

# Council of Governors (Public Meeting)

7 December 2017



# COUNCIL OF GOVERNORS MEETING

The programme for the next meeting of the Council of Governors will take place:

On: 7 December 2017

In: Malton Rugby Club, Old Malton Road, Malton, YO17 7EY

| TIME                     | MEETING                                   | LOCATION                 | ATTENDEES   |
|--------------------------|---|--------------------------|---|
| 9.00 –<br>9.50           | Nomination &<br>Remuneration<br>Committee | Malton Rugby Club        | Nomination &<br>Remuneration<br>Committee Members<br>Only |
| 10.00 –<br>10.50         | Private Council of<br>Governors           | Malton Rugby Club        | Council of Governors                                      |
| <b>11.00 –<br/>13.00</b> | <b>Public Council of<br/>Governors</b>    | <b>Malton Rugby Club</b> | <b>Council of<br/>Governors</b>                           |



# Council of Governors (Public) Agenda

| SUBJECT   | LEAD  | PAPER             | PAGE | TIME                |
|---|-------|-------------------|------|---------------------|
| <b>1. Apologies for absence and quorum</b><br>To receive any apologies for absence.   | Chair | Verbal            | -    | 11.00<br>–<br>11.15 |
| <b>2. Declaration of Interests</b><br>To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.  | Chair | <a href="#">A</a> | 07   | 11.00<br>–<br>11.15 |
| <b>3. Minutes of the meeting held on 7 September 2017</b><br>To receive and approve the minutes from the meeting held on 7 September 2017   | Chair | <a href="#">B</a> | 11   | 11.00<br>–<br>11.15 |
| <b>4. Matters arising from the minutes and any outstanding actions</b><br>To discuss any matters or actions arising from the minutes.   | Chair | Verbal            | -    | 11.00<br>–<br>11.15 |
| <b>5. Update from the Private Meeting held earlier</b><br>To receive an update from the Chair on the topics and decisions of the business discussed in the private meeting held prior to the meeting in public. | Chair | Verbal            | -    | 11.00<br>–<br>11.15 |

Our Quality and Safety Ambition: Our patients must trust us to deliver safe and effective healthcare



| SUBJECT  | LEAD                   | PAPER             | PAGE | TIME                |
|--|------------------------|-------------------|------|---------------------|
| <b>6. Governors Reports</b><br><br>To receive the reports from governors on their activities from: <ul style="list-style-type: none"> <li>• Lead Governor Report</li> <li>• Art Strategy Group</li> <li>• Out of Hospital Care Group to include approval of Terms of Reference</li> <li>• Transport Group</li> </ul> | Governors              | <a href="#">C</a> | 25   | 11.15<br>–<br>11.30 |
| <b>7. Chief Executive's Update</b><br><br>To receive a report from the Chief Executive including: <ul style="list-style-type: none"> <li>• Sustainability &amp; Transformation Plan Update</li> </ul>  | Chief Executive        | <a href="#">D</a> | 35   | 11.30<br>–<br>11.45 |
| <b>8. External Audit – Quality Account</b><br><br>To receive the External Audit Quality Account Report   | External Audit         | <a href="#">E</a> | 41   | 11.45<br>–<br>12.00 |
| <b>9. Out of Hospital Care Report</b><br><br>To receive the latest Out of Hospital Care Report   | Joint Head of Strategy | <a href="#">E</a> | 45   | 12.00<br>–<br>12.15 |
| <p>Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff</p>   |                        |                   |      |                     |
| <b>10. Governor Elections Update (External &amp; Internal)</b><br><br>To receive an update paper on the elections and the internal election process.   | FT Secretary           | <a href="#">G</a> | 71   | 12.15<br>–<br>12.25 |
| <p>Our Facilities and Environment Ambitions: We must continually strive to ensure that our environment is fit for our future</p>   |                        |                   |      |                     |



| SUBJECT   | LEAD                     | PAPER             | PAGE | TIME       |
|---|--------------------------|-------------------|------|------------|
| <b>11. PLACE Report</b>   | Head of Medical          | <a href="#">H</a> | 77   | 12.25      |
| To receive a report on the recent PLACE Assessments   | Engineering & Compliance |                   |      | –<br>12.40 |
| <b>Governance</b>   |                          |                   |      |            |
| <b>12. Constitutional Review Group Update</b>   | FT Secretary             | <a href="#">I</a> | 107  | 12.40      |
| To receive an update on the work of the Constitutional Review Group   |                          |                   |      | –<br>12.50 |
| <b>13. Any other business</b>   | Chair                    | Verbal            | -    | 12.50      |
| To consider any other items of business.  |                          |                   |      |            |
| <ul style="list-style-type: none"> <li>Reflections on the meeting</li> </ul>  |                          |                   |      |            |
| <b>14. Time and Date of next meeting</b>  |                          |                   |      |            |
| The next Council of Governors meeting will be held on 08 March 2018 at Malton Rugby Club, Old Malton Road, Malton, YO17 7EY |                          |                   |      |            |



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Richard Thompson added

Jill Sykes added

**A**

|   | 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>Jeanette Anness</b><br><i>(Public: Ryedale and East Yorkshire)</i> | Nil   | Nil   | Nil   | Nil  | Member, Derwent Practice Representative Grp<br>Member, NY Health watch<br>Member, SRCCG Patient Representative Grp | Nil  |
| <b>Andrew Bennett</b><br><i>(Staff Scarborough and Bridlington)</i>   | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Ann Bolland</b><br><i>(Public: Selby)</i>                          | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Andrew Butler</b><br><i>(Public: Ryedale and East Yorkshire)</i>   | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Roland Chilvers</b><br><i>(Public: Selby)</i>                      | Nil   | Nil   | Nil   | <b>Trustee</b> — Hemingbrough Institute and Playing Fields Association                                 | <b>Councillor</b> — Hemingbrough Parish Council  | <b>Councillor</b> — Hemingbrough Parish Council  |
| <b>Dawn Clements</b><br><i>(Appointed: Hospices)</i>                  | Nil   | Nil   | Nil   | <b>Director of Fundraising</b> —St Leonards Hospice York   | <b>Director of Fundraising</b> —St Leonards Hospice York   | Nil  |
| <b>John Cooke</b><br><i>(Public: York)</i>                            | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Helen Fields</b><br><i>(Public York)</i>                           | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |

| Governor  | Relevant and material interests   |   |   |  |  |  |
|---|---|---|---|--|--|--|
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| <b>Stephen Hinchliffe</b><br>(Public: Whitby)                 | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Sharon Hurst</b><br>(Staff: Community Staff)               | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Margaret Jackson</b><br>(Public: York)                     | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Mick Lee</b><br>Staff York                                 | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Sheila Miller</b><br>(Public: Ryedale and East Yorkshire)  | Nil   | Nil   | Nil   | <b>Member</b> —Derwent and SRCCG Patients Groups<br><b>Member</b> —Health Watch North Yorkshire (non-voting) | Nil  | Nil  |
| <b>Clive Neale</b><br>(Public: Bridlington)                   | Nil   | Nil   | Nil   | Member of Healthwatch East Riding.   | Nil  | Nil  |
| <b>Helen Noble</b><br>(Staff: Scarborough)                    | Nil   | Nil   | Nil   | Nil  | Nil  | Nil  |
| <b>Cllr Chris Pearson</b><br>(North Yorkshire County Council) | Nil   | Nil   | Nil   | Nil  | <b>Councillor</b> —North Yorkshire County Council  | <b>Councillor</b> —North Yorkshire County Council  |

| Governor   | Relevant and material interests   |  |   |  |  |  |
|--|---|--|---|--|--|--|
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| <b>Karen Porter</b><br>(Project Choice)          | Nil   | Nil  | Nil   | Nil  | Nil  | Nil  |
| <b>Gerry Richardson</b><br>(University of York)  | Nil   | Nil  | Nil   | Nil  | Nil  | Employed by Uni. of York—Centre for Health Economics   |
| <b>Michael Reakes</b><br>(Public: City of York)  | Nil   | Nil  | Nil   | Nil  | Nil  | Nil  |
| <b>Diane Rose</b><br>(Public: Scarborough)       | Nil   | Nil  | Nil   | Nil  | Nil  | Nil  |
| <b>Patricia Stovell</b><br>(Public: Bridlington) | Nil   | Nil  | Nil   | Nil  | Nil  | Nil  |
| <b>Jill Sykes</b><br>(Staff: York)               | Nil   | Nil  | Nil   | Nil  | Nil  | Nil  |
| <b>Richard Thompson</b><br>(Public: Scarborough) | Nil   | Nil  | Nil   | Nil  | Nil  | Nil  |
| <b>Catherine Thompson</b><br>(Public: Hambleton) | Nil   | Nil  | Nil   | Nil  | Nil  | Employed by NHS England  |
| <b>Robert Wright</b><br>(Public: City of York)   | Nil   | Nil  | Nil   | Volunteer for York Healthwatch   | Employee—NHS Leadership Academy  | Nil  |

## Council of Governors (Public) – 7 December 2017

### Chair:

Ms Susan Symington

### Public Governors:

Mrs Ann Bolland, Selby  
Mr Andrew Butler, Ryedale & East Yorkshire  
Mr Roland Chilvers, Selby  
Mr John Cooke, York  
Mrs Helen Fields, City of York  
Mr Stephen Hinchliffe, Whitby  
Mrs Margaret Jackson, City of York  
Mrs Sheila Miller, Ryedale & East Yorkshire  
Mr Michael Reakes, City of York  
Mr Clive Neale, Bridlington  
Mr Michael Reakes  
Mrs Diane Rose, Scarborough  
Mrs Pat Stovell, Bridlington  
Mrs Catherine Thompson, Hambleton

### Appointed Governors

Ms Dawn Clements, Appointed Governor, Hospices  
Cllr Chris Pearson, Appointed Governor, NYCC  
Mr Gerry Richardson, Appointed Governor, University of York

### Staff Governors

Dr Andrew Bennett, Scarborough/Bridlington  
Mrs Sharon Hurst, Community  
Mr Mick Lee, York  
Mrs Helen Noble, Scarborough/Bridlington

### Attendance

Mr Andrew Bertram, Finance Director  
Mr Patrick Crowley, Chief Executive  
Mrs Lynda Provins, Foundation Trust Secretary  
Mr Mike Sweet, Non-executive Director, York Teaching Hospital  
Mrs Jenny McAleese, Non-executive Director, York Teaching Hospital  
Cllr John Raper, Member of the public

### Apologies for Absence:

Apologies were received from the following:

Mr Robert Wright, Public Governor, York  
Mrs Jeanette Anness, Public Governor, Ryedale and East Yorkshire  
Ms Libby Raper, Non-executive Director  
Mrs Jennie Adams, Non-executive Director  
Ms Karen Porter, Stakeholder Governor

### **17/32 Chair's Introduction and Welcome**

Ms Symington welcomed everyone to the meeting.

### **17/33 Declarations of Interest**

There were no changes to the declaration of interests noted.

### **17/34 Minutes of the meeting held on the 15 June 2017**

The minutes of the meeting held on the 15 June 2017 were agreed as a correct record subject to the following amendments:

Page 13, Minute No 17/23, last paragraph – should read 'Mr Butler was incredibly annoyed with the regulators' not the CCGs.

Page 13, Minute No 17/23, 6<sup>th</sup> paragraph - should read Hambleton, Richmondshire and Whitby CCG.

Page 16 – Minute No 17/27- regarding the positions up for election lacked clarity as the paper stated:

Mrs Provins stated that the paper detailed the positions coming to the end of their term in September and the following vacancies:

- Scarborough Public Governor
- York Staff Governor
- Voluntary Appointed Governor

The full list is as follows:

Scarborough 1 seat – David Wheeler (resigned)

Bridlington 1 seat – Clive Neale (end of term)

York Staff 1 seat – Emma Sellwood (resigned)

Ryedale and East Yorkshire 1 seat – Sheila Miller (end of term)

York 2 seats – Margaret Jackson and Robert Wright (end of term)

Scarborough Staff 2 seats – Helen Noble and Andrew Bennett (end of term)

### **17/35 Matters arising from the minutes**

Page 13, Minute No 17/23 – what are place based systems – Ms Symington stated that the principle is that healthcare is no longer provided by a single organisation, but a number of healthcare providers and community solutions so that care is delivered centred on a place, not organisational boundaries.

### 17/36 Update from the Private Meeting held earlier

Ms Symington noted that the following items were discussed at the private meeting:

- Chair's Quarterly Report
- Chair's One to One Meetings with Governors Report
- NED succession planning at the Nomination and Remuneration Committee
- Chair succession planning
- Feedback from the Governors Forum
- Board to Council of Governors October meeting planning
- Internal Audit Report regarding information provided to Governors

### 17/37 Governors Reports

**Lead Governors Report** – Mrs Jackson highlighted the following items from her report:

- the Mobile Chemotherapy Unit
- the AMM/AGM taking place on the 12 September which included sessions on research and organ donation
- the next recruitment marketplace event on the 30 September
- The NHS carol concert in York Minster on the 6 December

**Arts Strategy Group** – no questions were raised.

**Out of Hospital Group** – Mrs Jackson stated that this was an excellent group and a lot of information was provided. She confirmed that there were no changes with the Selby community contract.

**Transport Group** – Mrs Miller encouraged everyone to use the hire car share scheme and stated that if anyone needed more information they should contact Zara Ridge.

Ms Symington thanked Governors for their helpful and succinct reports which provided a breadth of information around Governor engagement.

### 17/38 Chief Executive's Report

Mr Crowley provided a brief overview of the contents of his report and asked if there were any questions.

Mrs Bolland asked about the policy for recruiting to board level roles in the Trust. Mr Crowley stated that Mrs Scott had accepted the Chief Operating Officer role on an interim basis for a year and that this had been agreed at the Remuneration Committee. He noted that the Remuneration Committee received information on all changes to director remuneration, posts, and changes in portfolios. He noted that this change currently underpins continuity in leadership at a difficult time as winter approaches, which was judged by the CE and the REMCOM to be preferable to entering into a protracted recruitment process. Wendy Scott has strong credentials and a good reputation within the trust. Ms Symington stated that Mrs Scott filling the interim role would serve to bring out of hospital care and internal operations together, ensuring the same direction of travel and Mrs Scott was brilliantly placed to do that. There was also a strong COO team which will help to minimise the risk.

Mr Hinchliffe asked about whether the mobile chemo unit could go to Whitby and Mr Crowley stated that this involved a separate CCG, but that he would certainly raise it.

Mr Crowley noted the internal finance briefing to staff which had been leaked to the press. Governors were concerned that they had not received the briefing, but Mr Crowley stressed that it had been sent to staff in the first instance, but he would check whether it had gone to Governors. He was aware it may be leaked, but felt it was open and honest and very informative. His priority had been to allay staff fears about the cash position and stop them worrying that they may not get paid. York Press had used the email almost verbatim and Mr Crowley was not worried about this at all.

Mr Bertram provided the current finance position at the end of month 4. The Trust is £10.5m adrift of plan with a deficit of £13.8m, but he stressed the financial context of our organisation which has an annual turnover of circa £500m a year. Mr Bertram explained some of the factors which were impacting the trust financially: for example the Trust missing out on the £2.6m Sustainability and Transformational funding as it had not reached its control total in month 3 and £2m of pay pressures which relates to agency and locum staff. The Trust has currently spent £7.1m against a profile of £5.8m and the overspend is exclusively around safety of services and covering key rotas. £2.5m of the shortfall is in relation to the savings programme which is in its 8<sup>th</sup> year and therefore very challenging. £1m is in relation to non pay items which is less concerning at this stage.

The other £2m is in relation to income. Mr Bertram stated that he has discussed this with NHSI as it is in relation to HRG4+ and the change around pricing and reduction in length of stay for patients which is coming about due to the use of the ambulatory care and assessment units. He noted that the Trust is doing all the right things, but this does need further understanding as it is part of the story around current finances.

In relation to the national context, there are approximately 240 providers and roughly 160 of these were in deficit at the end of quarter 1. The combined deficit for month 3 was three quarters of a billion with the planned outturn being half a billion.

The cash position and profiling suggests that cash will run out in October or definitely November, which will be the first time in the Trust's history and is a very serious concern. Nearly half of all trusts are in the Distressed Cash Regime or like this Trust, about to enter it. The Trust is looking at payments to suppliers, chasing any debtors and also what if anything on the capital programme can be slipped. The Distressed Cash Regime is about taking out a working capital loan via the region/Treasury to ensure staff are paid. Interest rates on the loan will be charged at circa 6%. Mr Bertram provided assurance that all decisions made will be done within the context of maintaining patient safety.

Mr Bertram stated that a Financial Recovery Plan has been drafted and discussed with both the Board and NHSI. It is a collection of measures agreed by Corporate Directors or recommended by the regulators. There are a raft of actions already being progressed including vacancy control, changes in portfolios and discussions around study leave.

Ms Symington thanked Mr Bertram for the open and honest presentation of the financial position.

Mrs Fields asked what the likelihood of the plan working was especially as winter approaches. Mr Bertram stated he is optimistic and convinced the position can be improved and that safety will be maintained. However, he stressed the national position that the Trust is working in. Mr Crowley stated that the issue for him in relation to winter

approaching is recruitment which is also more of a challenge in this part of the country. He noted that the relative spend on recruitment in this area is amongst the lowest in the country and therefore underfunded, but this did not absolve the Trust of any responsibility to deal with its obligations seriously.

Mr Butler asked whether the national STP funding of £1.8bn would help to solve problems. Mr Bertram stated that the Trust had received most of its allocation for last year, but not the final quarter. Money not secured by individual Trusts was then reallocated, however, those Trusts receiving extra money were unable to spend it until the new financial year. This was to do with ensuring the provider sector deficit position was reduced at year end.

Mrs Thompson stated that after 8 years of savings there had to be a point when Trusts had to look at previously unthinkable actions instead of continual shaving of expenditure. Mr Bertram stated that this was what the capped expenditure process was there to do. He noted that the vast majority of those in the process had started to look at reducing planned care. The Trust had been in a position to be able to provide a detailed profiling of this which had showed a devastating effect on waiting times and targets. Therefore this had been rejected and the Trust were required to resubmit the CEP and explore other options like reducing demand. Mr Bertram stated that some CCGs had stated that they were not prepared to submit an undeliverable plan. The Board has also been having these discussions.

Mrs Miller asked if the CCGs deficit had caused the Trust's cash flow problem. Mr Bertram stated that it was not to do with the CCGs and decision not to go for the community care contract had been factored into the plan. In relation to delaying elective surgery, Mr Bertram stated that this had been discussed with the regulators as a reduction in planned care was about the only thing that would produce results before the end of March. Mr Bertram did highlight that the county does receive significantly less funding through the allocation process than some areas and that the funding system did not provide adequately for out of hospital care which was the direction of travel being taken to relieve pressure on hospitals.

