

# Board of Directors (Public Meeting)

30 September 2020



# BOARD OF DIRECTORS MEETING

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

On: 30 September 2020

In: via Webex

TIME	MEETING	LOCATION	ATTENDEES
9.00 – 11.45	Board of Directors meeting held in public	Via Webex	Board of Directors Members of the public
12.30 – 1.30	Board of Directors meeting held in private	Via Webex	Board of Directors
1.45 – 2.45	Remuneration Committee	Via Webex	Non-Executive Directors, Chief Executive & Director of Workforce & OD



# Board of Directors (Public) Agenda

SUBJECT	LEAD	PAPER	PAGE	TIME
<p><b>1. Apologies for absence and quorum</b></p> <p>To receive any apologies for absence</p>	Chair	Verbal	-	9.00 – 9.10
<p><b>2. Declaration of Interests</b></p> <p>To receive any changes to the register of Directors' declarations of interest or to consider any conflicts of interest arising from this agenda.</p>	Chair	<a href="#">A</a>	7	
<p><b>3. Minutes of the meeting held on 29 July 2020</b></p> <p>To receive and approve the minutes of the public meeting held on the 29 July 2020.</p>	Chair	<a href="#">B</a>	11	
<p><b>4. Outstanding actions</b></p> <p>To discuss any actions arising from the action log.</p>	Chair	Verbal	-	
<p><b>5. Staff Story</b></p> <p>To receive a staff story about the Physicians Associate Role.</p>	Care Group 6 Manager	Verbal	-	9.10 – 9.25
<p><b>6. Infection Prevention &amp; Control Update</b></p> <p>To receive an update on Infection Prevention &amp; Control.</p>	Dep. Dir of IPC	Presentation	-	9.25 - 9.40



SUBJECT	LEAD	PAPER	PAGE	TIME
<b>7. Chief Executives Update</b>  To receive an update from the Chief Executive	Chief Executive	<a href="#">C</a>	23	9.40 – 9.50
Strategic Goal: To deliver safe and high quality patient care				
<b>8. Phase 3 Recovery</b>  To receive an update on the Phase 3 Recovery Work	Chief Operating Officer	<a href="#">D</a>	27	9.50 – 10.10
<b>9. Winter Resilience Plan</b>  To receive an update on winter and emergency planning	Chief Operating Officer	<a href="#">E</a>	119	10.10 – 10.30
<b>Short Break</b>				10.30 – 10.40
Strategic Goal: To deliver safe and high quality patient care				
<b>10. Integrated Care System Update</b>  <ul style="list-style-type: none"> <li>HCV Update</li> </ul>	Chief Executive	Verbal	-	10.40 – 11.00





SUBJECT	LEAD	PAPER	PAGE	TIME
<b>11. Quality and Resources Committees</b>	Committee Chairs			11.00
Items for escalation to the Board.				–
<ul style="list-style-type: none"> <li>18.08.20 to receive and note the minutes</li> <li>22.09.20 to receive and discuss the Committee Logs</li> </ul>		<a href="#">E</a>	167	11.20
The Board is asked to approve the following:		<a href="#">F1</a>	To Follow	
<ul style="list-style-type: none"> <li>Revalidation Report</li> </ul>		<a href="#">F2</a>	191	
Strategic Goal: To deliver safe and high quality patient care				
Strategic Goal: To ensure financial sustainability				
Strategic Goal: To support an engaged, healthy and resilient workforce				
<b>12. Integrated Business Report</b>	All	<i>Separate Report</i>	-	11.20
To receive and discuss the IBR, highlighting any areas of concern not already discussed or escalated by the Quality & Resources Committees.				–
				11.30
Governance				
<b>13. Reflections on the meeting</b>	Chair	Verbal	-	11.30
<ul style="list-style-type: none"> <li>BAF</li> </ul>		<a href="#">G</a>	197	-
				11.40
<b>14. Any other business</b>	Chair	Verbal	-	11.40



SUBJECT	LEAD	PAPER	PAGE	TIME
<b>15. Items for information:</b>	Chair			
• CQC Update		<a href="#">H</a>	225	
• Infection Control Report incl. BAF		<a href="#">H1</a>	241	
• Continuity of Carer Report		<a href="#">H2</a>	251	
• Medical Directors Report		<a href="#">H3</a>	255	
• To receive the Sept 2020 Star Awards booklet		<a href="#">H4</a>	267	

### 16. Time and Date of next meeting

The next meeting will be held on 25 November 2020 via webex.

Items for decision in the private meeting: - None

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

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



**Additions:**

**Changes:**

**Deletions:**

**Lorraine Boyd—Equity Partner, Millfield Surgery**

**Jennie Adams—resigned**

**A**

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

Director	Relevant and material interests					
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<b>Mr Steve Holmberg (Non-Executive Director)</b>	Nil	Nil	Nil	<b>Act as Trustee</b> –on behalf of the York Teaching Hospital Charity	Nil	Nil
<b>Mr Jim Dillon (Non-Executive Director)</b>	Nil	LLP—Members Representative	Nil	<b>Act as Trustee</b> –on behalf of the York Teaching Hospital Charity	Nil	Nil
<b>Mr Matt Morgan (Stakeholder Non-Executive Director)</b>	Nil	Nil	Nil	<b>Act as Trustee</b> –on behalf of the York Teaching Hospital Charity	<b>Deputy Dean</b> —Hull York Medical School	Nil
<b>Mr Simon Morritt (Chief Executive)</b>	Nil	Nil	Nil	<b>Act as Trustee</b> –on behalf of the York Teaching Hospital Charity <b>Act as Trustee</b> Medicine		Nil
Other: Member of the Independent Reconfiguration Panel (Independent Committee advising the Secretary of State on contested health service re-configuration.						
<b>Mr Andrew Bertram (Executive Director Director of Finance/ Deputy Chief Executive)</b>	Nil		Nil	<b>Act as Trustee</b> –on behalf of the York Teaching Hospital Charity	<b>Member</b> of the NHS Elect Board as a member representative	Nil
<b>Mrs Heather McNair (Chief Nurse)</b>	Nil	Nil	Nil	<b>Act as Trustee</b> –on behalf of the York Teaching Hospital Charity	Nil	Nil

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

## Board of Directors – 30 September 2020 Public Board Minutes – 29 July 2020

### **Present: Non-executive Directors**

Ms S Symington	Chair
Mrs J Adams	Non-executive Director
Dr L Boyd	Non-executive Director
Mr S Holmberg	Non-executive Director
Ms L Mellor	Non-executive Director
Mr J Dillon	Non-executive Director
Prof. M Morgan	Non-executive Director

### **Executive Directors**

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

### **Corporate Directors**

Mrs L Brown	Acting Director of Communication
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### **In Attendance:**

#### **Trust Staff**

Mrs L Provins	Foundation Trust Secretary
Mrs S Haigh	Lead Nurse – Tissue Viability – for item 20/24
Dr V Jayagopal	HYMS Clinical Dean for item 20/25

### **Observers:**

Sally Light	YTHFT Governor
Margaret Jackson	YTHFT Governor
Michael Reakes	YTHFT Governor
Chloe Laversuch	York Press
Julie Southwell	YTHFT Staff
Pouya Alaghband	YTHFT Staff

Ms Symington welcomed everyone to the public Board meeting at York Hospital. The meeting was held in public via webex.

## 20/20 Apologies for absence

Apologies were received from Jenny McAleese (Non-executive Director).

## 20/21 Declarations of interest

Dr Boyd stated that she is no longer an equity partner in Millfield Surgery.

No further declarations of interest were raised.

## 20/22 Minutes of the meeting held on the 29 January 2020

It was noted that the minutes of the meeting held on the 29 January 2020 had been approved at the April private Board meeting due to the pandemic.

## 20/23 Outstanding Actions

Mr Taylor noted that in relation to the action asking executives to be visible in the hospital, all executives had been present throughout the pandemic, but due to infection prevention rules not all areas could be visited.

No further items were discussed.

### The Board:

- **Noted the action log and supported the comment in relation to visibility of the executive team.**

## 20/24 Patient Story

The Lead Nurse for Tissue Viability, Mrs Haigh, provided the Board with an overview of a patient journey through the Trust. The patient had been admitted to Scarborough Hospital with Covid 19 and had spent 8 weeks in both Scarborough and York ITU Departments before being transferred to a ward. Mrs Haigh explained that the patient had been very poorly. Her involvement in his care was as a result of him developing a severe pressure ulcer (category 4) on his sacrum. She detailed the care the patient received and provided a very compelling narrative about his care including the experience she had faced of going into ITU in full personal protective equipment (PPE) and the learning involved due the pandemic. Mrs Haigh also highlighted the good communication between teams and the importance of data and surveillance.

Mrs Haigh stated that the patient had eventually been discharged and was very thankful for his care during the period and that the pressure ulcer was almost healed now. The patient also wished his story to be highlighted to the Board to show how challenging conditions had been for staff at the height of the pandemic and that it was important that the public follow safety guidance about the pandemic.

Ms Symington thanked Mrs Haigh for sharing the patient episode with the Board.





Mrs Mellor thanked Mrs Haigh for her very eloquent story and for providing the Board with an overview of the pandemic period. She noted that learning had been rapidly taken on board and wondered what Mrs Haigh felt were the biggest learning opportunities going forward. Mrs Haigh stated that it was to continually talk and listen to the patient as you can learn so much that will help.

Mr Holmberg stated that the team had been hard on themselves as the patient had been really poorly and unlikely to survive, but he understood the importance of reflection and self-criticism focused on every aspect of his care.

Mr Dillon stated that this was a remarkable insight especially the description of staff wearing full PPE. He stated how proud the Board were of all staff. He asked how typical this patient journey was. Mrs Haigh stated cases like this were few and far between and that there were a number of factors involved in pressure ulcers such as age and lack of mobility.

Prof. Morgan stated that the work was very impressive and he noted the important role of communication between teams especially when wearing full PPE, but wondered if there was anything that could be improved. Mrs Haigh stated that staff had been innovative as it was difficult to recognise staff in full PPE let alone communicate. Staff had learnt ways to make sure they knew who was who and also provide some personality, but she stressed the important of using the 'hello, my name is...' with patients as it was all about explaining who you were and what you were doing so that the patient was fully informed.

Mrs McNair wished to provide Mrs Haigh with special thanks as she noted that she was the only tissue viability specialist who had been going into Covid positive areas such as ITU.

Ms Symington again thanked Mrs Haigh for her great and moving story.

#### **The Board:**

- **Were moved by the very compelling story of a Covid positive patient and the treatment they received at both Scarborough and York**

#### **20/25 HYMS Development Update**

Dr Jayagopal, HYMS Clinical Dean provided a presentation on HYMS Developments to the Board. He covered what had happened to the students during the pandemic, the provision of iPads to the Trust and was pleased to share the results of the latest survey which had improved.

Ms Symington thanked Dr Jayagopal for his informative presentation.

Prof. Morgan thanked Dr Jayagopal on behalf of HYMS for the work that he and his team had done during the pandemic and were continuing to do which had been phenomenal.

Dr Jayagopal stated that things were going to be different going forwards, but that this also brought opportunities! He noted that space was an issue as HYMS could not expose the students to patients in Covid positive areas and remote clinics would challenge teaching opportunities, however, HYMS are looking at how to make the changes work.

Mrs Mellor noted some of the learning described, but asked if there was anything else that HYMS could take forward. Dr Jayagopal stated that the biggest learning opportunities would be about how to adapt teaching methods, as student learning was truncated during the pandemic. He noted that medicine as an academic discipline would always be an “apprenticeship”.

Mr Dillon noted that the new facilities mentioned were crucial to attracting the best students (who proactively seek out the best facilities) so this was very important. He talked about the need to bridge the funding gap and look at multiagency use site. Mr Dillon stated that it was important to get the local council and LEP involved and get the best utilisation of space, for example virtual libraries. He stated that it was important to use different solutions to reduce the costs.

Mr Holmberg stated that it was really good to hear the progress, he asked if the success factors were known and if these could be sustained. Dr Jayagopal stated that all areas had been assessed to look at what improvements could be made going forwards.

Mr Morritt stated that the Trust supported the new build and the preferred option was a build close to the hospital, but there would need to be work to manage numbers and to expand on site accommodation in the short term prior to the build.

Ms Symington thanked Dr Jayagopal and asked him to provide a further update in December if appropriate.

**Action: Dr Jayagopal to provide the Board with a HYMS update in December, if appropriate.**

**The Board:**

- **Supported the HYMS work and were committed to working towards a new build**

**20/26 Chief Executive Overview**

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

**Covid 19** – Mr Morritt stated that this was the Trust’s first public meeting since the pandemic and although he and the Chair had thanked staff via a number of forums, he wished to formally place on record at this public Board meeting his thanks to all staff. Mr Morritt noted the presentations by Mrs Haigh and Dr Jayagopal which highlighted the resourcefulness of staff who had been innovative and developed solutions to problems during the pandemic and were now engaged in the recovery period. Mr Morritt also thanked all the Trust’s partners and organisations and communities that had supported the Trust and who had undoubtedly, helped to maintain a level of staff morale during the pandemic.

Mr Morritt stated that the Trust was through the first wave and in the restoration and recovery mode, which had been classified as phase 3. The Trust was in the planning stages of phase 3 and activity would be expanded in the coming weeks. He stressed that



Covid 19 had not gone away and that messages around social distancing, increased hand hygiene and wearing appropriate PPE would need to continue.

**Our Voice Our Future** – Mr Morrith stated that the Trust had taken advantage of technology used previously for the Our Voice Our Future work and used it to check with staff about what had worked well during the pandemic, together with any areas of learning.

Mr Morrith stated that the Trust were just about to feedback on a major piece of work on values and behaviours before the pandemic. He felt it had been right to suspend the work, but now wanted to bring it back in September. He noted that opportunities for getting large numbers of staff together were limited, but was committed to finding a way of bringing the work back to life.

**Action: Clever Together update to be provided in September.**

**Humber, Coast and Vale ICS** – Mr Morrith stated that the ICS had gone live in April and an update on the agreed operating arrangements was appended to his report. In essence, the operating arrangements were about focusing energies at a place and partnership level.

**New Board Members** – Mr Morrith welcomed Prof. Morgan to the Board and noted that Mr Roberts, the new Chief Digital Information Officer, would be joining the Trust on the 10 August. Mr Morrith also highlighted that Mrs Adams would be leaving the Board at the end of the August and the Trust was starting the recruitment process for a new Non-executive Director.

**The Board:**

- **Received and noted the Chief Executive's Report**

#### **20/27      Integrated Care System Update**

Mr Morrith stated that the briefing included in the pack goes to all organisations and the item he wished to highlight was the signed Memorandum of Understanding which allowed Harrogate Trust to be a part of the ICS whilst also being involved in the West Yorkshire ICS.

Ms Symington added that the ICS had become a reality during the Covid period and it was being made clear that any monies available to the Trust would come through that route.

**The Board:**

- **Received the update**

#### **20/28      Integrated Board Report**

The Integrated Board Report (IBR) is an opportunity to highlight issues for discussion.

**Performance** - Mrs Scott noted that currently the prevalence of Covid 19 is low with the Trust only having one Covid positive in-patient. Attendances in the Emergency Department at York and Scarborough had increased, but were still not back to pre-Covid levels and patient length of stay was also currently lower.

Mrs Scott stated that the really positive story was the way the pandemic was helping to change the way the Trust worked. She noted that fast track referrals were nearly back to normal and it was a key priority for patients to present to GPs so that any cancer diagnoses could be made earlier in the pathway. The Trust was now targeting getting routine services back on track whilst maintaining patient safety. Mrs Scott noted that productivity would be lower than before the pandemic, but the Trust was focusing on how to create as much capacity as possible whilst also preparing for winter and a possible second pandemic wave. Mrs Scott stated that the Trust needed to be mindful of the challenges of social distancing and was working collaboratively with the private sector who had been hosting some services to protect shielding patients. Mrs Scott stressed the need to continue to build the relationship with the private sector and wished to formally thank them for helping to maintain critical services.

**Finance** – Mr Bertram stated that the IBR provided data by month on page 26 and cumulatively on page 27. Mr Bertram stated that the plan set in March had been suspended by the Regulators and the Trust had been set an in-month balance figure of £46m which was shown in chart 601. The Trust receives £46m a month excluding any Covid 19 spend and then a truing up exercise is undertaken to allow balance to be achieved. He explained that the Trust was currently spending £45m against the £46m, however, Covid 19 spend amounted to £2m which puts the Trust the wrong side of the £46m so the truing-up exercise brought the Trust back to a balance position.

Mr Bertram stated that the truing-up arrangement will continue to the end of August and may continue into September, and it would be reasonable to expect the second half of the year will be some kind of allocation. This will inevitably mean that the Board will have to move back to managing the resources allocated. Mr Bertram stated that currently cash was not an issue as the Trust is being paid in advance, but this will also change in the second half of the year.

Ms Symington stated that she had heard a ‘use it or lose it’ phrase in relation to private facilities and wondered if she was right in assuming that the centre were now moving towards rewarding productivity? Mr Bertram stated that he thought that was right. The Trust was being provided with a base level of funding to deal with Covid 19 and the mechanisms in place encouraged organisations to deal with the patients whose treatment has been interrupted, but it was inevitable that there would be lost productivity due to social distancing, but there were gains to be made from new ways of working like online consultations.

Mrs Adams stated that things had been paused during the pandemic, but the Trust needed to focus on backlog maintenance and progress with capital projects. Mr Bertram stated that things had not been paused, but they were certainly moving slower and that the VIU works would start on the York site in four to six weeks. He noted that work was being done to refresh the capital programme and a full back log maintenance discussion would take place next month to allow discussions around risk and prioritisation.

Mr Bertram stated that the Trusts has made a significant number of capital bids which seek to access a variety of funding and he hoped that further clarity would be provided next month.



Dr Boyd asked if the funding would also include things required in the community and Mr Bertram was clear that it did. He noted that the CCGs were co-ordinating a number of bids which were modest in comparison to the Trust, but some of the initiatives included talk before you walk.

**Workforce** – Ms McMeekin stated that the IBR included the June data and that the team continued to proactively manage recruitment. The vacancy rate was down 1% from May to 6% and the nursing vacancy rate was down across the Trust. Staff retention has improved and absenteeism is slowing falling (5.9%). She noted the low compliance with appraisal rates and the position in relation to revalidation and the need for improvement with the non-medical appraisal rates over the next couple of months.

Prof. Morgan stated that he was aware that revalidation had been postponed for a year, but that the Trust had had a low compliance rate before this and asked if there was a plan to catch up as the backlog would be even bigger. Ms McMeekin stated that there would be a catch up plan and use of technology was planned to make this as easy as possible.

Mrs Adams stated that the Staff Survey continued to evidence little progress with quality of care and being a learning organisation. Ms McMeekin stated that the survey had been conducted at the end of last year and only 43% of staff had completed it. She provided an overview of the Staff Survey Report which was in the 'for information' section of the Board pack. She noted that the Trust was not good at encouraging incident reporting and sharing the learning, but she was encouraged that the new Deputy Director of Patient Safety and Clinical Governance who had been appointed would reinvigorate the process. She also noted that the Datix feedback element had been switched on.

Mrs McNair stated that a lot of this was wrapped up in the quality improvement work and that Mr Taylor was looking to appoint a QI lead from the clinical staff and the new Deputy Director of Patient Safety and Clinical Governance would help to underpin this work.

Ms Symington shared her significant concern about staffing numbers over the winter period. Mr Taylor stated that it was about engaging, supporting and empowering staff as well as talking about recovery, learning, safety and quality improvement. He stated that all the elements were entwined. He stated that while he was starting to see improved governance and learning which was there before, the evidence was lacking. Ms Symington asked if this would help retain staff? Mr Taylor stated that it was about creating the right culture and behaviours in the Trust, embedding the QI strategy and making staff feel valued.

Mrs McNair stated that she was also anxious about workforce and there needed to be increased psychological support for staff as the pandemic situation had not been normal for them. She was unsure what implications there would be for the Trust from a second pandemic wave and staff needed to be psychologically prepared.

Mr Taylor also agreed that the recovery would be challenging for staff and they would need support.

Mr Taylor stated that the summary from the Quality & Safety Report had been discussed at the Quality Committee.

It was noted that medical appraisal will restart on the 1 October.





## The Board:

- **Noted the discussions and expressed concern about staff numbers, and also the need to support staff through the coming winter**

## 20/29 Quality & Resources Committees – Items for escalation

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

**Resources Committee** - Mrs Adams stated that the items for escalation not already covered were:

**Digital** – Mrs Adams noted that Mr Dylan Roberts will be joining the Trust in August.

**LLP** – Mrs Adams highlighted the items and that the LLP were seeing quite a bit of sickness which although down in the Trust, was up in the LLP. There was also concern around the delivery of key performance indicators. Ms McMeekin stated that staff retention was positive, but that there were a number of individuals off with long term stress, anxiety and depression due to culture issues and aspects of change. She noted that there was an action plan in place and she was confident that things would improve in the coming months.

Mrs Adams stated that she was impressed with the added transparency and signs of improvement in some areas of the LLP.

It was noted that the digital team had been pivotal during the pandemic and the team had done a great job looking for solutions especially with regards to getting staff to work from home and providing better ward information.

**NHS Workforce Race Equality Standard** – Ms McMeekin provided an overview of the paper for information at page 167 of the Board pack. She noted that the Trust is required to do an annual submission against 9 indicators; however, this excludes the LLP who will report separately. She was pleased to report a greater proportion of staff with BAME ethnicity, but that there was a significant deficit in the bandings 8a and above in relation to non-medical staff. Ms McMeekin noted that overall staff numbers have grown, but this means there is a deterioration in the BAME position in relation to Board. Band 1 is being closed and currently only has 4 white staff members. She also noted that BAME staff are proportionally more likely to access more training than their white counterparts and there have been no BAME disciplinaries. She noted that improvements were required as there is still the perception that staff feel discriminated against. The report will be uploaded to NHSE/I August and placed on the Trust's website. The action plan will be delayed until the end of October.

Ms McMeekin stated that the Trust is in the process of developing a BAME Network and a Chair and Vice Chair have been appointed who will be supported to work up the framework and governance structure. The BAME Network will be used to hold the Trust to account and Ms McMeekin will update the Resources Committee in due course.



In relation to risk assessment for BAME staff linked to Covid 19, 79% of these have been completed according to the data pulled this week.

Mr Holmberg asked how the BAME Network Chair and Vice Chair were appointed when there is no Network. Ms McMeekin stated that she should have stressed that the appointments are interim until the Network is up and running when they can elect their own representatives. For these appointments, expressions of interest were invited together with a supporting statement.

Prof. Morgan asked if the Network will be practically supported with time allowed in job plans and access to admin support. Ms McMeekin stated that there has been a huge amount of national support as the Trust is not the only one who does not have a Network and HR will provide the support.

Prof. Morgan asked how it will work when the Network becomes self- supporting especially in relation to time allowances in job plans. Ms McMeekin stated that this was a valid point and they will look at what other Trusts are doing.

Ms McMeekin stated that previous actions have improved the position. In relation to the imminent NED recruitment the Trust has proactively changed the advert and are pursuing links to BAME Networks to encourage people to apply. She noted that previously the adverts have been very transactional and she would like to engage the new Networks help to make them more ambitious.

Prof. Morgan asked if Ms McMeekin had been in touch with other Trusts and she noted that Hull has an established BAME Network so help has been sought.

Ms Symington stated that she has asked Board members who have access to various networks to reach out to them about the NED recruitment. Mrs Mellor stated that she has already done this and the information has gone out across the networks in BT.

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

**Quality Priorities** – the Quality Committee recommended that the Board approved these.

**Cancer** – a presentation had provided assurance and helped to close the loop across this work.

**CQC** – the Board should note that the Committee were more assured that the previous risks had reduced and there was more proactive planning for future CQC engagement taking place.

Ms Symington asked when Mrs McNair thought the CQC would visit the Trust again. Mrs McNair responded that the CQC will step inspections back up in September; however, these are likely to be using less staff and more of a table top exercise. She thought it was likely that the Trust would be visited some time during the winter to stress test the plans put in place, but that the Trust was not currently top of the CQC's list as they were only currently performing reactive visits.

**Infection Control** – Dr Boyd stated that an IPC report had been received.



**Quality Priorities** – Mrs Adams stated that she was concerned that there were too many priorities to provide a real focus and that she thought that previous guidance had been to limit the number. Mrs McNair stated that the priorities were all tied to work that the Trust needed to do around quality improvement and it was all part of a work plan. Mrs Adams stated that she still felt it would be more productive to work on a few as in previous years there did appear to be a lack of progress.

The Board approved the quality priorities.

**CQC** – Mr Morrith wanted to highlight that a letter had been received from the CQC and that the CQC had stated that they were happy with the progress the Trust had made and that the Trust could now apply for the section regulations to be lifted. He noted that it is the Trust's intention to apply for the conditions to be lifted.

**The Board:**

- **Received and discussed the items for escalation;**
- **Approved the Quality Priorities**

**20/30 Organ Donation Report**

Ms Symington stated that this report was for the Board to note. She stated that she had taken over chairing the Organ Donation Committee following Mr Keaney's departure, but she was not as involved as he had been, to date

Mr Taylor stated that the report showed that the Trust was performing well, but there was an action plan to improve this further.

**The Board:**

- **Noted the report and were very supportive of the work being done**

**20/31 Quarterly BAF/CRR Report**

Ms Symington stated that this was the Board's opportunity to look at whether all the risks in the BAF had been covered during the conversations. She noted that a number of the risk scores had been changed and it was reflective of where the Board thought the Trust was.

Mrs Adams stated that sustainability had been discussed at the Resources Committee as the narrative had changed as it highlighted the growing risk for the Trust around being carbon neutral by 2050. She had also noted that this would be moving to the Quality Committee as Mrs McNair now led on this area. Mrs McNair stated that sustainability was now part of her portfolio but there were ongoing discussions about whether this was the right place for it.

Ms Symington felt that the gaps in discussion were around digital and the mitigation for that would be the new Chief Digital Information Officer, Dylan Roberts, who was due to start in the Trust on the 10 August.

**The Board:**

Our vision is to be collaborative leaders in a system that provides great care to our communities.





- **Noted the report and reflected on the areas of risk covered during the meeting discussions**

### 20/32 Reflections on the Meeting

Ms Symington stated that the Board would hold a further reflection session on the day, after the public meeting closed.

Reflections on the BAF and CRR were considered in the earlier item.

### 20/33 Any other Business

Mr Taylor stated that Prof. Morgan had agreed to take on the NED lead role for education and training.

Mr Taylor also wished to put on record that the Trust had made a successful organ donation during the pandemic.

No further business was discussed.

### 20/34 Date and Time of next meeting

The next public meeting of the Board will be held on 30 September 2020 via Webex. Details TBC.

### Outstanding actions from previous minutes

Minute No. & month	Action	Responsible Officer	Due date
19/68	Consider in discussion with new CE, PCN presentation to board.	Ms Symington	<del>Oct 19</del> <del>Jan 20</del> Jul 20 review
19/93	Mortuary to be kept under review on the action list.	Board	Until completed
19/106	Directors asked to be visible in hospital.	Executive Team	Close
20/11	Report front sheets to include items of real concern for Board discussion together with actions to address the concerns.	All	Feb 20 - ongoing
20/17	Invite Care Group Quality Committee Chair's to the Quality Committee	Mrs Provins	Close - Part of Committee structure work
20/25	Invite Dr Jayagopal to provide an HYMS update to the Board in December 2020	Mrs Provins	Dec 2020
20/26	Clever Together feedback to the Board	Mr Morritt	Sept 2020



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## Board of Directors – 30 September 2020 Chief Executive’s Overview

### Trust Strategic Goals:

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

### Recommendation

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

### Purpose of the Report

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

### Executive Summary – Key Points

The report provides updates on the following key areas:

- Looking ahead
- Phase three planning and recovery
- Clinical Strategy Development
- Development of Integrated Care System (ICS)
- Quality Improvement
- Staff engagement and culture change
- Staff wellbeing
- Race equality network

### Recommendation

For the Board of Directors to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: September 2020

## 1. Looking Ahead

The summer holiday season is now behind us, schools and universities have reopened, and - at least for our geographical area - lockdown restrictions have eased. The situation remains fluid and we have seen how quickly it can change, bringing with it new guidance and potentially increased restrictions which need to be implemented at short notice.

Whilst being mindful of the current context, it remains the case that the numbers of coronavirus admissions to our hospitals are relatively low, and we are some way off the levels we saw in the spring.

Therefore whilst we must of course be prepared for a second surge in admissions, I do believe that the time is right for us to focus on a number of key strategic pieces of work that will be the focus for us throughout the second half of the year, and to move these forward.

## 2. Phase three planning and recovery

The first of these is our recovery and restoration planning, which is continuing at pace and we will have the opportunity to discuss this in more detail in a separate agenda item.

If, and when, a second wave does come, it is fair to say we are much better placed to respond than we were several months ago. By adopting a similar approach but building on the lessons we have learned, our planning is now well advanced in how we will flex our hospital capacity and community services as needed. However, the ask of us in terms of the level of activity we are required to plan for is challenging, and we will need to maximise all of our available resources in order to deliver what is expected of us.

To support this, we also need to continue to follow the basics of infection prevention and social distancing, as they remain key to our management of coronavirus.

Wearing masks, good hand hygiene, social distancing, and working from home wherever possible must continue for the foreseeable future, and I want to see us demonstrating strong leadership and setting an example with this. We simply cannot afford complacency.

## 3. Clinical Strategy Development

A further important area is the development of the trust's clinical strategy, and I am pleased to say that Emma Fraser is now in post and is to help coordinate this work. Linked to this is the Scarborough Acute Services Review, and the joint appointment of Simon Cox as Programme Director between our trust and North Yorkshire CCG will give this work senior leadership at a system level as we start to deliver on the outcomes of the review.

#### 4. Development of the Integrated Care System (ICS)

In recent months there have been tangible changes in the way Humber, Coast and Vale ICS is forming its place with regard to system coordination and leadership. An obvious area where we are seeing the change is in the funding that is being made available via the ICS, for example for capital schemes and backlog maintenance. It is important that we understand our role in the ICS and the impact it will have on our organisation, so that we can influence and collaborate as appropriate.

#### 5. Quality Improvement

The challenges we were facing before the pandemic have not gone away, and wherever possible work has been continuing to deliver the actions set out by the CQC following their visits in the summer of 2019. Much of the urgent work has been delivered, however we still need to focus on addressing some of their broader concerns and ensure that tangible progress has been made as we go into winter. We also need to develop our wider approach to learning and quality improvement, and how we embed this into all elements of our work.

#### 6. Staff engagement and culture change

Internally to the trust, there is significant work to do to deliver the culture change that our staff have told us we need through the Our Voice Our Future workshops. As well as the quick wins, some of the larger pieces of work, for example the launch of a refreshed set of values and behaviours for the trust, and a potential new name, are being planned for roll out in the new year. It is particularly frustrating to me that we have not been able to progress with this crucial area of work as a result of coronavirus, as I am wholly committed to delivering the change that staff have told me is so important for our future.

#### 7. Staff wellbeing

These are all important pieces of work for our trust and it is vital that we increase the momentum now that we have come out of the first peak of the pandemic.

However this is also an enormous ask of our staff, who are no doubt feeling fatigued as coronavirus shows no sign of disappearing and we face a significant challenge, balancing the need to be ready for a second surge whilst preparing for a challenging winter and 'spinning the plates' of phase three recovery.

It is therefore more important than ever that we focus on the wellbeing of our workforce, ensuring staff can access the support they need and learning the lessons from the first wave of the pandemic.

The trust has a range of wellbeing initiatives to support staff, and this has been further bolstered during the pandemic.

An Occupational Health / Psychology Helpline and Psychology Drop in sessions were provided to help support staff who may be feeling anxious or concerned. In addition, staff have free access to a number of free wellbeing apps.

Our Organisational Development and Improvement team are also providing confidential supportive, coaching conversations, and have developed a number of resources for staff who have been redeployed or asked to work from home to ensure they feel supported in this new way of working.

We introduced Calm Rooms across our hospitals sites, which are spaces for staff to take a short break, access refreshments, read further information on support for both physical and psychological wellbeing, talk or just sit and relax.

York Teaching Hospital Charity delivered care boxes to wards and departments throughout the Trust following requests from staff for everyday essentials that they could have to hand at work for a much needed break - whether working days, nights or weekends. We also provided free meals for staff at the height of the pandemic.

## 8. Race Equality Network

In the summer the trust resolved to support the establishment of a Black, Asian and Minority Ethnic (BAME) network as a safe, supportive and confidential space for staff to share ideas and raise concerns, and to inform and influence the trust's strategies.

I am delighted to report that our Race Equality Network is now up and running thanks to Michelle Adeniji, who has been appointed Chair, supported by Hassena Karbani as Vice-Chair.

I am clear that racism has no place in our trust, and I support anyone in challenging unacceptable behaviours in our workplace. Respecting each other is at the heart of our Trust values, and now more than ever it is important that this is reflected in our behaviours, not just our words. The establishment of this network is significant and positive step for the Trust, and I look forward to seeing how it develops and grows.

## Board of Directors: 30 September 2020 Trust Operational Plan: Phase 3 Plan Submission

### Trust Strategic Goals:

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

### Recommendation

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

### Purpose of the Report

To present the Phase 3 Operational Plan for the Trust, as part of the Humber Coast and Vale Phase 3 Plan submission on the 21<sup>st</sup> September 2020.

### Executive Summary – Key Points

- The Phase 3 ‘Restoration of Elective Care’ requirements have been published, with an expectation to return to 100% of 2019/20 activity for Outpatients, Endoscopy and other diagnostics; and 90% of elective surgical work. This excludes any work delivered through the national Independent Sector contract.
- The Trust has worked across Care Groups to develop the Operational Plan for the remainder of the year and move significantly closer to the ‘national ask’ on activity levels.
- The Trust Operational Plan forms part of the Humber, Coast and Vale Integrated Care System submission.

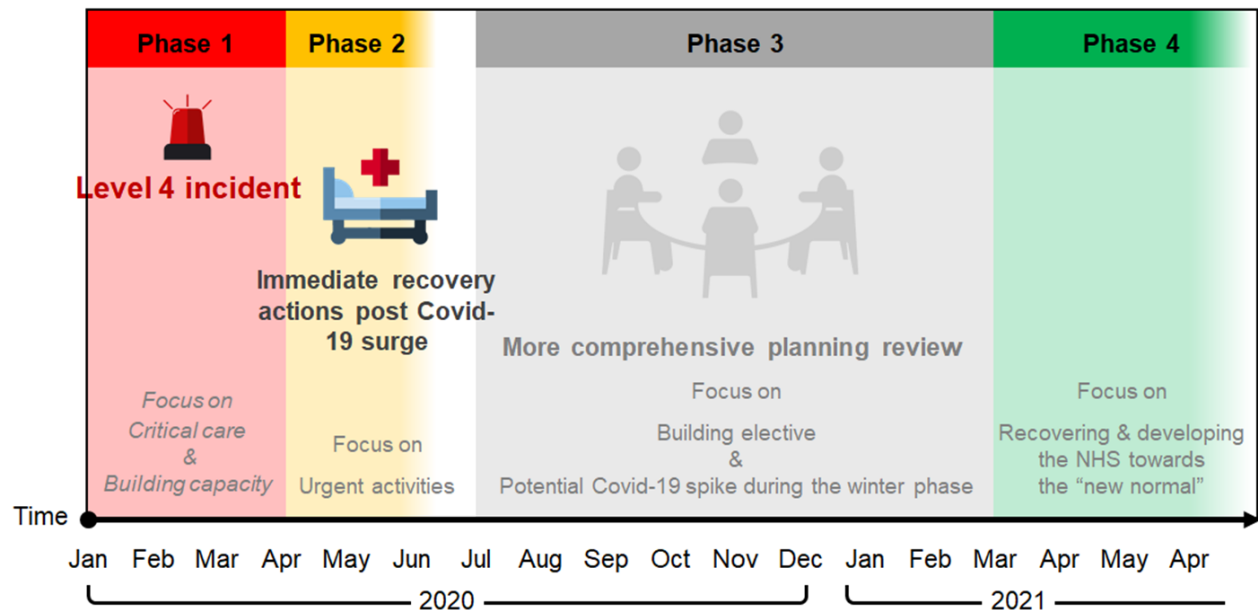
### Recommendation

The Board of Directors is asked to receive the Operational Plan, approved by the Executive Board and note the risks to delivery set out within the paper.

Author: Lynette Smith, Head of Performance and Planning  
Director Sponsor: Wendy Scott, Chief Operating Officer  
Date: September 2020

## 1. Introduction and Background

The national expectations have been set out in a series of 'phases' of work, determined by clinical priority. Phase 3 recovery looks to maximise elective work and work to resume all functions of the Trust's services by the end of the year.



The Trust received the July 31<sup>st</sup> Phase 3 letter from Simon Stevens and Amanda Pritchard which set out a series of expectation for acute providers within Integrated Care Systems, across workforce, winter preparation and elective care assumptions. The 'national ask' for elective work is to return to a % of the 2019/20 outturn against the point of delivery set out below.

2019/20 Expectations	Q2		Q3			Q4		
	August	September	October	November	December	January	February	March
Outpatients	90%	100%	100%	100%	100%	100%	100%	100%
Day Cases	70%	80%	90%	90%	90%	90%	90%	90%
Ordinary Electives	70%	80%	90%	90%	90%	90%	90%	90%

In addition further information was received on the development of an 'Elective Incentive Scheme' which sets out a financial penalty for activity delivered below the 'national ask' levels and a financial reward for activity delivery over and above the 'national ask'.





The activity levels expected in the Phase 3 letter were significantly higher than the Trust had planned to deliver during 2020/21. The Trust has worked across Care Groups to assess the activity gap, identify potential mitigations and understand the financial implication of the new Elective Incentive Regime.

## 2. Phase 3 Plan: Restoration of Services

The Trust submission forms part of the Humber, Coast and Vale Integrated Care System Phase 3 plan. This includes an operational activity submission and a narrative across the Integrated Care System. The narrative includes detail relating to acute, primary care and mental health provision, as well as the responses to the national 'asks' in the phase 3 letter in relation to inequalities and workforce. The deadline for the Humber Coast and Vale Plan is 21<sup>st</sup> September 2020.

The Trust continues to operate in a 'response' state, and is required to protect surge capacity for the COVID-19 pandemic as well as agile step-up escalation. In addition the Trust must maintain infection control measures, including appropriate personal protection equipment (PPE) and social distancing for staff and patients.

Collectively the above has reduced capacity across the Trust including a reduced bed base, it affects theatre and clinic productivity and reduces the physical space to see and treat patients. Throughout May – July 2020, the Trust has been reassessing its capacity to deliver elective and diagnostic activity taking into account national Infection Prevention and Control (IPC) guidance and the return levels of urgent care activity as lockdown was scaled back. This has been further refined through August, based on the actual activity delivered to date, opportunities to re-open theatres and updates to national Infection Prevention and Control guidance.

### Phase 3: Elective Services Restoration Plan

The revised plan reflects the following assumptions:

- Independent Sector activity is **not** included as per the national guidance. Note that we are still continuing to use the nationally contracted Independent Sector capacity; this is in addition to the activity within the plan and is funded separately by a national contract.
- Radiological work is **included** for Outpatients activity as well as for Inpatients.
- Other non-national contract IS sub-contracted activity is counted within the Trust plan.
- Assumes implementation of the national IPC guidance (latest 20<sup>th</sup> August 2020).
- Assumes no major second wave beyond the plan assumptions (North East and Yorkshire Regional Cell COVID-19 assumptions – 75% of April peak in Sept-Nov and 100% May activity for all other months).
- Assumes workforce delivering job plans and able to deliver extra contractual activity.
- Updated bed numbers to reflect winter bed modelling.

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- 20% Type 3 A&E activity reduction from December to reflect 'Talk before you Walk impact'.
- This plan does not include COVID-19 Swab activity (reported via SUS as first outpatient activity) nor any Community Stadium outpatients assumptions.

The Outpatients plan is based on actual activity from July, with assumptions made for:

- delivery of identified extra contractual activity.
- productivity - case per clinic increases based on updated infection control procedures.
- Increased non-face to face contact in both first and follow up outpatient appointments to achieve 25% first outpatient activity non-face to face and 45% of follow up activity non-face to face by March 2021.

The Elective plan is based on theatre capacity across the Trust identified through the plan for re-opening theatre space while maintaining theatre space for patients with suspected or confirmed COVID-19. This results in a plan for capacity across the Trust of 82% of 2019/20 capacity. In addition to this, the Trust will continue to run lists from Ramsay and Nuffield sites to provide contingency for Cancer patients in the event of urgent care pressures at York site and to maximise elective opportunities for patients on our waiting lists.

### 3. Trust Operating Plan

The revised plan for September to March is:

Day Case	19/20 outturn	Updated Submission	
		Trust Activity	Trust plus IS
September	6,269	4993	5525
October	6,801	5577	5827
November	6,534	5358	5608
December	5,765	4727	5042
January	6,714	5505	5755
February	6,195	5080	5330
March	6,183	5505	5815

OPNP	19/20 outturn	Updated Submission	
		Trust Activity	Trust plus IS
September	23,031	22367	22699
October	26,088	24057	24381
November	24,366	24044	24368
December	21,382	20193	20598
January	25,714	23967	24291
February	23,346	21648	21972
March	23,346	23967	24372

Ord Elec	19/20 outturn	Updated Submission	
		Trust Activity	Trust plus IS
September	657	455	521
October	763	626	680
November	764	626	680
December	529	434	502
January	631	517	571
February	599	491	545
March	616	517	584

OPFU	19/20 outturn	Updated Submission	
		Trust Activity	Trust plus IS
September	36,391	35246	36027
October	41,284	40315	41099
November	38,974	40277	41061
December	32,990	34588	35568
January	41,425	40045	40829
February	35,916	36170	36954
March	35,701	40045	41025



This level of activity equates to the following of 2019/20 outturn:

**Day Cases**

Month	Proportion of 19/20 outturn		
	National Ask	Updated Plan - YTHFT Only	Updated Plan plus IS
September	80%	80%	88%
October	90%	82%	86%
November	90%	82%	86%
December	90%	82%	87%
January	90%	82%	86%
February	90%	82%	86%
March	90%	90%	94%

**Ordinary Electives**

Month	Proportion of 19/20 outturn		
	National Ask	Updated Plan - YTHFT Only	Updated Plan plus IS
September	80%	69%	79%
October	90%	82%	89%
November	90%	82%	89%
December	90%	82%	95%
January	90%	82%	90%
February	90%	82%	91%
March	90%	84%	95%

**OP - 1st Attends**

Month	Proportion of 19/20 outturn		
	National Ask	Updated Plan - YTHFT Only	Updated Plan plus IS
September	100%	97%	99%
October	100%	92%	93%
November	100%	99%	100%
December	100%	94%	96%
January	100%	93%	94%
February	100%	93%	94%
March	100%	103%	104%

**OP - FU Attends**

Month	Proportion of 19/20 outturn		
	National Ask	Updated Plan - YTHFT Only	Updated Plan plus IS
September	100%	97%	99%
October	100%	98%	100%
November	100%	103%	105%
December	100%	105%	108%
January	100%	97%	99%
February	100%	101%	103%
March	100%	112%	115%

Note that March 2020 included the stand down of elective services.

This operating plan is higher than the draft plan developed and submitted in July, however it still does not meet the national ask across all point of delivery. It is anticipated that this may result in a financial penalty (currently estimated at around £400k), however the final guidance on how the Elective Incentive Scheme will work was not published at the time of writing this report.

Care Groups will continue to review and identify further activity opportunities throughout the year.

Impact on the Trust Waiting List position.

In fully delivering this plan, the Trust would manage:

- 160,243 cases in first Outpatients (including radiology)
- 266,686 cases in Follow Ups (including radiology)



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- 36,745 day case operations
- 3666 ordinary elective operations

Assuming referrals continue to increase as per the planning assumptions the forecast is that by March 2022 the Total Waiting List would reduce slightly to 25,531, with 6098 cases waiting over 52 weeks for treatment. The Trust is reviewing all opportunities to improve the 52 week position, including additional outsourcing.

### Non-Elective Plans

The Phase 3 plan has incorporated the bed modelling carried out for the Winter Plan, and includes the North East and Yorkshire Regional Cell COVID-19 related urgent care assumptions.

To continue to deliver elective services on site and manage non-elective pressures, it is anticipated that the current open bed-stock would increase to 85% of total bed stock. The Trust is undertaking a Quality Impact Assessment to assess (and mitigate) the risk of reducing social distancing to increase bed stock at York Hospital site. Scarborough Hospital has completed and implemented the Quality Impact Assessment to manage current demand. On this basis the Trust is aiming to sustain 92% bed occupancy across the Trust.

## 4. Risks to Delivery

As detailed above, the plan is based upon a number of assumptions and as such carries risk in the full delivery of the plan. It should be noted that Trusts have been asked to plan on the basis of an R value of 1 or less. Increasing Covid-19 'R' values will impact on the ability the plan and this is a significant risk.

Additional risks to delivery include:

- Workforce
  - Workforce availability to deliver full job plans and volunteer for extra contractual activity, in a context of potential Track and Trace, sickness and fatigue.
  - Ability to staff increased numbers of inpatient beds and clinics
- Infection Management
  - minimising transmission risks whilst maximising on site clinical assessment and treatment.
  - national or regional changes to the Infection Prevention and Control guidance in light of national or local transmission rates.
- Urgent Care demand
  - Winter pressures on hospital capacity.
  - COVID-19 demand surge above planned levels.



- Theatres
  - Distancing within theatre recovery spaces and the surgical bed base to accommodate increased numbers
  - Continued access to PPE
- Outpatients:
  - Maximising clinical space
  - Technology to rapidly expand Attend Anywhere.

To support the Trust in the management of these risks over the coming months, the following actions have been undertaken:

- a) Refreshed Command and Control Structure to support agile response in winter.
- b) Resilience plans have been developed, including plans to manage and mitigate the risks associated with winter, COVID-19 and the EU Exit.
- c) Review and Development of the Pandemic Flu Plan.

The risks within, and delivery of, the plan are being monitored and reviewed through the Command and Control 'Silver Command' structure, with twice weekly meetings with Bronze Commands established to action items and develop risk mitigation.

Clinical risks in delivery of the plan and management of the waiting lists are escalated to the Clinical Risk and Oversight Group, chaired by the Medical Director.

Operational delivery risks are escalated to Executive Board.

Appendix 1: Trust Operating Plan Submission – September 2020 to March 2021

Appendix 2: Restoration of Services Current Position

Appendix 3 – Humber, Coast and Vale Narrative Plan

Appendix 4 – Humber Coast and Vale People's Plan



# APPENDIX 1

RCB YORK TEACHING HOSPITAL NHS FOUNDATION TRUST

			Apr-20	May-20	Jun-20	July-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
		<b>RTT</b>													
<b>RTT Waiting List</b>	E.B.3a	The total number of incomplete RTT pathways at the end of the month	24,944	24,886				26619	26748	27733	28458	27126	26611	25531	
Number of 52+ Week RTT waits	E.B.18	The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	158	452				1900	2088	2676	2927	4112	5367	6098	
		<b>Referrals</b>													
Referrals made for a First Outpatient Appointment (General & Acute)	E.M.7a	GP Referrals	1,778	3,636				6219	7318	7550	6366	8125	7523	8136	
	E.M.7b	Other Referrals	3,741	5,064				4848	5706	5886	4962	6335	5865	6342	
	<b>E.M.7</b>	<b>Total Referrals</b>	<b>5,519</b>	<b>8,700</b>				<b>11067</b>	<b>13024</b>	<b>13436</b>	<b>11328</b>	<b>14460</b>	<b>13388</b>	<b>14478</b>	
		<b>Outpatients</b>													
Consultant Led Outpatient Attendances (Specific Acute)	E.M.8c	Consultant-led first outpatient attendances (face-to-face)	8,867	10,567				18453	19606	19355	16053	18814	16669	17975	
		<i>First Outpatient Attendances - Face to Face - of which commissioned by Specialised Commissioning</i>	317	336				637	676	668	554	649	575	620	
	E.M.8d	Consultant-led first outpatient attendances (telephone/video)	478	1,005				3914	4451	4689	4140	5153	4979	5992	
		<i>First Outpatient Attendances - Telephone/Video - of which commissioned by Specialised Commissioning</i>	220	200				135	154	162	143	178	172	207	
	E.M.9c	Consultant-led follow-up outpatient attendances (face-to-face)	16,737	17,763				22557	24995	24166	20407	23226	20436	22025	
		<i>Follow Up Outpatient Attendances - Face to Face - of which commissioned by Specialised Commissioning</i>	1,397	1,456				3036	3364	3253	2747	3126	2751	2965	
	E.M.9d	Consultant-led follow-up outpatient attendances (telephone/video)	4,376	4,204				12689	15320	16111	14181	16819	15734	18020	
		<i>Follow Up Outpatient Attendances - Telephone/Video - of which commissioned by Specialised Commissioning</i>	2,113	1,880				1708	2062	2169	1909	2264	2118	2425	
	<b>E.M.8-9</b>	<b>Total Outpatient Attendances</b>	<b>30,458</b>	<b>33,539</b>				<b>57613</b>	<b>64372</b>	<b>64321</b>	<b>54781</b>	<b>64012</b>	<b>57818</b>	<b>64012</b>	
		<i>Total Outpatient Attendances - of which commissioned by Specialised Commissioning</i>	<b>4,047</b>	<b>3,872</b>				<b>5516</b>	<b>6256</b>	<b>6252</b>	<b>5353</b>	<b>6217</b>	<b>5616</b>	<b>6217</b>	
			<b>Electives</b>						4348	4438	4438	4438	4438	4438	3739
	Total Elective Spells (Specific Acute)	E.M.10a	Day Case spells	1,930	2,445				4993	5577	5358	4727	5505	5080	5505
<i>Day Case spells - of which commissioned by Specialised Commissioning</i>			8	24				30	33	32	28	33	30	33	
E.M.10b		Ordinary spells	95	176				455	626	626	434	517	491	517	
		<i>Ordinary spells - of which commissioned by Specialised Commissioning</i>	6	7				12	16	16	11	13	13	13	
<b>E.M.10</b>		<b>Total Elective spells</b>	<b>2,025</b>	<b>2,621</b>				<b>5448</b>	<b>6203</b>	<b>5984</b>	<b>5161</b>	<b>6022</b>	<b>5571</b>	<b>6022</b>	
		<i>Total Elective spells - of which commissioned by Specialised Commissioning</i>	<b>14</b>	<b>31</b>				<b>42</b>	<b>49</b>	<b>48</b>	<b>39</b>	<b>46</b>	<b>43</b>	<b>46</b>	
		<b>Non Elective</b>													
Total Non-Elective Spells (Specific Acute)	E.M.11a	0 day length of stay	1,091	1,377				1420	1649	1593	1692	2063	1831	2064	
		<i>0 day length of stay - of which commissioned by Specialised Commissioning</i>	2	1				1	1	1	1	1	1	1	
	E.M.11c	+1 length of stay - COVID	411	176				328	328	328	219	219	219	219	
		<i>+1 length of stay - COVID - of which commissioned by Specialised Commissioning</i>	0	0				0	0	0	0	0	0	0	
	E.M.11d	+1 length of stay - Non-COVID	1,814	2,440				3144	3730	3663	4002	4414	3944	4417	
		<i>+1 length of stay - Non-COVID - of which commissioned by Specialised Commissioning</i>	3	6				7	8	8	8	9	8	9	
	<b>E.M.11</b>	<b>Total Non elective admissions</b>	<b>3,316</b>	<b>3,993</b>				<b>4,892</b>	<b>5,707</b>	<b>5,584</b>	<b>5,913</b>	<b>6,696</b>	<b>5,994</b>	<b>6,700</b>	
		<i>Total Non elective admissions - of which commissioned by Specialised Commissioning</i>	<b>5</b>	<b>6</b>				<b>8</b>	<b>9</b>	<b>9</b>	<b>9</b>	<b>10</b>	<b>9</b>	<b>10</b>	
		<b>A&amp;E</b>													
Type 1-4 A&E Attendances	E.M.12a	Type 1&2 A&E attendances	5,866	7,793				10449	11097	10685	10673	10334	10065	10161	
	E.M.12b	Type 3&4 A&E attendances	0	0				1327	1570	1482	1565	1438	1343	1525	
	<b>E.M.12</b>	<b>Total Type 1-4 A&amp;E Attendances</b>	<b>5,866</b>	<b>7,793</b>				<b>11776</b>	<b>12667</b>	<b>12167</b>	<b>12238</b>	<b>11772</b>	<b>11408</b>	<b>11686</b>	
		<b>Demand and capacity</b>													
General and Acute bed occupancy	E.M.26	Average number of G&A Beds available per day	751					727	751	806	806	806	806	806	
		Average number of G&A Beds occupied per day	377					610	690	740	740	740	740	740	
		%	50%					84%	92%	92%	92%	92%	92%	92%	
		<b>Diagnostic Activity</b>													
Diagnostic Test Activity	E.B.26a	Diagnostic Tests - Magnetic Resonance Imaging	614	910				1,686	2,113	2,056	1,946	2,176	2,090	2,130	
	E.B.26b	Diagnostic Tests - Computed Tomography	933	1,322				3,566	4,294	3,952	4,015	4,218	4,115	4,051	
	E.B.26c	Diagnostic Tests - Non-Obstetric Ultrasound	922	1,379				3,058	3,668	3,504	3,208	3,932	3,665	3,102	
	E.B.26d	Diagnostic Tests - Colonoscopy	7	77				437	495	523	444	650	655	494	
	E.B.26e	Diagnostic Tests - Flexi Sigmoidoscopy	2	10				169	279	215	144	180	189	201	
	E.B.26f	Diagnostic Tests - Gastroscopy	2	8				533	466	723	569	697	621	591	
		<b>Cancer</b>													
Urgent cancer referrals	E.B.30	All patients urgently referred with suspected cancer by their GP who received a first outpatient appointment in the given month	633	826				1105	1484	1367	1260	1464	1389	1287	
Cancer treatment volumes	E.B.31	Number of patients receiving first definitive treatment following a diagnosis within the month, for all cancers	217	172				196	227	228	190	251	231	279	
Number of patients waiting 63 or more days after referral from cancer PTI	E.B.32	Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	285	397				228	234	223	229	219	224	214	

# APPENDIX 2

## Weekly RTT Scorecard

Group	Measure	Notes	Pre-Covid as at 01/03/20	Week ending 06/09/20 Previous Week	Week ending 13/09/20 Current Week	Variance	% Change	Overview
RTT	RTT Total Waiting List Size		29,397	26,440	26,523	83	0.3%	▲ Referrals received reduced to 15,716 in August 2020, down from 17,738 in July 200 and compares to 18,471 in August 2019 (-2,755, -15%). Referrals from GPs were 6,629, a reduction of 30% (-2,775) compared to the same period last year.
RTT	RTT Number of patients waiting 40+ weeks		696	4,884	5,022	138	2.8%	▲
RTT	RTT Average wait time (Weeks)	Average wait for patients currently on the Total Waiting List (weeks)	12.0	20.6	20.6	0.0	-	▼ The Total Waiting List has increased in August; however the proportion of long waiters has decreased, with the overall RTT position improving from 42.3% (July 2020) of patients waiting less than 18 weeks from referral to treatment; to 52.7% at the end of August.
REF	GP Referrals (Volume)	Number of Referrals received from GPs	2085	1,335	1,584	249	18.7%	▲ The recommencement of surgery has seen a significant number of treatments completed in specialities with long wait patients during August, including 626 ENT cases and 217 MaxFax cases.
REF	2ww Referrals	Fast Track referrals	418	343	399	56	16.3%	▲
REF	A&G Requests		547	488	706	218	44.7%	▲ The Trust has set out key operational priorities for the Phase 3 recovery to support routine restoration, including reducing time to first appointment, overdue Follow Ups, long wait patients and reducing 'Do No Attend' rates to maximise capacity. These are being reviewed weekly by operational teams to monitor progress.
OP	New outpatient attendances		6568	5,373	6,652	1279	23.8%	▲
OP	Follow up outpatient attendances		10774	6,719	8,624	1905	28.4%	▲ Our Care Groups have worked to increase theatre productivity plans, in addition to use of the Independent Sector, with increased delivery expected during Quarter 3 and have refreshed the Outpatient productivity programme to maximise utilisation of capacity. Where possible, the Trust has implemented additional contractual activity to increase the number of patients seen and treated.
OP	Outpatient DNAs %		5.5%	5.5%	4.8%	-0.7%	-12.7%	▼
IP	Elective admissions		1314	785	963	178	22.7%	▲



RTT Specialty Overview

Group	Specialty	Measure	Pre-Covid as at 01/03/20	Previous Week	Current Week	Variance	% Change	Overview
RTT	Anaesthetics	RTT Total Waiting List Size	920	987	987	0	0.0%	◀▶ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	2	154	168	14	9.1%	▲
		RTT Average wait time (Weeks)	11.3	23.6	23.7	0.1	-	▲
RTT	Cardiology	RTT Total Waiting List Size	1,547	980	966	-14	-1.4%	▼ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	18	83	82	-1	-1.2%	▼
		RTT Average wait time (Weeks)	11.5	15.3	15.1	-0.2	-	▼
RTT	Dermatology	RTT Total Waiting List Size	1,354	904	922	18	2.0%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	4	11	10	-1	-9.1%	▼
		RTT Average wait time (Weeks)	9.4	6.3	6.3	0.1	-	▲
RTT	Ear, Nose and Throat	RTT Total Waiting List Size	2,819	2,552	2,614	62	2.4%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	21	381	398	17	4.5%	▲
		RTT Average wait time (Weeks)	10.7	19.6	19.4	-0.2	-	▼
RTT	Gastroenterology	RTT Total Waiting List Size	1,569	1,210	1,216	6	0.5%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	21	106	109	3	2.8%	▲
		RTT Average wait time (Weeks)	11.8	17.0	16.7	-0.3	-	▼
RTT	General Surgery	RTT Total Waiting List Size	4,061	4,340	4,320	-20	-0.5%	▼ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	131	887	911	24	2.7%	▲
		RTT Average wait time (Weeks)	12.5	20.0	20.0	0.0	-	▼
RTT	Gynaecology	RTT Total Waiting List Size	1,471	1,423	1,423	0	0.0%	◀▶ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	11	215	214	-1	-0.5%	▼
		RTT Average wait time (Weeks)	9.9	18.5	18.6	0.1	-	▲
RTT	Maxillo-Facial Surgery	RTT Total Waiting List Size	2,421	1,479	1,482	3	0.2%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	176	473	487	14	3.0%	▲
		RTT Average wait time (Weeks)	15.8	27.3	27.1	-0.2	-	▼
RTT	Neurology	RTT Total Waiting List Size	978	690	694	4	0.6%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	1	59	60	1	1.7%	▲
		RTT Average wait time (Weeks)	12.4	17.4	17.7	0.3	-	▲
RTT	Ophthalmology	RTT Total Waiting List Size	4,590	3,976	3,939	-37	-0.9%	▼ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	203	1,018	1,013	-5	-0.5%	▼
		RTT Average wait time (Weeks)	14.2	24.3	24.1	-0.2	-	▼
RTT	Paediatrics	RTT Total Waiting List Size	667	415	413	-2	-0.5%	▼ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	0	1	1	0	0.0%	◀▶
		RTT Average wait time (Weeks)	4.5	6.2	6.3	0.1	-	▲
RTT	Respiratory Medicine	RTT Total Waiting List Size	984	917	922	5	0.5%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	12	186	204	18	9.7%	▲
		RTT Average wait time (Weeks)	12.7	22.9	23.3	0.5	-	▲
RTT	Rheumatology	RTT Total Waiting List Size	755	374	382	8	2.1%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	2	22	23	1	4.5%	▲
		RTT Average wait time (Weeks)	11.4	11.7	11.9	0.2	-	▲
RTT	Trauma and Orthopaedics	RTT Total Waiting List Size	2,753	3,313	3,378	65	2.0%	▲ Service continues to utilise the Independent Sector (IS) at Clifton Treatment Centre & Nuffield.
		RTT Number of patients waiting 40+ weeks	18	890	922	32	3.6%	▲ Plans for patients who are unsuitable for the IS are continuing.
		RTT Average wait time (Weeks)	12.9	25.3	25.2	-0.1	-	▼
RTT	Urology	RTT Total Waiting List Size	1,401	1,775	1,784	9	0.5%	▲ As per National timescales service is working to restore routine capacity from wc 3rd August.
		RTT Number of patients waiting 40+ weeks	64	343	358	15	4.4%	▲
		RTT Average wait time (Weeks)	11.9	21.4	21.8	0.3	-	▲



# Plan Commentary

Humber, Coast and Vale Health and Care Partnership

Implementing phase 3 of the NHS response to the COVID-19 pandemic

FINAL 21<sup>st</sup> September 2020



## Health Inequalities

Planning requirement	Commentary
<p><b>Urgent actions to address health inequalities include:</b></p> <ol style="list-style-type: none"> <li><b>1. Protect the most vulnerable</b></li> <li><b>2. Restore NHS services inclusively</b></li> <li><b>3. Digitally enabled pathways that are inclusive</b></li> <li><b>4. Accelerate preventative programmes</b></li> <li><b>5. Support people with mental health problems</b></li> <li><b>6. Named Executive Board member and Boards to publish a five-year action plan.</b></li> <li><b>7. Ensure complete datasets</b></li> <li><b>8. Collaborate on planning and engage with communities</b></li> </ol>	<p><b>Healthier communities and tackling health inequalities</b></p> <p>The Covid pandemic has only highlighted further how people from different groups within our population have been disproportionately affected both directly and indirectly from Covid-19. It's important that we recognise where this has happened; put in place preventative measures; and ensure that the services we offer are targeted at those are at most risk of experiencing inequality.</p> <p>Reducing health inequalities is a priority across all Health and Care and Partners in Humber, Coast and Vale (HCV). We continue to work closely with the Local Authorities to develop the plans and support addressing the wider determinants of health. This includes looking at how as anchor institutions we can support for example, the local economy through the creation of job opportunities, buying local, climate change by reducing our carbon emission etc.</p> <p>Across HCV protecting the most vulnerable is key to the plans that have been developed by health and care partners in our two Geographical Partnerships (Humber and North Yorkshire &amp; York) and there is a strong commitment to population health led approach in the planning, design and delivery of services with a particular focus on addressing health inequalities in the population.</p> <p>The Partnership has established a HCV Population Health and Prevention Board with responsibility for the oversight of the health inequalities including the actions set out in the phase 3 planning implementation guidance. We have agreed to build our approach to tackling health inequalities at place and support this through the Geographical Partnership and at a HCV level by doing the things that can sensibly be done once.</p> <p>We have confirmed the names of the executive board level leads for every NHS organisation within HCV (see below), who will have oversight responsibilities for tackling inequalities in their organisations and will lead the development of action plans (where appropriate) aligned with their Places and Geographical Partnerships.</p> <ul style="list-style-type: none"> <li>• For the HCV Partnership – Andrew Burnell, Chief Executive City Healthcare Partnership</li> <li>• Tees, Esk and Wyre Valley Trust - Brent Kilmurray, Chief Executive</li> <li>• NHS Hull, East Riding and North Lincolnshire CCGs – Emma</li> </ul>

Latimer, Accountable Officer

- NHS North East Lincolnshire CCG – Dr Peter Melton, Chief Clinical Officer
- Hull University Teaching Hospitals – Chris Long, Chief Executive
- Northern Lincolnshire and Goole NHS Trust – Dr Peter Reading, Chief Executive
- Humber Teaching Foundation Trust – Michele Moran, Chief Executive
- NHS North Yorkshire CCG – Wendy Balmain, Director of Strategy & Integration
- NHS Vale of York CCG – Andrew Lee, Director of population health and primary care
- York NHS Foundation Trust - Jim Taylor, Medical Director
- Harrogate and District Foundation Trust – Dr Jacqueline Andrews, Medical Director
- PCNs – Clinical Directors

There are a number of actions that we have already put in place to reduce inequalities and support the restoration of services. We have:

- Commenced the Population Health Management (PHM) Development programme with a focus on Covid risk stratification with seven PCNs spread across HCV to enable rapid and widespread dissemination of the learning of PHM and service improvements
- Ensured that practices have reviewed and supported shielded patients. The CCGs have worked with local authorities and the voluntary sector to proactively ensure that those on the shielded list, and other vulnerable groups have had access to support where needed
- Established volunteer hub and community/voluntary sector support for vulnerable people, including shielding groups.
- Ensured access to social prescribing for marginalised, vulnerable and isolated groups
- Provided access to carers support teams for frail and complex patients and their carers
- Gained assurance that health and care providers are performing staff risk assessments including impact of Black, Asian and Minority Ethnic (BAME) groups
- Restarted National Diabetes Prevention Programme for our population and remote monitoring support apps are in place;
- Restarted the LD annual health checks in primary care
- Worked as a system with partners around ensuring people who are homeless are registered with practices for targeted support
- Arranged primary healthcare coverage for asylum seekers housed in York
- Commenced engagement with local communities to understand

how public attitudes and behaviours have changed in relation to accessing healthcare

- Production of rapid health needs assessment looking at the different impacts of Covid with recommendation for targeted actions. In North Yorkshire & York the HNA prioritised access to prevention programmes, shielded and vulnerable patients as over 70s, those with underlying conditions, in deprived areas, BAME and those in care home
- All care homes have been given details of their primary care and community identified key contacts to achieve a multi-disciplinary, preventative approach to care, involving weekly check-ins and the development of an integrated process of care planning.

We have drawn out below some particular initiatives that are in development and the 'Other' section later in this plan provides more detail on the activities being undertaken in Primary, Community and Social Care where the majority of activities to reduce inequalities, linked to the wider determinants of health, will be delivered.

**We are working across the Partnership on:**

- Developing a consistent methodology for practices to risk stratify patients for review based on their risks of and from covid – working with RAIDR and Ardens
- Using the risk stratification to prioritise reviews and preventative measures like smoking cessation and weight management
- Ensuring that we are monitoring and acting on the new data sets for digital pathways
- Building in the targeting of flu vaccinations for LD, BAME and deprived populations to the planning and assurance, as well as ensuring ethnicity is captured when vaccinations are given
- Monitoring providers around the extent of ethnicity recording
- Ensuring that we are maximising the additional roles for general practice in areas of deprivation
- Continuing to promote health checks and reviews for people with learning disabilities, and severe mental illness
- Re-starting screening programmes where safe to do so such as focusing on the early diagnosis of Cancer particularly in males through the Lung Health Check Programme in Hull and also accompanying these with targeted communication campaigns with a focus on tackling health inequalities
- Scoping the requirements for local diagnostic hubs to support community care and support
- Addressing backlogs and managing the expected surge in services for vulnerable children and young people, including

## SEND

- Supporting digital inclusion and maintaining non-digital access routes to avoid excluding vulnerable groups – services offer a blend of face to face and remote consultation
- Delivering an integrated Early Help offer to help, protect and reduce inequalities for more vulnerable children. Identifying more vulnerable children and providing both universal and targeted help
- Ensuring safeguarding measures are in place and effective, recognising that some institutions (e.g. schools) will not be able to provide the same level of service initially
- Developing a Humber-wide, strengths based community approach to developing Health Hubs – focusing on digital and health literacy, targeted at communities likely to be at risk of worsening health inequalities
- Working with Active Humber to support people who are disproportionately affected by the pandemic to access sport and physical activity
- A follow up health needs assessments with a more community health and care focus which is nearing completion in North Yorkshire & York
- Supporting people with respiratory conditions through the establishment of an Interim pulmonary rehab service, the roll out of the myCOPD app to support self-management, and the implementation of the CURB65 CQUIN to improve diagnosis and ensure patients on correct treatment pathway through winter
- Using a frailty ratified score to identify those who are most at-risk and enable proactive preventative care; stratification will be further developed across the Partnership during phase 3.

