Cath is a much loved and respected Team Leader and I think she deserves a star award to say a huge thank you for all you do for community therapies and The Trust.

Selby & South York Community Nursing Team **Community Services** **Nominated by Steve Reed A colleague**

Through the recent flooding the team have consistently gone above and beyond to ensure that their vulnerable housebound patients have continued to receive the care that they require. This has included travelling through flooded areas in 4x4s and other transport, working creatively with families and carers and working with other emergency services. The team have worked additional hours, through breaks and in their own time to make sure all visits were completed and should be recognised for their fantastic commitment and upholding of the Trust values.

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South Hambleton & Ryedale Community Nursing Team	**Community Services**	**Nominated by** **Steve Reed** **A colleague**

The Practice Education Team advised the following: Firstly, you may be aware that the way student nurses are assessed and supervised in practice has changed recently which has required wholesale training changes for all registered nurses in the trust. The community teams have been consistently the quickest to adapt to this process with currently 78% of community mentors transitioned to the new system – far ahead of the trust average. The engagement from community nurses has been all the more impressive from the practice education team's perspective because of the significant workforce transformation happening in the community. This engagement with the new system has minimised the impact on students and largely maintained a high quality learning environment. Additionally, despite significant changes two community areas have been incredibly accommodating of additional learners in their areas. The nurses at Kirbymoorside and Pickering in particular have had to take additional Trainee Nursing Associates (TNAs) over the past 6 months to ensure that our TNAs from Scarborough have had community experience. This is on top of their usual student allocation and in addition to them having TNAs of their own. I would say their help and support has been essential to the TNAs in question and in line with the high standards the community has set for band 4s already. I wanted to share this feedback because I understand there has been a reasonable amount of staff turnover lately, but in spite of that community staff have really helped us make sure learners are having a good experience and some teams have gone above and beyond what we would expect to help.

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Ioana Triboi, Kat Hughes & Laura Robson Therapies, Healthcare Assistant, Occupational Therapist & Team Leader	**Community Services**	**Nominated by Stuart Goodall A colleague**

These three individuals worked tirelessly on the evening of Friday 20/03/20 to ensure that a patient discharged from hospital could remain at home with the correct level of support and equipment. Their attitude of putting the patient first, dealing with the patient with great empathy and patience showed the key values that make the York Community response team such a great team!

Mary Glo Staff Nurse	**Scarborough Hospital**	**Nominated by Adam Newton A patient**

I attended as a day case patient on the SAU currently on Cherry ward. Mary was very professional and friendly and introduced herself and informed me on housekeeping procedures. Mary made me feel at ease and went out of her way to ensure my visit was as pleasurable as it could be, with my health issues and covid-19. She introduced me to other patients so we could talk amongst ourselves while waiting for our procedures etc., this eased our anxieties. Mary was also very efficient, and her hand hygiene was carried out to a high standard. She is an asset to your hospital and team and I hope she is recognised for this.

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The A&E Department	**Scarborough Hospital**	**Nominated by A colleague**

This A&E department at Scarborough hospital work tirelessly, always ready for whatever comes through the doors. The team are amazing they help each other regardless, quite often patients commend how they all work and are very thankful how they have been cared for noticing how very busy everyone is, but, they still make the patient feel nothing is too much trouble.

The Midwives and Maternity Support Staff	**Scarborough Hospital**	**Nominated by Wendy Rowbottom A relative**

I would like to nominate the midwives and maternity support staff as not only are they supporting very anxious, vulnerable Mums to be and mums who have just had their babies, their support of each other goes beyond outstanding. There are no words that can express my thanks to them all for the support they have given my daughter who is a midwife in the team, over the last 5 years. My tears flow every time I read their words of support and love to her.