In relation to the cash position, the decision taken by NHSE that all CCGs will pay contracts in 12<sup>th</sup> not 10<sup>th</sup> as some have been doing has affected the Trust's cash flow. NHSE felt that payments in tenths has been artificially masking issues.

Mr Reakes asked whether the STP provided further opportunities to make savings across the area. Mr Bertram stated that there are a number of savings opportunities being looked at across the STP, one being procurement and although the geography does not help, there are plans to exploit savings that can be made. The geography does make it hard in relation to clinical working, but he did note that radiology will be looking at buying a system that allows shared reporting.

Cllr Pearson asked about the 1% pay cap and whether it looks like this will be bridged. Mr Bertram stated that he hoped that this would happen and if it did the Trust's inflation rate would be adjusted to reflect this, if not it would provide further increased pressure on the position. If the cap is lifted in April the tariff will be increased to support this.

Cllr Pearson also asked whether the Junior Doctors dispute had had an impact. Mr Crowley stated that the damage was more subtle as doctors had been disenfranchised, some going abroad and others going into agency work.

Ms Symington thanked Mr Crowley and Mr Bertram for their informative session.

## 17/39 Governor Reports

Mrs Provins gave an overview of the position in relation to the current Governor elections. She noted that one candidate for York had submitted a photo which had not been published and that this was an oversight by the Electoral Reform Society. The online voting platform had now been updated to include the photo and an updated candidate statement had been posted out which should hopefully arrive at the same time as the original voting material. Mr Neale asked if photographs were really relevant to the voting process.

Mrs Jackson highlighted that staff Governors must be given time to engage in Governor activities.

Mr Bennett asked whether staff can be alerted to the fact that a voting email will be received and Mrs Provins agreed to talk to the Communication staff about this.

Mr Butler was concerned that there were a number of small issues with the election and asked for a report before the next Council of Governors. Mrs Provins will provide a report when she has more information.

**Action: Mrs Provins to provide a report to Governors on the issues around the election.**

## 17/40 Membership Development Group Update

Mrs Provins highlighted the membership matters statistics included in the report, which shows that just under half of those receiving the newsletter open it. She noted that a section will be added to the next newsletter which will ask for feedback about the content from members.

Mrs Provins stated that the AMM/AGM had been discussed at the meeting and the format agreed in terms of wrapping a couple of seminars around the AGM to try to boost attendance. Mr Neale asked if it was possible to know if the people attending the seminars were the same ones every time. Mrs Provins will see what information is available. Mrs Miller asked how many people had registered to attend and Mrs Provins stated that she did not have the figures. Ms Symington stated that she had written a large number of letters/emails inviting people to attend, but this had only generated a very small number of acceptances.

**Action: Mrs Provins to look at attendance at the members seminars and AGM.**

Mr Reakes asked about member recruitment and Mrs Provins stated that she had asked the group if they wanted sessions arranged for Governors to stand in the foyer to talk to people as they come into the hospitals, but it had been felt that this did not generate many new members. The group had stated that attending the recruitment fairs was the preferred option as this also generated younger members. Mrs Bolland stated that she had attended events both at York and Selby to try to recruit members and it was really difficult trying to persuade people to become members.

Mr Reakes asked about including stickers on the Friends and Family Test cards or adding to the texts being sent out. Mrs Provins reported that the Chief Nurse had stated that this was inappropriate at the present time. He also noted that QR codes for membership could be put up in Outpatients: it was felt that even when people are physically approached it is

difficult to get them to sign up to membership and using advanced technology would also limit sign up.

Mr Neale asked if Governors contact details could be placed on the boards going up in reception and Mrs Provins stated that she will ensure the generic email address is placed on each board.

**Action: Mrs Provins to add the Governor's contact email to the notice boards**

Mrs Stovell mentioned that there were no membership leaflets available in Bridlington foyer. Mrs Provins will look into this.

**Action: Mrs Provins to look at the availability of membership leaflets**

**17/41 Audit Committee Annual Report**

Mrs McAleese thanked the Council for appointing her and highlighted that she had big shoes to fill following Mr Ashton. She noted she was still the rookie, but promised to work diligently to fulfil the role requirement.

Mrs McAleese stated she was privileged to present the report which had been presented to the Audit Committee in July and the Board in August. She noted it was a standard format and wished to bring the following elements to the Council's attention:

Page 50 – she noted that following the departure of Mr Ashton the Audit Committee only had 2 NED members and that there were plans in place to bring in a third NED to this critical role.

Page 51 – she noted the duties of the Committee follow the guidelines laid down in the HFMA Audit Handbook.

Page 54 – she referenced the recent merger of Internal Audit with West Yorkshire to create Audit Yorkshire. Mr Ashton had previously chaired the Audit Yorkshire Alliance meetings and Mrs McAleese now attends as a member with Mr Bertram. Mrs McAleese highlighted how very beneficial it was to have 17 members of Audit Yorkshire which provided valuable networking opportunities. She has also arranged to meet the Chair of the Harrogate Audit Committee and Newcastle's Audit Committee Chair who is a former colleague.

Page 56 – Mrs McAleese stated that Mr Ashton's final comments were very important as it highlighted the Trust's strong, robust internal audit function which is well supported by the executive team. She also highlighted the openness and transparency described which gave her assurance.

Mr Neale was extremely encouraged by the strength of Internal Audit and the support provided by the Board as he felt this function had previously been undermined at a national level.

Ms Symington stated that it was about being open and looking for ways to do things differently, but it was also about taking credit for things that the Trust does well.

Mrs McAleese stated that the Trust also needed to be sighted on lessons such as that from Mid Staffs, which had focused heavily on finance to become an FT and put patient

safety and quality at risk as a result. She noted the next Audit Committee would take place on Monday and she would be working to ensure patient safety was not compromised in the current financial climate.

Mrs Bolland stated that this needed to be shared with staff at ward level so that they are aware of what is going on and receive assurance about the focus on patient safety.

Mr Neale highlighted recent headlines about a London Trust who were described as financially incompetent and the regulators had gone in. He was interested to know if this Trust was at risk. Mrs Thompson stated that this was more to do with irregularities than incompetence and Mrs McAleese stated that this Trust had a good record of financial delivery and this was more to do with the current wider context. Ms Symington stated that the Trust needed to be able to evidence that it had done everything it could to tackle and beat the current financial challenges.

Mrs Fields asked about the reappointment of External Audit and Mrs Provins stated that this was being dealt with by the Constitutional Review Group in the first instance and a recommendation would be brought to the December meeting of the Council.

Mrs Noble stated that as Head of Patient Safety at the Trust she could assure the Council that patient safety was number one on the agenda for the Board. She felt confident that patients remained safe and she had welcomed the level of openness and honesty around the financial discussion from the Chief Executive and Director of Finance.

Mr Sweet stated that the Council had received exactly the same level of information as that provided to the Finance and Performance Committee.

Ms Symington thanked Mrs McAleese for the report.

## **17/42 Any Other Business**

**Annual Members Meeting/Annual General Meeting** – Ms Symington reminded everyone that this will take place next week on the 12 September.

**NHS Carol Service** - this will take place at York Minster on the 6 December.

**Governors Christmas Lunch** – this will take place on the 5 December at 12 noon. All governors are very welcome to this informal, social event, and this year, in light of the financial challenges, governors will be asked to pay for their own lunch.

**Reflections on the meeting** – Mr Reakes stated that the open and honest conversation about the financial position had been really appreciated. Mrs Fields wished to thank Mr Crowley and Mr Bertram for giving up their time to come to the meeting and provide the detailed information. Mr Butler was concerned about the timings as questions on the finance section had been cut short. Ms Symington stated that she and Mrs Provins would reflect as always on the timings, but it could be difficult to gauge how long each section would take. Mrs Noble stated that the finance position was an important subject which had been really useful. Mr Neale highlighted that the group is large and so that does restrict the number of questions which can be asked. Mrs Jackson highlighted that the theme of patient safety is always a priority as evidenced in the discussion.

### **17/43 Time and Date of the next meeting**

The next meeting will be held on 7 December 2017 at Malton Rugby Club, Old Malton Road, Malton YO17 7EY

Council of Governors Action Log

| Date of Meeting | Private/<br>Public | Action   | Owner                      | Due Date | Open /<br>Closed | Comment  |
|-----------------|--------------------|--|----------------------------|----------|------------------|--|
| 06.12.16        | Public             | Mrs Provins to explore the use of NHS staff discounts for members    | Mrs Provins                | 15.06.17 |                  | Following discussions with North Lincs & Goole - looking at NHS Discounts  |
| 15.06.17        | Public             | Ms Symington to find out more about the Big Word procurement process | Ms Symington - Mrs Provins | 07.09.17 | Closed           | We are currently at the half way point in a 3 year contract with The Big Word (translation services). The contract is managed through the facilities helpdesk; individuals are signposted to book interpretation via the online portal and are encouraged to feedback any complaints / concerns directly to The Big Word. SNS are currently seeking an additional provider to give increased instant access in emergency scenarios but also where provisions have not been made or there has been an interpreter / translator cancellation. The fulfilment rate sits comfortably within the agreed Service Level Agreement- but there are areas which we seek to improve including telephone contact ( the call centre can be difficult to contact) and interpreters have fed back that bookings often come late. We have recently started to use the datix system to record complaints, working with PALS to develop a specific equality and diversity dashboard; this is showing in this financial year there has been 1 communication complaint logged. |

|          |        |   |                            |          |        |   |
|----------|--------|---|----------------------------|----------|--------|---|
| 15.06.17 | Public | Ms Symington and Mrs Provins to discuss the provision of Patient Experience data to the Council | Ms Symington - Mrs Provins | 07.09.17 | Closed | Minutes being circulated - other information requests through Margaret Jackson & Pat Stovell who attend the group |
| 15.06.17 | Public | Mrs Provins to ask for more data to be included in the Out of Hospital Care Report.             | Mrs Provins                | 07.09.17 | Closed | Further report available at December meeting.   |
| 07.09.17 | Public | Mrs Provins to provide a report to Governors on the issues around the election.                 | Mrs Provins                | 07.12.17 | Closed | Report provided   |
| 07.09.17 | Public | Mrs Provins to look at attendance at the members seminars and AGM.                              | Mrs Provins                | 07.12.17 |        |   |
| 07.09.17 | Public | Mrs Provins to add the Governor's contact email to the notice boards                            | Mrs Provins                | 07.12.17 | Closed | Done  |
| 07.09.17 | Public | Mrs Provins to look at the availability of membership leaflets                                  | Mrs Provins                | 07.12.17 | Closed | Membership leaflets currently on hold due to cost.  |

## Council of Governors Action Log

| Date of Meeting | Private/<br>Public | Action  | Owner         | Due Date | Open /<br>Closed | Comment  |
|-----------------|--------------------|---|---------------|----------|------------------|--|
| 09.12.15        | Public             | Governors to let Mrs Brown, the Head of Communications have details of the sessions on the 14th January 2016. | All Governors | 31.12.15 | Closed           |  |
| 09.12.15        | Public             | Discuss with Mr Golding the clash between Transport Group and Board to Board meeting dates.                   | Mrs Provins   | 31.12.15 |                  | Contacted Zara Ridge who is looking at all future dates.   |
| 09.12.15        | Public             | Circulate the lessons learnt information from the Chief Executive's visit to Alaska                           |               |          | Closed           | Emailed 23.12.15   |
| 09.12.15        | Public             | Council of Governors to received an update on the visit to China  | Mr Crowley    | 10.03.16 | Closed           |  |
| 09.12.15        | Public             | Find out when the Clinical Excellence Awards Group will finish their work.                                    | Mrs Pridmore  | 31.12.15 | Closed           |  |
| 09.12.15        | Public             | Discuss Annual Report presentation with Mr Bertram (presenter to note Governors views)                        | Mrs Provins   | 31.12.15 | Closed           |  |
| 09.12.15        | Public             | Check the status of the volunteer interviews  | Ms Symington  | 31.12.15 | Closed           | Mrs Provins contacted relevant individuals   |
| 09.12.15        | Public             | Raise walkrounds at the next Quality & Safety Committee   | Ms Raper      | Next Q&S | Closed           | BoD 30.03.16 - noted night walk rounds reintroduced  |
| 09.12.15        | Public             | Report back to the Governors regarding the Patient Experience Team and Volunteer numbers in early January.    | Ms Symington  | 11.01.16 | Closed           | Volunteer paper circulated. Chair's June report met with PALs Team and discussed patient complaints and compliments with the Patient Experience Team Leader. |

|          |        |  |              |          |        |  |
|----------|--------|--|--------------|----------|--------|--|
| 10.03.16 | Public | Mrs Bolland to provide an update on interpretation service in the next Forum Report.   | Mrs Bolland  | 16.06.16 | Closed | Contained in Governor Reports paper - Fairness Forum section.                      |
| 10.03.16 | Public | Mrs Provins to amend the Membership Terms of Reference   | Mrs Provins  | 31.03.16 | Closed |  |
| 10.03.16 | Public | Mrs Provins to link with Prof Jacobs around membership and research.   | Mrs Provins  | 31.03.16 | Closed | Meetings in progress - linking with University, Trust's Research Dept, Comms & PPI |
| 10.03.16 | Public | Mrs Provins agreed to send the headings of the group discussions out in the Friday communication.  | Mrs Provins  | 11.03.16 | Closed |  |
| 10.03.16 | Public | Ms Symington to talk to Mr Golding about using Equality and Diversity as an agenda item for the next meeting.  | Ms Symington | 31.03.16 | Closed | Equality & Diversity Strategy going to the BoD at the end of July. CoG Sept.       |
| 16.06.16 | Public | Add STP to the September Agenda  | Mrs Provins  | 08.09.16 | Closed | Added.   |
| 16.06.16 | Public | Report on the total number of members in a constituency and that as a percentage of the total population.  | Mrs Provins  | 08.09.16 | Closed | Paper to the September meeting   |
| 16.06.16 | Public | Send the Prospective Governor Information to governors   | Mrs Provins  | 08.09.16 | Closed | Sent 04.07.16  |
| 08.09.16 | Public | Deputy Director of HR to be invited to talk about staff development and work to encourage and support minorities development and applying to the Trust | Mrs Provins  | 09.03.17 | Closed | On agenda 09.03.17   |
| 06.12.16 | Public | Directorate Manager for ED to be invited to attend to provide the Governors with the presentation provided to the Board                                | Mrs Provins  | 09.03.17 | Closed | On agenda 09.03.17   |
| 06.12.16 | Public | Governors News Reports to be placed on the website   | Mrs Provins  | 09.03.17 | Closed | Reports placed on the website from 01.02.17  |
| 06.12.16 | Public | Selby Community Hub slides to be circulated  | Mrs Provins  | 16.12.16 | Closed | Sent out in the Friday email   |

|          |        |  |              |          |        |  |
|----------|--------|--|--------------|----------|--------|--|
| 06.12.16 | Public | Mrs Provins to provide details of internal election process in her Friday email                                      | Mrs Provins  | 16.12.16 | Closed | Sent out in the Friday email                                       |
| 09.03.17 | Public | Mrs Provins to put use of Enterprise on the next agenda.   | Mrs Provins  | 15.06.17 | Closed |  |
| 09.03.17 | Public | Mrs Provins to look at whether the FFT can be used to promote membership   | Mrs Provins  | 15.06.17 | Closed | On agenda  |
| 09.03.17 | Public | Mrs Provins to take the suggestions back to the membership group   | Mrs Provins  | 15.06.17 | Closed |  |
| 09.03.17 | Public | Mrs Provins to put the Associate Nurse role on the December agenda   | Mrs Provins  | 15.06.17 | Closed |  |
| 09.03.17 | Public | Mrs Provins to raise with the IPC Team about the use of eye catching IPC stations like those at St Monicas.          | Mrs Provins  | 15.06.17 | Closed | Meeting on 28 June 2017  |
| 15.06.17 | Public | Mrs Provins to email Ms Porter the Arts Co-ordinator details   | Mrs Provins  | 07.09.17 | Closed |  |
| 15.06.17 | Public | Ms Symington to place an article about the Governor elections in Staff Matters and talk to the NEDs about candidates | Ms Symington | 07.09.17 | Closed | Comms briefing sent out followed by press release and social media |
| 15.06.17 | Public | Mrs Provins to raise holding one election every three years with the Constitutional Review Group                     | Mrs Provins  | 07.09.17 | Closed | Placed on agenda 24.8.17   |
| 15.06.17 | Public | Mrs Provins to raise applying for membership with the Membership Development Group                                   | Mrs Provins  | 07.09.17 | Closed | Placed on agenda 21.8.17   |
| 15.06.17 | Public | Mrs Provins to raise recruiting members from the University with the Membership Development Group                    | Mrs Provins  | 07.09.17 | Closed | Placed on agenda 21.8.17   |
| 15.06.17 | Public | Mrs Provins will discuss the use of social media to recruit members with the Membership Development Group            | Mrs Provins  | 07.09.17 | Closed | Placed on agenda 21.8.17   |
| 15.06.17 | Public | Mrs Provins to send out the Out of Hospital Care Strategy Video link with the Friday email                           | Mrs Provins  | 07.09.17 | Closed | Friday email 16.06.17  |

## Council of Governors – 07 December 2017 Governor Activity Reports

### Recommendation

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

### Purpose of report

The Council of Governors is asked to note the report and the authors will respond to any questions or comments, as appropriate.

### Key points for discussion

This paper provides an overview from Governor activities.

### Trust Ambitions and Board Assurance Framework

([https://www.yorkhospitals.nhs.uk/about\\_us/our\\_values/](https://www.yorkhospitals.nhs.uk/about_us/our_values/))

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

### Reference to CQC Regulations

(Regulations can be found here: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers> )

Version number: 1

Author: Margaret Jackson – Lead Governor

Jeanette Anness - Public Governor (Ryedale & East Yorkshire)  
Stephen Reed – Joint Head of Strategy, York Hospital NHS Foundation Trust  
Sheila Miller – Public Governor (Ryedale & East Yorkshire)

Date: November 2017



## 1. Lead Governor Report

The Trust continues to work hard to meet targets and manage the current very difficult financial pressures. There is constant demand at all levels in the organisation with the Executives being regularly challenged by the Non-Executive Directors. All Governors and in particular those attending the Board meetings and committees are very aware of this. Please do attend the Board meetings if you can, or do read the papers to ensure you are familiar with the current issues and the plan to work towards improving the situation.