### **Support people with mental health problems:**

Accelerating preventative programmes to address inequalities such as health checks for people with learning disabilities or Serious Mental Illness (SMI) is a key priority for the Partnership. We are working with and supporting Practices through the Primary Care Networks (PCNs) to establish more integrated delivery models and personalised care.

We continue to ensure across the Partnership that our local population and communities, particularly those who are vulnerable, who may have developed mental health issues because of the pandemic are aware of how to access support locally.

We have drawn out some particular initiatives below; however, the mental health section later in this plan gives more detail on the activities being undertaken in this sector.

### ***Humber***

- Promotion of the MIND 24/7 helpline to support people and avoid escalation to constrained services e.g. IAPT
- Continuation of online provision in IAPT, including IESO and Silvercloud, to offer people a blended approach of remote and face to face support, maximising available capacity
- Development of Resilience Hubs across the Humber
- Development of Children and Young People Intensive Home Treatment as part of the 24/7 crisis response
- Continued delivery of Kooth, the online platform targeted at children and young people across the Humber, maintaining the social media profile
- Continued delivery of Social Mediation & Self Help (SMASH); working with schools to meet the needs of children returning to education. In addition working across CAMHS to identify a virtual peer support psychoeducation low intensity group
- Continuation of joint Humber/ HUTH Paediatric clinic for those young people most vulnerable and physically unwell
- Restart Memory Assessment Services (MAS) remotely, moving to then MAS face to face when safe and appropriate
- Development of Perinatal services to include increased support to fathers, Humber level review of referral criteria, increased psychological therapy, etc.

### ***North Yorkshire and York***

- Invested in Local Enhanced Service in primary care to ensure people with an SMI receive the recommended physical health checks. In addition, working under the remit of the North Yorkshire and York Learning Disability and Autism Board, an expression of interest has been submitted to become an exemplar site to increase the number of annual health checks for people with a learning disability
- Working with partners to address the issues faced by people with multiple complex needs, including homelessness, substance misuse, contact with the criminal justice system and mental ill health to close the gaps between services and systems
- Working with their local councils and TEWV on the development of an improved mental health housing and support pathway aimed at addressing a long-standing gap in provision across the geography for specialist mental health housing and support for people with multiple and complex needs
- The North and Yorkshire Learning Disability and Autism Board have completed the national audit on STOMP/STAMP and Ask, Listen & do and work is underway to review our practices with view to adjust our plans to address issues raised during active pandemic phase e.g. increases in medication.

### **Acute**

- Provision of rapid early input via Advice and guidance and establishment of Clinical Assessment Service to support clinicians and patients in primary care
- On-going and embedded process for Clinical validation and risk assessment / stratification of all waiting lists (including outpatients) and backlogs
- Risk Stratification of IP waiting list
- Booking patients in chronological order (following application of clinical prioritisation framework)
- Working to link insight into patient needs (new, emerging and changed due to Covid) to the on-going health needs assessment and the Population health management and Health inequalities work.

### **Digital**

During our response to the initial phase of the Covid-19 pandemic digital transformation was key aspect of supporting us as a Partnership to ensuring we could ensure access to services. We recognise that for some groups this may have also created greater inequalities. Across the Partnership we are looking to embed these new ways of working as well as consider further options however as mentioned earlier we are doing more work around digital inclusion and focusing on digital and health literacy, targeted at communities likely to be at risk of worsening health inequalities

## Elective activity plans (1)

Planning requirement	Commentary
<p><b>Planned referral levels</b></p>	<p>Across the NHS in HCV a number of planning assumptions for the remainder of 2020/21 have been agreed for elective referrals, based on 2019/20 actuals, these are:</p> <p>Q2 – 70% Q3 – 80% Q4 – 90%</p> <p>The exception to this is in North Lincolnshire and Goole NHS Foundation Trust (NLaG) where based on previous experience these assumptions have been revised upwards as follows:</p> <p>Q2 – 80% Q3 – 90% Q4 – 100%</p>
<p><b>Outpatient</b></p>	<p>By March 2021 across HCV we plan to achieve 70% of First Outpatient Appointment and 86% of Follow-up activity based on 2019/20 activity.</p> <p>Of these the face to face and virtual / telephone will be: First outpatient face to face - 70% First outpatient virtual / telephone – 30% Follow-up face to face – 48% Follow-up virtual / telephone – 52%</p> <p>Across the Trusts in HCV reviews of specialty activity have been undertaken for the remainder of the year with assumptions made about the impact of annual leave and more accurate phasing based on previous trends and knowledge.</p> <p>Clinical validation of the patients waiting for follow up and moving patients to patient-initiated follow-up pathways or discharge with results have been considered and reflected in the activity position for each Trust.</p> <p>Some face to face outpatient capacity has been built in for those patients who require direct contact, to reach those groups where digital poverty is an issue or where people are unwilling to engage in a digital approach.</p> <p>The activity split between non-face to face and face to face across all the Trusts is reliant on the Outpatient Transformation</p>



	<p>Programmes that is in place and being co-ordinated across HCV. The programmes are being developed to reflect the high impact interventions from adopt and adapt plans. Further updates to activity position may be considered prior to the final submission to reflect the impact of this work.</p> <p>Other actions that have been taken to restore Outpatient services include:</p> <ul style="list-style-type: none"> <li>• Clinical Assessment of Outpatient Appointments</li> <li>• Use of advice and guidance where appropriate to reduce the need for appointments</li> <li>• Triage for clinical referrals</li> <li>• Utilising external space to mobilise face to face clinics</li> <li>• Infrastructure work to support infection management.</li> </ul> <p>Outpatient activity relating to swabbing in the Covid-19 service has not been included in the activity plans. Across Elective the Trusts are looking at their plans and what else could be done once there is further understanding of the finances.</p> <p><b>NLaG</b> The Trust has a requirement as part of its CQC action plan to reduce follow-ups to no more than 9000 by the end of March 2021. The volume of new follow-up outpatient appointments in the plan is weighted towards achieving this. Work is taking place with primary care to review pathways of care which may impact on this in the future, however a whole system approach is required to implement this.</p> <p><b>HUTH</b> Face to face and non-face to face split assumptions re based on July 2020 levels, with a stretch target to deliver 60% non-face to face by February 2021.</p> <p><b>YFT</b> The independent sector will continue to be used to deliver outpatient appointments in York.</p>
<p><b>Day case</b></p>	<p>Across HCV the Trusts day case activity fluctuates over months to recognise known variation and planning assumptions. The target of 80% of 19/20 activity in September likely to be achieved. However, the 90% from October is currently not planned to be achieved in any month except March 2021, performance will remain around the 80-85% position in the other months.</p> <p>The Trusts in HCV have, for each specialty, reviewed capacity available for the remainder of the year, undertaken risk</p>

	<p>stratification of elective waiting lists and have made assumptions in the activity to reflect the following constraints:</p> <ul style="list-style-type: none"> <li>• the impact of annual leave</li> <li>• sufficient personal protective equipment (PPE) availability</li> <li>• infection prevention requirements</li> </ul> <p>All Trusts have built in additional sessions funded through waiting list initiatives to address backlog in YFT this is notably in endoscopy. Also the continued use of the independent sector.</p> <p>All the Trusts are have factored in (where appropriate) additional activity whilst ensuring it fully reflects the implementation of the guidance on social isolation across all specialties and the reduced turnaround between cases.</p> <p><b>NLaG</b> It must be noted that the number of beds which are currently closed impacts on the ratio of day case to elective activity. The Trust does have additional unfunded beds it could use at risk, as escalation beds. This equates to 32 at SGH, 57 at DPOW and 29 at Goole. These are not shown in the plan. Zoning and social distancing has reduced the bed base by 14% and zoning will have impact on flow</p> <p><b>NLaG and HUTH</b> The plans are based on working days.</p> <p><b>YFT</b> The Trust’s plan assumes a move back to 82% available theatre space and full utilisation of Bridlington and Scarborough sites. The plan is based on calendar days.</p> <p><b>HDFT</b> Baseline activity for day cases has been reduced by circa 265 per month to reflect the fact that the nationally commissioned bowel screening will not be commissioned in 2020/21 which has an impact on the activity position looking to be undertaken. The plan is based on calendar days.</p>
<p><b>Ordinary elective activity</b></p>	<p>Across HCV the Trusts elective activity fluctuates over months to recognise known variation and planning assumptions. The target of 80% of 19/20 activity in September is unlikely to be achieved and the 90% from October onwards whilst is achieved in some months, the overall position remains below required targets at this draft submission stage.</p> <p>As with days cases the Trusts have reviewed each specialty and have</p>

made assumptions on inpatient activity that includes:

- Waiting list initiatives
- Optimised capacity through removing downtime on elective lists
- Continued use of the Independent sector although there have been some reduction with the change in national contract to 75%/25% (Harrogate specifically)
- Implementation of national guidance on social isolation prior to surgery.

#### **NLaG**

The Trust has seen a reduction of c100 beds due to zoning and the management of the 2 metres distancing to achieve IPC standards. For NLAG, the reduction of c100 beds in the Trust has had an impact on the elective in-patient activity. This is as a result of the aging estate and infrastructure which does not meet latest HTM guidance such as 2m bed space and also a paucity of side rooms. We have recently received funding to support the development of additional side rooms and the improvement to a further ward at Scunthorpe Hospital site to improve capacity. This provides greater flexibility in the bed base and will facilitate the ability to manage infection control risks in a more appropriate way, reduce patient transfers, LOS and subsequently patient experience; it does not increase bed numbers.

#### **YFT**

Increased August activity 200% from original forecasts in June – reflecting the significant effort to restore elective capacity  
Increasing theatre capacity to 82% across day case and ordinary electives. The surgical plan requires 11 additional beds to return to pre-covid levels. These are currently closed to enable social distancing to be maintained. This will be reviewed in October 2020.

#### **HDFT**

The Trust has made no assumptions about additional non job planned theatre sessions in their plans. In addition to the constraints noted for day cases, inpatient activity plans are impacted by the requirement for 2m bedhead spacing.

The Trust is also reliant on independent sector capacity provided by BMI The Duchy to increase the elective activity plan and move closer to the planning ask. The main constraint preventing the trust from undertaking this activity in house is bed capacity with pre-covid bed capacity of up to 55 beds across 2 wards being reduced to 1 surgical ward of 22 beds with no ring-fenced orthopaedic beds available. A number of options have been explored but have been discounted due the need for capital works, staffing availability, location in relation to theatres, the need for weekend working and displacement of other elective work, including cancer.

	<p>The case for delivering activity in the independent sector can be further strengthened by the following factors:</p> <ul style="list-style-type: none"> <li>• HDFT consultants deliver the work in predominantly job planned sessions and retain control of scheduling</li> <li>• 18 inpatients and 4 day cases per week across 10 lists Monday – Friday, 22 procedures in total</li> <li>• The theatre and recovery staff are provided by the independent sector provider</li> <li>• This approach enables delivery close to pre-covid capacity (excluding WLIs)</li> <li>• We are also consistently running at 95 – 100% bed occupancy across the site</li> <li>• The approach ensures that we do not displace our cancer work</li> <li>• This approach enables the trust to maintain a focus on 52 week waiters over winter noting that orthopaedics currently make up circa 40% of the patients waiting in excess of 52 weeks.</li> </ul>
<p><b>RTT waiting list position</b></p>	<p><b>RTT and 52 week waits</b> are forecast to significantly increase over the period to March 2021 (although there has been an improvement in the figures since the draft submission in August):</p> <ul style="list-style-type: none"> <li>• RTT list size by March 2021: <ul style="list-style-type: none"> <li>○ NLaG – 34,985</li> <li>○ HUTH – 68,714</li> <li>○ YFT – 25,531</li> <li>○ HDFT – 17,727</li> <li>○ <b>HCV – 146,957</b></li> </ul> </li> <li>• 52 week waits by March 2021: <ul style="list-style-type: none"> <li>○ NLaG – 6,088</li> <li>○ HUTH – 18,618</li> <li>○ YFT – 6,098</li> <li>○ HDFT – 1,332</li> <li>○ <b>HCV – 32,136</b></li> </ul> </li> </ul> <p>All Trusts have completed NECS PTL validation exercise, which has confirmed a positive position for all Trusts.</p> <p>The HCV Clinical and Professional Group have developed a set of principles and actions to support planning and prioritisation and these have been adopted across the Partnership.</p> <p>The Adopt and Adapt Outpatients transformation priorities will focus on mitigating pressures on waiting list through ‘optimising referrals’ (Advice and Guidance and scoping of HCV specialty waiting lists). Although impact not currently fully reflected in referral assumptions and waiting list numbers.</p>

Rapid Expert Input mobilisation through to March 2021 will support mitigating further pressures however this likely to contribute from April 2021.

A HCV outpatients capacity gap 'bridge' will be agreed in early September based on the assessed impact of local and Partnership wide interventions through Phase 3. There is currently no mitigation impact of outpatients transformation work on referrals assumptions and growth of RTT/ Trust waiting lists for YFT and HDFT in Phase 3.

An assessment of the impact of the implementation of the Phase 2 Evidence Based Interventions (EBI) is currently being made by the Trusts and will be reflected in the final submission.

#### **Humber (HUTH and NLaG) Management of risk within the PTL**

The Trusts have implemented a rigorous approach to management of clinical risk within the PTL and undertake the following steps

1. All referrals are clinically reviewed on receipt
2. Any patient not appointed by 12 weeks is clinically reviewed and every 12 weeks thereafter (HUTH). Urgent patients should be appointed within 6 weeks, and are flagged until they are, routine patient will be triggered a further review as they trigger 18weeks (NLAG).
3. The admitted PTL has been reviewed and prioritised in line with RCOS guidelines, new additions have their priority assessed
4. Specialties review and present their priorities for access to theatre lists to a clinically led theatre resource allocation panel. Any inability to appoint priority 1A, 1B, 2 or 3 that is over 12 weeks is escalated for resolution
5. Patients who are at risk of reaching 52 weeks have a further clinical review. If patients have not been risk stratified previously, a clinical harm review will be undertaken as the patient triggers 52ww.

The Trusts are working with primary care colleagues to review referral thresholds and to ensure patients are counselled on the risks and benefits of potential treatment and are prepared to isolate prior to elective admission.

All four Trusts in HCV are actively working closely together and sharing their processes and learning from each other and

considering collective options approaches to improve the position.

## Elective activity plans (2)

Planning requirement	Commentary
<p><b>The level of activity expected to be delivered through additional sessions e.g. through extended hours / at weekends</b></p>	<p><b>NLaG</b> During a 4 week period over August/September 2020 agreement for additional sessions to support recovery are as follows: 220 theatre / endoscopy sessions, 88 new and 88 review clinics during evening and weekends, this will equate to 792 day case and 264 new outpatients and 528 outpatient reviews.</p> <p>To continue this level until the end of March 2021 would require circa £3.6 million in additional funding.</p> <p><b>HUTH</b> The following additional sessions planned per month from August: 260 clinics / 2000 appointments 63 Theatre lists / 285 cases 55 diagnostic sessions / 228 cases</p> <p>The activity plan assumes this level of additional activity is funded within the current resources and continues each month until March 2021.</p> <p><b>YFT</b> The plan assumes the following additional sessions: 828 elective 5616 Outpatient appointments.</p> <p><b>HDFT</b> No assumptions have been included in the activity submission. The use of additional sessions and remuneration is under review.</p>
<p><b>Actions to maximise independent sector activity under the national contract</b></p>	<p><b>Humber (HUTH and NLaG)</b> Both Trusts are working closely to utilise the operating and diagnostic capacity within their local IS providers that are part of the national NHS contract: St Hugh's in North East Lincolnshire and Spire in Hull/East Riding. The theatre and diagnostic capacity has been fully integrated into the Trusts' prioritisation and booking processes</p> <p>The limiting factor is workforce particularly anaesthetists, surgeons and radiographers. The inclusion of IS activity accounts for around 3% of Day Case and 4.5% Elective activity against the 19/20 baseline.</p> <p>In North Yorkshire and York (YFT and HDFT) the following actions</p>

	<p>are in place or being worked through.</p> <p><b>YFT</b></p> <ul style="list-style-type: none"> <li>• Theatre timetables to fully utilise York Teaching Hospital element of the 75% allocation of theatres, with focus on day case work</li> <li>• Aim to influence IS adoption of local PPE / downtime</li> <li>• The Ramsay and Nuffield will be included on internal Trust theatre utilisation dashboards</li> <li>• Performance management against weekly activity submissions</li> </ul> <p><b>HDFT</b></p> <ul style="list-style-type: none"> <li>• To secure capacity an agreed solution for overnight medical cover within the private sector is still required.</li> <li>• Current proposals need to be finalised / agreed - significant risk of impacting on activity volumes later in the year.</li> <li>• Use of recently updated clinically signed off internal guidelines related to downtime between cases and cleaning protocols</li> <li>• Focus on productivity and flow as within the NHS setting</li> </ul>
<p><b>Availability of workforce and actions to use the skills of people and teams most effectively and efficiently across the system (linked to overall workforce narrative)</b>  <b>Note:</b> this could also include increased capacity as a result of work placements, students and trainees</p>	<p>The plans assume availability of workforce to deliver activity as set out in the submitted plans.</p> <p>The Trusts across HCV have deployed centralised staff support systems and are ensuring all staff have an individualised risk assessment and are safely and appropriately deployed in light of the Covid. These will continue to be reviewed / undertaken as information evolves.</p> <p>There have been significant levels of enhanced training and redeployment to optimally deploy staff to meet the needs of both care of suspected and confirmed Covid patients and the delivery of the restoration plans. Some of the previously redeployed staff are staying within the role. In YFT during phase 1 and 2 primarily surgical teams were deployed to our private sector partners to continue to progress elective work. For phase 3 these staff are being upskilled (predominantly ODPs) within the private sector to continue to deliver much of this work whilst the substantive NHS employees return to their base site to continue to drive up activity.</p> <p>The Trusts also recruited and trained a number of medical and nursing students and many continue to work for the Trusts. In YFT this has resulted in a zero vacancy position and work continues to ensure retention of staff is high.</p> <p>Consideration is being given where some of the workforce is available and motivated to deliver additional contracted activity. There is a risk in delivering the plan around increased Covid</p>



	community transmission and staff absence through self-isolation.
<p><b>Availability of protected diagnostic and treatment facilities (surgical and non-surgical)</b></p>	<p>The Trusts have made arrangements, as far as is possible, to protect their elective facilities from the acute flows of patients that may present a higher risk of Covid.</p> <p>All Trusts are utilising the independent sector capacity for CT and MRI. NLAG and HUTH are currently using independent sector capacity for elective, day case and diagnostic activity (currently CT and MRI).</p> <p><b>NLAG</b> has increased operating at its Goole site.</p> <p><b>HUTH</b> has a cold site at Castle Hill and has re-organised staff and patient parking and circulation areas to separate the patients attending for the limited acute facilities (cardiac and oncology) from the elective flows.</p> <p><b>HDFT</b> has an Isolated Green Endoscopy unit in place, isolated Gynae and Urology diagnostic capacity.</p> <p>To provide Lung function tests HDFT require new equipment and air flow to support Covid-19 ICP requirements which is subject to a phase 2 capital case</p> <p>Across <b>North Yorkshire and York</b> a business case is being progressed for capsule endoscopy and a case is being developed for cytosponge for upper GI.</p> <p>Through the <b>HCV Cancer Alliance</b> work is underway on the development of Radiology community Hub and Mobile Endoscopy Unit.</p> <p>Also see diagnostics section.</p>
<p><b>Actions to maximise the use of digital technology to provide care more efficiently</b></p>	<p>Across the Trusts in HCV video consultation using the Attend Anywhere solution is an active project and is already in use in a number of specialties. It will continue to be rolled out across all specialties to support delivery of the non-face to face appointments. Telephone clinics are also being utilised to maximise non-face to face activity and optimise clinical time.</p> <p>National funding has been secured to pilot a patient portal, providing the ability to share clinical correspondence and results with patients.</p>

Across the Partnership the integration to the YHCR (Yorkshire and Humber Shared Care Record) and GP Connect will continue along with integration on and data sharing.

Digital enablement for networked diagnostics reporting is in place, and digital enablement will facilitate patient activation through the use of patient portals, NHS apps and remote monitoring are all priorities in the outpatients transformation programmes across HCV.

#### **NLAG**

- A project is currently underway to digitise all outpatient appointment and admission letters to patient by March 2021 Plan to extend this to other services during 2021
- Funding has been secured to procure an e-form package which will allow us to send patient's questionnaires specific to their condition to determine what follow-up is required. This same solution will also be used to support virtual pre-assessment
- There is an internal development to provide an out-patient module, this will enable the data collection in Outpatients to be captured electronically and for a letter to the patient and GP to be automated. This has been developed for use in Cardiology initially, consideration will be given to developing for other specialties once it is proven to be successful.

#### **HUTH**

- Upgrade of Network infrastructure and WiFi to support mobile and flexible working
- Continued rollout of Patient Know Best (PKB) platform to support patients digitally to manage Outpatient appointments and health care plans electronically
- Further deployment of equipment (laptop bundles, devices) and software to support flexible and home working for clinical and admin staff
- Continuation of rollout of the Lorenzo Digital Exemplar programme to expand digitisation both Outpatient pathways (Virtual consultation, automation, recording of outcomes electronically) and Inpatient pathways to build a data rich patient record, covering ED, advanced bed management, e-observation at bedside, assessments and care plans, e-prescribing, clinician aide app to support patient flow using mobile technology.

## Elective activity plans (3)

Planning requirement	Commentary
<p>Additional actions planned to sustain the continued recovery of services during the winter period</p>	<p>The winter planning and escalation and management of a second Covid-19 surge and potential flu across the Humber and North Yorkshire and York geographical partnerships will consider all actions to protect the on-going delivery of the elective, cancer and diagnostic capacity planned.</p> <p>Across HCV and through the cancer and elective hub arrangements Partners are working together to ensure parity of prioritisation across the patch and to develop refined clinical pathways.</p> <p>As previously mentioned there will be continued and optimised use of IS capacity.</p> <p><b>YFT</b></p> <ul style="list-style-type: none"> <li>• Revised bed modelling completed and analysed to work to mitigate the bed pressures identified. This includes: <ul style="list-style-type: none"> <li>○ Review of low risk management on the wards to enable further beds to open in escalation</li> <li>○ Implementation of national guidance on low risk management</li> <li>○ Capital build work to create additional side-rooms to support infection control</li> <li>○ Review of urgent care flow system and processes through ECIST, including additional senior management for flow</li> <li>○ System planning to continue effective discharge and avoidance of delays</li> </ul> </li> <li>• Undertake additional contractual payments for elective work</li> <li>• Capital bid for modular critical care unit to protect elective capacity (YFT Stepped-up case).</li> </ul> <p><b>HDFT</b></p> <ul style="list-style-type: none"> <li>• Separate green elective ward, with isolated flow from acute patients.</li> <li>• Other wards areas currently closed which would allow them to open through an increase in acute pressure</li> <li>• Separate Green theatres in place for In-patient and Day case work</li> <li>• Bed modelling based on maintaining elective Green inpatient bubble and is linked to Covid-19 bids for virtual team, community discharge hub but also winter planning requirements.</li> </ul>

**Any other key issues and risks associated with the elective activity plans and assumptions**

**Our plans have assumed an R=1 there for a key risk is the size and timing of a further peak or peaks in Covid 19 admissions -**

workforce pressures are a concern particularly if demand in non-elective increases that would impact on availability of workforce through sickness and redeployment but also the fatigue in relation to continuing high levels of delivery. The impact of use of PPE, enhanced infection control measures and the impact of bed numbers / availability.

The Trusts have set out plans to manage Covid 19 and surge plans to respond to a peak of activity. The surge plans do include the cancellation of elective activity once case numbers exceed the capacity available within the designated facilities.

The Trusts have completed gap analyses against the Adopt and Adapt recommendations for theatres and are assured that the opportunities identified have either already been considered as part of the restoration response or are being taken forward.

There is despite encouragement in accordance with access policies and the national and local communications concerns that patients are still anxious and will continue to refuse or not be able to present for elective appointments.

A further risk is the impending EU Exit deadline. Previous EU Exit planning had identified the potential, through transport vehicle stacking, that Scunthorpe General Hospital would become gridlocked. Given the unknown around the deal being made or not and the certain position that the borders will close, there is an inevitably a risk that could have an impact on clinical elective and emergency delivery from January 2021.

**Humber**

The inability to have the community beds in place for winter would create a significant risk to elective recovery. In Feb 2020 the lack of community beds led to elective work being ceased for a period of 4 weeks. All bed requirements will require validation across the system and to align to the existing utilisation of community facilities for the final submission

Across Northern Lincolnshire an additional 80 beds are planned. HUTH have a requirement and plans for 56 winter beds.

**North Yorkshire and York**

There is a reliance on the funding and completion capital works as well as a need to purchase capital equipment such as endoscopy scopes. There is also the need to fund the independent sector costs for specialities with significant gaps to required activity levels.

It should be noted that Harrogate FT has assumed that all capital bids submitted will be funded as they have already committed to this expenditure. This includes all retrospective claims of £3.534m plus Phase 3 recovery capital bids of £3.663 a total of 7.017m. The Trust is working on calculating the activity impact of not doing these schemes so that this is understood for the final submission.

The rationale for this includes the following:

- A number of the schemes are already committed in line with discussions with NHSE/ICS colleagues earlier in the year. Due to the configuration of the hospital the Trust needed to go at risk with these to enable any level of elective activity through allocating red and green zoning
- A decision has been taken not to pause/cancel works around endoscopy and outpatients as this would seriously impact on the operational team's efforts in mobilising this and could lead to distracting efforts in mobilising significant changes required in working practices in general
- Capital bids have been submitted and resubmitted in a number of forums and the Trust are concerned that at this stage of mobilisation there is a risk that schemes might be stopped/paused only for it to be expected to go live quickly later.

## Non-elective activity plans (1)

Planning requirement	Commentary																				
<b>A&amp;E attendances</b>	<p>Across the NHS in HCV a number of planning assumptions for the remainder of 2020/21 have been agreed for A&amp;E attendances, based on 2019/20 actuals, these are:</p> <p>Q2 - 80% Q3 - 90% Q4 - 100%</p> <p>Due to the level of activity already being seen in NLaG their assumptions in the activity plans are based on 100% of 19/20 across all quarters.</p> <p>To support the management of demand in to A&amp;E there are a number of approaches being implemented across HCV and these are set out below. The assumption that has been made around their impact on activity position is a 20% (10% in NLaG) reduction in minors attendances from January 2021 / quarter 4.</p> <ul style="list-style-type: none"> <li>• Talk before you walk/111 First local implementation</li> <li>• Increased capacity and access to SDEC</li> <li>• ECIST Strategic Input</li> <li>• Use of ART (Acute Referral Team) to support 'right place first time' for GP referrals and link to Talk Before you walk</li> <li>• Winter planning and escalation criteria at Place.</li> </ul>																				
<b>Non-elective admissions (including 0 vs +1 length of stay)</b>	<p>Across the NHS in HCV a number of planning assumptions for the remainder of 2020/21 have been agreed for A&amp;E attendances, based on 2019/20 actuals, these are:</p> <table border="1"> <thead> <tr> <th></th> <th>NLaG</th> <th>HUTH</th> <th>YFT</th> <th>HDFT</th> </tr> </thead> <tbody> <tr> <td><b>Q2</b></td> <td>100%</td> <td>83%</td> <td>80%</td> <td>80%</td> </tr> <tr> <td><b>Q3</b></td> <td>101%</td> <td>90%</td> <td>90%</td> <td>90%</td> </tr> <tr> <td><b>Q4</b></td> <td>104%</td> <td>108%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>The Trusts are working across the acute specialties and have agreed a range of addition Same Day Emergency Care management plans.</p> <p>Enhanced community frailty and respiratory services are being rolled out across the Humber with a target of a 10% reduction in non-elective admissions for an identified cohort of patients who are frail and/or have a respiratory long term condition.</p> <p>In North Yorkshire and York, increased capacity in adult community</p>		NLaG	HUTH	YFT	HDFT	<b>Q2</b>	100%	83%	80%	80%	<b>Q3</b>	101%	90%	90%	90%	<b>Q4</b>	104%	108%	100%	100%
	NLaG	HUTH	YFT	HDFT																	
<b>Q2</b>	100%	83%	80%	80%																	
<b>Q3</b>	101%	90%	90%	90%																	
<b>Q4</b>	104%	108%	100%	100%																	

teams to support care planning, high intensity users and multi-disciplinary teams. Step up/down virtual community beds and expansion of ambulatory care capacity will continue. They are introducing an Acute Frailty model on assessment units to support increase in % of frail admissions turned around on day 0-1

The impact of a range of work by and with PCNs and other out of hospital services to support frail and vulnerable patients and care planning at home or as close to home as possible, will continue to support lower NELs and reduce LOS, e.g. advanced care planning, GP support to care homes facilitated with remote consultations/ward round; further health checks and review for those patients with long term conditions to avoid deterioration; local diagnostics hubs.

NHSX and AHSN are developing an offer to support ‘virtual wards’ working across HCV.

**NLAG**

The Trusts experience over recent months has shown that its non-elective activity does not assume the HCV planning assumptions. The anticipated non elective activity will have risen back to 19/20 levels by September 20 and therefore as per North East and Yorkshire guidance assumption around a second peak the numbers are based on 75% of April for Sept to Nov, and 100% of May plus winter demand for Dec to Mar.

The split of non-elective LOS has been modelled at 30% for 0 LOS and 70% at 1+ days. This has led to the Trust undertaking a consultation to move wards during Winter to give us the ability to achieve this split. The 80 beds planned in the community across Northern Lincolnshire will enable the step up/step down beds required to achieve this.

**Available G&A beds and occupancy**

**NLaG**

Occupied beds are based on non-elective and elective work delivered across the NLaG sites with a small decrease in non-elective LOS. Bed availability based upon current funded G&A bed count. The Trust does have additional unfunded beds it could use, at risk, as escalation beds. **This equates to 32 at SGH, 57 at DPOW and 29 at Goole.** These are not shown in the plan. Zoning and social distancing has reduced the bed base by 14% and zoning will have impacts on flow. Independent sector beds not in bed base (activity excluded from bed requirement calculation).

This plan is based on no additional funding for general admission beds. Due to zoning, there has been the loss of circa 100 beds.

### **HUTH**

The Trust has created dedicated Covid general bed base and for its non-Covid elective and non-elective inpatient activity, set its plan to target 92% bed occupancy. There are plans in place for 56 additional Winter beds but these are subject to funding and there is a risk around workforce pressure to support these additional beds.

### **YFT**

The plan reflects additional beds to open over the winter period as set out below. This will increase the bed stock to 85% on the main sites and York Teaching Hospital is predicting 92% bed occupancy as a result. A Quality Impact Assessment will be required to manage infection control requirements in the event of urgent care demand.

- October: additional 23 beds
- November: additional 24 beds
- December – March: additional 55 beds.

### **HDFT**

The plan for the Trust is to not exceed 92% bed occupancy to support flow and social distancing in the emergency department. The bed model has been updated to include impact of Covid 19 and the impact of additional 20 virtual beds commissioned as part of Phase 2 response. The Trust NEL activity based in line with 2019/20. There is a requirement to open beds above funded establishment as follows:

- Dec to Feb – 22 beds
- March – 31 beds.

The Trust have identified that it will not be able to continue to support social distancing on wards throughout the winter.



## Non-elective activity plans (2)

Planning requirement	Commentary
<p><b>Minimise demand on A&amp;E services</b></p>	<p>The HCV Urgent and Emergency Care Programme has a range of initiatives in development to reduce A&amp;E attendances. These include:</p> <ul style="list-style-type: none"> <li>• NHS111 to clinically assessed 100% of patients disposed to ED by call handlers; resulting in a reduction of ED attendances</li> <li>• Redirection of some minors from ED to alternative settings.</li> <li>• Improved use of UTCs – increase in cat 4 &amp; 5 referrals diverted to UTCs</li> <li>• 111 First or Talk Before You Walk.</li> </ul> <p>Talk before you Walk is being planned and implemented across HCV to impact on ED attendances. This will be piloted in Hull in September 2020 with a view to rapid roll out to NLaG thereafter. The go live date for the whole of HCV is no later than 19 October 2020. The Trusts have assumed a 20% (10% for NLaG) reduction in minors attendances in quarter 4 to reflect the impact of these initiatives.</p> <p>111 First / TBYW priorities are as follows:</p> <ul style="list-style-type: none"> <li>• Expand pathway options and increase direct booking (e.g. primary care in and out of hours, UTC) for low complexity urgent care – YAS completing activity/demand modelling to inform additional capacity “ask” and requirements as safe alternatives to ED disposition</li> <li>• Expand clinical capacity to increase clinical validation for 111 ED dispositions – increase central (YAS) and local CAS offer increasing clinical input from 30% to 50% of all 111 calls and validating as close to 100% as possible of all ED dispositions</li> <li>• Ensure all DoS profiles are validated and up to date (e.g. UTCs)</li> <li>• Maximise “hear and treat” and “see and treat” capacity (e.g. within CAS and through SP/APs and ANPs)</li> <li>• Y&amp;H single care record – looking at how this can be used. – 3 trusts are on-boarding now, Primary Care flowing in now and EPACT data going in by end of the month. It is available now just the data is not rich and therefore improving input from various data sources to make it useful</li> <li>• Advanced e-mail notification (key patient information) from 111 to ED – as mentioned above testing in Hull ED commences 1<sup>st</sup> September 2020</li> <li>• Support and integrate the HCV communications strategy to support 111 First (likely through initial “soft” launch learning from pilot sites).</li> </ul> <p>In addition, further information is set out in the non-elective and</p>

	<p>other section of the plan around Primary and Community Care actions to support reduction and minimise demand on A&amp;E.</p>
<p><b>Increase acute admission capacity and improve flow</b></p>	<p><b>Humber</b>  Across the Humber, the Trusts have reviewed their acute admission capacity and have moved to integrated acute assessment units. Other initiatives include:</p> <ul style="list-style-type: none"> <li>• Implementation of board rounds within doctors job planning</li> <li>• Early identification of patients with emergency department.</li> </ul> <p><b>NLaG</b> has received confirmation of funding to support for additional side room capacity to be create. This will provide flexibility within the bed base and will facilitate the ability to manage infection control risks in a more appropriate way, which will reduce patient transfers, LOS and subsequently patient experience, it does not increase bed numbers.</p> <p><b>HUTH</b> has created a separate acute admission unit for suspected Covid patients.</p> <p><b>North Yorkshire and York</b>  <b>York Teaching Hospital</b> has improved access and turnaround for Covid 19 testing to support availability of side rooms on assessment. With the support of NHSEI Intensive supporting funding the Trust is creating a digitally enabled framework within the scope of the acute admitting pathways at York Hospital, specifically to review current acute systems and processes, refresh the risk management and escalation processes, including the Trust OPEL framework and Full Capacity Protocol, taking into account the Covid 19 requirements and redesign site management and approach to flow. Maximising use of medical and surgical same day emergency care and the frailty pathway.</p> <p><b>HDFT</b> have a Ward based doctor model, dedicated junior team for medical assessment, increase capacity on medical rotas for twilight shifts, increased medical cover at night in ED. They are proposing an increase footprint of ED Department to support distancing and capacity pressures – Linked to Covid 19 Phase 2 case and HCV ED capital scheme as it requires relocation of other Outpatient services and improved ED environment. They are also looking to introduce an Acute Frailty Consultants on Assessment Unit to support sustainable model of Acute Medical Assessment (will pick up 40% of acute take).</p>

## Sustain reductions in length of stay

Across the Trusts in HCV, they continue to actively address length of stay through a variety of approach including:

- Use of expected dates of discharge
- Use of virtual wards and ward rounds
- Performance management with specialties and individual consultants, supported by business intelligence.
- Continued Discharge to assess.

There is also strong support from our health and social care partners, with plans incorporating:

- Sustaining the Covid-19 Hospital Discharge Service requirements and arrangements
- Focus on supporting individuals to return to their usual place of residence. However, access to flexible step up / step down care plays a role in supporting rapid discharge and preventing admissions and a range of community bed arrangements are in place across the Places (see comments above)
- The split between hot and cold sites is expected to continue
- East Riding Community Hospital will continuing as a hot health site (30 community beds with piped oxygen and enhanced medical support)
- 12 hospice beds representing potential additional hot capacity that could be scaled up in case of a second wave
- Support for care homes to manage infection control internally and flex up hot and cold beds
- Introduction of / Rollout of the community frailty models.
- Review the emerging reablement and rehabilitation requirements of patients recovering from Covid across the Partnership to ensure appropriate care is in place to support return to health.

## Non-elective activity (3)

Planning requirement	Commentary
<p><b>COVID patient demand</b></p>	<p><b>NLaG</b> As per North East and Yorkshire guidance assumption for a second peak. Numbers are based on 75% of April for Sept to Nov, and 100% of May plus winter demand for Dec to Mar.</p> <p><b>HUTH</b> For Covid admissions we will retain capacity, including in critical care, to accommodate May 2020 levels of activity and have a surge plan that can accommodate 150% of previous Covid admissions</p> <p>As per North East and Yorkshire guidance assumption for a second peak.</p> <p><b>YFT</b> The numbers are based on North East and Yorkshire Region assumptions of 100% of May for Jul-Aug (219 spells), 75% of April for Sept-Nov (328 spells) and 100% of May plus winter demand for Dec-Mar (219 spells).</p> <p><b>HDFT</b> Bed modelling in line with WYAAT using NHSI developed approach, based on 92% occupancy for all months of the year.</p>
<p><b>Additional actions planned to sustain the continued recovery of services during the winter period</b></p>	<p>The Trusts have winter plans in place which are being further reviewed and will be finalised by the end of September 2020. The Trusts are engaging with system partners in relation to these plans, which include the development of enhanced community pathways for long term conditions.</p> <p>Further detail can be found in the 'Other' section under winter plans.</p> <p><b>Humber</b> The Trusts have the following actions in place to respond to winter and minimise its impact on the delivery of their recovery plans:</p> <ul style="list-style-type: none"> <li>• Development of plans for surge with agreed triggers of escalation in hospital and community services</li> <li>• Maintenance of rapid system escalation response arrangements in and out of hours</li> <li>• Provision of capacity to meet the peaks in seasonal demand</li> <li>• A plan to manage delayed transfers of care</li> <li>• Ensure smooth and timely ambulance handover to support ambulance response times</li> </ul>

	<ul style="list-style-type: none"> <li>• Streamline A&amp;E front door processes e.g. primary care streaming &amp; mental health response</li> <li>• Communicate public information about access to and use of urgent and emergency care pathways</li> <li>• Ensure the adoption of best practice in respect to urgent and emergency care.</li> </ul> <p><b>North Yorkshire and York</b></p> <p>The Trusts have the following actions and plans in place to respond to winter:</p> <ul style="list-style-type: none"> <li>• Covid-19 related scheme to continue / embedded for winter</li> <li>• Transfer team</li> <li>• TTO doctor</li> <li>• Extended on day transport capacity</li> <li>• Enhanced medical cover on weekends and BH</li> <li>• Escalation beds from Dec and March to support opening of additional bed capacity (above funded establishments)</li> <li>• Covid-19 and flu near patient testing capacity and approach</li> <li>• Increase critical care capacity from Nov to March by opening ARCU (Acute Respiratory Unit). Part of the Covid-19 phase 2 requirements submission.</li> </ul> <p>Additional new schemes for winter 2020/21</p> <ul style="list-style-type: none"> <li>• Development of a plan for complex rehab which will develop the capability of the ward (HDFT) to see more patients (could also be flipped to be a Covid-19 rehab unit) if funding is available to support.</li> </ul>
<p><b>Any other key issues and risks associated with the non-elective activity plans and assumptions</b></p>	<ul style="list-style-type: none"> <li>• Risk of greater second surge combined with Flu and Covid</li> <li>• Risk of increased impact from neighbouring systems e.g. Lincolnshire</li> <li>• Risk of second shielding/lockdown</li> <li>• Risk of EU Exit</li> <li>• Clarity on funding for digital infrastructure and staffing for TBYW to mitigate demand</li> <li>• Failure/delay to commence Talk Before You Walk programme</li> <li>• Alignment/delivery with OOH programmes</li> <li>• Space constraints due to social distancing/IPC requirements</li> <li>• Availability of workforce (isolation/sickness)</li> <li>• Procurement – PPE</li> <li>• Additional demand that isn't/ can't be mitigated</li> <li>• Availability of Covid-19 testing</li> </ul>

## Cancer activity plans (1)

Planning requirement	Commentary
<p><b>Urgent cancer referrals</b></p>	<p>Following the publication on the 3<sup>rd</sup> August of the National Cancer Programme key priorities we have been working across the Partnership to restore urgent 2 week wait (2WW) referrals to pre-pandemic levels.</p> <p>In August 2020, the overall target recovery position for HCV was between 85-100% of pre-Covid activity levels. Early indications predict that in August the referrals to NLaG will exceed 90% of pre-pandemic levels and will return to 100% shortly thereafter. In HUTH they are over 80% and are expected to return to 100% by the end of the year. For YFT referrals have returned to between 85%-100% of pre-Covid levels across all specialities and for HDFT referrals stand at over 85% with a predicted return to pre-covid levels of 100% by January 2021.</p> <p>Over the next three months further work will be undertaken to determine other routes to a diagnosis of cancer (e.g. A&amp;E) to assess the overall impact of Covid re total numbers of cancer diagnoses.</p> <p>Across HCV we will work in partnership to address both latent demand (i.e. patients who have not made contact with health services during Covid to date) and the demands of new patients to understand the 2WW position as it returns to pre pandemic levels and also the aligned cancer conversation rate.</p> <p>In order to complete this work the Trusts are working with the Cancer Alliances, both HCV and West Yorkshire (HDFT – West Yorkshire Cancer Alliance) to ensure restoration plans support patient confidence; promote ‘Help us to Help you’ public campaign and address wider health inequalities that may have presented across our population during the first wave of Covid-19.</p> <p>We will also work across HCV to optimise the conversion rates for cancer ensuring our approach adopts the principles of risk stratification and clinical prioritisation of those who are identified as most in need.</p> <p>We will also work with primary care to look at how care navigators can help support patients from referral to treatment across primary and secondary care. Helping patients to understand what to expect and thereby strengthening the patient pathway to ensure patient confidence increases as the uncertainty of Covid continues.</p> <p>The new Adopt and Adapt programme for cancer will also have a</p>

strong focus on a national media message and a full programme of work via online media is being supported to ensure patient confidence is restored. A full programme of work has now commenced in collaboration with the Cancer Alliance for the implementation of the **Early Cancer Diagnosis Network DES**.

#### **Restoring Screening and other Services**

The restoration of screening services has commenced with capacity expected to be between 50-60% including:

- **Bowel Screening:** Programmes are now restored to usual screening invitation processes and are building up capacity towards meeting pre-Covid rates of invitation and then to address the backlog of invitations
- **Breast Screening:** Restoration of usual screening processes has commenced with an initial invitation rate at 50% of that in place before Covid
- **Cervical Screening:** Intervals for invitations for individuals on a normal call/ recall pathway have now returned to normal
- **Targeted Lung Health Check** programme to recommence in Hull from Q3 (October commencement)
- Implementation of **clinical triage** of 2 week wait referrals, signposting clinically appropriate patients to 'Straight to Test' (risk stratification of patients with high risk of cancer, e.g. use of FIT in Colorectal)
- Increase use of **advice and guidance to GPs**, particularly in tumour sites where conversion rates are below 5%.

#### **Cancer treatment volumes**

As at July treatment volumes stood at 94.26% of pre-Covid levels. This is a total of 83% of overall treatments completed compared to the same time last year.

The HCV Cancer Alliance has modelled recovery against this position and we expect treatment levels to improve each month until across the Partnership we have recovered to 100% of pre-Covid treatment volume position by March 2021. However, we recognise in YFT all cancer diagnostic and treatment services have been restored in line with national cancer specialty and IPC guidance and in HDFT surgical and SACT (systemic anti-cancer therapy) are all now restored with remaining concerns around the restoration of Endoscopy and CT capacity (for pathways such as upper GI & colorectal)

To mitigate the concerns the Trusts will work with the Cancer Alliance on the Endoscopy and Imaging Adapt & Adopt Programme to ensure maximum use of capacity and workforce across HCV is in place to address the current backlog and bring this back to pre-pandemic levels of activity. This will ensure we work collaboratively to use our most scarce resource appropriately and allow for flexible



	<p>working and to clinically prioritise patients most at risk as we plan for further system impacts with regards to Covid-19.</p> <p>During the response to Covid-19 all patients have been risk stratified for both surgical and diagnostic procedures with priority level treatments that were not able to proceed during the height of the pandemic now being undertaken, however delivering them is also dependent on patient’s willingness. Across HCV there is a clear strategy for supporting patients who are anxious about attending hospital. Cancer Nurse Specialists communicate with them to provide assurance that hospital departments comply with Covid-19 secure guidance.</p> <p>All Trusts are working with the Cancer Alliances to model the recovery trajectory based on the three key national restoration metrics support the restoration of 2WW referrals, reduce the system backlog for 62/104 day position and ensure there is sufficient capacity to for both surgical and diagnostic procedures as we move forward based on our recovery assumptions.</p> <p>We will also work across the Partnership to further embed digital technology, advice and guidance ensuring we ‘lock in’ the innovations that we have developed. By working in this way we will create additional capacity to reduce our waiting list backlogs in a more timely way.</p>
<p><b>Number of patients waiting 63 or more days after referral from cancer PTL</b></p>	<p>The number of patients waiting over 63 days has shown a steady reduction across Humber, Coast &amp; Vale. The peak of activity being at the end of May in HUTH and end of June in NLAG. However, we anticipate we will see a rise in this area in the coming weeks due to pent up demand now moving through our system.</p> <p>It should be noted that the majority of patients over 63 days remains as those Lower GI patients suspended in the diagnostic stage following a FiT test and awaiting further tests to exclude cancer (Colonoscopy/CT).</p> <p>The Cancer Alliance has supported the development of a new pathway for the use of risk stratification of patients in the colorectal pathway, with the use of a FiT test at the point of referral for 2WW. This has now been approved and will commence on the 1<sup>st</sup> October with an assumption that we will see a significant reduction in the overall waiting list (particularly 62/104 day for colorectal) as we move forward.</p> <p>Across HCV there is a clear process for oversight &amp; assurance for the management of all patients waiting over 62 &amp; 104 days. This applies</p>



to patients that are waiting for a decision to treat and those patients that have been diagnosed.

All Trusts have internal oversight of their cancer PTLs and patients who are waiting are reviewed weekly via weekly tracking reports. Management of these patients is also monitored via formal performance reports at the Humber Cancer Board & York Cancer Board.

The HCV Cancer Alliance also produces a detailed monthly Oversight & Assurance report that clearly identifies what is happening across the Partnership, how we are tracking and managing these patients and ensuring (where appropriate) clinical patient harm reviews are being conducted (as per the 104 + backstop national guidance) to ensure patient safety of these long waits is being proactively managed and patients are not experiencing clinical harm as a result of the length of wait.

Specific measures being taken to support cancer delivery include:

- Retain clinical triage of 2WW referrals signposting clinically appropriate patients to Straight to Test (risk stratification of patients with high risk of cancer, e.g. use of FIT in Colorectal)
- Increase use of advice and guidance to GPs, particularly in tumour sites where cancer conversion rates are below 5%
- Increased diagnostics and/or treatment in green zone(s)/independent sector/ facilities where appropriate
- Development of tumour site recovery plans
- Clinical risk assessment of patients on cancer pathways (safety netting), particularly for patients reluctant to attend diagnostic test procedures/treatment
- Re-focus on timed pathways designed to support recovery building on new ways of working
- MDT equipment upgrade to facilitate virtual MDT functionality
- Acceleration of development and implementation of self-supported follow up pathways
- Development of Rapid Diagnostic Centre pathway for Upper/Lower GI
- Adopt and adapt model for endoscopy and imaging (CT/MRI) to drive the pace of implementing all high impact interventions.

## Cancer activity plans (2)

Planning requirement	Commentary
<p><b>Availability of capacity and workforce (both diagnostic – especially endoscopy and CT/MRI – and treatment) to meet current and returning demand, including from <u>independent sector</u>.</b></p>	<p>Across HCV the Trusts have prioritised the protection of capacity and workforce for cancer pathways in determining which staff are redeployed to support the Covid-19 response.</p> <p>All Trusts are part of a HCV Programme to increase diagnostic capacity including:</p> <ul style="list-style-type: none"> <li>• Substantial investment in both new and replacement equipment</li> <li>• Deployment of a digital solution for reporting and sharing images across providers an optimally managing reporting capacity</li> <li>• Investment in reporting radiographers</li> <li>• Investment in digital pathology</li> <li>• Risk stratification of surgical procedures already in place; backlogs monitored on weekly basis; waiting list validations completed</li> <li>• Initial triage of all referrals risk stratifies all urgent GI referrals. Endoscopy waiting lists and backlogs constantly reviewed and updated</li> <li>• Exploring the feasibility of HCV wide PTL to support equity of access; aligning patients to capacity; ensuring all partners can best address inequalities and build resilience for responding across the Subsystem and ICSs to a second surge</li> <li>• Modelling of the backlogs by the Cancer Alliances continues and will be considered / aligned with current and future capacity to understand the capacity gap and challenge from pre-COVID in Phase 3 and into Phase 4</li> <li>• Endoscopy capacity remains a significant risk across HCV but particularly in North Yorkshire and York. HCV endoscopy workshops undertaken to scope restoration of services in Phase 3 and development of sustainable services for the future</li> <li>• Full Endoscopy Adapt &amp; Adopt programme is now in place</li> <li>• Full Imaging Adapt &amp; Adopt programme is now in place</li> <li>• Work is ongoing with IS partners to ensure that all possible capacity available to support the delivery of cancer diagnostics, treatment and care can continue safely. This will be finalised in line with the national IS capacity planning process and incorporated in final submission</li> <li>• Discussions around the scope and scale of Community Diagnostic Hubs has already commenced and initial scoping options have been shared with PCNs and other provider partners in some Places to support mobilising the community diagnostic capacity required over the next 6 months and beyond.</li> </ul>

<p><b>Availability of protected diagnostic and treatment facilities (surgical and non-surgical)]</b></p>	<p>Across HCV the Trusts have implemented a wide range of measures to minimise the risk of Covid-19 infection and protect the availability of diagnostic and treatment facilities, including:</p> <ul style="list-style-type: none"> <li>• Swabbing of patients pre-admission (72 hours)</li> <li>• Asking patients to self-isolate before admission (where practical to do so)</li> <li>• Reduced visitors</li> <li>• Enhanced cleaning, observance of social distancing as far as possible segregation of flows</li> <li>• Increased diagnostics and/or treatment in green zone(s)/independent sector / facilities where appropriate</li> <li>• Development of a Rapid Diagnostic Centre pathway for Upper / Lower GI</li> <li>• Working with the Cancer Alliance on protected community diagnostic hubs (mobile capacity across the HCV) with priority on endoscopy</li> <li>• Completion of HCV Endoscopy Adopt and Adapt – to provide additional system wide capacity of circa 1900 (gap) subject to capital and workforce financial support set out in phase 3 plans; utilisation of additional IS capacity; mobile screening capacity; extended hours; weekend working</li> <li>• Imaging Adopt &amp; Adapt – provide additional system wide capacity; mobile workforce solutions;</li> <li>• Optimising utilisation of additional IS capacity</li> <li>• SACT delivery in house using home delivery to free up unit (HDFT).</li> </ul>
<p><b>Any significant expected variation in access to services for particular patient groups and how this is being mitigated.</b></p>	<p>Across HCV some patients are still choosing to wait longer for treatment. This is being mitigated by the scheduling of telephone consultations to reassure patients, and explain the mitigations in place to ensure the environment is Covid safe. Some of the mitigations are outlined below.</p> <ul style="list-style-type: none"> <li>• Virtual clinics (consultant and nurse-led)</li> <li>• Straight to Test</li> <li>• A HCV wide cancer PTL for the management of complex risk stratified patients; aligned to capacity; workforce availability and ensuring equity of access to cancer services across HCV; reducing inequalities and support aligning risk and clinical prioritisation of patients to available staffed capacity</li> <li>• Patient engagement plan; virtual walk through; patient stories re accessing services during Covid; community groups; faith groups; social media; virtual consultations</li> <li>• CRUK working with the Cancer Alliance and local primary and secondary care partners to support safety netting of patients, early diagnosis and the re-starting of screening focusing initially</li> </ul>

on cervical screening (bowel screening remains a high risk intervention for which recovery is being considered nationally with Cancer Alliances)

- Undertake Cancer Alliance modelling re impact and restoration of top 5 tumour sites; have full programme of LTP transformation to support restoration and fast track outputs; aligned to patient communication and engagement to promote confidence and attendance for treatment
- Pathway navigators supporting specific pathways and any issues identified (GI, prostate and lung) and continued focus on faster diagnosis
- Certain specialty pathways (upper and lower GI) are more impacted from IPC impact on capacity and the subsequent delays in diagnosis and adapted treatments for those patients remains an area of variation which all partners along with the Cancer Alliance (and nationally) are aware of and continue to work to drive equity of access from these pathways and associated diagnostics
- Bowel Cancer screening patients, in some circumstances, are choosing to wait longer to access the site of their choice for colonoscopy
- Triage and vetting of Lung 2WW has led to faster diagnosis of patients
- Chemotherapy day units are not experiencing patients reluctant to come in (all tumour sites).

## Cancer Activity Plans (3)

Planning requirement	Commentary
<p><b>Any key issues and risks associated with the Cancer activity plans and assumptions</b></p>	<p>A programme of pathway transformation is being undertaken across HCV with standards of care being developed to expedite stages of the cancer pathway for patients. Protocol driven decision making will be agreed with key MDTs (high volume tumour sites).</p> <ul style="list-style-type: none"> <li>• Securing financial allocations for transformation in this next phase particularly for RDC / Diagnostic funds</li> <li>• Developing and Implementing Diagnostic and Surgical Hubs</li> <li>• Re-commencing the National Lung Health Check programme</li> <li>• Supporting and maintaining a partnership wider approach to risk mitigation via the development of HCV wide understanding of impact of Covid and planning for phase 3 for further spikes with the HCV Cancer Alliance and geographical partnership Cancer Boards maintaining oversight and management of risk</li> <li>• Building staff and patient confidence in delivering and accessing current / adapted cancer treatment and care pathways safely and in a timely fashion</li> <li>• Ensuring we have the workforce at the right time in the right place – HEE are working with Cancer Alliance to establish endoscopy and radiology groups to explore all short, medium and long term opportunities</li> <li>• Developing the Long Term transformation agenda post Covid: supporting primary care; early diagnosis; fast track RDC / Diagnostics; treatments and pathways, Living With and Beyond</li> <li>• Understanding what level of activity will be provided via short term restoration; longer term revenue investment; longer term aspirations of capital development; workforce plans and timelines for additional / new roles</li> <li>• Continuing to develop and expand virtual consultations; embed innovations that have been introduced during Covid (FiT; Digital; Advice &amp; Guidance; Virtual; Straight to test)</li> <li>• Other delivery challenges             <ul style="list-style-type: none"> <li>○ PCN capacity to deliver requirements.</li> <li>○ Capacity of mobile CT scan units and radiology.</li> <li>○ Return of respiratory staff to the lung health checks.</li> </ul> </li> </ul>

## Diagnostic activity plans (1)

Planning requirement	Commentary
<p><b>Key strategic actions and assumptions that underpin planned activity volumes, where not covered under the elective and cancer elements covered in the commentary submission.</b></p>	<p><b>Humber</b></p> <p>The HUTH restoration plans enable 74% of 2019-21 activity to be restored, for NLaG it is 77%</p> <p>Recommendations from the Endoscopy Adopt and Adapt programme have been reviewed and assumptions incorporated into plans.</p> <p>A wide range of actions have been implemented to address the need to expand diagnostic capacity:</p> <ul style="list-style-type: none"> <li>• Substantial investment in both new and replacement equipment</li> <li>• Deployment of a digital solution for reporting and sharing images across providers an optimally managing reporting capacity</li> <li>• Investment in reporting radiographers</li> <li>• Investment in digital pathology.</li> </ul> <p>In addition plans for a rapid diagnostic pathway for colorectal patients and utilisation of additional IS capacity are in development and will inform the final submission.</p> <p>The Radiology teams continue to work with both GPs in relation to direct access requests and specialties within the Trust to manage demand and optimise deployment of capacity.</p> <p><b>North Yorkshire and York</b></p> <p>YFT plan indicates that national requirements will be met. It should be noted that capacity did not meet demand in 2019/20, leading to large backlogs; hence the capital request as part of planning.</p> <p>The recovery of CT at HDFT is based on:</p> <ul style="list-style-type: none"> <li>• Use of Nightingale facilities</li> <li>• Second CT and infrastructure to support its use which is highlighted in the Covid 19 phase 2 capital submission</li> <li>• Staffing for second CT highlighted in Covid 19 phase 2 revenue submission</li> <li>• Use of IS/ off site locations to support other radiological diagnostic capacity.</li> </ul> <p>A wide range of actions have been or are being implemented to address the need to expand diagnostic capacity, including:</p> <ul style="list-style-type: none"> <li>• Maximisation of all pre Covid-19 lists and full productivity</li> </ul>

	<p>within them (YFT)</p> <ul style="list-style-type: none"> <li>• Additional support staff recruited to support turnaround of equipment and to minimise the impact of Covid 19 on efficiencies as highlighted in Covid 19 phase 2 revenue submission (HDFT)</li> <li>• Retain full workforce capability through second wave</li> <li>• On-going review of IPC processes, sharing good practice and minimising impact on capacity</li> <li>• Demand management and pathway work to reduce pressures on services/ clinical capacity for radiology</li> <li>• Retain current access to mobile units and IS capacity, monitoring ongoing to ensure maximised utilisation</li> <li>• Reliance on capital/ availability of staffed additional mobile and/or modular units to support adapt and adopt</li> <li>• Clinical time to support service changes (noted in feedback to region in Adopt and Adapt work across all blueprint frameworks)</li> <li>• Development of imaging and endoscopy networks to maximise collaboration, sharing/ mutual aid and sustainable benefits</li> <li>• Exploring innovation including alternatives to invasive/ high risk interventions; e.g. endoscopy such as cytosponge and capsule endoscopy and use of AI/new technologies in radiology working with the AHSN and NHSX.</li> </ul>
<p><b>Any other key issues and risks</b></p>	<p><b>NLaG</b></p> <p>The Trust has seen an increase CT activity in July 2020 compared to July 2019. This increase is predominately attributed to unplanned care patients. Demand for unplanned is being met however the increase in activity is not improving the planned care waiting lists. A significant backlog was built up in Endoscopy during Phase 1 and 2 and its clearance is being limited by the ongoing PPE and other enhanced infection prevention measures in place. <b>Providers across HCV have agreed to form an Endoscopy workstream to act jointly to expand capacity.</b></p> <p><b>HDFT</b></p> <p>As previously mentioned it should be noted that Harrogate FT has assumed that <u>all</u> capital bids submitted will be funded as they have already committed to this expenditure. This includes all retrospective claims of £3.534m plus Phase 3 recovery capital bids of £3.663 a total of 7.017m. £770k of capital included in these bids is for enabling works to embed a CT scanner (the funding for which is already agreed).</p>

## Workforce plans (1)

Planning requirement	Commentary
<p><b>Retaining and deploying NHS returners</b></p>	<p>Across HCV the Trusts have recruited people through the Bringing Back Staff (BBS) initiative and are now working with them to identify how to retain them in the short and longer term.</p> <p>The Trusts have successfully recruited student nurses who were deployed with them into newly qualified band 5 posts.</p> <p>The use of retire and return programmes to retain the skills and experience of recently retired staff is positive. All the Trusts are having discussions with staff as they approach their retirement age, to explore flexible employment / deployment models with those individuals.</p> <p>The BBS initiative is due to transfer to HCV Partnership from October 2020 and we are working with organisations on the best way to support that currently. The funding is for a band 8a and band 5 until March 2021. As BBS transfers the Partnership will undertake a more detailed analysis of the progress to date, including barriers to employing/deploying people will take place. Across HCV, employers have reported low take up due to challenges meeting individuals' requirements for remote and/or flexible working. A localised system approach may support further deployment of BBS, linked to a return to practice programme.</p>
<p><b>Further recruitment plans</b></p>	<p>The local labour market continues to be challenging but the Trusts across HCV have successfully recruited new qualified staff from Higher Education Institutes. They also continue to achieve positive recruitment outcomes with health care assistants.</p> <p>International Recruitment programmes are now being re-started as integral elements of recruitment plans. This includes the Medical Training Initiative (MTI) scheme for international doctors.</p> <p>The level of uncertainty around recruitment (including international recruitment) and retention makes planning recruitment initiatives more challenging than usual. Particularly the uncertainty of the impact of EU Exit, Covid-19 surges and flu. Trusts are (re-)starting International Recruitment programmes post Covid-19 lock downs and they are having discussions about developing a more co-ordinated system approach to International Recruitment.</p> <p>The People Plan explains in greater detail what system work is planned on recruitment.</p>



<p><b>Use of bank and agency</b></p>	<p>The Trusts across HCV will continue to use flexible options to support service delivery, including those posts that are notoriously difficult to fill. The use of bank and agency staff is key to covering annual leave, sickness absence, and staff that are shielding and self-isolating. The utilisation of temporary staffing is difficult to predict. Most of the Trusts in HCV are looking to increase their reliance on bank staff, rather than agency. However, it is common for the majority of bank staff to also be trust substantive staff therefore there is some concern about the availability of those staff as they need to take leave and maintain their own health and wellbeing as well as the possibility of increases in sickness absence during the winter months.</p>
<p><b>Use of additional hours (balanced with health and wellbeing considerations)</b></p>	<p>There is a recognised risk to people’s own health and wellbeing. The Trusts in HCV are using their rostering systems to monitor hours (over and under) including bank and overtime hours. There is an undoubted tension between the requirement to step up services and consider the rest and recuperation needed for people.</p>
<p><b>Redesign of teams and roles</b></p>	<p>Where staff are shielding and are unable to safely carry out their normal duties they are being deployed in different roles, including supporting virtual and digital services from home, or other safe locations. A number of services have already moved to virtual and digital pathways and staff are being deployed to support this new way of working and we anticipate this will be a continuing direction of travel.</p> <p>Initial work from adopt and adapt programmes have considered the workforce implications and action plans are being developed and will be shared across the different workstreams to avoid silo working. This will support service delivery but will not ensure all services deliver activity to 100% of pre-Covid levels. However, there are a number of examples of good practice being identified and implemented.</p> <p>More services are expanding to operate over seven days and into evenings to support the required increases in activity, prevent admissions/attendance at ED’s and to deliver backlog activity.</p> <p>The Trusts are directly (or working with local training providers) developing rapid/immersive/accelerated training programmes to upskill existing staff to work in different ways. Examples include Nursing Associates, IAPT’s, ODP’s in theatres, and Critical Care for nurses, follow-ups with patients using digital platforms.</p> <p>The People Plan provides greater detail what system work is planned.</p>

## Workforce plans (2)

Planning requirement	Commentary
<p><b>Managing redeployment following risk assessments</b></p>	<p>All the Trusts are proactively managing risk assessments and ensuring people are safe. They have implemented follow ups for those people at most risk, including pregnancy, long term conditions as well as BAME colleagues. The Trusts have established links with Occupational Health and ESR to monitor real time activity.</p>
<p><b>Deployment across systems, sectors and organisations</b></p>	<p>There is a local and regional MOU in place to support the deployment of staff across organisations. Locally this includes deployment of staff into care homes, Nightingale Hospital and other non-NHS employers (including our Community Interest Companies). The use of flexible approaches to working and deployment is supported through this approach.</p> <p>Through the development of the HCV Partnership People Plan (which will include all sectors and organisations) we will develop a plan to expand the arrangements for the deployment of staff. Collation of data has already taken place and some of this will be referenced in the People Plan submission however we intend engage on a Partnership People Plan that reflects all sectors by December 2020.</p> <p>In the meantime across HCV we will use the “belonging to the NHS” message to support staff moving between organisations to support patients and service users as flexibility as possible, but recognise this will extend to the Independent Sector, Community Interest Companies, Care providers and Education providers.</p>
<p><b>Addressing sickness absence</b></p>	<p>The Trusts across HCV are reviewing their approach to long term sickness and two have mentioned re-establishing formal reviews for those on long term sick leave.</p> <p>All Trusts have anticipated sickness levels for the rest of the year and will be monitoring actual levels against these levels. This will allow for rapid response if levels start to increase. The use of special leave for shielding and self-isolating is also being monitored and managed in the same way.</p> <p>For other than Covid-19 the common sickness absence reasons are stress and MSK. Please see the next section.</p> <p>All trusts are concerned about the impact of flu, and resurges of Covid-19 and some of the Trusts have assessments in place of best</p>

	and worst case scenarios.
<p><b>Supporting health &amp; wellbeing, including rest and recuperation</b></p>	<p>All the Trusts in HCV have implemented enhanced support for staff, examples include: Employee Assistance Programmes, additional Mental Health support, resilience training, buddy systems for people returning to work.</p> <p>They will be implementing the Health and Wellbeing conversations as identified in the People Plan, with specific training for managers being put in place by some trusts. The conversation will include focusing on the need for people to take annual leave and breaks from work. The development of resilience hubs will provide more support in parts of the system.</p> <p>Health and Wellbeing is identified as a key metric within the major incident command structures and is being kept under review.</p> <p>The need for testing and track and trace for staff is seen as a key element, with some trusts identifying this area of work requiring further work.</p> <p>Local flu campaigns will start in the next few weeks.</p>

## Workforce plans (3)

Planning requirement	Commentary
<p><b>An assessment of the match between workforce availability and the workforce requirement linked to the activity and service redesign plans</b></p>	<p>Some Trusts in HCV have modelled this, and others are currently undertaking this work as part of a wider refresh of their clinical strategy.</p> <p>The need to link with supply of staff (recruitment) as well as deployment of existing staff, linked to further training and development is being explored by Trusts. Retention is a key part of this work also and could be supported by the retention pathfinder for North East and Yorkshire.</p> <p>The need to link to contingency plans for a possible second wave of Covid-19 is part of these plans as well as consideration of increased absence levels for staff through sickness absence, shielding or self-isolating.</p>
<p><b>Plans to complete staff risk assessments on an ongoing basis</b></p>	<p>Trusts have plans in place to review and update the risk assessments with links to ESR and Occupational Health IT systems to support decision making and prioritisation. All trusts in HCV are working to submit to the current portal submission which closes on 2 September 2020.</p>
<p><b>Any other key issues and risks associated with the workforce plans</b></p>	<p>The Partnership will use this process to develop a system wide People Plan. This will include inputs from Community Interest Companies and social care.</p> <p>As a Partnership we have also requested that our Community Interest Companies complete the same phase 3 templates and data from Primary Care Network workforce plans (for the Additional Roles Reimbursement Scheme) will also be incorporated into the HCV Partnership People Plan.</p> <p>Health Education England is working with employers and Higher Education Institutes (HEI's) to maximise the numbers of students starting healthcare courses in September and this includes supporting the provision of high-quality clinical placements. We have had a number of successful bids across the Partnership to support the expansion of clinical placements and HEI's have increased numbers of their undergraduate programmes. There is good working between HEI's and employers and a commitment to support students.</p> <p>The Trusts are establishing lessons learnt processes to review their response to Covid-19. This will include reviewing and updating</p>

policies and procedures where appropriate, or as part of the normal review and update process.