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Lauren Williams, Lisa Nicholson and Joanne Barstow
Domestics

Scarborough Hospital

Nominated by
Louise Fisher
A patient

Lisa, Jo and Lauren do a brilliant job, day in, day out. They have consistently high standards in what they do, which they maintain despite having a huge amount to do in the time they have. No matter how busy they are or whatever else is going on, their levels of patient care are second to none, brightening the bays as they work. During a recent admission of mine, Lisa, Jo and Lauren all went over and above for an elderly patient who had a tendency to become quite agitated or unsettled. They were endlessly patient with her, happily making her extra cups of tea or coffee and having an extra chat with her. They quickly realised that, if she was hungry, she was much more agitated so were proactive in making sure she'd had a snack during the morning. Such a little thing really but it made a huge difference to the lady herself in remaining calm, and to the rest of us in a bay where there was a significant level of need over a couple of weeks. Their care and attention also helped the ever-under-pressure nurses and healthcare assistants.

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Jeanette Almond	**Scarborough**	**Nominated by**
Outpatient Services	**Hospital**	**Kayleigh Bradshaw**
Administrator		**A colleague**

Jeanette received a call from a patient on Tuesday 31st March and could not understand him because he could barely speak. She asked her Team Leader to listen in to the call who could also not understand him. We were worried about how his speech was slurring and how he sounded out of breath and in distress. Jeanette asked if there was a carer or a family member who could speak on his behalf, to no avail. After 15 minutes of attempting to extract any information from the patient, Jeanette reassured him that she would take down his number, attempt to find out who he is & call him back. She decided to call 101 to see if the police could track the landline number that he called from. She was advised by the police to call BT. She spent more than 1 hour speaking to several different sources in the police and BT in order to help this patient. After a while of trying, the police contacted Jeanette to explain that they have found out the patient's details and have sent an ambulance and police car round to the patient's address to check on him. We are unaware of the outcome of this scenario but as a team, we were extremely proud of Jeanette's attitude and determination towards helping this patient.

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Rachel Brook
Fundraising Manager

Trust Wide

Nominated by
Emma Dunnill
A colleague

It's not possible to list all the ways that Rachel has helped make a difference to York Teaching Hospital Charity but it's safe to say it would be a long list! Despite covering maternity leave, Rachel has created a strong team atmosphere and achieved so much throughout the year. Whether it's going above and beyond for her team, assisting with significant changes to financing methods or putting in endless hours to help fundraising efforts and ensure donor wishes are met. Rachel is truly inspiring and deserves to know how much of a positive impact she's had to the Trust and colleagues. She has personally helped me develop confidence in my position and given me so many opportunities for professional development that I would never have been given the chance to do. Thank you Rachel!!

Tracey Gofton
Senior Training Manager

Trust Wide

Nominated by
A colleague

We have rolled out drug ordering across York, Whitecross Court, St Helens, Bridlington and Scarborough, which is a huge piece of work, to staff members who were not always positive about the change. While everyone on the EPMA team and the trainers and pharmacists worked hard, I don't think it would have gone as well without Tracey. She co-ordinated all the teams, making sure targets were possible, cover was provided, and everyone was given the right roles, and ensured everything went smoothly - and it did.

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Aileen Smith
Deputy Sister

York Hospital

Nominated by
Andrew Mate
A patient

I believe that when you come to hospital in an emergency it is not necessarily the treatment that you get but, how that treatment is handled by the people administering it. In my case I was pretty much out of it by the time I was received in the Critical Care Unit (CCU). Aileen came to me with a large warm blanket which she threw around me saying and I quote " oh you poor wee thing", I immediately felt comforted because you cared for me not my condition. I told Aileen I needed to defecate "Aileen said to me just let it go" I said it is very loose “Aileen said to me once again, just let it go" I did. No chastisement, just sheer loving care. Aileen Smith, you are without doubt so much more than a Senior Nurse you are a senior person.

Adrian Chesterton,
Paulo Cardoso &
Phil Copley
Storekeepers

York Hospital

Nominated by
The Microbiology
Team
Colleagues

The guys in stores have been incredibly understaffed the last few weeks. They have continued throughout this period to be upbeat helpful when ever our department require anything bringing up or taking away. Any stock items we require from stores they gladly bring up for us and even when so understaffed and take out our waste bins. They always have a smile on their face even when incredibly busy and everyday make our lives easier in the lab.