I would like to take the opportunity to welcome any new governors successful in the last elections and congratulate those who were successful in their own re-election. Can I also thank everyone for their support in my re-election to the role of Lead Governor. I am very pleased to know that I have your support and as part of the way forward I would like to start meeting with governors in their localities to learn more about the issues that are important to you and your communities and how best I can help you in addressing, or dealing with these if it is agreed as appropriate to do so. I will send out for dates for you all to review and then if you would please let me know which suits you. I will try to do this in the first 3 months of the New Year (2018).

The Annual Members Meeting and the Trust AGM were held at the Principal Hotel, York Station on Tuesday, 12th September 2017. Sue Symington opened the meeting and then Patrick Crowley, Andrew Bertram and Beverley Geary gave their presentations explaining the Trusts current position with particular emphasis around the financial position and staffing issues. I gave a presentation on behalf of the Governors and outlined the activities undertaken throughout the year. At the end there were a number of questions from the audience present addressed to the panel of Executives. It was a good start to the first of the Annual Members Meetings as well as the Trust AGM.

Another Recruitment Fair was held in the reception area at York Hospital on Saturday 30th September, which was well attended. Thank you to those Governors who were able to support having a Governors stand and help recruit members.

In addition to meeting with Sue Symington and Patrick Crowley, I have started meeting with Lynda Provins to discuss issues and agree how to address these on behalf of Governors to ensure we are both aware of any concerns or issues, and to support each other.

One of the issues Governors have had concerns about, and wanted to know if it was being reviewed were the new visiting hours. At the last Patient Participation group it became apparent that this is going to happen and will be led by Kay Gamble. Please read the Patient Experience Steering group notes or look out for the feedback from Pat Stovell or myself. We attend this group on your behalf.

As you are aware a focus group for Governors to meet a team from the CQC was held on Wednesday 18th October. Three members of the CQC team came to discuss how the Governors worked and were able to fulfil their role. They also asked about any thoughts the group might have on the future of the organisation. Thank you to all who were able to attend. Please look out for the report from the visit and the action plan produced by the Trust to address any issues found.



Once again, I am aware that sometimes the venue makes this difficult but if you can attend a Board meeting it is a very helpful way to find out in more detail what is happening within the Trust, how it is being addressed and how the Non-Executive Directors are fulfilling their role. Papers for the meeting are distributed on the day and are available at a later date on the website.

As you are aware a number of the Non-Executive Directors will be due to leave in the not too distant future and discussions are underway as to how this election process will be managed. Please look out for more information on this topic and how you can be involved.

Margaret Jackson, Lead Governor

## 2. Arts Strategy Group Report

Unfortunately neither Mick Lee nor I could attend the last meeting held on 12 October 2017 therefore this report is based on the minutes and other papers from the meeting which include the Work Plan Update for January to December 2017, and the Work Plan for January to December 2018. The three main themes to be addressed that came out of the needs analysis undertaken with internal and external stake holders are:

- Continued Professional Development of the Arts Team
- Proactive and planned approaches
- Network with Community Partners

From these; during 2017 the Arts team has developed ongoing evaluation, particularly with the participatory and music areas so that they can create good practice, work with patient needs and evidence the work they do. In the 2018 Work Plan the team has responded by creating practical actions and priorities to manage the workload by creating workable time scales, particularly in exhibition planning.

The 2018 Work Plan was presented, noting the theme of 70years of the NHS, the team have planned music and participation projects to celebrate, some of which will need funding. They hope the projects can take place across all sites. One of these will be a Humans photography exhibition touring around the Trust patch during the year. From June to December there will be a Paintings in Hospital Exhibition showing work from the Ingram Collection, the largest publicly accessible collection of Modern British and Contemporary Art.

It was noted that a development group has been set up with Andrew Bennett from Capital Planning to try to reduce last minute involvement in Capital and Estates Schemes. Griselda Goldsbrough stressed the need for evaluation, especially of participation work, as this will be crucial in proving it is credible for future funding for projects. I feel confident that the Arts Team are formulating a strong basis and structure for the future development of their role.

Jeanette Anness, Public Governor



### 3. Out of Hospital Care Group Report

#### **Summary of topics discussed at the meeting on 10 November 2017**

##### **Matters arising:**

Steve Reed confirmed that the Malton League of Friends had kindly agreed to fund the equipment for a Ryedale 24hr ECG service. Following the meeting Steve has confirmed that the vacancy has been approved for recruitment and the service is expected to commence in January 2018.

Steve Reed updated on the Trust-wide refresh of an approach known as SAFER to improve earlier discharge planning and prevent delays for patients. Implementing this across community units would incorporate the principles of the Ticket Home initiative previously presented to the group.

Steve Reed provided a brief overview of the CQC Review of the Health and Social Care Interface in the City of York and confirmed that a report would be received describing the findings in December 2018.

##### **Terms of Reference:**

Steve Reed presented updated terms of reference for the group to consider. A number of small changes required were noted. Most significant was a review of the previous membership list which did not reflect the current membership. It was confirmed that Margaret Jackson will be the Deputy Chair of the group.

##### **Stranded Patient Reviews:**

Steve Reed discussed two reports that had been circulated to the group in advance. The reports described reviews on the York and Scarborough hospital sites of all patients who had been in hospital for over seven days. The reports highlighted that a significant number of patients on both sites were 'stranded' in hospital and did not medically need to be in an inpatient bed. The reviews highlighted that more of these patients were under the care of Elderly consultants but that were under the care of all specialisms. The reasons for delays included internal process delays (such as waiting for MDT decisions), waiting for health funded services in the community, waiting for social care assessments or funded services in the community and delays due to patient or family choice.

Steve confirmed that the reviews will be repeated every six months and that following the reports being considered by the A&E Delivery Board it has been agreed that organisations across health and social care will meet every week to review patients who are stranded in hospital. Steve also described a service that is piloted with funding from the Trust charity. Working with AgeUK York, the service will provide evening or overnight support to people who would otherwise require admission to hospital or to stay in hospital longer.

##### **General Update:**

Jeanette Anness described a meeting held by Scarborough and Ryedale CCG on opportunities to save money locally. The meeting identified opportunities around thresholds for treatment, changing prescribing practices and people potentially needing to travel further to access some services. Jeanette advised that a vote was held on the opportunities described and that these received broad support.



### **Home First Engagement Plan:**

Lucy Brown (Head of Communications) described work that she has been leading to develop an engagement plan on 'Home First'. On the basis of the community bed audit and national evidence on the harm associated with deconditioning, accountable officers from commissioners and providers have asked for a plan to be developed to start a conversation with local people about the findings.

The objectives of the proposal are to:

- Increase awareness of the evidence on the harm associated with deconditioning;
- Get feedback about peoples' experiences in hospital and what a good approach would look like;
- Gain insight about to communicate the key messages.

Lucy described the plan was to work through existing groups and forums and would link closely to work communicating with staff on the importance of Home First. She advised that some of the work has already started and the proposal described six months of engagement resulting in a report on the key findings.

The group discussed how governors could support this engagement. An initial suggestion was through Practice Patient Groups but it was noted that governors would need a briefing session to ensure consistency. It was also recommended to use the Members Newsletter.

### **Actions Agreed**

- Ensure distribution list reflects Terms of Reference attendees – Steve Reed
- Discuss development of 24hr ECG service in Ryedale with Selby League of Friends – Ann Bolland
- Circulate proposed 2018 dates – Steve Reed
- Discuss updated membership of terms of reference with Lynda Provins – Steve Reed
- Recirculate draft terms of reference to group prior to sending to Council of Governors for approval – Steve Reed
- Contact Andrew Bertram regarding financial implications of patient choice related delays – Mike Sweet
- Circulate Home First engagement proposal – Steve Reed
- Organise briefing session for governors – Lucy Brown

Stephen Reed, Joint Head of Strategy

Appendix 1 – Out of Hospital Care Group Terms of Reference



### 3. Transport Group Report

There is to be a Focus Group to refresh the Travel Plan with the various groups; this will include working with all staff (Clinical, Nursing, Ward staff, shift workers, Junior Doctors) at all the Trusts Hospitals, together with the City of York. As there are problems with the lack of parking for staff some of this work will concentrate on withdrawing some parking passes, but doing this in a sensitive way and offering staff some alternative benefits. There continues to be problems with bus services, and many staff coming in for early shifts cannot get busses within York to get to work which means they drive and some staff come early and have their breakfast in their car to ensure car parking. Following on with Patrick Cowley's consultation with Governors about charging in the Disabled Car park, work is also being done to see how this can be done fairly for all visitors as there has been abuse of this facility by members of the public, with some even parking and then going down into York. The car parking staff are aware of this and do try and monitor as they do at the 20 minute drop off point. I did ask that it should be easier to find wheelchairs at the main entrance, as often there are none available.

The Transport plan impact assessment including sustainability, Car Park, Staff and Environmental issues will be discussed at an away day at Scarborough on the 28 November to try and take a more strategic approach, and then to concentrate on the car park review. So far things being looked at are: Malton Urology community transport, pool cars and car parking. A meeting took place on 02 November with Caroline Wilkinson of NYCC to begin to link up regarding traffic problems at Scarborough. NYCC has funding to help with infrastructure, roads, traffic, car parking, cycling and public transport.

Good work is being done involving pool cars and community staff in York saving £11,000 per year, and night staff are using the available pool cars at York. There are also enquiries about the possibility of a similar arrangement being set up at Selby. Currently there are 50 staff based in Selby who work in communities, one at night, so similar savings could be made.

The web page is to be updated; York City council is working on plans to improve access along Wigginton Road; it may be possible to use the old Nestle site for staff parking.

A new endoscopy unit is to be built above the existing Physiotherapy Department at the north end of the Hospital costing £19m. This means physiotherapy staff temporarily being moved to Archways, where there will be difficulties for staff parking and deliveries. Processes are in place to plan for this to work with minimal disruption. There is to be a new Dermatology Outpatients at Malton and together with the 3 day a week Urology outpatients studies are being made about the car parking.

The Pool and Hire car schemes continue to make good savings both financial and in carbon emissions. There is still some wastage when people fail to cancel but use has increased, particularly at Scarborough and Malton and continues to slowly increase; regret was expressed that no Governors have yet taken advantage of the scheme.

Sheila Miller, Public Governor



# Out of Hospital Care Group: Summary of Governance



Version 5.2  
November 2017

## APPENDIX 1:

### Out of Hospital Care Group

#### Terms of Reference

|                               |   |
|-------------------------------|---|
| <b>1 Status</b>               |   |
| 1.                            | The Out of Hospital Care Group is a sub-group of Council of Governors. A summary of the discussions and progress of the group will be presented to the Council of Governors.  |
| <b>2 Purpose of the Group</b> |   |
| 2.                            | <p>Under the Foundation Trust model; Governors are expected to ensure that the wider community views are taken into account when developing strategies around services and plans. This means that it is implicit that communication with the wider community is a key responsibility of the members of the group. Wider community includes members and the community this trust serves.</p> <p>The group, including wider public representatives, provides a lay reference forum for the development of out of hospital care.</p> |
| <b>3 Authority</b>            |   |
| 3.                            | The Council of Governors provides devolved authority to the Out of Hospital Care Group to undertake an approved work programme.   |
| <b>4 Roles and functions</b>  |   |
| 4.1                           | The group will report to the Council of Governors on the Trust led strategies in relation to out of hospital care. It will review and influence their development on behalf of the Council of Governors.  |
| 4.2                           | The group provides a forum for the 'voice of the community' to be shared with the organisation, including where relevant the Out of Hospital Care management team.  |
| 4.3                           | The members of the group will be actively involved in seeking the views of the community on existing and developing community services.   |
| <b>5 Membership</b>           |   |
| 5.                            | <p>The membership of the Out of Hospital Care Group will comprise:-</p> <ul style="list-style-type: none"><li>• Joint Head of Strategy (Chair)</li><li>• Membership from 5 governors representing different constituencies</li><li>• 1 Staff Governor</li><li>• 1 Non-Executive Director</li><li>• Member of Out of Hospital Care Directorate Senior Management Team</li></ul> <p>The group will also invite attendance from others (both Trust employees and from the</p>  |

## APPENDIX 1:

|                      |   |
|----------------------|---|
|                      | wider community) as appropriate.  |
| <b>6</b>             | <b>Quoracy</b>  |
| 6.1                  | The Group will be quorate with 4 members attending, of which 2 must be Public Governors, including either the Chair or Deputy Chair.  |
| <b>7</b>             | <b>Meeting arrangements</b>   |
| 7.1                  | The Out of Hospital Care Group will meet at least quarterly (usually at Malton Hospital). Copies of all agendas and supplementary papers will be retained by the Chairman of the meeting.   |
| 7.2                  | The Chairman of the Out of Hospital Care Group has the right to convene additional meetings should the need arise and in the event of a request being received from at least 2 members of the group.                                |
| 7.3                  | Where members of the Out of Hospital Care Group are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the Chairman of the group.  |
| <b>8</b>             | <b>Review and monitoring</b>  |
| 8.1                  | The Out of Hospital Care Group will maintain a register of attendance at the meeting. The attendance record will be reported as part of the annual report. The group's annual report will be presented to the Council of Governors. |
| 8.2                  | The terms of reference will be reviewed every two years or following a significant change in governance arrangements.   |
| <b>Author</b>        | <b>Steve Reed, Head of Strategy for Out of Hospital Services</b>  |
| <b>Owner</b>         | <b>Out of Hospital Care Group</b>   |
| <b>Date of Issue</b> | <b>November 2017</b>  |
| <b>Approved by</b>   | <b>Council of Governors</b>   |
| <b>Date</b>          |   |
| <b>Review date</b>   | <b>November 2019</b>  |

## Council of Governors – 07 December 2017

### Chief Executive's Overview

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#### Recommendation

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

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#### Current approval route of report

This report was drafted for the Board of Directors.

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#### Purpose of report

The attached report is the overview presented by the Chief Executive to the Board of Directors at their meeting on 29 November 2017. It is provided as for the Council of Governors as an update from the Chief Executive for information and discussion.

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#### Key points for discussion

There are no specific points to raise.

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#### Trust Ambitions and Board Assurance Framework

([https://www.yorkhospitals.nhs.uk/about\\_us/our\\_values/](https://www.yorkhospitals.nhs.uk/about_us/our_values/))

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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### Reference to CQC Regulations

(Regulations can be found here: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>)

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Version number: 1

Author: Patrick Crowley, Chief Executive

Executive sponsor: Patrick Crowley, Chief Executive

Date: December 2017



## 1. Chief Executive's Overview

As we have discussed at recent Board meetings, the NHS continues to struggle financially at a local and national level, and as a Trust we reported a significant financial deficit at the half-way point of the financial year.

The scale of the problem is the worst this Trust has ever faced, however we have a history of strong financial performance, in particular in our delivery of our efficiency requirements, and we should take comfort in our ability to engage staff in making an individual and collective contribution to this.

Staff from across the organisation have collaborated to develop our financial recovery plan, which is being implemented, and along with the Director of Finance and other Board colleagues I have been actively briefing staff through all of our operational meetings and our established internal communications routes to ensure that the messages around finance and performance are shared and understood.

The key message is that it is essential that we arrest the deterioration of our finances, and in order to do this it has to feel different for everyone in the organisation. If we continue to do the same as we have always done, the situation will not change. We need everyone to work with us, no one can assume it is someone else's responsibility. The only way we can protect our ability to make choices, particularly around investments and future developments, is to be in control of our resources.

We are starting to see early signs of improvement in our projected deficit position, as we shall hear further as part of our Board agenda, but the situation remains precarious and we cannot take any improvement for granted.

We continue to work closely with our regulator NHS Improvement and last week I, along with our Director of Finance, Chair, and the Chair of the Finance and Performance Committee met with members of NHSI's finance team. We will update Board members as to the outcome of this meeting in due course.

I have re-stated to all staff through my briefing that how you choose to spend your time at work is the biggest contribution you can make. Our basic principle must be to make sure every minute of time and every penny spent on behalf of the organisation counts towards doing the best for our patients. This really is everyone's job.

This is all the more important as we approach winter, and there has inevitably been some national media coverage about the ability of health and social care services to cope. We have now finalised our winter plans in partnership with local authorities and CCGs, with significant emphasis on increased investment in out of hospital care to alleviate some of the pressure on our acute sites.

Providing care for the most urgently sick people is our core purpose and everyone contributes to this either directly or indirectly in their role. Each and every one of us works in this organisation for one reason only, and it is together to provide the very best healthcare we can.



This has been illustrated perfectly in recent weeks, when, faced with a drop in our performance against the four hour target, we have reasserted ourselves and are now seeing performance that is vastly improved. This is despite the evident recruitment issues we face, and which continue to be our biggest risk.

This is as a result of everyone's attention to detail, particularly around early assessment, appropriate diagnosis and where necessary admission. It is dependent on ensuring we have the appropriate flow of patients through the system, and we must all focus on only keeping people in hospital when absolutely necessary.

We have been subject to a number of CQC assessments in recent months, and whilst we do not expect to have the formal reports until the new year, we have received some early feedback where they clearly saw and heard from all staff that patient safety is first and foremost in their thoughts and actions, and they see this as a credit to the organisation.

Our improving performance against the emergency care standard demonstrates this, and shows that by focusing on every detail, not just around their specific treatment but also on how patients are managed throughout their time with us, we can keep patients safer. This should be at the core of our professional purpose, and this really is living up to our values.

Whilst the recovery plan and its delivery are rightly at the forefront of everyone's minds, it is still important that we do not lose sight of our overall strategy or longer term ambitions.

Earlier this month we held a strategy time out as part of our planning cycle, bringing together the clinical leadership and senior management of our organisation to contribute to the strategic planning round for this year.

At this event we heard from our local STP leaders and the NHS Improvement Productivity Team leadership to support formulation of plans, not only connected to our STP where appropriate, but also focused with our regulators on our internal productivity. This is closely linked to the recent visit to the Trust by Lord Carter, and there is more on this below.

We are at a pivotal stage in our strategic development, as we are now five years post-merger. The context we are working in today is very different to that which we faced in the lead-up to the merger, and far more challenging than the worst-case scenario we were able to envisage at that time. There is no indication that there will be any improvement to the financial constraints we are working with, and whilst I welcome the increased NHS funding announced in the budget, it is likely to come with conditions attached, and we must assume it will not be relief package. All of this means that we need to continue to consolidate, develop and change. The event therefore presented the opportunity to further develop our clinical strategy, and to frame the principles and values that shape and constrain our service developments.

## 2. Lord Carter Visit

We were privileged to host a visit from Lord Carter of Coles last month. Lord Carter's 2015 report into how large-scale savings could be made in the NHS has been the driving force behind much of the NHS's efficiency programme, and the visit gave us the opportunity to share first hand some of the work we have been doing.