Employers are reviewing the re-establishment of back office functions, both in terms of how best to establish them and preparation for potential suspension due to a second wave.

Staff networks are seen as important stakeholders in supporting staff within trusts. The Partnership has established a HCV Black Lives Matter and BAME Steering Group, chaired by the Chief Executive of Harrogate and Rural District Foundation Trust. Other system wide networks may also be established.

The Partnership is working with union partners to develop their current arrangements to work more closely with Y&H SPF.

The Partnership People Lead has established a fortnightly informal meeting of HR leads for Trusts and CCG's to support the development of system wide responses to the People agenda and to support the development of the Partnership People Plan. The group are sharing learning across a range of priorities areas.

## Workforce plans (4)

Planning requirement	Commentary
<p><b>STPs/ICSs may want to provide their initial system level response to the priorities set out within 'We are the NHS: People Plan 2020/21</b></p>	<p>There are references made through the previous workforce sections of some of the HCV Partnership response to the priorities in the NHS People Plan.</p> <p>Across the Partnership we will work collaboratively to use the up and coming annual staff survey to promote the belonging to the NHS message. We are keen to promote a wider health and care approach and we are mindful that we need to ensure what we do engage our community interest companies, local authorities and other care organisations / partners as well.</p> <p>The HCV Workforce Board will be review the People Plan on 21st September with the aim to support further engagement of partners and the agreement to a clear set of priorities to be included in a further iteration of the HCV People Plan that will represent all sectors which we aim to produce by December 2020.</p>

## Other

Planning requirement	Commentary
<p><b>This might cover the following if not fully addressed in earlier sections of commentary:</b></p> <ul style="list-style-type: none"> <li>• Outbreak management</li> <li>• Seasonal Flu</li> <li>• Surge</li> <li>• PPE</li> </ul>	<p><b>Outbreak Management and Surge</b></p> <p>Both Geographical Partnerships continue to work closely with the Local Resilience Forums in relation to emergency planning for spikes in Covid-19 but are also picking up other pressures such as EU Exit and seasonal flu. They have all completed lessons learned work from Phase 1 of the pandemic and have used this to inform planning and updating of major incident plans and other plans such as flu. The North Yorkshire LRF has increased their level of response and Humber has increased the frequency of meetings in light of future events.</p> <p>In addition, we have as a Partnership maintained Chief Executive Leaders on areas such as PPE and EU Exit (Dr Peter Reading), Testing (Phil Mettam) and Flu and Covid Vaccination (Amanda Bloor) to ensure we have links in to the regional and national arrangements, information and messages and to ensure the Partnership has the appropriate action / response in place.</p> <p>All the Local Authorities have effective outbreak management plans in place and all Partners in HCV continue to support the Directors of Public Health and each other in relation response, learning and future planning.</p> <p><b>Seasonal Flu / Vaccinations</b></p> <p>Across HCV local flu plans are being developed working with partners including public health, Primary Care Networks and practices who have their own flu plans. The local flu plans cover the roles of various agencies and providers and new ways of delivering the programme to ensure as wide access as possible to the flu vaccination for all eligible groups, as well as public and staff communications. Implementation of flu plans will be monitored closely in each place to seek assurance from primary care and provide support to maximise uptake.</p> <ul style="list-style-type: none"> <li>• Practices have commenced planning for BAU cohorts and the CCGs are developing plans for at scale services.</li> <li>• Trajectories for meeting the 77% standard for the 64+ year cohort have been developed</li> <li>• Community providers will support delivery of the flu programme to ensure housebound people, and people in care homes are vaccinated through an ‘every contact counts’ approach</li> <li>• HCV Flu Board established with all places participating</li> <li>• Regular place flu meetings supporting delivery of the programme and supporting practices in achieving trajectories</li> <li>• Communications being used to promote programme and range of opportunities for accessing a vaccine e.g. through community pharmacy</li> </ul>

- Practices deploying additional staff and utilising additional accommodation, including community venues, to support increased uptake rates
- Additional workforce being made available at a system level to support programme e.g. Y&H Foundation Dentists being made available to support delivery
- We will be encouraging all our front-line workforce in particular, to take up the offer of a vaccine.

### **Continuing Health Care (CHC)**

#### ***Humber***

All four Humber CCG's plan to complete outstanding assessments by end of March 2021. Hull and North Lincolnshire CCG's plan to complete by end of December 2020.

Clearance will be delivered at Place between health, local authorities and other partners with Humber-level overview. There are plans to secure additional resource in North and North East Lincolnshire and fill existing vacancies in East Riding of Yorkshire. Potential issues and risks have been identified and plans put in place to mitigate.

#### ***North Yorkshire and York***

Recovery of CHC assessments has commenced. CCGs have developed plans to ensure that the backlog of CHC assessments are completed by the end of October and then within 6 weeks of discharge.

North Yorkshire CCG are required to complete 70 CHC assessments to deliver the backlog, extra CHC panels have been arranged on a weekly basis and staff allocated to complete this work as a priority.

For the Vale of York CCG there are 210 DSTs/checklists to be undertaken across 3 Local Authorities and these commenced on 1<sup>st</sup> September 2020. There are also arrangements dovetailing into this retrospective work for the efficient management of new referrals and reviews during this time. The CCG will review its existing hospital discharge to assess arrangements across the system to fit with the 6 week guidance.

#### ***Humber***

##### ***Primary Care***

During the Covid-19 response, numbers of appointments in primary care declined due to patient driven reduction in demand due to Covid, the standing down of some routine primary care activity to reduce face to face appointments, working arrangements in light of Covid e.g. Hot sites, PPE/cleaning and social distancing requirements reduce capacity of premises.

Demand is now increasing again due to the following factors:

- Patients grow in confidence to utilise



- Routine work increases as part of recovery phase
- Other parts of system re-commence and impact upon demand in primary care
- Implementation of Network DES.

To reflect the increase demand capacity will also increase through:

- Changes in working practices and management of Hot / Cold activity
- Bringing extended access capacity back in to the system (some had been stood down / reduced)
- PCNs recruitment to additional roles in primary care.

In addition to the above are the following initiatives will also support Primary Care:

- Active recruitment to PCN Additional Roles to provide resilience and capacity, targeted at reducing health inequalities and supporting the vulnerable (e.g. Social Prescribers, Respiratory Nurses)
- A range of initiatives to support patients to self-care and improve the management of their long term conditions will be implemented; including the revised National Diabetes Prevention Programme, restarting diabetes structured education services, and increased use of self-help apps or patient coaching models
- Continuing to develop an approach to Personalised Care, in line with the NHSE framework, improving health literacy, developing self-management and utilisation of the PAM tool (Hull and East Riding are mentee sites for this) in Respiratory, Parkinson's and at PCN level.
- Humber wide engagement with patients & public regarding changes to service delivery in primary care July/Aug
- New models of care delivery - including Total triage and self-care - embedded within primary care. Supported by investment in IT (primary care digital investment plan) and associated support to patients/public in terms of raising awareness of primary care online service availability
- Increase in utilisation of online services – utilising Leisure Services / Council contact centres in some circumstances, particularly for those without digital access (potentially East Riding initially with a Humber approach being developed).

Community Pharmacy has continued to become an integral part of the development of primary care services through increasing collaboration with PCNs such as providing more services to support access by the most appropriate healthcare professional. Pharmacy implemented an *open-door* approach to underpin access to medicines at the start of the Covid Pandemic and will continue to do so through winter. HCV will continue the development of role for community pharmacy to support PCNs.

Dental Services have mobilised for face to face care but there are capacity limitations due to the need for infection control. Rooms are being cleaned between each patient, this increases the overall length of each



appointment slot and waiting areas in a number of practices are proving challenging. Focus is on urgent / most vulnerable cases initially.

Similarly Optometry Practices are now open for business and face to face appointments. Capacity is less than prior to Covid due to infection control. As with dental appointment slots have lengthened to accommodate cleaning and waiting rooms are proving challenging for many.

### ***Community and Social Care***

Across the Humber the following actions / plans will be implemented to support the vulnerable and frail members of our population and support care homes:

- Implementation of Network DES for PCNs including Enhanced Health in Care Homes service, structured medication service and medication optimisation
- Sustain the existing frailty response and develop an integrated model of targeted, proactive, interventions to include prevention, proactive support and crisis management. This service will reduce ED attendances and admissions to the Acute Sector and Care Homes
- All care homes have been given details of their primary care and community identified key contacts to achieve a multi-disciplinary, preventative approach to care, involving weekly check-ins and the development of an integrated process of care planning. All care homes are now connected through investment in IT
- Voluntary organisations are embedded in communities across the system to support shielded and vulnerable patients; this support will continue to be available during phase 3, supported with proactive outreach and active sign-posting of suitable patients by community providers, Optometry and primary care to help people to stay well, reduce deconditioning and acute presentation.

In addition to the above in community and social care we will:

- Continue use of hot sites/zones to manage suspected Covid patients in community settings
- Recommence day and preventative activities for people with LD and / or autism and, on the North Bank, developing an adult neurodiversity pathway
- Reduce waiting times for autism assessment through (majority) online methods
- Risk stratify and prioritise safeguarding issues, working with schools for children and young people when the autumn term commences. We will work towards establishing a single point of contact and pathway for CETRs on the North Bank
- Ensure that LeDeR case reviews are up to date and lessons learned.
- Work on a programme to reduce the prescribing of analgesics in areas of high opioid use
- Assure full implementation of the BAME standards set out within the phase 3 letter.

### ***Post-Covid Rehabilitation***

Wherever possible individuals who are recovering from Covid are being supported via existing rehabilitation routes. Those who have spent a period of time on ICU are followed up on the wards as per usual post ICU support and if there looks to be any neurological rehab needed the rehabilitation ward at Castle Hill Hospital have been supporting these patients. For non-ICU patients they have started rehab on the wards and due to the implementation of Discharge to Assess those who need additional nursing / care support are being transferred into Hull and East Riding of Yorkshire community bed base for ongoing rehabilitation in the community. For those patients who are discharged directly home with nursing / social support through the door services we are supporting them with rehabilitation. There have been no specific reports of an increased burden upon therapy services but we are continuing to monitor especially as we consider further waves which will increase the numbers of post Covid Patients.

### ***North Yorkshire & York - Primary, Community and Social Care Developing Place Based Integrated Provider Collaboration***

Across NY&Y Place Based collaboration across health and care is recognised as being required to deliver services the population needs within the resources and capacity available. The next phase of the delivery plan includes further development of Provider Collaboratives that are already in place across NY&Y: HARA in Harrogate, Heartbeat Alliance in Hambleton and Richmondshire, Scarborough MCP and Nimbus in York.

### ***Primary Care***

The following are the plans in place for how Primary Care will support elective activity, these include:

- Rolling out the use of primary care dashboards to support proactive real time management with partners to understand referral activity and patterns and then target actions and interventions
- Use of Referral Support Service/Rapid Expert Input/Consultant Led Triage to triage elective referrals and provide advice and guidance where appropriate to ensure that patients receive the right care in the right place
- Promotion and implementation of self-care/public health messages for our population e.g. condition specific webpages and videos within acute provider websites
- Active expansion recruitment to PCN additional roles to provide resilience and capacity.

The following are the plans in place for how Primary Care will support non-elective activity, these include:

- Reviewing urgent care and 'on the day' access to appointments to improve same day access in primary care and make best use of extended access, extended hours

- Frailty work streams with primary care, community services to support identified groups of patients and prevent admission to hospital and care homes
- Enhanced Health in Care Homes:
  - Implemented a local LES agreement from May ahead of DES from October
  - Project Group in place to deliver an embedded approach and monitor benefits and outcomes
  - Next steps - roll out of MDTs and care planning records
- Implementing use of OPEL notification with primary care across Vale of York and Scarborough. This ensures CCG is sighted on emerging issues and able to support system partners on peaks in activity.

Primary care will also support of partners through the following:

- New focus on annual health checks for LD patients and recording of ethnicity.
- Continued use of hot sites/zones to manage suspected Covid patients in community settings.
- Clinical Summit in late September between primary care leads and their care group leads to:
  - share understanding of the pressures in primary care and secondary care
  - identify how primary care and secondary care clinicians can work collaboratively to address a mounting clinical workload and risk.

### ***Community Services***

The following are the plans in place for how community service partners will support elective activity, these include:

- Restarting services, e.g. phlebotomy, community physiotherapy, which will contribute to the restarting of planned care pathways
- Discharge Command Centres and rapid discharge processes will similarly facilitate rapid discharge during phase 3 for people recovering from operations.

The following are the plans in place for how community service partners will support non-elective activity, these include:

- Crisis response services are in place across the system to facilitate admission avoidance in the community, with augmented capacity in key parts of the system where there has been increased deployment of acute therapy staff in the community
- Proactive rehabilitation and reablement, including support for people who have deconditioned or are recovering from Covid-19, will help to reduce readmissions or health deterioration
- Multi-disciplinary team working between primary care and community services is being strengthened with resumption of MDT meetings, to proactively identify and support vulnerable people

- Discharge Command Centres are being maintained in York, Scarborough, Harrogate and the Friarage Hospitals throughout the winter period to facilitate rapid discharge during phase 3 and reduce pressure on acute bed capacity
- All parts of the system are operating a Home First policy, with community therapy, rehabilitation and reablement capacity over 7 days available to bring people home and reduce system delays
- For those patients requiring step-down into a community bed, additional community bed capacity to accommodate people requiring rehabilitation or recuperation or 'Discharge to Assess' is being arranged:
  - In North Yorkshire we have learned from the initial Covid response actions and are continuing with block-booked capacity in private care home beds in Scarborough (12) and Selby (10) for September / October for Covid-negative patients so as to continue to facilitate discharge in areas of high occupancy rates; other 'Discharge to Assess capacity will be through a combination of spot-purchase in private care homes or existing facilities
  - Further beds to safely support Covid-positive patients are being arranged in North Yorkshire County Council facilities (8 residential beds) and potentially clinically-approved North Yorkshire private care homes where 24/7 nursing care is required (10 beds)
  - Peppermill Court will continue to be commissioned in York to support recuperation.

Community providers will undertake engagement with staff to embed successful Covid-19 working patterns that the system wants to make permanent. This is likely to include the following initiatives:

- Discharge Command Centres
- Acute Hospital therapy staff brought out to work in the community
- 7 day working
- An assurance process is being undertaken with community providers to confirm delivery of phase 3 requirements and identify areas where development or support is required
- Additional capacity within community providers is largely being achieved through redeployment of staff from acute settings or other roles
- For consideration – As services are re-established and opportunities for additional community-based support are identified, additional costs may be incurred in relation to:
  - Increased admission avoidance (particularly HARA)
  - 7 day working (Whitby)
  - Flu campaign (all areas)
  - Support to care homes (all areas)
  - Increased support to community-based beds.

### How draft Phase 3 plan is connected with the system's Winter Plan

The plans include the capacity to manage winter based on activity seen in 2019/20 and actions have already been set out in the Elective and Non-elective sections in the plan. For example key initiatives to support winter planning and surge management include:

- Flu vaccination - review of existing provision in Q2, delivery of flu vaccination commencing Q3
- Talk Before You Walk
- Preventing admissions among frail patients.

To deliver effective winter and surge planning, the HCV Urgent and Emergency Care Network (UECN) and A&E Delivery Boards held an 'are we ready for winter' workshop on 16<sup>th</sup> September 2020 with the aims to:

- Share good practice across the Partnership
- Share our plans for winter by A&E Delivery Board as well as the latest position on the HCV UECN programmes that will support all
- Check we have everything covered to meet with the direction of travel
- Identify the top 3 objectives and actions for each A&E Delivery Board to help us get through winter
- Share and commit to these actions to move forward as a system.

Common challenges and themes that were identified across HCV included:

- Scale of recovery and pace is a significant challenge in a short timescale
- Application and discipline of the discharge guidance
- Clinician access and advice in secondary care to be a point of contact for 111 / local CAS
- Growing mental health demand
- Bed numbers and length of stay
- Diagnostics
- Workforce to deliver required transformation across the system especially with all the additional risks this winter and the agility across organisations to share workforce, particularly AHPs
- Covid-19 Testing.

The A&E Delivery Boards and their respective areas are clear on what needs to be done and have plans in place which they are starting to implement. We need to ensure opportunities for sharing the learning of excellent practice across the Partnership are available and we need to explore how we ensure they are spread and implement rapidly. There is also further work across the Partnership to look at how we mitigate the additional risks of winter on the workforce and ability to deliver transformation across HCV.

A review of the **non-urgent emergency care services** (urgent treatment centres) has just been completed and there is an imperative to provide assurance in the next month how we will get our UTCs to meet the national specification and delivering the 27 standards in line with the requirement by December 2019. As part of this we will consider:

- The model for non-urgent emergency care that meets the health needs of the population and uses resources in a way that will have the greatest impact in terms of patient outcomes and value.
- Integrated end to end pathways within an environment of continuous quality improvement across the system
- Co-ordinated urgent and emergency care communication and engagement strategy that supports local understanding of how to use services appropriately in a way that will deliver the best outcomes for patients.

In 2019, the Partnership made a collective agreement to fully implement the RAIDR UEC app to enable the system to understand the current pressures across the system in near to real time. Work continues to ensure full implementation to support winter, key actions include:

- York is fully live; NLaG and HUTH are working to expand current metrics prior to winter
- Care Homes are live
- Ambulance services YAS & EMAS are both live
- Primary care is implemented in North and North East Lincolnshire, mobilisation is in progress in York & discussions ongoing with North Yorkshire, Hull & East Riding of Yorkshire
- UTCs in Hull & East Riding of Yorkshire go live at the end of September, further work to do to confirm plans with NLaG, York and North Yorkshire
- Conversations are underway across HCV in relation to onboarding of Community and Mental Health .

**Mental Health planning and any cross-reference with separate mental health submission, incl. progress against the NHS Mental Health Implementation Plan 19/20–23/24 and COVID-19 related constraints and enablers e.g. workforce, digital Any other areas of focus:**

- IAPT
- CMHT caseloads

The HCV Mental Health Partnership have confirmed the following principles to inform the response to the mental health/learning disability and autism implementation plan:

- People with mental health needs, a learning disability or autism should receive the same degree of protection and support with managing Covid-19 as other members of the population. This may mean providing additional support, including making reasonable adjustments
- In preparing for and responding to Covid-19, staff in mental health / learning disability and autism providers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions will need to balance clinical need (both mental and physical), patient safety and risk. Due to the need for rapid decision making, providers may choose to use an existing patient panel or an ethics committee to provide advice on decisions
- When considering plans, providers should consider not just patients' vulnerability to the physical infection but vulnerability stemming from mental health needs, a learning disability or autism too. People will be at risk of mortality through suicide, injury through self-harm and of self-neglect, so changes to services need to have patient safety as the paramount concern



- CYP

- Partnership working is crucial, and responses will need to be co-produced where possible. To both maximise the use of community assets and to draw on the insight and expertise of partners, response plans will need to be developed alongside patients, families, carers, voluntary community sector (VCS) organisations as well as neighbouring mental health/ learning disability and autism providers. This will include planning within an NHS-led provider collaborative, with social care partners, the criminal justice system, commissioners and education providers for children and young people (CYP)
- Providers will need to maximise delivery through digital technologies to ensure continuity of care where patients are asked to isolate and in response to reduced staff numbers or mobility. Digital technology can also be used to support continuity of social contact for patients, families and carers
- Providers should bear in mind the longer-term impact of the pandemic and associated impacts on the mental health needs of the population and seek to minimise changes that impact on the capacity and capability of the system longer term
- As a collaborative programme, we will work across the Humber, Coast and Vale in partnership with our mental health providers and commissioners in both of the two evolving geographical partnerships (Humber and North Yorkshire & York).

**All the Clinical Commissioning Groups in HCV have confirmed that they will meet the requirements of the Mental Health Investment Standard (MHIS).**

We have reaffirmed the HCV Mental Health, Learning Disability and Autism priorities for the remainder of 2020/21 as:

- **Mental Health Resilience Hubs** proposal based on the Greater Manchester model (One access point in the ICS, virtual hub, separate to existing SPAs, to target people identified in scope)
- **Children and Young People’s Mental Health** focus on redesign of whole CYP MH pathway through delivery of the “Thrive” Framework and single set of outcomes
- **Psychological Impact of COVID 19** linked to resilience hubs
- **Suicide Prevention** focus on men and building resilience through training and community engagement
- **Perinatal Mental Health** expansion of workforce to deliver LTP ambitions
- **Community Mental Health** early implementer site in Hull/East Riding for new models of CMHT. Adult mental health programme lead to be appointed to lead **CMHT, IAPT, SMI health checks and Individual Placement Support workstreams** (deep dive reports completed for IAPT and SMI physical health checks)
- **Delivery against the NHS Long Term Plan** plans refreshed as part of the phase 3 planning process
- To lead our work on **Learning Disabilities and Autism** a programme

lead was appointed in September 2020, focus on:

- Transforming Care Programme
- Annual Health Checks
- Green Light Toolkit
- Review of Autism assessment and pathways for children and young people and adults.

In both our geographical partnerships there are some specific priorities that have been identified as follows:

- **Humber**

- Manage the IAPT Surge
- Maintain the Crisis Response
- Manage the Psychological Impact of COVID 19 on the population
- Children and Young People
- Mental Health Long Term Plan.

- **North Yorkshire and York**

- Managing the Surge
- CYP – managing the backlog (ADHD and CAMHS)
- 24/7 All age crisis line
- Crisis – increased offer around alternative places of safety and expanding the team
- Mental Health Resilience hub
- Autism backlogs (adult and children)
- Long Tem Plan – supporting the system / bring forward plans for EIP, IAPT and CYP.

### **Impact of Covid-19 on agreed trajectories**

There are a number of trajectories that we believe have been negatively affected by the Covid-19 pandemic and for which, we have submitted revised figures. The trajectories in question are:

- IAPT – a task and finish group has been established to take forward recommendations made in our recent deep dive report (available upon request – looking at issues of service delivery, workforce and commissioning arrangements)
- CYP Access – work around whole pathway commissioning will be ramped up via the steering group, focussing on the Thrive Delivery Framework
- Out of Area Placements – to be explored further post submission with NHSE/I
- SMI Physical Health checks – A clinical lead has been appointed to address issues relating to this area of work. The clinical lead will work with a newly appointed “Adult mental health programme lead” (currently out to advert) to include SMI physical health checks in the wider community mental health and PCN development work
- Perinatal mental health – workforce proposals have now been agreed and although 7% target will not be achieved by end of Q4 2020/21, we are expecting this to be hit in Q1 2021/22



- Dementia – this is a long standing issue. To be included in the work of the adult mental health programme.

The proposed reductions can be attributed to suppressed levels of referrals, reduced opportunity for face to face interventions (where required), staff sickness levels and capacity.

It is accepted that any reduced activity will be expected to be re-profiled over the coming three years. We are keen to work with NHSE/I to agree the approach to this process.

### **Mental Health Surge**

Whilst there no national modelling available to support what future demand might look like for mental health services as a result of Covid, TEWV formed a group consisting of public health experts, researchers, clinicians, data analysts, commissioners and planners to develop a forecast by identifying segments of the population who are at risk, and drawing conclusions from research papers about increased prevalence of illness following large scale social traumas.

The initial forecast identified that there is expected be a surge, or swell of mental illness across our populations lasting up to 5 years. Organisations across HCV that support people with mental illness could see an increase in demand that is the equivalent of :

- 52% more of children and young people
- 23% more of adults
- 22% more of older people.

To deal with this unprecedented surge of mental illness, families, the voluntary and community sector, schools, GPs, employers, social care and NHS mental health services are going to need to work together. If any one part of the system collapses, then the whole system could collapse.

This means that we need to:

- Plan long term: – this is a 5 year surge in demand
- Recognise we have to tackle as a system, in partnership with each other
- Give the mental health impacts of the pandemic / lockdown the same level of priority as physical health
- Think differently about workforce design and recruitment
- Don't overlook the "normal" pre Covid-19 demand for mental health support which is still there
- Keep referring people who have needs that MH providers would normally deal with to us – our services are open.

Additional national investment into mental health above the level of the current Mental Health Investment Standard will be essential, but systems must also consider reprioritising existing resources.

It is recognised that secondary care services manage only 30% of the overall mental health and well-being demand, which means that we would expect a proportionate increase to other services including primary care, the voluntary sector and LA run initiatives. There is no assessment at this time of how this would be managed.

As part of the phase 3 planning, providers have quantified the financial pressures of such a surge plus any continuation of developments put in place as a result of Covid. If additional funding was not made available and the surge presents, this would risk delivery of the long term plan developments as resources would need to be reprioritised towards those patients that present. In addition pressures in services such as Crisis could impact on other parts of the system including Emergency Departments.

As it is expected that the surge could last up to 5 years additional funding is also needed in future years so as to ensure that MHIS continues to support delivery of the LTP and not directed to manage other areas of pressure.

### **Workforce**

The following have been identified as specific priorities for the Mental Health workforce:

- Increase in staffing will be necessary to meet the forecast surge in mental health service demand, however by supporting the system, we can improve early intervention and reduce the proportion of the total demand requiring secondary mental health services.
- Increasing the number of embedded clinicians in primary care settings and schools in line with the aspirations set out in the Long Term Plan.
- Increased IAPT training places – we are working with Hull University to develop these
- Retire and return schemes
- Productivity gains from use of technology
- Reducing agency staffing (appropriate use of bank)
- International recruitment - working together to recruit
- Staff resilience and wellness – linking in with the resilience hubs work
- Complete staff risk assessments on an ongoing basis
- Ensuring RMN courses have a solid mental health element.

Please also see the Mental Health return.

### **ICS development planning**

As a Partnership we gained ICS status in April 2020 with the recognition that there were some aspects which we would further develop over the next year.

The Partnership Operating Arrangements have been refreshed, strengthened and are now beginning to embed. This includes at it's a core a population health led approach that will support us to achieve the vision for our people to start well, live well and age well.

The approach to how we operate has been clarified and includes a:

- Focus on the six Places through the two Geographical Partnership (Humber and North Yorkshire & York)
- Revised Partnership Executive Board
- Reshaped Clinical and Professional Group
- New Chairs and Members Advisory Group
- Population Health and Prevention Board
- Renewed approach to Finance, Planning and Performance across the Partnership.

We have reviewed the Oversight and Assurance arrangements and these will be established from October 2020.

In addition, we are developing our approach to Strategic Commissioning and are working to establish a number of provider collaboratives for Mental Health (already well established and supported nationally), Acute and Community Health and Care. Further update to be provided as part of the final submission following discussions at the Partnership Board on 9<sup>th</sup> September.

To support the Population Health led approach the Partnership is currently part of the National Population Health Management Development Programme which is working with 7 PCNs to develop the approach and spread learning for adoption across the Partnership. In addition the Partnership has been successful in being selected to be part of the Enhanced Finance and Contracting element which supports a Place (City of York) with the development of approaches and links to the aspiration of being a Pathfinder as a region in relation to the financial framework and how it might work in the future.

Pre-Covid the Partnership was starting to explore the development of its Leadership Development and Talent Management programme. With the appointment of the HCV People Lead we are now looking to progress this and link it also with the plans we are developing around the Black and Minority Ethnic members of the workforce.

**Use of quality improvement strategies or methodology to support recovery/ learning/ increasing activity levels**

At the height of the Covid-19 pandemic, a large number of rapid changes and service improvements were made to working practices. Changes that would have previously taken at least a few months to design and implement have been accomplished in days or weeks. The changes and service improvements were made to ensure across HCV, our organisations could continue to deliver quality health and care services in a safe manner for patients, service users and staff, during these difficult times.

The speed and scale of the changes and service improvements made is difficult to track and document them and evaluate their impact. Therefore,

across HCV we were keen to take the opportunity to assess the practicality and effects of the new working practices and to identify, refine and embed those which have delivered real benefits.

A piece of work was initiated by the HCV Clinical and Professional Group to do a rapid capture and evaluation of the changes and service improvements that had been made in response to Covid-19.

To support the rapid evaluation and learning, the Partnership has been supported by and worked alongside the Yorkshire & Humber Academic Health Science Network (AHSN) to review and analyse the results of the information capture and develop a number of initial case studies through interviews and facilitated discussions, to help generate insights into the learning from the impact of Covid-19 on delivery of our health and care services.

More than 330 examples of changes and service improvements across HCV were identified through the initial request for information that was circulated to organisations, individuals and teams across the health and care sector.

There were recurring themes within the submissions and in many cases a number of primary and secondary, clinical and non-clinical reasons for why the changes could be identified.

In summary the categorised themes cover:

1. **Advice, Guidance, Referral and Triage:** The need to reduce face to face interactions to keep staff and patients led to the implementation of referral assessment systems and triage processes. This has led to increased capacity, greater collaborative working and a reduction in patient anxiety.
2. **Discharge:** The Discharge to Assess Model has enabled an increased capacity in acute hospitals has been positively received by patients and staff but considerations are needed around funding streams and the maintenance of community beds to maintain this process.
3. **Patient Care:** The need to reduce hospital footfall and patient anxiety led to the changes in patient care. This has enabled good collaboration between partners and creation of responsive services for patients.
4. **Use of Technology:** Technology has enabled staff to continue to care for patients even while shielding / isolating. Covid-19 was a common challenge which reduced resistance from patients and staff, however considerations are needed around capability and access to technology for both staff and patients.

5. **Workforce:** Redeployment of staff, reduced capacity and increased demand has affected staff wellbeing and resilience. Organisations across HCV have been working hard to support staff welfare and wellbeing.
6. **Pandemic Response:** Staff attitudes and availability of technology have enabled staff and services to change in response to Covid-19, but considerations are needed around how we balance changes made as a pandemic response with delivery of services as part of routine delivery.
7. **Other:** Covid-19 has enabled virtual change, and the utilisation of third and voluntary sectors has supported community and care sectors. Funding and evidence to establish the effect of the changes need to be considered.

To support these broad themes, we have also gathered some information on the key changes and developed a report and a series of case studies to help support learning, spread and adoption through Phase 3 Planning.

We have recognised that the widening of health inequalities and ensuring equitable access to quality and safe health and care services for our population is a priority for us. To support us in tackling and addressing these challenges we have identified across the Partnership a gap in our strategy and approach to innovation and improvement i.e. what innovations should we consider implementing and how should we spread and adopt learning from each other across the Partnership.

Led by Dr Jacqueline Andrews, Medical Director at Harrogate And District NHS Foundation Trust, we are considering how we:

- **Promote what good quality health and care looks like** (including vision/sharing good practice etc)
- **Celebrate success in delivering good outcomes** (including evaluation/creating a learning environment/learning from issues including patient safety)
- **Tackle unwarranted variations in clinical care** (including using information as an improvement tool/approach to understanding the problem/triangulating information including patient safety and benchmarking)
- **Ensure effective quality planning** (effective quality planning/ service improvement/using information to understand impact (including unintended consequences of change/ robust and coordinated governance arrangements etc.).

In addition, we are exploring the development of a Partnership approach to innovation and improvement, development of a single framework for improvement and the development a Partnership Innovation Strategy. We will continue to with YHAHSN to utilise a QI sustainability approach to

embed key changes and transformation initiatives across the region.

**Humber, Coast and Vale  
Health and Care Partnership**

**Local System People Plan 2020/21**

**September 2020**



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# Introduction

In July 2020 an NHS People Plan was released '[we are the NHS People Plan 2020/21 - action for us all](#)'.

This People plan sets out practical actions that employers and systems will take, as well as the actions that NHSEI, HEE and CQC will take. It focuses on:

- **Looking after our people** – with quality health and wellbeing support for everyone.
- **Belonging in the NHS** – with a particular focus on the discrimination that some staff faces.
- **New ways of working** – capturing innovation, much of it led by our NHS people.
- **Growing for the future** – how we recruit, train and keep our people, and welcome back colleagues who want to return.

There is a requirement to develop an ICS system plan by 21 September 2020 and this paper set the direction and content of that plan for Humber, Coast and Vale (HCV). HCV have set out in this document the initial response to the People Plan with a plan to work collaboratively across the system with partners between now and the end of the year to generate a system plan rather than purely an NHS response. This paper describes the work that has happened in HCV and the proposed direction where it is known. This work will build on the partnerships developed across our system and recognise all the strengths that exist across our workforce.

## HCV workforce plan

The HCV workforce plan was originally developed in November 2018 following a review that was carried out in 2017 and understanding some of the challenges faced across the system with regards to workforce. The system developed four priority areas.

- **Developing the current workforce** by concentrating on retention, development of skills and system leadership
- **Increasing the future workforce supply** by developing new roles linking with and increasing training places, developing apprenticeships and maximising recruitment
- **Developing the workplace** by focussing on employment practice, wellbeing of the workforce and looking at new employment models
- **Building the infrastructure and investment** by understanding what we need and ensuring appropriate use of the funding available

There were two main workforce areas of focus developed earlier in 2018, the faculty of advanced practice and the excellence centre that has now become the workforce consortium. Both receive funding through HEE.

Oversight of these priorities is through the HCV workforce board which was established for this purpose and also for workforce oversight of key workstreams throughout the ICS. During early 2020 there was agreement to recruit a dedicated People Lead to lead the development of the work on people and workforce across HCV. This role has been in place since July 2020.

It was agreed at the workforce board in July 2020 to relook at the workforce priorities aligned with the release of the People Plan which was released shortly after the Board meeting.

Also in 2020 workforce governance was enhanced with the development of three workforce boards across our three partnership levels. These three ICP's are based in Hull and East Riding, York and North Yorkshire and North and NE Lincolnshire. These three ICP's are led by an SRO with support provided through the consortium. There is also a workforce meeting for primary care. Each of the three ICP's have developed an action plan and a plan on a page of priorities.

In March 2020 after discussion with senior HEE and NHSE/I colleagues it was agreed to conduct a review in HCV into education and quality which resulted in a suggested action plan (that was put on hold with the development of Covid-19, along with other workforce priorities) that will be considered alongside the people plan and redesign of the workforce priorities although some actions are already in place.

More recently NHSE/I and HEE have developed a Regional People Leadership Group that is intended to have regional oversight of the people plans from the 4 ICS's and is attended by the four ICS People Leads.

Further development and changes of the workforce board is anticipated as these priorities are developed further in coming weeks and further discussion on support to be provided to the ICP's to develop a place based people plan is needed.

## Our People Plan

The NHS People plan is focused on people delivery at an NHS level and the ICS is made up of partnerships across local government, social care providers and education, therefore the ICS response for the 21 September can only be an initial response with a desire to collaborate and engage across the wider system with our partners for a fuller more comprehensive plan where it makes sense and where decisions need to be made across a local labour market or benefit from economies of scale.

Additionally where it makes sense to make improvements across a region to deliver national priorities or increase capacity then working at a regional level would be appropriate.

Those areas of focus are currently specific to Equality, Diversity and Inclusion and Health and Wellbeing and have been run regionally alongside the people lead from each ICS and has enabled collaborative working at scale for national challenges.

Individual NHS organisations are developing their local response to the plan, some have shared these plans and others will do so once it has been through their respective boards. Once this is complete we will be able to agree any opportunities for working at scale and pace.

## Looking after our People

The People Plan has a focus on three key areas: **safe and healthy, flexible working and support.** Prior to Covid-19 individual organisations across the system developed their approach to looking after their people and as Covid-19 arrived developed at pace and scale what was being offered. This was supported by national offerings from NHS Employers and also NHSE/I.

In the initial stages it became clearer who was 'at risk' within organisations and risk assessments have been carried out across NHS organisations in order to ensure their people are safe. This work has developed as it has become clearer (as we get more knowledge of Covid-19) which of our people are at risk and as organisations have become more skilled at both the 'what' and the 'how' of carrying out risk assessments. In some cases this development has meant a reduction in assessments being completed but the end result is far more comprehensive.



This is developing yet again with the health and wellbeing offers being developed in individual organisations with comprehensive support packages for psychological support. There are some ground-breaking examples of support that is being offered and the development of a HCV resilience hub to support our people that need mental health support being developed for launch in the coming weeks. Individual organisations have during the pandemic developed at pace the support that is being offered to their people with the development of safe spaces and wobble rooms and external providers ensuring support for people to stay at work with appropriate intervention.

A number of employers have developed programmes to ensure workplace environments and behaviours are improving. Hull University Teaching Hospital runs leadership programmes based on remarkable people, extraordinary place which has contributed to a much improved staff engagement score through the NHS staff survey and Northern Lincolnshire and Goole NHS Foundation Trust have been running their pride and respect campaign based on the principles of civility in the workplace that a large number of their people have now attended and similarly Hull CCG has been working together at a sub system level with York/North Yorkshire CCG around flexible working . There is an intention to share best practice more widely across health and care as the plan is developed.

Trusts across HCV have triggers for absence levels with identified contingency plans and the absence position is a standing agenda item on the fortnightly meeting with Trust and CCG HR leads. Trusts are also monitoring hours and leave to ensure staff are not working too many hours and are supporting their own health and well-being.

The ICS has worked with the other 3 ICS workforce leads and mental health colleagues and the NHSE/I regional health and well-being team on areas to focus on at scale, these have involved discussions at operational and strategic level. There have been two stocktakes undertaken across NHS Trusts during the pandemic about health and well -being support although HCV Trusts did not respond to the second stocktake which was run to understand what was needed during the pandemic to support our people. This resulted in a further process about childcare provision.

There has also been a developed 'pulse check' for NHS organisations to participate in with results that can be shared at an ICS level. This can help develop priority areas to focus on. There has been limited uptake in HCV and therefore further discussion about the value to the system with only a small area of the system completing them. A number of organisations run their own pulse checks and surveys.

Flu vaccinations campaigns are being run through all our organisations with a system leadership and focus to keep as many of our people well over the winter period as possible.

## **Belonging in the NHS**

It is incredibly important to develop working environments where all of our people can bring all of themselves to work. It is incredibly important that the workforce across the system is

representative of the communities that it serves, there is much evidence to support this and that discrimination, violence and bullying have no place in our workplaces.

The system approach would look to include all groups that are discriminated against and agree system wide actions that can make a difference to all of our people. In HCV we have begun with development of our system response to the impact on our work and life experiences of our BAME colleagues.

NEY ICS leaders worked on developing a collective promise that HCV supported the development of and approval of, this statement sets the ambition that racism or bias is not tolerated. The collective promise has been discussed with our ICS volunteer BAME group and is intended to be refined ready for launch as we agree the actions across the ICS for our BAME areas of focus.

We have begun this work in HCV with a number of meetings across our partnership which is being led by a partnership Chief Executive and has resulted in 33 volunteers that had their inaugural meeting on 27 August. This resulted in an outline of actions to progress this further that was endorsed at the Partnership Board and will go to the Workforce Board in September 2020. The areas of focus from this work so far are only proposals as it needs to be informed by our BAME colleagues experiences at work and also in the communities that they live in. This initial progress has been encouraging and we are keen to commission a review across our system of experiences from our BAME colleagues to provide the evidence for the actions that we take, alongside developing an active BAME network of networks constituted of the network chairs in our partnership organisations. There are examples already within organisations of the value of BAME networks and the difference that can be made to our BAME colleagues.

These next steps will involve writing to all our partners to determine what networks exist and to look at where the needs will be, combining the output of the review and the development of a network of networks. This work will be across all our networks with a plan developing to include all of our minority groups.

Across the NEY ICS leads meet regularly with regional colleagues to develop the work across equality, diversity and inclusion led by NHSE/I and next steps will be looking at areas of collaboration across the NEY area.

## **New Ways of Working**

In March 2020 with the development of Covid-19 employers across the region rapidly moved to remote working and had to quickly utilise technology to enable the workforce to be able to work in a more agile and flexible way utilising digital in a proactive way and removing the barriers to implementation that had been present before. The system is committed to maintain that change and build on the collaborative work that has been done during the pandemic.

The system has a digital strategy and an ambition to develop that strategy across the workforce and to progress work with the NHS digital staff passport and to progress this across other partners

in the system. There has been some good progress on streamlining but that could be built on with this approach.

Our Voluntary care partners and charities are crucial to support those in most need and HCV is keen to develop the relationships that already exist.

One of the key legacies of the Covid-19 response across the Humber, Coast and Vale Health and Care Partnership has been the role of the voluntary and community sector.

In each of our places, the voluntary and community sector has been integral to the response to our most vulnerable communities. The work they have undertaken has been hard to measure but they were key partners in coordinating services at a time when communities needed them most.

This included food provision, prescription collection, continuing to provide frontline services and mobilising an army of volunteers. The value and importance of the sector has never been better demonstrated.

As with all partner organisations, the voluntary, community and social enterprise sector in each of our places faces significant challenges over the next few months. The long-term sustainability and resilience of the sector is a key priority for all of us.

With challenges come opportunities and there has never been a better time to look at how the HCV Partnership engages with a diverse and skilled voluntary, community and social enterprise sector. This allows us to build on the strong partnerships we have already achieved and look at what we can do together in the future.

The commitment of the HCV Partnership to developing a new relationship with the voluntary, community and social enterprise sector is via a new Voluntary, Community and Social Enterprise Leadership Programme, which brings together senior voluntary, community and social enterprise leaders from all our places, alongside colleagues from both health and local government.

Although the programme was only established in July, there has already been significant progress. This is not only about voluntary, community and social enterprise representation in existing workstreams but raising awareness about what is contributed and what we can do in the future. To support this we have agreed to work together to better understand current levels of partner investment into the sector and look at our longer-term sustainability.



The voluntary, community and social enterprise sector currently makes a significant contribution to place-based working and we need to recognise the value of what is done and make better use of what exists already. This workstream is designed to build on this and unlock the VCSE sector potential as a system partner.

HCV is keen to learn from national, regional and ICS adopt and adapt work which includes sharing this learning with other services.

## Growing for the future

HCV established in 2018 a workforce consortium focused on health and social care workforce challenges. It has become an established platform and reflects the partnerships formed and collaborative way of working. The focus of the consortium is the promotion of system wide, cross sector leadership in the creation and implementation of strategies that enable recruitment, retention and development of health and social care support staff.

There is a shared memorandum of understanding between health and social care with education and training providers. The review carried out by HEE in March 2020 described the consortium as *'This is an exciting innovation with the ambition to improve access to high quality learning opportunities for all support staff, reduce unnecessary duplication, strengthen connectivity and scale up good practice, innovation and transformation'*

HCV have developed an engagement framework that can be used for career advice or to promote health and social care as a career option. This AEIM framework has national interest and is being used across the system to strengthen the work at place and widen participation.

There has been development of the nursing associate role across the health and care sector with a particular focus on smaller, independent employers such as GP practices and Nursing Homes. Growth in these areas has now been achieved and positive impacts are already being realised. Specific highlights include:

- Development of tailored guidance on funding, training and resources for primary and social care including an [infographic](#)
- Successful negotiations with employers for over £250k of levy transfer to establish and support NA trainees in primary and social care .
- Webinars to promote the role, working with Skills for Health and the social care sector with employers taking on trainees NAs as a direct result
- Tailored guidance and signposting to information and support in order to overcome organisation-specific challenges
- Development of case studies to promote the role and illustrate the benefits for employers and patients (one adopted by Skills for Health)



There has been a lot of work with apprenticeships with the development of a rotational apprenticeship that proved difficult to get off the ground and initial numbers were less than expected but the learning and development now that a model has been established can be utilised for integrated apprenticeships going forward.

Work has been ongoing across the system on increasing apprenticeships across the primary and social care sector.

- Webinars taking place weekly on a variety of topics to increase awareness of opportunities e.g. Nurse Associate development, Supporting apprentices and the levy, bespoke customer services qualification for healthcare, traineeships, workforce development in general practice.
- DAS accounts established in a number of General Practices and discussions taking place to increase apprenticeship opportunities in a variety of different apprenticeship roles. Tailored support to practice managers is provided around workforce development and succession planning, offering both short and long term solutions to workforce gaps. In addition to this, support is provided to look at how apprenticeships offer a solution and new role development offers opportunities.
- There are examples now of levy transfers across the system to enable nurse associate trainees in primary care and care homes and across North and North-East Lincolnshire, Northern Lincolnshire and Goole NHS Foundation Trust have shared their levy with GP surgeries to develop nurses and with social care for non-clinical roles.

Prior to Covid-19 regular events with registered managers commenced across care homes in Hull and East Riding and is now being rolled out across HCV. Topics are identified by the managers and the purpose of the events is to increase learning opportunities, support through networking and value placed on the role, reducing the isolation some have reported feeling. The feedback from these seminars has been excellent.

Project ECHO offers benefits to individual staff, providers and the system as a whole. It can reduce some of the barriers to learning faced by care staff. For instance, as training is delivered virtually, staff do not need to travel to a venue to access training. Several managers mentioned that not all of their staff can drive or have access to a vehicle, with the result that managers have to arrange rotas so that a driver can be available to take other colleagues to off-site training. For training provided on-site, a minimum number of staff is often required which can present staffing difficulties, e.g. releasing sufficient numbers of staff to make a training session viable. With Project ECHO, care providers can access sessions even if only one member of staff is able to attend.

- Three hubs have been established (NE/NLincs, NYorkshire and ERY/Hull) to enable a more targeted place based approach to increasing learning opportunities for hard-to-reach staff groups, starting with care homes. Extensive work has been undertaken to establish benchmarks for activity in each area, working with CCGs, identifying key stakeholders, educators from across each community and relevant topics.

- ECHO has been well received in each area with CCGs, identifying key stakeholders, educators from across the community and relevant topics and starting to deliver on a variety of topics.
- Response to COVID19 was excellent. Unlike other areas, systems were able to respond with immediacy in response to COVID19 topics due to ECHO teams being in place. All three hubs were asked by CCGs and NHSE in their areas to deliver urgent education and learning to care homes on specific topics such as Infection control, use of PPE, End of life care. In HCV we were fortunate to have ECHO in place at the time of the pandemic because it enabled an immediate response to delivering the learning needed to the local community of care homes and others through a model that accommodated the need to self-isolate, social distance and safety measures instigated by the Government.
- Organisations are connecting locally to share resource and expertise.
- **In excess of 1100 care home staff have accessed ECHO** learning opportunities across Humber, Coast and Vale between October 2019 and July 2020 with more sessions continually being accessed.

Local workforce groups focus on system-wide workforce solutions to issues around workforce planning, recruitment/retention and improving the workplace environment. Highlights of these groups are shown below:

#### North & North East Lincolnshire

- Action plans have been developed to support local ownership and achievement of system-wide objectives; these are iterative and have been recently amended to reflect changing priorities in relation to COVID19, for instance with a focus on rising levels of unemployment and new routes into health and care. There is also a renewed focus on staff wellbeing following the publication of the new NHS People Plan (2020).
- A system-wide placements group is established to increase capacity for students to gain exposure of health and social care in the area; this group is linked to regional developments around placement work and is currently exploring recovery of activity in relation to COVID19 – for instance exploring new models of placement delivery such as ‘TECS’ (Technology Enabled Care Services) placements.
- ‘Career Confidence’ project group created to strengthen work with young people, schools and colleges as a community, promoting routes into health and care with a focus on vulnerable groups linked to the wider determinants of health.
- Sharing of good practice is now also being encouraged in relation to new ways of working since the advent of the pandemic.

## Hull & East Riding of Yorkshire

- As with the other locality groups, action plans have been developed and there has been a focus on sharing recruitment and retention initiatives across Health and Social Care supporting the development of parity across the local system whilst also considering the challenges of skills shortages in particular entry level roles in both health and care, such as support workers. Work has already begun on developing a framework for staff wellbeing, highlighting areas of best practice across the local system and providing the opportunity for employers to create a more equitable offer at an organisational level.
- The group has fostered the development of relationships across health and social care boundaries, supporting discussions between Local Authorities and the local Hospice in developing End of Life Care 'Champions'.
- The representation of education and training providers at the group has enabled health and social care employers to consider wider, more joined up approaches to training and development, for example in relation to developing Nursing Associates in Health and Social Care, with the sharing of resources where applicable.
- Aligned with the NHS People Plan (2020), volunteering is considered as a 'route in' to health and social care and work is beginning to consider how schemes already in place within organisations can be scaled up across the local and wider system in HCV.

## North Yorkshire and York

- The first health and social care careers event 'Could you care?' was deemed to be a great success from colleagues across Scarborough and the surrounding area. The event took place in Scarborough in 2019 showcasing career opportunities and pathways into various roles. The 2020 event was cancelled due to COVID, however the locality group are looking at ways this may be able to run virtually.
- The group are working on strengthening succession planning, developing new roles linking with and increasing training places to support continued professional development, developing apprenticeships and maximising recruitment. As with other groups a focus been given to sharing recruitment and incentives for employees and how these can be shared across the local system.
- Work has started on reviewing and planning a local recruitment campaign, along with investing how we can strengthen the links with other organisations such as DWP and the Job centre in order to provide opportunities for those looking for work and demonstrating the varied roles available in health and social care.

## Faculty of Advanced Practice

Humber, Coast and Vale also has a faculty of advanced practice which was established in 2018. Employers of Advanced Clinical Practitioners (ACP) and Physician Associates (PA) across HCV form

the membership of the Faculty working in partnership with education providers, the primary care workforce hubs and HEE, led by a Board sponsor and Programme Director. Growth in the ACP and PA workforce numbers will not only address workforce gaps but also create more diversity within the workforce and [improve patient outcomes](#). A highly skilled, confident workforce able to work at an advanced level is fundamental to the delivery of sustainability and transformation of healthcare across HCV.

The Faculty is an established, pioneering platform that is already fulfilling part of the brief set out by national policy, led and supported by the programme team. The recent [We are the NHS: People Plan 2020/21 - action for us all \(2020\)](#) and [The Healthcare Workforce in England report \(Kings Fund, 2018\)](#), demonstrates a need for advanced roles and greater multi-professional working as teams to deliver high quality safe services across the Integrated Care System.

HCV Faculty continues to be well represented by key stakeholders, with two sub groups (1. Strengthen ACP education in HCV. 2. Promote employability of PAs in HCV) developed to undertake more detailed work to ensure system-wide growth.

COVID19 has inevitably impacted on the delivery of projects in 2020, deferring some planned outcomes. In March 2020 with stakeholders focussed on the pandemic, the team relocated and were redeployed to support various COVID19-related work streams across HCV whilst maintaining basic momentum on projects. Colleagues across HCV requested a restart of meetings (virtually) during May/June 2020 to enable them to reconnect locally and consider collaboration on workforce challenges. ACP training was put on hold for a few months whilst many ACP trainees were redeployed within their organisations and some HEI staff were deployed to establishing a team at the Nightingale hospital, Harrogate. COVID19 has also impacted on employers' ability to put applications forward for the HEE scheme. Therefore decisions were made to forego September start dates for new cohorts to concentrate on existing ACP trainees and recruit for January 2021 intakes. PA placements have also been affected. Consequently some ACP trainees and PAs will complete their studies a few months later than expected, but with high level commitment from employers and HEIs, this is being kept to an absolute minimum.

- The faculty supported employers with recruitment of 67 ACPs out of the 93 agreed in the 19/20 application round; 63 applications were received for 20/21. HYMS have 20 PA students due to graduate in Autumn 2020 with 21 students planned for the 20/20 intake with employers in HCV expressing an interest to take 22 in 2020/21. The faculty has worked with its stakeholders to evaluate trends in training and recruitment with measures explored for future cohorts.
- A two-year PA preceptorship programme was developed by stakeholders in 2018 and funding was secured from HEE (despite this being an anomaly with other areas offering one-year). Stakeholders believed year one would give the PA support in transitioning into the workplace as a newly qualified PA and year 2 would enable them to develop the skills of supporting future PA learners. This gave HCV the traction needed to go from having no PAs employed across the system to 40 in 18/19. Further funding was secured for 19/20 but

many employers took the decision to continue the support with the initial cohort of PAs and were unable to extend that support to increased numbers. Building on this programme, a foundation programme / internship is being developed (which will be available in September 2021 if agreed).

- To enable a more coordinated approach to the recruitment of ACP trainees across HCV a timetable was established. This has enabled all actions in preparation for a University start date to be system-wide and more efficient.
- A [website](#) has been established on the workforce pages specifically for careers advisors, employers, aspiring and qualified ACPs and PAs with information of how to become an ACP or PA, education provider links, projects, information booklets, national information and much more. Prior to COVID19 a number of events took place to bring trainee and qualified ACPs and PAs together to share information on national and local developments, highlight the commitment of the Faculty in supporting ACP and PAs across HCV and enable them to engage in various projects. Feedback has been excellent and more events were planned to take place in 2020 in response to their comments. Given the challenges COVID19 presents around social distancing, a number of webinars are being planned for this year and 2021.
- The Primary care workforce hub, as part of their ACP ready scheme, agreed to coordinate all applications for ACP trainees from General Practice. This allowed for one HCV primary care application on behalf of the primary care system to be submitted to the Faculty and then HEE in order to receive sufficient ACP scheme funding for the whole system, not only promoting a consistent approach to information and guidance, but highlighting where the hub could provide additional support to those that needed it. The hub has also coordinated the information of PA employment across General practices in HCV and the recruitment of PAs under the PA preceptorship scheme. Funding from HEE for primary care is now managed by the hub. Coordination of activities across General Practices in HCV has enabled a more cohesive approach to growing the number of ACPs and PAs in primary care, monitoring activity and most importantly, instigating where more support from the hub is needed to support growth.

A number of learning opportunities have been created for ACPs and PAs and more are planned for the future.

- Planned events have included elements of training as requested by the clinicians with topic experts keen to be involved. These will now be undertaken through regular webinars. If/when it is appropriate to hold face-to-face events there will be a mixture of events and webinars.
- Discussion with HEE deanery colleagues has enabled access for ACPs and PAs to medical learning opportunities. Whilst take up of these sessions has been low to date, we are seeking to develop them further in collaboration with HEE colleagues.

- This interactive [Pipeline](#) is now on the Faculty website. It demonstrates the various routes to becoming an ACP and offers localised information for aspiring ACPs to consider the best route for them.

'Minimum standards' for supervisors of ACPs/PAs in HCV, [Best Practice to retain the ACP Workforce](#) and an employer 'Governance Framework' have been developed to create greater consistency and understanding of what is required of employers and those that support learning in clinical areas. This has created a standard to ensure trainees receive a positive learning experience whilst in clinical practice, promoting effective governance and best practice across the whole system. These will be further developed with members to align to future developments including quality assurance and improvement interventions alongside a preceptorship model for ACPs

The HCV Faculty is an established platform from which the delivery of a significant part of the new [NHS People Plan \(NHS, 2020\)](#) supply can be assured within its existing [Delivery Plan](#). The appointment of a Programme Manager in 2020, in support of the Programme director, will enable traction on delivery of this and establishment of a quality assurance strategy to strengthen work already established; this will provide support to employers and ACPs and promote bottom-up, evidence-based interventions to promote consistently high quality employer and learner experiences.

The elements within the existing delivery plan will need to be implemented and managed beyond March 2021 in support of the Integrated Care System. Further review will be required as discussions progress, informed by the People Plan and other national developments, and emerging local workforce priorities; for instance, more emphasis could be on the health and wellbeing agenda going forwards in light of its prominence within the new People Plan.

Whilst the 20/21 delivery plan has been reviewed in-year to ensure it meets local and national policy, future delivery plans can work to longer-term objectives given the security of permanent team contracts and Faculty sustainability. HEE have highlighted a wish to provide this directly, with discussions taking place to develop a regional Faculty model within each ICS. HCV and South Yorkshire are national forerunners with Faculties already established for some time.

The pioneering development of an ICS-based Faculty of Advanced Practice in HCV is clearly aligned to national drivers promoting workforce transformation. There is an expansion of Undergraduate places at our local Higher education Institutes and the collaborative working of employers to provide quality clinical placements.

North East and Yorkshire are participating as a regional pathfinder from September 2020 as part of the national [Looking After Our People- Retention Programme](#). All four ICS are participating. There has already been work carried out in HCV on retention with some promising results and this pathfinder will enable further development with the development of a Regional Community of Practice to share and develop best practice. We will participate fully in this and build on the support available through NHS England/Improvement.

Bringing Back Staff national recruitment campaign was part of the NHS workforce response to COVID-19 and is a potential workforce supply to meet short, medium, and longer term workforce demands

- BBS identified approximately 40,000 clinicians nationally who have agreed to return and approximately 5,000 of these were in the NEY region – although these numbers have reduced with time due to pre-employment checks and withdrawals . In HCV there were 227 transferred for deployment with only 38 being employed, that is 17%.
- A challenge at national, regional, ICS and organisational levels has been to match this potential workforce supply with demand and place these returners into employment
- Approximately 50% of BBS returners have indicated they would be interested in returning to the NHS in the medium to long term and could support.
  - Any potential Covid-19 second peak or local outbreaks
  - Preparing for recovery and re-establishing elective and other paused services
  - Coping with winter pressures and the additional strain that this winter may pose given the impact of Covid-19
  - Supporting flu and potential Covid-19 vaccinations
  - Longer term workforce pressures such as the national shortage of nurses
  - We are also developing plans for how this work can transition from a national campaign with regional implementation into an ICS demand led approach as of October 2020.

Recruitment was interrupted during 2020 as a direct result of COVID-19 but recently recruitment has recommenced with a number of organisations either carrying out international recruitment or planning to do so in the near future. We will begin to look at a system wide approach to international recruitment in the work to develop a detailed plan.

We are looking at the Government kickstart scheme and considering the best way to develop pathways into employment for those facing redundancy or unemployment from other industries to attract new entrants into health and care.

# System Actions

## Humber, Coast and Vale People Plan actions

	Action	Timeline
Recruitment	Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	2020/21
Recruitment	Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money.	
	Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24.	Immediate
Retaining Staff	Support the GP workforce through full use of the GP retention initiatives outlined in the GP contract, which will be launched in summer 2020.	
	Strengthen the approach to workforce planning to use the skills of our people and teams more effectively and efficiently.	
	Work with HEE and NHSEI regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it.	2020/21
Recruitment and Deployment Across Systems	Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.	
	Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.	By March 2021
	Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.	

The People Plan has actions for the system to focus on as referenced above in the areas of recruitment, retaining staff and recruitment and deployment across systems.

In HCV we already have made good progress against a number of these priority areas and intend to pick up the development of these actions through our workforce boards at place level and in the primary care workforce board.





## Next Steps

The development of a people plan in a short time frame across a system naturally presents some challenges and resource constraints. Although we have had funding through HEE since 2018 to develop our consortium and faculty focusing on role development and supply which has enabled specific work in developing the ACP and PA workstream and support roles there is a paucity of resource across other obvious areas such as system leadership development and health, well-being and equality, diversity and inclusion. This will need resolving to enable work to be carried out at pace and scale across the system.

The people plan itself is very health focused and along with other colleagues across other ICS in NEY we will ensure this is developed with our partners over the coming weeks. This will mean developing the plan with employers, unions and voluntary and social enterprise colleagues to ensure it is a health and care plan.

Our people working in health and care have responded brilliantly in the pandemic but further challenges are already here with resetting of services and the risk of a COVID wave 2 when our people are exhausted. Supporting our people in these extreme times remains a number one priority.

We will now progress with developing a full response to the people plan with a detailed action plan and the development of a strategy at system level alongside developed workforce priorities working with all our partners.

The plan will be agreed at the workforce board and delivered at place.

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## Board of Directors – 30 September 2020 Winter Resilience Plan 2020-2021

### Trust Strategic Goals:

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

### Recommendation

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

### Purpose of the Report

The purpose of this report is to inform the Board how the Trust will respond to the various operational pressures that may arise over the winter period 2020-2021. It should be noted that the “Winter Plan” title has been amended to “Winter Resilience Plan”. The new plan, although based on previous Winter Plans, will also articulate the schemes and methodology that the Trust will implement to respond to operational pressures arising from seasonal flu, an increase in COVID-19 presentations and changes to regulations as a result of the EU Exit transition period coming to an end.

### Executive Summary – Key Points

The lessons learnt from the implementation and review of the Winter Plan 2019-20 has provided the basis for the draft Winter Resilience Plan 2020-21. This year the plans are supplemented by schemes that have been developed during the COVID-19 pandemic and have been identified as being beneficial to support service delivery during the winter period.

National expectations and priorities are set out in the Third Phase of NHS Response to Covid-19 dated 31 July 2020 and assessments of increases to operational activity have been reviewed in documents such as The Academy of Medical Sciences – Preparing for a Challenging Winter 2020-2021 (14 July 2020). This has allowed this plan to be benchmarked against the previous winter requirements and the expectations (for planning purposes) of further COVID-19 outbreaks.

This year’s plan comprises of:

- Focusing on admission avoidance and ambulatory care pathways / same day emergency care (SDEC) / Talk Before You Walk principles;

- Creating the capacity to meet increased demand for both seasonal flu and incremental surges in COVID-19;
- Reducing the time patients need to spend in hospital once admitted, using Home First principles;
- Maintaining a command and control structure that is responsive to operational pressure escalation, surges in COVID-19 and issues relating to the transition period of EU Exit coming to an end in order to sustain the safety and quality of services.

The paper has been endorsed at Executive Committee on 16<sup>th</sup> September 2020 and at the Quality Committee on 22<sup>nd</sup> September 2020.

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### Recommendation

The Board is asked to:

- Endorse the Winter Resilience Plan 2020-2021;
- Endorse the expenditure for new and repeat schemes that support the plan.

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Author: Melanie Liley, Deputy Chief Operating Officer and Chief Allied Health Professional

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: 22<sup>nd</sup> September 2020



## 1. Introduction and Background

### 1.1 Introduction

The Trust-wide Winter Resilience Plan sets out the organisation's arrangements for the winter period. Winter is not an emergency or considered an unusual event, but it is recognised that this period results in increased pressure due to demand both in the clinical acuity of the patients and the increased presentation of particular clinical conditions (such as respiratory illness). In addition, the winter period often brings with it untoward events such as widespread infectious diseases including norovirus and influenza. This year the Trust will be managing the additional burden of COVID-19 and the EU Exit Transitional period coming to an end.

The lessons learnt from the implementation and review of the Winter Plan 2019-20 has provided the basis for the initiatives to be included into the Winter Resilience Plan 2020-21. This year the plans are supplemented by schemes that have been developed during the COVID-19 pandemic and have been identified as being beneficial to support service delivery during the winter period. National expectations and priorities are set out in the Third Phase of NHS Response to COVID-19 (31 July 2020) and assessments of increases to operational activity have been reviewed in documents such as The Academy of Medical Sciences – Preparing for a Challenging Winter 2020-2021 (14 July 2020).

The Winter Resilience Plan 2020-2021 will be an integrated plan, responding concurrently to:

- Increases in clinical demand and widespread infectious diseases resulting in increased operational pressure;
- Surges in COVID-19 presentations;
- Disruption to services as a result of the EU Exit Transition period coming to an end.

The plan is built on the following assumptions:

- The needs of patients will be at the centre of all proposals;
- All patients will receive a daily review / board round by senior decision makers;
- Plans will be in place each day to create sufficient capacity through the out of hours period;
- Routine activity will be modified as part of a phased planning process (where safe and appropriate);
- Clinical priorities may require supporting professional activities (SPA) to be protected and re-scheduled. This will not adversely affect compliance with Schedule 15;
- There will be a multi-disciplinary response to periods of escalation;
- Surges in COVID-19 will not immediately result in a suspension of non-urgent activity;
- The Critical/Major Incident command and control structure will endure throughout the winter to implement the Trust operational response to increased pressure.

The plan comprises of:

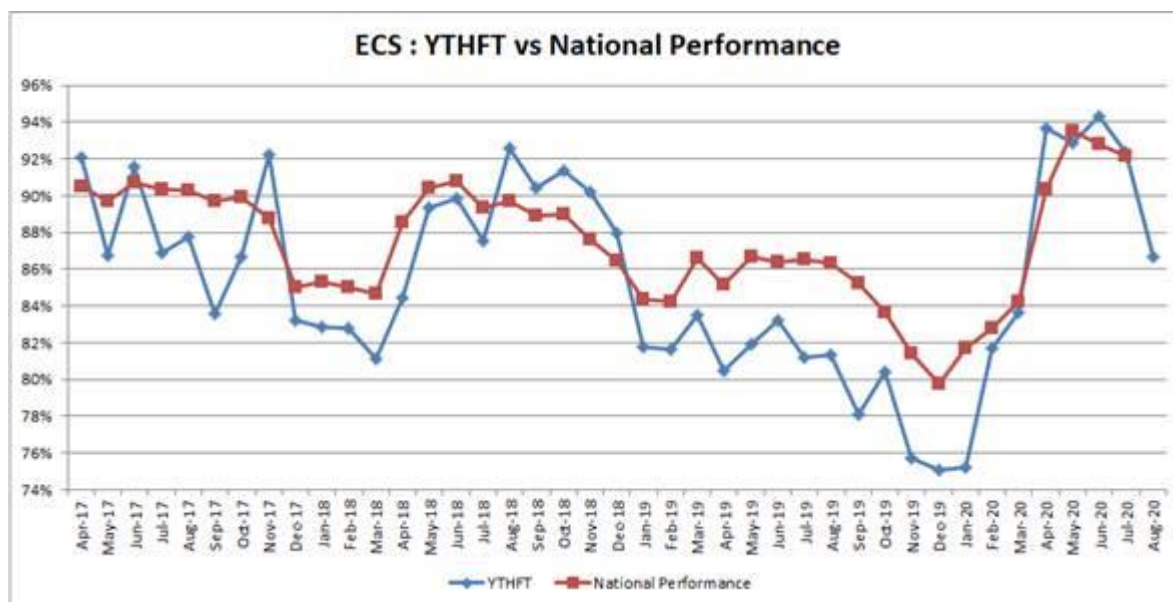
- Focusing on admission avoidance and ambulatory care pathways / same day emergency care (SDEC) / Talk Before You Walk principles;
- Creating the capacity to meet increased demand for both seasonal flu and incremental surges in COVID-19;
- Reducing the time patients need to spend in hospital once admitted, using Home First principles;
- Maintaining a command and control structure that is responsive to operational pressure escalation, surges in COVID-19 and issues relating to the transition period of EU Exit coming to an end in order to sustain the safety and quality of services.

Although winter represents a period of increased pressure, many of the actions that are identified are crucial to improve urgent and emergency care for our patients at all times of the year.