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Victoria Beattie **York Hospital** **Nominated by**
Staff Nurse **Dianne Sloan**
A relative

My daughter came in after suffering what she thought was a miscarriage. The pregnancy test came back positive so they had to be certain it wasn't ectopic. The care Victoria gave was amazing!! My daughter was terrified of an internal and also having bloods but Victoria was so wonderful with her! She came and spoke to her and reassured at all times. She even made us drinks while we waited for bloods to come back. I wish there was more people like her! Victoria deserves recognition!! Thank you so much.

The Endoscopy **York Hospital** **Nominated by**
Waiting List Team **Faye Barnett**
A colleague

The Endoscopy Waiting List Team have been working under extreme pressure recently, for a variety of reasons. Despite this, they have willingly taken on additional work which has been generated by insourcing work and waiting list initiative (WLI) lists being put in place in order to manage the operational pressures Endoscopy have been experiencing. Waiting lists are often forgotten about in a patient's journey as they are not visible, but they are a vital part in the patient's journey and the 'front door' to the trust. The helpful and accommodating way they have gone about this additional work and pressure, even when 'hiccups' have occurred along the way, deserves recognition as this epitomises the trust values. Well done team.

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Patricia Moorhouse Audiologist **York Hospital** **Nominated by Natalie Goodwin A relative**

I can't thank Trish enough for all the help and support she has given to me and my daughters Limerick 8 and Lilly-Anne 7 with not just their hearing loss but with helping fund raise and helping me with gathering the relevant information for sponsorship and funding opportunities to help them to fulfil their dreams of being able to represent England and the deaf community in kickboxing at the world and European championships she has gone above and beyond for them she is just amazing.

The Maternity, Labour, Triage & Antenatal Teams **York Hospital** **Nominated by Rebecca Davies A patient**

I have had a lovely experience throughout my pregnancy at York Hospital. At 28 weeks I started my journey to weekly consultant appointments and day unit monitoring! The midwives are absolutely fantastic! I felt very looked after each week! They go above and beyond! The midwife I had in labour Karen Smith was brilliant. During my labour I was very anxious and worried about how I was coping with my labour! Karen made me and my partner feel very reassured and was supportive. My partner at times felt helpless but Karen made him feel a massive part of my labour. After the birth of my little girl Karen was brilliant from start to finish and we are very grateful for such a wonderful experience! Thank you to you all you made a stressful few weeks not as stressful as it could have been.

The Maxillofacial Team 02/03/2020 **York Hospital** **Nominated by Julie Brown A patient**

I was worried about a wisdom tooth extraction following painful treatment at a dentist. The surgeon explained procedure, why I could feel it at the dentist and the way he numbs it differently so that there would be no pain. I felt no pain felt during the procedure. All of the team were knowledgeable and the surgeon was very efficient.

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Natasha Dyer
Deputy Sister

York Hospital

Nominated by
Alice Hunter
A colleague

This nurse went above and beyond to ensure the acute stroke unit service was covered on a Friday night following short notice sickness and when there were no other alternatives. Natasha showed true Trust values and came in to work to cover the service at very late notice without any hesitation. If Natasha had not done this patient safety would have been compromised and Stroke patients would not have had access to a time critical treatment. She showed true dedication to the service and is a valuable member of the team, continually supporting her staff and providing fantastic patient care.

The Outpatient Antibiotic Therapy Team (OPAT)

York Hospital

Nominated by
Jon Livesey
A colleague

The necessity to provide weeks or months of intravenous antibiotic therapy is a life-saving requirement of modern medicine. The only way to provide this treatment before OPAT was for patients to be an inpatient, occupying a bed. An outsourced OPAT service was withdrawn. The microbiology team developed an in-house service which is superior to the old service, improves patient experience and saves weeks of bed days for many patients. I feel that I should be saying much more in support of this recommendation but I also believe that a brief exploration of the OPAT service will speak for itself.

The Team on G1

York Hospital

Nominated by
Neil Houghton
A patient

I would just like to thank everyone on ward G1 from the nurses, food trolley angel's right to the cleaners. I was working away from home and got food stuck in my throat and after ringing 111 I went to Bridlington but later transferred to York on Monday 24th February. They made everything as good as possible and made me feel so comfy and relaxed, they really are all angels.