As part of our discussions with NHS Improvement regarding our recovery plan, we have been offered help and support from NHSI's Operational Productivity Team, and have begun working with them. The expectation is that this will be a two-way process, as this is the first time the team has worked with a Trust in developing and shaping their support package, giving us the chance to work with NHSI as a critical friend during our financial recovery process and helping to shape their national support package.

The five areas identified for the first phase of this work are trauma and orthopaedics, cardiology, radiology, procurement and estates rationalisation, and the exploratory work on this has already begun. Linked to this work, Lord Carter is interested in helping us to develop a service and estate strategy for the East Coast.

The developing debate with Lord Carter and NHSI's Productivity Team will continue in the session we have planned as part of today's Board meeting, both of whom will be attending.

It is positive for us that the work we are doing here is being given such a high profile, and a consequence of this is that we have been put in contact with Tim Briggs, the national lead for the Getting it Right First Time programme. Tim will also be joining our Board session as we consider how we embrace this work and its importance to us.

### **3. Scarborough and Ryedale Community Services**

It has been announced that Scarborough and Ryedale Clinical Commissioning Group has awarded preferred provider status to Humber NHS Foundation Trust for the new community services contract in Scarborough and Ryedale from April 2018.

We will be working with Humber, who currently provide community services in Whitby and Pocklington, over the next four months to ensure that we transfer services safely and effectively. All staff involved have been informed of the outcome of the tender process and they will have an opportunity to meet with the Humber team in the near future.

### **4. Outpatient Clinic Activity – Whitby Hospital**

Following a review of our clinical activities at Whitby Hospital, we have taken the decision to withdraw from providing outpatient sessions at the site.

To continue providing outpatient sessions is not be financially viable for the Trust and leaves us no choice but to withdraw.

We have formally given notice to Hambleton, Richmondshire and Whitby CCG, with services due to end on 20 May 2018.

This decision has not been taken lightly and we will work closely and cooperatively with any successor provider organisation to ensure a smooth transition. The CCG will now consider their options in terms of potential future provision, and we will keep the Board updated during the next six months.



## 5. Recruitment Campaign

As you may have seen in updates that have gone out to staff, we are at the start of developing a more coherent recruitment marketing strategy for the organisation. We are working with an agency who are experts in recruitment marketing and employer branding, and they are starting the process with a series of focus groups with a wide range of staff to better understand our organisation and the benefits of choosing us as a place to work.

## 6. Celebration of Achievement

Finally, it was a great pleasure to be joined by almost 300 staff at our annual Celebration of Achievement Awards in Bridlington last month. I have been asked whether such an event can be justified in the current financial climate, when we are asking staff to scrutinise any and all discretionary expenditure, no matter how small. This is a fair question, and the decision is not one that is taken without thought. We were fortunate that a significant proportion of this year's event was funded through generous sponsorship from a number of our suppliers and our staff benefits fund, minimizing the costs to the Trust, however our aim is for this event to be entirely funded through sponsorship in future years, and the costs are closely monitored. However, for me, it is precisely because of the pressures our staff are under that it is all the more important that we do not lose sight of reward and recognition, and that we take the time to celebrate all of the things we do well, which is why I introduced these awards when I became Chief Executive. The value to those individuals who receive a nomination in terms of pride and morale cannot be overstated, and continuing to celebrate this no matter how difficult the circumstances is, to me, at the heart of our values.



## **Independent Practitioner's Limited Assurance Report to the Council of Governors of York Teaching Hospital NHS Foundation Trust on the Quality Report**

We have been engaged by the Council of Governors of York Teaching Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respect of York Teaching Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

### **Scope and subject matter**

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (see page 199); and
- Percentage of patients with total time in Accident and Emergency of four hours or less from arrival to admission, transfer or discharge (York Teaching Hospital and Scarborough Hospital) (see page 199).

We refer to these national priority indicators collectively as the 'Indicators'.

### **Respective responsibilities of the directors and Practitioner**

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2016 to 30 May 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 30 May 2017;
- feedback from Commissioners dated 16 May 2017;
- feedback from Governors dated 12 May 2017;

- feedback from local Healthwatch York dated 15 May 2017;
- feedback from North Yorkshire Scrutiny of Health Committee dated 27 April 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30 May 2017;
- the national patient survey dated 8 June 2016;
- the national staff survey dated 7 March 2017; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 19 May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of York Teaching Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting York Teaching Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and York Teaching Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

### **Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

## **Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by York Teaching Hospital NHS Foundation Trust.

Our audit work on the financial statements of York Teaching Hospital NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as York Teaching Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to York Teaching Hospital NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to York Teaching Hospital NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of York Teaching Hospital NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than York Teaching Hospital NHS Foundation Trust and York Teaching Hospital NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

## **Basis for qualified conclusion**

The indicator 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' did not meet the six dimensions of data quality in the following respect:

- Validity – Our testing identified errors where the Trust's validation process had not been carried out in a timely manner causing 3 out of the 60 cases tested to be incorrectly included in the sample period.

## **Qualified conclusion**

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;

- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

*Grant Thornton UK LLP*

Grant Thornton UK LLP  
Chartered Accountants  
Manchester

30 May 2017

## Council of Governors – 7 December 2017

### Out of Hospital Care Board Strategy Report – September 2017

#### Recommendation

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

#### Current approval route of report

This draft was presented to the Board of Directors in September 2017.

#### Purpose of report

The purpose of this quarterly report is to provide the Board of Directors and the Council of Governors with a strategic update relating to out of hospital services.

This report describes the results of two recent reviews that emphasise the scale of the challenge (and opportunity) in taking a 'Home First' approach in both acute and community inpatient settings. It sets out how we will respond to the results, including how we will work with staff and the public to do this.

The Stranded Patient Review identified nearly 240 patients on the York Hospital site who had been in hospital over seven days. Over half of these (126) were medically ready for discharge. The Community Inpatient Bed Audit found 54 patients (43% occupied beds) who were still in hospital beyond the date they were deemed able to leave – and that on average these patients spent 18 days in hospital after the date they were deemed able to go.

The report describes how the Complex Discharge Programme (a multi-agency initiative as part of the A&E Delivery Board) is working to reduce the delays that patients experience in hospital and the development of a proposal for a ward-based approach to support staff in delivering this.

The report provides a brief overview of the planned CQC review of the health and social care interface in the City of York that is scheduled to take place in the week commencing 30 October.

It also describes how we have been able to support 14% more patients through intermediate care services since the Archways Intermediate Care Unit was re-provided as a home based service.

Finally, it outlines a proposed conversation with local people about what Home First means to them and how we can work together to embed this in all that we do.

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### Key points for discussion

The purpose of this quarterly report is to provide the Board of Directors and Council of Governors with a strategic update relating to out of hospital services.

The developments described in this report are based upon the organisation's commitment to a 'Home First' approach. Motivated by the harm caused to older and vulnerable patients by the physical and functional de-conditioning that often accompanies a stay in hospital, Home First challenges our current approach to risk and safety. It encourages discussion with patients, and their carers, to understand what their priorities are and how they can be supported to achieve these – challenging ourselves as to why this cannot happen at home.

Delivery of 'Home First' will require a step change in both the capacity of community based health and social care services and attitudes of staff and the public. However, as noted in the recent Out of Hospital Care Board Sub-Committee Report, we do not need to wait for this to make a start.

This report describes the results of two recent reviews that emphasise the scale of the challenge (and opportunity) in both acute and community inpatient settings. It sets out how we will respond to the results, including how we will work with staff and the public to do this.

The Board of Directors and Council of Governors are asked to note the contents of the report and to support the proposed approach.

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### Trust Ambitions and Board Assurance Framework

([https://www.yorkhospitals.nhs.uk/about\\_us/our\\_values/](https://www.yorkhospitals.nhs.uk/about_us/our_values/))

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.



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

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### Reference to CQC Regulations

(Regulations can be found here: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers>)

There are no direct references to CQC outcomes.

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Version number: 1.1

Author: Steve Reed, Head of Strategy for Out of Hospital Services

Executive sponsor: Wendy Scott, Chief Operating Officer

Date: December 2017



## 1. Developments

### 1.1 Stranded Patient Review

The Complex Discharge Programme Task and Finish Group (a multi-agency sub-group of the A&E Delivery Board) recently commissioned a review of ‘stranded’ patients in York Hospital. ‘Stranded’ patients are defined as those who have spent seven days or more in hospital. The purpose of the review was to allow system leaders to understand the reasons why patients were waiting in hospital and therefore ensure that the Complex Discharge Programme is focused on the most significant barriers to discharge.

On the 17 August, a multi-agency team reviewed the 237 patients who were ‘stranded’, going through the information contained in the electronic whiteboard with each ward manager and allocating a coded reason why the patient was still in hospital. The results have been summarised in a report which is included as Appendix 1. The key findings include:

- 96% of stranded patients were admitted non-electively;
- 114 patients (48%) were under the care of Elderly Medicine but all specialties and wards were caring for stranded patients;
- 126 patients (53%) were coded as being medically ready for discharge;
- Of these, 25 were coded as waiting for multi-disciplinary team decisions;
- 26 were coded as waiting for services provided by ‘health’, including 20 who were waiting for intermediate care (home and bed based);
- 23 were coded as waiting for services provided by ‘social care’ including 10 who were waiting for a social care assessment.

The recommendations from the review are:

- for this to be repeated in Scarborough Hospital (and then on both sites at regular intervals);
- for there to be a regular and frequent focus on stranded patients at ward level as part of SAFER principles;
- system partners to review our approach to managing flow, discharge pathways and escalation processes to ensure the actions we are putting in place have an impact (and develop a dashboard to measure this).

The Complex Discharge Programme Task and Finish Group have also undertaken a self-assessment against the national 8 High Impact Changes to Reducing Delayed Transfers of Care (DToC). The Trust has signed up to a targeted reduction in the number of beds occupied by patients who are recorded as being a DToC (to no more than 3.5% of all occupied beds, a reduction of 22% on current levels). CCGs and Local Authorities are also required to commit to reductions as part of Better Care Fund plans. The 8 High Impact Changes are:

|  |                                     |
|--|-------------------------------------|
| 1. Early discharge planning                  | 2. Systems to monitor patient flow  |
| 3. Multi-agency/disciplinary discharge teams | 4. Home first / Discharge to assess |
| 5. Seven day services                        | 6. Trusted assessors                |
| 7. Focus on choice                           | 8. Enhancing health in care homes   |



The self-assessment is shown at Appendix 2 and shows that, whilst plans are in place across a number of the changes, there is significant work to do for these to be established. The Complex Discharge Programme includes many of these plans and a summary is included at Appendix 3 for reference.

Feedback from ward teams shows confusion with the varied initiatives that have been undertaken to prevent unnecessary delays for patients – for example ‘discharge to assess’, ‘supported discharge’, ‘ward principles’, ‘SAFER’, ‘Intensive Reviews’. Operational and Corporate Nursing teams are working together to develop a proposed approach to address this. This could take a modular approach, starting with why de-conditioning is so important and teaching improvement skills. Further modules could include tools to ensure patients receive daily senior reviews, a focus on early discharge planning, a Home First approach and how to address and escalate delays. Delivering this ward by ward will provide local ownership and working as a bundle will support keeping it simple and understandable. Once the approach is agreed, it is recommended that this is maintained over an extended time period to provide consistency.

### 1.2 CQC Review of Health and Social Care Interface

On the 7 July 2017, the Secretary of State for Health announced that the Care Quality Commission (CQC) would be asked to review 20 local health and care systems. The reviews will focus on the interface between health and social care. The initial twelve areas for review have been identified based on a number of factors, including the systems’ performance against six key metrics. The City of York Health and Wellbeing Board area is one of the twelve identified and the review is scheduled for the week commencing 30 October.

The scope of the review is the health and social care ‘system’ within the Health and Wellbeing Board area. The review team will consider the system performance along a number of pressure points on a typical pathway of care. The review will concentrate on older people (those aged over 65 years) and will focus on the interface between social care, primary care, community health and acute services. It will not look at mental health services but will include people with dementia.

The question being asked by the review is “How well do people move through the health and social care system, with a particular focus on the interface, and what improvements could be made?” Locally, the review process will be overseen by both the Health and Wellbeing Board and the A&E Delivery Board.

The process of the review is expected to take 14 weeks. This will include six weeks of preparation, involving data and evidence submissions and the review team meeting with local people to understand their experiences (supported by HealthWatch York). The review itself will last a week, with between five and eight inspectors holding focus groups, ‘interface pathway’ interviews and speaking with system leaders. There will also be a ‘case tracking’ of six individuals who have accessed the health and social care system to understand their experience over an extended period of time.

Their findings will be summarised in a letter that will include advice for the Health and Wellbeing Board to take forward and presented through a local summit.



### 1.3 Community Inpatient Bed Review

The Community Unit Inpatient Bed Audit was undertaken during April and May 2017. The aims of the audit were to:

1. Understand the reasons why patients had been admitted to a community bed;
2. Identify what interventions patients were receiving;
3. Identify whether the needs of the patient could be met at home or by an alternative service (as perceived by ward staff).

The audit team included GPs, nurses, therapists and social workers who worked with the ward multi-disciplinary teams. The audit team used a locally developed proforma to ensure that information was captured consistently and objectively. They used a set of agreed questions with both staff and patients.

The key findings from the audit are:

- Patients were predominantly referred from acute hospital (York or Scarborough Hospital) (80%);
- 66 patients (53%) reviewed were initially admitted to hospital following a falls related incident;
- 54 patients were discharged after the date they were deemed able to leave hospital – representing 43% of occupied beds;
- These delayed patients waited an average of 18 days from being deemed able to leave hospital to their date of discharge;
- 61 patients were receiving interventions that could be undertaken at home (49%);
- 80 patients were deemed to require support with night time needs (64%).

A number of stakeholder workshops were held to review and validate the initial results, identify the key themes and identify actions to address the operational issues raised. The workshops included clinical staff from the units and partners from the health and social care system. The strategic themes arising from the workshops were:

- The cultural approach to risk, harm and safety from staff and the public is perpetuating de-conditioning – evidenced by perceived ‘night needs’;
- The need to work together more effectively as a system – with community beds not seen in isolation from the continuum of care and wider developments;
- The importance of ‘trust’ and joint working in adopting new approaches – an example would be adopting a trusted assessor approach;
- How to move as a system to a ‘Home First’ approach rather than a default to ‘beds’ when alternatives are not available.

The overall message was that people are receiving the right care but in the wrong place due to:

1. Lack of alternatives or lack of capacity in existing services;
2. Culture and expectations (staff and public).

The re-provision of Archways Intermediate Care Unit as home based intermediate care in December 2016 has shown how creating additional capacity at home has allowed significantly more patients to be supported. The update report shown at Appendix 4



shows that the York Community Response Team are exceeding activity targets by 19 patients per month on average (so 133 patients between January and July). This also includes increases in the numbers of patients being referred either directly from the community or from ED, avoiding the need for an acute admission. Overall, the change has resulted in an increase of 14% of people being able to access intermediate care (both home and bed based) and increased the proportion of intermediate care being delivered at home from 37% to 50%.

#### 1.4 Taking a co-production approach

Both the Stranded Patient Review and Community Inpatient Bed Review have highlighted the importance of culture in taking a Home First approach. This includes those who work for the Trust, those working in partner organisations, patients, their carers and families together with the wider public. Simply making changes to processes, or increasing the availability of capacity of community based support, will not be enough to make the step change that the system needs.

With this in mind we are working with HealthWatch and engagement leads from a number of local organisations to develop a co-production proposal. This will allow us to start a conversation with local people to understand their experiences of being in hospital and what could have been done to allow them to return home earlier. We will be able to share the results of the reviews that we have undertaken and work with people to design how we can work differently in the future.

Following the initial workshops held to review the results of the community inpatient audit, we agreed to hold a follow up clinical workshop in October. The purpose of the workshop is to understand what each unit currently does and what the needs are of patients being referred from the acute hospitals or the community. The workshop will then seek to define what the purpose of community inpatient beds should be going forwards. Attendees will include consultants and GPs who provide medical support to the units, nursing and therapy leads and local authority colleagues.

## 2. Conclusion

The next steps for the developments described are:

- Undertake a stranded patient review in Scarborough;
- Refresh the Complex Discharge Programme;
- Develop the ward based 'Home First' bundle;
- Complete the co-production proposal;
- Undertake the clinical workshop for community inpatient beds.

## 3. Recommendation

The Board of Directors and Council of Governors are asked to note the contents of this report and support the proposed approach.



## 4. Appendices

Appendix 1: Review of Stranded Patients in York Hospital August 2017

Appendix 2: Self-Assessment against High Impact Changes to Reduce DToC

Appendix 3: Overview of the Complex Discharge Programme September 2017

Appendix 4: Update Report on Reconfiguration of Archways September 2017



## **Appendix 1**

### **Review of stranded patients in York Hospital, August 2017**

**Sponsor: Complex Discharge Task and Finish Group**

#### **Introduction**

The purpose of the stranded patient review is to support system leaders to better understand the reasons for unnecessary delays and to have detailed information to support action planning and the development of solutions. The information will be used to ensure that the Complex Discharge Programme is focussed on the most significant barriers to discharge.

#### **Methodology**

NHS Improvement, through ECIP, have issued a Rapid Improvement Guide to undertaking a 'Stranded Patient Review' (appendix 1) offering an established methodology to undertake the review.

The process took place on August the 17<sup>th</sup> involving a multi-agency team of 11 people from YFT, Tees, Esk and Wear Valley NHS Trust and North Yorkshire County Council. YFT Systems and Network provided the team with a list of all patients who had been in hospital for 7 days or more with their ward and bed numbers. Prior to going onto the wards the teams were briefed on the electronic Whiteboard which is situated on each ward. This has live information regarding the clinical status of the patient including their status regarding their discharge. The briefing session also included explanations of the coded reasons for being in hospital with opportunity to clarify any ambiguities to ensure consistency. All data queries were brought back to the review facilitator following the visits to the wards. On each ward, the review team discussed with the ward manager the reasons for each stranded patient remaining in hospital and plans for discharge. The reasons were collated using a combination of standard codes provided by ECIP and locally agreed codes to allow for more sensitivity in data collection (appendix 2).