## 1.2 Current performance and expected emergency care standards

The Emergency Care Standard (ECS) measures the percentage of patients who are admitted or discharged within four hours of arrival in the Emergency Department (ED). Performance during Q1 and Q2 (peaking in June 2020 – 94.3%) reflects the reduction of ED activity during the COVID-19 pandemic and the service improvements (supported by the Emergency Care Intensive Support Team, ECIST) which were made pre-pandemic. The Trust has agreed with NHSE/I to roll over the 2019-20 ECS trajectory to reflect the anticipated increase in non-elective demand throughout the winter in line with previous years activity (Dec – 90%, Jan – 85%, Feb 82.5% and Mar 90%).

The chart below illustrates performance since April 2017; it is clear to see the deterioration in performance experienced through the winter periods with the recent upturn in ECS performance during the COVID-19 pandemic (as a result of reduced activity):



The schemes described in this plan have been developed to support improvement of the key national expectations that:

- Routine care of patients in hospital corridors should be eliminated. To monitor progress towards this, there is a national ‘zero-tolerance’ approach to patients waiting over twelve hours in the ED for a hospital bed to become available.
- All Trusts continue to demonstrate a reduction in the number of patients who experience the longest lengths of stay (over 21 days).

In order to monitor the impact of the schemes within this plan, the Trust will monitor the following metrics throughout the winter period:

- ECS performance (including non-admitted breaches);
- Ambulance handover times;
- 12hr breaches;
- Total Referral to Treatment (RTT) incomplete waiting list size / cancer performance / 52 week waits;

- Numbers of stranded (long length of stay) patients;
- Numbers of patients streamed away from ED;
- Ambulatory care numbers;
- Weekend discharges.

## 2. National Expectations and Priorities

NHS E/I have directed that Resilience Planning for winter 2020-2021 is to have a holistic approach and include initiatives that will allow Trusts to respond to multiple issues that will increase operational pressure on acute services. Initiatives to respond to operational pressures generated by the annual seasonal flu outbreaks, responding to an increase in COVID-19 presentations and any difficulties arising from the EU Exit transition period coming to an end are to be included into one Winter Resilience Plan. In addition the Third Phase of NHS Response to COVID-19 (31 July 2020) requires that non-urgent elective work should be maintained throughout the winter even when responding to surges in COVID-19.

The challenges facing the NHS this winter are:

- **A large resurgence of COVID-19 nationally, with local or regional epidemics.** The Academy of Medical Sciences has modelled a reasonable worst-case scenario – in which the effective reproduction rate of COVID-19 ( $R_t$ ) rises to 1.7 from September 2020 onwards – this suggests a peak in hospital admissions and deaths in January/February 2021 of a similar magnitude to that of the first wave in spring 2020, coinciding with a period of peak demand on the NHS.
- **Disruption of the health and social care systems** due to reconfigurations to respond to and reduce transmission of COVID-19 with a knock-on effect on the ability of the NHS to deal with non-COVID-19 care. The remobilisation of resources for COVID-19 (staff and facilities) that occurred during the first wave of COVID-19 is unlikely to be possible this winter, due to other winter pressures, urgent delayed care, and a likely increase in staff sickness absence, as well as the requirement to sustain routine elective services.
- **A backlog of non-COVID-19 care** following the suspension of routine clinical care that is likely to result in an increased number of poorly-managed chronic conditions or undiagnosed diseases and be combined with a surge in post-COVID-19 morbidity. Estimates suggest that the overall waiting list in England could increase from 4.2 million (pre-COVID-19) to approximately 10 million by the end of the year. Reducing the backlog of care will be hampered by reduced operational capacity across NHS organisations designed to prevent nosocomial transmission of COVID-19.
- **A possible influenza epidemic that will be additive to the challenges above.** The size and severity of the influenza epidemic in winter 2020/21 will be particularly difficult to estimate, but the most recent significant influenza season in winter 2017/18 coincided with a colder winter; led to over 17,000 excess respiratory deaths; and caused NHS Trusts to cancel all elective surgery in January 2018, resulting in 22,800 fewer elective hospital admissions when compared to the previous year. It is also projected that a generalised increase in respiratory infections over the winter could also rapidly overwhelm test and trace capacity.

### 2.1 Winter Operational Pressure Planning

The Trust will continue to deliver against existing national expectations by implementing initiatives from the previous year's winter plan and from the COVID-19 Restoration plans.



### ***Reduce long lengths of stay by 34% by March 2021 and weekend working to address the 'Monday surge'***

The work undertaken as part of the 2019-20 Winter Plan (including the introduction of the weekly long length of stay clinically led peer reviews at ward level), in conjunction with a system action plan which was developed in response to the national guidance to support local health and care systems to reduce the time patients spend in hospital, has been advanced during the COVID-19 pandemic with the introduction of locally based multi-agency Discharge Command Centres. This has been monitored through the System Interface Group (a progression of the previous Complex Discharge Steering Group), a sub group of the A&E Delivery Board.

The introduction of the Discharge Command Centres and other initiatives during the COVID-19 pandemic have supported elements of seven day working and therefore the Trust has seen an increase in the number of patients who are discharged at the weekend, resulting in a reduction of hospital occupancy at the beginning of the week. To sustain and extend this, continued improvements are included in the Winter Resilience Plan 2020-21, such as repeat schemes which provide additional medical staff at the weekend to support senior decision making. In addition, this year a new initiative to extend the period of time that operational managers will be present on site at weekends and bank holidays to support clinical colleagues and patient pathways will be introduced as a result of lessons learnt during the COVID-19 response.

### ***Streaming and ambulatory care to triage patients away from the ED and admission pathways***

The national ambition remains for 50% of medically referred patients to be treated without the need for an overnight admission to hospital. The Trust has embedded Same Day Emergency Care (SDEC) services and embraced the 'assess to admit' approach, integrating them into Trust Business as Usual (BaU) models. The Trust continues to expand the availability of alternatives to admission to maximise the SDEC principles and is now working with the Urgent & Emergency Care Network and ECIST to accelerate further developments, including the local system implementation of the national Talk Before You Walk (TBYW) / NHS 111 First programme across the ICS. We will continue to stream at the front door of the EDs and the TBYW scheme will enable referral and ultimately direct booking by NHS111, primary care and the ambulance service to further direct patients to the most appropriate services; this includes streaming to primary care, frailty teams, liaising with community teams to prevent the need for admission, SDEC and specialty 'hot' clinics / slots (to provide urgent access to specialist advice) and ambulatory pathways, allowing patients to receive treatment without the need to stay in hospital overnight.

### ***Flu vaccination***

The national teams have confirmed their expectation that providers aim to vaccinate all frontline staff against the flu virus. This is vitally important this year due to the presence of the COVID-19 virus and the lack of a COVID-19 vaccine at this time. Where staff working in high-risk areas decline the vaccination the recommendation is that they are redeployed (where possible given the need to maintain safe staffing levels) to lower risk areas to protect patients. The Trust is working to achieve a target of 90% of frontline staff receiving the flu vaccination for 2020-21. The Trust has purchased the quadvariant vaccination, and also vaccine appropriate for those staff over 65 (historically over 65s have been asked to get their flu jab via their GP). Last year 4,869 frontline staff, 71.09% of the total, were vaccinated. In addition a further 1244 non frontline staff were vaccinated. The Trust is currently planning the 2020-21 flu campaign which will commence in October 2020. There will be a focus on significantly increasing the numbers of Peer Vaccinators to vaccinate their frontline colleagues for this campaign, which has been shown to be the most effective way of reaching frontline staff, as well as maximising safety in the current climate. Occupational Health clinics will be run for LLP staff and those aged over 65.



## **Working with system partners**

There is a national recognition that the delivery of unplanned care requires the whole system to play its part. From preventative activities that avoid a health crisis, providing alternatives to hospital when a crisis happens or ensuring support is available to allow someone to leave hospital, the Trust plan sits within a broader system-wide approach. The System Resilience Group (a sub-group of the A&E Delivery Board) focusses on system winter planning; the group is led by the CCG's and co-ordinates the plans across all providers, including social care, to provide assurance to the Delivery Board and NHSI/E that the necessary arrangements are in place. The focus during winter 2019-20 was to improve Escalation Plans across the system and the Trust refreshed the OPEL plans as part of the winter offer. There will be a refresh of the system plans for winter 2020-21 to build on the partnership working from previous winters and from system delivery during the COVID-19 pandemic.

## **2.2 COVID-19 Surge Planning**

There is a high degree of uncertainty in how the COVID-19 epidemic in the UK will evolve in the coming months. The Academy of Medical Sciences consider a scenario in which it is not possible to respond to a rising incidence of COVID-19 with a national lockdown of similar effectiveness to that imposed in March 2020. Under the worst-case scenario (in which  $R_t$  rises to 1.7 from September onwards; just over half of the initial level of transmission experienced in early March 2020) **infections could be expected to rise gradually with a peak in hospital admissions and deaths of a similar magnitude to the first wave**. This is projected to occur in January/February 2021, coinciding with a period of peak demand on the NHS.

## **2.3 EU Exit Transition Period**

NHS England expects Winter Resilience Plans to incorporate the mechanisms with which to manage any issues resulting from the end of the EU Exit Transition period which is due to end on 31 December 2020. Significant planning to prepare the Trust for an expected No Deal EU Exit was conducted in January 2019 and this work will be updated and refreshed to reflect the possible issues from the transition period coming to an end.

Very little national guidance has been issued to date and the Trust activity has centred on updating the focus areas of:

- Supply of medicines and vaccines;
- Supply of medical devices and clinical consumables;
- Supply of non-clinical consumables, goods and services;
- Workforce;
- Professional regulation;
- Reciprocal healthcare;
- Research and clinical trials;
- Data sharing;
- Business continuity;
- Communications and escalations;
- Reporting, assurance and Information;
- Finance.

### 3. Key Elements of the Trust Plan

#### 3.1 General

Evidence from previous winters shows that the Trust needs to create additional inpatient bed capacity to meet the demand for unplanned care over the winter period. Lessons learnt indicate that by planning earlier which cohorts of patients could be cared for in each ward, allows Care Groups to proactively identify the medical, nursing, therapy and non-clinical support services required, as well as any additional training and support (e.g. equipment) for these areas.

The consequence of the COVID-19 pandemic will be a significant feature of the Winter Resilience Plan 2020-21; the social distancing recommendations have reduced the inpatient bed capacity by approximately 20%. Unless ward based social distancing is flexed as part of the surge planning, this has a potential patient quality and safety implication as it will impact on patient flow as non-elective admissions increase, potentially creating long waits in ED, a deterioration of ambulance handover times and a risk of 12 hour ED breaches.

A detailed analysis of the refreshed bed modelling to inform the Trust Surge Plan and can be found at Appendix 1. The current trajectory shows a requirement of circa 23 additional beds every 4 weeks at York and circa 29 additional beds every 4 weeks at Scarborough. Projections will be refreshed on a weekly rolling basis.

The current projections suggest that York will need to reduce the number of socially distanced beds by mid-December 2020 to manage the increasing demand.

The current projections also suggest that the current capacity at Scarborough will be consistently insufficient by the end of September 2020. This is especially concerning as all socially distanced beds are already open; this been a feature of daily operational planning and delivery since early August 2020. The refurbishment of Ann Wright Ward and Haldane Ward to create 23 additional side rooms at Scarborough (creating a net gain of 6 beds) by January 2021 still does not create enough capacity to manage the projected demand.

Quality Impact Assessments (QIA's) have been undertaken for each ward at Scarborough and York Hospitals prior to any easement of social distancing to ensure risks have been identified and, where possible, mitigated.

A standard operating procedure is being developed to enable the consistent and safe transfer of York, Pickering, Malton and Pocklington residents who are inpatients at Scarborough Hospital to York Hospital to support the bed capacity constraints.

#### 3.2 Non Elective Activity

##### ***Acute Attendances***

The focus of EDs in the first half of the year focussed primarily on the response to COVID-19. Reorganisation of patient pathways has been numerous and staff have been divided between "Hot (blue) and Cold (yellow)" areas and this is likely to remain a theme of how EDs will operate throughout the winter period. Social distancing regulations will provide challenges and risks in already busy departments and the Trust will have to provide appropriate waiting areas for ambulatory and non-ambulatory patients. In addition to the specific Winter Plan initiatives, Care Groups are exploring initiatives that will reduce attendances at ED such as TBYW and admission avoidance services (eg. heart failure).

Urgent and emergency care transformation programmes are well advanced in both York and Scarborough; Care Groups are currently reviewing these to refocus efforts over the summer period and into winter. These programmes are delivered through the site specific Working Groups and are governed through Care Group Boards; regular updates provided to the Executive Committee.

### Admissions

The Trust has continued to develop ‘Assess to Admit’ models with a number of specialty SDEC assessment areas providing an alternative to inpatient admission. A critical element of the TBYW programme is how the Trust can enable NHS111 to refer patients into appointments in SDECs and ED, with the ultimate goal of direct booking. We are working with the system Urgent & Emergency Care Network and the Trust IT teams to seek a rapid solution to facilitate this ahead of the winter period. The requirement to test all non-elective admissions poses a further challenge for the clinical and operational teams; all acute patients must be isolated on admission pending their COVID-19 test result. Each test requires an average of 10 hours turnaround time; decision on patient placement should not be made until the result is known otherwise patient safety may be compromised. Plans for a moderate increase to COVID-19 rapid testing should be provided by October 2020 and should reduce the average turnaround time for urgent and emergency admissions.

### Surge Plans

The Trust response to COVID-19 has resulted in the development of a detailed Trust Surge Plan that articulates the bed base requirements when responding to a small, medium and large scale demand for inpatient beds on both sites. Care Groups 1, 2 and 3 now have well developed and practiced surge plans that allow the bed stock to be adjusted to reflect where the greatest requirement is needed. A summary of the total bed availability in the Surge Plan is as follows:

Title	Description	Trust Inpatient Bed Availability			
		York Hospital		Scarborough Hospital	
		Positive	Negative	Positive	Negative
S1	Small Response = Mitigation	59	580	42	264
S2	Medium Response = Surge	204	432	111	199
S3	Large Response = Super Surge	309	256	170	159

A robust command and control structure will monitor pressures on operational activity and direct how the Trust will transition between the varying scales of demand for inpatient beds. The detail of the Trust Surge plan which includes action cards covering governance, workforce, triggers, escalation and decision making can be found at Appendix 2.

## 3.3 Elective Activity

### Elective Activity

The suspension of elective services through the COVID-19 response has resulted in new challenges in comparison to previous years as the Trust enters winter. The national priority to restore NHS elective services will reduce flexibility in the Winter Plan and will add to already stretched resources such as PPE. It has been agreed that the block contracting of Independent Sector services will be extended to the end of the calendar year.

Initiatives that are being worked on for this Winter Plan are:

- Maximising day case activity by opening additional Day Case bays and an extension of opening hours;
- Weekend waiting list initiatives at York (2 x GA lists on a Saturday at York);
- The establishment of a daily Independent Sector weekday all day list;

The revised planning assumptions for 2020-21 detailed in the Phase 3 recovery plan include the seasonal planning impact from previous years to reflect the anticipated stand-down of elective activity at the main sites to support non-elective pressures. The Trust is continuing to work with providers across the Humber Coast and Vale to secure cold site access over the winter period to protect elective capacity due to the backlog pressures created during the quarter 1 stand down of elective surgery.

As in previous years, day case activity will be maximised and surgical specialties will look to utilise outpatient capacity created through reductions in planned activity for medical and elderly specialties (to free clinical staff for acute assessment and inpatient work).

### 3.4 Discharges

The establishment of the Discharge Command Centres on both sites during the COVID-19 response has been successful. The Centres are multi-disciplinary and supported by the system health and social care partners. The COVID-19 Recovery work will establish the Discharge Command Centres as BaU to allow a coherent approach for discharging patients seven days a week. This is further supported by the refreshed Hospital Discharge Service: Policy and Operating Model (21 August 2020).

The Trust continues to support a Home First approach. Several schemes are now established as BaU but still benefit from further development and / or extension (eg. SAFER, the community based intravenous antibiotic service and the community sub-cutaneous fluids service).

### 3.5 Workforce

Following the COVID-19 pandemic all care groups are producing interim workforce plans to set out their requirements for the restoration of services and the winter period. The workforce plans will be reviewed with the Trust resourcing teams to ensure targeted recruitment and support in the areas with the highest demand. Throughout the COVID-19 pandemic temporary deployment schemes were set up in the Trust; these will continue for medical staff into the winter period so that the workforce can be deployed appropriately. Rotas within the medical workforce will be designed to meet the demands of the winter service. During the COVID-19 pandemic an additional 35 bank nurses and 109 bank HCAs were recruited; work is underway to try and recruit these individuals into the organisation on substantive contracts to reduce the Trust's vacancy factor as we move into the winter period.

Throughout the COVID-19 pandemic there has been a proportion of the workforce shielding; these staff members will start to return to the workplace, where possible, in August 2020. However, adjustments will need to be made for these vulnerable staff members whilst the COVID-19 virus is present; this may continue to impact on the availability of the clinical workforce and is captured as part of the workforce planning.

Staff members will continue to require support in the workplace following the COVID-19 pandemic; additional health and wellbeing support has been put in place and this will continue into the winter period.

### 3.6 EU Exit Transition Period

The planning conducted for the possibility of a No Deal EU Exit will be retained and integrated into the Winter Resilience Plan 2020-2021. The Trust leads for each focus area (see paragraph 2.3) will remain unchanged and the Trust Senior Responsible Officer (SRO) for EU Exit will remain the Director of Finance.

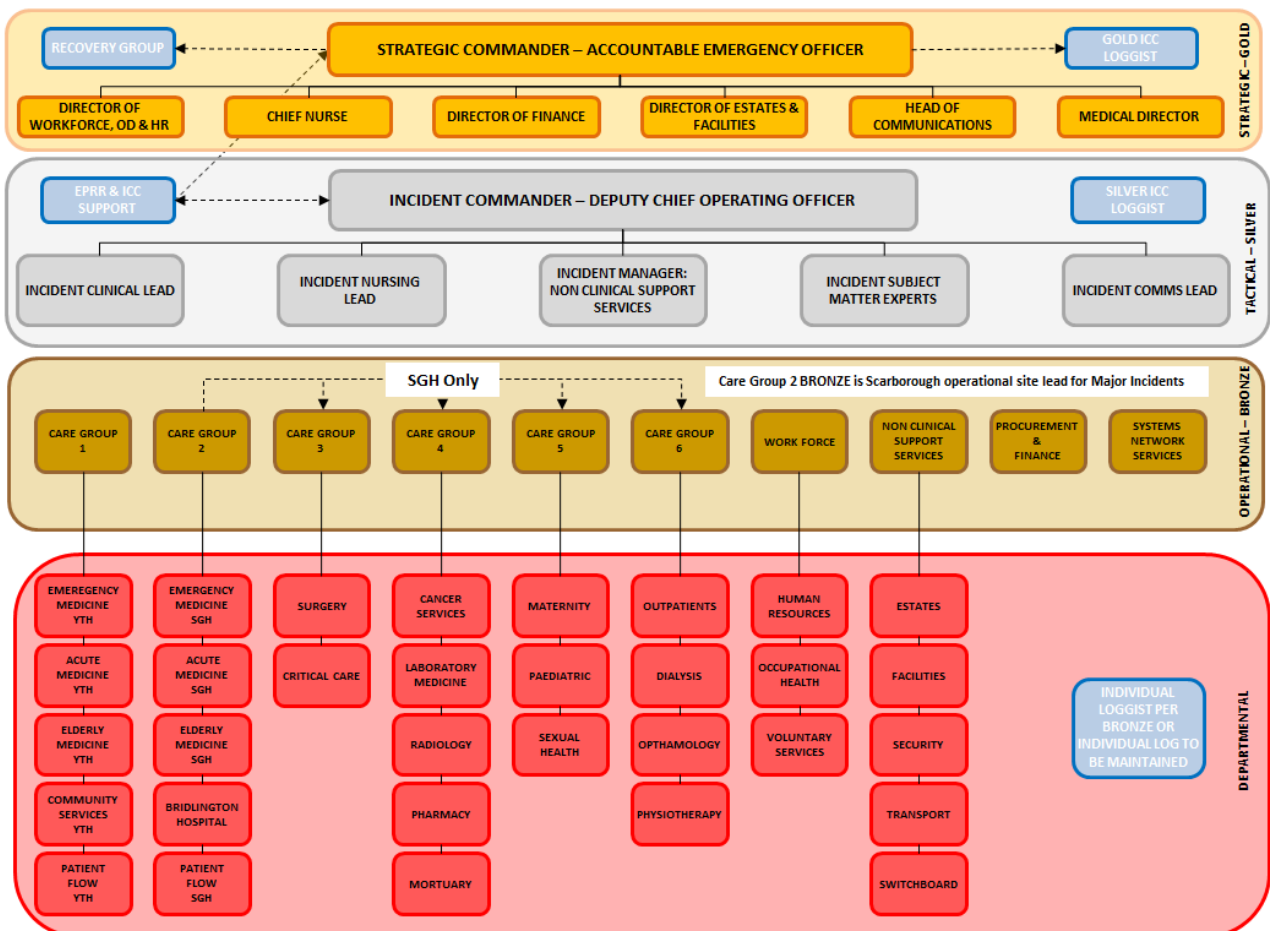
Preliminary meetings to prepare for the end of the EU Exit Transition period are likely to take place out with of the Command and Control structure. Once preparations have been finalized then the responsibility for the coordination of EU Exit issues will be handed over to SILVER Command. Escalation of EU Exit matters will be directed to GOLD Command where the SRO is already a member. The months of December and January may warrant dedicated EU Exit SILVER briefings.

The updated EU Exit Readiness Assessment Action Plan can be found at Appendix 3.

### 3.7 Command and Control

The COVID-19 lessons learned exercise has highlighted the value of a collaborative command and control structure that can coordinate activity and facilitate mutual support between sites and departments. The Winter Plan 2020-21 will integrate the incident management command and control structure with the routine operational management processes to improve Trust situational awareness across all sites, to facilitate internal mutual aid and to initiate any requests for external mutual aid.

The structure will operate as:





It is proposed that the weekly routine meetings to coordinate activity over the winter period will take place as follows:

- **SILVER Briefings.** A full briefing by the SILVER Commander to all BRONZE Commands will take place at 1000hrs every Monday. The focus will be to reflect on issues / escalations from the weekend and for BRONZE Commands to brief on their activity and issues for the week ahead.
- **Ops Meetings.** Operational meetings will take place on both sites as usual at 0900hrs and 1500hrs, with additional meetings scheduled according to the site pressures and OPEL level. The 1300hrs operational meeting will be conducted across both sites with each Ops Centre dialing into a WEBEX conference chaired by the SILVER Commander. The meeting will allow both sites to articulate their positions for the day as per the ops report and the Trust will provide updates on issues controlled at Trust level such as IPC and PPE stocks.
- **Handover to Weekend On Call Management Team.** A WEBEX handover to the Weekend On Call Management Team will be held at 1600hrs every Friday. It will be chaired by the SILVER Commander and will be attended by 1<sup>st</sup> On Call Managers for both sites for Friday, Saturday and Sunday, IPC representatives and the duty Procurement manager for the weekend. During the COVID-19 pandemic band 7 Operational Managers were rostered to be present on site 0800-1430hrs on each weekend and bank holiday. This provided continuity and operational oversight until the 1<sup>st</sup> On Call Manager arrived on site at 1400hrs when a handover was conducted. The Winter Plan 2020-21 will consider the formalisation of this duty for the winter period.
- The Trust Operational Performance Escalation Levels (OPEL) framework has been refreshed over the previous 2 years and is now part of the system Escalation processes with partners, contributing to the System Resilience Plan for 2020-21. The framework supports BaU arrangements at OPEL 1, with a series of actions to be taken as the escalation levels rise, supported by corporate actions internally and equivalent plans in partner organisations. The response is led by the Care Groups and coordinated by the Corporate Operations Team.
- The City of York and the North Yorkshire COVID-19 Outbreak Control Plans aim to provide central frameworks to preventing and controlling outbreaks of COVID-19 and reducing the spread of the virus. The Local Authorities lead the Outbreak Control meetings (the Trust is a member), ensuring that the Winter Plan 2020-21 coordinates with the plans, especially regarding the impact of the national and local Test and Trace services.

### 3.8 Supporting Elements to the Trust Plan

#### ***Infection prevention and Influenza***

2019-20 saw the Trust's Influenza Plan tested for the third time. Patient flow was supported by efficient laboratory testing, allowing early decisions about isolation and patient placement. At York, Ward 23 was once again a great success as a cohort area. This model was successfully replicated on the Scarborough site using Lilac ward. As a result the Trust built up a cohort of nurses with experience of managing respiratory virus patients at both main hospital sites. This was a valuable asset in responding to the arrival of COVID-19 in March 2020. The response to the pandemic also included a rapid scaling up of the FIT testing process. As a result almost all front line staff have now been through the process. It also saw IPC training focused on managing respiratory virus patients, covering areas such as PPE, delivered to over 2000 staff. The segregation of EDs and the acute wards into COVID-19 and non-COVID-19 areas was undertaken successfully and at pace. All of this activity and experience is currently being used to develop models for ensuring the identification, assessment, testing and placement of both COVID-19 and influenza patients during winter 2020-21. This activity is taking place principally at Care Group level, with site planning meetings. Oversight of influenza and COVID-19 planning for winter has been moved to the SILVER Command Winter Planning Group.

York community nurses support primary care in the vaccination of the high risk local population with the aim to reduce hospital admissions due to influenza. As with last year the community nursing teams in the Vale of York area will offer to vaccinate residential home residents, patients on their own caseloads and high risk housebound patients (not on their caseloads) for GP practices that want the teams to do this. York Community Services are working with the CCG and GP practices to ensure the required agreements are in place and to understand when the vaccines are available to plan in the campaign (usually around October) with a more streamlined process for identifying the patients to be vaccinated and improved communication with practices. Given the significant increased workload this creates, qualified staff within the senior community management team will work clinically to support teams through this period.

### ***Inclement Weather***

The Trust has Adverse Weather Guidance in place for staff and there are extensive Business Continuity action cards that would be enacted allowing the organisation to continue to function in the event of an incident caused by inclement weather. Responses to inclement weather will initially be coordinated by SILVER Command at the Monday meetings and if required will stand up further meetings to coordinate any further response.

### ***Weekend & Bank Holidays***

The timing of Christmas and New Year this year means that there will be a four day 'long weekend' and as with previous years the expectation is that bed occupancy of 70% will be achieved by Christmas Eve. This will give capacity to allow the Trust to manage the Christmas and Boxing Day bank holiday period and the subsequent days of increased demand. Care Groups will have plans in place by the start of December to ensure operational and clinical cover is in place to achieve this. SILVER Command will coordinate the 4 day public stand down period with all On Call Management Staff on Thursday 24 December 2020.

### ***Communicating the Plan***

For 2020-21, the communications team will be supporting a comprehensive approach to sharing the key messages regarding this year's Winter Plan, building on last year's approach and lessons learned.

Key messages will be cascaded across the Trust via the existing communications channels including Chief Executive's monthly Staff Brief, the weekly staff bulletin, and accompanied by a screensaver campaign. Where appropriate the Trust's social media channels will also be used to share key messages for staff.

Regular updates will be shared throughout the winter period, utilising the all staff weekly bulletin - detailing updates and changes to the plan, what's working well/success, areas of focus/challenge and where we have listened and acted upon staff feedback.

In addition, there will be a dedicated 'Winter Plan' section on Staff Room, which acts as a one stop shop for information, local plans and resources. Internal plans will see the plan briefed at a range of key forums including the Executive Committee.

Care Group managers will take the lead in ensuring staff in their Care Group are briefed on the plans specific to their own area of work.

Externally, the Trust will continue to work with partner organisations to deliver a system-wide communication plan. This will focus on preventative messages, infection control good practice and signposting alternatives to ED. All messages will align with national communications and

awareness raising campaigns as part of the incident response approach to the COVID-19 pandemic.

#### 4. Investment Summary

The Trust has an agreed allocation to fund various initiatives designed to create additional capacity to deal with winter demand. In 2020-21 the normal finance and contracting arrangements have been suspended to support the NHS in dealing with the COVID-19 pandemic. Provider organisations have been funded through block arrangements with expenditure plans based on the run rate for the reference period November 2019 to January 2020. The emergency arrangements that were put in place initially until 31 July 2020 have been extended until 31 October 2020. As a result the availability of additional funding for winter initiatives is currently uncertain.

In the absence of an addition funding control total the Winter Resilience Plan 2020-2021 schemes have been prioritized to meet last year's control total of £1M. Schemes falling outside of the top prioritisation have been placed into an order of merit should extra funding become available in the future.

A number of schemes are now BaU, are funded through an alternative route or do not require funds; a number of schemes (refreshed from last year or new for this year) are subject to funding requests against the Winter Resilience Plan 2020-2021 funding. The total request for funding new and repeat schemes for this year's plan is £1M which is articulated in detail at Appendix 4.

#### 5. Risk Summary

##### 5.1 Workforce

- Morale, fatigue, Track and Trace, self-isolation and carers responsibilities, sickness, BAME.
- Staffing pre-COVID bed levels and access to agency staff.

##### 5.2 Infection Management

- How we balance the transmission risks vs risks to delayed clinical assessment/ treatment.

##### 5.3 Urgent Care Demand

- COVID regional assumptions included: 75% April peak Sept-Nov, 100% May all other months.
- Winter pressures on hospital capacity; Talk before you Walk and Discharge Guidance not fully implemented or not having the projected impact.
- Balance decisions to cancel non-urgent and non-cancer electives vs clinical risk associated with cancellations and growing backlog.

##### 5.4 Delivery of Phase 3 Plan for Elective Care and Outpatients

- Distancing within PACU and surgical bed base to accommodate increased numbers
- Continued access to PPE
- Access for all relevant staff to technology to rapidly expand Attend Anywhere (Windows 10/ Chrome)



## 6. Detailed Recommendation

The Board is asked to:

- **Endorse the Winter Resilience Plan 2020-2021;**
  - **Endorse the expenditure for new and repeat schemes that support the plan.**
- 

Author: Melanie Liley, Deputy Chief Operating Officer and Chief Allied Health Professional

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: 22<sup>nd</sup> September 2020

Appendices:

1. Trust Bed Modelling Winter Resilience Plan 2020-2021.
2. Trust Surge Plan.
3. EU Exit Readiness Assessment Action Plan.
4. Winter Resilience Plan 2020-2021 Investment Summary.



## Appendix 1 - Trust Bed Modelling Winter Resilience Plan 2020-2021

### Winter Bed Planning Summary *(Data as at Sunday 30<sup>h</sup> August 2020)*

Evidence from previous winters shows that the Trust needs to create additional inpatient bed capacity to meet the demand for unplanned care over the winter period. Lessons learnt indicate that by planning earlier which cohorts of patients could be cared for in each ward, allows Care Groups to proactively identify the clinical workforce and non-clinical support services required, as well as any additional training and support (e.g. equipment) for these areas.

The consequence of the COVID-19 pandemic will be a significant feature of the Winter Resilience Plan 2020-21; the social distancing recommendations have reduced the inpatient bed capacity by approximately 20%. Unless ward based social distancing is flexed as part of the surge planning, this has a potential patient quality and safety implication as it will impact on patient flow as non-elective admissions increase, potentially creating long waits in ED, a deterioration of ambulance handover times and a risk of 12 hour ED breaches.

This summary explains the detailed analysis of the refreshed bed modelling which has informed the Trust Surge Plan. The bed numbers will be refreshed on an ongoing basis. At the time of this report York Hospital continues to maintain social distancing of inpatient beds but is undertaking a Quality Impact Assessment to assess (and mitigate) the risk of reducing social distancing and thereby increasing capacity. However, Scarborough Hospital has already had to reduce all social distancing beds due to current demand.

Projections are based on the current trajectory (the difference between the current 4 week average and the 4 week average for the preceding 4 weeks) and the weekly change in the 4 week average at the same time last year (to approximate potential seasonal variation) and are based on the number of beds that are currently open due to infection prevention measures to reduce nosocomial infections (social distancing of beds).

Methodology:

- Occupied beds based on the weekly 95<sup>th</sup> percentile of a 4-hourly snapshot of patients in beds, and the specialty of the responsible consultant at that time. Trolleys, chairs and SDEC wards are not included.
- The projection will give an idea of when the required number of beds could be consistently above capacity, not the first point at which occupancy would be above capacity.

### **York**

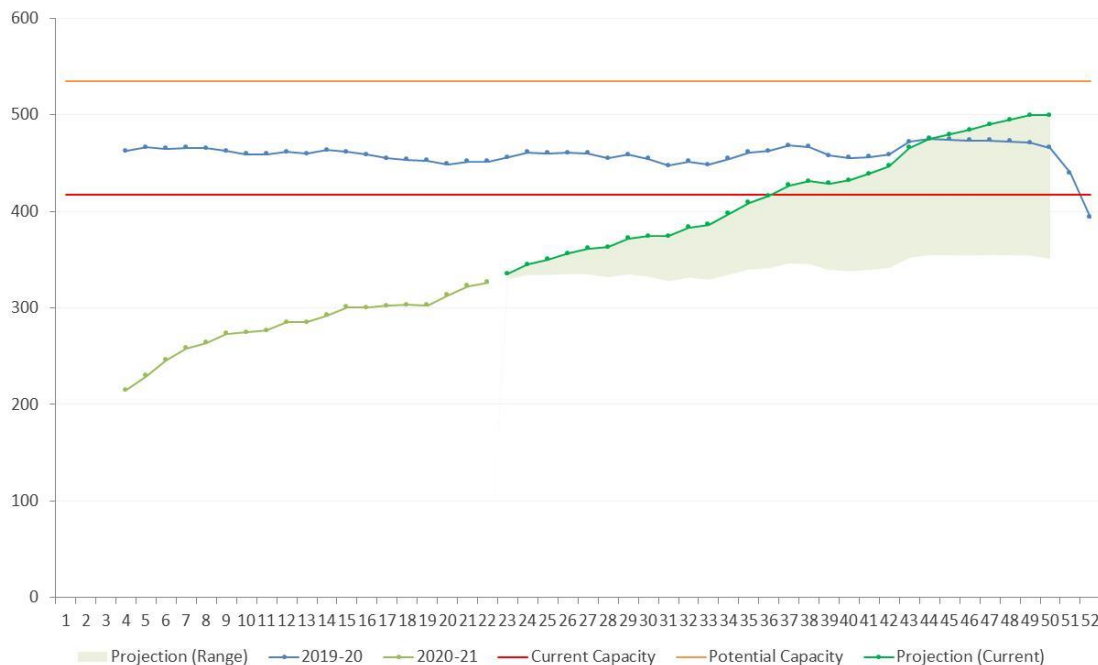
Available beds based on current ward configuration and open beds:

**Available Beds (As at Noon, 27th August 2020)**

Ward Name	Parent Specialty	Specialty	Current Beds	Potential Beds	Note
29	Covid	All	19	23	
25	Covid	All	21	27	Admissions
AMB	Elderly	Geriatric Medicine	25	30	Admissions
28	Elderly	Geriatric Medicine	25	30	
35	Elderly	Geriatric Medicine	25	30	
37	Elderly	Geriatric Medicine	19	22	
39	Elderly	Geriatric Medicine	19	24	
36	Elderly	Geriatric Medicine	20	24	#NOF
AMU	Medicine	Acute Internal Medicine	23	29	Admissions
CC	Medicine	Cardiology	8	8	
32	Medicine	Cardiology	23	28	
33	Medicine	Gastroenterology	25	30	
31	Medicine	Medical Oncology	15	18	
34	Medicine	Respiratory Medicine -Thoracic	25	30	
15	Surgery	Ear, Nose And Throat	20	30	
ESA	Surgery	General Surgery	17	21	Admissions
11	Surgery	General Surgery	25	30	
16	Surgery	General Surgery	17	20	
G1	Surgery	Gynaecology	0	22	
26	Surgery	Trauma And Orthopaedic Surgery	25	30	
14	Surgery	Urology	21	29	

- The average of the weekly 95<sup>th</sup> percentile for the last four weeks is 326 occupied beds, which is equivalent to 72% of the activity at the same time last year (452 occupied beds).
- Current trajectory shows an increase of 23 occupied beds from the average for w/e 2<sup>nd</sup> August to w/e 30<sup>th</sup> August. The projection therefore adds 23 beds every four weeks for York site, with some weekly variation.
- Current projections suggest that there will be insufficient capacity by December 2020.

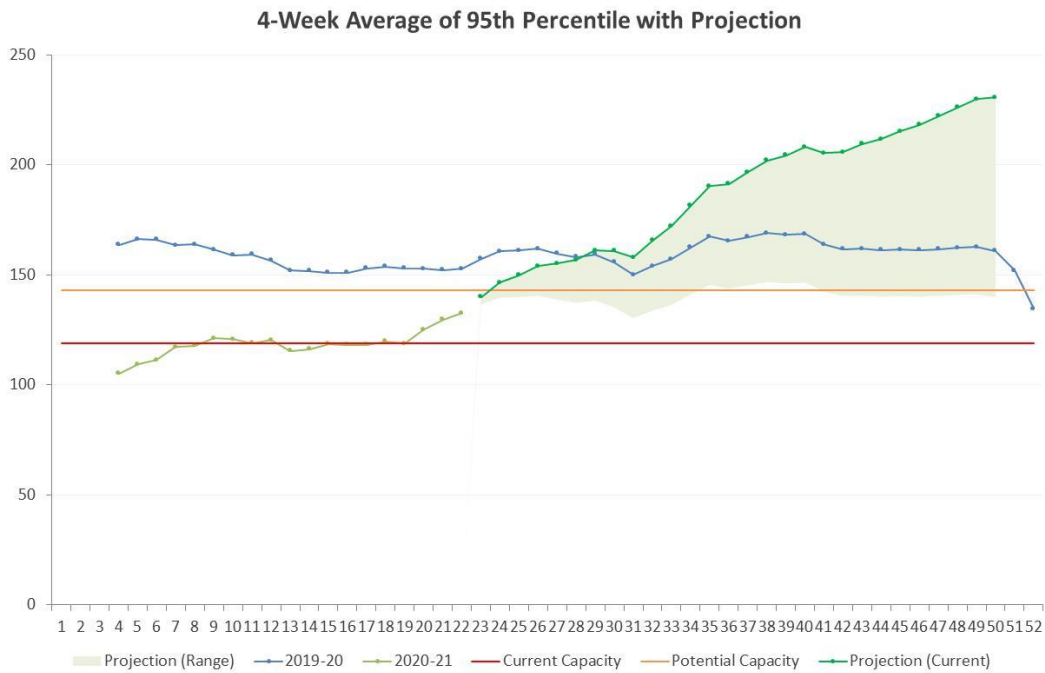
**4-Week Average of 95th Percentile with Projection**



**Medicine**

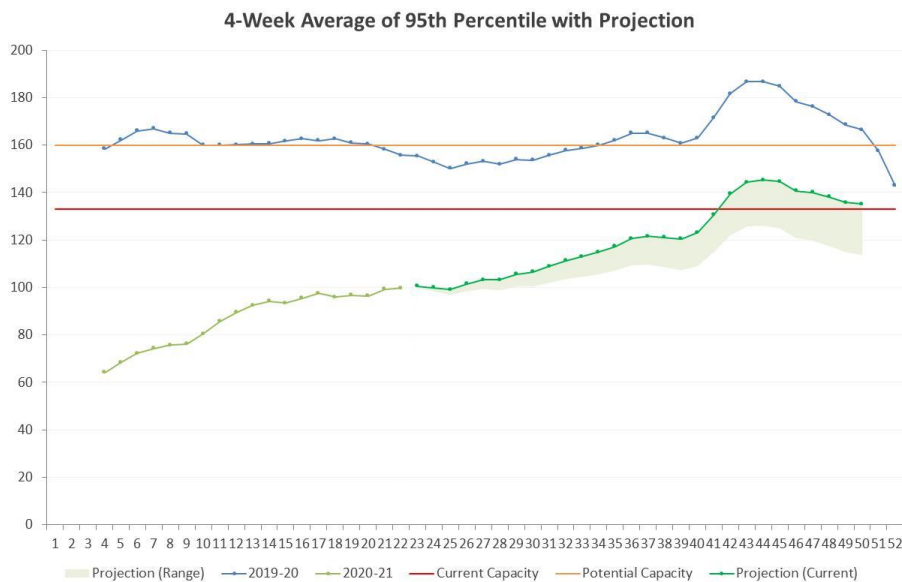
Medicine is currently operating at 87% of activity at the same time last year (133 occupied beds compared to 153); if the current trajectory of +13 beds per month continues, there won't be enough Medical beds by the end of September 2020.





## **Elderly**

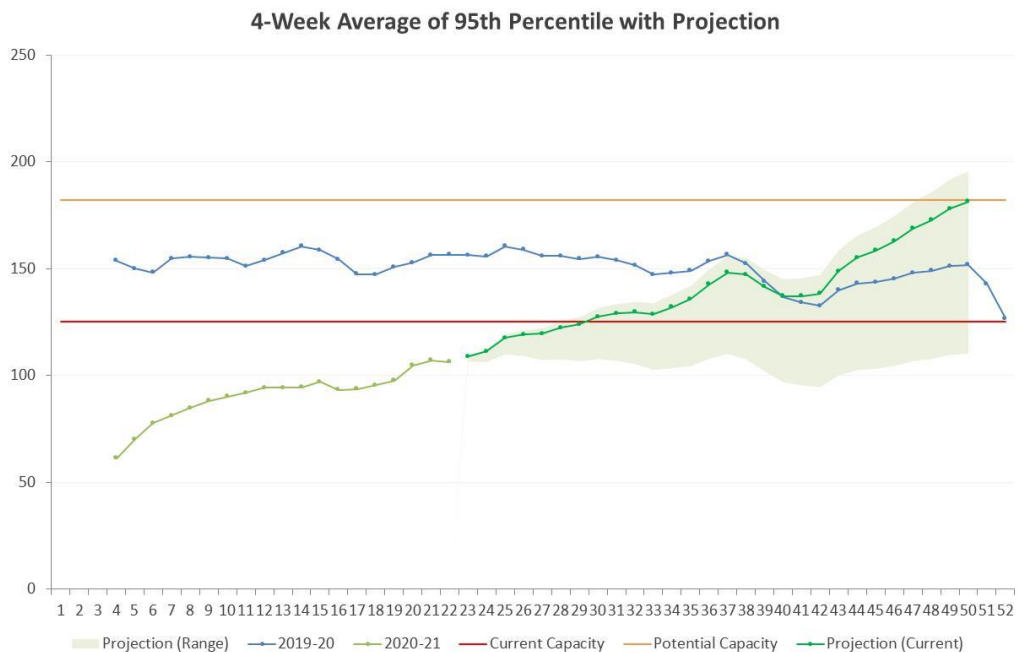
Elderly medicine is currently operating at 64% of activity at the same time last year (100 occupied beds compared to 156); if the current stable trajectory of +4 beds per month continues, there would be enough Elderly beds until February 2021.



## **Surgery (Inc. T&O)**

Surgery is currently operating at 68% of activity at the same time last year (106 occupied beds compared to 156); if the current trajectory of +11 beds per month continues, there won't be enough Surgical beds by the end of October 2020.





## Scarborough

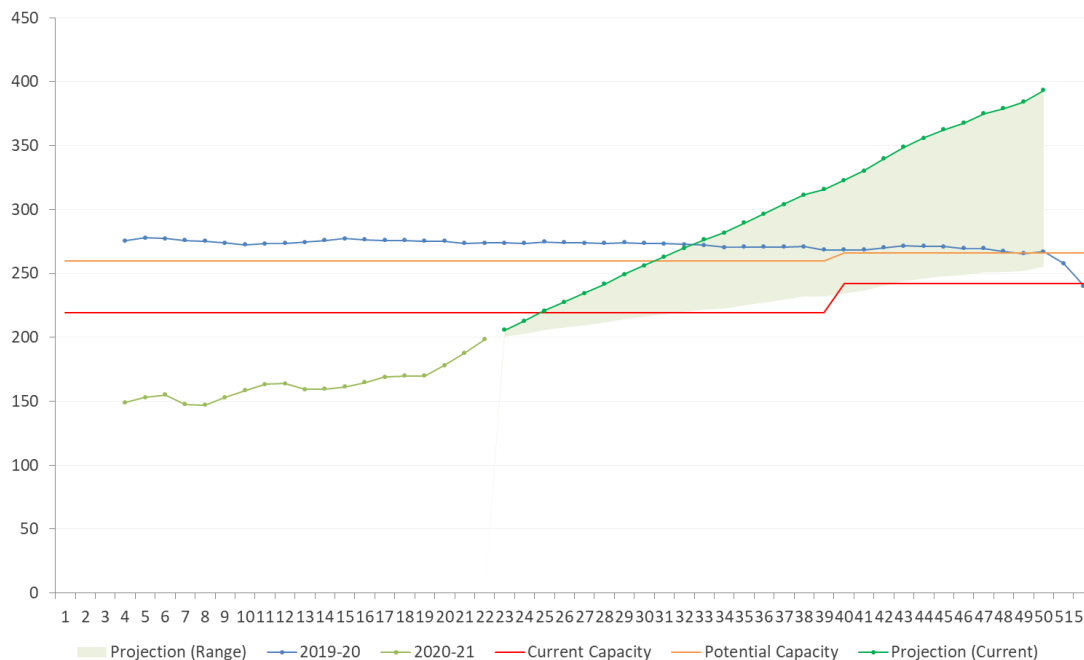
Available beds based on current ward configuration and open beds:

Ward Name	Parent Speciality	Speciality	Current Beds	Potential Beds	Note
AWR	Covid	All	0	17	Closed
OAK	Elderly	Geriatric Medicine	33	33	
CHR	Medicine	Acute Internal Medicine	28	28	
LIL	Medicine	Acute Internal Medicine	32	32	Admissions
CCU	Medicine	Cardiology	20	20	
CHN	Medicine	Endocrinology	27	28	
ASH	Medicine	General Medicine	15	16	
ASP	Medicine	General Medicine	6	6	
BEE	Medicine	Respiratory Medicine -Thoracic	10	32	
MAP	Surgery	General Surgery	28	28	
HOL	Surgery	Trauma And Orthopaedic Surgery	20	20	

- The average of the weekly 95<sup>th</sup> percentile for the last four weeks is 198 occupied beds, which is equivalent to 72% of the activity at the same time last year (274 occupied beds)
- Current trajectory shows an increase of 29 occupied beds from the average to w/e 2<sup>nd</sup> August to the w/e 30<sup>th</sup> August. The projection therefore adds 29 beds every four weeks, with some weekly variation
- Current projections suggest that there will be insufficient capacity by September 2020



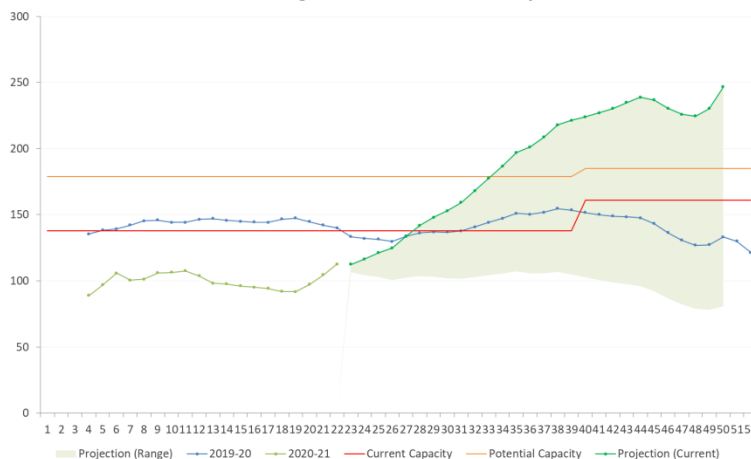
4-Week Average of 95th Percentile with Projection



## Medicine

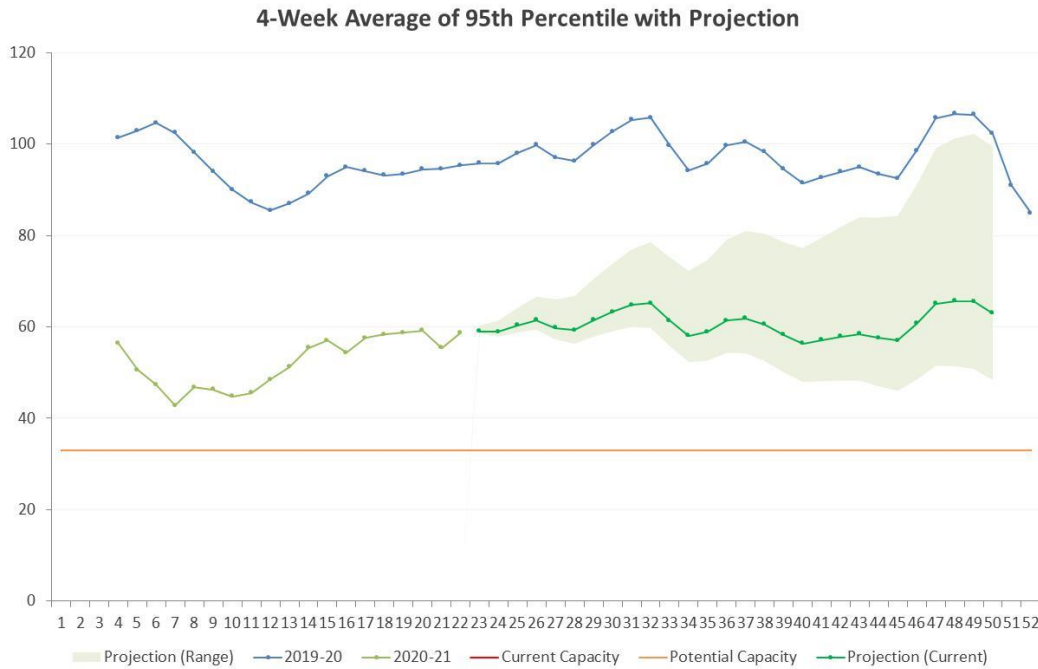
- Medicine is currently operating at 81% of activity at the same time last year (113 occupied beds compared to 140); if the current trajectory of +21 beds per month continues, there won't be enough Medical beds by the end of September 2020.
- The refurbishment of Haldane ward (+11 beds) and Anne Wright ward (+12 beds) creates additional side room capacity in January 2021 (illustrated by a step change in the graph below)
- Ann Wright ward currently has the potential to open up to 17 beds, but capital works will reduce this to 12 side rooms, therefore the potential capacity is reduced by 5 beds. However, Haldane ward is an additional ward which will uplift the potential by 11 beds. These 2 wards therefore provide a net potential capacity increase of 6 beds.
- However, even with these additional beds and with all wards operating at their full potential capacity, there will still not be sufficient capacity to contain the projected levels of activity during Q4.

4-Week Average of 95th Percentile with Projection



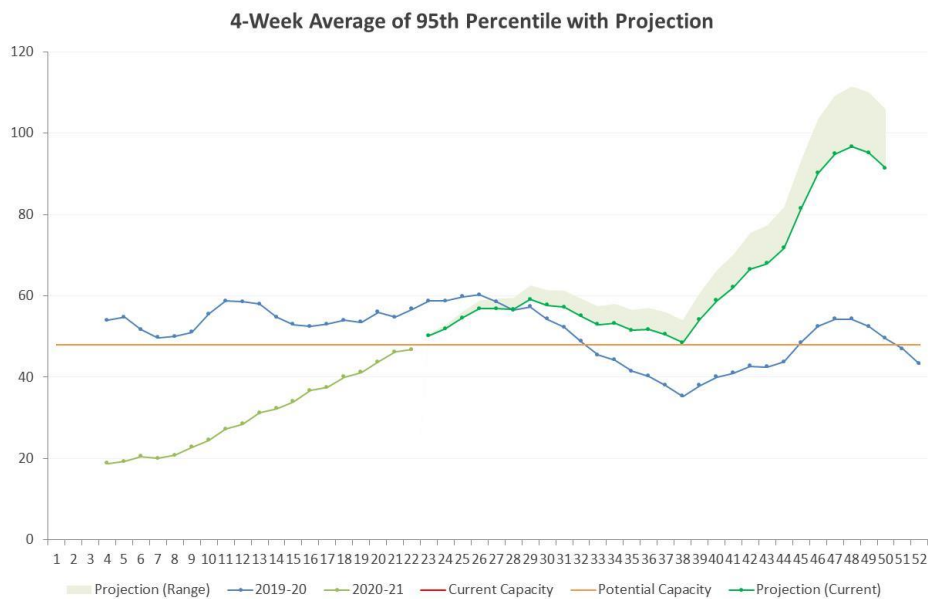
**Elderly**

- Elderly medicine is currently operating at 62% of activity at the same time last year (59 occupied beds compared to 95); if the current stable trajectory of +0 beds per month continues, there would be enough Elderly beds throughout the winter period.



**Surgery (Inc. T&O)**

Surgery is currently operating at 82% of activity at the same time last year (47 occupied beds compared to 57); if the current trajectory of +7 beds per month continues, there won't be enough Surgical beds by the end of September 2020.



## **Summary:**

The current trajectory shows a requirement of circa 23 additional beds every 4 weeks at York and circa 29 additional beds every 4 weeks at Scarborough. Projections will be refreshed on a weekly rolling basis.

The current projections suggest that York will need to reduce the number of socially distanced beds by mid-December 2020 to manage the increasing demand.

The current projections also suggest that the current capacity at Scarborough will be consistently insufficient by the end of September 2020. This is especially concerning as all socially distanced beds are already open; this has been a feature of daily operational planning and delivery since early August 2020. The refurbishment of Ann Wright Ward and Haldane Ward to create 23 additional side rooms at Scarborough (creating a net gain of 6 beds) by January 2021 still does not create enough capacity to manage the projected demand.

A standard operating procedure is being developed to enable the consistent and safe transfer of York, Pickering, Malton and Pocklington residents who are inpatients at Scarborough Hospital to York Hospital to support the bed capacity constraints.

Author: Melanie Liley, Deputy Chief Operating Officer and Chief AHP

Date: September 2020





## Appendix 2 – Trust Surge Plan

York Hospital Trust Acute Sites - COVID Surge & Escalation Plans					
Phase S1 - Maintain/ Moderate Pressure					
York Hospital					
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL	
Emergency Department	AAA	6	0	6	
	Cubicles	13	0	13	
	Plexus	3	0	3	
	<b>TOTAL Capacity</b>	<b>22</b>	<b>0</b>	<b>22</b>	
Hospital Zone	Ward 25 (Covid suspect)	21	0	21	
	Ward 29 (Covid positive)	19	0	19	
	Ward 28	0	26	26	
	Ward 26	0	26	26	
	Ward 35	0	26	26	
	Ward 36	0	23	23	
	Ward 37	0	21	21	
	Ward 34	0	26	26	
	Ward 32	0	23	23	
	Ward 31	0	18	18	
	Ward 24	0	19	19	
	Ward 23	0	26	26	
	Ward 21 (AMB)	0	26	26	
	Ward 33	0	30	30	
	Ward 39	0	19	19	
	Ward 11	0	30	30	
	Ward 14	0	29	29	
	Ward 15 (COVID LHL2)	0	26	26	
	Ward 16	0	28	28	
	GI	0	23	23	
ESA	0	23	23		
Stroke (Ward 22)	0	25	25		
CCU	0	8	8		
	<b>TOTAL Capacity</b>	<b>40</b>	<b>501</b>	<b>541</b>	
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL	
	Paediatric Inpatient	Ward 17	0	20	20
	Ward 18 (CAU assessment)	6	10	16	
	<b>TOTAL Capacity</b>	<b>6</b>	<b>30</b>	<b>36</b>	
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL	
	Maternity, Obstetrics & Gynaecology	Labour Ward	2	10	12
	G3 (Antenatal)	3	8	11	
	G2 (Post natal)	0	21	21	
	Maternity theatre 1	0	1	1	
Maternity theatre 2	0	1	1		
	<b>TOTAL Capacity</b>	<b>5</b>	<b>41</b>	<b>46</b>	
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL	
	Critical Care	ICU	8	8	16
	PACU	0	0	0	
	<b>TOTAL Capacity</b>	<b>8</b>	<b>8</b>	<b>16</b>	
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL	
	Out of Hospital VFT	Selby	24	0	24
	White XC	0	23	23	
	St Monicas	0	12	12	
	St Helens	0	20	20	
Out of Hospital	Malton	0	0	0	
	<b>TOTAL Capacity</b>	<b>0</b>	<b>79</b>	<b>35</b>	

Scarborough Hospital						
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL		
Emergency Department	First Assessment	0	5	5		
	Main Floor	0	12	12		
	Plexus	0	3	3		
	EAU (SDEC & HFU)	0	22	22		
	UTC	0	5	5		
	Resp Assessment Zone	7	0	7		
	<b>TOTAL Capacity</b>	<b>7</b>	<b>47</b>	<b>54</b>		
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL		
	Adult Inpatient	Lilac (Admission unit - await sw)	32	0	32	
	Aspen (Swab Positive)	6	0	6		
	Maple	0	28	28		
	Holly	0	20	20		
	Ash	0	16	16		
	Beech	0	31	31		
	Chestnut	0	28	28		
	Haldane (Day Surgery)	0	6	6		
	Anne Wright (Decant)	0	0	0		
	Cherry	0	28	28		
	Dak	0	33	33		
	Stroke	0	16	16		
	CCU	0	20	20		
		<b>TOTAL Capacity</b>	<b>38</b>	<b>226</b>	<b>264</b>	
	Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL	
		Paediatric Inpatient	Duke of Kent	0	14	14
		CAU Assessment Space	2	0	2	
		<b>TOTAL Capacity</b>	<b>2</b>	<b>14</b>	<b>16</b>	
	Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL	
Maternity, Obstetrics & Gynaecology		Labour Ward	1	4	5	
Hawthorn		0	14	14		
Maternity theatre	0	1	1			
	<b>TOTAL Capacity</b>	<b>1</b>	<b>19</b>	<b>20</b>		
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL		
	Critical Care	ICU	1	5	6	
	PACU	0	0	0		
	<b>TOTAL Capacity</b>	<b>1</b>	<b>5</b>	<b>6</b>		
Hospital Zone	Ward / Department / Area	Capacity HOT	Capacity - COLD	Capacity - TOTAL		
	Bridlington	Johnson	0	28	28	

Total Capacity S1 - YORK	
Total Hot Beds at S1	Total Cold Beds at S1
59	580

Total Capacity S1 - SGH	
Total Hot Beds at S1	Total Cold Beds at S1
42	264

Excluding ED and Out of Hospital

\* NB Prior to the implementation of a full surge plan Ward 15 at YH was opened on 6th April as a COVID admission ward for both sites if Castle Hill ID Unit was unable to accept the admission. The Surge Plan described above began implementation on 13th April 2020.

Level S1 (Mitigation) - YORK Hospital Decision Support Tool & Action Card Guidance			
<b>Notes</b>			
At Level S1 a decision has been made by the Pandemic Operational Group to stand up an identified COVID assessment, suspected and confirmed ward area. This area will be multi speciality and provide the immediate response in relation to the COVID surge plan.			
<b>Ward Areas and Departments Identified</b>			
Those areas are identified as follows:			
<ul style="list-style-type: none"> <li>- Ward 25 - Adult COVID Suspected patients (9 beds)</li> <li>- Ward 29 - Adult COVID Confirmed patients (19 beds)</li> <li>- Ward 18 - Paediatric COVID Inpatient &amp; Inpatient (6 beds)</li> <li>- Labour Ward - Suspected / Confirmed labouring, antenatal or postnatal women (2 rooms)</li> </ul>			
Please refer to Trust COVID SOP for the steps to be taken to mobilise the above areas.			
<b>Impact on Services</b>			
Routine Elective Surgical Care Urgent Elective Surgical Care SDEC Outpatients Diagnostics (Endoscopy, Radiology, Lab Med)			
<b>Impact on Workforce</b>			
AHP: usual ward cover to run initially, staff to be redeployed from S2			
Nursing: ward 28 will close to provide the team for 25			
Medical: tiered rotas according to demand to be used. JC/GR owners for adult COVID			
<b>Decision to escalate into next phase of the plan (in Hours) - BRONZE Command - Within the relevant Care Group</b>			
At Level S1 it is required that a number of existing and new groups are 'stood up' in order to support decision making relating to the surge management plan and ongoing capacity planning and response.			
The Site Daily Operational Meeting will continue to lead the management of the surge plan and will assess and escalate the need to consider			
<b>Triggers, Escalation and Decision Making</b>			
The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan.			
If any of the below triggers are met a decision will then be required to implement the next phase of the surge plan. That decision will be made by the following:			
Decision to escalate into next phase of the plan (in Hours) - <b>BRONZE Command - Within the relevant Care Group, where appropriate with silver command endorsement.</b>			
Decision to escalate into next phase of the plan (Out of Hours) - <b>SILVER Command - on call manager</b>			
Area	Trigger	Decision Made by (In hours)	Decision Made by (Out of hours)
Emergency Department	N/A	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Adult Inpatient - Suspected	at 9 patients, full capacity on ward 25, an increase should be made to 2 patients in a bay and progression made to opening the next suspected ward as per S2. Any covid contacts created as a result of 2 patients in a bay will need to be isolated for 14 days.	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Adult Inpatient - confirmed	<4 beds available on ward 29, progression to opening the next positive ward as per S2	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Paediatrics	>2 transfers in 24 hours from SGH or >2 cubicles remaining at York	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
Maternity	> 2 Women requiring 'Hot' Area in a single 24 hour period	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
Critical Care	>7 COVID patients in York ICU	CG Bronze Command and Critical Care Consultant <b>Liz Hill</b>	Site Silver Command in discussion with Critical Care Consultant



**Level S1 (Mitigation) - SCARBROUGH Hospital****Decision Support Tool & Action Card Guidance****Notes**

At Level S1 a decision has been made by the Pandemic Operational Group to stand up an identified COVID assessment, suspected and confirmed ward area. This area will be multi speciality and provide the immediate response in relation to the COVID surge plan.

**Ward Areas and Departments Identified**

Those areas are identified as follows:

**ED/Front Door:**

- HOT ED: A Respiratory Assessment Zone (RAZ) in the UTC space previously occupied by VOCARE (4 SRs / 3 Trolleys).
- COLD ED: 1st Assessment (5 trollies), COLD RESUS (3 trollies), COLD ED majors (10 trollies / 3 side rooms),
- COLD SDEC/HFU: Standard SDEC/HFU space (2 trollies / 10 chairs).
- COLD AMU: Relocated to ASH Ward (16 Beds).

**IN-PATIENT AREAS:**

- LILAC Ward: Adult COVID Suspected patients & CPAP (20 beds; can surge to 32 if not cohorting)
- MAPLE Ward: Adult COVID Confirmed patients (28 beds)
- Labour Ward: Suspected / Confirmed labouring, antenatal or postnatal women (1 rooms)
- CAU Assessment Space - Paediatric COVID suspected / Confirmed (2 beds)
- Labour Ward - Labour / Postnatal / Antenatal COVID suspected or confirmed (1 bed)

Please refer to Trust COVID SOP for the steps to be taken to mobilise the above areas.

**Impact on Services**

Routine Elective Surgical Care  
Urgent Elective Surgical Care  
SDEC  
Outpatients  
Diagnostics (Endoscopy, Radiology, Lab Med)

**Governance**

At Level S1 it is required that a number of existing and new groups are 'stood up' in order to support decision making relating to the surge management plan and ongoing capacity planning and response.

**Triggers, Escalation and Decision Making**

The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan.

If any of the below triggers are met a decision will then be required to implement the next phase of the surge plan. That decision will be made by the following:

Decision to escalate into next phase of the plan (in Hours) - **BRONZE Command** - Within the relevant Care Group. Within the relevant Care Group, where appropriate with silver command endorsement.