Kelly Williams
Occupational Therapist
Rich Wakefield
Physiotherapist

York Hospital

Nominated by
Emma Crooks
A colleague

Kelly and Rich have taken a lead role in re-vamping the huddle / SAFER on ward 39 (stroke rehab). They have successfully reduced the time it was taking the therapists and nursing staff from 30-40mins to under 8 minutes! This is a great achievement. They have had some amazing responses trust wide and have gained national interest (via twitter) with teams wanting to know what our secret is. This of course if great communication, team work and seeing the benefits that SAFER / huddle bring to patients and the ward / team as a whole. The trust Improvement Team have also asked if we would kindly let them film huddle for training purposes across the trust - again this is a great improvement and recognition of the teams hard work. Although Kelly and Rich have led on the huddle improvements I would also like to thank every member of the MDT (especially nurses) who has dedicated themselves to being at the whiteboard promptly, with the correct information. Kelly is now in the process of designing a rota for therapists in particular but hopefully will include nurses too who will become “experts” in leading huddle and updating the whiteboard. Since implementing the changes the DLO has commented on how this has made her job a huge amount easier

Maureen Welsh
Domestic

York Hospital

Nominated by
Emma Brown
A colleague

I am a student nurse who has been on placement in the ICU department. Maureen was always there in the mornings. She does a great cleaning job and is a lovely lady who is friendly and goes above her job title by spending time talking to patients who need a chat or need some company.

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Katie Fisher
Clerical Officer

York Hospital

Nominated by
Nicola Moore
A colleague

I want to thank Katie for going above and beyond. She recognised and rearranged clinic lists for us making the day run so much smoother due to staff shortages. Katie kept morale high between the women attending ante natal clinic and kept them informed and updated. Nothing is ever too much trouble for her. She is always happy to help!

The Acute Stroke Unit Team

York Hospital

Nominated by
Becky Thomas
A relative

My grandad, Neville Dickinson, had a major stroke, which unfortunately lead to him passing away after a week on the stroke unit in York Hospital. The only thing that made this easier for us was the care given to him (and us) by the nurses, they were fantastic. Always very friendly and we were never made to feel like we were in the way or inconveniencing them when we asked for updates. And we did that a lot. For me personally, they gave me the strength to get through my visits so that instead of breaking down by his bedside I spent them talking to him, which I will always appreciate. One name that has come up with every family member that visited was Lindsay but unfortunately we didn't get a last name. She always seemed to be there whether we called or visited and always seemed happy to see us which gave us comfort when we ha d to leave him because we knew he was never left completely alone.

Gaynor Hall
Emergency Nurse Practitioner

York Hospital

Nominated by
Stuart Varndell
A patient

Gaynor went above and beyond was very professional and gave me as much information as she possibly could she spoke to Hull hospital and got me into Hull Royal Infirmary the following morning for an operation on my finger very grateful for all she did.

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Paul Davies 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 and 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.

Leanne Covey
Senior Bereavement Officer

York Hospital

Nominated by
Hayley Dawson
A patient

I would like to nominate Leanne from bereavement. She has the biggest kindest heart of gold, going above and beyond with her kindness through the loss of my baby boy. Leanne helped arrange his funeral, which I couldn't have done by myself, her support was invaluable. Leanne has also just been there to listen when I have felt I had no one else to turn to, she has helped me get through the most heart breaking experience of my life she truly is a special person who definitely deserves to be noticed.

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Helen Suwareh
Healthcare Assistant

York Hospital

Nominated by
Abigail Rescorle &
Esther Taylor
Colleagues
Chris Elliot
Retired Colleague

Abigail and Esther said:
In our opinion, Helen has shown that she has gone above and beyond displaying the Trust values and made a huge difference to an individual and his family. Helen had seen a North Yorkshire Police urgent appeal for a missing man from the Selby area. Helen recognised this man outside the hospital's main entrance in the early hours of the morning. Helen contacted the hospital's security team so she could view CCTV footage to check to see if her concern was correct. Her quick thinking led to her alerting the police who then safely located the vulnerable man within the grounds of the hospital.

Chris Said:
Facebook had posted an elderly gentleman had gone missing asking for help. Helen while on her break during the night shift and getting some fresh air saw the man who asked her if he could go in to use the loo. She recognised him and called the police and he has now been re-united with his family.

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

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