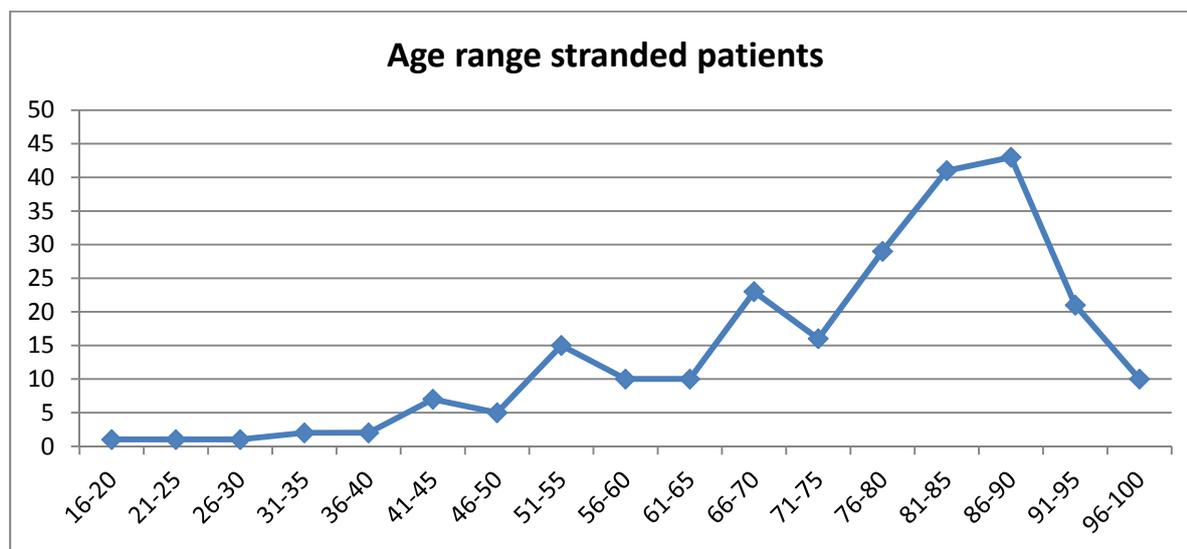
## Findings

**237 stranded patients** were reviewed (including 6 ICU patients) of which 227 (96%) were non-elective; maternity and paediatrics were excluded from the review.

## Demographics

**Age:** Patients ranged in age from 19 to 99 years.

Chart 1: Age range



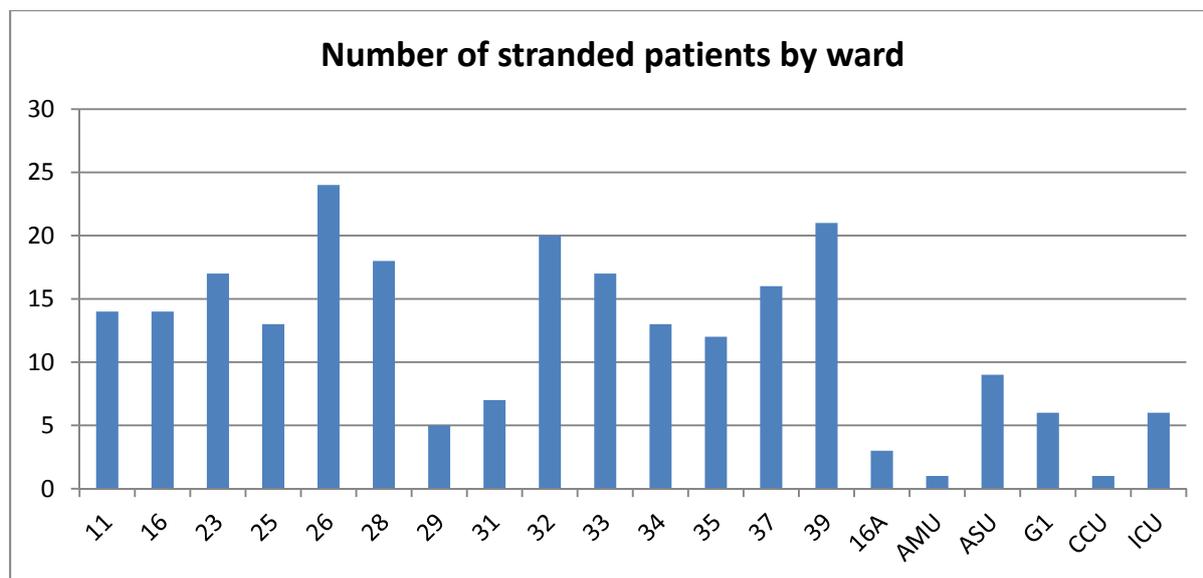
**Specialities:** There were stranded patients in all of the following specialties:

Table 1: Numbers of stranded patients per specialty

| Numbers of stranded patients per specialty |     |                         |   |
|--|-----|-------------------------|---|
| GERIATRIC MEDICINE                         | 114 | CARDIOLOGY              | 6 |
| GENERAL SURGERY                            | 32  | MEDICAL ONCOLOGY        | 4 |
| TRAUMA AND ORTHOPAEDIC SURGERY             | 25  | HAEMATOLOGY (CLINICAL)  | 2 |
| RESPIRATORY MEDICINE -THORACIC             | 13  | ACUTE INTERNAL MEDICINE | 1 |
| NEPHROLOGY                                 | 10  | MAXILLOFACIAL SURGERY   | 1 |
| GASTROENTEROLOGY                           | 9   | UROLOGY                 | 1 |
| ENDOCRINOLOGY                              | 9   | PLASTIC SURGERY         | 1 |
| NEUROLOGY                                  | 8   | GYNAECOLOGY             | 1 |

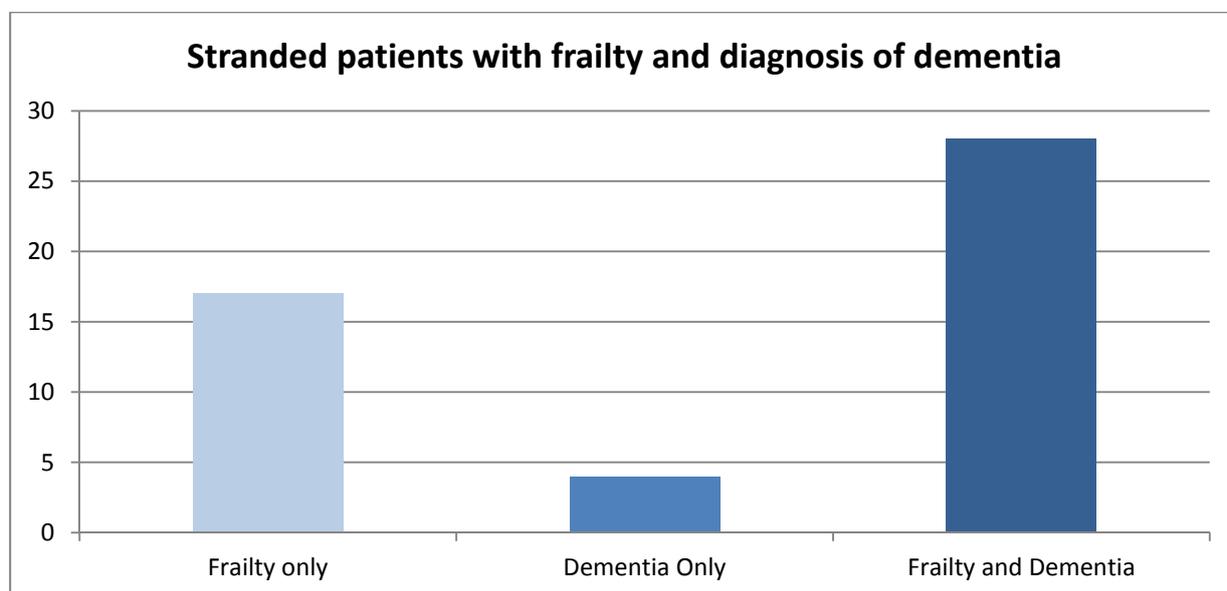
**Location:** The following chart shows the number of stranded patients per ward (appendix 3 for ward descriptors)

Chart 2: Number of stranded patients by ward



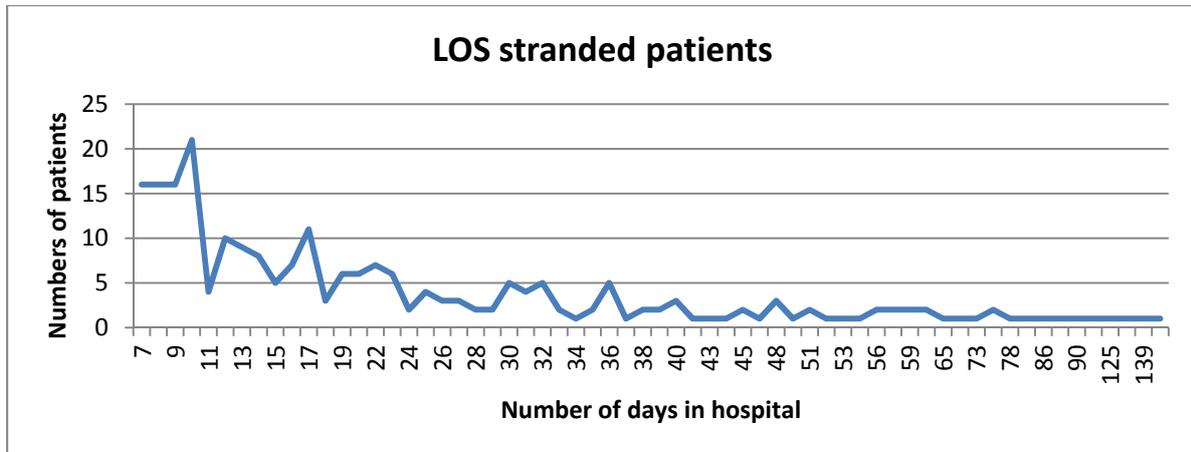
**Frailty and diagnosis of dementia:** Patients' frailty status and diagnosis of dementia were captured from the electronic Whiteboard system; 19% were frail and 14% had a diagnosis of dementia. 28 of the patients with dementia were also frail (88%).

Chart 3: Numbers of patients with frailty and a dementia diagnosis



**Length of Stay (LOS):** Patients were in hospital between 7 and 162 days; the following chart shows how the numbers were distributed for the LOS.

Chart 4: Length of Stay Stranded Patients



**Analysis**

Over half the patients (126) were coded as medically fit for discharge (53%). Of the 126, 82 (65%) were from Care of the Elderly (Geriatric Medicine)

The following two charts show the number of stranded patients fit for discharge / not fit for discharge per grouped specialty (appendix 4 shows how the specialties have been grouped), and per ward.

Chart 5: Fit for Discharge / Not fit for Discharge by Grouped Specialty

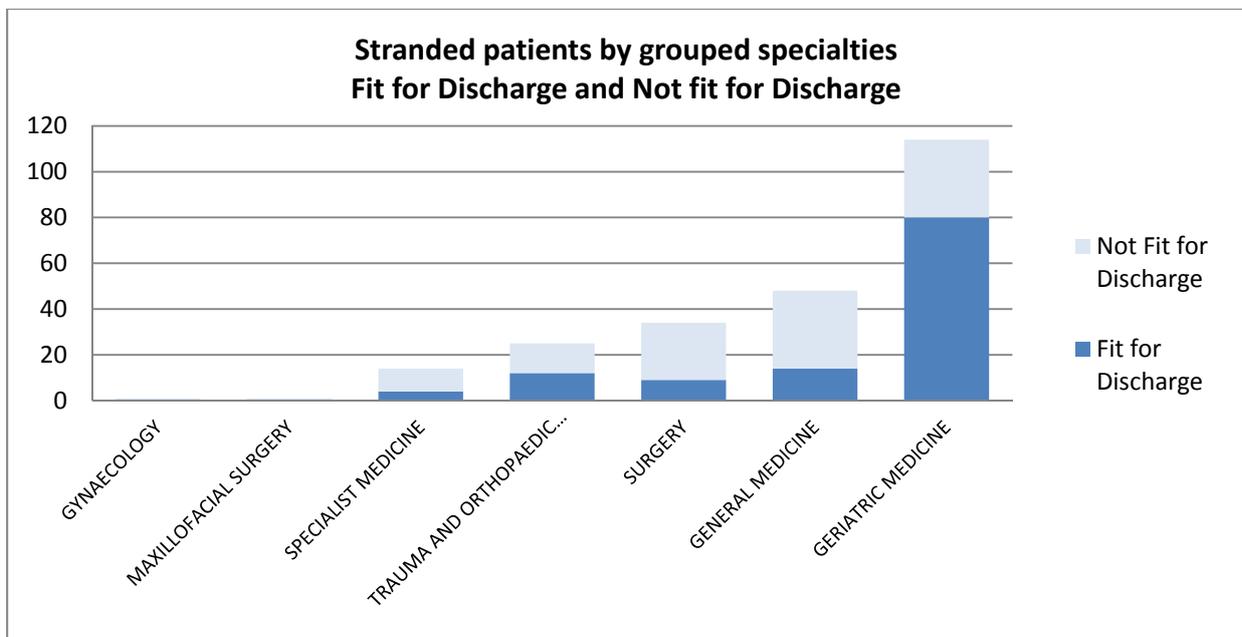
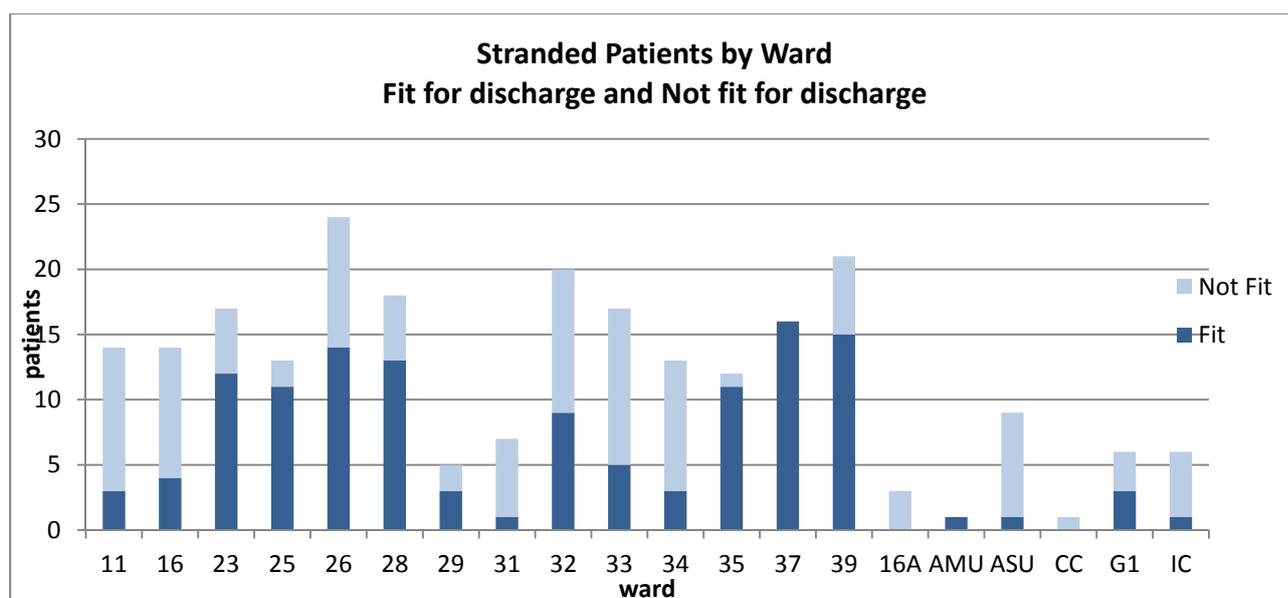


Chart 6: Fit for Discharge / Not fit for Discharge by Ward



**Reasons for being in hospital:**

The reasons for being in hospital have been categorised into 3 groups: A: not fit for discharge / fit for discharge; B: Themes and C: services provided by Health, Social Services and/or both.

**A: Not fit for discharge / fit for discharge**

The following tables show the reasons for being in hospital categorised by ‘not fit for discharge’ and ‘fit for discharge’. ECIP codes were used for those patients who were not fit for discharge. A combination of ECIP and locally agreed codes were used for those who were fit for discharge.

Table 2: Reasons for being in Hospital – Not fit for Discharge

| Reasons for being in Hospital - Not fit for Discharge                              |            |
|--|------------|
| Requiring clinical intervention that can only be achieved in this hospital         | 46         |
| Active ongoing clinical treatment non-specific and not as sick as categories below | 30         |
| Waiting for internal test, specialist opinion or similar                           | 15         |
| Intravenous therapy that cannot be given in the community                          | 11         |
| LCP/ end of life care and wants to die in hospital                                 | 3          |
| Unpredictable and erratic condition that may require immediate intervention        | 3          |
| National Early Warning Score (NEWS) of 5 or above                                  | 1          |
| Optimising pre surgery (oncology)  | 1          |
| No clear plan (patient from India)   | 1          |
| <b>Total</b>   | <b>111</b> |

Table 3: Reasons for being in Hospital – Fit for Discharge

| <b>Fit for Discharge – Reason for being in hospital</b>   |            |
|---|------------|
| Waiting for patient/family choice or input to decision making                                   | 15         |
| Waiting for community unit placement YTH  | 11         |
| Waiting for occupational therapy/physiotherapy approval for discharge                           | 10         |
| Waiting for assessment for social care  | 10         |
| Waiting for time limited home based Intermediate care (CRT)                                     | 9          |
| Ready for home today - ask whether they are confident nothing will stop the discharge           | 8          |
| Receiving Specialist Stroke Rehab   | 6          |
| Waiting for internal assessments/diagnostics/results/reviews before discharge agreed            | 5          |
| Waiting for nursing home or residential home assessment   | 5          |
| Waiting EMI placement   | 4          |
| Waiting best interest meeting/ case conference/ MDT   | 4          |
| Waiting for start of new domiciliary care package - long term packages                          | 3          |
| Waiting for out of area rehab   | 3          |
| Waiting for equipment / adaptations   | 3          |
| Waiting for CHC Package (Brokerage)   | 3          |
| Waiting for residential or nursing home self-funder   | 2          |
| Waiting for step down bed   | 2          |
| Waiting for residential or nursing home, social care  | 2          |
| Waiting discharge home visit  | 2          |
| Waiting for time limited home based social care re-ablement                                     | 2          |
| Waiting for palliative placement  | 2          |
| Waiting EDN   | 2          |
| Waiting for restart of domiciliary care package – long term packages                            | 1          |
| Waiting for family to take patient home   | 1          |
| Suitable for home but has an overnight nursing need   | 1          |
| Waiting for CHC Funding Approval / Decision   | 1          |
| Out of county/borough assessments   | 1          |
| Waiting for CHC Care Home Placement   | 1          |
| Waiting for a capacity assessment   | 1          |
| Discharge planned for tomorrow – what is stopping the patient going today? Text in comments box | 1          |
| Family dispute  | 1          |
| Patient / family refuses discharge  | 1          |
| Waiting for CHC Care Home Assessment  | 1          |
| Waiting for CHC processes e.g. checklist completion, DST assessments                            | 1          |
| Fit and no clear plan of what is needed for discharge   | 1          |
| <b>Total</b>  | <b>126</b> |

**B: Grouped by themes**

The following set of tables show the reasons for being in hospital grouped into Multi-Disciplinary Team (MDT), waiting for assessments, waiting for a bedded unit, 'family and patient' and Continuing Health Care reasons.