Area	Trigger	Decision Made by (In hours)	Decision Made by (Out of hours)
<b>Emergency Department</b>	N/A	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call
<b>Adult Inpatient - Suspected</b>	When LILAC side rooms full, cohort patients into bays to use full 32	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call
<b>Adult Inpatient - confirmed</b>	Transfer confirmed cases to York. Use Aspen for 6 beds when York can no longer support.	CG Bronze Command David Thomas	Site Silver Command in discussion with Consultant on-call
<b>Paediatrics</b>	>10 patients seen within 24 hours or > 5 transfers to York	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
<b>Maternity</b>	> 2 Women requiring 'Hot' Area in a single 24 hour period	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
<b>Critical Care</b>	>1 COVID patients in York ICU	CG Bronze Command and Critical Care Consultant <b>Liz Hill</b>	Site Silver Command in discussion with Critical Care Consultant

York Hospital Trust Acute Sites - COVID Surge & Escalation Plans						
Phase S2 - Surge (Severe Pressure)						
York Hospital			Scarborough Hospital			
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
Emergency Department	AAA	6	4	10		
	Cubicles	14	12	26		
	Resus	5	4	9		
	<b>TOTAL Capacity</b>	<b>25</b>	<b>20</b>	<b>45</b>		
Adult Inpatient	Ward 25 (Covid suspected)	9	0	9		
	Ward 29 (Covid positive)	19	0	19		
	Ward 28	25	0	25		
	Ward 26	25	0	25		
	Ward 35	25	0	25		
	Ward 36	21	0	21		
	Ward 39	21	0	21		
	Ward 37	18	0	18		
	Ward 32	0	23	23		
	Ward 34	0	25	25		
	Ward 33	0	25	25		
	Ward 24	0	9	9		
	Ward 23	0	25	25		
	Ward 22 (AMU)	0	25	25		
	Ward 21 (AMB)	0	26	26		
	Ward 31	0	18	18		
	Ward 11	0	30	30		
	Ward 14	0	29	29		
	ESA	0	23	23		
	G1	0	23	23		
	Stroke (Ward 22)	0	25	25		
	CCU	0	8	8		
	<b>TOTAL Capacity</b>	<b>163</b>	<b>314</b>	<b>477</b>		
	Paediatric Inpatient	Ward 17	0	20	20	
		Ward 18 (CAU assessment)	19	0	19	
		<b>TOTAL Capacity</b>	<b>19</b>	<b>20</b>	<b>39</b>	
	Maternity, Obstetrics & Gynaecology	Labour Ward	2	10	12	
		G3 (Antenatal)	3	8	11	
		G2 (Post natal)		21	21	
		Maternity theatre 1	0	1	1	
		Maternity theatre 2	0	1	1	
		<b>TOTAL Capacity</b>	<b>5</b>	<b>41</b>	<b>46</b>	
	Critical Care	Ward 15 (COVID L1& L2)	26	26	52	
Ward 16 (NON COVID L1 & L2)		0	28	28		
ICU (L2&3)		17	0	17		
PACU (L2 & L3)		0	9	9		
<b>TOTAL Capacity</b>		<b>17</b>	<b>9</b>	<b>26</b>		
Independent Sector	Ramsay IS	0	24	24		
	Nuffield IS	0	24	24		
	<b>TOTAL Capacity</b>	<b>0</b>	<b>48</b>	<b>48</b>		
Out of Hospital YFT	Selby		26	26		
	White XC		24	24		
	St Monicas		14	14		
	St Helens		32	32		
Out of Hospital Humber	Humber	0	0	0		
<b>TOTAL Capacity</b>	<b>0</b>	<b>96</b>	<b>70</b>			

Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL	
Emergency Department	First Assessment	0	5	5	
	Main Floor	0	5	5	
	Resus	2	3	5	
	EAU (SEC & HFU)	0	22	22	
	UTC	0	5	5	
	Respiratory Assessment Zone	19	0	19	
	<b>TOTAL Capacity</b>	<b>21</b>	<b>40</b>	<b>61</b>	
	Adult Inpatient	Lilac (Admission - await swab)	32	0	32
		Aspen (Swab Positive)	6	0	6
		Holly (swab positive)	20	0	20
Ash (Swab Positive)		16	0	16	
Beech (Flex Yellow/Blue)		15	15	30	
Haldane (Day Surgery)		0	6	6	
Anne Wright (Decant)		0	0	0	
Cherry		0	28	28	
Oak		0	33	33	
Maple		0	28	33	
Chestnut		0	28	28	
Stroke		0	16	16	
CCU		0	20	20	
<b>TOTAL Capacity</b>		<b>89</b>	<b>174</b>	<b>268</b>	
Paediatric Inpatient		Duke of Kent	14	0	14
		CAU Assessment Space	0	2	2
		<b>TOTAL Capacity</b>	<b>14</b>	<b>2</b>	<b>16</b>
Maternity, Obstetrics & Gynaecology		Labour Ward	2	2	4
		Hawthorn	0	14	14
	Maternity theatre	0	1	1	
<b>TOTAL Capacity</b>	<b>2</b>	<b>17</b>	<b>19</b>		
Critical Care	ICU (L2 & 3)	6	0	6	
	PACU (L2 & L3)	0	6	6	
	<b>TOTAL Capacity</b>	<b>6</b>	<b>6</b>	<b>12</b>	
Bridlington	Johnson	0	28	28	

Total Capacity S2 - YORK	
Total Hot Beds at S2	Total Cold Beds at S2
204	432

Total Capacity S2 - SGH	
Total Hot Beds at S2	Total Cold Beds at S2
111	199

Excluding ED and Out of Hospital

SGH Stroke (15 beds) and CCU (20 beds) will remain cold areas

YH CCU (8 beds) will remain cold capacity

Would require staffing in order to open capacity
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NB: ALL BAY SPACES ON ALL WARDS SHOULD BE USED TO A MAXIMUM BEFORE TRIGGERING SURGE 3

Level S2 (Surge) - YORK Hospital Decision Support Tool & Action Card Guidance			
<b>Notes</b>			
At Level S1 a decision has been made by the Pandemic Operational Group to stand up an identified COVID assessment, suspected and confirmed ward area. This area will be multi speciality and provide the immediate response in relation to the COVID surge plan.			
<b>Ward Areas and Departments Identified</b>			
Those areas are identified as follows in order: ( ward function will be allocated on opening the ward, either as admissions for suspected cases or confirmed positive ward). Admissions should be managed in isolation to prevent the need for contact wards to be implemented.			
- Ward 25 - Adult COVID Suspected patients (9 beds) - Ward 29 - Adult COVID Confirmed patients (19 beds) - Ward 28 - Adult COVID (25 beds) - Ward 26 - Adult COVID (25 beds) - Ward 35 - Adult COVID (25 beds) - Ward 36 - Adult COVID (21 Beds) - Ward 39 - Adult COVID(21 beds) - Ward 37 - Adult COVID (18 beds) - Ward 15 - Adult Level 1 / 2 Patients (20 beds) - Ward 18 - Paediatric COVID Inpatient & Assessment (19 beds) - Labour Ward - Suspected / Confirmed labouring, antenatal or postnatal women (2 rooms) - ICU - COVID Confirmed Patients (32 beds)			
Please refer to Trust COVID SOP for the steps to be taken to mobilise the above areas.			
<b>Impact on Services</b>			
Routine Elective Surgical Care Urgent Elective Surgical Care SDEC Outpatients Diagnostics (Endoscopy, Radiology, Lab Med)			
<b>Impact on Workforce</b>			
AHP: staff redeployment to be commenced to provide enhanced ward cover (SA)			
Nursing: staff redeployment to be commenced, ward nursing teams will be reviewed and individuals allocated to ensure specialist care can be provided appropriately.			
Medical: tiered rotas according to demand to be used. IC/GR owners for adult COVID			
<b>Governance</b>			
At Level S2 it is required that a number of existing and new groups are 'stood up' in order to support decision making relating to the surge management plan and ongoing capacity planning and response.			
The Site Daily Operational Meeting will continue to lead the management of the surge plan and will assess and escalate the need to consider			
<b>Triggers, Escalation and Decision Making</b>			
The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan. If any of the below triggers are met a decision will then be required to implement the next phase of the surge plan, that is increasing bed capacity per ward for COVID 19 positive wards prior to progressing to S3 the super surge plan. That decision will be made by the following:			
Decision to escalate into next phase of the plan (in Hours) - <b>BRONZE Command</b> - Within the relevant Care Group Within the relevant Care Group, where appropriate with silver command endorsement.			
Decision to escalate into next phase of the plan (Out of Hours) - <b>SILVER Command</b> - on call manager			
Area	Trigger	Decision Made by (In hours)	Decision Made by (Out of hours)
Emergency Department	N/A	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Adult Inpatient - Suspected	at 9 patients, full capacity on ward 25 and additional suspected wards, an increase should be made to 2 patients in a bay and progression made to opening the next suspected ward as per S2 until all S2 wards are occupied. Then progression to S3. Any covid contacts created as a result of 2 patients in a bay will need to be isolated for 14 days.	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Adult Inpatient - confirmed	< 4 beds available on ward 29 and additional positive wards, an increase should be made to 2 patients in a bay and progression made to opening the next positive ward as per S2 until all S2 wards are occupied. Then progression to S3	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Paediatrics	>5 transfers in 24 hours from SGH or >2 cubicles remaining at York	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
Maternity	> 2 Women requiring 'Hot' Area in a single 24 hour period	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
Critical Care	15 positive COVID patients and/or 7 non-positive COVID patients	CG Bronze Command and Critical Care Consultant <b>Liz Hill</b>	Site Silver Command in discussion with Critical Care Consultant



<b>Level S2 (Surge) - SCARBOROUGH Hospital</b>			
<b>Decision Support Tool &amp; Action Card Guidance</b>			
<b>Notes</b>			
At Level S1 a decision has been made by the Pandemic Operational Group to stand up an identified COVID assessment, suspected and confirmed ward area. This area will be multi speciality and provide the immediate response in relation to the COVID surge plan.			
<b>Ward Areas and Departments Identified</b>			
Those areas are identified as follows:			
<b>ED/FRONT DOOR:</b>			
- HOT ED: Covering all of the current ED main cubicle area into a HOT zone including HOT RESUS bays (2 RESUS trollies / 9 majors trollies/ 5 side rooms).			
- COLD ED: 1st Assessment (5 trollies), COLD RESUS (3 trollies), converting current SDEC and Home First Unit in COLD ED majors (5 trollies / 10 chairs).			
- COLD SDEC/HFU: GRAHAM ward (16 chairs).			
- COLD AMU: GRAHAM ward (10 trollies / 2 side rooms).			
<b>IN-PATIENT AREAS:</b>			
- LILAC Ward: Adult COVID High Acuity suspected patients & CPAP (20 beds; can surge to 32 if not cohorting).			
- ASH Ward: Adult COVID Lower Acuity suspected patients (12 beds).			
- ASPEN Ward: Adult negative COVID step down (following swab) but high suspicion of COVID (6 beds).			
- HOLLY Ward: Adult negative COVID step down (following swab) but lower suspicion of COVID (20 beds).			
- MAPLE Ward: Adult COVID Confirmed patients (28 beds).			
- Duke of Kent Ward - Paediatric COVID Cofirmed / Suspected (14 beds)			
- Labour Ward: Suspected / Confirmed labouring, antenatal or postnatal women (2 beds)			
-ICU - COVID Cofirmed Patients (9 beds)			
<b>Impact on Services</b>			
Routine Elective Surgical Care Urgent Elective Surgical Care SDEC Outpatients Diagnostics (Endoscopy, Radiology, Lab Med)			
<b>Governance</b>			
At Level S1 it is required that a number of existing and new groups are 'stood up' in order to support decision making relating to the surge management plan and ongoing capacity planning and response.			
<b>Triggers, Escalation and Decision Making</b>			
The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan.			
If any of the below triggers are met a decision will then be required to implement the next phase of the surge plan. That decision will be made by the following:			
Decision to escalate into next phase of the plan (in Hours) - <b>BRONZE Command</b> - Within the relevant Care Group Within the relevant Care Group, where appropriate with silver command endorsement.			
<b>Area</b>	<b>Trigger</b>	<b>Decision Made by (In hours)</b>	<b>Decision Made by (Out of hours)</b>
<b>Emergency Department</b>	N/A	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call
<b>Adult Inpatient - Suspected</b>	When LILAC side rooms full, cohort patients into bays to use full 32 beds.	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call
<b>Adult Inpatient - confirmed</b>	When ASPEN full or York can no longer support, convert HOLLY first, then ASH.	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call
<b>Paediatrics</b>	>10 patients seen within 24 hours or > 5 transfers to York	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
<b>Maternity</b>	> 2 Women requiring 'Hot' Area in a single 24 hour period	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
<b>Critical Care</b>	5 positive COVID patients and/or 5 non-positive COVID patients	CG Bronze Command and Critical Care Consultant <b>Liz Hill</b>	Site Silver Command in discussion with Critical Care Consultant



York Hospital Trust Acute Sites - COVID Surge & Escalation Plans						
Phase S3 - Super Surge (Extreme Pressure)						
York Hospital						
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
Emergency Department	AAA	6	4	10		
	Cubicles	14	12	26		
	Resus	5	4	9		
	<b>TOTAL Capacity</b>	<b>25</b>	<b>20</b>	<b>45</b>		
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
Adult Inpatient	Ward 25 (Covid suspected)	9	0	9		
	Ward 29 (Covid positive)	19	0	19		
	Ward 28	25	0	25		
	Ward 26	25	0	25		
	Ward 35	25	0	25		
	Ward 36	21	0	21		
	Ward 39	21	0	21		
	Ward 37	18	0	18		
	Ward 32	23	0	23		
	Ward 34	25	0	25		
	Ward 33	25	0	25		
	Ward 24	0	9	9		
	Ward 23	0	25	25		
	Ward 22 (AMU)	0	25	25		
	Ward 21 (AMB)	0	26	26		
	ESA (COVID Positive)	23	0	23		
	Stroke (Ward 22)	0	25	25		
	Ward 33	0	30	30		
	Ward 31	0	18	18		
	CCU	0	8	8		
	<b>TOTAL Capacity</b>	<b>259</b>	<b>166</b>	<b>425</b>		
	Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL	
	Paediatric Inpatient	Ward 17	20	20	40	
		Ward 18 (CAU assessment)	19	0	19	
		Ward G1	0	23	23	
		<b>TOTAL Capacity</b>	<b>19</b>	<b>0</b>	<b>19</b>	
	Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL	
	Maternity, Obstetrics & Gynaecology	Labour Ward	2	10	12	
G3 (Antenatal)		11	0	11		
G2 (Post natal)		0	21	21		
Maternity theatre 1		1	0	1		
Maternity theatre 2		0	1	1		
<b>TOTAL Capacity</b>	<b>14</b>	<b>32</b>	<b>46</b>			
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
Critical Care	Ward 15 (COVID positive L1 & 2)	26	0	26		
	Ward 16 (Non Covid L1&2)	0	28	28		
	ICU	17	0	17		
	PACU	0	9	9		
<b>TOTAL Capacity</b>	<b>17</b>	<b>10</b>	<b>26</b>			
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
Independent Sector	Ramsay IS	0	24	24		
	Nuffield IS	0	24	24		
	<b>TOTAL Capacity</b>	<b>0</b>	<b>48</b>	<b>48</b>		
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
Out of Hospital YFT	Selby		26	26		
	White XC		24	24		
	St Monicas		14	14		
	St Helens		32	32		
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
Out of Hospital Humber	Humber	0	0	0		
<b>TOTAL Capacity</b>	<b>0</b>	<b>96</b>	<b>70</b>			

Scarborough Hospital							
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL			
Emergency Department	First Assessment (Graham)	0	1	1			
	Main Floor (Graham)	0	6	6			
	Resus	5	2	7			
	EAU (SDEC & HFU)	0	0	0			
	UTC	0	5	5			
	<b>TOTAL Capacity</b>	<b>31</b>	<b>0</b>	<b>31</b>			
Adult Inpatient	Resp Assessment Zone	31	0	31			
	<b>TOTAL Capacity</b>	<b>36</b>	<b>14</b>	<b>50</b>			
	Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
	Lilac (Admission - await swab)	Lilac (Admission - await swab)	32	0	32		
		Aspen (Swab Positive)	6	0	6		
		Holly (Swab positive)	20	0	20		
		Ash (Swab Positive)	16	0	16		
		Beech (Flex Yellow/Blue)	15	15	30		
		Haldane (Day Surgery)	0	6	6		
		Anne Wright	0	7	7		
		Cherry (Swab positive)	28	0	28		
		Oak	0	33	33		
		Maple	0	28	28		
		Chestnut (Swab Positive)	28	0	28		
		Stroke	0	15	15		
		CCU	0	20	20		
		<b>TOTAL Capacity</b>	<b>145</b>	<b>124</b>	<b>300</b>		
		Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL	
		Duke of Kent	Duke of Kent	14	0	14	
			CAU Assessment Space	0	2	2	
	<b>TOTAL Capacity</b>	<b>14</b>	<b>2</b>	<b>16</b>			
	Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
	Maternity, Obstetrics & Gynaecology	Labour Ward	2	2	4		
		Hawthorn	0	14	14		
		Maternity theatre	0	1	1		
		<b>TOTAL Capacity</b>	<b>2</b>	<b>17</b>	<b>19</b>		
	Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL		
	Critical Care	ICU	3	6	9		
PACU		0	0	0			
<b>TOTAL Capacity</b>		<b>3</b>	<b>6</b>	<b>9</b>			
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL			
Critical Care	ICU	6	0	6			
	PACU	0	6	6			
	<b>TOTAL Capacity</b>	<b>6</b>	<b>10</b>	<b>12</b>			
Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL			
Bridlington	Johnson	0	28	28			

Total Capacity S3 - YORK	
Total Hot Beds at S3	Total Cold Beds at S3
309	256

Total Capacity S3 - SGH	
Total Hot Beds at S3	Total Cold Beds at S3
170	159

Excluding ED and Out of Hospital

\*the theatres could be used to have a mix of hot and cold patients within the theatres complex as need requires within this surge.

NB: Only Ward 15 and Lilac can accommodate NIV patients

NB: Adult IP ward sat York show the max beds in bays that can be accommodated - they may not reach this max capacity during S3

York staffing model

Ward	Type of ward	Beds	Long Day	Night	RN	HCA wte
15	Level 2	20	6+4	5+4	32	22.8
25	Suspected Covid	21	4+4	3+4	20.5	22.8
26	Suspected Covid	25	4+4	3+4	20.5	26.2
27	Assessment area	-	1+1	closed	11.4	11.4
28	Positive Covid area	30	4+5	3+4	20.5	26.2
29	Positive Covid area	23	4+4	3+4	20.5	22.8
32	Negative Covid area	25	4+4	2+4	20.5	26.2
34	Negative Covid area	25	4+4	2+4	20.5	26.2
35	Suspected Covid	25	4+4	2+4	20.5	26.2
36	Negative Covid area	19	3+3	2+3	14.8	17.2
37	Negative Covid area	19	3+3	2+3	14.8	17.2
39	Positive Covid area	19	3+3	3+3	17.1	17.1

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

Level S3 (Super Surge) - YORK Hospital Decision Support Tool & Action Card Guidance			
<b>Notes</b>			
At Level S1 a decision has been made by the Pandemic Operational Group to stand up an identified COVID assessment, suspected and confirmed ward area. This area will be multi speciality and provide the immediate response in relation to the COVID surge plan.			
<b>Ward Areas and Departments Identified</b>			
Those areas are identified as follows: (ward function will be allocated on opening the ward, either as admissions for suspected cases or confirmed positive ward). Admissions should be managed in isolation to prevent the need for contact wards to be implemented, this may not be possible at S3 - Ward 25 - Adult COVID Suspected patients (9 beds) - Ward 29 - Adult COVID Confirmed patients (19 beds) - Ward 28 - Adult COVID (25 beds) - Ward 26 - Adult COVID (25 beds) - Ward 35 - Adult COVID (25 beds) - Ward 36 - Adult COVID (21 Beds) - Ward 39 - Adult COVID (21 beds) - Ward 37 - Adult COVID (18 beds) - Ward 32 - Adult COVID (23 beds) - Ward 34 - Adult COVID (25 beds) - Ward 33 - Adult COVID (25 beds) - Ward 15 Adult Level 1 / 2 Patients (20 beds) - Ward 17 - Paediatric COVID Confirmed patients (24) - Ward 18 - Paediatric COVID Suspected Patients (19 beds) - Labour Ward - Suspected / Confirmed labouring, antenatal or postnatal women (2 rooms) - G3 - Postnatal / Antenatal confirmed or suspected patients (11 beds) - ICU - COVID Confirmed (32 beds) Please refer to Trust COVID SOP for the steps to be taken to mobilise the above areas.			
<b>Impact on Services</b>			
Routine Elective Surgical Care Urgent Elective Surgical Care SDEC Outpatients Diagnostics (Endoscopy, Radiology, Lab Med)			
<b>Impact on Workforce</b>			
AHP: continued as per management in S2 Nursing: staff redeployment to be continued, ward nursing teams will be reviewed and individuals allocated to ensure specialist care can be provided appropriately continued from S2 Medical: tiered rotas according to demand to be used. JC/GR owners for adult COVID			
<b>Governance</b>			
At Level S3 It is required that a number of existing and new groups are 'stood up' in order to support decision making relating to the surge management plan and ongoing capacity planning and response.  The Site Daily Operational Meeting will continue to lead the management of the surge plan and will assess and escalate the need to consider			
<b>Triggers, Escalation and Decision Making</b>			
The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan. If any of the below triggers are met a decision will then be required to implement the next phase of the surge plan, which is the full hospital plan. That decision will be made by the following:  Decision to escalate into next phase of the plan (In Hours) - <b>BRONZE Command</b> - Within the relevant Care Group Within the relevant Care Group, where appropriate with silver command endorsement. Decision to escalate into next phase of the plan (Out of Hours) - <b>SILVER Command</b> - on call manager			
Area	Trigger	Decision Made by (In hours)	Decision Made by (Out of hours)
Emergency Department	N/A	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Adult inpatient - Suspected	at 9 patients, full capacity on ward 25 and additional suspected wards, an increase should be made to 2 patients in a bay and progression made to opening the next suspected ward as per S3 until all S3 wards are occupied. Then progression to full hospital Any covid contacts created as a result of 2 patients in a bay will need to be isolated for 14 days.	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Adult inpatient - confirmed	< 4 beds available on ward 29 and additional positive wards, progression made to opening the next positive ward as per S3 until all S3 wards are occupied. Then progression to full hospital	CG Bronze Command <b>Gemma Ellison</b>	Site Silver Command in discussion with Consultant on-call
Paediatrics	>5 transfers in 24 hours from SGH or >2 cubicles remaining at York	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
Maternity	> 2 Women requiring 'Hot' Area in a single 24 hour period	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call
Critical Care	2 or fewer ICU beds available across both sites	CG Bronze Command and Critical Care Consultant <b>Uz Hill</b>	Site Silver Command in discussion with Critical Care Consultant





## Level S3 (Super Surge) - SCARBOROUGH Hospital

### Decision Support Tool & Action Card Guidance

#### Notes

At Level S1 a decision has been made by the Pandemic Operational Group to stand up an identified COVID assessment, suspected and confirmed ward area. This area will be multi speciality and provide the immediate response in relation to the COVID surge plan.

#### Ward Areas and Departments Identified

Those areas are identified as follows:

##### ED/Front Door:

- HOT ED: Convert all the front door area into HOT ED (5 RESUS trollies / 19 majors trollies/ 12 side rooms).
- COLD ED: 1st Assessment (5 trollies), COLD Resus (3 trollies), COLD ED majors (ex SDEC) (5 trollies / 10 chairs).
- COLD AMU: GRAHAM ward (10 trollies / 2 side rooms).

##### IN-PATIENT AREAS:

- LILAC Ward: Adult COVID High Acuity suspected patients & CPAP (20 beds; can surge to 32 if not cohorting).
- ASH Ward: Adult COVID Lower Acuity suspected patients (12 beds).
- ASPEN Ward: Adult negative COVID step down (following swab) but high suspicion of COVID (6 beds).
- HOLLY Ward: Adult negative COVID step down (following swab) but lower suspicion of COVID (20 beds).
- MAPLE Ward: Adult COVID Confirmed patients (28 beds).
- BEECH Ward: Adult COVID Confirmed patients (32 beds).
- HALDENE Ward: Adult COVID Confirmed patients / ?palliative (11 beds).
- ANNE WRIGHT Ward: Adult COVID Confirmed patients / ?palliative (17 beds)
- Duke of Kent Ward - Paediatric COVID Confirmed / Suspected (14 beds)
- Labour Ward: Suspected / Confirmed labouring, antenatal or postnatal women (2 beds)
- ICU - COVID confirmed Patients (9 beds)

Please refer to Trust COVID SOP for the steps to be taken to mobilise the above areas.

#### Impact on Services

Routine Elective Surgical Care  
 Urgent Elective Surgical Care  
 SDEC  
 Outpatients  
 Diagnostics (Endoscopy, Radiology, Lab Med)

#### Governance

At Level S1 it is required that a number of existing and new groups are 'stood up' in order to support decision making relating to the surge management plan and ongoing capacity planning and response.

#### Triggers, Escalation and Decision Making




The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan.


If any of the below triggers are met a decision will then be required to implement the next phase of the surge plan. That decision will be made by the following:



Decision to escalate into next phase of the plan (in Hours) - **BRONZE Command** - Within the relevant Care Group Within the relevant Care Group, where appropriate with silver command endorsement.

Area	Trigger	Decision Made by (In hours)	Decision Made by (Out of hours)
Emergency Department	N/A	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call & gold command
Adult Inpatient - Suspected	When LILAC side rooms full, cohort patients into bays to use full 32 beds.	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call & gold command
Adult Inpatient - confirmed	Expand confirmed cases to CHERRY & CHESNUT	CG Bronze Command <b>David Thomas</b>	Site Silver Command in discussion with Consultant on-call & gold command
Paediatrics	>2 transfers in 24 hours from SGH or >2 cubicles remaining at York	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call & gold command
Maternity	> 2 Women requiring 'Hot' Area in a single 24 hour period	CG Bronze Command <b>Jamie Todd</b>	Site Silver Command in discussion with Consultant on-call & gold command
Critical Care	2 or fewer ICU beds available across both sites	CG Bronze Command and Critical Care Consultant <b>Liz Hill</b>	Site Silver Command in discussion with Critical Care Consultant & Gold

### Appendix 3 – EU Exit Readiness Assessment Action Plan






Nationally Identified Risk		Nationally Required Action	Responsible Officer	Local Task	Evidence	Target Completion Date	September 2020 Review Comments	Current Status	
1. Supply of medicines and vaccines	1.1	Follow the Secretary of State's message not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the continued supply of medicines and vaccines from the moment we leave the EU is being developed alongside pharmaceutical companies and other government departments.	D Pitkin	Confirm with procurement team that they are clear on the importance of not stockpiling and they are acting accordingly.  Issue statement attached to joint Trust/CCG formulary emphasising need for clinicians to adhere to OP prescribing policy	Confirmatory email from procurement lead(s).  <b>1.1 (1) - RE No deal Brexit.msg</b>  Statement included on front page of web-formulary.  <b>1.1 (2) - Formulary News Feed Screensh</b>	✓ 31 Jan 19	As previous  Formulary guidance to be reviewed and re-issued. (Oct 2020)	Yellow	
	1.2	Note that there is no need to contact suppliers of medicines directly.	D Pitkin	Noted		✓ 31 Jan 19	As previous		Green
	1.3	Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.	D Pitkin	Link with Lloyds OP and staff and ward based clinical staff to undertake briefing with individual patients likely to encounter supply chain issues.	Information card designed to hand to patients at inpatient counselling and through Lloyds. This will commence 21 <sup>st</sup> Jan. Lloyds and IP pharmacy to display notice on counter.  <b>1.3 - No deal Brexit (Pt Info Card).docx</b>	✓ 31 Jan 19	As previous		
	1.4	Note that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.	D Pitkin	Noted		✓ 31 Jan 19	As previous		

	1.5	Note that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.	D Pitkin	Noted		✓ 31 Jan 19	As previous	
	1.6	Be aware that UK-wide contingency plans for medicines supply are kept under review, and the Department will communicate further guidance as and when necessary.	D Pitkin	Noted		✓ 31 Jan 19	As previous	
	1.7	Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.	D Pitkin	Utilising existing reporting mechanism through regional procurement in Leeds.	Ordering patterns are audited via DEFINE and local commercial procurement collaborative. Any spikes in ordering activity to be challenged.	✓ 31 Jan 19	As previous	
	1.8	Regional pharmacists and emergency planning staff to:  Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.	D Pitkin	There is a regional procurement system now in place that provides NHS England with real time visibility of NHS Organisations Pharmacy holdings. This will allow regional redistribution to take place should it be required.		✓ 22 Sept 19	As previous	
2. Supply of medical devices and clinical consumables	2.1	Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance by the end of January 2019.	I Willis	Noted. No stock pile action commenced	 2.1 - RE DHSC Trust's preparedness	✓ 31 Jan 19	As previous	
	2.2	Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.	I Willis	We have a Partnership Programme with NHSSC where we regularly communicate with the account management (Martin Hale & Andrew Ward). No queries identified to date.  In relation to other suppliers, usual communication channels are in place. No queries identified to date.	We are already engaged with NHSSC and have addressed Brexit No Deal (BND) with our other high volume suppliers  BND statements for key suppliers and copies of contingency received.	✓ 31 Jan 19	As previous	

	2.3	Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.	I Willis	We will remain aware and ready to receive further guidance.	NA	✓ 31 Jan 19	Will need review following Gov actions taken in relation to Covid 19 (i.e. PUSH)	
	2.4	Send queries regarding medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.	I Willis	We have done this already and received a reply. We will continue to use this useful support if needed.	 2.4 - RE NHS Self-Assessment Que	✓ 31 Jan 19	As previous	
3. Supply of non-clinical consumables , goods and services	3.1	All providers to:  Be aware that NHS Trust and Foundation Trust procurement leads have been asked to undertake internal reviews of purchased goods and services to understand any risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously.	I Willis	We have completed and returned the Gov'ts requested EU Exit NHS Trusts Contract Review Self-Assessment Methodology.  Additionally we have received BND statements for key suppliers and copies of their overall contingency plans..	 3.1 Link3.xlsx	✓ 31 Jan 19	As previous	
	3.2	Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.	I Willis	As part of continued commercial preparation for EU Exit we are working with NHSSC to identify directly bought items and including them as part of a demand capture process. The process is in draft (spreadsheet) and planned to be completed by 25 <sup>th</sup> January		✓ 31 Jan 19	As previous	
	3.3	Continue to update local business continuity plans to ensure continuity of supply in a 'no deal' scenario. Where appropriate, these plans should be developed in conjunction with your Local Health Resilience Partnership. All health organisations should be engaged in their relevant Local Health Resilience Partnership, which should inform Local Resilience Forum(s) of local EU Exit plans for health and care.	I Willis	Contingency 'Action Cards' have been created. Additionally we are assessing alternatives to the Trust's top 100 via NHSSC.  See actions under 12.1 in relation to LHRP and LRH.	Work in progress	✓ 31 Jan 19	As previous	
	3.4	Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care.	I Willis	We are aware of the DHSC EU Exit NHS Trusts Contract Review.	N/a	✓ 31 Jan 19	As previous	

	3.5	Await further advice from the Department on what actions should be taken locally.	I Willis	We will remain ready to receive further advice.	N/a	✓ 31 Jan 19	As previous
	3.6	NHS Trusts and Foundation Trusts to:  Submit the results of their self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk, if not done so already.	I Willis	We have completed and returned and returned the Govt's requested EU Exit NHS Trusts Contract Review Self-Assessment Methodology.	Copy of document at 3.1	✓ 31 Jan 19	As previous
	3.7	Act upon further guidance to be issued by the Department in January 2019. This will be based on analysis of NHS Trusts and Foundation Trusts' self-assessments.	I Willis	We will remain aware and ready to receive further guidance.	NA	✓ 31 Jan 19	As previous
4. Workforce	4.1	Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.	P McMeekin	Undertake a comparison of the number of EU staff as a % of the workforce as at 1 <sup>st</sup> July 2016 and 1 <sup>st</sup> January 2019.	1 <sup>st</sup> July 2016 269 EU national staff employed at the Trust, this was 2.95% of the total workforce. 1 <sup>st</sup> January 2019 333 EU nationals employed by the Trust which is 3.36% of the total workforce. Therefore we haven't so far incurred a reduction in EU nationals in our workforce.	✓ 31 Jan 19	August 2020: 343 EU nationals employed by the Trust which is 3.22% of the total workforce. Therefore we haven't so far incurred a reduction in EU nationals in our workforce the percentage has slightly decreased however.
	4.2	Publicise the EU Settlement Scheme to your health and care staff who are EU citizens. The scheme will open fully by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register. Further information can be viewed here.	P McMeekin	EU National Settlement Scheme charge has now been scrapped and therefore there is no method of tracking staff up take. Publicity of the scheme continues through social media and CAB stands in staff restaurants.		✓ 22 Sept 19	Publication of the scheme has taken place however further publicity of the scheme shall be undertaken in the run up to December.
	4.3	Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with your Local Health Resilience Partnership, feed into	P McMeekin	Will continue to monitor and report to the Board on developments. As it stands there is little workforce impact to further mitigate against.	.	✓ 31 Jan 19	As before

		your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the impact that would have on your organisation.					
	4.4	Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.	P McMeekin	Will continue to monitor and report to the Board on developments. As it stands there is little workforce impact to further mitigate against.		✓ 31 Jan 19	As before
	4.5	Ensure your board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.	P McMeekin	A number of work streams underway to mitigate the impact. These include the East Coast Recruitment project and international nurse recruitment project.  Business continuity plans are in place & have been table top tested.		✓ 31 Jan 19	As before
	4.6	Notify your local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.	P McMeekin	There is risk due to the NHS training insufficient numbers of clinical staff but this is not related to Brexit.	Noted	✓ 31 Jan 19	As before
	4.7	Escalate concerns through existing reporting mechanisms.	P McMeekin	Noted		✓ 31 Jan 19	As before
	4.8	Send queries on workforce to WorkforceEUExit@dhsc.gov.uk.	P McMeekin	Noted		✓ 31 Jan 19	As before
5. Professional regulation (recognition of professional qualifications)	5.1	Inform your staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.	P McMeekin	Added to Staff Bulletin (11 <sup>th</sup> Jan) and include as a payslip message in January.	As below.	✓ 31 Jan 19	Complete
	5.2	Inform your staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.	P McMeekin	Add to Staff Bulletin and include as a payslip message.	Message re prof quals going out on January payslips (evidence - email request attached, will attach copy of template payslip when end of month)	✓ 31 Jan 19	As before




					 <b>5.2 (1) - FW Key messages re Brexit n</b>			
					 <b>5.2(2)-FW Key messages re Brexit &amp;</b> Message re prof quals went out in Staff Bulletin (11 Jan)			
					 <b>5.2(3)-REKey messages re Brexit n</b>			
					 <b>5.2(4)STAFF BULLETIN Issue 2 Ft</b>			
	<b>5.3</b>	Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.	P McMeekin	No action required until instructed.	In addition to the EU national numbers above we currently have three members of staff from the EEA. One Norwegian and two Swiss.	✓ 31 Jan 19	As before	
<b>6. Reciprocal healthcare</b>	<b>6.1</b>	All providers to:  Note that, in a no deal scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.	S Kitching	To ensure the overseas visitor's team are made aware of the action.	The action plan has been sent to the Overseas Visitors Manager for information and action.   <b>6.1-6.7-FW Trust's Brexit No Deal Group</b>	✓ 31 Jan 19	No further updates have been received	
	<b>6.2</b>	Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).	S Kitching	To ensure the overseas visitor's team are made aware of the action.	The action plan has been sent to the Overseas Visitors Manager for information and action.	✓ 31 Jan 19	No further updates have been received	

6.3	Note that the Department will provide updates and further information on reciprocal healthcare arrangements prior to 29 March 2019.	S Kitching	Noted	The action plan has been sent to the Overseas Visitors Manager for information and action.	✓ 31 Jan 19	No further updates have been received	
6.4	NHS Trusts and Foundation Trusts to:  Maintain a strong focus on correctly charging those who should be charged directly for NHS care. Information on implementing the current charging regulations can be viewed on the webpage here.	S Kitching	To ensure the overseas visitor's team are made aware of the action.	The action plan has been sent to the Overseas Visitors Manager for information and action.	✓ 31 Jan 19	No further updates have been received	
6.5	Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.	S Kitching	This action is noted. The overseas visitor's team have been made aware, on-going training forms part of the team's normal duties.	The action plan has been sent to the Overseas Visitors Manager for information and action.	✓ 31 Jan 19	No further updates have been received	
6.6	Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.	S Kitching	Noted	The action plan has been sent to the Overseas Visitors Manager for information and action.	✓ 31 Jan 19	No further updates have been received	
6.7	GP practices to:  Promote completion of the supplementary questions section of the GMS1 form, and then, as appropriate, send the form to NHS Digital (NHSDigital-EHIC@nhs.net) or the Department for Work and Pensions' Overseas Healthcare Team (overseas.healthcare@dwp.gsi.gov.uk). The response on a person's non-UK EHIC/S1 helps the Department seek reimbursements from EU member states for those who are covered by the reciprocal healthcare arrangements. More information on the GMS1 form can be found here. Further information for primary care staff on providing	S Kitching	This is a primary care action and is noted.	The action plan has been sent to the Overseas Visitors Manager for information and action.	✓ 31 Jan 19	Awaiting revised Primary Care Action plan	



		healthcare for overseas visitors from the EU/EEA can be found here.						
7. Research and clinical trials – EU research and innovation funding schemes	7.1	Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after exit, until the end of 2020.	L Harris	N/A we don't hold any EU funded projects or contribute to any	N/a	✓ 31 Jan 19	As before	
	7.2	Provide information about your Horizon 2020 grant here. This should be actioned as soon as possible. Further guidance can be found here and all queries should be sent to EUGrantsFunding@ukri.org.	L Harris	N/A we don't hold any 20/20 projects or contribute to any	N/a	✓ 31 Jan 19	As before	
	7.3	Contact officials at EU-Health-Programme@dhs.gov.uk with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.	L Harris	N/A we don't hold any Third Health Programme grant or contribute to any	N/a	✓ 31 Jan 19	As before	
8. Research and clinical trials – clinical trials and clinical investigations	8.1	Follow the Government's guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario, if you sponsor or lead clinical trials or clinical investigations in the UK.	L Harris	We only sponsor a very small amount of trials and will adhere to government guidance in a no deal scenario	N/a	✓ 31 Jan 19	As before	



8.2	Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.	L Harris	We only sponsor a very small amount of trials and have liaised with all sites accordingly and are liaising with suppliers of IMP already. There are currently no areas of concern and the trials will remain open and contingency plans have been put into place.	SEE BELOW	✓ 31 Jan 19	All sponsors and suppliers information remains the same and no further updates have been given regarding any delays in supplying clinical trial medication.	
8.3	Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.	L Harris	We have reviewed all studies open, in set up and in follow up to identify any trials where supply of consumables or sample processing will come from, or via, the EU or EEA . We have then contacted all sponsors of such studies and received positive responses from most of them. The trials will remain open and contingency plans have been put into place by suppliers.	 <b>8.3 (2) List 2 - Non CTIMP OPEN 15_01 ;</b>  <b>8.3 (3) list 3 Non CTIMP IN FOLLOW 1!</b>  Updated August 20 ctim	✓ 31 Jan 19	As Before	
8.4	Respond to any enquires to support the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.	L Harris	We will respond to any enquires to support the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations.	N/a	✓ 31 Jan 19	As before	
8.5	Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.	L Harris	All our clinical trials will remain open and contingency plans have been put into place by suppliers, we do not foresee any issues.	N/a	✓ 31 Jan 19	As before	
8.6	Send queries concerning IMPs or medical devices to <a href="mailto:imp@dhsc.gov.uk">imp@dhsc.gov.uk</a>	L Harris	Noted we will send all queries concerning IMPs or medical devices to <a href="mailto:imp@dhsc.gov.uk">imp@dhsc.gov.uk</a>	N/a	✓ 31 Jan 19	As before	





9. Data sharing, processing and access	9.1	Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.	F Jamieson	We will have completed an annual programme of the mapping of information flows by the end of January 2019. This will identify any flows outside of the UK. SNS also looking at any of our IT providers who might hold information on servers held in the EU.	Flow Maps	✓ 31 Jan 19	Flow maps were updated during 2019/2020 with a plan to complete the refresh by the end of December 2020.	
	9.2	Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.	F Jamieson	Noted		✓ 31 Jan 19	Noted.	
	9.3	Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on gov.uk and on the ICO website, in particular to determine where to use and how to implement standard contractual clauses.	F Jamieson	The ICO have provided 6 steps that need to be considered, the IG Team are currently looking at these to determine what actions we might need to take for any information flows that will potentially go into the EU. Update. We have identified through information flow mapping that there are some flows into the EU for example private patients, xfer of information to insurance companies. Health Navigator is held on servers in the EU but holds anonymised data only. We await national guidance on any further required actions.	Flow maps and establishment of international flows of information	✓ 31 Jan 19	Flow maps and establishment of international flows of information to be refreshed by the end of 2020	
	9.4	Ensure that your data and digital assets are adequately protected by completing your annual Data Security and Protection Toolkit assessment. This self-audit of compliance with the 10 Data Security Standards is mandatory to complete by the end of March 2019, but completing it early will enable health and adult social care providers to more quickly identify and address any vulnerabilities.	F Jamieson	The organisation has already submitted its mid-year assessment. An action plan is in place to deliver requirements by the end of year upload on 31 March 2018.	DSP Toolkit interim submission	✓ 31 Jan 19	DSP Toolkit submission to be made by 30/9/2020 with accompanying action plans	
	9.5	Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.	F Jamieson	Noted.		✓ 31 Jan 19	Noted.	


## Additional Risks

Area		Required Action	Responsible Officer	Local Task	Evidence	Target Completion Date	September 2020 Review Comments	Current Status
10. National	10.1	Consider the potential for increases in demand associated with the wider impacts of a non-deal exit.	A Bertram	Discussed at Brexit No Deal Group on 4 & 23 January 2019. No issues identified or additional tasks necessary but group agreed to keep under review pending further information releases.  Any significant short term demand increases would be managed under the Trusts OPEL scoring process & Major Incident Response Plan. This has been both table top tested & tested under the LIVEX initiative.		✓ 31 Jan 19	Latest position reviewed at Sept 20 meeting.  Any significant short term demand increases would be managed under the Trusts OPEL scoring process & Major Incident Response Plan. This has been both table top tested & tested under the LIVEX initiative.	
11. Local	11.1	Identify any local specific risks resulting from a no deal exit.	A Bertram	Brexit No Deal Group to discuss any local issues. None identified at 4 & 23 January 2019 meeting outside of the Trust's existing business continuity scenario plans.		✓ 31 Jan 19	Latest position reviewed at Sept 20 meeting.	

## Additional Actions

Action Area		Nationally Required Action	Responsible Officer	Local Task	Evidence	Target Completion Date	September 2020 Review Comments	Current Status
12. Business Continuity	12.1	Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.	R Chadwick	System EU No Deal Group, led by CCGs being established. MH to be member.  Business continuity plans are in place across the organisation for a number of standard scenarios. Four core BC cards have been created covering specific scenarios; see 13.1  Plans have been tested in line with Trust procedures for	System meeting minutes.  Organisational BC Action Cards (see 13.1)	✓ 31 Jan 19	EU Exit planning incorporated into Winter Resilience Plan and measures for end of transition period to be managed by SILVER Command on a routine basis. SRO has convened monthly separate EU Exit planning group.  As per 31 Jan 19	

				Business Continuity. In addition the LHRP February meeting is being extended to run the LRF Exercise for Health partners. This will enable organisations not only to take part in an EU-Exit specific table-top, but also to identify some of the next steps in preparing for worse case scenarios. The Trust is already an active member of this group.			comments.  As per 31 Jan 19 comments.	
13. Business Continuity	13.1	Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.	R Chadwick	<p>Risk Assessment Scenarios are:</p> <ol style="list-style-type: none"> <li>1. Increased demand</li> <li>2. Supply of medicine &amp; vaccines</li> <li>3. Supply of medical devices &amp; consumables</li> <li>4. Supply of non-clinical consumables</li> <li>5. Workforce</li> </ol> <p>Four core BC cards have been drafted covering the following scenarios:</p> <ul style="list-style-type: none"> <li>- Supply of medical devices</li> <li>- Pharmacy SOP Communicating supply problems</li> <li>- Pharmacy SOP Outstanding orders</li> <li>- Supply of non-clinical consumables</li> </ul>	<ol style="list-style-type: none"> <li>1. Increased demand – discussed at Trust Brexit No Deal Group; contingency arrangements are in place; Winter Plan &amp; Full Capacity protocol. Regular occurrence in acute care; BC Plans: Fit for purpose.</li> <li>2. Action card developed.</li> <li>3. Pharmacy SOPs in place.</li> <li>4. Action card developed.</li> <li>5. Plans in place – staffing issues very unlikely to affect the Trust on the 30<sup>th</sup> March. See HR section.</li> </ol> <div style="text-align: center;">                   20200908 Supply of medical devices &amp; cor             </div> <div style="text-align: center;">                   Adobe Acrobat Document             </div> <div style="text-align: center;">                   Adobe Acrobat Document             </div> <div style="text-align: center;">                   20200908 Supply of non-clinical consumab             </div>	✓ 31 Jan 19	BC Action Cards with Pharmacy and Procurement have been revised.	

14. Communicati on and escalation	14.1	All providers to:  Ensure your board is sighted on EU Exit preparation.	A Bertram	Action plan to be prepared and presented to January 2019 Board of Directors meeting.	Board paper	✓ 31 Jan 19	Board of Directors updated at 30 Sep 20 board meeting.	
	14.2	Take steps to raise awareness amongst staff.	L Brown	Updates via weekly all staff email from 18 January 2019.  Chief Executive's Team Brief – 31 January & 1 February 2019.	 <b>14.2 - STAFF BULLETIN Issue 3</b>	✓ 31 Jan 19	Comms plan to be prepared	
	14.3	Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.	R Chadwick	System wide groups have been set up comprising representatives from all partner organisations including the organisations who attend Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards;  <ul style="list-style-type: none"> <li>• EU Exit - No-Deal preparations (organised by City of York Council) – 7 January 2019. Finance Director attended from the Trust.</li> <li>• Health &amp; Social Care EU Exit No Deal preparations (organised by Scarborough &amp; Ryedale CCG) – Date TBC. Deputy Chief Operating Officer attending from the Trust.</li> <li>• Local Health Resilience Health Partnership is having a dedicated meeting to consider a range of scenarios. - 5 February 2019. Deputy Chief Operating Officer attending from the Trust.</li> </ul>		✓ 31 Jan 19	Covid-19 Regional Incident Coordination Centre still stood up and likely to be the Regional Coordinating Authority for all Winter Resilience issues including EU Exit. Regional Head of Emergency Preparedness Resilience and Response confirms that further planning detail is awaited and will include a series of planning events. RC to coordinate once known.	
	14.4	Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.	R Chadwick	Completed. Director on-call the weekend of the 29 <sup>th</sup> March is Director of Estates & Facilities, supported by Head of Strategy and Head of Nursing at other sites.	Incident Response Plan Annex A – Command and Control	✓ 31 Jan 19	Once details are known then appropriate end of year On Call cover will be coordinated and briefed through SILVER Command meetings.	

14.5	Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.	R Chadwick	Email address established: <a href="mailto:eu.exit@york.nhs.uk">eu.exit@york.nhs.uk</a>			✓ 31 Jan 19	Shared inbox retitled to <a href="mailto:emergency.planning.YTHFT@York.nhs.uk">emergency.planning.YTHFT@York.nhs.uk</a> in line with Winter Resilience Plan.	
14.6	NHS providers to:  Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document.	R Chadwick	Email address established. SRO established and regional teams also have details for the Trust lead for Emergency Planning.	Trust Incident Response Plan. Annex A – Command & Control		✓ 31 Jan 19	As above	
14.7	Note your nominated regional NHS lead for EU Exit and their contact details (included in the overview on page 5).	L Brown	Contact details noted.	<a href="mailto:England.euexitnortheast@nhs.net">England.euexitnortheast@nhs.net</a>		✓ 31 Jan 19	As before	
14.8	Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.	L Brown/ R Chadwick	Discussed at our Brexit No Deal Group on 4 & 23 January 2019. Issues will be identified through the escalation routes set out in our business continuity plans. A single point of contact has been set up (see item 14.5) for staff to escalate issues which will then be escalated to the regional EU exit team if appropriate.	Trust Incident Response Plan		✓ 31 Jan 19	<u>Intended escalation is: Dept to SILVER to GOLD (SRO) and then to Regional Incident Coordination Centre .</u>	
14.9	Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.	A Bertram	Confirmation provided from A Bertram as SRO			✓ 31 Jan 19	Confirmation of no change to SRO role. Remains Andrew Bertram.	

15. Reporting, assurance and information	15.1	Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.	A Bertram	Contact details for A Bertram provided to NHSE		✓ 31 Jan 19	No change. Details provided.	
	15.2	Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions	A Bertram	Contact details for A Bertram provided to NHSE		✓ 31 Jan 19	No change.	
	15.3	For queries relating to specific topic areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox	A Bertram	A Bertram identified as lead and contact details shared with NHSE		✓ 31 Jan 19	No change.	
16. Finance	16.1	Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.	A Bertram	A Bertram to record any material costs associated with no deal preparations. To be managed through the Brexit No Deal Group.		✓ 31 Jan 19	Noted. Recording of any material costs will be actioned by Andrew Bertram.	





## Appendix 4 – Investment Summary Winter Resilience Plan 2020-2021

Historically the challenges of recruiting to schemes that only endures for 4-6 months has resulted in only 80% of allocated funding being expended. The Winter Resilience Plan has therefore allocated a control of £1.25M in the expectation that £1M will be expended. The summary of schemes is:

### Winter Resilience Plan Schemes

Care Group	Category	Scheme Detail	Summary	CG Lead 2020-21	FY 20-21 (Dec - Mar)	FY 21-22 (Apr +)	Total	Expected Impact of Scheme	Measure of Success
1	Repeat	CRT - staffing	Staffing - AHP	Laura Robson	150,000	50,000	200,000	Continue to provide additional capacity to support delivery of the national standard of all rehabilitation discharges commencing within 48hrs of referral (local ambition remains for same day discharge - or next day for later referrals), maintaining capacity for admission avoidance and continued ambulance diversionary pathways.	Waiting time data for starting CRT; activity data (referrals/contacts)
1	New	ED - SDEC access to resp hot clinic	Staffing - Doctor	Amy Worsfold	8,142	0	8,142	To reduce admissions for respiratory conditions	0 LOS for respiratory
1	New	ED - FY3 /CT ED jnr doc additional evening shifts	Staffing - Doctor	Amy Worsfold	26,318	13,159	39,477	To ensure the increased numbers of patients attending ED will be seen in a timely manner	Time to see a doctor in ED
1	Repeat	Additional overnight acute floor doctors - York	Staffing - Doctor	Gemma Ellison	167,400	41,040	208,440	To ensure all patients are seen and clerked in a timely manner to avoid delays to patients care	Clerking times
1	Repeat	Outlier medical cover - York	Staffing - Doctor	Gemma Ellison	38,000	0	38,000	To ensure outlying patients receive adequate and timely care	Outlier LOS
1	New	ED - Senior streamer at front door (10 hours - 7 days a week)	Staffing - Nursing	Amy Worsfold	33,620	16,810	50,430	To ensure the increased numbers of patients attending ED will be seen in a timely manner	Time to streaming, number of patients streamed away from the dept
1	New	ED - Ambulance handover senior nurse (Band6) (10 hours - 7 days a week)	Staffing - Nursing	Emma George	33,620	16,810	50,430		
1	New	Extra Physio fro Pulmonary rehab and resp out patients	Staffing - AHP	Sally Ann Richardson	48,636	0	48,636	To provide capacity for additional winter demand	Reduced admissions for respiratory patients
2	Repeat	Additional Middle Grade to support weekend discharge 12 hours per day (0800-2000 Sat and Sun)	Staffing - Doctor	David Thomas	22,400	11,200	33,600		
2	Repeat	ED - Ambulance handover senior nurse (Band6) (10 hours - 7 days a week)	Staffing - Nursing	David Thomas	33,620	16,810	50,430		
3	New	York Site (3 WTE B6 -6 months: Surgery: OT + Physio and Critical Care: Physio). Scarb Site 1 wte Band 5 OT - 6 months	Staffing - AHP	Liz Hill	78,934	0	78,934	Increased therapy support for the wards will help ensure that there are no delays to discharge. Increased therapy support for critical care is required to manage the increased demand for critical care over the winter period.	Length of stay for surgical inpatient wards.
4	New	Extending the dispensary opening times at Scarborough into the evening (8.00pm) and at weekends (4.00pm)	Staffing - AHP	David Pitkin	20,666	0	20,666	Improved flow as discharges can be supported later in the day by the pharmacy team so support increasing bed capacity at SGH	Number of discharges during extended period

5	Repeat	SGH CAU - 2200 (1 x B6 and 1 x B3)	Staffing - Nursing	Jamie Todd	42,662	14,221	56,883	To provide additional capacity and maintain flow from ED	Time to admit / transfer from ED
5	New	Opening CAU at YTH 24/7 (cover the gap between 0000-0800)	Staffing - Nursing	Jamie Todd	35,000	14,221	49,221	To provide additional capacity and maintain flow from ED	Time to admit / transfer from ED
5	New	Additional Paediatric Registrar overnight (YTH)	Staffing - Doctor	Jamie Todd	42,662	14,221	56,883	To provide additional capacity and maintain flow from ED	Time to admit / transfer from ED
5	New	Locum O&G Cons to support Entrustable Emergency Cover (YTH)	Staffing - Doctor	Jamie Todd	60,000	20,000	80,000	To provide Entrustable emergency cover due to forecast demand	Admission rates for gynaecology acute presentations
5	New	Locum O&G Middle Grade to support Entrustable Emergency Cover (YTH)	Staffing - Doctor	Jamie Todd	42,662	14,221	56,883	To provide Entrustable emergency cover due to forecast demand	Admission rates for gynaecology acute presentations
6	New	OPAT Expansion		Karen Cowley	92,560	0	92,560	Reduced LOS for patients on IV antibiotics who are otherwise fit to be discharged	LOS, increased patients under OPAT service
6	New	Hot Clinics (2 daily clinics staffed by B5 nurse)	Staffing - Nursing	Karen Cowley	14,208	0	14,208	To reduce admissions for respiratory conditions	LOS
Corp Ops	New	B7 Ops Manager 0800-1430 Sat & Sun to support On Call Management (21 weekends & 5 Bank Holidays)	Staffing - Manager	Melanie Liley	11,885	2,971	14,856	Improved command and control over the weekend and bank holidays to support patient flow.	On Call Manager and Care Group feedback
<b>Totals</b>					<b>1,002,995</b>	<b>245,684</b>	<b>1,248,679</b>		

## Board of Directors – 30 September 2020 Quality Committee Minutes – 18 August 2020

**Attendance:** Lorraine Boyd (LB) (Chair), Lynda Provins (LP), Heather McNair (HM), Jenny McAleese (JM), Stephen Holmberg (SH), Wendy Scott (WS), Donald Richardson (DR), Tara Filby (TF), Catherine Rhodes (CR), Rhiannon Heraty (RH) (minutes)

**Apologies for Absence:** James Taylor (JT), Lynette Smith (LS), Caroline Johnson (CJ)

### 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 21 July 2020

It was noted that action 40 on the action log was incorrect and should have been 'Quality & Safety Group TOR' rather than 'PSG TOR'. This has now been updated and the rest of the minutes were agreed as a true and accurate record.

### 4. Matters arising from the minutes and any outstanding actions

P8 - JM asked for an update on breast screening and WS confirmed it had restarted as part of the restoration plan.

P10 – LB asked for an update on planning guidance. WS confirmed that we have received the Phase 3 planning letter and that the final ICS planning submission date is 21<sup>st</sup> September. WS confirmed she would bring the proposed draft plan to the next Quality Committee and feedback on progress to date.

WS confirmed that Emma Fraser will be joining the Trust on 7<sup>th</sup> September for nine months as Programme Director for Clinical Strategy and will report to WS.

P17 – JM asked LP for an update on governance structure. LP said a positive mapping session has been held and that the current state and future state has been mapped. There are still a large number of groups reporting to Quality Committee, which needs scoping, and this is still a work in progress.

Action 39 – WS confirmed this has been fed into a broader piece of work across HCV and that any of our successes will be shared as learning. JM said this was a good piece of work.

**The Committee:**

- **welcomed the appointment of the Programme Director for Clinical Strategy and look forward to progress updates on the development of the Clinical Strategy**

**Action: WS to bring restoration activity plan to next Committee meeting and feedback on progress to date**

**Action: LP/CJ to provide governance structure update in October**

## **5. Escalated Items**

There were no items escalated from the Board or other Committees.

## **Focus on Risk**

### **6. To receive the following updates including any COVID-19 updates:**

#### **Patient Safety Updates including:**

##### **i) Nurse Staffing (CN2)**

HM gave an overview of the report and confirmed positive feedback from CQC around paediatrics. HM stated that a ward establishment review is underway. She acknowledged this is a big piece of work and that engagement of ward and department level staff around ownership of budgets is needed. It was agreed that the review will be brought back to the Committee in November.

JM noted the patient impression that wards are understaffed even if our staffing levels are good and asked if there is any work required around managing patient expectations. SH asked how much is linked to staff attitude and HM agreed that a lot of this is learned behavior and that we do need to address expectations and follow through on improvement of fundamentals of care. HM said that, in terms of benchmarking, we are not as well staffed as some hospitals and that this would be an investment decision in the future but that for now, we need to improve communication with patients.

**The Committee:**

- **received and discussed the Nurse Staffing Update Paper**
- **were assured that ward establishment reviews have commenced and look forward to progress updates**
- **noted the continued challenge relating to collecting and validating ward level data, mitigated by daily assurance mechanisms delivered by Matrons of the Day on both sites**

- noted the potential risk to Nurse staffing as a result of quarantine following foreign travel and the need to treat staff consistently and fairly should the need arise
- assured by the progress on training and recruitment of nurses
- assured by collaborative working with York University and Coventry University Scarborough Campus to support the national ambition to increase student numbers and support expansion of the registered nurse workforce.

**Escalation to Board:**

**For information:**

- safe nurse staffing has been maintained through daily oversight and adjustment by Matrons of the Day
- review of nurse staffing establishment has commenced and aims to be completed by November 2020.

**Action: HM to bring the ward establishment review back in November 2020**

**ii) Infection control risks (IPC BAF Report) (CN7, CN8)**

HM gave an overview of the report. HM confirmed that IPC BAF has been submitted and this will be shared at September Quality Committee once a second iteration with further detail of systems and processes has been completed. HM drew attention to the CQC response which was positive.

SH asked if we are as robust as we say in case of a deep dive on C.diff and antibiotic usage. HM said the CQC assurance was around ensuring we have systems and processes in place and assured Committee that CQC are aware of our C.diff issues. DR also confirmed evidence of reduced antibiotic usage detailed in Medical Director Report. SH asked if our antibiotics process for sepsis is working as well as it could be and DR said although there are still cases of late start antibiotics there is good evidence of antibiotic usage in the first 48 hours. DR said he would ask Anita Chalmers (lead antimicrobial pharmacist) to forward the report to SH for assurance.

HM said we need to be able to demonstrate mitigation and manage risk at the front door. WS confirmed that whilst on-call over the weekend, social distancing had to be relaxed due to bed shortages but that each case was assessed clinically in terms of how to mitigate risks and reinstate social distancing as soon as possible. Both risks and decision-making at the time were fully documented. HM said that there may be some further guidance for winter from Public Health England but that nothing is confirmed yet.

HM thanked the Scarborough teams which had implemented a full HPV of ED including the front door at Scarborough and that are now looking at a proactive programme. HM confirmed that York C.diff cases were random scattered rather than a cluster.

**The Committee:**

- received and discussed the IPC BAF Report
- were assured by the updates to the Trust Covid 19 SOP for IPC as a result of continual learning and revisions to national guidance

- noted that the IPC BAF has been reviewed by the Executive Committee and the self-assessment has been endorsed
- noted that the IPC BAF will be regularly reviewed at the Trust Infection Prevention & Control Steering Group and assurance presented quarterly to Quality Committee
- noted the challenge to maintain social distancing in the face of bed shortages and the mitigating actions taken and documented, following decisions based on appropriate risk assessment.

**Escalation to Board:**

**For information:**

- Assurance that the IPC BAF will be regularly reviewed and used as a dynamic tool

**iii) Potential patient harms (COO23, MD5 patient harms associated with Covid-related service delivery risks)**

The next Clinical Risk & Oversight Committee meeting is scheduled for next week so an update will be provided at the September Quality Committee.

JM asked how we are handling psychological harm with regard to patients as this seems more prevalent than physical harm and HM said this needs to be part of the discussions with primary care. DR said it is variable according to specialties and that patients with chronic psychological conditions have a specialty nurse contact. DR added that this is difficult to quantify as it depends on service provision. LB said this demonstrates the importance of having a GP input into Clinical Risk & Oversight Committee and DR agreed to bring this up at next week's meeting.

**The Committee**

- received and discussed the verbal update on potential patient harms

**Action: JT/CJ to provide update/feedback from Risk & Oversight Committee at next Quality Committee meeting**

**Action: DR to raise importance of GP input and handling of psychological harm at next Clinical Risk & Oversight Committee**

**iv) Items escalated by Care Groups via Executive Quality Group including new and emerging quality or performance risks for information or discussion**

LB referred to paper B3 and said there is still work to be done on escalation processes, which is part of the structure work being done by LP/CJ to ensure correct information flow. LP confirmed that CJ is working with Care Groups around incident mapping. LB noted that some Care Groups might use different methodology for risk stratification and HM confirmed that CJ is working with them on consistency plans.

SH said that the measurements of harm need to be appropriate to the method of treatment and HM said we need governance around documentation.

JM asked about student nurse recruitment (item 10) and HM confirmed that if student nurses are not having a good experience then they choose to work elsewhere. JM said there is a misalignment between nurses' views of themselves and the negative feedback from both patients and student and foreign nurses. HM agreed that this is factually correct and we should learn from Trusts with a higher retention rate, but added that we have retained more staff this year than previously. Nurse retention is not an issue in Scarborough and JM asked if we can showcase Scarborough's success for York to learn from them. HM agreed that this would be a good idea.

#### **The Committee:**

- **received and discussed the Executive Quality Group Minutes**
- **acknowledged that supporting governance arrangements remain work in progress and look forward to update over the next few months**

#### **v) Consider other potential new or emerging risks**

WS highlighted the increasing ED activity and confirmed that Scarborough site is back to pre-Covid levels, likely due to being a holiday hotspot and that while overall Trust ECS performance is good, ECS performance has deteriorated at Scarborough.

SH asked if we are meeting our own restoration projections and WS said that we widely over-performed against the July activity assumptions but that we are being cautious in Phase 3 planning assumptions. Elective care still has IPC constraints and productivity is not yet up to pre-Covid levels but confidence is building in clinical teams and as part of Phase 3, we will complete more activity than originally predicted in July.

The amount of elective work is the biggest challenge along with winter pressures and a potential second surge. There is an expectation that Covid will be managed along with the delivery of activity plans but we do not know what non-elective admissions will look like at this stage. IPC and social distancing remains a challenge as well as our reduced capacity and reduced clinic and theatre list productivity. Our July plan was shared with Board of Directors and WS will take the planning letter response and associated risks back to Board in September.

JM asked for an update on waiting lists being managed on an ICS basis and WS said there is much debate but nothing concrete yet. JM acknowledged the difficult situation that Board of Directors is responsible for patient safety but that it would be hard to support patients from the ICS in addition to our own. There is a nationally negotiated contract until the end of December for access to independent hospitals and we will meet with Nuffield and Ramsay to discuss activity undertaken on our behalf as well as any expectations around sharing staff. WS addressed LB's concerns regarding communications with the public around waiting lists and confirmed that Lucy Brown has been heavily involved at Trust and HCV level around providing a consistent message. WS said there is an appetite to work together and confirmed a call this week with primary care colleagues to discuss. JM noted social media activity around the idea that harm is being caused to cancer patients waiting for diagnostic treatment and WS agreed that there has been a lot of fallout due to Covid but that the message is that secondary care services will not be stepped down again if there is a second spike.

HM said that complaints are nearly back to pre-Covid levels (9 in April compared to 41 in July).

DR confirmed work on Quality and Safety dashboard around mortality and deaths in ED so that any abnormal cases can be highlighted as well as work on 14 hour review (to look at patients in the building that have not had a post-take) and senior review (data was not showing correctly). DR noted that midwives are not classed as senior reviewers so a lot of patients are being reviewed by them but then show as not having been reviewed on the system, so he will speak to Jo Mannion about updating this. This data gathering review should give us a more detailed report and allow us to highlight shortfalls in processes across departments and services.

LB identified CPAP and a lack of provision outside of CCU as a potential risk and DR said this is a longstanding issue but that Executive Committee has approved this to move forward and Andrew Bertram is applying for additional funding out of the Covid budget. There is also a need for proper NIV resources in ward areas and Care Groups 1 & 2 are aware of this. WS said Care Group 1 has developed a proposal that has been accepted. The Committee noted that there is more NIV capacity in Scarborough than York at present. LB said this needs to be added to the risk register if it has not already.

JM noted the improvement in Duty of Candour and DR said this is the first question being asked on a Monday morning when incidents are discussed to ensure it has happened.

#### **The Committee:**

- **received and discussed the Integrated Business Report**
- **noted the rise in the number of 52 week waiters as a result of existing pressures on the system and the stand down of elective surgery, expected to be a continued trend.**
- **were assured that activity assumptions are continually under review**
- **gained assurance from the multiple mitigations in place by care groups to stratify and risk assess waiting lists, overseen by the Clinical Risk & Oversight Committee to minimise the risk of patient harm within this group**
- **noted the tension between keeping the number of 52 week waiters down, whilst ensuring priority use of resources for those at highest risk of deteriorated outcome.**
- **noted the current ECS performance metrics and the risk of deteriorating metrics as activity continues to grow to pre Covid levels**
- **noted the potential impact of Covid related IPC and social distancing requirements on productivity**
- **noted the continued challenge of restoration of services and mitigating actions in place**
- **were assured that the identified NIV risk is being managed through Care Group 1 and the Executive Committee**

#### **Escalation to Board:**

**For information and discussion:**



- the anticipated continued rise in number of 52 week waiters and mitigating actions
- the tension between minimising long waits whilst ensuring priority use of resource are for those at highest risk of deteriorated outcome

#### vi) Board Assurance Framework / Corporate Risk Register

LP said the next quarterly review is being started as the last one went to Board of Directors in July. JM said that lots of our risks stay on the risk register for a long time, which suggests that we are behind target in terms of mitigating actions and that we need to acknowledge a triangulation with CQC feedback. LP said that CJ is in the process of reviewing what is captured on Datix.

#### The Committee:

- received and discussed the BAF and CRR update
- welcomed the systematic review of the Risk Register outlined in the MD Report to ensure effective capture and mitigation of risk

### 7. Focus on Quality Assurance

- IPC assurance update (CN7, CN8)

This was previously discussed under patient safety. No further discussion was required.

- Patient Experience progress and assurance

TF gave an overview of Patient Experience slides and paper C, and confirmed a focus around the inpatient survey.

There is potential for increase in complaints and PALS due to long wait times. The Care Groups are making good progress resolving longstanding complaints, particularly Care Group 1, and over the last three months there has been better engagement. The number of open complaints is significantly lower and response time is slowly improving.

There was need to strengthen the framework around patient stories in terms of taking patient consent and how their stories are used/stored/shared. This piece of work will come back through Patient Steering Group who have also agreed to a 6-weekly informal meeting to maintain momentum.

Volunteers were stood down during Covid due to shielding as most are 70+ but CR is undertaking risk assessments to tentatively look at bringing them back in.

In the last quarter there were 17 PALS cases and 5 complaints around loss of personal property, which is detailed in paper C.

#### The Committee:

- received and discussed the Q1 Patient Experience Report

- **were assured by the progress made by Care Groups in resolving long standing complaints, noting that the metrics do not fully reflect this at present.**

- **National Inpatient Survey 2019**

TF and CR gave an overview of paper C1 and TF said that in response to the survey results the Trust is looking at a programme of work built around the fundamentals of care. TF said it was a shame that we cannot drill down into Care Groups and individual ward areas to identify themes. Our planned approach is to enlist NHSE support for launching 'Always Events', such as 'Hello my name is' (HMNI), which involves taking a programme approach to co-design solutions with patients and front line teams to test out possible solutions. NHSE have confirmed that we will be in the next cohort of 'Always Events', which are a registered trademark under NHSE so their support would be guaranteed. This will be a longer process as it is about building sustainability in the long term but it would be worth it and would be the preferred approach

JM asked if we could set specific targets for the next survey. CR confirmed that the National Inpatient Survey was changing this year and will have a stronger focus on online responses, which means that the results will not be comparable to previous years' results. We have added a question onto the online survey for friends/family around HMNI that we have a baseline for from last year so this can be compared.

SH noted his disappointment that there are recurring themes in the survey and asked if we are too busy measuring small changes rather than a large qualitative shift in Trust values. TF agreed and said this is about effective leadership and how ward sisters and departments hold standards and how we can do the right thing for patients. CR confirmed she has spoken to JT about HMNI and has also brought Jo Dea into discussions for an Estates & Facilities input as there are some elements that they deliver in the inpatient survey. TF confirmed she is a member of the LLP Management Group so will bring this conversation to the next meeting and she will also begin chairing Patient-Led Assessments of the Care Environment (PLACE) from next month, which reports formally to Patient Experience Group and is made up of nursing, AHP's and LLP representatives to help strengthen links.

HM said that Clever Together had temporarily lost momentum due to Covid-19 and that this work needs to be tied into its' relaunch. TF said she is exploring an umbrella programme approach as well as 'Always Events'. TF said she had looked into whether we have a campaign around 'fixing the basics' but was not happy with the word 'basic' as the work is around the fundamentals of care.

**The Committee:**

- **received and discussed the National In Patient Survey 2019, supplemented by a presentation**
- **were disappointed that progress from the previous year was limited**
- **noted the planned focus on embedding the fundamentals of good patient care**
- **were assured that the Care Groups are beginning to take ownership of quality improvements in response to Patient Experience Team findings and engaging constructively with the Patient Experience Group.**
- **gained assurance from the link between the LLP and Patient Experience Team through member representation on the LLP Management Board**

- **acknowledged the close link between delivering the Fundamentals of good patient care and the need for cultural change across the organisation highlighted through the Clever Together consultation exercises.**

#### **Escalation to Board:**

- **National IP Survey outcomes and plans for improvement**

**Action: TF to discuss Estates & Facilities involvement around Inpatient Survey at next LLP Management Group meeting**

**The following updates were received for information:**

- **Pressure Ulcer assurance update received and noted**

Committee referred to paper C2. HM confirmed that this went to Executive Quality Group for information. There is still some uncertainty around where Pressure Ulcer and Falls Reports should go for discussion and this will be looked at as part of the mapping structure work. HM said they should go to Executive Committee as a patient safety issue. TF confirmed that they went to Pressure Ulcer and Falls Improvement Group in draft format for contribution and data validation prior to going to Executive Committee.

- **Falls assurance update received and noted**

TF gave an overview of paper C3 and confirmed a high level of reporting for falls and noted a reduction in numbers due to reduced occupancy during Covid.

- **Duty of Candour Report received and progress noted**

The Committee acknowledged the progress made and compliance over the last twelve months. No further action was required.

- **Continuity of Carer in midwifery services received and progress noted**

It is a requirement to share progress to date. The Committee noted this and no further action was required.

- **Perinatal Mortality Review Tool (PMRT) Q1 received and noted**

This report was received for information and it will also be taken to Private Board for information.

**Escalation to Board for information as a statutory requirement**

- **Mortality review assurance**

Q1 Mortality Report was received and noted.

LB confirmed the reinstatement of Mortality Steering Group to ensure learning is captured.

- **Any other assurance from Medical Director Report**

**The Committee:**

- **noted that a paper on improvements to Clinical Effectiveness and Audit processes should come to Quality Committee in September**
- **noted the gaps in assurance relating to cooperation with the CCG Serious Incidents Panel and steps taken to rectify and improve future responses**
- **were assured that Themes from ‘First Do No Harm’ Report have been noted and will be taken account of in reviewing patient safety, patient experience and governance processes.**

## **Focus on Governance and Policies**

### **8. Committee Annual Report was received**

LP confirmed this will go to Council of Governors on 1<sup>st</sup> September.

### **9. Consideration of items to be escalated to the Board or other Committees**

LB said PMRT as a statutory requirement should be escalated.

HM said that the inpatient survey should be flagged for discussion as the outcome was disappointing, but a number of actions are being put in place under the fundamentals of care work.

SH noted maternity concerns around number of post-partum bleeds on the unit and confirmed that Freya Oliver shared an action plan to reduce this. HM said this has been flagged on the dashboard and noted different practices between York and Scarborough sites around third stage management. A Task & Finish group has been set up to explore consistency and improvement work.

It was agreed nurse staffing and the ward establishment review would be flagged to the Board as sources of assurance.

52 week waits will also be escalated to show that this is under continual review.

**Action: HM to provide Quality Committee with update on maternity action plan to reduce post-partum bleeds in October**

## 10. Any other business

There was no other business to discuss.

## 11. Time and Date of next meeting

The next meeting will be held on 22 September 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	Nov 20
31/7/19	2.	Provide more assurance around outputs & triangulation with numbers.	HM	Ongoing
27/11/19	3.	To provide a hyperlink to informational appendices instead of including them in the report. Still to include essential appendices	HM	Ongoing
27/11/19	4.	JT to consolidate information streams from multiple external sources into, & within the Trust. To report progress back at April meeting.	JT	Oct 20
21.01.20	8.	FJ to provide Duty of Candour update at Feb meeting	FJ	Completed
17.03.20	21	JT to provide an update report on the plans to embed 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	Sep 20
17.03.20	23	JT to report on three baseline assessments on NICE guidelines	JT	Sep 20
16.06.20	29	LS to update Committee with developments around endoscopy and routine care	LS	Sep 20
16.06.20	30	LS to bring diagnostic recovery plan to next Committee meeting	LS	Sep 20
16.06.20	32	JT to amend Quality Priorities objectives to make these SMARTER and circulate to Committee	JT	Completed

21.07.20	34	KH to provide cancer update, including staging data, to November Committee meeting	KH	Nov 20
21.07.20	35	HM to separate complaints out into categories to bring back to next Committee	HM	Completed
21.07.20	36	CJ and TF to combine inpatient survey findings with current CQC position to bring to next Committee	CJ TF	Sep 20
21.07.20	37	LP/CJ to provide update on Committee structure at next Committee meeting	LP/CJ	Oct 20
21.07.20	38	LP to add Dementia Report as a quarterly agenda item	LP	Completed
21.07.20	40	HM to bring Quality & Safety Group TOR to next meeting	HM	Sep 20
18.08.20	41	WS to bring restoration activity plan and feedback on progress to date	WS	Sep 20
18.08.20	42	HM to bring the ward establishment review back in November 2020	HM	Nov 20
18.08.20	43	JT/CJ to provide update/feedback from Risk & Oversight Committee	JT CJ	Sep 20
18.08.20	44	DR to raise importance of GP input and handling of psychological harm at next Clinical Risk & Oversight Committee	DR	Sep 20
18.08.20	45	TF to discuss Estates & Facilities involvement around Inpatient Survey at next LLP Management Group meeting and provide update to Committee	TF	Sep 20
18.08.20	46	HM to provide Quality Committee with update on maternity action plan to reduce post-partum bleeds in October	HM	Oct 20

## Board of Directors – 30 September 2020 Resources Committee Minutes – 18 August 2020

**Attendance:** Jennie Adams (JA) (Chair), Lynne Mellor (LM), Jim Dillon (JD), Andrew Bertram (AB), Adrian Shakeshaft (AS), Polly McMeekin (PM), Andrew Bennett (ABe), Delroy Beverley (DB), Kevin Beatson (KB), Dylan Roberts (DR), Lynda Provins (LP) Liz Johnson (LJ), Joanne Best (minute taker).

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

### 1. Welcome

JA welcomed everyone to the meeting noting this was Dylan Roberts first meeting as the new Chief Digital Information Officer. She declared the meeting quorate.

### 2. Declaration of Interests

There were no changes to the declarations.

### 3. Minutes of the meeting held on 21<sup>st</sup> July 2020

The minutes of the meeting held on 21<sup>st</sup> July 2020 were approved as a correct record with the following amendment.

LM – Page 8 – Paragraph 6 – Matters arising from the minutes - amend 'British Telecom' to read 'BT'.

### 4. Matters arising from the minutes and any outstanding actions

**Item 2 – Provide update on GIRFT** - JA asked AB for an update – AB confirmed Richard Khafagy will attend the October meeting to update the Committee.

**Item 6 – Review future plan for Asset Tracking** - JA noted this item arose following audit checking and asked if there was an update. AB - Following a limited audit report, objectives have been picked up by the Audit Committee relating specifically to IT asset tracking, noting there is less concern in relation to general assets.

**Item 9 - Workforce Report to be in IBR format** - JA - As the majority of Workforce data has been integrated into the IBR, should this item be deleted from the log. PM - Although this is still a work in progress it no longer required to be noted as an action.

**Action: LP**

**Item 10 - ACAS report and LLP update to be shared with the Resources Committee** - JA - This will be covered in today's LLP report therefore should be removed from the action log.

**Action: LP**

**Item 12 - Extra column to be added to the action log to include a number allocation -** JA – Action complete – to be removed.

**Action: LP**

**Item 15 - BPPC Performance Chart – add 14 day indicator** - JA confirmed with AB that recording of 7, 14 and 21 day monitoring for the BPPC was included in the IBR. AB noted that generally the Trust's peers are monitoring the 30 day payment and delivering similar performance to the Trust achieving approximately 90% payment of invoices within 30 days of receipt. It was agreed that as there is more clarity around the financial regime going forwards, the provision of information will be reviewed. JA confirmed this item should now be removed from the action log.

**Action: LP**

**Item 16 - Sustainability to move to the Quality Committee work programme** - LP - Sustainability will move to the Quality Committee Agenda. JA - Item to be removed from the action log.

**Action: LP**

JA asked the Committee if there were any other outstanding items which had not been included on today's agenda which needed highlighting. There were no further items to discuss.

## **5. Executive Reports**

### **YTHFMLLP**

**Compliance Report** - DB gave an overview of the Compliance Report noting it allows KPI issues across the LLP to be viewed easily. He offered assurance that supplying data this way will give the Committee and the Organisation confidence that a number of critical issues are being dealt with. DB stated since the last Resources meeting there had been a number of positive changes in some key critical areas, acknowledging there are still some ongoing challenges within the LLP particularly around sickness absence, cleaning of high risk areas and others but confirmed work to address these issues is continuing.

ABe - This report delivers the audit results across sites for 120 KPI's noting 59 green, 13 amber and 9 red, this is an improvement from the June performance which delivered 48 green, 11 amber and 12 red. He noted that it is not possible to monitor all KPI's until the Computer Aided Facilities Management (CAFM) system is in place.

ABe - The month on month compliance overview for KPI's allows the Resources Committee to view the trajectory of all recorded KPI which are also highlighted using colour codes. The key areas of concern and risk were as follows:

**Sickness Absence Rates** ABe – A key area of concern is sickness absence rates which are recorded over different service areas, noting catering is the largest contributor to these levels along with domestic services but this is as expected as these are the two largest



areas of head count. One area of focus for the service leads within the YTHFM LLP is to reduce sickness to a more acceptable level.

**Auditing of the Cleaning of Very High and High Risk areas** - ABe – The KPI for ‘very high risk areas’ improved in July to 98% but unfortunately the KPI for ‘high risk areas’ deteriorated delivering a KPI of 93.83% for July against June’s KPI of 94.41%. This is an area of concern and service leads are focusing their attention on understanding what is causing this deterioration.

ABe – Confirmed action plans have been put in place to address high risk KPI performance, focusing on sickness absence management and its reduction, along with training and support for supervisors within Domestic Services ensuring Supervisors are visibly checking and supporting front line Domestic staff. There is a need to review the Trust’s cleaning requirements against the LLP’s current resources noting the report refers to a cleaning deficit within the YTHFM LLP.

**Catering Hygiene Audits** -ABe - Overall Catering Hygiene Audits show an improving position, but one of the barriers which prevents the LLP achieving a green rating is due to backlog maintenance issues which have not been progressed due to funding constraints.

**Computer Aided Facilities Management System (CAFM)** - ABe - Due to the lack of a CAFM system only a quarter of all KPIs are measurable currently but discussions have taken place at the EPAM meeting with a view to the purchase of this system.

**Policy and Procedure Compliance** - ABe - Compliance against policies and procedures remains at 92% which is a good position but two areas are highlighted red, these are Transport and Pest control. Both of these will be focused on in the next month.

**Items for Escalation to the LLP Board** - ABe highlighted the following items for escalation to the LLP Board:-

- Senior Management need to have site of all outstanding action plans, with agreed timescales and responsible managers
- Ongoing review of all current risk areas outlined in this report
- Issue with regards to the North Entrance at York Hospital to be addressed

Liz Johnson, YTHLLP Business Manager joined the meeting.

JD noted he is on the YTHFM LLP Board so has an awareness of issues and actions taken to address them but noted concern in relation to pest control and asked if there is a specific issue. LJ assured the Committee there is not an actual pest control issue at any site. The Trust has a contract in place with a pest control company which is monitored and receives a good response. The issue is with the centralisation of processes, action plans and risk assessments which are required for PAM (Premises Assurance Model). The acting Assistant Head of Estates has been reviewing this but had experienced IT issues which have now been resolved.

LJ – Once these documents are centralized with working links, the Trusts compliance team will have access which will improve the PAM score resulting in it progressing from amber to green overall. The expectation is this will be brought to fruition during August which should deliver a positive improvement for the September report.

JD was assured that the issue relates to system engagement and not an underlying pest control issues.

LM noted her assurance by the picture of change across the organisation, noting that there are still concerns with the KPI's which are highlighted red. LM referred to page 25 of the YTHFM LLP Compliance Report asking what the following sentence meant and what the impact of it is. 'in relation to Energy, there is no Premises Assurance Model module to measure against'.

LJ noted that when the Service Level Agreement was set up it included a KPI which referred to meeting the PAM. She stated that the energy agenda fits under sustainability which is not part of the LLP portfolio, so it is difficult to measure.

DB stated that prior to his appointment the Energy Management and Sustainability team had resided under the Trust but following recent discussions this functionality will move to the YTHFM LLP allowing an overview to be managed by Estates. He confirmed he had a meeting with Jane Money this afternoon (18/08/20) and this move should happen within the next couple of weeks.

LM requested DB update the Committee at the next meeting highlighting this as a risk.

**Action: DB**

LM referred to page 29 of the LLP Compliance Report – referring to the high level of sickness absence and expressed concern for the wellbeing of staff within the YTHFM LLP as highlighted in the ACAS report. LM asked if the risk to the quality of service caused by sickness absence has an impact on patients. LJ thanked LM for this question noting any impact on patient care will be addressed in next month's YTHFM LLP report.

**Action: LJ**

LM referred to page 32 of the LLP Compliance Report – noting a discussion had taken place at the EPAM meeting in June with regard to the provision of new handsets for the CAFM system and clarity on numbers / costs had been requested. LM asked if there were any other issues causing the delay or if it was possible to progress this forward quickly. AS confirmed he had given advice with regard to data privacy impact assessment and would be happy to discuss any issues with Andrew Bennett away from today's meeting.

**Action: AS/ABe**

LJ – Upgrade handset model will cost approximately £64k for an additional 130 handsets which will replace current stock, noting the cost will be spread over this financial year and next. This will allow the implementation of the Micad system rather than using the current back track system. If the upgrade handsets are not purchased the current handsets will still need replacing at a cost of £1k each. The new Micad handsets would be compatible with whichever system is chosen for use in the future through the tendering process. Once the spend is agreed, it will take 2 - 3 months for installation and implementation, although this will not support all the issues with KPI reporting it will replace some of the back track reporting. It is not clear how many additional KPIs will be able to be reported but the hope is that once the system is embedded the number will increase.

DB assured the Committee that he would deliver an update at the next meeting aiming to progress this and achieve a positive conclusion.

**Action: DB**

JA noted her concern that investment in these handsets does not appear to clearly support a service improvement. DB confirmed there is a need to assure the replacement of the handsets fully meet with required needs. This will be reviewed by himself, LJ and ABe.

**Action: DB / LJ / ABe**

AB – Confirmed he will discuss requirements with DB outside this meeting aiming to achieve completion.

**Action: AB / DB**

JA noted she was pleased that AB and DB are keen to find a way to complete this action.

JA asked DB if the Trusts Contract with the LLP required reviewing referring to comments within the report which related to the level of agreed hours for cleaning and the physical state of some of the premises which had impacted on cleaning standards. DB agreed it would be a good time to refresh the Master Service Agreement. He will discuss this with AB outside of the meeting.

JA asked DB if issues with the backlog maintenance plan had impacted on the ability to clean to the required standard. DB agreed this had impacted on required cleaning standards but noted the backlog maintenance plan is large and the LLP will be submitting a report to the Trust Board noting improvements which can be made before the end of this financial year. Prioritisation planning had taken place to priority areas for improvement and although these were just the start of addressing the back log maintenance programme they will make a difference.

AB stressed the Trust completely relies on the YTHFM LLP to communicate priorities with regard to the backlog maintenance programme.

JA referred to highlighted issues with the North Entrance at York Hospital which will be escalated to the YTHFM LLP Board, noting it had not been referenced in the main body of the report. LJ stated that some departments store items in the entrance area which is impacting on the LLP achieving a green score when audited. These departments had been approached but resistance was met when requested to move these items. This will be reviewed as a Health and Safety issue.

**LLP Workplace Culture Report** - DB confirmed incidents of concern had been addressed immediately with the support of HR.

LM referred to page 43, development of bespoke courses to support staff and managers in handling difficult conversations and asked if on-line access would be available. DB confirmed there is a focus group which includes HR representation who are involved in exploring and developing support in the short to medium term.

LM asked DB for assurance that any safety breaches in relation to COVID 19 are being addressed. ABe assured LM he has regular contact with HR and following Policy / Procedure guidance these breaches are followed up with the individuals concerned.

JD noted he had attended meetings with front line staff and senior staff and JD assured the Committee that moving forward he is confident that the proposed changes to the management team which will be presented to the Committee by DB are on the right path to support changes to the culture in both short and longer term.

JA noted the ratio of LLP supervisors to staff was highlighted in the report as being very low which supports staff feeling isolated. DB stated the supervisory ratio is high priority and is under review. A number of proposals have been developed one being new managers joining the LLP will be asked to look at the structure beneath them in relation to supervisory front line ratio. Investment will be required for training and support.

PM noted that although the number of supervisors is a clear issue it is also about confidence / competence of supervisors and people management skills. The paper also refers to the need to develop bespoke difficult conversations training and the Trust already has this training which could be reviewed and adapted to support LLP staff development. PM also noted that LLP staff are included in the Trusts annual survey which will allow annual checks.

JA thanked PM for this input and thanked DB noting her assurance by his response.

DB confirmed to JA following today's comments he will review both the BAF and the Risk register.

DB - He has received excellent support from all areas across the Trust but agreed with JD that much of the issues are ingrained in the LLP and that these issues will be addressed with training and support offered to correct this culture. DB confirmed the LLP Workplace Culture Report will be shared with every LLP employee within the next two weeks along with a joint covering letter from DB and the Chair of the LLP Board stressing the determination to make changes to the embedded unacceptable culture.

### **Finance Report**

AB confirmed the Trust is still operating under the NHS emergency regime which was implemented in response to COVID-19, the expectation is this will continue until the end of September.

**Income and Expenditure** - AB referred to chart 6.02 of the IBR report, noting the Trust's operational expenditure set by NHSE/I for July is £45,785m excluding COVID expenditure. The Trust continued to deliver an under spend for July, noting an increase in the spend level of approximately £1m with an actual spend of £44,605m.

AB - The Trusts COVID spend for July was £1.908m which is 4.3% of the monthly operational spend and within normal range. Internal Audit have completed a report which bench marks organisations in terms of their COVID expenditure, this will be shared with the Resources Committee next month.

**Action: AB**

AB - Although the income position had increased slightly for July the Trust is still under recovering against the NHSE/I plan, confirming the Trust continues not to charge staff parking and catering receipts are also reduced. Under the current Truing up regime the Trust required £2.104m for July, slightly increased on previous months this relates to the overall spend within the Trust increasing as service activity restarts.

**Better Payments Practice Code (BPPC)** - AB - The Trust is compliant with this standard noting in July the Trust paid 91% of suppliers within 30 days of receipt of invoice. All Trusts had been asked to accelerate payments down to 7 days where possible, it had proved challenging to complete the usual checks and assurances required to validate payments noting the Trust is averaging around 7% of payments within 7 days. AB confirmed there is no benchmark data to assess performance against.

**Capital** - AB referred to chart 6.16 which indicates the Trusts Capital programme spend, noting an actual spend of £3.357m against the plan of £5.640m. The updated Capital Report will be shared with the Executive Committee tomorrow and the Trust Board next Wednesday. The report will highlight £4m essential spend for urgent backlog maintenance requirements. The expectation is that £3.5m will be supported by the release of backlog maintenance capital at National level, although the Trust has not yet received formal confirmation of this.

AB - The size of the Capital Programme brings a new finance risk which will be added to the Finance Risk Register which is around having the capacity in the LLP to progress the level of work required. The Trusts Capital Programme is significant this year and the risk is also around the Trusts ability to spend at the proposed levels.

In conclusion AB confirmed the current regime of truing up at the end of each month will operate for month 5 with the expectation it will continue for month 6. No planning guidance has been received from the Treasury for the second half of the financial year. The Department of Health has not yet been able to agree a financial settlement with the Treasury.

JD noted it is positive to hear the release of National funds to support the backlog maintenance programme and asked if AB had an update in relation to Capital work spending to improve both York and Scarborough Hospitals. AB stated no capital had been released since last month's discussion at Trust Board. An MOU was submitted to the Secretary of State to release £950k and this will support the conversion of two wards to single occupancy side rooms at Scarborough hospital and six rooms at York Hospital back to single occupancy accommodation which will support infection control issues.

AB - No formal paperwork had been received for the £15m capital spend planned for York Hospital Emergency Department, but advice is to continue with planning with the expectation £6m will be spent in this financial year. AB stated his disappointment that paperwork had not yet been received.

LM expressed concern about not receiving financial guidance for the second half of the financial year asking if this could potentially be a risk. AB agreed there is a risk of an unknown regime but the expectation is if no further guidance has been received before the end of September the current regime would continue, which mitigates the risk.

LM referred to graph 6.03 COVID expenditure which is 4.3% of the Trusts operational spend asking if a second wave of COVID could see an increase in this cost. AB stated

COVID expenditure had been at a consistent level over the previous four months with no expectation of a rise unless there is a second wave of COVID-19. It was confirmed that PPE stock is not included as the costs are covered centrally which, if this changed there would be an increase in the COVID spend.

AB stated there is an expectation Operational Expenditure will increase as services reopen, with additional costs for extra weekend services.

LM asked AB whether there were any risk in relation to BREXIT which need highlighting. AB - The BREXIT Operational Group has been reconvened with the last assessment document which was supported by the DOH re sent out to be updated. As no new direction had been received the Trust will continue as previously advised, which is business as usual and no stock piling. Future updates will be shared with the Committee.

AB assured JA that once the planning guidance has been received he would share this with the Board.

AB noted the uncertainty of the future is causing stress across the department in terms of efficiency requirements, recovery requirements, along with patient backlog volumes and clinical safety risks.

JA asked if the previously discussed Capital Programme Executive Group (CPEG) changes in relation to clinical / senior staff input have now become embedded in to the process as the spend begins to increase. AB gave an overview of the function of the CPEG meetings and how it is used to shape the programme with all investment decisions discussed by the Executive Committee prior to recommendations to the Board which has increased transparency and allows Care Group input to decision making.

### **Digital Report**

KB provided some brief updates on the following:

- Patients Know Best – Patient Held Record
- SDEC At a glance board - KB delivered a brief demonstration of the live board, explaining its capabilities to the Committee.

JA thanked KB for this demonstration stating it helped the Committee understand development and changes that have occurred.

LM asked if he had received feedback from staff using the boards. KB stated that generally the feedback had been positive but noted York and Scarborough use the system differently, confirming this is an ongoing project with staff giving input to support further development.

JA noted the report had highlighted staff working from home had received poor user experience asking for an explanation and how this would be addressed. AS explained staff connect to the Trust system remotely either with Trust devices which uses an always on VPN or with a personal device which logs in to a Trust terminal server. With the increase in staff working from home additional servers had been built to support the unprecedented demand, issues have occurred resulting in the servers closing down. The anti-virus software has been identified as the issue, this has been logged with the support company. In addition new servers using an upgraded version of the operating system have been

built, subject to successful testing the number of servers will be increased with staff moved to the new system later this week. AS confirmed issues with the VPN have been addressed and appear to be working well.

DR acknowledged as the Pandemic hit the IT team were under immense pressure to rollout a large amount of technology and kit very quickly confirming this may have resulted in equipment not been configured optimally, but assured the Committee user issues are raised and discussed on a weekly basis.

JA asked if there had been a delay on the Windows 10 rollout? AS stated that prior to the COVID situation the intention was Windows 10 rollout be completed by the end of October, this has now been slightly delayed until the end of this calendar year which is in line with NHS guidance. This will be reassessed weekly with the appointment of short term contracts to support completion if necessary.

JA noted the help desk had received an increase in calls in relation to the Digital Dictation upgrade and asked if there are any lessons to be learned. AS noted that it did not appear to be one core issue but moving forward it maybe useful to have a dedicated project manager. KB noted minor changes had been made which had not warranted a formal training course but these changes had delivered major impact and in hindsight the team could have improved the way these changes were delivered to the clinical users.

JD asked if it would be possible to have a short presentation at a future meeting covering the video consultation project, noting it will be transformational for the Trust and will have a significant impact longer term. JA asked if this could be delivered to the Committee either next meeting or the one after.

**Action: DR/KB/AS**

### **Workforce**

JA referred to The Workforce Disability Equality Standard report noting there were no questions from the Committee.

PM apologised to the Committee there had been issue with submission of some of the medical staff vacancy rate data. This was due to the Junior Doctor change over at the beginning of August resulting in the team requiring the team to reprioritise.

PM provided highlights on the following areas:

**Vacancy Rate** - PM - Vacancy rate for the Trust is in a positive position with Nursing and Midwifery vacancy rate down from 8% for June to 4.6% for July, this is extremely low. The nurse vacancy rate for York reported at 0.8% with Scarborough at 13.3%.

This positive position is due to nurse recruitment along with improved staff retention levels which could be due to the COVID situation noting the usual number of retirements have continued.

PM – Medical staff vacancy rates offer a similar picture reporting 6.9% vacancy rate which is down from 11.11%, reporting 5.5% at York and 10.6% at Scarborough.

**Statutory and Mandatory Training** - PM – The Trust is achieving seven out of eight Statutory and Mandatory Training compliance metrics, work continues to improve Medical

& Dental staff compliance with core training which has improved by 14% over the previous 10 months. If these compliance levels continue consideration will be given to increasing the targets from 85% to 90%.

PM – There is some concern in relation to staff sickness absence which although showing a reduction of approximately 1% from last month to 4.5% which is back within ‘normal range’, of this 26% absence relates to mental ill health. Normal range for mental ill health absence tracks at around 20%. This is not surprising given the pressures staff have experienced during these unprecedented times. The Trust has a number of initiatives underway to tackle this.

**Non-medical Appraisal Rates** - PM – At the beginning of March the Trust reset appraisal completions of non-medical staff to zero extending the appraisal window to the end of September from June. Currently 22% of the workforce have had an appraisal, there needs to be significant rapid improvement to achieve compliance. Medical appraisal rate is tracking at 76%.

LM asked PM if with the impact of COVID and the potential of a second wave is there an expectation that the number of absences relating to mental ill health will rise further. PM noted the development of clinical strategies are ongoing with the support of a clinical Psychologist which will support staff as they continue to work from home as this can be isolating. LM suggested work fit programmes could also be considered as a way of supporting home workers as often when working at home they don't move far from their desks.

LM asked PM to explain how the issues with appraisal compliance will be addressed. PM stated that generally the appraisal compliance looks to have a slow start and as more people are appraised it filters down increasing the volume of staff appraised in the later months. The need to progress with appraisal has been debated but moving forward Trust wide communications could be used to highlight the appraisal requirements prior to the appraisal window being extended.

JD also noted his concern that appraisals need to be performed especially to discuss mental ill health issues and asked PM if there is a specific plan to achieve appraisal compliance. PM - NHS published a People Plan recently stated every employee must have a health and wellbeing programme. Line manager will agree individual programmes including flexible working options. Health and wellbeing and flexible working is already included within Trusts appraisal discussions for non-medical staff, but HR will be strengthening this conversation in line with the people plan also exploring how it could be incorporated for medical staff.

JA thanked PM for integrating the workforce data in to the IBR but noted that the time series for vacancies does not appear. PM confirmed it is noted at the top of the first graph on page 17 of the IBR.

JA thanked PM noting the Nurse Vacancy rate is the lowest it has been over the previous eight years she had been with the Trust.

JA noted that there are not many new starters on the Scarborough site in relation to the York new starters, hoping Coventry University will support a solution to this issue. PM agreed Coventry University will commence this time next year and be included in the



numbers. One of the reasons that nurse vacancy rate have shown a significant improvement this year is following a paediatric nurse campaign for the emergency department the Trust appointed 13.2 wte to York and 3 to Scarborough in response to the CQC actions.

JA – campaign to recruit senior physicians in to Scarborough, what is happening to support this recruitment.

PM - Continuing with the East Coast Medical Project, consultant recruitment has been reviewed overall with some significant changes made, one of these changes will require some duties to be carried out across site, unless exceptional circumstances prevent this. Paper will be submitted to the Executive Committee tomorrow.

## **6. Any Other Business**

JA confirmed the Annual Report of the Resources Committee was included in the Resources pack for information and will be submitted to the Council of Governors on 1<sup>st</sup> September. JA gave the Committee a brief overview of the reports content.

JA noted this is her final meeting as Chair of the Resources Committee and thanked everyone for their support in making her time a pleasurable experience. AB thanked JA for her support of the Resources Committee and wished her good luck.

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

### LLP

- Performance - early signs of improvement
- Cultural changes and behaviour update
- Backlog maintenance
- CAFM monitoring system

### Finance

- Month 4 position & looking ahead
- Capital projects and backlog maintenance

### Digital

- Covid inpatient testing prompt
- ED Dashboard demonstration
- Windows 10 rollout update and working from home issues
- Digital dictation
- Virtual consultations

### Workforce

- Staff absence and vacancy rates
- Appraisal rates

## **8. Time and Date of next meeting**

The next meeting will be held on 22<sup>nd</sup> September 2020 at 9am via webex. Dial in details will follow.

## ACTION LOG

Item number	Meeting Date	Action	Owner	Due Date
1.	29.05.19	Highlight new limited assurance audits in their report to the Committee.	Executives	Monthly
2.	30.01.20 25.10.19	Provide update on GIRFT	AB	<del>Mar 2020</del> Oct 20
3.	21.01.20	Papers to be submitted in line with Committee deadline to enable effective dissemination of the agenda	All	Monthly
4.	21.01.20	Minutes from committees reporting into resources committee to highlight items for escalation or be FIO	All	Monthly
5.	10.02.20	Digital section to be added to IBR in March.	AS/KB	<del>March</del> Sept 20
6.	19.05.20	LLP Report on lessons learnt during the Covid period.	DB	Aug 2020
7.	19.05.20	Board discussion on digital Transformation leadership support	AB	May/June 2020
8.	21.07.20	Artificial Intelligence Report to come through.	KB	<del>Sept 20</del> Oct 20
9.	18.08.20	Update Action Log – remove Completed action	JB	Completed
10.	18.08.20	Sustainability Team Management to move from Trust to Estates Management	DB	September 20
11.	18.08.20	Update on handsets to support CAFM system	AS/Abe/D B	Sept 20
12.	18.08.20	Provide update COVID spend bench mark	AB	Sept 20
13.	18.08.20	Video consultant project demonstration	DR/AS/KB	Sept / Oct 20

## Board of Directors – 30 September 2020 Medical Appraisal and Revalidation

### Trust Strategic Goals:

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

### Recommendation

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

### Purpose of the Report

To update the Board on medical appraisals and revalidation. NHS England requires all Designated Bodies to produce annual reports.

The Trust is required to submit to the Board the appraisal and revalidation statistics, and the Annual Organisational Audit (AOA). This must be signed off on behalf of the Board by the end of October.

### Executive Summary – Key Points

- Due to the appraisal program being paused in March, as a result of Covid-19, the appraisal compliance for the year is below the normal 90% target, at 86%.
- A Senior Appraiser is now in post
- Appraiser allocation is being rolled out, alongside restarting the appraisal program on October 1st.

### Recommendation

The Board is asked to accept this report, which will be shared with a higher level Responsible Officer and NHS England.

Author: Paul Whittle, Revalidation Specialist Adviser

Director Sponsor: Jim Taylor, Medical Director and Responsible Officer

Date: August 2020

## 1. Introduction and Background

The purpose of this paper is to provide assurance to the Board that appropriate arrangements exist to ensure a robust approach to the appraisal and revalidation of our medical staff. The report is a requirement of NHS England.

Separate reports will be produced by St Leonard's and St Catherine's Hospices and The Schoen Clinic, for whom the Trust acts as Designated Body.

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

York Teaching Hospital NHS Foundation Trust has a statutory duty to support their Responsible Officer in discharging their duties under the Responsible Officer Regulations and it is expected that Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The Trust is a Designated Body, as defined by The Medical Profession (Responsible Officers) Regulations 2010. For the period this report covers (1<sup>st</sup> April 2019 – 31<sup>st</sup> March 2020) 515 doctors were attached to the trust for the purpose of revalidation. The Trust also acts as Designated Body for St Leonard's and St Catherine's Hospices and The Schoen Clinic. The Trust receives an income for this.

The Trust is required to report to NHS England in June each year. The latest report is included in Appendix A.

The Trust's appraisal uptake rate for 2019-20 was **86%** against a usual target of **90%**. 2.6% had no appraisal and no agreed reason within the reporting period.

NHS England has reduced the requirement for 2020 appraisals. The level of documentation will be less, and the focus will be on a Covid-19 debrief (achievements, challenges, aspirations, wellbeing etc.).

The NHS England People Plan requires all NHS staff to undertake an annual Health and Wellbeing discussion. Functionality will be added to the online appraisal system to record this discussion as part of the appraisal process.

## 2. Appraisers

NHS England suggests that doctors must not be appraised by the same appraiser for more than three years in a five year revalidation cycle. In exceptional circumstances a fourth appraisal may be allowed. To mitigate against this, York Teaching Hospital NHS Foundation Trust has trained over 90 of its senior medical personnel in enhanced appraisal, giving a ratio of approximately 1:6 appraisers to appraisees.

Previously all of the doctors no longer in formal training and dentists within the Trust can request an appraisal from any trained appraiser, however the trust is moving to NHS England's preferred method of allocation of appraisers. This will spread the appraisal workload more fairly, save doctors time each year in finding an available appraiser, and reduce the number of late appraisals.

### 2.1 Quality Assurance

#### **Outline of quality assurance processes:**

*For the appraisal portfolio:*

- Approximately 1:3 appraisal portfolios and Input Forms are checked for quality by Medical Staffing and the Senior Appraiser.
- The Trust has used PremierIT's PReP system since revalidation was introduced in 2012 for managing appraisal and revalidation. Appraisees are offered training on this system in groups or 1 to 1. A system user guide is also available. A rolling programme of appraisal workshops was introduced in 2016 to enhance practitioners' understanding of the system, and provide guidance to aid their appraisal preparation. These are currently being held remotely.

*For the individual appraiser:*

- Medical Staffing and the senior Appraiser reviews a sample of Appraisal Output Forms, scoring these based on the eAppraisal system's integrated audit tool. This is then combined with anonymous feedback from appraisers, which is provided at the end of the appraisal process, and reported back to appraisers with any potential areas of improvement. Appraisers are encouraged to undertake between five and ten appraisals per year in order to build and maintain their skills.
- The Trust's Medical Appraisal Policy has been updated to include the circumstances under which the appraiser role may be removed. This can include consistently poor feedback from appraisees, or an appraiser carrying out insufficient appraisals. It is now being negotiated with the Joint Local Negotiating Committee JLNC.
- The Trust holds annual appraiser update sessions which are mandatory for all trained appraisers. These sessions cover new developments with appraisal and GMC revalidation. They also provide networking opportunities for appraisers to discuss how their own appraisal standards can be developed, and include case studies of difficult situations, tackled in groups to share experience. These sessions commenced in early 2014 and have been beneficial in helping appraisers set their own standards, calibrate their decision making and produce tangible improvements to the quality of Output Forms.

An annual Appraisal Satisfaction survey has not been carried out this year due to Covid-19. The team is keeping appraiser and appraisees updated using newsletter and email updates.

### 3. Revalidation

In 2019/20 the trust made 169 revalidation recommendations, all of which were accepted by the GMC. There were no non-engagement notifications. Appendix A gives details of the recommendation.

### 4. NHS England Visit

NHS England visit all Designated Bodies within each 5 year revalidation cycle. A visit in 2019 was made, focusing on the trust's relatively high level of measure 3 doctors (defined as no appraisal within the year, with no agreed reason).

One of the reasons for moving to allocation of appraises is to reduce the number of missed appraisals, by ensuring that appraisees know who their appraiser is well in advance, and therefore be able to arrange a meeting in a timely manner.

<b>Name of designated body</b>	York Teaching Hospital NHS Foundation Trust	
<b>Name of responsible officer</b>	Mr James Taylor	
<b>Area/concern/issue identified at Review Visit</b>	<b>Action</b>	<b>Timescale</b>
Reduced appraisal non-compliance % and high level of measure 3	Trust to implement their allocation system in association with a review of the delivery of appraisal across the programme year.	Following consultation, to start spring 2020. Fully implemented by 2023
Reduced appraisal non-compliance % and high level of measure 3	Consider changes to appraisal policy, particularly non-engagement stage. Meeting to take place with Dr following first letter	Summer 2020
	Trust to establish a programme of medical appraiser networks to provide leadership to the cohort of appraisers	To start summer/autumn 2020
Reduce the number of revalidation deferments	Trust to instigate an action plan to review their management of Revalidation recommendations: <ul style="list-style-type: none"> <li>• Education of appraisers</li> <li>• Re-issue of appraisal checklist</li> <li>• Increase frequency of new starter workshops</li> </ul>	Spring 2020

The above timescales will be reviewed due to the pandemic delaying the process.

## 5. Conclusion

- The Trust's appraisal percentage has decreased slightly over the period, with the final month being affected by Covid-19.
- The appraisal compliance figure for 20-21 will be lower than our normal standard due to the pausing of appraisals due to Covid-19.
- A move to the allocation of appraisers is intended to have several benefits, including decreasing the number of non-engagements, and a more fair distribution of appraisees.
- It is anticipated that local guidance, written to expand upon and clarify changes to national guidance, will ease the administrative burden by reducing the number of documents doctors are expected to provide.

## 6. Next Steps

- More appraiser meetings will be held to share good practice and gain peer support. We are considering how to achieve this remotely.

## 7. Appendices

### Appendix A - Audit of all late or incomplete appraisals

### Audit of revalidation recommendations

<b>Revalidation recommendations between 1 April 2019 to 31 March 2020</b>	
Recommendations completed on time (within the GMC recommendation window)	102
Revalidation recommendation	128
Deferral recommendation	41
Non-engagement recommendation	0
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
<b>TOTAL</b>	<b>169</b>
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other (difficulty contacting doctor)	0
Describe other	
<b>TOTAL [sum of (late) + (missed)]</b>	<b>0</b>





**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	16	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	12 ↑	1
Finance	12. Failure to achieve the System's financial plan	25	9 ↔	6

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## Board Assurance Framework

BAF definition adopted by the Governance, Assurance & Risk Network (GARNet): ‘the key source of information that links the strategic objectives to risk and assurance’.

### Introduction

All Trusts are required to prepare public statements to confirm that they have done their reasonable best to maintain a sound system of internal control to manage the risks to achieving their objectives. This is achieved by the Chief Executive providing a signed Annual Governance Statement, which covers the risk management and review processes within the Trust. The evidence to back up this Statement is supported by the Board Assurance Framework.

The Trust’s Board Assurance Framework is based upon the identification of the Trust’s strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Board of Directors to resolve issues or concerns and to improve control mechanisms.

The risk scoring matrix (appendix 1) is part of the Trust’s Risk Management Framework and will be used to score risks. Risk Appetite (appendix 2) is part of the Trust’s Risk Management Framework

<b>Strategic Goals</b>	<b>The planned objectives which an organisation strives to achieve</b>
<b>Principal Risks</b>	<b>The key risks the organisation perceives to achieving its strategic goals</b>
<b>Key Controls</b>	<b>The controls or systems in place to assist in addressing the risk</b>
<b>Assurances on Controls</b>	<b>Sources of information (usually documented) which service to assure the Board that the controls are having an impact, are effective and comprehensive</b>
<b>Gaps in Controls</b>	<b>Where we are failing to put control/systems in place</b>
<b>Gaps in Assurance</b>	<b>Where we are failing to gain evidence that our control systems, on which we place reliance are effective</b>
<b>Risk Appetite</b>	<b>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.</b>

## 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

<b>Strategic Goal:</b> To deliver safe and high quality patient care as part of an integrated system  <b>Principal Risk:</b> (1) Failure to maintain and improve patient safety and quality of care  <b>CRR Ref:</b> MD 2a&b, 3, 4, 5, 6a&b, 7, 8, 10, 11 – CN 2, 7, 8, 17, 22, 24, 25, 26 – COO 2, 3, 6, 7, 8, 17, 18, 19, 20, 23 – HR 1a&b, 4, 9, 15, 18 – CE 5a&b, 9 – DE1, 2  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Quality)  <b>Director Lead:</b> Medical Director, Chief Nurse, Chief Operating Officer	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	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)
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structure including <ul style="list-style-type: none"> <li>o Assigned Director Portfolios, Structures &amp; Teams</li> <li>o Ward to board nursing structures &amp; teams</li> <li>o Patient Experience Steering Group</li> <li>o Safeguarding Children &amp; Adults Teams &amp; Internal &amp; External Structures</li> <li>o Health &amp; Safety Systems &amp; Groups</li> <li>o Infection Prevention &amp; Control meeting structures</li> </ul> </li> <li>- Strategies, Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Nursing and Midwifery Strategy, Patient Experience Strategy, Sign up to Safety Campaign pledges and Patient Safety Strategy.</li> <li>o Risk Management Framework</li> <li>o Performance Management Framework</li> </ul> </li> <li>- Systems &amp;Monitoring <ul style="list-style-type: none"> <li>o Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities</li> <li>o CQUINs &amp; contract monitoring</li> <li>o Recording of escalation systems NEWS etc</li> <li>o Medicines Management/EPMA implementation</li> <li>o National Surveys</li> <li>o NICE, NSF and Clinical Audit</li> <li>o Capital Programme</li> <li>o Maternity CNST</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- External inspections including CQC Reports</li> <li>- Internal Audit Programme</li> <li>- CQC and Choices website feedback</li> <li>- SHMI</li>   <li>- National Survey Action Plans, Friends &amp; Family Test</li> <li>- Premises Assurance Model, PLACE/TAPE Reports</li> <li>- Patient Experience Work Plan &amp; Quarterly Reports</li> <li>- Quarterly Pressure Ulcer &amp; Falls Reports</li> <li>- Mortality Reports – Learning from Deaths</li> <li>- IPC Quarterly Report &amp; Annual Report</li> <li>- Patient Safety, Quality, Workforce, Finance and Performance Report to Board/Committees</li> <li>- Annual Complaints Report to Board</li> <li>- Quality Report</li> <li>- Patient Safety Walk Rounds</li> <li>- NICE, NSF and Clinical Audits/Effectiveness Reports</li> <li>- Safeguarding Children &amp; Adult Reports to Board</li> <li>- Maternity Reports</li> <li>- Staffing Reports</li> <li>- Learning Hub Data</li> <li>- Health &amp; Safety Reporting</li> <li>- 7 day audit – 7 day task &amp; finish group &amp; plan</li> <li>- Integrated Board Report</li> </ul>	<ul style="list-style-type: none"> <li>- Implementation of 7 day working systems and controls <ul style="list-style-type: none"> <li>- Jnr Drs Contract (National)</li> <li>- 2003 Consultants Contract does not facilitate 7 day working(National)</li> </ul> </li> <li>- Mortality Reporting</li> <li>- Staffing Vacancies (CQC Report following unannounced visits – further CQC requests in Dec 19)</li> <li>- Infection Rates</li> <li>- Limited capital</li> <li>- Under performance against key national targets and standards</li> <li>- Safeguarding – specifically Adult MCA/DoLS</li> <li>- The potential risk of harm to patients in light of the issues raised by the CQC report/letters</li> <li>- Surge plan if social distancing ineffective</li> <li>- Critical care capacity – establishment of Nightingale Y&amp;H facility – transfer of care</li> </ul>

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<ul style="list-style-type: none"> <li>o Performance reporting and accountability/ performance reviews/ performance dashboards</li> <li>- Statutory and mandatory training – trained professional staff</li> <li>- A number of local adaptations in relation to 7 day working</li> <li>- Lead medical examiner role introduced</li> <li>- Covid 19 command structure</li> <li>- Daily bronze, silver and gold meetings</li> <li>- Action Log and Loggists in place</li> <li>- Weekly gold strategic meeting chaired by CEO</li> <li>- HCV &amp; North Yorks &amp; York command structure in place</li> <li>- Processes, pathways and SOPs in place</li> </ul>	<ul style="list-style-type: none"> <li>- COO led monthly operational performance meetings with each Care Group</li> <li>- CEO led efficiency meetings with each Care Group</li> <li>- QIA of each efficiency scheme signed off by MD and Chief Nurse.</li> <li>- Medical Examiner appointed</li> <li>- Local ownership of MCA/DoLS – matrons audit carried out – Nothing raised by CQC</li> <li>- Performance recovery plans</li> <li>- Performance framework (OPAMs)</li> <li>- Daily and weekly Covid 19 actions logs</li> <li>- Review at weekly gold CEO led group</li> <li>- Covid 19 dashboard</li> <li>- Submission of required Covid 19 returns for assurance</li> <li>- MCA/DoLS action plans/reaudit- took place in Nov 19 with action plans now in place &amp; no significant concern raised.</li> <li>-</li> </ul>	<ul style="list-style-type: none"> <li>- Access &amp; maintenance of adequate oxygen supply</li> <li>- Access to appropriate supply &amp; distribution of PPE</li> <li>- Increased risk of secondary deaths due to services not being accessed</li> <li>- Possible increased risk to children &amp; adults in community due to social distancing</li> <li>- Possible increased risk that some routine elements may be negatively impacted due to reduced reporting or staff absence</li> </ul> <div style="background-color: #e0e0e0; padding: 2px;"> <p><b>Actions</b> (Identify plans to address gaps)</p> </div> <ul style="list-style-type: none"> <li>- Mortality – Team to support Medical Examiner also linked to PS &amp; HCG Team restructure (Apr 20)</li> <li>- Staffing – East Coast Review looking at sustainability – CQC weekly monitoring continues (review Oct 20)</li> <li>- Infection Control - NHSE/I Lead Review &amp; Report – HPV Business Case approved &amp; machines on site (completed)</li> <li>- Care Group improvement programmes &amp; performance recovery plans developed by each Care Group (reviewed &amp; updated monthly)</li> <li>- CQC Unannounced visit &amp; Well Led responses and action plans (monthly monitoring at Board &amp; Quality Committee)</li> <li>- Safeguarding Team aware of risk to vulnerable adults &amp; children – access to team for advice &amp; support established during this period (review Oct 20)</li> </ul>
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<b>Strategic Goal:</b> To deliver safe and high quality patient care as part of an integrated system  <b>Principal Risk:</b> (2) Failure to maintain and transform services to ensure sustainability  <b>CRR Ref:</b> MD 8, 10 – CE 3, 5a&b, 8, 9 – COO 2, 3, 6, 7, 8, 13, 17, 18, 19, 20, 24 – DE1, 2  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Quality)  <b>Director Lead:</b> Chief Operating Officer	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 4	Likelihood = 5 Severity= 4	Likelihood = 2 Severity= 3
	Score: 20	Score: 20	Score: 6

Controls/Mitigation	Assurance	Gaps in Control/ Assurance
(What controls/ responses we have in place to assist in securing delivery of our objectives)	(Where our controls/ systems on which we are placing reliance, are effective)	(Where we are failing to put control/ systems in place)
<ul style="list-style-type: none"> <li>- Trust Committee &amp; Governance Structure <ul style="list-style-type: none"> <li>o Directors Portfolios – Transformation Lead</li> <li>o Business case management system</li> <li>o System Transformation Board</li> <li>o Care Group Structure implemented</li> </ul> </li> <li>- Strategies Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Development of Trust Strategy and supporting strategies</li> <li>o Development of Care Group Service Plans and associated Business Cases</li> </ul> </li> <li>- Partnership working <ul style="list-style-type: none"> <li>o HCV HCP engagement</li> <li>o ECIST Support</li> <li>o McKinsey Engagement</li> <li>o Partnerships &amp; Alliances</li> <li>o Health &amp; Wellbeing Board &amp; Place Based Boards</li> <li>o Peer Review</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Reports from E &amp; Y – McKinsey Reports</li> <li>- HCV HCP Reports/Papers</li> <li>- External Review - Scarborough</li> <li>- Peer Review</li> <li>- External Benchmarking of systems and pathways</li> <li>- Executive/ Board Papers</li> <li>- Care Group Pathway Redesign</li> <li>- Performance data</li> <li>- Partnership &amp; Alliance Reports</li> <li>- Y &amp; H Clinical Senate review of Urology and Paeds proposals</li> </ul>	<ul style="list-style-type: none"> <li>- Stakeholder Session to review Phase 2 of McKinsey Review due to be held on 31.01.20</li> <li>- Programme of work agreed with NHSI &amp; Stakeholders (commenced May 2019)</li> </ul>
		Actions (Identify plans to address gaps)
		<ul style="list-style-type: none"> <li>- Developed specs and tendered for a partner to support the review</li> <li>- McKinsey appointed and commenced the phase 2 review in May 2019 – concluded in Oct 19</li> <li>- Acute services review phase 2 steering group established with multi stakeholder representation</li> <li>- 2 Clinical reference groups undertaken to date which include hospital clinicians &amp; GPs.</li> <li>- McKinsey Review – oversight now by Programme Director (recruitment in Jul 20) (review Sept 20)</li> <li>- NY CCG to lead East Coast Redesign (Aug 20)</li> <li>- Finance Group established</li> <li>- Comms Group established</li> <li>- Presentation to Trust Board and Stakeholders following completion of the second phase (31.07.19) – planned for Nov 19 - completed</li> <li>- Yorks &amp; Humber Clinical Senate Review of proposed paediatric &amp; urology clinical/service models</li> <li>- Clinical senate review document to Board (Feb 20) –</li> </ul>

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		completed - Phase 3 commenced Jun 20 – Development of an East Coast narrative and engagement (Aug 20) - Engage public with proposed service models (review Oct 20)
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<b>Strategic Goal:</b> To deliver safe and high quality patient care as part of an integrated system <b>Principal Risk:</b> (3) Failure to meet national standards <b>CRR Ref:</b> COO 2, 3, 6, 7, 8, 13, 17, 18, 19, 20, 24 – CE 8 – MD 6a&b, 7, 8, 10 <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Quality) <b>Director Lead:</b> Chief Operating Officer, Chief Nurse, Medical Director	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 5	Likelihood = 5 Severity= 4	Likelihood = 1 Severity= 1
	Score: 25	Score: 20	Score: 1

Controls/Mitigation <small>(What controls/ responses we have in place to assist in securing delivery of our objectives)</small>	Assurance <small>(Where our controls/ systems on which we are placing reliance, are effective)</small>	Gaps in Control/ Assurance <small>(Where we are failing to put control/ systems in place)</small>
<ul style="list-style-type: none"> <li>- Trust Committee Structure/Governance <ul style="list-style-type: none"> <li>o Corporate Performance Team</li> <li>o Integrated Acute &amp; Planned Care Board (York &amp; SGH)</li> <li>o Care Group Structure implemented</li> </ul> </li> <li>- Partnership Working <ul style="list-style-type: none"> <li>o Ernst &amp; Young Diagnostic Work</li> <li>o ECIST engagement</li> <li>o YAS engagement</li> <li>o Health &amp; Care Resilience Board</li> <li>o HCV HCP Cancer Alliance Board</li> <li>o Complex Discharge Working Group</li> <li>o System Planned Care Steering Group</li> </ul> </li> <li>- Strategies, Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Trust Strategy, Clinical Strategy and Care Group Strategies</li> <li>o Policies &amp; Procedures/Standard Operating Procedures</li> <li>o Performance Recovery Initiatives</li> <li>o Winter Planning/System Resilience/Winter Plan</li> <li>o Trust Operational Plan</li> </ul> </li> <li>- Training &amp; Development</li> </ul> <p>Elements of assurance framework deferred ie: work plans, engagement with Internal Audit and 'routine' operational planning In line with national guidance, usual reporting</p>	<ul style="list-style-type: none"> <li>- E &amp; Y Reports</li> <li>- External Benchmarking of systems and pathways</li> <li>- Internal Audit Programme</li> <li>- Performance Reports</li> <li>- Operational Performance Recovery Plan</li> <li>- Winter Plan/System Resilience Plan</li> <li>- SAFER Local Delivery Plan</li> <li>- Planned Care Transformation Plan</li> <li>- Validation</li> <li>- Operational Plan</li> <li>- Learning Hub Data</li> </ul>	<ul style="list-style-type: none"> <li>- Continued challenges around achieving the ECS on a sustainable basis</li> <li>- Need to develop primary care and community services – East Coast Review – to include a system plan for out of hospital services.</li> <li>- Recruitment</li> <li>- Robust process required to identify harm</li> <li>- Due to pause in required reporting nationally during Covid, oversight of previous priorities may be lost.</li> </ul> <p style="text-align: center;"><b>Actions</b> <small>(Identify plans to address gaps)</small></p> <ul style="list-style-type: none"> <li>- East Coast Review Phase 2 (31.07.19) – presentation to Board (Nov 19) completed</li> <li>- HCV HCP capital bid for SGH – business case approved &amp; machines on site – Trust working to national timetable for submissions (review quarterly)</li> <li>- Recruitment - linked to strategic staffing risk (6) actions</li> <li>- Single integrated improvement plans being developed with regular monitoring via PAMs (from 1.8.19 onwards) – Y &amp; S refreshed post Covid (review quarterly)</li> <li>- Daily reporting of ECS performance &amp; ED breach analysis – identification of learning or areas for improvement (new format from Jul 19) – continues to be refined with support from ECIST) ECIST due back in Jul 20 (Sept 20)</li> </ul>

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<p>arrangements have been suspended. Current reports as per national requirements but minimal.</p>		<ul style="list-style-type: none"> <li>- Development of an ECS recovery plan for both sites – which continues to be refined with weekly monitoring by COO – ECIST due back in Jul 20 to support single implementation plans (Sept 20)</li> <li>- CEO led Acute Board responsible for oversight of York &amp; Scarborough improvement plans</li> <li>- Performance recovery plans developed for under performing areas (Jul 19 Board Subcommittee) – refresh &amp; forecast to Board (Nov 19) – Recovery Plan being drafted – to Board (Jul 20)</li> <li>- Ambulance handover action plan developed – improvement trajectory agreed with NHSI – monthly improvement trajectories monitored at Board sub committee</li> </ul>
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<b>Strategic Goal:</b> To deliver safe and high quality patient care as part of an integrated system  <b>Principal Risk:</b> (4) Failure to maintain and develop the Trust's estate  <b>CRR Ref:</b> DE 1, 2 – CN 8, 17 – MD 7  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources)  <b>Director Lead:</b>	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	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)
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structures               <ul style="list-style-type: none"> <li>o Estates Operational Management Structures</li> <li>o Health &amp; Safety Systems &amp; Groups</li> <li>o Capital Programme Executive Group</li> <li>o HCV HCP Capital Group Representation</li> <li>o SLAs between Trust and LLP</li> <li>o LLP Committees/Governance Structure</li> </ul> </li> <li>- Strategies, Policies &amp; Procedures               <ul style="list-style-type: none"> <li>o Capital Programme</li> <li>o Estates Strategy</li> <li>o PLACE/TAPE Programme</li> <li>o Compliance Report Schedule</li> <li>o HCV Estates Strategy</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Compliance with P21+ and DH approved process for specific capital schemes</li> <li>- Condition Surveys</li> <li>- HCV HCP Capital Group Reports &amp; Minutes</li> <li>- Internal Audit Programme</li> <li>- NHS Premises Assurance Model</li> <li>- Capital Programme Reports</li> <li>- PLACE/TAPE Reports</li> <li>- PLACE Report to Council of Governors</li> <li>- Sustainable Development Reports</li> <li>- Health &amp; Safety and Fire Reports</li> <li>- Capital Programme Executive Group Reports</li> <li>- Monthly Facilities Management Report</li> <li>- Board/Committee Reports</li> <li>- Health &amp; Safety Reports</li> <li>- First Party Audit Process</li> <li>- EPAM terms of reference</li> <li>- EPAM minutes to Resources Committee</li> </ul>	<ul style="list-style-type: none"> <li>- Contract management arrangements – structure in place (premeet Sept – 1<sup>st</sup> meeting Oct)</li> <li>- Lack of capital</li> <li>- Work associated with realigning wards for Covid has meant some minor works have been deferred (although some work has taken place)</li> <li>- Some key projects aligned to the CQC plan have been put on hold ie ligature and childrens area in York ED</li> <li>- Assurance meetings associated with Estates &amp; Health &amp; Safety have been deferred due to delivery of Covid actions.</li> </ul>
		<b>Actions</b> (Identify plans to address gaps)
		<ul style="list-style-type: none"> <li>- Condition Survey finalised -link to capital programme (Aug 19) (Resource Committee meeting being organised for Oct 19 – scrutiny at Resources Committee – Capital/Backlog maintenance discussion at Aug 20 Board</li> <li>- MSA (Apr 19) (+200 day review) - completed</li> <li>- Lack of capital put on CRR following Board discussion – management of programme through CPEG – Capital/Backlog maintenance discussion at Aug 20</li> <li>- Management Group – Executive Perf ToRs to Board (Sept 19) (Pre-Oct 19) (Commence Nov 19) EPAMs commenced – approved minutes to Resources</li> </ul>

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		<p>Committee (feb 20) - completed</p> <ul style="list-style-type: none"><li>- Business Case – computer aided facilities management system (Jul 19) – approved now being implemented – goes live (review Oct 20)</li><li>- CQC Plan areas ie: ligature and childrens area in York ED will be delivered immediately post Covid 19</li></ul>
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<b>Strategic Goal:</b> To deliver safe and high quality patient care as part of an integrated system  <b>Principal Risk:</b> (5) Failure to develop, maintain/replace and secure digital systems impacting on security, functionality and clinical care  <b>CRR Ref:</b> SNS 1, 74, DE2  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Resources – Jun 20)  <b>Director Lead:</b> Director of Finance	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 4  Score: 20	Likelihood = 4 Severity= 4  Score: 16	Likelihood = 3 Severity= 2  Score: 6

Controls/Mitigation	Assurance	Gaps in Control/ Assurance
(What controls/ responses we have in place to assist in securing delivery of our objectives)	(Where our controls/ systems on which we are placing reliance, are effective)	(Where we are failing to put control/ systems in place)
<ul style="list-style-type: none"> <li>- Systems &amp; Networks Team - governance structure <ul style="list-style-type: none"> <li>o Senior Management team meetings</li> <li>o Project Management Group</li> <li>o Technical Steering Group</li> <li>o Security Focus Group</li> <li>o Change Board</li> <li>o Information Governance Executive Group</li> <li>o Named SIRO and Caldicott Guardian</li> <li>o Attendance at Operational meetings</li> <li>o Capital Programme Executive Group</li> <li>o Digital Strategy Group</li> <li>o Performance Management Group</li> <li>o CCIO/CSO</li> <li>o Clinical Safety process</li> </ul> </li> <li>- Systems <ul style="list-style-type: none"> <li>o Capital Programme</li> <li>o Risk management</li> <li>o On-call Service</li> <li>o Internal monitoring/alerting systems</li> <li>o Third Party Monitoring</li> <li>o Ongoing User Awareness Programme</li> </ul> </li> <li>- External <ul style="list-style-type: none"> <li>o DSP Toolkit</li> <li>o NHS Digital Cyber Security Support Model</li> <li>o Third party support &amp; maintenance contracts</li> </ul> </li> <li>- Strategies, Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Digital Strategy</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- External &amp; Internal Audit Reports</li> <li>- Resources Committee and Board Reports</li> <li>- Board NHSI Declaration – Data Security &amp; Protection Requirements</li> <li>- Learning Hub Data</li> <li>- DSP Toolkit Compliance</li> <li>- Cyber Incident Handling Process</li> <li>- Disaster recovery plans</li> <li>- SNS Information Asset Register</li> <li>- Risk Register</li> <li>- Cyber Security Assessment &amp; Action Plan</li> <li>- SUS Data Quality</li> <li>- Development Programme – infrastructure, information &amp; clinical systems</li> <li>- Digital maturity assessment</li> <li>- Benchmarking data (Model Hospital)</li> <li>- User engagement and feedback</li> <li>- Incident Management reporting</li> </ul>	<ul style="list-style-type: none"> <li>- Continued challenges around end user experience</li> <li>- Lack of capital</li> <li>- Digital readiness (NHS Long Term Plan)</li> <li>-</li> <li>- Lack of CCIO available capacity</li> <li>- There are no nominated Digital leads in Care Groups and across the entire MDT structure</li> <li>- A structured programme of user engagement</li> <li>- greater demand on the team’s time, IT infrastructure and network due to Covid 19</li> <li>- Opportunites for transformational working lost once the pandemic is over</li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p style="text-align: center;">Actions</p> <p style="text-align: center;">(Identify plans to address gaps)</p> <ul style="list-style-type: none"> <li>- Lack of capital put on CRR, managed via CPEG</li> <li>- Resources Committee to oversee digital - completed</li> <li>- Digital Strategy Group to meet monthly as part of Executive Committee meeting (review Oct 20)</li> <li>- CDIO appointment in progress (Apr 20) – CDIO commences (Aug 20)</li> <li>- Building a Digital Ready Workforce engagement ongoing (Sept 20)</li> <li>- User feedback to be gained via a number of methods; surveys, email, roadshows, user training (ongoing, review Feb 20 inc. Clever Together feedback) (review</li> </ul> </div>

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<ul style="list-style-type: none"> <li>○ Information Security Management System</li> <li>- Training and induction of staff</li> </ul>		<p>Sept 20)</p> <ul style="list-style-type: none"> <li>- Cyber Essentials+ accreditation (June 2021)</li> <li>- Staffing increased to be reviewed (Sept 20)</li> <li>-</li> <li>- Transformational working to be picked up by Digital Strategy Group and Care Group Leads to ensure opportunities are not lost (Oct 20)</li> </ul>
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<b>Strategic Goal:</b> To support an engaged, healthy and resilient workforce  <b>Principal Risk:</b> (6) Failure to ensure the Trust has the required number of staff with the right skills in the right location  <b>CRR Ref:</b> HR 1a&b, 4, 9, 15,187 – CN 2, 24 - MD 2a&b, 8 – CE3, 5a&b, 9  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources)  <b>Director Lead:</b> Director of Workforce and OD	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 5	Likelihood = 5 Severity= 4	Likelihood = 3 Severity= 3
	Score: 25	Score: 20	Score: 9

Controls/Mitigation <small>(What controls/ responses we have in place to assist in securing delivery of our objectives)</small>	Assurance <small>(Where our controls/ systems on which we are placing reliance, are effective)</small>	Gaps in Control/ Assurance <small>(Where we are failing to put control/ systems in place)</small>											
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structure</li> <li>- Strategies, Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Supportive polices and processes</li> <li>o Workforce &amp; OD Strategy</li> </ul> </li> <li>- Processes &amp; Systems <ul style="list-style-type: none"> <li>o HCV HCP Workforce Strategy</li> <li>o Workforce redesign including ACPs, Nurse Practitioners, Nursing Associates and Physicians Associates</li> <li>o Bank Management and Governance</li> <li>o Appraisal processes – Job Plans</li> <li>o Apprenticeship Programme</li> <li>o Overseas Recruitment</li> <li>o Employer Brand including Partnership with FE/HE providers</li> <li>o Volunteering Programme</li> <li>o HYMS Expansion</li> </ul> </li> <li>- Statutory and Mandatory Training <ul style="list-style-type: none"> <li>o Development Opportunities ie: Leadership</li> <li>o Mentoring, Coaching/Mediation &amp; training</li> <li>o Learning Management System development</li> <li>o Post &amp; Undergraduate Medical Education</li> <li>o Medical library</li> </ul> </li> <li>-Covid19 specifically Skills questionnaire circulated to clinical staff – collating responses to enable safe deployment of staff</li> </ul>	<ul style="list-style-type: none"> <li>- Staff Survey/Staff FFT</li> <li>- National Apprenticeship standards</li> <li>- ROA reporting to HEE</li> <li>- Internal audit programme</li> <li>- National accreditation schemes</li> <li>- Annual quality assurance visits from HEE/HYMS</li> <li>- Library quality standards</li> <li>- Programmes designed and evaluated by HEI and NHS Elect</li> <li>- National Leadership Academy assurance</li> <li>- SSW/FTSUG Monitoring Reports</li> <li>- Turnover analysis (quantitative and qualitative)</li> <li>- Board &amp; Committee reports covering turnover, vacancy rates, stat &amp; mand take up, sickness absence data</li> <li>- Portfolios of learning evidence available</li> <li>- Staffing reports</li> <li>- E-rostering Data/CHPPD Data</li> <li>- Learning Hub Data including training course material</li> <li>- Exit Questionnaire Data</li> <li>- NHSI maintaining workforce safeguards</li> <li>- QIA for new nurse roles</li> </ul>	<ul style="list-style-type: none"> <li>- Work/life balance expectations of the future workforce</li> <li>- Brexit/ Immigration Policy</li> <li>-</li> <li>- Removal of nurse bursary</li> <li>- Objective Structural Clinical Exam (OSCE)</li> <li>- Age Profile</li> <li>- National changes to standards, applications &amp; implementation of new policies.</li> <li>- Effective utilisation of E Rostering Tool</li> <li>- Implementation of electronic job planning</li> <li>- HEE Policy/FE/HE varied uptake</li> <li>- Medical rostering system</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Actions (Identify plans to address gaps)</th> </tr> </thead> <tbody> <tr> <td>- Workforce redesign in partnership with FE/HE (Sept 20)</td> </tr> <tr> <td>- Staff Survey Action Plan in place &amp; being implemented (Sept 20)</td> </tr> <tr> <td>- Health &amp; Wellbeing Initiatives being implemented (Sept 20)</td> </tr> <tr> <td>- Workforce Plan (Oct 20)</td> </tr> <tr> <td>- Apprenticeship Steering Group Outputs (Jul 20)</td> </tr> <tr> <td>- Implementation of e-Job Planning (Oct 20)</td> </tr> <tr> <td>- Continue to develop Bank (Dec 20)</td> </tr> <tr> <td>- HCV HCP Workforce Action Plan (Oct 20)</td> </tr> <tr> <td>- East Coast medical recruitment project (Dec 20)</td> </tr> <tr> <td>-</td> </tr> </tbody> </table>	Actions (Identify plans to address gaps)	- Workforce redesign in partnership with FE/HE (Sept 20)	- Staff Survey Action Plan in place & being implemented (Sept 20)	- Health & Wellbeing Initiatives being implemented (Sept 20)	- 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)	-
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-													

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<p>Training of non-stat and man stepped down;  Retirees being contacted to facilitate returning  Students (nursing – final year and medical 4<sup>th</sup> 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)</p>	<ul style="list-style-type: none"> <li>- Covid 19 update</li> </ul> <p>Realtime sickness data being captured through  central 'hub'  Staff requiring isolation to be signed off via OH  and placed on medical suspension</p>	<ul style="list-style-type: none"> <li>- International Nurse recruitment (Sept 20)</li> <li>BAME risk assessment (Jan 21)</li> <li>-</li> </ul>
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<b>Strategic Goal:</b> To support an engaged, healthy and resilient workforce  <b>Principal Risk:</b> (7) Failure to ensure a healthy engaged and resilient workforce  <b>CRR Ref:</b> HR 1a&b, 4, 15 – CE8, 9  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources)  <b>Director Lead:</b> Director of Workforce & OD	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 4  Score: 20	Likelihood = 4 Severity= 4  Score: 16	Likelihood = 3 Severity= 2  Score: 6