Table 4: MDT

| <b>MDT</b>  |           |
|---|-----------|
| Waiting for occupational therapy/physiotherapy approval for discharge | 10        |
| Receiving Specialist Stroke Rehab                                     | 6         |
| Waiting best interest meeting/ case conference/ MDT                   | 4         |
| Waiting for out of area rehab   | 3         |
| Waiting discharge home visit  | 2         |
| <b>Total</b>  | <b>25</b> |

Table 5: Waiting for assessments

| <b>Waiting for Assessments</b>                                       |           |
|--|-----------|
| Waiting for assessment for social care                               | 10        |
| Waiting for nursing home or residential home assessment              | 5         |
| Waiting for a capacity assessment                                    | 1         |
| Waiting for CHC processes e.g. checklist completion, DST assessments | 1         |
| Out of county/borough assessments                                    | 1         |
| Waiting for CHC Care Home Assessment                                 | 1         |
| <b>Total</b>   | <b>19</b> |

Table 6: Waiting for a bedded unit

| <b>Waiting for Bedded Unit</b>                      |           |
|---|-----------|
| Waiting for community unit placement YTH            | 11        |
| Waiting for out of area rehab                       | 3         |
| Waiting for step down bed SS                        | 2         |
| Suitable for home but has an overnight nursing need | 1         |
| <b>Total</b>  | <b>17</b> |

Table 7: Family and Patient

| <b>Family and patient</b>                                     |           |
|---|-----------|
| Waiting for patient/family choice or input to decision making | 15        |
| Family dispute  | 1         |
| Patient / family refuses discharge                            | 1         |
| <b>Total</b>  | <b>17</b> |

Table 8: Continuing Health Care

| <b>Continuing Health Care (CHC)</b>                                  |          |
|--|----------|
| Waiting for CHC Package (Brokerage)                                  | 3        |
| Waiting for CHC Care Home Assessment                                 | 1        |
| Waiting for CHC processes e.g. checklist completion, DST assessments | 1        |
| Waiting for CHC Care Home Placement                                  | 1        |
| Waiting for CHC Funding Approval / Decision                          | 1        |
| <b>Total</b>   | <b>7</b> |

### **C: Health and Social Care**

Finally the reasons for being in hospital were grouped according to services provided by Health, Social Services or by either/both.

Table 9: Services provided by Health

| <b>Waiting for services provided by Health</b>                       |           |
|--|-----------|
| Waiting for community unit placement YTH                             | 11        |
| Waiting for time limited home based Intermediate care (CRT)          | 9         |
| Waiting for out of area rehab  | 3         |
| Waiting for palliative placement                                     | 2         |
| Waiting for CHC processes e.g. checklist completion, DST assessments | 1         |
| <b>Total</b>   | <b>26</b> |

Table 10: Services provided by Social Services

| <b>Waiting for Services provided by Local Authority</b>                | <b>CYC</b> | <b>ER</b> | <b>NYCC</b> | <b>Total</b> |
|--|------------|-----------|-------------|--------------|
| Waiting for assessment for social care                                 | 5          | 1         | 4           | <b>10</b>    |
| Waiting EMI placement  | 2          |           | 2           | <b>4</b>     |
| Waiting for start of new domiciliary care package - long term packages | 1          |           | 2           | <b>3</b>     |
| Waiting for time limited home based social care re-ablement            | 2          |           |             | <b>2</b>     |
| Waiting for residential or nursing home, social care                   | 1          | 1         |             | <b>2</b>     |
| Waiting for a capacity assessment                                      | 1          |           |             | <b>1</b>     |
| Waiting for restart of domiciliary care package – long term packages   |            |           | 1           | <b>1</b>     |
| <b>Total</b>   | <b>12</b>  | <b>2</b>  | <b>9</b>    | <b>23</b>    |

Table 11: Services provided by Health or Social Services

| <b>Waiting for Services provided by Health or Social Services</b> |          |
|---|----------|
| Waiting for equipment / adaptations                               | 3        |
| Waiting for CHC Package (Brokerage)                               | 3        |
| Waiting for step down bed   | 2        |
| Suitable for home but has an overnight nursing need               | 1        |
| <b>Grand Total</b>  | <b>9</b> |

### **Conclusions:**

The review has demonstrated that there are a significant number of people receiving acute care who do not require it and it also confirms the reasons why people are delayed from both Trust and System perspectives. It supports the programme of work of the Complex Discharge Task and Finish Group, linking the issues to SAFER principles and the high impact changes.

### **Recommendations:**

1. A regular and frequent focus on stranded patients is included as part of SAFER principles at ward level supported by a non-ward based facilitator
2. System partners review our approach to managing flow and constraints, discharge pathways and escalation processes to ensure that the actions we put in place have an impact
3. A dashboard is developed as a way of measuring success (e.g reduced LOS, reduction in DTOCs) which is reviewed at the Complex Discharge Task and Finish Group with escalation to the A&E Delivery Board
4. The stranded patient review is repeated in Scarborough
5. The stranded patient review is repeated in 6 and 12 months' time in York and Scarborough.

Author: Ina James, Project Manager - Out of Hospital Care  
Date: 1 September 2017

## **Appendices**

### **Appendix 1:**



reviewing-stranded-  
patients-in-hospital-R

### **Appendix 2:**



Codes for stranded  
patient review August

### **Appendix 3:**

| <b>Ward</b> | <b>Specialty</b>                     |
|-------------|--------------------------------------|
| 11          | Surgical                             |
| 16          | Surgical                             |
| 16A         | Surgical Nurse Enhanced Unit         |
| 23          | Elderly (Geriatric Medicine)         |
| 25          | Fracture Neck of Femur               |
| 26          | Elderly (Geriatric Medicine)         |
| 28          | Trauma and Orthopaedic, non-elective |
| 29          | Trauma and Orthopaedic, elective     |
| 31          | Clinical Haematology                 |
| 32          | Cardiology and Neurology             |
| 33          | Nephrology and Gastroenterology      |
| 34          | Respiratory                          |
| 35          | Elderly (Geriatric Medicine)         |
| 37          | Mental Health Ward                   |
| 39          | Stroke Rehabilitation Ward           |
| AMU         | Acute Medical Unit                   |
| ASU         | Acute Stroke Unit                    |
| CC          | Coronary Care Unit                   |
| G1          | Gynaecology                          |
| IC          | Intensive Care Unit                  |

**Appendix 4:**

## Specialties Grouped

|                                       |                                |
|---------------------------------------|--------------------------------|
| <b>Geriatric Medicine</b>             | Geriatric Medicine             |
| <b>Gynaecology</b>                    | Gynaecology                    |
| <b>Maxillofacial Surgery</b>          | Maxillofacial surgery          |
| <b>General Medicine</b>               | Acute Internal Medicine        |
|                                       | Cardiology                     |
|                                       | Endocrinology                  |
|                                       | Gastroenterology               |
|                                       | Nephrology                     |
|                                       | Respiratory Medicine -Thoracic |
| <b>Specialist Medicine</b>            | Haematology (Clinical)         |
|                                       | Medical Oncology               |
|                                       | Neurology                      |
| <b>Surgery</b>                        | General Surgery                |
|                                       | Plastic Surgery                |
|                                       | Urology                        |
| <b>Trauma and Orthopaedic Surgery</b> | Trauma and Orthopaedic Surgery |

## Appendix 2 - Executive Summary

### High Impact Change Model: Managing Transfers of care between Hospital and home

| Change Descriptor  | Overall self assessment  | Links to initiative/Project   |
|--|--|---|
| <p><b>Change 1: Early Discharge Planning.</b><br/>In elective care, planning should begin before admission.<br/>In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.</p>   | <p><b>Elective:</b><br/><b>Not established</b><br/><b>Unplanned: <i>Plans in place</i></b></p> | <p><i>TBC- Stranded patient review to identify proportion</i><br/>SAFER</p>   |
| <p><b>Change 2 : Systems to Monitor Patient Flow.</b><br/>Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.</p>   | <p><i>Plans in place</i></p>   | <p>SAFER<br/>Discharge Levelling/Golden Patient<br/>Complex Discharge Project</p>   |
| <p><b>Change 3: Multi-Disciplinary/ Multi-Agency Discharge Teams, including the voluntary and community sector.</b><br/>Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients</p>  | <p><i>Plans in place</i></p>   | <p>Complex Discharge Project<br/>-One Team York<br/>-Integrated Discharge Liaison<br/>CHC Review</p>                                    |
| <p><b>Change 4: Home First/ Discharge to Access.</b><br/>Providing short-term care and reablement in people’s homes or using ‘step-down’ beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.</p>                     | <p><i>Plans in place</i></p>   | <p>Complex Discharge Project<br/>-One Team York<br/>-Pathway review<br/>CHC Review</p>  |
| <p><b>Change 5: Seven-Day Service.</b><br/>Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people’s needs.</p>   | <p><b>Not yet Established</b></p>  | <p><i>TBC –Through priority setting at Complex Discharge task and finish group</i></p>  |
| <p><b>Change 6: Trusted Assessors.</b><br/>Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.</p>   | <p><b>Not yet Established</b></p>  | <p>Complex Discharge Project<br/>-Assess current baseline against national guidance published July 2017 and identify priority areas</p> |
| <p><b>Change 7: Focus on Choice.</b><br/>Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so people can consider their options. Voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care</p> | <p><i>Plans in place</i></p>   | <p>Complex Discharge Project<br/>CHC Review</p>   |
| <p><b>Change 8: Enhancing Health in Care Homes.</b><br/>Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.</p>  | <p><i>Plans in place</i></p>   | <p>Care Home Project</p>  |

## **Appendix 3 - Complex Discharge Programme Overview** **September 2017**

### **Introduction**

This paper provides a brief overview of the projects that sit within the Complex Discharge Programme. The Programme is overseen by a multi-agency Task and Finish Group on behalf of the A&E Delivery Board. The Task and Finish Group are developing a performance report which includes length of stay for older patients, delayed transfers of care and stranded patients, weekend discharge rates and occupied bed days. The group are currently in the process of establishing improvement trajectories for each of the key measures.

### **Programme Overview**

#### **Integrated Complex Discharge Planning Project**

- This project aims to improve the discharge planning process for patients with complex needs, based on best practice from NICE. It has four key workstreams; workforce (an integrated discharge liaison team), training and development, policies and procedures and communication (between acute and community teams and with patients and their carers).

#### **Community Bed Review**

- Following an audit across all community inpatient beds and a range of stakeholder workshops, this project aims to take a home first approach to ensure that intermediate services (home and bed-based) meet the needs of patients. It will work with local people and clinicians to develop a co-produced model for the future.

#### **Integrated Intermediate Care and Reablement**

- In each locality, projects are underway (at different stages) to develop an integrated intermediate tier of services. These will bring together health intermediate care (Community Response Teams) with local authority reablement services and voluntary sector wellbeing support in order to simplify referral pathways (for both step up and step down referrals), ensure people receive the right service first time and maximise capacity within available resources.

#### **Ensuring 85% of Continuing Health Care Assessments take place outside Acute Settings**

- This project sits within a wider context of redesign of Continuing Health Care and aims to deliver the national requirement for assessments of continuing health care needs to take place outside of acute settings, ensuring patients have reached their optimum independence before making decisions about long-term care needs.

#### **Improving Discharge into Care Settings**

- This project sits within wider developments to improve the support provided to care home residents and staff. It aims to improve the communication between hospital teams and care home staff, minimising the time that residents need to spend in hospital.

The Task and Finish Group will also be **Tackling Delayed Transfers of Care from Mental Health Settings**.

Author: Steve Reed, Head of Strategy for Out of Hospital Services, York FT  
Date: September 2017

**Appendix 4 - Delivering home first – re-providing Archways  
Intermediate Care Unit  
Update Report – Health and Adult Social Care Policy and  
Scrutiny Committee, September 2017**

**Introduction**

This paper provides the Committee with the requested update of key performance information related to the re-provision of the Archways Intermediate Care Service. The context for the change and actions carried out were outlined in the report presented to the Committee on 19 April 2017 and are therefore not repeated here.

**Performance Information**

Charts 1 shows the total referrals to the Community Response Team. It shows progress against the planned increase, in order to provide assurance that the planned additional 350 patients per year are being supported.

**Chart 1: Number of referrals to the York Community Response Team**

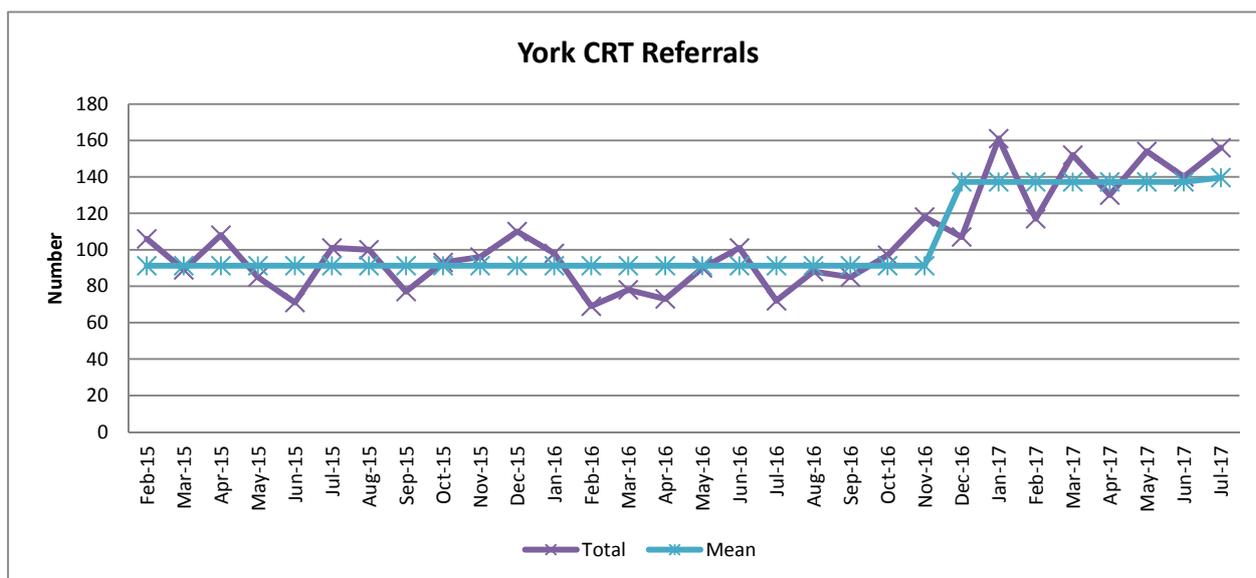


Chart 1 demonstrates that the expansion has continued on and above plan. The team were expected to increase the average monthly referrals from 91 to 120. The team are actually supporting an average of 139 referrals per month. Over the seven month (January – July) this would represent an additional 133 patients supported in the community rather than needing to remain in an acute hospital bed.

Chart 2 shows the total number of patients who have ‘stepped up’ into the York Community Response Team. These are patients who are referred without having been admitted to hospital. This can be from a range of community teams e.g. GPs, District Nurses, Ambulance service or ED.

**Chart 2: Step up patients referred to the York Community Response Team**

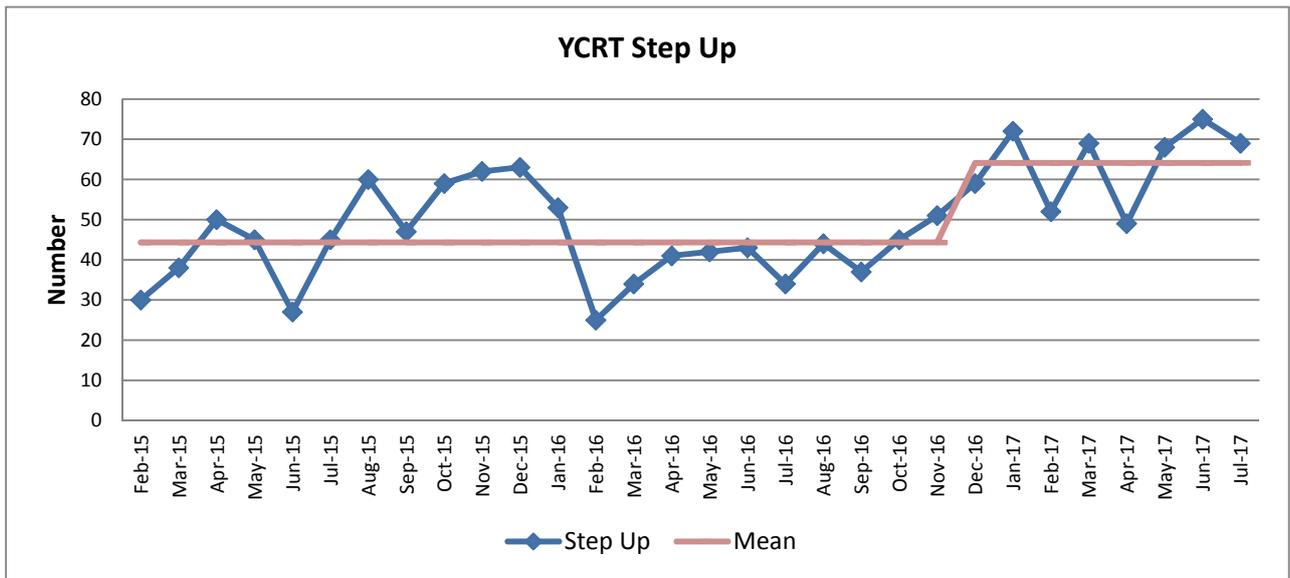


Chart 2 demonstrates that an increased number of patients are being supported in their own homes since the reconfiguration and as a result have not required an admission to hospital or a community unit. The addition of the roles of the advanced clinical practitioner and the outreach pharmacist has also enabled the community response team to maintain a more dependent cohort of patients at home.

Chart 3 shows the number of patients admitted to White Cross Court and St Helens community rehabilitation units and includes the number of 'step up' patients admitted to White Cross Court.