Controls/Mitigation	Assurance	Gaps in Control/ Assurance
(What controls/ responses we have in place to assist in securing delivery of our objectives)	(Where our controls/ systems on which we are placing reliance, are effective)	(Where we are failing to put control/ systems in place)
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structure <ul style="list-style-type: none"> <li>o Occupational Health Service/EAP</li> <li>o Junior Doctor Forum</li> <li>o LNC/JNCC</li> </ul> </li> <li>- Strategies, Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Supportive policies and processes</li> <li>o Workforce &amp; OD Strategy</li> </ul> </li> <li>- Processes &amp; Systems <ul style="list-style-type: none"> <li>o Star Awards/Celebration of Achievement</li> <li>o Recruitment and Retention Processes</li> <li>o Workforce redesign including ACPs, Nurse Practitioners, Nursing Associates and Physicians Associates</li> <li>o Appraisal processes – Job Plans</li> <li>o Schwartz Rounds &amp; RAFT</li> <li>o HYMS expansion</li> <li>o LIVEX</li> </ul> </li> <li>- Statutory and Mandatory Training <ul style="list-style-type: none"> <li>o Development Opportunities including Leadership</li> <li>o Mentoring, Coaching/Mediation &amp; training</li> </ul> </li> </ul> <p>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</p>	<ul style="list-style-type: none"> <li>- Staff Friends and Family Test</li> <li>- Sickness absence analysis, Turnover analysis (quantitative and qualitative)</li> <li>- Board &amp; Committee reports covering turnover, vacancy rates, stat &amp; mand take up and appraisal rates</li> <li>- E-rostering Data/Flexible working data</li> <li>- Health &amp; Wellbeing Data</li> <li>- Learning Hub Data</li> <li>- Staff Survey</li> <li>- Health Assured Data</li> <li>- RAFT evaluation</li> <li>- FTSU/SWG monitoring data</li> <li>- Staff Benefits Programme</li> <li>- Fairness Champions</li> </ul> <p>Covid 19  Real-time sickness data collated via central 'hub'.  Support for Managers for virtual working</p>	<p>Work/life balance expectations of the future workforce  Shift patterns and impact on Health &amp; Wellbeing and HEE national policy  Insufficient training places</p> <p>Increased staff testing capacity for Covid 19  Delayed values and behaviours implementation due to Covid 19</p> <p style="text-align: center;"><b>Actions</b></p> <p style="text-align: center;">(Identify plans to address gaps)</p> <p>Staff survey action plan in place &amp; being implemented (Sept 20)  Continued Implementation of RAFT (Nov20)  Implementation of Health &amp; Well being Strategy (Dec 20)  Workforce Plan implementation (Oct 20)  Safer Working Group Feedback initiatives (continuous)  Line Manager Competency Training (Oct 20)  Clever Together Programme (Sept 20)</p> <p>Increase staff swabbing (Aug 20)  Test &amp; Trace set up (Sept 20)</p>

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<p>Staff testing for Covid 19 Helpline and support sessions staffed by Clinical Psychologists RAFT/TiPi Apps to support mental wellbeing (Headspace, unmind and Sleepio).</p>		
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<b>Strategic Goal:</b> To support an engaged, healthy and resilient workforce  <b>Principal Risk:</b> (8) Failure to ensure there is engaged leadership and strong, effective succession planning  <b>CRR Ref:</b> CE3, 8, 9  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources)  <b>Director Lead:</b> Chief Executive	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 4 Severity= 4  Score: 16	Likelihood = 4 Severity= 3  Score: 12	Likelihood = 1 Severity= 1  Score: 1

Controls/Mitigation	Assurance	Gaps in Control/ Assurance
(What controls/ responses we have in place to assist in securing delivery of our objectives)	(Where our controls/ systems on which we are placing reliance, are effective)	(Where we are failing to put control/ systems in place)
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structure <ul style="list-style-type: none"> <li>o Remuneration Committee</li> <li>o Nomination &amp; Remuneration Committee</li> </ul> </li> <li>- Strategies, Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Workforce &amp; OD Strategy</li> <li>o Gender Pay Analysis</li> <li>o WRES/WDES</li> <li>o HCV HCP workforce plan</li> </ul> </li> <li>- Statutory &amp; Mandatory Training <ul style="list-style-type: none"> <li>o Training and Development including various leadership courses</li> </ul> </li> <li>- Processes &amp; Systems <ul style="list-style-type: none"> <li>o Facilities Career Pathway development</li> <li>o Appraisal Processes</li> </ul> </li> </ul> <p>Talent Management Framework Covid Guidance for Managers for remote working</p>	<ul style="list-style-type: none"> <li>- Succession Planning Papers</li> <li>- Directors Portfolios</li> <li>- Team Structures</li> <li>- Learning Hub Data</li> <li>- Board/Committee HR Reports</li> <li>- Internal Leadership Programmes</li> <li>- Internal Managerial Programmes</li> <li>- Revalidation data</li> <li>- AIC Contract Monitoring across system</li> </ul>	<p>HEE National Policy</p> <p>Board gaps Board Development Up to date Succession Plan BAME representation at Board and in senior management</p> <p style="background-color: #cccccc;">Actions</p> <p>(Identify plans to address gaps)</p> <p>Progression and evaluation of internal leadership courses (Sept 20) Board development – Programme agreed at the December Board – Programme starts (Jan 21) CQC Action Plan in place – monitored monthly at Board (monthly) Clever Together portal to inform future plans (Sept 20)</p> <p>Succession Plan being developed (Sept 20)</p>

<b>Strategic Goal:</b> To ensure financial stability	Assurance Level
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<b>Principal Risk:</b> (9) Failure to achieve the Trust's financial plan  <b>CRR Ref:</b> DOF 1, 3, 4, 8, 9, 11 – COO 2, 8 – DE1, 2  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources)  <b>Director Lead:</b> Finance Director	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 5	Likelihood = 3 Severity= 3	Likelihood = 2 Severity= 3
	Score: 25	Score: 9	Score: 6

Controls/Mitigation	Assurance	Gaps in Control/ Assurance
(What controls/ responses we have in place to assist in securing delivery of our objectives)	(Where our controls/ systems on which we are placing reliance, are effective)	(Where we are failing to put control/ systems in place)
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structure <ul style="list-style-type: none"> <li>o Annual Planning Cycle and Business Planning Process</li> <li>o SFIs, Scheme of Delegation, Policies and Procedures</li> <li>o Efficiency Delivery Group and implementation of recommendations</li> <li>o Collective Board Ownership</li> <li>o Legally binding contracts</li> <li>o External and Internal Audit Services</li> <li>o PMM meetings</li> </ul> </li> <li>- Partnership Working <ul style="list-style-type: none"> <li>o Shared Risk Contract</li> <li>o HCV HCP and Partnership working ie: Contractual MOU</li> <li>o Local patch wide engagement through the System Delivery Board (SDB)</li> <li>o Medium Term Financial Plan for the system</li> </ul> </li> <li>- Processes &amp; Systems <ul style="list-style-type: none"> <li>o Care Group CIP Delivery Plans</li> <li>o Sound financial systems, cost controls and monitoring</li> <li>o Capital Programme Executive Management</li> <li>o Control Total Agreement (multi-year)</li> </ul> </li> <li>- COVID-19 Exceptional Measures <ul style="list-style-type: none"> <li>o Temporary suspension of PbR with nationally set block contracts recognising cost of services.</li> <li>o COVID-19 claims process for exceptional capital and revenue.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- External and Internal Audit Programmes</li> <li>- NHSI Reporting</li> <li>- External Audit - Value for money review</li> <li>- NHSI Use of Resources Review</li>   <li>- Monthly Accounts &amp; Reports</li> <li>- Operational Plan</li> <li>- Business Cases and benefits monitoring</li> <li>- Committee Papers including Audit and Resources Committee</li> <li>- Capital Programme Reports and monitoring</li> <li>- Medium Term Financial Planning</li> <li>- East Coast Review</li> <li>- HCV Partnership work</li> <li>- North Yorkshire &amp; York Leadership System</li> <li>- Primary Care Networks through CCGs</li> <li>- Engagement with stakeholders</li> <li>- Engagement with Local Authorities</li> <li>- Engagement with Partner Trusts (Harrogate, Hull &amp; Leeds)</li> </ul>	<ul style="list-style-type: none"> <li>- Continued recruitment difficulties placing financial pressure from agency and locum replacement staff resulting in pressure against the Trust's agency cap.</li> <li>- Failure to deliver system wide QIPP with financial pressure on the system partners and the Trust through the shared risk contract.</li> <li>- System affordability issues in relation to delivery of constitutional standards</li> </ul> <p><b>Actions</b></p> <p>(Identify plans to address gaps)</p> <ul style="list-style-type: none"> <li>- Multiple Recruitment initiatives listed on strategic risk 6 – MD, CN &amp; DoWF scrutiny &amp; challenge of agency rates, structured review of long term commitments each week (ongoing review quarterly).</li> <li>- Development and refinement of a system wide medium term financial recovery plan with deliverable QIPP requirements by the SDB Awaiting planning guidance &amp; financial operating framework post initial Covid response. Due July 20. Work underway with ICS on understanding current financial positions and resource requirements going forwards. Expected plan submission Aug/Sept 20</li> <li>-</li> <li>- Restoration and recovery draft plan prepared and submitted. Awaiting national planning guidance for next and final iteration. Expected plan submission Aug/Sept 20.</li> </ul>

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<ul style="list-style-type: none"><li>○ National cash process paying on 1 Apr and 15 Apr to ensure strong cash position for all providers.</li><li>- Temporary suspension of efficiency requirements</li></ul>		
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<b>Strategic Goal:</b> To ensure financial stability  <b>Principal Risk:</b> (10) Failure to develop and maintain engagement with partners  <b>CRR Ref:</b> CE3 – DOF 4, 11 – COO 2, 3, 6, 7, 8  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources)  <b>Director Lead:</b> Chief Operating Officer	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 4 Severity= 4  Score: 16	Likelihood = 3 Severity= 3  Score: 9	Likelihood = 2 Severity= 2  Score: 4

Controls/Mitigation	Assurance	Gaps in Control/ Assurance
(What controls/ responses we have in place to assist in securing delivery of our objectives)	(Where our controls/ systems on which we are placing reliance, are effective)	(Where we are failing to put control/ systems in place)
<ul style="list-style-type: none"> <li>- Partnership Working <ul style="list-style-type: none"> <li>o York/Harrogate Alliance</li> <li>o HCV HCP Executive Group and subsidiary working groups</li> <li>o HCV HCP Place Based Boards</li> <li>o HCV HCP Cancer Alliance Board and subsidiary working groups</li> <li>o York Primary Care Home Steering Group and subsidiary working groups</li> <li>o HCV HCP Hospital Partnership Group</li> <li>o SGH Acute Service Review Steering Group</li> <li>o Health &amp; Wellbeing Board</li> <li>o East Coast Strategic Review Group</li> <li>o Systems Transformation Board</li> <li>o OHC Services Strategy</li> <li>o HCV HCP Strategy &amp; Place Based Plans</li> <li>o Complex Discharge Steering Group</li> </ul> </li> <li>- Strategies, Policies &amp; Procedures <ul style="list-style-type: none"> <li>o Refreshed Trust &amp; Clinical Strategies</li> </ul> </li> <li>- HCV &amp; NY &amp; Y Covid 19 command &amp; control structure in place to ensure all partners understand role &amp; responsibilities during Covid 19 crisis - YTHFT engaged in all working groups. Covid – system meetings being held to co-ordinate actions</li> </ul>	<ul style="list-style-type: none"> <li>- CQC System Report</li> <li>- Agendas, minutes and papers of the various HCV HCP and partnership groups</li> <li>- HCV Executive Group – CEO attendance</li> <li>- Hull/York Partnership Board</li> <li>- Harrogate/York Partnership meetings</li> <li>- Quarterly System Finance Meetings</li>   <li>- OHC Services Reports</li> <li>- NHSI Action Plan</li> </ul>	<ul style="list-style-type: none"> <li>- Place Based Plans</li> <li>- System governance arrangements that describe approach to delivery of the system transformation programme</li> </ul> <div style="background-color: #cccccc; padding: 5px; margin-top: 10px;"> <b>Actions</b>  (Identify plans to address gaps) </div> <ul style="list-style-type: none"> <li>- Development of system plan (part of ICS work – review quarterly)</li> <li>- Proposal that sets out future ‘system’ governance, currently being developed by system partners – SM attended a workshop in July (review quarterly)</li> <li>- Clinical reference group (sponsored by Trust MD &amp; CCGs Clinical Chairs) established.</li> <li>- Quarterly System Finance Meetings – suspended due to Covid (review Nov 20)</li> </ul>

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<p><b>Strategic Goal:</b> To ensure financial stability</p> <p><b>Principal Risk:</b> (11) Failure to develop a trust wide environmental sustainability agenda</p> <p><b>CRR Ref:</b> DOF 1, 3, 4, 8, 9, 11 – HR 1a&amp;b, 4, 15, 18 – DE1, 2</p> <p><b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources) – now going to Quality Committee</p> <p><b>Director Lead:</b> Chief Nurse (reviewed April 2020)</p>	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 4  Score: 20	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)
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structure               <ul style="list-style-type: none"> <li>- Trust Sustainable Development Management Group                   <ul style="list-style-type: none"> <li>o Board Commitment</li> </ul> </li> <li>- Travel and Transport Group</li> <li>- Head of Sustainability</li> </ul> </li> <li>- Processes &amp; Systems               <ul style="list-style-type: none"> <li>o Good Corporate Citizen/ Sustainability Development Assessment Tool</li> <li>o Sustainable Development Unit Template (measures Carbon footprint)</li> <li>- Sustainability Champions</li> <li>- Consultancy Contract Phase 1 and 2</li> <li>- 12 month sustainable awareness development programme</li> </ul> </li> <li>- Partnership Working</li> </ul>	<ul style="list-style-type: none"> <li>- Sustainable Development Management Plan/Green paper under development to comply with Standard Contract 2020/21</li> <li>- Sustainable Development (SD) Reports/Papers</li> <li>- Transport Group Reports/papers</li> <li>- Compliance with NICE</li> <li>- Sustainability Annual Report</li> <li>- Trust Annual Report Sustainability Section</li> <li>- Carbon Savings figures</li> <li>- Savings Cost Benefit Analysis</li> <li>- Travel Plan</li> <li>- Benchmarking using SD Assessment Tool</li> <li>- Travel Survey</li> <li>- York Hospital selected as one of 12 in UK for Modern Energy Partners Programme to provide free sub-metering and pathway programme for buildings with aim of achieving 50% carbon reduction by 2032</li> <li>- Feasibility for electric vehicle charging at York Hospital</li> </ul>	<ul style="list-style-type: none"> <li>- Engagement of staff including Senior Management trust wide</li> <li>- Raised awareness when procuring plus Covid 19 impact on waste</li> <li>- Energy Reduction Working Group – est Oct 19 (work stopped in Mar 20 due to Covid 19 (SD Grp not held in May 20)</li> <li>- National Clinical Waste Provision Issue</li> <li>- Travel Survey Analysis – completed – Travel Plan being updated</li> <li>- Long Term Climate Change Act target changed to 0 carbon by 2050</li> <li>- NHS operational planning guidance 2020 requires all new builds to be net zero carbon standard</li> <li>- NHS Long Term Plan targets 2019 and NHS Standard Contract 2020-21- new risks highlighted – the contract requires a plan by Mar 21</li> <li>-</li> <li>- <b>Capital budgets not yet allocated</b></li> </ul> <p style="text-align: center;"><b>Actions</b></p> <p style="text-align: center;">(Identify plans to address gaps)</p> <ul style="list-style-type: none"> <li>- Restart Energy Reduction Working Group and SD Group ( July 2020)</li> <li>- Green Plan to with projects to achieve Climate Change Act Targets – reviewed annually – Aug 20</li> <li>- Business cases then to be developed ( March 2021)</li> <li>- Sustainable Development Assessment Tool Action Plan (reviewed annually) (last score Mar 20 62% - to improve by Mar 21</li> <li>- Clinical Waste – NHSI to monitor contract – nationally agreed to Mar 21 - awaiting further developments National Waste Strategy to be published in Summer of 2020 (delayed due to COVID 19 New frameworks expected, Improve recycling of waste for domestic black back and catering waste- new tenders delayed due to Covid 19 work - new</li> </ul>

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		<p>contracts Oct 2020)</p> <ul style="list-style-type: none"> <li>- Travel Survey actions to be included in the Travel Plan (Jun 20)</li> <li>-</li> <li>- Review of SD/Green plan including risks being conducted against Long Term Plan targets and NHS Standard Contract 2020-21 – risks to be reviewed at SD Grp (Jul 20) Comprehensive Business cases needed for electric vehicle charging infrastructure, reducing estate carbon emissions; reducing waste, water, vehicle use and procurement carbon impacts; &amp; achieving Climate Change Act Targets 50% by 2032 from 2017 and net zero by 2050 (Mar 21)</li> </ul>
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<b>Strategic Goal:</b> To ensure financial stability  <b>Principal Risk:</b> (12) Failure to achieve the system's financial plan  <b>CRR Ref:</b> DOF 1, 3, 4, 8, 9, 11 – COO 2, 8 – CE3  <b>Lead Committee:</b> Board (last formal review – Apr 20)(Jun 20 – Resources)  <b>Director Lead:</b> Finance Director	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 5	Likelihood = 3 Severity= 3	Likelihood = 2 Severity= 3
	Score: 25	Score: 9	Score: 6

Controls/Mitigation	Assurance	Gaps in Control/ Assurance
(What controls/ responses we have in place to assist in securing delivery of our objectives)	(Where our controls/ systems on which we are placing reliance, are effective)	(Where we are failing to put control/ systems in place)
<ul style="list-style-type: none"> <li>- Trust Committee/Governance Structure <ul style="list-style-type: none"> <li>o Annual Planning Cycle and Business Planning Process</li> <li>o SFIs, Scheme of Delegation, Policies and Procedures</li> <li>o Efficiency Delivery Group and implementation of recommendations</li> <li>o Collective Board Ownership</li> <li>o Legally binding contracts</li> <li>o External and Internal Audit Services</li> <li>o PMM meetings</li> </ul> </li> <li>- Partnership Working <ul style="list-style-type: none"> <li>o Shared Risk Contract</li> <li>o HCV HCP and Partnership working ie: Contractual MOU</li> <li>o Local patch wide engagement through the System Delivery Board (SDB)</li> <li>o Medium Term Financial Plan for the system</li> </ul> </li> <li>- Processes &amp; Systems <ul style="list-style-type: none"> <li>o Care Group CIP Delivery Plans</li> <li>o Sound financial systems, cost controls and monitoring</li> <li>o Capital Programme Executive Group</li> <li>o Control Total Agreement (multi-year)</li> </ul> </li> <li>- COVID-19 Exceptional Measures <ul style="list-style-type: none"> <li>o Temporary suspension of PbR with nationally set block contracts recognising cost of</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- NHSI&amp;E Reporting</li> <li>- Quarterly System Finance Meetings</li>   <li>- Monthly Accounts &amp; Reports</li> <li>- Operational Plan</li> <li>- Medium Term Financial Planning</li> <li>- East Coast Review</li> </ul>	<ul style="list-style-type: none"> <li>- Failure to deliver system wide QIPP with financial pressure on system partners and the Trust through the shared risk contract.</li> <li>- System affordability issues in relation to delivery of constitutional standards</li> <li>- Pressure on non-York FT CCG contract expenditure</li> <li>- Operational pressures for the Trust</li> </ul>
		<b>Actions</b> (Identify plans to address gaps)
		<ul style="list-style-type: none"> <li>- Awaiting planning guidance &amp; financial operating framework post initial Covid response. Due July 20. Work underway with ICS on understanding current financial positions and resource requirements going forwards. Expected plan submission Aug/Sept 20</li> <li>- Restoration and recovery draft plan prepared and submitted. Awaiting national planning guidance for next and final iteration. Expected plan submission Aug/Sept 20.</li> <li>- Full engagement with the ICS to develop and agree recovery plans for Aug/Sept 20 anticipated submission date.</li> </ul>

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<p>services.</p> <ul style="list-style-type: none"><li>○ Commissioner allocations adjusted to reflect increased provider funding.</li><li>○ COVID-19 claims process for exceptional capital and revenue.</li><li>○ National cash process paying on 1 Apr and 15 Apr to ensure strong cash position for all providers.</li><li>○ Temporary suspension of efficiency requirements</li></ul>		
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## Appendix 1: Calculating Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring.

SEVERITY INDEX		LIKELIHOOD INDEX*	
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely Very good control; or < 1 in 1000 chance (or less) within 12 months

\*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

**Severity** - Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

**Likelihood** - Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

**Differing Risk Scenarios** - In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the risk score is determined it is the highest I 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.

## Board of Directors – 30 September 2020 Care Quality Commission (CQC) Update Report

### Trust Strategic Goals:

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

### Recommendation

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

### Purpose of the Report

The purpose of this report is to provide the Board of Directors with an updated position of communication between the Trust and the Care Quality Commission (CQC), as well as action plan progress for regulatory requirements.

### Executive Summary – Key Points

- A new relationship owner from the CQC has been in position since the beginning of September 2020, communication is much improved.
- The Nominated Individual for the Trust has been updated, and the registration certificate now reflects the current Chief Executive Officer.
- The Statement of Purpose will be updated by the end of September 2020, allowing appropriate removal of registered locations that the Trust no longer manages.
- Director notifications will be submitted by the end of September 2020 for any Directors who have been appointed in the last 12 months.
- Regulatory action plans continue to make progress. Risk areas at present are Registered Sick Children Nurse (RSCN) within Scarborough ED – though recruitment is going well, so this is a short term risk.
- A “next-steps” CQC action plan will be developed and implemented by the end of October 2020, with a “Quality & Regulations Group’ being implemented to provide oversight.

### Recommendation

1. Accept this report as an updated position for the Trust in relation to communication with the CQC and the CQC action plan (Regulation 29A & Regulation 31 actions)

**Author:** Shaun McKenna, Head of Compliance & Clinical Effectiveness

**Director Sponsor:** Caroline Johnson, Deputy Director of Healthcare Governance & Patient Safety.

**Date:** 11/09/2020

## 1. Introduction and Background

York Teaching Hospital NHS Foundation Trust is a CQC registered care provider. Registration with the CQC was granted in 2010, but in order to maintain this registration the Trust must operate in line with the requirements of the Health & Social Care Act 2008 and associated regulations. An unannounced focused inspection took place within York Hospital Emergency Department, Scarborough Hospital Emergency Department and Scarborough Hospital Medical Services in January 2020. These areas were rated as 'inadequate' overall with Medical Care being rated as 'inadequate' for the safe domain. The Trust's overall rating is 'requires improvement'. An urgent notice of decision to impose conditions on registration was sent to the Trust on 17th January 2020. In addition to the conditions imposed, a Section 29A Warning notice was received on 21<sup>st</sup> January 2020. The warning notice serves to notify the Trust that the CQC have formed the view that the quality of healthcare provided by the Trust requires significant improvement. The purpose of this report is to provide the Quality Committee with an updated position of communication between the Trust and the Care Quality Commission (CQC), as well as action plan progress for regulatory requirements.

## 2. Detail of Report and Assurance

### 2.1 Engagement Meetings

Engagement meetings are taking place monthly between the Trust and the CQC. In July 2020, the Trust was informed that the current relationship owner from the CQC would be moving to a different Trust and a new relationship owner would be allocated to York Teaching Hospitals NHS Foundation Trust. The new relationship owner, who is a dual trained Nurse/Paramedic, took over the role from the beginning of September 2020 and is working closely with the Head of Compliance & Clinical Effectiveness. There is an intention, by October 2020, to change how engagement meetings will take place; the CQC anticipate they will be face-to-face (COVID dependent) and will include representatives from care groups with a presentation theme each month. This will support in demonstrating the progress the Trust is making in relation to the CQC action plan, and how this is improving patient safety & patient experience. Upon receipt of the new agenda, this will be shared with Care Group triumvirates along with any relevant outputs from the meetings.

### 2.2 Notifications

During July 2020, it was noted that the nominated individual on the Trust's registration certificate and the CQC website was not up to date. With this in mind, a notification was submitted to CQC on 6<sup>th</sup> August 2020 informing them of the current nominated individual. This was updated on 11 August 2020 and now reflects the current Chief Executive Officer. Whitby Hospital remains as a registered location for the Trust, which is no longer managed by the Trust. In order to remove this as a location, a revised Statement of Purpose is required. This is currently being developed, with a view to have this completed by 30 September 2020. Upon completion, the CQC will receive a notification and it is anticipated that registered locations will be updated to reflect current service delivery. Additionally it has been established that the CQC have not received notifications for any Directors that have been appointed within the last 12 months. Notifications have been drafted and are

due to be submitted by 30<sup>th</sup> September 2020. CQC are aware of the upcoming notifications and are content with the plan.

## 2.3 Communication

Since the new CQC relationship owner came into post, communication between the Trust & CQC has greatly improved. A minimum of 2 weekly calls are taking place between the Relationship Owner & the Head of Compliance & Clinical Effectiveness; these calls will discuss any notifications that the CQC have received from other providers such as safeguarding referrals and/or complaints and whistleblowing incidents. At the point of the new Relationship Owner taking over from her predecessor there were 4 safeguarding incidents that the CQC had open for the Trust; in addition a further 3 safeguarding incidents and 2 complaints have been received. The main theme identified is the perception of failed discharges, though when the investigation is complete; it may demonstrate that the perception of the reporter was incorrect. The safeguarding incidents have been shared with the Safeguarding Adults Lead and all incidents will be uploaded to Datix with immediate effect; this will ensure automatic notifications are sent to the relevant Care Group leads. Themes will be shared with Care Group triumvirates so that appropriate action and learning can take place.

## 2.4 Regulatory Action Plan Update (Appendix 1&2)

- 1. The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the Emergency Department with mental health needs. The system must take account of the relevant national clinical guidelines.**
- 2. The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the Emergency Departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.**

Both Emergency Departments have a mental health risk assessment tool in place to aid staff in their decision making and risk management for patients presenting to the departments with mental health presentations. In addition an environmental SOP is in place, this includes risk assessing the area in which the patient is located. Data is collected monthly on risk assessment compliance within the Emergency Departments, which demonstrates increasing compliance. Data has been shared with Tees Esk and Wear Valleys (TEWV) and the Clinical Commissioning Group (CCG), regarding delayed mental health assessments. A business case has been submitted from TEWV for a core24 service delivery model at Scarborough.

- 3. The registered provider must by 20 January 2020 ensure there must be a minimum of two registered sick children's nurses (RSCN) in the Emergency Departments at York Hospital, twenty-four hours a day, seven days a week.**

Staffing rates for RSCN's within both Emergency Departments are shared with the CQC on a monthly basis. A significant improvement was seen in June and July, however August seen a decrease in shifts covered for Scarborough Emergency Department. 8 clinical shifts did not have a RSCN within the Emergency Department; however the Paediatric In-Reach service was enacted with 2 hourly phone support offered from Paediatric Ward



Nurses. 2.8 WTE RSCN's commenced in the Emergency Department at the beginning of September with a further 1.4 WTE commencing at the end of September 2020. Upon completion of their supernumerary period, an improvement in consistent coverage at Scarborough will be noted. Agency and bank staff continue to be utilized for any shortfalls in the meantime. An escalation plan has been put in place within Care Group 5 for any occasions whereby shifts are not covered with at least one RSCN. 8 WTE RSCN's have been recruited for York Emergency Department and their fill rate has been consistently good for the last 3 months.

**4. 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).**

Assessment of environment across both Emergency Departments took place and resulted in identification of a designated anti-ligature mental health room. This was significantly delayed due to the COVID19 pandemic as contractors were unable to safely continue the work whilst active COVID19 cases were within the departments. Works have resumed with the specialist doors now fitted, minor works are remaining and a weekly plan is being provided from the project manager. The current working handover date is 5 October 2020. This is further strengthened through the actions in 1&2.

**5. 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 carried out since receiving the Regulation 29A Warning Notice. The COVID19 pandemic has seen a large reduction in attendances across the organization. Attendances have increased over the last few months and so the actions need to be reviewed to ensure they are having the desired effect. The Operations Improvement Plan will be explored to link this to the CQC action plan; this will be included in October's paper.

**6. Neither Emergency Department were meeting the standards from the Facing the future: standards for children in emergency settings.**

Standards have been audited across both Emergency Departments. This information feeds through the Paediatric Operational Steering Groups and Paediatric Strategic Oversight Group. An updated status against the standards is being created with an aim to have this in a report format by the end of October 2020; this will highlight any areas of work which require a focused view. Paediatric pathways and SOP's have been developed and are in use across both Emergency Departments. Nursing competencies for the adult workforce with the Emergency Departments have been carried out, to provide assurance that adult nurses are safely able to carry out Paediatric vital signs and understand the interpretation and escalation requirements. Scarborough Emergency Department does not have a Paediatric Emergency Medicine Consultant in post; the funding for this post has been agreed with the job role advertised externally. Mitigating actions (Appendix 3) have

been put in place to reduce any associated risk, which has brought the risk score down to 9.

There has been progress made in relation to creating appropriate environments to accommodate the needs of children, and accompanying siblings / parents. Scarborough Emergency Department has a waiting room in use which can accommodate three Paediatric patients with an accompanying adult and one designated Paediatric cubicle. Further work is required to meet the standards and possible Paediatric areas are being explored within Care Group 2. York Emergency Department has six Paediatric cubicles and no designated waiting area; options are being explored regarding a suitable waiting room for Paediatrics as there are occasions whereby more than 6 Paediatric patients are in the department at any one time.

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

Standardised paper documentation has been implemented across the Trust, including care plans and risk assessment tools. The Documentation Lead Nurse role has been appointed to, and the candidate is waiting to start in post. A working group for documentation is commencing by the end of October 2020. Perfect Ward went live at the beginning of September 2020, and will provide actions to improve documentation standards where required.

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

Scarborough Medical Services had their nurse staffing increased immediately after the January 2020 inspection; bank & agency staff members were utilized to fill these shifts. The fill rates are shared with the CQC on a monthly basis. A daily staffing huddle takes place between the Matrons, utilizing a staffing spreadsheet which demonstrates shift fill compliance for Scarborough Hospital. Risk and management of unfilled shifts are discussed at these meetings, and action taken with escalation where necessary. PILS compliance is monitored through the Integrated Board Report and shows that compliance for July 2020 in Care Group 2 was a combined total of 82%. York Emergency Department nursing staffing numbers were increased due to the COVID19 pandemic. The increase in staffing has continued and will be reviewed following the establishment review which is due to be completed by November 2020.

### **3. Next Steps**

By the end of Quarter 3, it is anticipated that evidence will be submitted to the CQC to provide assurance that the regulatory actions have been addressed; a request will be submitted to have the conditions associated with the trusts registration lifted. All regulatory actions identified during the inspections, highlighted in this report, will be addressed with substantial evidence to demonstrate compliance. The current action plan for all CQC

actions will be reviewed, highlighting specific actions that have been taken and establish whether the actions can be closed as complete. With this information a new “next-steps” action plan will be devised to explore what more can be done to streamline systems and processes to ensure further improved patient safety and patient experience. Any actions that cannot be closed from the existing action plan will be transferred to the new “next-steps” action plan which will use SMART actions. This will require joint working from the Care Groups, and the Patient Safety & Governance Team. A “Quality & Regulations Group” will be implemented from October 2020 to provide oversight and delivery of the “Next-Steps” CQC action plan. The terms of reference are being devised and will be ready for circulation by the end of September 2020.

#### **4. Detailed Recommendation**

1. Accept this report as an updated position for the Trust in relation to communication with the CQC and the CQC action plan (Regulation 29A & Regulation 31 actions)

# Appendix 1

## CQC Action Plan York Teaching Hospital NHS Foundation Trust - August 2020

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	Next steps/ timescales	RAG Rating
<b>Section 31 requirements</b>										
<b>1&amp;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</b>										
	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 anti-ligature 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 Facilities 2) Heads of Nursing CG1 and CG2	31.3.20	For the environment to be in line with the guidance.	Scarborough - Mental Health risk assessment implemented from 21.01.2020 Environmental SOP implemented in Scarborough ED from 22.04.20.  York - Mental Health risk assessment implemented. 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.  Audit demonstrates increased compliance for completion of mental health risk assessments.  Doors for anti-ligature mental health rooms have been fitted, due to be completed on both sites by the end of September 2020.	Trust Wide Ligature Risk Assessment.  Single policy streamlining mental health care to be developed, including paediatrics, adults, ED, and ward care.	
	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.	Review undertaken on both sites 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 Clinical Director.  SLA work ongoing with all partners.	Regular monthly monitoring to be undertaken, with escalation to TEWV / CCG as appropriate.  To continue to work with the CCG to ensure a robust SLA with KPI's that meet national standards.  There are now some issues with TEWV not being able to cover their current contractual obligations. Paper being prepared for CN&MD.	

	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 describe how they would assess and safely care for patients presenting with MH needs when waiting for support from a MH NHS Trust.	Scarborough - Mental Health risk assessment implemented from 21.01.2020. Environmental SOP implemented in Scarborough ED from 22.04.20.  York - Mental Health risk assessment implemented. 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.  Audit demonstrates increased compliance for completion of Mental Health risk assessments.  Doors for anti-ligature mental health rooms have been fitted, due to be completed on both sites by the end of September 2020.	Trust Wide Ligature Risk Assessment.  Single policy streamlining mental health care to be developed, including paediatrics, adults, ED, and ward care.		
<b>3. Paediatric nurse staffing was not in line with national guidance in the emergency department (York and Scarborough)</b>											
	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. Fill rates shared with CQC on a monthly basis.  In reach system from the ward used to support times when paediatric staffing is below planned.  Permanent RCN's appointed in to posts.	Training & Development plans for RCN's.  Streamline Paediatric Pathway documents to create one document which is accessible to all staff.		
	Chief Nurse	At the Scarborough ED 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.		Business as usual operational management.  Review SOP's now that compliance has consistently increased.		

## Appendix 2

CQC Action Plan York Teaching Hospital NHS Foundation Trust - August 2020										
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	Next steps/timescales	Rag Rating
<b>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 Network (PLAN) Quality Standards for Liaison Psychiatry Services.)</b>										
<b>Overall Rag Rating AMBER</b>										
Links to MD 7	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  Delayed due to Covid (Contractors unable to work on site).	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.	MH Risk Assessment to be covered in induction.  Re-Assess departments against standards set out within RCEM / PLAN.	
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	Scarborough - Mental Health risk assessment implemented from 21.01.2020 Environmental SOP implemented in Scarborough ED from 22.04.20.  York - Mental Health risk assessment implemented. 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.  Audit demonstrates increased compliance for completion of Mental Health risk assessments.  Doors for anti-ligature mental health rooms have been fitted, due to be completed on both sites by the end of September 2020.	Trust Wide Ligature Risk Assessment  Single policy streamlining mental health care to be developed, including paediatrics, adults, ED, and ward care.	
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.	Heads of Nursing	Ongoing	DATIX submitted SLA in place and being monitored.	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.  SLA work ongoing with all partners.	Regular monthly monitoring to be undertaken, with escalation to TEWV / CCG as appropriate.  To continue to work with the CCG to ensure a robust SLA with KPIs that meet national standards.  There are now some issues with TEWV not being able to cover their current contractual obligations. Paper being prepared for CN&MD.	

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.										
Overall Rag Rating AMBER										
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. Social distancing is likely to provide a challenge on available beds and flow. Daily attendances continue to increase.	Operations Improvement Plan to be included in CQC Action Plan.	
	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 for 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. Social distancing will also mean that ambulance handover times increase.	Operations Improvement Plan to be included in CQC Action Plan.	
	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 the 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.		SMART Actions to be agreed and implemented.	
	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.	Review effectiveness of implementation of SAFER bundles. Operations Improvement Plan to be included in CQC Action Plan.	

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 had been made against the target.	Actions require review to determine next steps. Operations Improvement Plan to be included in CQC Action Plan.	
<b>3. Neither Emergency Departments were meeting the standards from the Facing the future: standards for children in emergency settings</b>										
<b>Overall Rag Rating GREEN</b>										
	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 Scarborough 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 and implemented.  A new childrens record has been established which captures both nursing and medical information.	Streamline Paediatric Pathway documents to create one document which is accessible to all staff.  Facing the Future Re-Audits to be completed in September 2020 to determine next steps.	
	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.	Nursing competency pack developed with training delivered from Clinical Educators. All registered Nurses have completed the competency pack which includes observations and pain scores.		
	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.	Scarborough - Paediatric Waiting Area identified and in-use. (Can accommodate 3 paediatrics with one adult due to COVID19) 1 dedicated Paediatric cubicle.  York - 6 cubicles identified and children would be moved straight to a cubicle from streaming.	Dedicated waiting area to be identified in line with capital funding received for York.  Facing the Future Re-Audits to be completed in September 2020 to determine next steps.	
	Medical Director	At Scarborough Hospital Emergency Department there was no Paediatric emergency medicine trained doctor.	CG2 SGH	To ensure that there is appropriate support for paediatrics in the Emergency Department from a clinical perspective.	CG1 Clinical Director	31.03.2020	Appropriate clinical support in place.	PEM Consultant post advertised on NHS Jobs. Highlighted on risk register with numerous mitigating actions.	Further mitigating actions to be completed. (Due October 2020)	
<b>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.</b>										
<b>Overall Rag Rating GREEN</b>										
	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.	Paper documentation has been implemented across the organisation, including care plans and risk assessments.	Trust has agreed to fund the development of a digital nursing record to be implemented January 2021.	
	Chief Nurse	Of the 26 patients we reviewed where a decision to admit had been made in York Hospital Emergency Department, 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	30.04.20	Appropriate risk assessments in place. Audit showing improvement in risk assessments being undertaken.	Paper documentation has been implemented across the organisation, including care plans and risk assessments.	Perfect Ward system commencing September 2020.  Introduction of Documentation Lead Nurse (Interviews in September 2020).	



5. Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients										
Overall Rag Rating BLUE										
	Medical Director	Staff did not always report incidents and where they did there were often significant delays in reporting.	Corporate	To ensure that staff are appropriately reporting incidents as per Trust policy.	Deputy Director of Healthcare Governance	This issue was covered in the Trust response to the CQC on the Regulation 29a on 23 Jan 2020.	CQC responded 7/2/2020 advising no further information required.		Incident Reporting is currently being process mapped, this will determine any next steps that are required.	
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.										
Overall Rag Rating GREEN										
	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. A daily staffing huddle takes place, utilising a staffing template which demonstrates shift fills across the Scarborough medical wards. Bank and Agencies are used where necessary to ensure shifts are covered.	Monthly submission of staffing data to the CQC. Establishment reviews are taking place and are due to be completed by November 2020.	
	Medical Director	b) During the inspection it was found that: There were 3 WTE consultant vacancies at York Hospital Emergency Department.	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 Emergency Department.	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.	Staffing numbers uplifted during COVID Pandemic and have continued since. This will remain in place until completion of the establishment reviews.	Establishment reviews are taking place and are due to be completed by November 2020.	
	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.	Rolling programme of training to be visible and available	
	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 Emergency Department course. HEE advise a decision has been deferred until the end of June 2020.	Awaiting confirmation of the places via HEE once Universities are able to commence courses. This will not be before the end of June 2020.	

## Appendix 3

### Risk Assessment

<b>Risk Assessment Number:</b>	YTHFT003	<b>Assessment Date:</b>	6 <sup>th</sup> August 2020
<b>Revision Number:</b>	N/A	<b>Date last assessed:</b>	N/A
<b>Ward / Department</b>	Emergency Department: Scarborough	<b>Scheduled review date:</b>	Risk Register
<b>Activity</b>	PEM Consultant		
<b>Assessed by (1) – Print name</b>	Dr Ed Smith	<b>Signature:</b>	
<b>Assessed by (2) – Print name</b>	Dr Stephen Lord	<b>Signature:</b>	
<b>Assessed by (3) – Print name</b>	Shaun McKenna	<b>Signature:</b>	S.McKenna

Almost certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5
<b>Probability</b>	<b>Negligible / None (1)</b>	<b>Minor / Low (2)</b>	<b>Moderate (3)</b>	<b>Serious / Severe (4)</b>	<b>Catastrophic / Death (5)</b>
<b>Severity</b>					

**Remember**, it is advisable that risk assessments are reviewed annually, or sooner should any of the following occur

- New equipment is introduced, changes to working practices or processes occur, changes to legislation, following and accident / incident or any other significant change.

Risk	Person at Risk any environmental risk	Original Risk Score (without measures)
There is a risk of reduced governance around paediatric healthcare within Scarborough Emergency Department, caused by the lack of a Paediatric Emergency Medicine Consultant, resulting in care not being delivered in line with national standards.	Any child presenting to the Emergency Department in Scarborough.	P(4) * S(4) = 16

## Risk Assessment

<p>This risk assessment is to identify practicable mitigations, controls and safety measures that need to be applied or followed to eliminate or reduce the risk presented by the identified hazard.</p> <p><b>Controls / Mitigations in place:</b></p>		<p><b>Modified Risk Score (with measures in place)</b></p>
<ul style="list-style-type: none"> <li>At least one staff member trained in EPALS is on each shift within the Emergency Department</li> <li>There is at least one Registered Children's Nurse on each shift within the Emergency Department.</li> <li>All staff are trained in PILS within the Emergency Department (Compliance is 85%)</li> <li>Business case for PEM consultant with flexible rota submitted. Post advertised on 06/08/2020</li> <li>Children's Assessment Unit pathway updated to enable early direct access for Paediatrics.</li> <li>Competency Assessments have been completed on Adult Nurses to ensure competence when carrying out Paediatric Vital Signs.</li> <li>Paediatric training (including life support, safeguarding, and sick child) is a core part of induction for junior doctors.</li> <li>Board round hot topics relating to Paediatrics.</li> <li>Lead Nurse for Paediatric Safeguarding within the department</li> <li>Mandatory Safeguarding Training</li> <li>Early escalation to paediatrics for children causing concern either by paediatric nurse or medical team</li> <li>Information regarding best practice for Paediatric patients has been provided from PEM at York ED, and this information is available within the department.</li> </ul>		<p>P(3) * S(3) = 9</p>
<p><b>FURTHER RISK CONTROLS REQUIRED</b></p> <p>This section is to identify what further risk controls are needed where existing measures do not reduce risks to an acceptable level</p>		
<p><b>Further risk controls required</b></p>	<p><b>Person(s) responsible for development and implementation</b></p>	<p><b>Due Date</b></p>
<p>Identify a process whereby Medics discuss potential paediatric discharges with the EPIC prior to discharging from the department.</p>	<p>Clinical Director (CG2 ED)</p>	<p>September 2020</p>
<p>Working Group for standardised Paediatric pathways / guidelines / policies across the organisations Emergency Departments to be created.</p>	<p>Head of Compliance / Chief Nurse / Medical Director</p>	<p>October 2020</p>
<p>All doctors who need EPALS training have been identified; ensure all attend appropriate courses.</p>	<p>Clinical Director (CG2 ED)</p>	<p>October 2020</p>
<p>Recognised competencies for all Emergency Department Nurses (This is a long term action which could take over 12 months to complete)</p>	<p>Deputy Chief Nurse CG2</p>	<p>Commence by October 2020</p>
<p>Consider "crumpet" course delivery at Scarborough Hospital.</p>	<p>Medical Director to nominate a lead.</p>	<p>September 2020</p>

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## Board of Directors – 30 September 2020 Infection Prevention and Control (Q1- 2020/21)

### Trust Strategic Goals:

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

### Recommendation

- |                 |                                     |                          |                          |
|-----------------|-------------------------------------|--------------------------|--------------------------|
| For information | <input checked="" type="checkbox"/> | For approval             | <input type="checkbox"/> |
| For discussion  | <input type="checkbox"/>            | A regulatory requirement | <input type="checkbox"/> |
| For assurance   | <input checked="" type="checkbox"/> |                          |                          |

### Purpose of the Report

The report summarises surveillance information on healthcare-associated infections for Q1. The report also highlights environmental cleaning in relation to Healthcare Associated Infections (HCAI) management.

The Quality Committee are asked to note the current position in respect of HCAI and for their support for the actions being taken.

### Executive Summary – Key Points

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, *Methicillin Resistant Staphylococcus aureus* (MRSA) and *Methicillin Sensitive Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to *glycopeptide-resistant Enterococci*, bacteraemia due to three Gram negative bacteria (*Escherichia coli* (*E. coli*), *Klebsiella* species. and *Pseudomonas aeruginosa*) for Q1. The report also highlights environmental cleaning in relation to HCAI management.

- The *Clostridium difficile*-associated diarrhoea objective for 2020/21 has not been set but it is expected to be the objective for the previous year minus 1 which will mean having no more than a combined total of 60 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There have been a total of 11 COHA + HOHA cases for the first 3 months of 2020/21. We are currently under trajectory.

- The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There have been 0 trust-assigned cases for the first 3 months of 2020/21.
- There is no official MSSA bacteraemia target for 2020/21. There have been 13 trust-apportioned cases in the first 3 months of 2020/21.
- There has been an outbreak of *C.difficile* in Scarborough; strain type 001 which started on 27/06/2020 and affecting 3 patients on the Stroke ward. A combined Post Infection Review (PIR) meeting for the 3 cases has taken place and action plans have been developed and are being monitored by the IPC team. It is worth noting that the predominate strain from the current outbreak (001) is the same predominate strain from the Outbreak in early 2019 – suggesting we have not eliminated this strain from our environment

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Authors: Astrida Ndhlovu, Lead Nurse Infection Prevention & Control-York

Director Sponsor: Heather McNair, Director of Infection Prevention & Control

Date: 30/07/2020

## 1. Surveillance data

### 1.1 *Clostridium difficile*

The 2019/20 *C. difficile* definitions are as follows:

- a) Hospital onset healthcare associated (HOHA): cases detected in the hospital  $\geq 2$  days after admission.
- b) Community onset healthcare associated (COHA): cases that occur in the community (or within  $< 2$  days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- c) Community onset indeterminate association (COIA): cases that occur in the community (or within  $< 2$  days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.
- d) Community onset community associated (COCA): cases that occur in the community (or within  $< 2$  days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

There were 27 cases of *C. difficile* infection in Q1, 5 of which were classed as COHA and 6 were classed as HOHA, totaling 11 classed as trust-apportioned according to the new definition (table 1). The 2019/20 annual objective was to have no more than 61 COHA + HOHA cases.

An action plan detailing control measures that have been put in place in response to the *C. difficile* outbreak in Scarborough has been developed (appendix 1); and will be monitored through TIPCG.

Post Infection Reviews (PIR) are undertaken for all trust-apportioned *C. difficile* cases.

#### **Prior trust exposure**

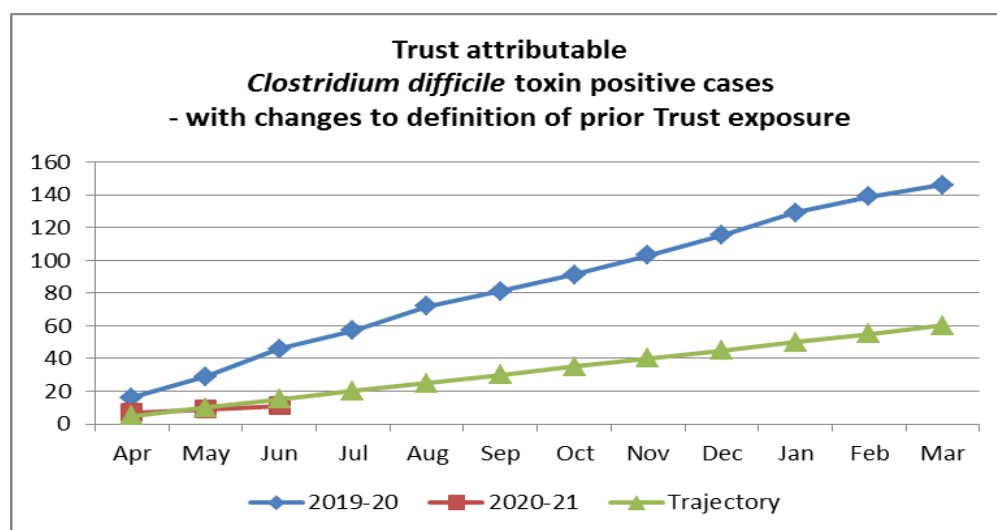
From 2020/21 the classification of *C. difficile* and MSSA bacteraemia cases that are to be determined as trust-apportioned has changed as outlined below. This means that cases that were not previously reported as trust-apportioned in 2019/20 will now be included.

The patient's admissions that should be included must meet all of the following:

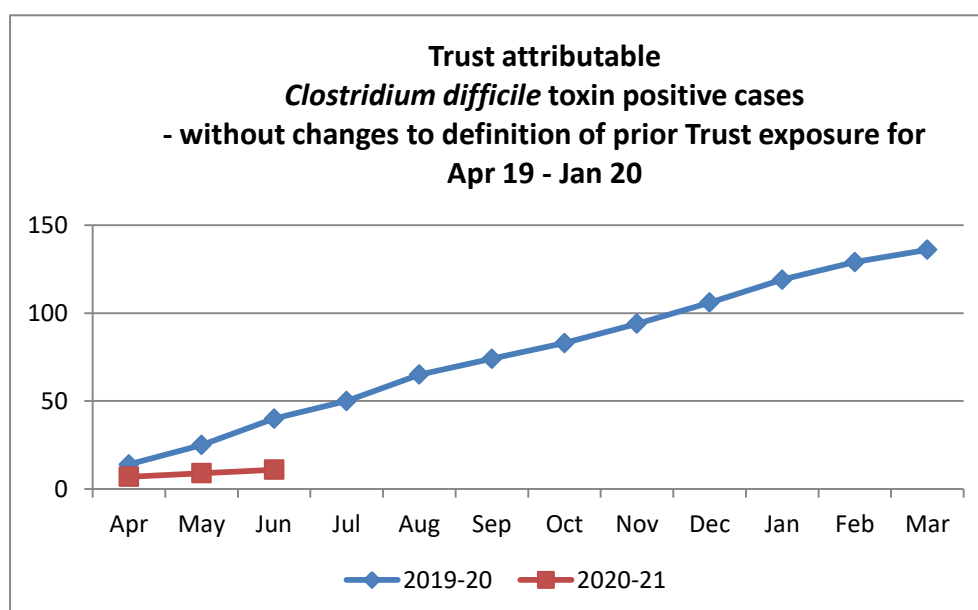
- admitted to the acute trust that reported the infection case
- admission either inpatient, day patient, regular attender or emergency assessment admissions

The following patient care episodes are excluded:

- all outpatient episodes should be excluded



Graph 1. Trust-attributable *C. difficile* toxin positive cases with new definition



Graph 2. Trust-attributable *C. difficile* toxin positive cases without new definition

## 1.2 MRSA bacteraemia

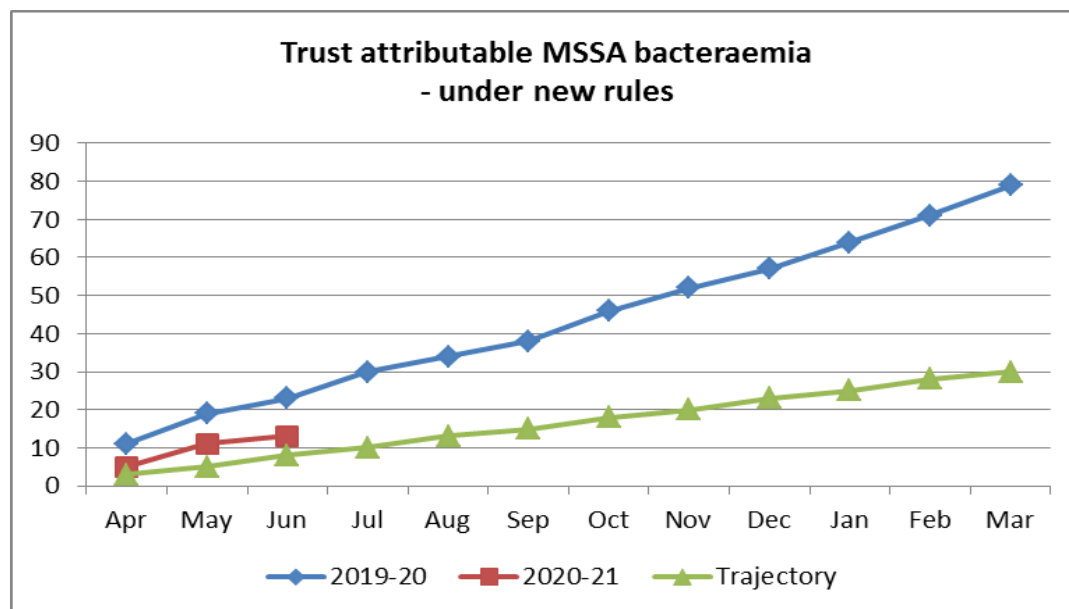
There have been 0 cases of MRSA bacteraemia for the first 3 months of 2020/21.

### 3 MSSA bacteraemia

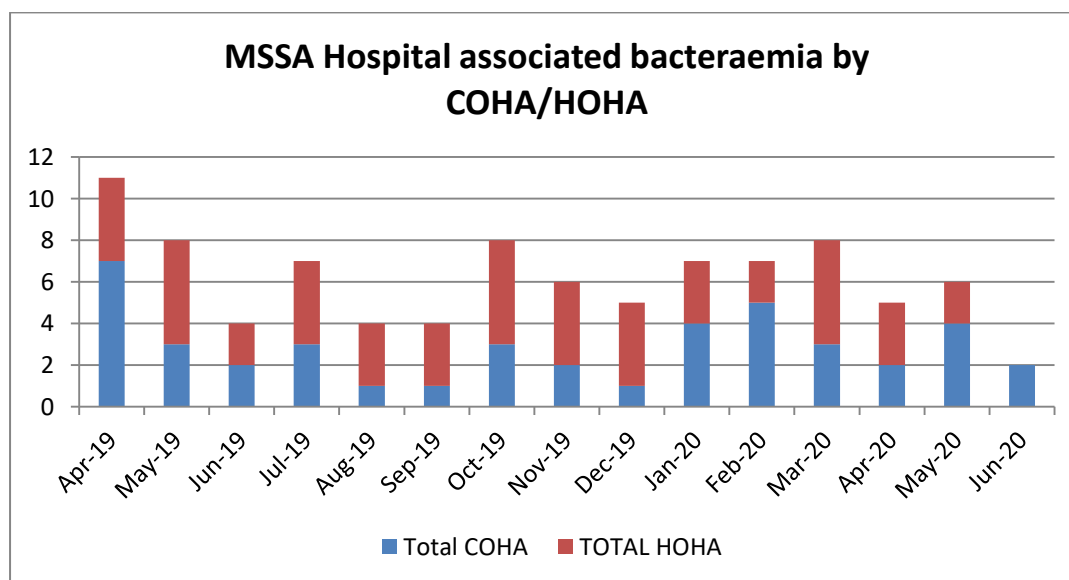
There were 37 cases of MSSA bacteraemia in the first 3 months of 2020/21; of which 13 were classed as trust-apportioned. Whilst there is no external target for MSSA, the trust has set an internal target of *Staphylococcus aureus* infections of which it was 30 of trust-apportioned cases for 2019/20. The trust is currently over trajectory based on last year's objective of 30 cases as we have 13 cases against 8 cases after 3 months.



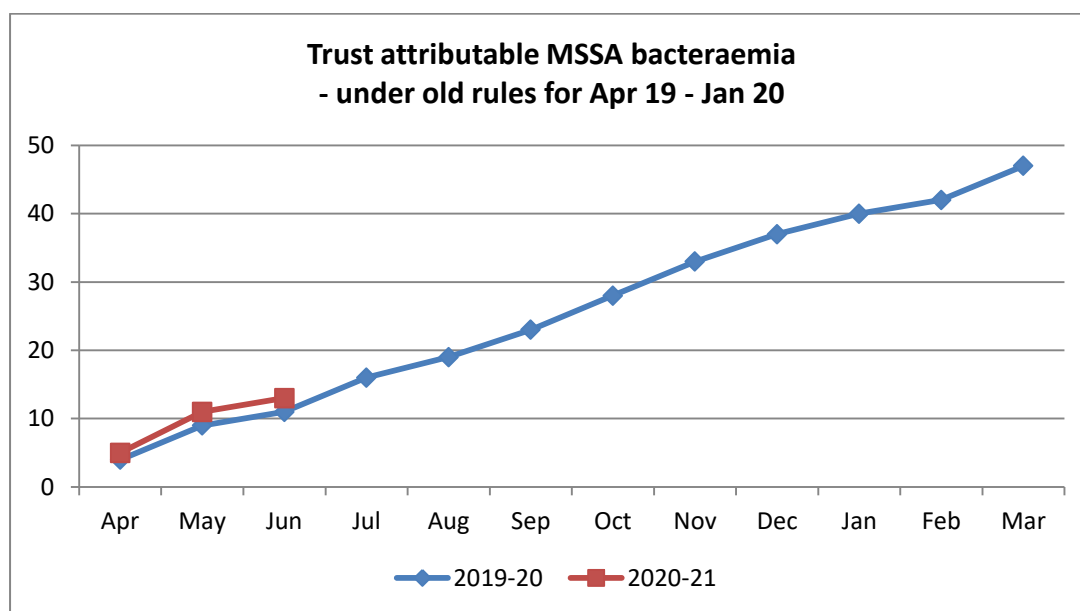
The trust continues to conduct peripheral cannula audits and share results with all Care Groups through the dashboard on the Q-Drive. The trust is also in the process of launching an app called 'my perfect ward' which will capture cannula management as a whole.



Graph 3. Trust-attributable MSSA bacteraemia cases with new definition



Graph 4. Trust-attributable MSSA bacteraemia cases by COHA/HOHA definition



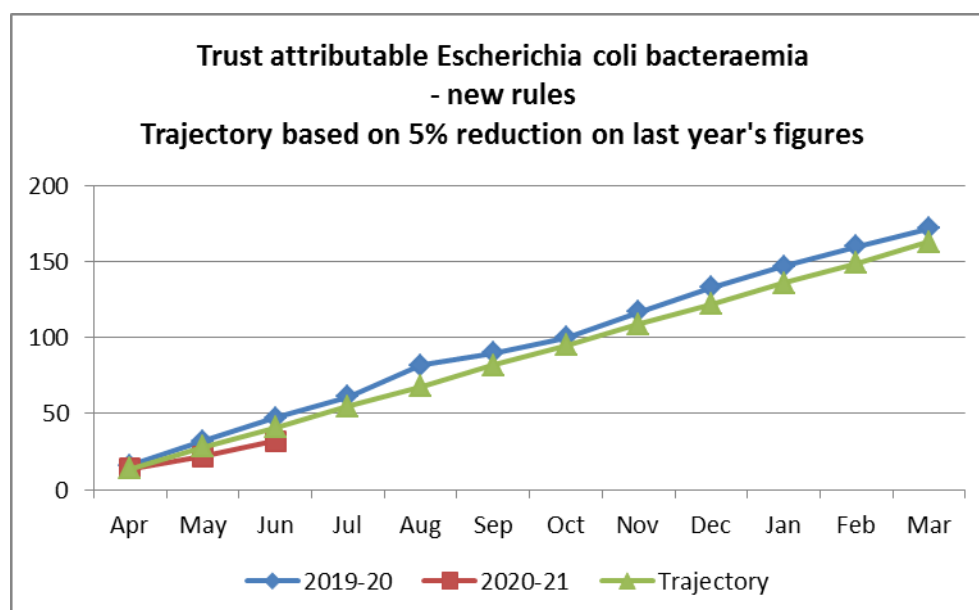
Graph 5. Trust-attributable MSSA bacteraemia cases without new definition

### 1.4 Gram Negative Blood Stream Infections (GNBSI)

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2022/2023.

In the first 3 months of 2020/21, the trust reported a total of 157 cases of three GNBSI organisms which are part of national surveillance (*E. coli*, 120; *Klebsiella sp.* 29; *Pseudomonas aeruginosa* 8). Of these, 44 cases were classed as trust-apportioned as defined by the Department of Health definition (*E. coli*, 32; *Klebsiella sp.* 7; *Pseudomonas aeruginosa* 5).

The trust is developing initiatives and reduction strategies to reduce rates of GNBSIs including central venous catheter care and training and education for staff.



Graph 6. Trust-attributable *E.Coli* bacteraemia cases with new definition

## 2. Outbreaks of diarrhea and vomiting

There were no outbreaks of diarrhoea and vomiting in the first 3 months of 2020/21

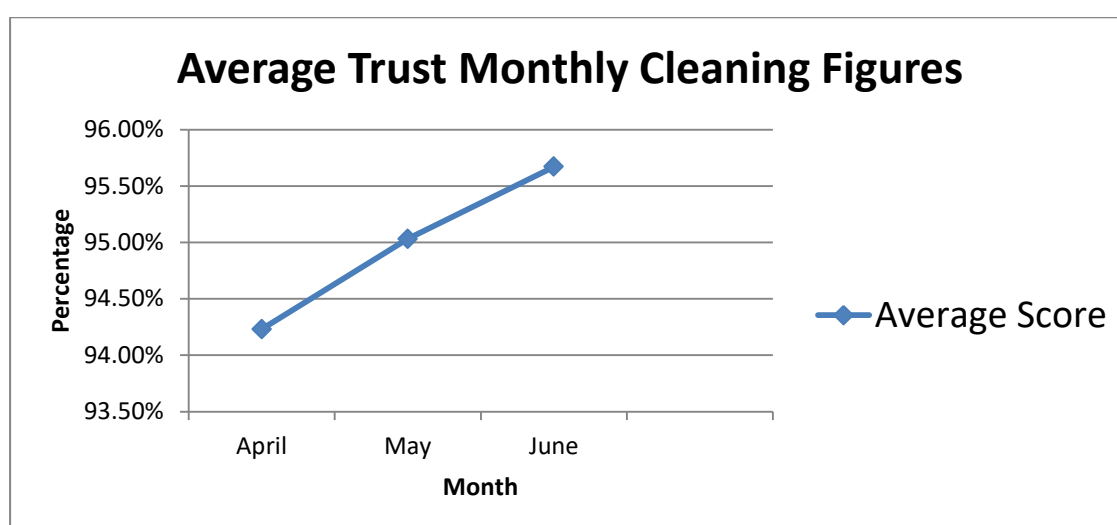
## 3. COVID-19

There were 612 cases of COVID-19 admitted to the trust in the first 3 months of 2020/21. There were 187 deaths of patients who tested positive to COVID-19 in the first 3 months of 2020/21.

The local prevalence of COVID-19 continues to be low according to PHE figures that are published weekly.

## 4. Cleaning scores

There has been a consistent improvement in the trust cleaning scores with the first 3 months of 2020/21 reaching over 95.5%. The trust will continue to monitor monthly cleaning scores through TIPSG.



Graph 6. Average trust monthly cleaning scores

ACTION PLAN FOR:	<b>Reduction in Clostridium Difficile Cases at SGH/BDH</b>
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DATE:	31/07/2020
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<b>OVERALL STATUS:</b>	In the last financial year (2019-2020) we had 76 cases of Clostridium difficile (Toxin positive) at Scarborough Hospital. In the current financial year, to date (23/07/2020), there have been 12 cases of Clostridium difficile (Toxin Positive) with the dominant ribotype of 001.
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<b>OVERALL RAG:</b>	
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Issue	Action	RAG	Owner	Review Date	Measure of Success	UPDATE
1 <b>Estates:</b> Wash hand basin not at every ward entry point	Request quote from LLP for the installation of a wash hand basin at the entry point to every ward on the Scarborough/Bridlington sites.		A Whitfield	31/07/2020	A Wash hand sink is installed at every ward entry location on the SGH site	A Whitfield emailed Jacob Snelson/Jason Wilshire 31/7/20
2 <b>Estates:</b> Unclear which areas of SGH site can't be HPV'ed	Undertake/update review of locations suitable for HPV'ing		J Pownell	31/07/2020	Up to date list of suitable areas for HPV'ing	Sent reminder 23/07/2020
3 Currently have a reactive model with regards to HPV Program	Identify a decant facility for SGH and BDH		D Thomas	24/07/2020	Identify an area to use as a decant facility	Ann Wright Identified as a decant area whilst awaiting potential work to be done to convert into 11 siderooms.
	Develop Proactive HPV plan for SGH and BDH		A Whitfield/S Kelly	31/07/2020	Have an agreed plan for the proactive HPV'ing of all areas at Scarborough hospital.	Have a draft plan produced. For review w/c 10/7/20. Requires Innovos Input
4						
5 <b>Estates:</b> Lack of isolation facilities	Work up plans to increase sideroom capacity		D Thomas	August	Increase of Sideroom capacity onsite from siderooms	Will hear if bid for funding to convert Ann Wright Ward into 11 siderooms was successful in August
6 <b>Estates:</b> Decontamination of beds	Complete Decontamination of Beds program at SGH and Enterprise Bed Upgrades		A Whitfield	24/07/2020	All beds have gone through Decontamination and upgrade program of work	Shaun Bryan reply - As of 31/7/20 we have 11 beds in Scarborough and 27 in Bridlington out of a total of 182 left to complete (79% completed). Pause during Covid due to lack of spares and resources. We now have the spares but we are waiting for confirmation from LLP finance manager that we have the money from the trust to claim overtime to complete the process.
7 <b>Facilities:</b> Use of Kentucky Mop heads across SGH site	Move to the use of reuseable Microfibre Mop heads across site		J Lough	31/07/2020	Reusable Microfibre mop heads in use across SGH and BDH	Confirm with Jenny Lough regarding progress for the funding
8 <b>Cleanliness:</b> Commode's regularly identified as being soiled via Audit	Regular Commode 19 audits (Weekly) performed		A Smith	31/07/2020	Weekly IPC audits completed and Improvement in results over a period of time (End August 2020)	
9 Patients currently transferred from ward to ward on own hospital bed	Setting up of a group to look at this particular issue and implement process		P Raferty to identify project lead	10/08/2020	Trolley's used to transfer patients, unless absolutely necessary to occur on a bed	Meeting Paul R 27.7.20
10 Improve Antibiotic prescribing	ARK Project – Relaunch/ reinvigorating the project		D Mawer/ Anita Chambers	End Sept	An increase of the proportion of antibiotics stopped within 72 hours	
12 Reduce Intra-ward transfers throughout the Trust	Intra ward transfer reduction project and associated documentation launched		TBC	End August		Meeting Paul R 27.7.20 to identify lead

	Unlikely to be completed without additional time or resource
	Likely to be completed but may require addition resource or time
	Due to be completed with no additional resource or time required

13	Learning from Post Infection Reviews (PIR's) to sit within the appropriate care group	Move to a model where the PIR's are run by the individual care groups - In this first instance by CG2 as a pilot for rest of Trust		P Raftery/ A Whitfield	End August	Care Group 2 C- Diff PIR's run by CG and monitored by Care Group Quality Group and then plans to replicate across all other care groups	Meeting with Paul Rafferty on 27.7.20 See Annette Williams SOP from 23/07/20
14		Develop a strategy with the communications team to raise awareness		A Whitfield	10/08/2020	Have a communication strategy document	Sent email Comms 22/07/20
15	Lack of awareness on site of current Clostridium Difficile issue on SGH/BDH sites	Identify a lead clinician on site to drive message forward		Tim Houghton	03/08/2020	To have an identified consultant to lead/assist in program of work to reduce C.Diff across the site.	Tim Houghton will identify a consultant from care of the elderly to attend the C.Diff outbreak meeting
16		Introduce weekly IPC matron's huddles		IPC Team	31/08/2020	To have weekly IPC matron huddles	
17	Different products in use by staff to decontaminate equipment. Including separate Sporicidal wipes that require water to be activated	Explore potential of moving to a single wipe which contained detergent, disinfectant and sporicidal agents to reduce confusion among staff and to ensure that the sporicidal was being used all the time everywhere.		Astrida Ndhlovu/IPC Team	End Sept	Identify potential alternative product to be put forward to procurement	
18	When a patient with C.diff is moved out of a bay it is currently adhoc as to if the bay would be decanted to allow for terminal clean and HPV.	Look at establishing a process that when a patient with C.diff is moved out of a bay, the bay has to be decanted to allow for terminal clean and HPV.		Alison Wright	01/09/2020	It becomes the exception not to decant a bay to allow for a terminal clean and a HPV	
19	Lack of storage in general and equipment stored in inappropriate places	Introduction of declutter programs		IPC Team	01/09/2020	Have a declutter program established	
20	Improve assurance around cleanliness and quality of Mattresses	Introduction of mattress audits which results in replacing damaged/soiled mattresses.		IPC Team	End Sept	Regular Mattress audits introduced and established	

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## Board of Directors – 30 September 2020 Implementing Continuity of Carer in midwifery services

**Trust Strategic Goals:**

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

**Recommendation**

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

**Purpose of the Report**

Action plan to deliver 51% of continuity of midwifery carer to York Teaching Hospitals NHS Foundation Trust by March 2021

**Executive Summary – Key Points**

There is strong evidence along with many national drivers to support the use of Continuity of Carer in maternity services as an operating service model and choice for women.

To implement this recommendation, with relation to achieving the 2019/2020 target of 35% of women being cared for within a continuity of carer model, at York Hospitals we have:

- Piloted 3 schemes at Scarborough and York sites
- Successfully bid for transformation funds 2019/20 to implement wholesale change at Scarborough site
- Launched the wholesale change at Scarborough site
- Launched an on-call case-loading team at York site
- Launched an on-call case-loading team at Scarborough site

**Recommendation**

The key recommendation linked to this report is for most women to receive continuity of carer (CofC), to ensure safe care based on a relationship of mutual trust and respect in line with the woman’s choices and decisions.

Author: Gillian Locking

Director Sponsor: Heather McNair, Chief Nurse

Date: 08/09/2020





## 1. Introduction and Background

Maternity Services in England have remained in the spotlight since the publication of Better Births in April 2016, the report of the National Maternity Review. The national Maternity Transformation Programme is the vehicle used to facilitate the implementation of the Better Births recommendations.

Continuity of carer means there is consistency of the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour, and the postnatal period. This includes a named midwife taking responsibility for coordinating a woman's care, and for ensuring all the needs of the woman and her baby are met, at the right time and in the right place, throughout the antenatal, intrapartum and postnatal periods. Consequently the woman will develop an ongoing relationship of trust with her midwife, who cares for her over time.

## 2. Detail of Report and Assurance

Month	Number of births attended by woman's continuity team midwife	Births attended by woman's continuity team midwife as a percentage off all Scarborough births.	Births attended by Continuity Team midwife as percentage of all Trust births	Births attended by non-continuity midwife as percentage of Trust births
January	33	31%	9%	91%
February	28	26%	8.5%	91.5%
March	32	27%	8.7%	91.3%
April	21	21%	6.4%	93.6%
May	28	24.8%	7.7%	92.3%
June	36	26%	11%	89%
July	60	39%	16.5%	83.5%
August	58	38%	17%	83%

Total Trust bookings for August = 413

All women booking for care with Scarborough teams are placed onto a continuity pathway.

Scarborough bookings = 126

York Sapphire teams include 4 GP cohorts / geographically based.

Sapphire team bookings = 14

**CoC booking percentage for June = 34%**

**As a Trust we have provided 17% of continuity of carer for births in August.**

In January, Scarborough established 5 geographical teams to provide an integrated approach to continuity of carer. One team, the Jasmine team have opted for an on call model of care, which commenced on 13<sup>th</sup> July 2020. Since the team have commenced, they have provided continuity of carer, including intrapartum care to 80% of their caseload.

In August, 38% of all births at Scarborough had their continuity team midwife present. This is similar to July, evidencing the benefits of the on call model. The Jasmine team were

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

commenced without additional staffing and work is currently underway to explore the option of commencing a second on call team at Scarborough.

Our York based Sapphire team, provided 71% of intrapartum care to their caseload in August. July evidenced a similar percentage. There are plans in place to expand the team by 1 midwife and an MSW, funded by the LMS to allow the team to incorporate a further caseload, with the aim to increase BAME women booked onto a continuity of carer pathway as outlined in national drivers. This should increase sustainability of the Sapphire team.

The continuity of carer lead midwife reports progress locally, to the LMS and regional continuity of carer sub group. Assurance reports and visits have been conducted from the regional continuity team, with feedback indicating York Teaching Hospitals NHS Foundation Trust are progressing well with plans.

Local audits are completed on a monthly basis, with plans to involve service user feedback to continually improve care.

### 3. Next Steps

A business case will be required to support plans for 2020/21.

Based on available evidence, case-loading 700 women will provide the following positive outcomes:

- 16% less likely to lose their baby
- 15% fewer epidurals, providing an annual cost benefit of £21,250.
- 24% fewer preterm birth, providing a cost benefit of £12,505.87 for each Level 2 cot day plus ongoing costs of caring for a preterm infant.
- 16% fewer episiotomies, which would equate to 22 women every year not having an episiotomy
- 10% less likely to have an instrumental birth, which would equate to 10 fewer women having an instrumental birth every year.

We will continue to report our monthly progress to the board.

## Board of Directors – 30 September 2020 Medical Director's Public Report

### Trust Strategic Goals:

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

### Recommendation

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

### Purpose of report

This report provides an update from the Medical Director in, quality, safety and effectiveness.

### Executive Summary -Key Points

The report updates the Quality Committee on the redesign of the Governance, SI processes and risk registers.

The report also provides an update in relation to improvement work underway to improve the Trust performance in relation to 7-day services.

The proposed implementation of ReSPECT in Care Group 5 is outlined. ReSPECT is a process whose aims are to facilitate individualised shared decision making with people who are at risk of acute deterioration, and the documentation of such discussions and decisions.

The Board are provided with an update in relation to progress against the actions arising from an internal audit of consent.

### Recommendation

The Board is asked to note the Medical Directors Report for September 2020.  
The Board is asked to approve the development of a project plan for Care Group 5 to move to using ReSPECT.

Author: Caroline Johnson – Deputy Director of Governance and Patient Safety.

Director sponsor: Mr. James Taylor, Medical Director

Date: 14.09.2020



## 1. Introduction and Background

The Medical Director’s report provides an update in relation to quality, safety and effectiveness, antibiotic usage, serious incident process review, risk management and 7-day services.

## 2. Quality Governance

The review of governance processes is continuing in September with the Care Group mapping sessions. Options for the proposed corporate clinical governance structures were discussed with Care Group Directors and the Chief Pharmacist at the September Executive Quality Committee. The consensus of the group was to streamline the number of meetings that senior leaders are required to attend, and it was proposed that the Executive Quality Meeting be replaced by a Quality and Patient Safety (QPaaS) group which will be longer in duration (3 hours) and the agenda will be developed to ensure the 3 domains of quality are covered – safety, experience and effectiveness.

The review of the governance structures facilitated by the Service Improvement Team has commenced and the proposed new Corporate level structures and associated terms of references will be presented to the Quality Committee in October 2020 as agreed.

## 3. Clinical Effectiveness and Audit

The redesign of our approach to the clinical audit and clinical effectiveness processes continues. The lead internal audit team is undertaking a controls improvement audit in September to support the overall improvement process. This section provides an update in relation to NICE baseline assessments and National Audit Outlier Status.

### NICE Baseline Assessments Overdue for Completion

Table 1 below outlines the baseline assessments that are currently overdue. These have been shared with the relevant care group or corporate team and will be monitored for delivery.

**Table 1 – Overdue Baseline assessment**

Ref no	Title	Date	Care Group	Update
NG 056	Multimorbidity: clinical assessment and management	09/2016	Corporate	Previously escalated to CEG.
NG 130	Ulcerative colitis: management	05/2019	CG1: CG2	No baseline received, lead requested further time to complete
NG 129	Crohn’s disease: management	05/2019	CG1: CG2	No baseline received, lead requested further time to complete
NG 140	Abortion care	09/2019	CG5	No baseline received, lead requested further time to

Ref no	Title	Date	Care Group	Update
				complete
NG 147	Diverticular disease: diagnosis and management	11/2019	CG3	No baseline received, requested update from CG governance lead.
NG 150	Supporting adult carers	01/2020	Corporate	No baseline received, requested update from lead
CG 137	Epilepsies: Diagnosis and management	02/2020	CG6	No baseline received, lead requested further time to complete
NG 156	Abdominal aortic aneurysm: diagnosis and management	03/2020	CG3	No baseline received, requested update from CG governance lead.
NG 158	Venous thromboembolic diseases: diagnosis & management	03/2020	CG1: CG2	No baseline received, lead working on completion
CG 095	Chest pain of recent onset: assessment and diagnosis	11/2016	CG1:CG2	Lead working on completion

### **Actions Arising from Not Compliance with Baseline Audits**

A total of 2 NICE guidelines have previously been agreed by the Clinical Effectiveness Group and escalated to the Trust board as 'Not compliant'. Table 2 below provides an update of actions to address these.

**Table 2: Non-Compliant NICE Baseline Audits**

Ref no	Title	Last updated	Update
CG094	Unstable angina and NSTEMI: early management	01/11/2013	Due to be superseded by NICE <b><u>Acute coronary syndromes</u></b> November 2020. Baseline will be requested for the new guidance and this one will be marked as obsolete.
NG033	Tuberculosis	01/09/2019	Occupational health have confirmed 'not compliant' with this guidance, however, there is currently no agreed plan to achieve compliance. Head of Compliance will liaise with occupational health regarding completion of this Baseline as there has recently been a RIDDOR reportable incident related to TB.

### **National Audit Outlier**

The Chronic Obstructive Pulmonary Disease (COPD) clinical audit, a component of NACAP, is a continuous audit launched on February 2017 in England and Wales and 2018 in Scotland. It captures the process and clinical outcomes of treatment in patients admitted in England, Scotland and Wales with COPD exacerbations. As can be seen in the outcomes and action plan below, the audit has identified some learning for the Trust.



The latest audit data relates to the cohort of patients discharged between 01 October 2018 and 30 September 2019. NACAP COPD forms part of NHSE Quality Accounts 2020-21.

### Standards Audited

NICE Quality standard [QS10] – Chronic obstructive pulmonary disease in adults, 2011  
 NICE guideline [NG115] – Chronic obstructive pulmonary disease in over 16s: diagnosis and management, 2018

### Audit Outcomes and Action Plan

Table 3 below outlines the outcomes and actions arising from this audit.

**Table 3: Outcome and Actions**

Summary of Issue	Actions Required	Action Lead	Completion Date	Evidence
<b>Scarborough Hospital</b>				
Oxygen Prescribing	This is a medical prescribing issue. - We will continue to prompt on EPMA - For a persistent non prescriber we will complete a DATIX. - We have discussed a default prescription but this needs a trust wide permission.	Dr Mike Pond Hazel Kavanagh	December 2021	Training dates for medical staff from 03/09/2020
Smoking Cessation	Following clarification from the NACAP team, when a patient declines a referral / advice, this is now recorded as an intervention; we previously have not reported this despite having had the conversation with the patient.	Dr Mike Pond Hazel Kavanagh	June 2021	As per the clarification by NACAP

Summary of Issue	Actions Required	Action Lead	Completion Date	Evidence
<b>York Hospital</b>				
Appropriate patients with COPD do not receive non-invasive ventilation (NIV) within 2 hours of admission.	Improve access to NIV within 2 hours of admission for those patients who are acutely unwell and require NIV. Respiratory Outreach Service to be established over winter 2020/21 in conjunction with Ward 34.	Judith Norell, Donna Jack, Rebecca Howells	September 2021	Improved audit results going forward 2020-21





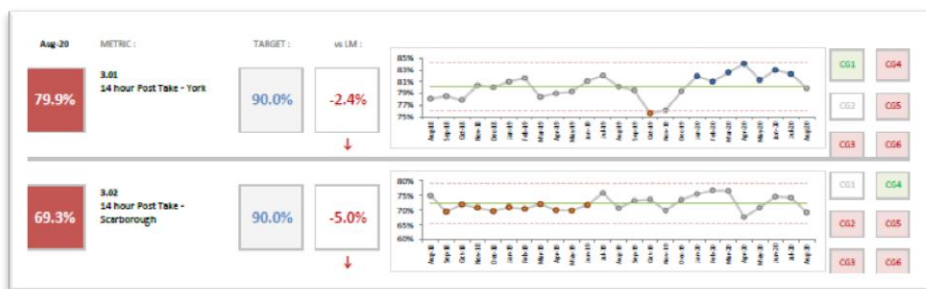
## 4.1 Patient Safety

The redesign of the Serious Incident processes is continuing. Six serious incidents were declared in August (3 pressure ulcers, 2 falls and 1 surgical complication). In total there are currently 22 serious incidents (SIs) under investigation which consist of 13 Clinical SIs, 4 Fall SIs and 5 Pressure Ulcer SIs. Three reports are overdue for submission to the CCG which is a reduction of 2 from the previous month, and work is ongoing to ensure the backlog is addressed.

## 4.2 Seven day services

As can be seen in figure 1 below overall performance with the 14-hour post take standard is below the 90% target. However, it must be noted that Care Group 1 are consistently performing above the target.

**Figure 1- 14 hour post-take reviews – August 2020**



An audit is being undertaken of 14-hour post take performance for 1 week-day (1<sup>st</sup> September 2020) and 1 weekend-day (5<sup>th</sup> September 2020) for Care Groups 2 and 3, to enable a snapshot of themes to be identified, to enable an improvement plan to be developed. It is not at present clear whether the lowered performance is due to a documentation issue or actual non completion of post take reviews.

In addition to the diagnostic audit it is proposed that the SOP/policy based on the 7- day services document is updated to improve delivery of post-take reviews in the Trust. This document will also include an accountability framework. The aim within post-take review is to define clearly what Consultants are reasonably accountable for during their job-planned work.

## 4.3 Antibiotic Usage

The Pharmacy Antimicrobial Team Antibiotic Usage Summary Report Jan19-June 20 is included for review as part of this report in Appendix 1.

It is important to note that in order to achieve improved stewardship, pharmacy highlight that there are a number of improvements required to the EPMA system. It is also not currently possible to extract consultant level data to identify areas of concern or good practice.





#### 4.4 Recommended Summary plan for Emergency care and Treatment (ReSPECT)

Increasing evidence suggests that combining a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decision with an 'emergency treatment plan' leads to a significant reduction in frequency and severity of harm, compared to people with a DNACPR decision alone. This can help to provide clarity about the goals of treatment and to reduce the sometimes negative associations that can be present with CPR decisions.

ReSPECT is a process whose aims are to facilitate individualised shared decision making with people who are at risk of acute deterioration, and the documentation of such discussions and decisions. The ReSPECT process and documentation can be initiated and completed in any healthcare setting (acute, hospice or community); it can be shared between settings, and be valid across them, to ensure best care for the person wherever they may be. Currently, the Trust has not implemented the ReSPECT process and continues to use the DNACPR process which is well embedded. However, it is becoming increasingly problematic that the Trust has not adopted ReSPECT as the majority of providers that the Trust interfaces with have done so, which is causing transfer of care complications between our partners. One particular example is in the palliative care of children and young people, who have a detailed ReSPECT document from specialist providers but the Trust is not able to follow it upon transfer.

Discussion took place at the Executive Quality Group in relation to ReSPECT implementation and it was agreed that Care Group 5 (Family and Sexual Health) should begin the work to implement ReSPECT. The learning achieved from the move of Care Group 5 to ReSPECT will then be utilised to enable a plan for a wider adoption across the Trust to be developed. The Board are asked to approve this plan.

#### 4.5 Consent to treatment

In 2019/20 internal audit undertook an audit of Consent and provided the following conclusion:

*The Trust's approach in ensuring that consent for examination and/or treatment and/or participation in a research trial is received has been documented and disseminated to relevant staff via StaffRoom.*

*Consent form templates have been developed. However, pre-printed department specific forms were found to be lacking some fields as required as part of Department of Health Guidelines (DoH).*

*Weaknesses were also identified in relation to the completion of consent forms, evidence of the provision of information to patients prior to the procedure, the completion of the two stage consent process and a lack of capacity assessments for patients who do not have capacity to give or withhold consent*

*Therefore, an opinion of **Limited Assurance** was given.*

In response to the audit findings an action plan was developed to address the issues. This action plan is complete with the exception of the revision of the templates, which was delayed somewhat by the pandemic. However, progress resumed during from June onwards, particularly in relation to the documentation of mental capacity assessments. As



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the mental capacity form was separate to the consent form it was at times missed. A new combined consent form has been developed which meets the legal requirements for consent, mental capacity and legal power of attorney. Consultation is underway to refine the forms and agree the implementation plan. In addition e-consenting is being explored by several specialties and a demonstration by a software company is planned for 18 September 2020.

A repeat internal audit is currently ongoing and discussions with the auditor indicate that all the recommendations from the last audit have either been completed or partially completed.

#### 4.6 Risk Registers

A review of risk registers has commenced. New fields have been built into Datix to enable the gaps in controls, sources of assurance, gaps in assurance and target risk to be clearly articulated. It is proposed that the initial work to improve commences with the Corporate risk register. Caroline Johnson will contact each Executive to meet to review the risk registers. It is envisaged that this will be complete before the October Quality Committee when the revised Corporate risk register can be reviewed.

#### 5.0 Recommendations

The Board are asked to note the ongoing improvements to the governance processes, incident management processes, risk registers clinical effectiveness and audit. In addition the Board are also asked to approve Care Group 5 undertaking a project to implement ReSPECT.



## Appendix 1

### Pharmacy Antimicrobial Team Antibiotic Usage Summary Report Jan19-June 20

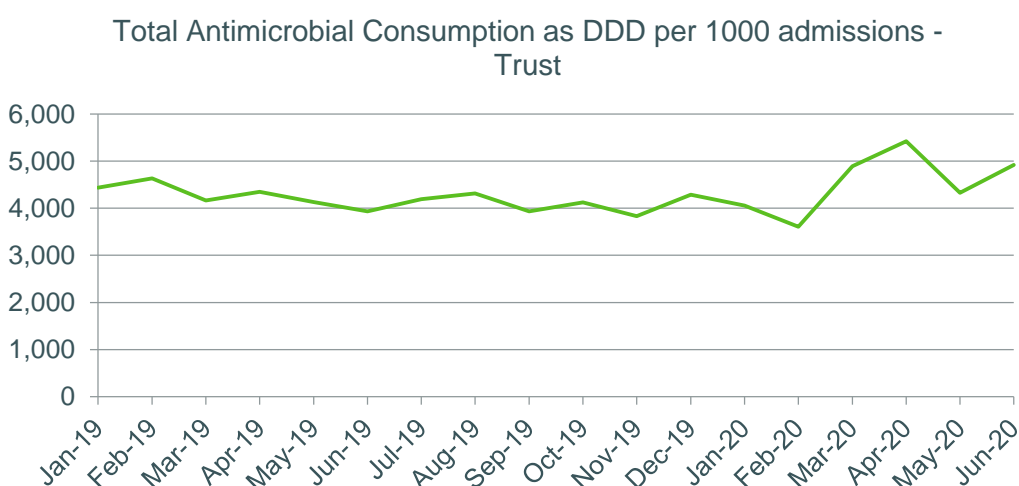
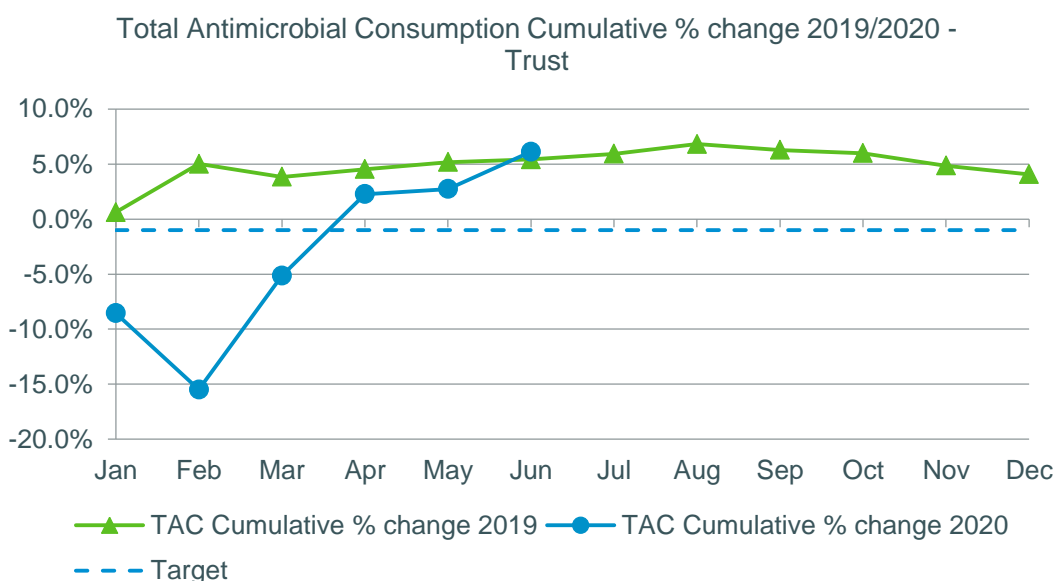
This report details a summary antibiotic consumption data for the Trust that was extracted from the Rx Info web site at the beginning of July, and reports on antimicrobial usage up to June 20. There is a 10 week lag before the complete data set can be reported.

Consumption data % change of cumulative totals as detailing results for June 20

#### National Contract Targets – Trust wide

National contract target 1% reduction

#### Key Total Antimicrobial Consumption TAC



The total up to the end of June shows a 6.1% increase. Please note that the consumption data is based on what is supplied to the wards, departments and outpatients and may be held in stock in those areas. This data has been greatly affected by the restructuring of the hospital into blue and yellow areas. This means that there are more areas which stock



antimicrobials. The Pharmacy Team is currently working on a project to improve stock management which should be completed by the end of September.

The antimicrobial stewardship team has now agreed antimicrobial stewardship objectives with each of the Care Groups. This shows that all the care groups are actively involved in antibiotic stewardship. The objectives are included in the table below.

Date agreed	Date achieved	CG	objectives	Lead	Steward
Apr-20	Apr-20	CG1	Guideline for the treatment of bacterial pneumonia secondary to Covid 19	Kim Chandler	Rebecca Thomas/ Becky Hampson
Apr-20		CG1	Audit of prescribing against guidance for bacterial pneumonia secondary to Covid 19	Sousan Shahi & Hazel Watchorn	Rebecca Thomas/ Becky Hampson
Apr-20		CG1	Audit of York ED TTO packs	Anita Chalmers & Gary Kitching	Rebecca Thomas/ Becky Hampson
May-20	Jul-20	CG2	Audit of prescribing against guidance for bacterial pneumonia secondary to Covid 19	Shadia Ahmed	Lisa Green
Aug-20		CG2	Survey of prescribing antimicrobials in geriatrics	Imola Borganou/ Claire Kershaw/ Becky Hampson	Lisa Green
Jun-20		CG2	Audit of TTOs for ED	Martin Ward/ Rachel Hodgson	Lisa Green
Dec-19		CG3	Colorectal CQUIN	Michael Lim	Mr Wong/ Mr Andy Thompson
Dec-19	Jul-20	CG3	Lap chole prophylaxis audit by Mr Wong and co	Mr W Wong et al	Mr Wong/ Mr Andy Thompson/ Peter Stone
Dec-19		CG3	Major head and neck prophylaxis survey	Mr Whitfield et al	Mr Wong/ Mr Andy Thompson/ Peter Stone
Jun-20		CG3	Protocol for pre-operative screening for urology procedures	Mr Ben Blake-James	Mr Wong/ Mr Andy Thompson/ Peter

					Stone
Aug-20		CG4	Survey of patients with neutropenic sepsis	Dawn Platt	TBC
Aug-20		CG4	Survey of patients with prolonged neutropenia	Meka Mohan	TBC
Aug-20		CG4	Guide to managing Posaconazole levels	Dani Powdrille	TBC
Aug-20		CG5	Audit of management of Bacteraemias in the under 18s excluding neonates	Dominic Smith	Dominic Smith
Aug-20		CG5	Prospective audit on patients started on IV antibiotics and compliance with guidelines	Dominic Smith	Dominic Smith
Aug-20		CG5	Review of Doxycyclines stocks and audit of PGD	Alison Chorlton	TBC
Dec-19	Feb 20	CG6	ARK for orthopaedics	Nick Carrington	Tom Fearnley
Dec-19	Aug 20	CG6	OPAT performance	Karen Cowley	Tom Fearnley
Aug-20		CG6	Survey of prophylaxis for open fractures	Mr Nick Carrington/ Bethany Wyatt	Tom Fearnley

It should be noted however that the common themes emerging from the C.diff PIRs are not covered by these audits. The Infection Prevention team is redesigning the process of learning and improving understanding, as well as quantifying the scale of the problems involving antimicrobials.

The key themes emerging from the C.diff PIRs across all care groups are:

1. Failure to take samples before commencing antimicrobial prescriptions.
2. Failure to follow Trust guidelines for the treatment of infections. In particular, over use of Pip tazo in patients who do not have sepsis.
3. Failure to complete the review and revise stage of antimicrobial prescribing; especially stopping antibiotics, de-escalating, antibiotics and IV oral switches.
4. Durations in line with the formulary recommendations, including resetting the clock when the oral switch is made.

The next set of Care Group reports will include a recommendation to audit these areas of practice for a better understanding of why these things are recurring; or to provide assurance that the local systems prevent these things from recurring.



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Nominations Booklet  
September 2020

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## Nominations for September 2020

The Children's Community Nursing Team	Community	Nominated by Pam Toas A colleague
<p>The Children's Community Nursing Team are a small team of highly skilled and experienced specialist practitioners, nurses, nursery nurses and invaluable admin. During the pandemic they have seen their workload increase to meet the needs of some of our most vulnerable children. A lot of the families on the caseload were isolating, the team were often the only contact some of the families had. They supported them with getting the most basic day to day essentials, initially some families were unable to obtain food, they couldn't get home deliveries and didn't have people locally, they helped provide information on local independent stores, helped collect prescriptions, liaised with supermarket chains to ensure children on chemotherapy were able to get the foods they needed delivered at times that fitted around travelling to Leeds for treatment. They offered support and advice on the current situation, listened to family's fears and worries. The nursery nurses whilst unable to visit kept in touch to offer practical support, send or deliver activities to help entertain and stimulate the children whilst not attending school. They acted as a link between the families and consultants when they were too anxious to visit the GP or hospital to keep these vulnerable children and young people at home whenever possible and safe to do so. Although the team work Monday-Friday they worked weekends to provide support to immunosuppressed children requiring treatment at a weekend to save the family visiting the hospital, also a young person requiring daily support with a syringe driver and palliation. Whilst dealing with the increased workload and parental anxiety their usual office became part of a COVID ward, they had to quickly adapt to using laptops and working more remotely, which resulted in less time as a team to support and offer supervision to each other. The team's admin plays a crucial part as the hub of the team, taking constant phone calls and getting messages out to the nurses, dealing with and inputting referrals and ensuring all the staff are safe at the end of the day.</p>		



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<b>Janie feathers</b> <b>Healthcare Assistant</b>	<b>Community Based</b>	<b>Nominated by</b> <b>Melanie Linley</b> <b>A colleague</b>
<p>Jaime has shown true dedication and passion in her role going above and beyond for the patients she cares for, she works exceptionally hard to ensure they receive all the support and care they need and leaves no stone unturned in all aspects of community care. She is currently undertaking the Associate Practitioner course and I have been so impressed with how hard she has worked and also applied what she has learned during this time, the patients truly benefit from Jaime's care, passion and dedication to the role she is a true asset to the team.</p>		
<b>Kate Atkinson</b> <b>Physiotherapist</b>	<b>Community Based</b>	<b>Nominated by</b> <b>Carol Williams</b> <b>Colleague</b>
<p>Kate was redeployed from MSK outpatients to the inpatient wards at York Hospital during the pandemic. After 20 years of very little ward work this would have been daunting at the best of times. Kate stepped up to the plate and was willing to work on whichever ward she was needed on the day. Soon Kate was working as the sole Physiotherapist on some of the wards. She was involved with complex patient's treatments and discharge planning which is not a skill utilised that often in Outpatient Physiotherapy. Many other new skills were learned throughout her redeployment. Kate was also flexible in her working pattern offering to work weekends during the 7 day working period, She would step in if there were not enough staff to cover even if she had already worked the previous week or weekend. Kate put the patients first at the same time supporting her colleagues and I am proud to have had the pleasure of working with her over the past 4 months.</p>		

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<b>The Team at Easingwold Renal Unit</b>	<b>Community Based</b>	<b>Nominated by Sonia Crawford A colleague</b>
<p>Renal services have been stretched nationwide during this pandemic. Easingwold Renal Unit suffered a large amount of sickness for varying reasons, leaving the unit extremely short staffed. Agency nurses are largely unavailable and although some help has been given from the other units, they are also under pressure. I would like to recognise our team for the absolute dedication they have shown, working so many extra hours, sacrificing precious time with children and families to support the service that without their dedication would've seen patients potentially have their treatments reduced. The Renal units are very warm, and in full PPE, at times intolerable. The staff don't moan or breach guidelines; they get on with it and have absolutely kept our cohort of extremely vulnerable patients as safe as possible in a difficult environment.</p>		
<b>Alison Greenhalgh Sister</b>	<b>Community Based</b>	<b>Nominated by Roisheen Childs A relative</b>
<p>Alison became involved with David my husband shortly after his diagnosis for terminal cancer at the end of April 2020. It was a very surreal and sad time given the COVID virus situation. Alison was an absolute star in the support and care she and the rest of the team gave to my husband while at home. On her first visit a hospital bed was ordered and arrived later that day. Top quality service indeed. Initially the visits were on a weekly basis but then daily once the syringe driver was in place. Alison and her team are a wonderful and caring group of professionals who brought comfort and support in helping David to manage his pain. As David stated Alison listened to what he was experiencing with the pain and did her very best to help relieve it. The visits were a lifeline and reassured us both given all the restrictions imposed by the COVID virus. My grateful thanks and appreciation to Alison and all the team.</p>		

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<b>Harriet Rossol          Physiotherapist          Neil Forsyth          Therapy Assistant          Emily Haldenby          Physiotherapist</b>	<b>Scarborough Hospital</b>	<b>Nominated by          Henrietta Tully          A colleague</b>
<p>Myself, Harriet, Neil and Emily have been the only staff redeployed from the Children’s Community Therapy team into the adult ward therapy team during the COVID pandemic. I can honestly say these three incredible people have been the ones keeping me going during these difficult times, not only at work but also supporting me with my family. The past four months have been tricky for us, but we have managed to pull together and support each other where needed. They continue to make me smile on days where I could have cried and picked me up when needed. I just want to thank these guys for being amazing.</p>		
<b>Stevie Moir          Staff Nurse          Jess Rodger          Healthcare Assistant</b>	<b>Scarborough Hospital</b>	<b>Nominated by          Timothy Adlesee          A patient</b>
<p>These two ladies dealt with a very challenging patient throughout the whole night shift. She remained kind and professional throughout even though the patient was trying to hit her and was swearing at her.</p>		
<b>Tracey Ellis and          Mandy Derby          Domestic</b>	<b>Scarborough Hospital</b>	<b>Nominated by          Angela Too          A colleague</b>
<p>Tracey and Mandy have made such a difference to the cleaning of the laboratory areas at Scarborough. We received a report from the audit team yesterday and the standards of hygiene in the area have increased and this is noticeable. The lab areas are a particularly difficult area to clean both with the specialist environment that this is in but also as it is held within a particularly old part of the hospital which often feels a little forgotten. They do this with a general cheeriness and they add an upbeat cheeriness to the start of the day for anyone who encounters them- a delight to work with.</p>		

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<b>Jane Appleton</b> <b>Domestic</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Tracey Cleminson,</b> <b>Lynn Lamb and Sue</b> <b>Bullamore</b> <b>Colleagues</b>
<p>Jane is a ray of sunshine on the ward. From the minute she walks in she brightens everyone up. She is always happy and smiley, making everyone laugh. When people are down she tries her utmost to cheer them up. Jane is fantastic with all the parents and the children she has such a caring nature. When Jane is in the cubicles cleaning she will pick up on how the parent or children are feeling and try and help wherever possible. The children love her she has such a lovely manner with them, laughing and joking and acting silly or asking them if there is anything they need. I don't know what we would do without her she is aa appreciated member of our team and we love her to bits.</p>		
<b>James Blacker</b> <b>Staff Nurse</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Anita Bennett</b> <b>A colleague</b>
<p>James has spent lots of time teaching cardiac based learning to many staff, especially to student nurses who attended emergency COVID placements on the ward recently. He did it in a none-judgemental and informative way, and ensured we understood what he was teaching. James has a welcoming and approachable demeanour to staff and patients alike which is refreshing in any kind of setting.</p>		
<b>Laura Buckle</b> <b>Secretary</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Chris Allen</b> <b>A colleague</b>
<p>Being new to the trust Supervisory role Laura has helped me settle in and show me how to complete forms, reports, ordering of supplies and also help to set up a new induction programme for new starters to the LLP. She is always friendly and happy to go that extra mile to help.</p>		

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<b>Antonia Moore</b> <b>Deputy Sister</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Dawn Foster</b> <b>A colleague</b>
<p>Antonia and myself were both redeployed to Oak ward during Covid19. I am currently a student nursing associate and Antonia was assigned as my mentor whilst redeployed. We were both in unfamiliar areas, with unfamiliar staff, but Antonia went above and beyond to support me and assist with my training. She was an excellent teacher and was always willing to help me. She is also an Amazing nurse. Nothing is ever too much trouble for patients and colleagues. Her professionalism and dedication to her job is outstanding! Antonia is my role model. She is an absolute asset to the trust! Thank you Antonia</p>		
<b>Shermeem Henderson</b> <b>Practice Education</b> <b>Facilitator</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Amanda Horrocks</b> <b>A colleague</b>
<p>Shermeem has successfully managed to maintain provision of Practice Education support to educators and students across Scarborough, Bridlington and Malton placements while new in her part time role and covering long term sickness within the team. She is a diligent worker who strives for excellence and has ensures that educators and students are well supported. It has been a particularly testing time for placement support and provision and Shermeem has excelled with the challenge and worked in partnership with the wider team and staff and University partners to ensure quality learning experiences are maintained. She has managed to locate and monitor employees on Clinical Apprenticeship programmes and their Assessors (which have often been moved to support the pandemic provision) to ensure the standards required to complete programmes are met and competencies are signed off. This has all been achieved working 3 days per week and supporting workload of a full time member of staff who is not at work.</p>		

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<b>Alison Kearney Specialist Nurse</b>	<b>Scarborough Hospital</b>	<b>Nominated by Josephine Halliwell A relative</b>
Alison is without doubt very dedicated to her job and will always go the extra mile to help those she is looking after. The nurse that assists in clinic is also wonderful.		
<b>Sue Ingle Healthcare Assistant</b>	<b>Scarborough Hospital</b>	<b>Nominated by Susan Fergusson A relative</b>
Sue is a very special person. Who went above and beyond requirements looking after dad, Sue is very caring, thoughtful, and compassionate and always went the extra mile, listening to family, being very supportive and left us with extra special memories to treasure as dad has since passed away. Sue is the right person in the right job, an angel.		
<b>Lisa Fullerton Healthcare Assistant</b>	<b>Scarborough Hospital</b>	<b>Nominated by Nicky Simpson A patient</b>
I wish to Lisa because she has gone above and beyond to assist me during my admission. Lisa has helped me with everything from personal care to assisting with mobilising. She has been there throughout her shift to assist in any way she can. Lisa has also been very polite and respectful to all the patients in the bay.		

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<b>The Emergency Department</b>	<b>Scarborough Hospital</b>	<b>Nominated by Julie Young A colleague</b>
<p>I was moved from Bridlington to work at Scarborough Hospital during COVID-19 and although I have banked with this team, for a few years, I have not worked on a full time basis, the whole team has been fantastic welcoming and ready to show their skills to me I have learnt so much from this great bunch of people who in my opinion get little praise for what they do been on the front line of health care, and who have worked so hard during the pandemic, they live up to the trust values in all they do, there is good a good atmosphere in the team which makes you feel at ease when being shown new skills, the care and compassion that I have seen has been great and I have felt very privileged to have worked with them all including the domestics, admin, doctors, porters, all in all a great team.</p>		
<b>Kelly Render Children's Diabetes Care Co-ordinator</b>	<b>Scarborough Hospital</b>	<b>Nominated by Ali Morgan Harrison-Lee A colleague</b>
<p>Kelly has given her time to help me in my role of diabetes admin assistant. I wasn't clear about what I needed to do and she stepped in to guide me over the phone and by email. Kelly has never made me feel bad for taking up her precious time and she has really demonstrated what the Trust values are about. She has helped me start enjoying the job because if I get stuck I know she is a phone call away. She has also shared her knowledge and resources without question.</p>		

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<b>Meera Radhakrishnan Nair</b> <b>Hyper Acute Stroke Nurse</b>	<b>Scarborough Hospital</b>	<b>Nominated by Alison Wilson</b> <b>Patient</b>
<p>Although the whole team working on the stroke unit at Scarborough have been fantastic in every aspect from domestics to ward manager. I would like Meera Nair to receive special mention. Her smiling face, unwavering care and knowledge has made such a huge difference to me at a very difficult. Nothing is ever too much trouble and is always greeted with her beautiful smile. Professional to a fault whilst very easy to talk to about my worries and concerns. She has taught me how to be a patient, patient and I can never repay her for her time, care and courteous respect even at 3am on a busy night shift. Meera is an asset to the ward, the hospital and the Trust.</p>		
<b>The Stores Team</b>	<b>Scarborough Hospital</b>	<b>Nominated by Jeanette Clews</b> <b>A colleague</b>
<p>I would like to nominate the Stores Team at Scarborough Hospital. They are so helpful and efficient. They are also ready to provide advice if you need it, and will help you source the right products for your needs. They deliver promptly and are also friendly, helpful and approachable at every contact.</p>		
<b>Sharon Miles</b> <b>Service Manager</b>	<b>Scarborough Hospital</b>	<b>Nominated by Ali Morgan Harrison-Lee</b> <b>A colleague</b>
<p>Sharon has stepped in as my line manager for administration (even though I work in York). She has demonstrated what a manager should be: Supportive and guiding. She knew I was struggling and she has been motivating me by giving me constructive positive feedback. I know I can go to Sharon for support and this has made my situation so much better. She really shows the Trust values in the way she has treated me (as welcomed me as an extra person in her team).</p>		



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<b>Tracey Ingleton</b> <b>Advanced Practitioner</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Heather Crowe</b> <b>A relative</b>
<p>We would like to say thanks for the kindness and compassion shown to my Mother when she visited the department for suspected cellulitis/ DVT during these difficult times. She said everyone was so helpful and lovely, which is so important when you are worrying about elderly people attending appointments. We would like to say a particular thank you to Tracy Ingleton for her diligence. I have worked as a nurse and midwife in the NHS for 30 years and know how just one person can make a difference, but they need the help of a good team too. Many thanks.</p>		
<b>Rebecca Headlam</b> <b>Radiographer</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Kerry Headlam</b> <b>A colleague</b>
<p>When bringing a dementia patient down for a scan who struggles with communication, Rebecca was overwhelmingly kind and compassionate towards the patient. Rebecca introduced herself, explained what she was going to do to the patient. Having worked with dementia patients for a long time, I have to say that Rebecca's compassion and communication skills showed that she cared and wanted the best outcome, Rebecca used multiple different techniques to make things more pleasant for the patient in the circumstance, with them having dementia it can be scary not knowing where you are, or who anyone is and Rebecca's friendly face made a huge impact.</p>		
<b>John Pownall</b> <b>Deputy Manager</b>	<b>Scarborough Hospital</b>	<b>Nominated by</b> <b>Carol Poppleston</b> <b>A colleague</b>
<p>I would like to nominate John for a star award because during the pandemic he worked tirelessly ensuring that the wards and departments were kept clean for staff and patients, giving support and encouragement to his team. He worked well above his contracted hours and more often than not didn't have any days off.</p>		

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<b>Emma Darrell</b> <b>Medical Secretary</b>	<b>Scarborough Hospital</b>	<b>Nominated by Sarah Hall</b> <b>A colleague</b>
<p>I was booked in for a hysterectomy and have been waiting for over a year. My consultant was off long term sick in 2019; he returned and then has gone off on long term sick again. I have contacted Emma on a regular basis to enquire about my procedure; she has been patient and courteous on every occasion. She has enquired on my behalf and found me another consultant. She has delivered prescriptions to my place of work within the hospital. On the few occasions she couldn't answer my queries she has taken the time to call me back with the answers. On every occasion I have spoken to her I have felt confident in her knowledge and reassured by her skills.</p>		
<b>Casey Arnott</b> <b>Staff Nurse</b>	<b>Scarborough Hospital</b>	<b>Nominated by Penny Furness</b> <b>A colleague</b>
<p>Casey is a dedicated nurse and has worked so hard, especially in these trying times. Casey works in RAZ most shift and just of late has been the only Registered Nurse in there, often going without a proper break. Her passion for nursing is very clear; her patients are her priority and she always ensures her colleagues are safe and happy. Casey is a breath of fresh of air to the department I would like to nominate her for a star award as I just think she's a credit to the department.</p>		
<b>Joyce Concepcion</b> <b>Healthcare Assistant</b>	<b>Scarborough Hospital</b>	<b>Nominated by Marianne Stephens</b>
<p>Joyce was absolutely amazing when looking after a young man with mental health problems. She kept this man calm, explained everything to him in detail, even showing him on herself what she was going to do. She took her time, gained his trust - which was a really difficult thing to do, as due to his mental health thought we were going to harm him. She showed compassion and professionalism.</p>		

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<p><b>Sean Doughty and Wally Bacon Drivers</b></p>	<p><b>Trust Wide</b></p>	<p><b>Jemma Hadaway A colleague Lynne Brown A Colleague Hannah Dixon A colleague</b></p>
<p><b>Jemma said:</b> Sean and Wally are huge assets to the Mobile Chemotherapy Unit (MCU), they have played such a big part in helping the Pharmacy and the MCU to work around the pressures of COVID and have gone out of their way to make the service run smoothly. We genuinely couldn't have done it without them. They are both friendly, approachable and all round nice guys and they'll both be really missed when they go back to working their normal roles. Thank you for everything you have done, you should both be very proud as we all are of you!</p> <p><b>Lynn said:</b> Sean &amp; Wally are truly gentlemen; they are always on hand to help the Chemotherapy unit in this very difficult time. Since we have had to move from the hospital to the mobile unit they have both shared the role of being constantly "there" They will and have done anything we ask of them from pharmacy runs to collecting lunches for patients and making tea/coffee. When we move back to the hospital we will all miss them. But they will be back to the mobile unit and travelling to Bridlington, Malton and Selby so the patients will not have to travel too far from home for their chemotherapy.</p> <p><b>Hannah said:</b> In the middle of March we had to move the chemotherapy unit from within the main hospital to the mobile unit. This enabled us keep our high risk patients receiving chemotherapy as safe as possible and still able to have treatment during the COVID pandemic. Sean and Wally normally visit Scarborough with the mobile unit once a week however it has become our permanent base the last few months. Sean and Wally have been a huge role in keeping cancer treatments going on the unit. They have helped with the everyday running of the unit but taken on many extra tasks going above and beyond their role! Many of the staff had not worked or worked very little on the unit previously. Wally and Sean have been a constant support to the staff during a very difficult time. They have made sure that the unit is set up each day ready for staff and patients, collect medications from pharmacy, stores, patients lunches, cleaned the unit, the list is endless! All these extra tasks done with no questions asked. I really do believe they both deserve recognition for their dedication to patients and the daily running of the mobile unit over the very difficult past few months. They are an asset to the trust and we will miss them lots when 'normal' service is resumed.</p>		

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<b>The Transport Team</b>	<b>Trust Wide</b>	<b>Nominated by Phil Bland A colleague</b>
<p>For the past 6 months the whole department has gone above and beyond to ensure that staff and the hospital has everything when and where it is needed, including additional food supplies, the collection and delivery of PPE supplies from around the country, moving numerous department and wards to new locations and providing regular additional collections for COVID-19. In order to accommodate all of this on top of our regular service, the team worked tirelessly together to start providing a 24/7 service, sacrificing their weekends, bank holiday and scheduled time off to support the Trust and public.</p>		
<b>The York Teaching Hospital Fundraising Team</b>	<b>Trust Wide</b>	<b>Nominated by Rachel Brook A colleague</b>
<p>I would like to nominate the Fundraising Team for the fantastic year they have had. 3 of the 6 team members were new in 2019; 2 to professional fundraising. They held successful challenge events; Sky Dive, York 10k, GNR and Yorkshire 3 Peaks, SCBU toddle and Summer Fair. They raised over £235,000 for the Butterfly Appeal including holding a raffle which raised over £4k. They celebrated National Elf Service engaging schools and corporates for the first time. They were chosen by Marks and Spencer, St Olave's School, Grand Opera House and Yorkshire Charity Clay Days as charity partners. The team exceeded the £1.035m annual target by £85k with only £113,000 coming from legacies and stewarded 78 third party events. They processed over 500 applications from across the Trust granting £1.6m of funding, following up delivery and produced case studies. They have overhauled the website, increased social media following (e.g. Facebook by 1.7k) and held roadshows in each hospital. During Covid-19 the pace they have had to work has been incredible. The team have received and distributed over £100k worth of gift in kind including over 12,000 Easter eggs, 5,700 bags of tea and 5,000 Kit-Kats! They have raised over £550k in the first four months of this financial year, have implemented a new Finance Harlequin system, created a Covid-19 specific newsletter and helped departments order items quickly working with purchasing to ensure they met the needs created by the pandemic. The team comprises of Maya Liversidge, Joe Fenton, Emma Dunnill, Rob Taylor, Janet Harrison &amp; Colin Richardson.</p>		

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<b>Claire Gray</b> <b>Deputy Sister</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Kathleen Merrick</b> <b>A colleague</b>
<p>A patient admitted to have her baby became unwell with Supraventricular Tachycardia (SVT), Claire was wonderful supporting the maternity team and staying with the patient as the situation became more complicated. Claire was helpful, kind, knowledgeable, friendly, and reassuring. Thank you, Claire!</p>		
<b>Lucy Pannett</b> <b>Occupational Health Nurse</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>A colleague</b>
<p>A while ago I was sent to Occupational Health and met with Lucy, I was diagnosed with anxiety related stress and she took the time to listen to me and advised a GP appointment, which she helped me with and arranged follow up meetings with her on a regular basis. I was then advised at a later date that I go on the Medical redeployment register after which I was fortunate to find a more suitable position. I just want to say a very big thank you to her as she has been invaluable to me. She tells me she is just doing her job but to me she has gone that extra mile.</p>		
<b>Ward 22 Nursing Team</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Louise Sherlock</b> <b>A relative</b>
<p>I had to leave my daughter Megan Sherlock in tears at A &amp; E as I couldn't go in with her. The nurses on ward 22 showed her care and compassion in their care for a scared young adult. Meg said the nurses were so kind and reassuring for her, and when I rang, listened to my concerns about her and acted accordingly to help her. My thanks go to all the professionals involved in helping her. Unfortunately she can only remember Grace but says she had a couple of nurses!</p>		

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<b>Gillian Jackson and Helen Harrison Haematology Clinical Nurse Specialists</b>	<b>York Hospital</b>	<b>Nominated by A patient</b>
<p>Gillian and Helen are extremely well-prepared health professionals. Their approach is very well balanced; mixing an honest display of cordiality, compassion and a professional performance well over the average. They make patients feel heard whilst clinically treating them with the seriousness and responsibility a human being may expect.</p>		
<b>The Head and Neck Outpatient Department Nursing Team</b>	<b>York Hospital</b>	<b>Nominated by A colleague</b>
<p>The Head and Neck OPD registered nurses have gone above and beyond their normal duties during this pandemic. Head and Neck Specialist Nurse Lisa Flesher, Deputy Sister Leigh Mundy-Gill, and Staff Nurses Jane Plant, Sue Coyne and Rebecca Robb all volunteered to be redeployed to wards and did so for several weeks, undertaking roles which some of them have not participated in for many years. For a short time this left Staff Nurses Lindsay Routledge and Katherine Mann to hold the fort along with Head and Neck Specialist Nurse Debbie Wardle and myself. During the pandemic the clinic has remained open and patients have still been able to have procedures performed. Nursing Head and Neck patients has been extremely challenging as the care and treatment they require are associated with aerosol generation, meaning that a whole new way of working was adopted. Most of the time PPE 3 was required followed by terminal cleaning of rooms and equipment. The nursing staff have ensured that the safety of clinicians and patients has been their priority and that all patients needing to be seen have been able to attend the clinic and receive their treatments.</p>		

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<b>The Dental Nurse Team</b>	<b>York Hospital</b>	<b>Nominated by Kirsty Bottomley A colleague</b>
<p>The dental nurses have played a vital role in ensuring the maxillofacial department has continued to provide a high class service to patients alongside running orthodontics and restorative services. As many of my staff have been shielding or have been redeployed the max fax service would have struggled to continue to run effectively. The department has seen many patients which would normally have been seen in day theatres and the dental nursing team have assisted the clinicians with performing some skin cancer surgery in the department in order to reduce a potentially harmful delay to treatment. They as a team have supported me and the maxillofacial clinicians in ensuring that patient safety is maintained. Procedures performed on Head and Neck patients are potentially aerosol generating and Cheryl along with her Deputy Amanda White have ensured that all of the right PPE has been available and relevant safety procedures have been adhered to in order for clinicians to treat their patients and feel protected. I would have struggled to run the department without their support.</p>		
<b>Karen Whitehead Administrator</b>	<b>York Hospital</b>	<b>Nominated by Amy Gains A colleague</b>
<p>Karen has always been a very creative person and is happy with fabric and a needle in hand, however, she used her sewing skills to benefit the wards recently, of which we are so grateful. She has made 100's of beautiful fabric face masks that staff have been able to buy (£5 adult, £3.50 child) She has made over £1000 and has donated all this money straight back to the wards in the care group. She has bought them a laminator, stationary, files and much more. This has helped enormously with the implementation of the new nursing documentation across the whole of the Care Group. I feel as though Karen deserves the recognition for going above and beyond, making these masks in her own time for the benefit of wards. It's almost a double thank you, as not only have the wards got lots of lovely new equipment but we can all walk around with our new face masks outside of work, protecting each other! Thank you so much Karen, you are a super star and we appreciate you greatly!</p>		

# StarAward

★ A monthly award which recognises the achievements of staff and volunteers ★  
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<b>Stacey O'Brien</b> <b>Healthcare Assistant</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Angie Mead</b> <b>A colleague</b>
<p>Stacey was working as part of our team on G2, while attending a bedside to cup feed a baby- She recognised a deteriorating patient and promptly asked me to review her as she was concerned about her. When I attended the room the patient reported feeling ok, just a little cold, I completed a full set of observations, and it quickly became it evident the patient had likely become septic and had very deteriorated rapidly. Due to Stacey's prompt recognition and escalation-the patient was quickly managed appropriately with in the golden hour, and despite an unexpected extended in patient stay, she recovered well. Stacey impressed me on how quick she was to recognise a deteriorating patient, how humble she was when it was acknowledged, and the care she provided to both the woman and her baby!</p>		
<b>Lucy Hodge</b> <b>Staff Nurse</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Mariah Marshall</b> <b>A colleague</b>
<p>I have been working alongside Lucy as a HCA on the HDU COVID Ward. Lucy has put her all in taking care of patients on the C PAP side. Lucy as a nurse will go out of her way to help us as HCA's even when she is busy herself! I fell ill mentally when we were working in HDU and Lucy picked me up every time we were on shift! Also when we went back to our normal ward, Ward 34, Lucy was working the ward running to other wards to set up C PAP! Lucy is a massive credit to our team and hand on heart deserves this award and more!</p>		
<b>The OPAT Team</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Anita Chalmers</b>
<p>I wish to nominate the Outpatient Parenteral Antibiotic Therapy (OPAT) team for their work during the Covid-19 crisis. Their work meant that patients were kept safely at home away from the risk of infection but also prevented infection being brought to the hospital. At any one time in York there were up to 18 patients being cared for at home. This also helped the trust achieve its objective of reducing the number of patients in the bed stock. A recent patient experience survey for the OPAT team illustrates how much being able to stay at home is appreciated by the patients too.</p>		



# StarAward

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 ★★ ★ staff and volunteers ★★ ★

<b>Andrew Smith</b> <b>Physiotherapy</b> <b>Assistant</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Laura Wiedenbruch</b> <b>A colleague</b>
<p>Andy has been working at the Discharge Command Centre (Archways) to support the ongoing pandemic response. Each day is a potential challenge. Some days it can be difficult simply getting out of bed in the morning, going to work and facing the reality of COVID-19. However, when you have a team member that goes out of their way to support and uplift others it can make a big difference to your working day. From covering long shifts at the weekend to chasing missing documentation Andy always goes above and beyond to help the discharge team, ensuring continuity of patient care. His dedication deserves to be recognised by the Trust. Thank you for everything you do, Andy. Please know you are valued and appreciated by the team!</p>		
<b>Debbie Taylor</b> <b>Ward Clerk</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Fawn Maddison</b>
<p>I would like to nominate Debbie on behalf of all the staff on our ward. She is an absolute asset to the team. She is always smiling, and nothing is too much for her. She goes above and beyond on a daily basis with little thanks. She has an excellent manner with both staff and patients. She works to a very high standard all of the time and we never have to ask her to do anything- she will have already done it.</p>		
<b>Kevin Craven</b> <b>Materials Management</b> <b>Officer</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Joanne Copley</b>
<p>Hi, I would like to nominate Kevin in Purchasing at York hospital. We have just moved to a new unit at Nelson Court and he has been extremely helpful in sourcing equipment and goods while we have been struggling to locate things. He is always positive and knowledgeable and will even drop things off himself if he can.</p>		

# StarAward

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<b>Sarah Bainbridge</b> <b>Heart Failure</b> <b>Specialist Nurse</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Nicola Lynch</b> <b>A colleague</b>
<p>Sarah took on the role of Lead Heart Failure Nurse in the acute team to cover maternity leave. Since then she has transformed the service to enable it to function during the Covid-19 pandemic. She set up a new Rapid Access Heart Failure clinic offsite and used her nurse prescribing skills to keep our vulnerable patients away from the hospital. Sarah goes above and beyond her role in caring for the holistic needs of heart failure patients and their families. She is an inspiration and I would like to thank her for all the support she has given me since I started in the service and during these difficult times.</p>		
<b>Respiratory Outreach</b> <b>Team</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Rebecca Thomas</b> <b>A colleague</b>
<p>At the start of the COVID pandemic, it was recognised that ventilator support outside of ICU was going to be necessary in a large number of patients, requiring ventilation to be provided in a way we haven't needed before. To facilitate this, the ward 34 nursing staff, the respiratory specialist nurse team and the sleep team came together to work an outreach rota to provide advice, guidance, support and training in non-invasive ventilation across the hospital. They organised protocols and training for non-respiratory staff, support for staff and patients starting and continuing on CPAP and BIPAP ventilators on the COVID wards, enabling the safe provision of this life-saving treatment to a large number of patients. They took on additional hours and additional roles on the front line of COVID care. Their hard work and dedication, improved patient care, reduced mortality and IP stays, and reduced pressure on ICU beds at this time.</p>		

# StarAward

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<b>Vascular Imaging Support Workers</b>	<b>York Hospital</b>	<b>Nominated by Liz Hodges A colleague</b>
<p>This team have worked tirelessly during the COVID pandemic to ensure that the Vascular Imaging Unit and our associated equipment are spotlessly clean at all times and that the patients are transported around the hospital safely and with dignity. They are an integral and essential part of our team who do many of the jobs that are 'under the radar' but crucial in making the department function in an exceptional way.</p>		
<b>The Nursing Team on Ward 34</b>	<b>York Hospital</b>	<b>Nominated by Rebecca Thomas A colleague</b>
<p>This team deserve a star award for their hard work in re-establishing the non-invasive ventilation (NIV) service on ward 34. There has not been the ability to provide NIV on ward 34 for several years, due to staff shortages and training gaps. This has put significant pressure on intensive care services, and led to poorer outcomes for patients. Patients have had to go to an intensive care setting for acute NIV which could have been started in a ward environment, and for chronic NIV there have been delays waiting for community start-ups. Over the last year the ward team have worked hard with the management team to increase staffing levels, and have focused on staff training and skill enhancement. Over the last few months we have seen the service reinstated on ward 34, and the benefits in patient care are evident. Patients have been given protocol-led NIV on Ward 34 in the acute setting, with reduction in A&amp;E waits and ICU admissions. Chronic NIV has been started prior to discharge in patients, with improvement in symptoms and readmission avoidance. The team have worked so hard and really need to be recognised.</p>		

# StarAward

★ A monthly award which recognises the achievements of staff and volunteers ★

<b>Rachel Middleton Waiting List Co-ordinator</b>	<b>York Hospital</b>	<b>Nominated by Luda Laycock A colleague</b>
<p>I would like to nominate Rachel based on a very positive feedback we have received from one of the urgent Orthopaedic patients. Rachel is one of our newly appointed Waiting List Co-ordinators. Therefore, I believe it is especially remarkable that Rachel went above and beyond for a patient so early in her new role. Rachel received a phone call from a highly distressed patient awaiting an urgent hip replacement. The patient's surgery has been delayed since February 2020 due to bed pressure and then COVID situation. To add to the patient's distressed she has been transferred between different hospitals for a number of times without much explanation. The patient was in a lot of pain and did not have any indication as to when her surgery would take place. Rachel was very sympathetic. She swiftly approached the responsible consultant and got back to the patient within a day. She organised all the required tests and arranged a surgery date based on the level of urgency. I believe Rachel deserves a Star Award as she truly lived Trust's Core Values in this particular example. It is especially commendable considering all the challenges and pressures that Waiting List is facing in current COVID situation.</p>		

# StarAward

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<b>Maggie Bulman</b> <b>Capital Projects</b> <b>Manager</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Andrew Bennett</b> <b>A colleague</b>
<p>On the 27 April 2020 Maggie took the lead for delivering a review of the property-related backlog maintenance for the Trust, which determines where there are building and engineering risks and what it will cost to address them. At this point the review had been significantly delayed by some 2 years. This review was the new LLP Managing Director's single biggest priority in order to provide assurance to the Trust that its properties were being well-managed to support the delivery of its healthcare services. The report also needed to provide a plan for investment in the properties to make further improvements to the buildings and engineering systems. To deliver the report, Maggie relocated her base to work alongside the Estates Team to obtain the information needed. She got to grips with new, and complex, subject-matter and won praise for her support from colleagues. Less than three months later, Maggie delivered her report to the LLP Board, who were extremely impressed with its clarity, the comprehensiveness of its findings and its elucidation of the way forward in terms of investment required by the Trust in its properties in order to improve their condition and to eliminate risk. I'm confident that the Trust Board will be similarly impressed when they receive the report and that the work Maggie has completed will be at the heart of capital investment planning for a number of years. Given that Maggie has produced a much-needed and important piece of work in a very short space of time to such a high quality, it would be wrong not to recommend her for a Star Award in order to formally recognise her impressive achievement. We are very lucky to have Maggie in the LLP team and I'd like to thank her for her hard work and support.</p>		
<b>Steven Rice</b> <b>Storekeeper</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Alan Britton</b> <b>A colleague</b>
<p>Steven is always cheerful and helpful, whenever I have needed a hand carrying item from main stores over to estates stores, he is a shining example to all of his colleagues and Adrian Chesterton who is his supervisor should be really proud of him.</p>		

# StarAward

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<p><b>The Heart Failure Team</b></p>	<p><b>York Hospital</b></p>	<p><b>Nominated by Adrianne Scouling A Colleague Derek Baldison A patient</b></p>
<p><b>Adrianne said:</b>          Having recently done some bank work for the heart failure team, I have seen just what an amazing job they are doing. They are working so hard as a team to make sure that every single one of their patients come and go with a smile on their face and that they get to see everyone they need to and can physically see. They greet everyone with a beautiful smile and with so much passion and care; it's been amazing to work with them this week. No matter what is thrown at them they pick it up and keep going, they work really hard and well as a team. They're a credit to the trust and a credit to themselves they should be so proud. Well done guys keep it up.</p> <p><b>Derek said:</b>          The team were so professional in all aspects. I was treated with the utmost kindness at all times to such an extent I was reduced to tears. The information provided was succinct and spoken in such a way that I was put at ease from the outset. They richly deserve recognition.</p>		
<p><b>Paula Smith, Linda Brodie and Helen Lawrence Radiology Image Support Workers</b></p>	<p><b>York Hospital</b></p>	<p><b>Nominated by Emma Chappell A colleague</b></p>
<p>I had a particularly challenging afternoon on Monday 3rd August. The three ladies named went over and beyond with their support for me which resulted in my patient list running as smoothly as it could have been despite many obstacles. Regardless of the difficulties they encountered, the ladies carried on relentlessly with such professionalism and with smiles on their faces.</p>		

# StarAward

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<b>Tomasz Karmazyn</b> <b>Physiotherapist</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Emma Lee</b> <b>A colleague</b>
<p>Tomasz has worked in MSK outpatients for years and was redeployed to inpatients during the COVID-19 pandemic. He has supported mainly the medical and elderly teams. This is a huge change of setting and patient group but Tomasz has shown a keen interest to learn new things and help wherever he can. On the 31st July, Tomasz accompanied one of the Occupational Therapists on an access visit to a patient's home. This was completed with the patients family who were polish and only able to speak minimal English. The home visit had been organised and the Occupational Therapist had arranged a telephone translator in case she was unable to communicate fully with the patient's family. Tomasz is Polish by background and was able and willing to help translate. Not only that, whilst on the visit, Tomasz was able to ask the more pertinent questions and follow up questions to assist in gathering the information, and helped reassure the family who were understandably anxious. This assessment would have been more difficult and less personal via a telephone translator. Tomasz was able to help the occupational therapist complete the assessment with the additional information he was able to gain. He was able to explain his clinical reasoning and what was needed in the patient's home to help prepare for discharge.</p>		
<b>Belinda Smale</b> <b>Urgent Care Nurse</b>	<b>York Hospital</b>	<b>Nominated by</b> <b>Jeremy Gerken</b> <b>A relative</b>
<p>We today visited York A&amp;E due to a very sore leg pain that my granddaughter had and was referred to the Urgent Treatment outpatient department, my granddaughter was attended to by Belinda, her manner, approach and professionalism was first class, she took the time to explain why Erin why she feeling so much pain and how to support her recovery. Belinda was a real credit to her profession.</p>		

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<b>Elizabeth Sweeting Specialist Nurse</b>	<b>York Hospital</b>	<b>Nominated by Pamela Corkill A relative</b>
<p>Liz has overseen the management of my mum’s mental health condition on separate occasions over two years. I met Liz accidentally in the corridor while at work and she kindly enquired about mum’s health. The last time she was involved in my mums care was when a decision was made for my mum to be placed in a residential home. Liz was surprised she was still in a home but was happy to oblige in calling the community nurse in regard to my mum’s mental health. Mum’s mental health had deteriorated over the COVID pandemic as she was confined to her room with no one to converse with. Liz kindly rang the community nurse who then liaised with her consultant. Mums medication was increased through the simple means of a conversation being held and her mental health has improved tremendously since this, thank you Liz for this.</p>		
<b>Victoria Finch Healthcare Assistant</b>	<b>York Hospital</b>	<b>Nominated by Gareth Greetham A visitor</b>
<p>Victoria provides exceptional support to a patient I was escorting to hospital. My patient was displaying challenging behaviour and experiencing a mental health crisis as well as the complaint that brought her to A&amp;E. Victoria dealt with my patient with care, compassion and patience and was instrumental in avoiding physical intervention being required. All in all an amazing staff member!</p>		



# StarAward

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<b>Abigail Hickton Staff Nurse</b>	<b>York Hospital</b>	<b>Nominated by A colleague</b>
<p>Over the past three nights, Abi has gone above and beyond to deliver outstanding care to patients. When she has been floating Abi has volunteered to help with anything and everything, always with a friendly smile and caring nature. It may be said that it's just 'her job', but Abi's actions have been greatly appreciated during moments when we have been faced with multiple deteriorating patients and she has just got stuck in without needing to be asked.</p>		
<b>Ward 37</b>	<b>York Hospital</b>	<b>Nominated by Jackie Fieldhouse A relative</b>
<p>All of the staff on Ward 37 should receive a Star Award for the care they gave to my Mum, Phil Wells, in her final days before she sadly passed away. Also for the kindness and compassion they showed to us, as a family, during this most difficult time. They made sure my Dad was well looked after and enabled all of the family to spend precious time with Mum before she died, even with all of the current restrictions. They are a very dedicated and caring team and we feel they deserve to be recognised for the amazing work they do.</p>		
<b>Karen Harrison Staff Nurse</b>	<b>York Hospital</b>	<b>Nominated by Sue Heaton A colleague</b>
<p>I would like to Nominate Karen for all her hard work and input for urology services during Lockdown. Whilst the Day Unit was closed she continued to provide on-going urology care for our patients on TWOC clinic and also saw patients urgently with catheter problems. Karen also helped set up a service for patients to learn to self-administer bladder treatments, which they otherwise would not have had due to COVID 19, and this continues whilst we cannot bring patients in to have their treatments normally given by the nurses. She quietly worked behind the scenes making sure our urology patients still got input and care in whatever way she could offer during these difficult times. Karen has been such a big help and I feel she needs to be recognised by receiving Star Award.</p>		

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<b>Lauren Hick Domestic</b>	<b>York Hospital</b>	<b>Nominated by A colleague</b>
<p>Lauren has been a domestic on ward 34 for quite a few months. Ward 34 can be a very busy environment to work on. One particular evening we had 2 patients who were quite distressed. One in particular required quite a few nursing staff to help calm them. The second gentleman started to become distressed while Lauren was completing some of her domestic duties and due to the nursing staff dealing with the first patient, Lauren showed empathy and compassion toward the second distressed gentleman by talking to him, ensuring he was reassured and spent a few moments walking up and down the corridor to comfort the patient and reassure him where he was. The patient soon calmed down and Lauren simply deescalated the situation by using caring skills despite having her own jobs to do. The staff on 34 really appreciates the help Lauren selflessly gave that evening.</p>		

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

# StarAward

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