**Chart 3: Number of admissions to White Cross Court and St Helens community rehabilitation units**

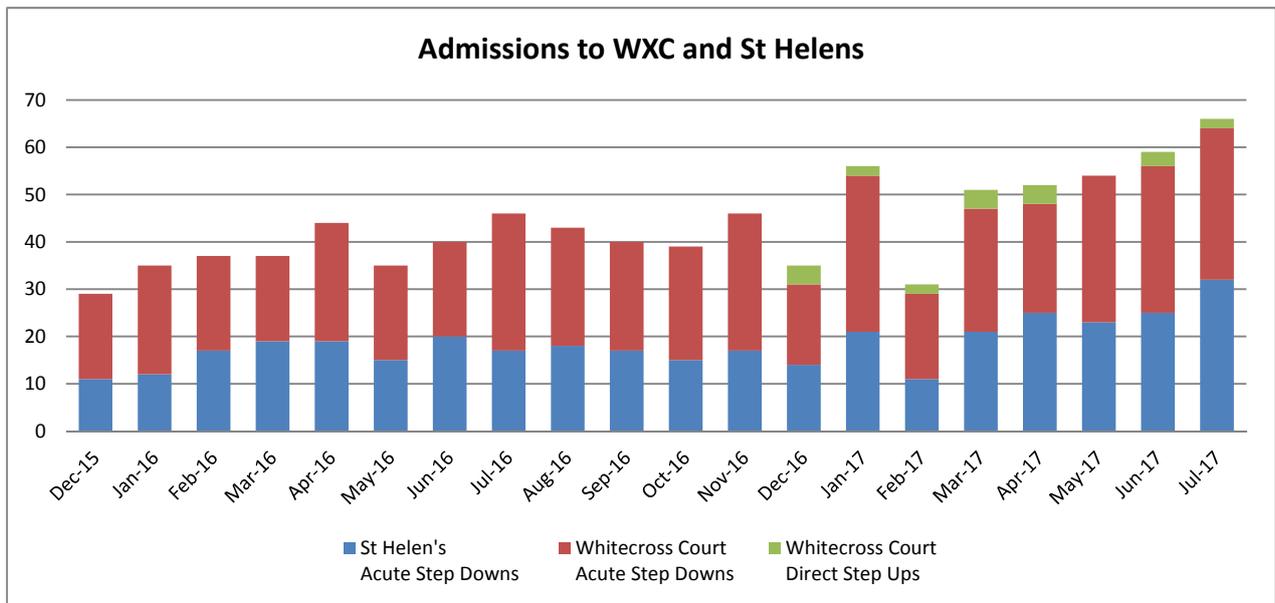


Chart 3 demonstrates that the same number of step up patients who were previously stepped up to Archways (average 3 per month) have been accommodated by the change of admission criteria to White Cross Court.

Chart 4 shows the monthly referrals to the Community Response Team from the Emergency

Department (including the Rapid Assessment Team that works within the department).

**Chart 4: Monthly referrals to York and Selby Community Response Teams from the Emergency Department and Rapid Assessment Team**

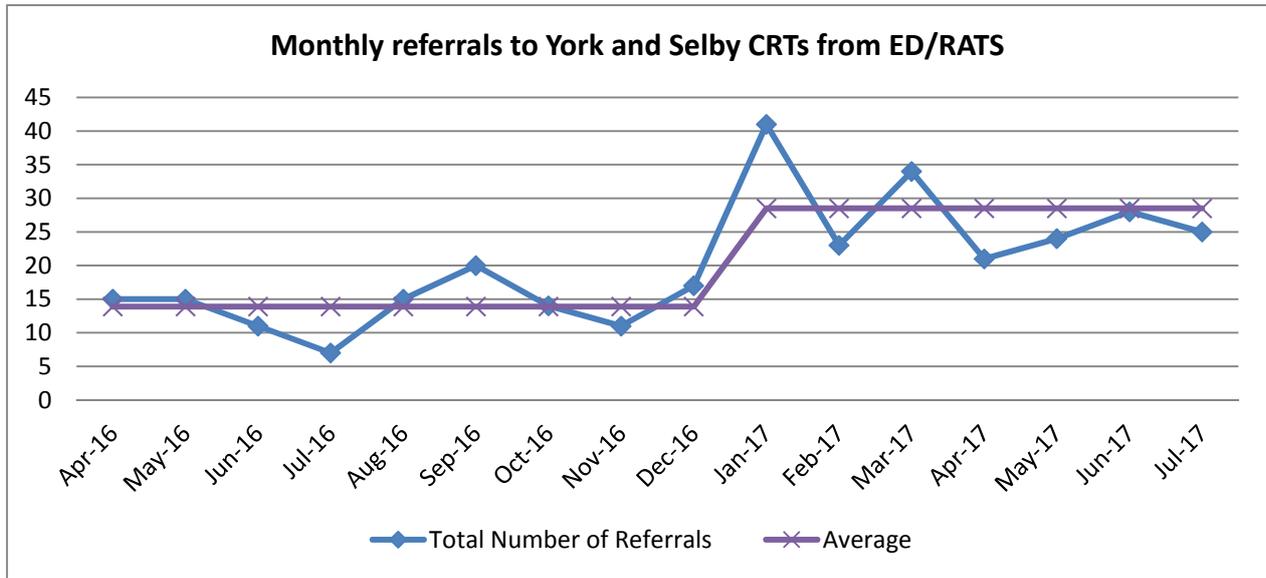


Chart 4 demonstrates a sustained increase in the number of referrals from the Emergency Department directly into Community Response Teams, avoiding the need for an admission to an acute or community hospital bed.

The Discharge Liaison Team provides a single point of triage into inpatient beds. This enables better overall utilisation of the community resources and enables flow across the system. The following charts (5 and 6) show the utilisation of the community hospital/units.

**Chart 5: Total Number of Admissions across community hospitals/ units**

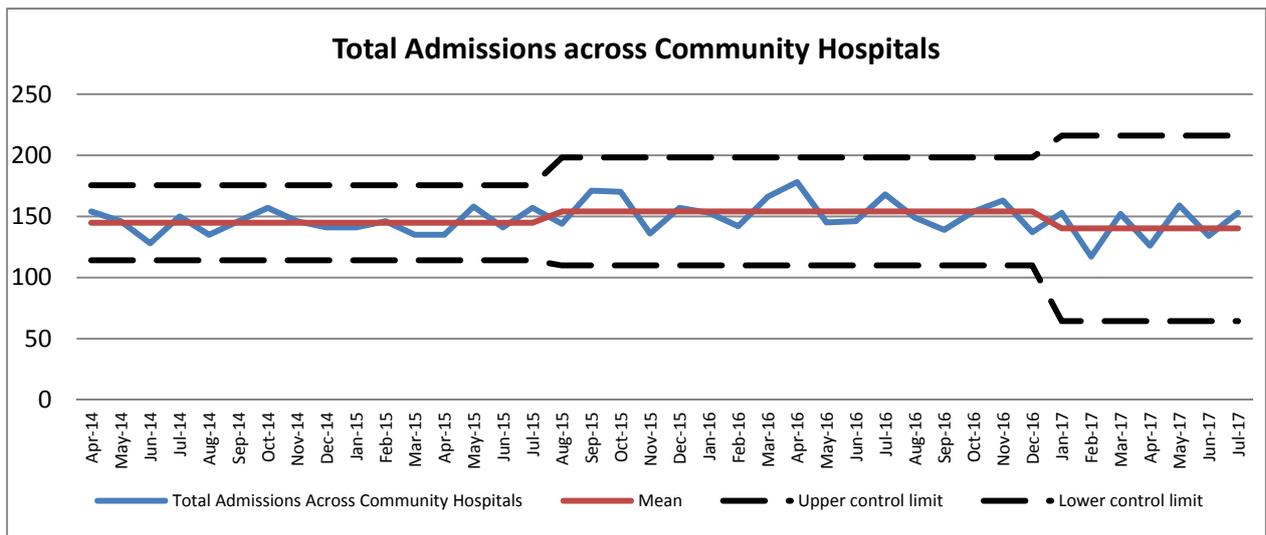


Chart 5 demonstrates that admissions have reduced as we would have expected (with 22 fewer beds and the increased referrals to the Community Response Team). However, the reduction (14 fewer admissions on average) has been smaller than previous activity levels at Archways (29 admission per month on average) due to the increased utilisation of the other bedded units for those patients who require bed based care.

**Chart 6: Average length of stay across community hospitals/units**

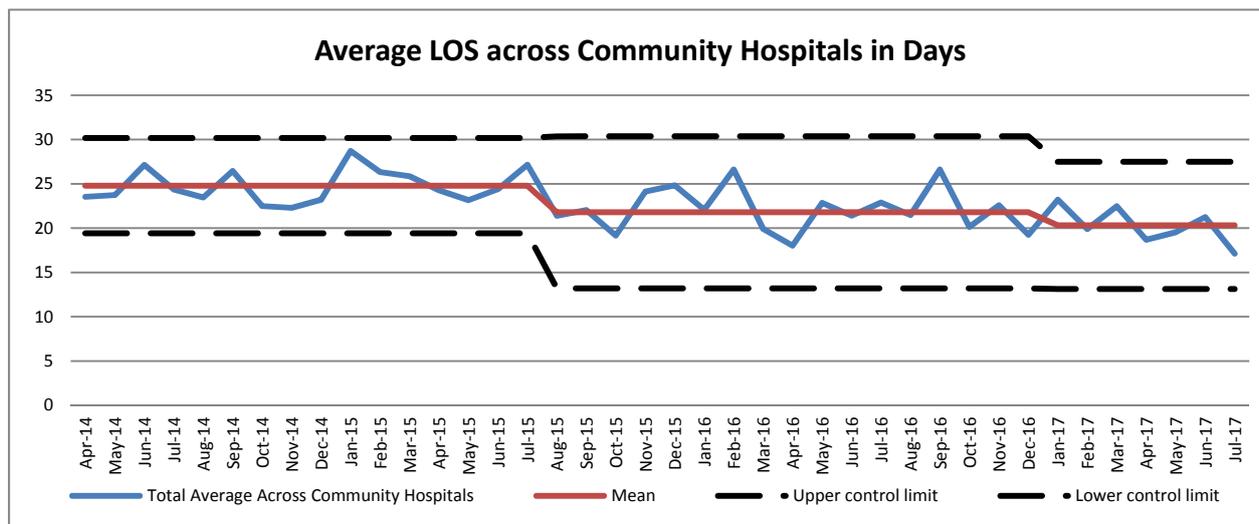


Chart 6 demonstrates that the average length of stay has reduced by 1.5 days following the reconfiguration and the combination of Discharge Liaison, the Acute Clinical Practitioners and the improved access to the Community Response Team. This reduction in length of stay is supporting the increased throughput shown in chart 5.

**Conclusion**

The performance information included within this report shows that the previous improvements reported at the April committee meeting have been sustained over a longer time period.

Prior to the reconfiguration an average of 245 patients a month were supported by intermediate care services (either at home or in a bed based unit). Since the change an average of 279 patients per month have been supported. This represents an increase of 14%.

This has also supported our ambition to deliver care closer to home as we are now delivering 50% of intermediate care at home, compared to 37% prior to the change.

The Policy and Scrutiny Committee are asked to note the content of this report.

**Author: Steve Reed, Head of Strategy for Out of Hospital Care**

**Owner: Wendy Scott, Chief Operating Officer**

**Date: September 2017**

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## Council of Governors – 7 December 2017 Governor Elections & Internal Elections

### Recommendation

- For information
- For discussion
- For assurance
- For approval
- A regulatory requirement

### Current approval route of report

Council of Governors only

### Purpose of report

The Governors are asked to note the results of the recent Governor elections and the re-election of the Lead Governor as well as the timetable for internal elections and the process being adopted.

### Key points for discussion

The Council of Governors has recently completed elections for new Governors, one of which was the current Lead Governor. Following the election the Lead Governor was also reconfirmed in the position. The Council of Governors is now looking to fill any spaces on internal groups.

### Trust Ambitions and Board Assurance Framework

([https://www.yorkhospitals.nhs.uk/about\\_us/our\\_values/](https://www.yorkhospitals.nhs.uk/about_us/our_values/))

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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Reference to CQC Regulations

(Regulations can be found here: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers> )

17

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Version number: v0.01

Author: Lynda Provins, Foundation Trust Secretary

Executive sponsor: Susan Symington, Chair

Date: November 2017



## 1. Introduction and Background

This paper has been prepared to outline the results of the recent Governor Elections and the confirmation that the Lead Governor will remain in position. The paper will also look at involvement of Governors in the Trust through the committees and groups which report to the Council of Governors. The paper describes the type of groups and committees that Governors can be involved with and explains the process for becoming involved.

## 2. Governor Election Results

This year the following constituencies had seats available for election:

| Constituency                             | Name of Person Elected  |
|--|---|
| Scarborough – 1 seat                     | Richard Thompson - elected                                    |
| Ryedale and East Yorkshire - 1 seat      | Sheila Miller – re-elected                                    |
| York - 2 seats                           | Margaret Jackson (Lead Governor) & Robert Wright – re-elected |
| Bridlington - 1 seat                     | Clive Neale – re-elected                                      |
| York Staff – 1 seat                      | Jill Sykes - elected  |
| Scarborough/ Bridlington Staff – 2 seats | Helen Noble & Andrew Bennett – re-elected                     |

## 3. Lead Governor Position

Margaret Jackson was re-elected to her position of York Public Governor in the 2017 Elections. As Margaret is also the Lead Governor, all Governors were asked whether they wished to apply for the position of Lead Governor or were happy to confirm Margaret as Lead Governor for a further term. Margaret was unanimously reconfirmed as Lead Governor.

## 4 Internal Elections

There are a number of groups and committees, which report into the Council of Governors that Governors can be involved in. The process for becoming involved can differ depending on the group or committee.

- The **formal** committees and groups of the Council of Governors includes the Nominations/Remuneration Committee, Community Services Group, Membership Development Group and the Constitutional Review Group.
- The **informal** approach is where the Trust approaches either Margaret Jackson as Lead Governor, or me as Foundation Trust Secretary requesting Governors to be involved in a particular project or activity (which may be ongoing or “task and finish”

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



activities). There are no elections to these groups and Margaret or I will seek individuals to be involved when these requests are received usually through the Friday email system.

- The final approach is more **ad hoc** and is related to specific time-limited projects such as the Annual Plan or the Quality Report. Specific requests will be made to the Council of Governors for their involvement in a group, if required.

The role of Governors in these groups and committees is vital to ensuring that the Trust understands the needs of the communities we serve. In addition, it provides ways in which the Governors can feel more involved in how the Trust works, and often affords opportunities for Governors to work alongside Directors and other members of staff.

#### 4.1 Internal Elections Process

The process adopted by the Trust in the past has been to review and consider the membership of each formal group and committee following an external election.

- If a Governor has been subject to an external election because their term of office has reached its end, then the Governors time on that group or committee will also come to an end.
- If a Governor has not been part of the election process, then their membership of a group continues until they reach the end of their term of office as a Governor.

To stand for membership of a group or committee, Governors are asked to write two or three paragraphs on why they would like to be involved in that particular group or committee.

The process will be as follows:

|                     |   |
|---------------------|---|
| 08.12.17 – 22.12.17 | Governors nominate themselves to sit on a group |
| 03.01.17 – 10.01.17 | Internal election carried out                   |
| 12.01.17            | Results available                               |

An election will only be held if there are more nominations than seats available on the group.

#### 4.2 Summary of the Places Available

The list below details the Governors whose places are becoming available:

| <u>Governor</u>  | <u>Membership of formal groups/Committees</u>   |
|------------------|---|
| Sheila Miller    | Nomination & Remuneration Committee (Public)<br>Constitutional Review Group<br>Membership Development Group |
| Robert Wright    | Nomination & Remuneration Committee   |
| Margaret Jackson | Membership Development Group  |



(NB: Margaret will continue to sit on the Constitutional Review Group as Lead Governor)

|                |  |
|----------------|--|
| Clive Neale    | Membership Development Group           |
| Andrew Bennett | Membership Development Group           |
| Andrew Butler  | Constitutional Review Group – resigned |

### 4.3 Groups to be elected to

The groups or committees which require an election process are as follows:

**Nominations/Remuneration Committee – 2 Public Seats & 2 Stakeholder Seats** - This committee meets on a quarterly basis and is chaired by the Chair of the Trust. The Committee looks at key aspects such as the appraisal of the Chair and Non-executive Directors, the review of the remuneration for the Chair and the Non-executive Directors and is the Committee responsible for overseeing the appointment of both the Chair and Non-executive Directors. The membership of the Nomination Committee has been designed to be quite specific so that it reflects the membership of the Council of Governors. The membership is made up as follows:

Chair of the Trust,  
Foundation Trust Secretary,  
Lead Governor  
Five public governors  
two stakeholder members,  
one member of staff

**Constitutional Review Group – 2 Seats** - The membership of this Group has in the past been quite small, with only initially 6 Governors involved. This group reviews the Trust's Constitution and its supporting documents. The membership of the group is 5 public governors, 1 stakeholder governor and 1 staff governor.

**Membership Development Group – 4 Seats** – The membership of the Group reviews, monitors and supports the development of plans for membership recruitment, engagement and involvement. The group currently has 4 Governors on it together with the Foundation Trust Secretary and the Head of Communications.

All Governors are encouraged to put their name forward to the groups and Committees. Those that have previously held seats in those Committees are not barred from standing again for a further term. The length of term a Governor has on a committee or group is equal to the length of their term left as a Governor.

In respect of the informal Groups, I will highlight positions as they become available through the Friday emails.

## 5. Next Steps

In summary the seats available in each group that can be elected to are:



- 4 in the Nominations/Remuneration Committee (2 Public & 2 Stakeholder Governors)
- 4 in the Constitutional Review Group (2 Public, 1 Stakeholder & 1 Staff)
- 4 in the Membership Development Committee (not specific)

It is proposed that Governors will be asked to provide a statement including which Group or Committee they would like to put their name forward to by 22 December 2017. Ballot papers will be circulated on the 3 January 2018. Voting will remain open until 10 January 2018 and will be electronic. Governors have one vote for each group or committee and the successful candidate(s) will be the Governor with the most votes

Where seats on groups or committees are uncontested, Governors will automatically become a member of that group or committee.

## 6. Detailed Recommendation

The Governors are asked to note the results of the recent Governor elections and the re-election of the Lead Governor as well as the timetable for internal elections and the process being adopted.



**Environment & Estates Committee- 4<sup>th</sup> October 2017**

**NHS PLACE Assessment 2017**

Action requested/recommendation

The Environment & Estate committee consider this report which provides a position statement on York NHS Teaching Hospitals Foundation Trust current compliance against NHS Patient Led Assessment of the Care Environment (PLACE) Assessment 2017.

Summary

**Strategic Aims**

**Please cross as appropriate**

- 1. Improve quality and safety
- 2. Create a culture of continuous improvement
- 3. Develop and enable strong partnerships
- 4. Improve our facilities and protect the environment

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Reference to CQC outcomes

Health & Social Care Act 2008 (Regulated Activities) Regulations 2014;

Progress of report            Director & Head of Estates & Facilities

Risk                                Low to Medium

Resource implications        Some Resource requirements

Owner                                Brian Golding, Director of Estates & Facilities

|                |   |
|----------------|---|
| Author         | David Biggins, Head of Estates & Facilities<br>Compliance |
| Date of paper  | 20 <sup>th</sup> September 2017                           |
| Version number | <b>1.0</b>  |

DRAFT

|  |
|--|
| <b>Environment &amp; Estate Committee</b>  |
| <b>Patient Led Assessment of the Care Environment (PLACE) Report 2017</b>  |
| <b>1. Introduction and background</b>  |
| <p>The PLACE Assessment process is a national mandatory assessment of the care environment that seeks to examine through assessment, cleanliness, food, condition and appearance, and dementia and disability and access strategies and operational arrangements within our care environment.</p> <p>This year`s annual PLACE Assessments were undertaken between 28<sup>th</sup> February and 2<sup>nd</sup> June at all Trust sites with inpatient facilities this was in line with the national timetable stated by the Department of Health.</p> <p>The PLACE assessment teams were made of Patient assessors, Estates &amp; Facilities staff, Matrons and Health watch and Governor representation.</p> <p>The attached report seeks to describe the findings and results of the 2017 PLACE Assessments, make comparisons against national average data for the same year and identify opportunities for improvement over the next 12 month cycle until reassessment.</p> |
| <b>2.</b>  |
| <p><b>Summary of Findings of PLACE Assessment</b></p> <p>The attached report provides details of site results and performance against the key domains, this summary provides an overview of the report content.</p> <p>Generally our assessment for this year shows we are not demonstrating a standard that is consistent with the national average of PLACE Results in all of the domains with the exception of cleanliness where the Trust broadly meets the national average and at some sites exceeds the national average in relation to cleanliness.</p> <p>The Trusts PLACE Position on ward food and food service, condition and appearance of our environment and arrangements for privacy, dignity and well-being, accessibility and dementia are generally inconsistent across the sites with a high proportion of Community sites scoring above the national average on ward food but main acute sites and Malton CH. scoring below this average.</p>             |
| <b>Summary of Findings</b>   |
| <p>The organisation scored below the national average on many elements within Food domain these were in the main not around the quality or choice of the food served but around some logistical elements of the key nutritional elements of patient care.</p>  |

Elements such as not having space in some cases to service patient food away from the bed area, menus that are not easy to understand and are not available in other languages, lack of protected meal times on occasions and food courses not being served separately were all noted.

The condition and appearance element of the assessment provides an opportunity for assessment teams to make visually inspect both internal and external fabric and buildings on our sites and again generally the community sites exceeded the national average score in this area with York, Scarborough and Malton not meeting the national average.

As part of the assessment team involved in this domain assessment in my opinion the assessments can at times be quite subjective and this leads to inconsistent scoring at some points.

The attached report gives details of exceptions noted during the PLACE assessments and in terms of condition and appearance, issues such as grounds maintenance, standard and quality of internal and external signage and car parking markings, poor condition of some doors and ceiling tiles at the Bridlington site and signage, hand rails some areas, decoration in some communal and clinical areas and general tidiness in some areas at the Scarborough site.

The York site scored less than 1% under the national average for condition and appearance and again the availability of hand rails in corridors, (also an access issue) and general tidiness and storage in some ward areas were noted during the assessments.

The Privacy, Dignity and wellbeing, Dementia and Disability and access elements of the assessment showed disappointing results with all the acute sites scoring below the national average in all three domains the type of observations made in these areas across the acute sites were issues with:

- Use of clear Dementia friendly signage at all sites
- General signage and wayfinding at Scarborough, Malton and Bridlington sites
- Lack of hearing loops at all sites
- Family/Overnight stay accommodation at Bridlington site
- Disabled toilet access on inpatient wards at all sites
- Curtains around bed spaces that do not afford privacy

All exceptions found during the assessments are noted in the attached report.

### **3. Conclusions**

60% of the opportunities to meet the national average against PLACE Assessment have been missed this year however this must be put into context in that the assessment was found to be a subjective process on occasion and is a one off snapshot look at an environment which can vary on a day to day basis. These factors coupled with the very recent management re-structure in the Estates & Facilities Directorate and the challenges the organisation faces as a whole in the recruitment and retention of staff to maintain our environment I believe have led us to the position we are in.

It is worth noting that already Estates & Facilities Directorate teams are working on plans and actions to improve our position this includes a review of signage at Bridlington and

Scarborough sites, regular site walk rounds planned by the Senior Management team and regular site Facilities group meetings at which local improvement plans associated with PLACE will be presented.

#### **4. Recommendations**

1. This report is noted and local improvement plans for any exceptions against PLACE Assessment 2017 are regularly monitored for progress by Estates & Facilities Management Teams.
2. An Internal project to improve signage, wayfinding and access arrangements is undertaken within the Estates & Facilities Team.
3. All exceptions (attached at appendix 1) are planned to be addressed via the PLACE Local improvement plan within the next 12 months.
4. Trust PLACE Lead fosters stronger links and training with Patient Assessment teams including Health watch and Governors to ensure that a consistent approach to PLACE Assessment is taken.
5. Trust PLACE Leads undertake validation exercises against PLACE 2017 Results.

#### **5. References and further reading**

|               |  |
|---------------|--|
| <b>Author</b> | <b>David Biggins, Head of Medical Engineering &amp; EFM Compliance</b> |
| <b>Owner</b>  | <b>Brian Golding, Director of Estates &amp; Facilities</b>             |
| <b>Date</b>   | <b>21<sup>st</sup> September 2017</b>                                  |

# Directorate of Estates and Facilities

## PLACE Results 2017



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Appendix – Exception Reports as separate document

## **1 Context**

The PLACE results were published on 15<sup>th</sup> August 2017.

## **2 Process**

The Patient Led Assessments of the Care Environment (PLACE) took place between 28<sup>th</sup> February and 2<sup>nd</sup> June 2017 on all of the Trust in-patient sites.

All of the assessments were self-assessments with an external validator being used for five sites – St Helens, St Monica's, York, Selby and Bridlington. The external validators used were Ross Mitchell from Harrogate District Foundation Trust and Geoff Sweeney from County Durham and Darlington Foundation Trust.

Unfortunately we were unable to reciprocate to attend the assessments at County Durham and Darlington Foundation Trust.

Members of Trust Board of Governors were eligible to act as `patient assessors` within their Trust since their primary role is to represent the interests of patients/public.

In-house training was delivered by Carol Birch prior to the assessments to ensure the assessment process was understood by the patient assessors and Trust staff involved in the assessment process. Carol Birch previously attended a workshop with Health Watch York to support with the content of their training and it is hoped that the Trust and Health Watch York will jointly deliver PLACE training prior to any further assessments.

## **3 Assessment Process**

PLACE teams consisted of the mandatory 50% patient assessors and leads from Facilities and Matrons. Infection, Prevention and Control team did not take part in this year's assessments.

The minimum 25 per cent of wards, departments and non-ward areas with varying age and condition was met which allowed the PLACE teams to make informed judgements about the areas visited.

## 4 Results

At the end of the process, each hospital/ unit which has undertaken an assessment is provided with a result against each of the six areas of the assessment namely Cleanliness; Food and Hydration; Privacy Dignity and Wellbeing, Condition Appearance and Maintenance, Dementia and Disability.

This result is calculated by reference to the score (points) achieved expressed as a percentage of the maximum score (points) which could have been achieved had every aspect of the assessment they undertook achieved the maximum score.

With the exception of the assessment of food, the maximum score for any question is 2.

The food assessment is split into two components – an Organisational component which addresses the catering services provided by the organisation, and an assessment of ward based practice and the quality (taste, texture and temperature) of the food provided. The questions in the Organisational section are scored according to a weighting algorithm which reflects the relative importance of each question. To allow for the fact that different hospital types answer a slightly different number of questions there are three weighting algorithms. All questions in the Ward-based component have a maximum score of 2 with the exception of Food Taste which from 2015 uses the weighted methodology.

Participating organisations and others who may use these data will be able to benchmark their performance or the performance of particular types of organisations.

For the purposes of comparison, a national average of scores from all participating hospitals/ units has been calculated. This average is weighted to take account of the fact that hospitals vary in size and that in larger hospitals not all areas are assessed. The weighting factor used in this calculation is bed numbers. Bed numbers are used since they are common to all organisations, whereas some premises in which assessments are undertaken do not have wards e.g. certain mental health/learning disabilities units and Treatment Centres.

The calculation used to produce the National Average is:

*The sum of [Each site's score (points) multiplied by the number of beds in that site]*

---

*The total number of beds in all assessed sites*

3

## 5 National Results

The number of assessments undertaken was 1,230 compared to 1,291 in 2016.

This table details the national highest, lowest scores and national average across the five domains.

| DOMAINS                               | HIGHEST SCORE | LOWEST SCORE | NATIONAL AVERAGE SCORE |
|---------------------------------------|---------------|--------------|------------------------|
| Cleanliness                           | 100%          | 74%          | 98.4%                  |
| Condition, Appearance and Maintenance | 100%          | 65.7%        | 94%                    |
| Privacy, Dignity and Wellbeing        | 100%          | 51%          | 83.7%                  |
| Organisational Food                   | 100%          | 52.6%        | 88.8%                  |
| Ward Food                             | 100%          | 47.3%        | 90.2%                  |
| Dementia                              | 100%          | 39.8%        | 76.7%                  |
| Disability                            | 100%          | 52.6%        | 82.6%                  |

The national average for cleanliness in 2017 was 0.3% higher than in 2016.

The national average for Organisational Food in 2017 was 1.8% higher than in 2016.

The national average for Ward Food in 2017 was 0.5% higher than in 2016.

The national average for Condition, Appearance & Maintenance in 2017 was 0.6% higher than in 2016.

The national average for Privacy, Dignity & Wellbeing in 2017 was 0.5% lower than in 2016.

The national average for Dementia in 2017 was 1.4% higher than in 2016.

The national average for Disability in 2017 was 3.8% higher than in 2016.

All domains have improved nationally except for Privacy, Dignity and Wellbeing.

## 6 Regional Comparisons

The table below details the comparisons across the five domains for the Commissioning Regions.

| Region  | Cleanliness | Condition, Appearance & Maintenance | Privacy, Dignity & Wellbeing | Food & Hydration | Dementia | Disability |
|---|-------------|-------------------------------------|------------------------------|------------------|----------|------------|
| North of England Commissioning Region             | 98.6%       | 94.9%                               | 84.9%                        | 89.6%            | 76.7%    | 83.3%      |
| South of England Commissioning Region             | 98.4%       | 93.5%                               | 83.3%                        | 89.7%            | 77.9%    | 83.2%      |
| Midlands and East of England Commissioning Region | 98.2%       | 93.5%                               | 83.5%                        | 89.6%            | 75.6%    | 82.9%      |
| London Commissioning Region                       | 98.2%       | 93.8%                               | 82.3%                        | 90%              | 76.9%    | 79.7%      |

## 7 York Teaching Hospital NHS Foundation Trust Results

The table below details the final results (%) for York Trust organisation scores against the national averages.

|                             | Cleanliness | CAM      | PDW      | Food     | Org Food | Ward Food | Dementia | Disability |
|-----------------------------|-------------|----------|----------|----------|----------|-----------|----------|------------|
| National Average Score (%)* | 98.36% ↑    | 94.02% ↑ | 83.68% ↓ | 89.68% ↑ | 88.80% ↑ | 90.19% ↑  | 76.71% ↑ | 82.56% ↑   |
| York Trust (%)              | 98.15% ↓    | 93.32% ↓ | 77.79 ↓  | 80.45% ↓ | 81.04% ↓ | 80.26% ↓  | 60.19% ↓ | 68.45% ↓   |

\*shows if higher or lower than 2016 scores

### Cleanliness

7 sites scored above the national average. Scarborough's score was 1.83% below.

### Condition, Maintenance & Appearance

Scores across 5 of our sites are above the national average. Overall we are just below the national average score which is pleasing given the age and variety of our estate.

### Food & Hydration

Scores have fallen from 2016 however this is due to the perception of the assessment team on the day. There are a combination of areas within the ward food section, e.g. food taste, protected mealtimes not observed, availability of allergen information.

### Privacy, Dignity & Wellbeing

Privacy, dignity and wellbeing scores are again down nationally. Locally we are making improvements as and when opportunities arise. Scores in this domain are highly influenced by the form of the built environment.

### Dementia

This is the third year that this domain has been assessed. Capital developments include dementia awareness and there is further work in relation to signage, clocks, etc that are being addressed. It is anticipated that this score will increase gradually over the coming years.

### Disability

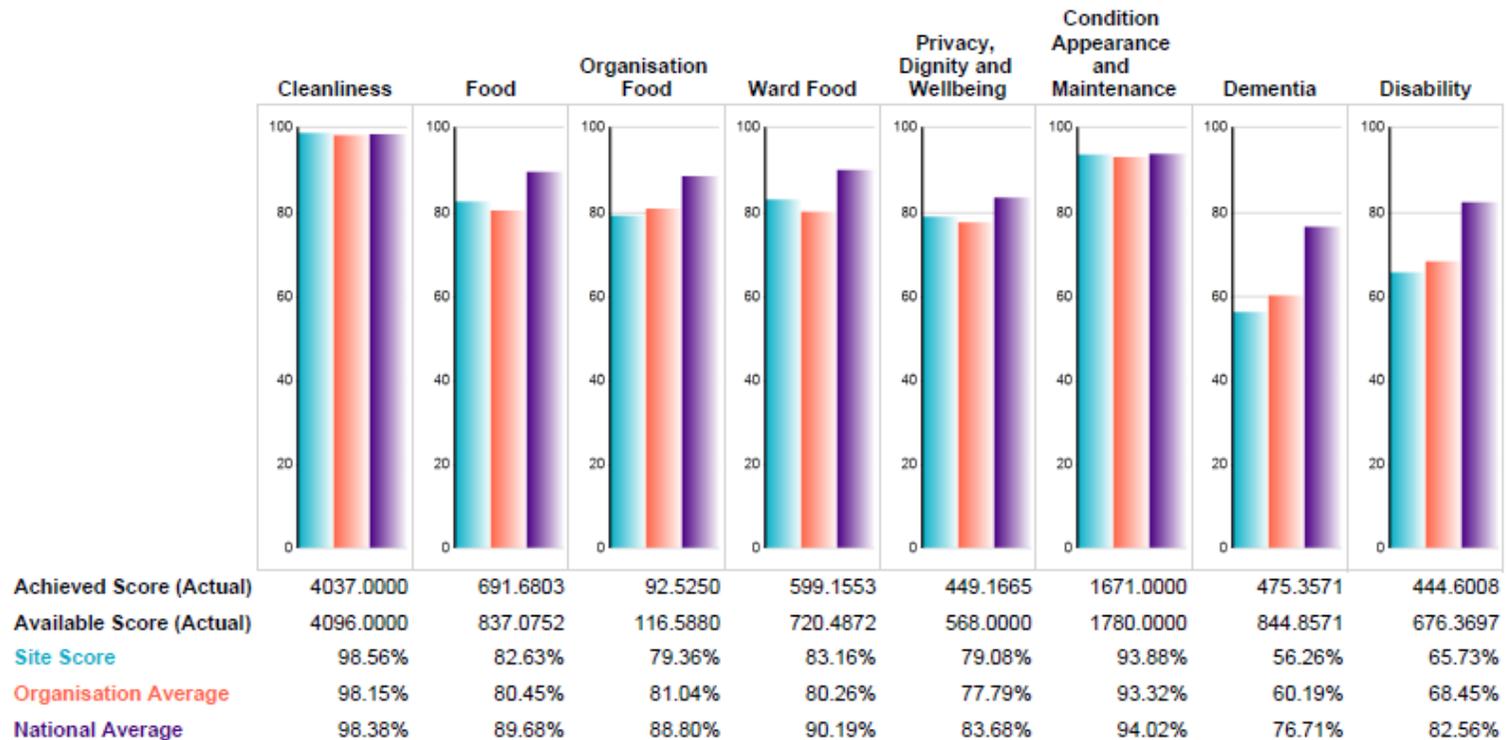
The disability domain was new to the 2016 assessment and does not constitute the full range of issues but focuses on a limited range with strong building/environment related aspects. Sites scoring above the national average are Selby and St Monica's.

|                         | Cleanliness   | CAM           | PDW           | Food          | Org Food      | Ward Food     | Dementia      | Disability    |
|-------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| <b>National Average</b> | <b>98.36%</b> | <b>94.02%</b> | <b>83.68%</b> | <b>89.68%</b> | <b>88.80%</b> | <b>90.19%</b> | <b>76.71%</b> | <b>82.56%</b> |
| York                    | 98.56% ↑      | 93.88% ↓      | 79.08% ↓      | 82.63% ↓      | 79.36% ↓      | 83.16% ↓      | 56.26% ↓      | 65.73% ↓      |
| Scarborough             | 96.53% ↓      | 90.60% ↓      | 75.88% ↓      | 75.68% ↓      | 84.46% ↓      | 73.26% ↓      | 61.57% ↓      | 68.20% ↓      |
| Bridlington             | 99.06% ↑      | 95.21% ↑      | 70.17% ↓      | 75.30% ↓      | 79.48% ↓      | 73.63% ↓      | 66.52% ↓      | 74.28% ↓      |
| Malton                  | 99.83% ↑      | 93.59% ↓      | 90% ↑         | 79.31% ↓      | 81.63% ↓      | 77.30% ↓      | 70.66% ↓      | 75.74% ↓      |
| Selby                   | 100% ↑        | 99.53% ↑      | 92.50% ↑      | 87.53% ↓      | 79.68% ↓      | 93.52% ↑      | 93.52% ↑      | 87.75% ↑      |
| St Helen's              | 98.93% ↑      | 94.07% ↑      | 72.44% ↓      | 87.42% ↓      | 80.12% ↓      | 94.66% ↑      | 69.65% ↓      | 76.10% ↓      |
| St Monica's             | 100% ↑        | 99.35% ↑      | 80.95% ↓      | 93.39% ↑      | 86.55% ↓      | 98.42% ↑      | 82.07% ↑      | 86.53% ↑      |
| Whitecross Court        | 100% ↑        | 97.81% ↑      | 74.36% ↓      | 89.74% ↑      | 85.02% ↓      | 93.58% ↑      | 73.44% ↓      | 80.01% ↓      |

## 8 Individual Site Results

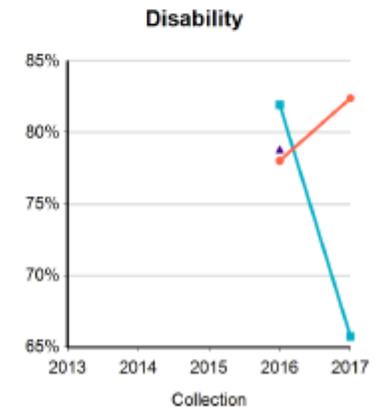
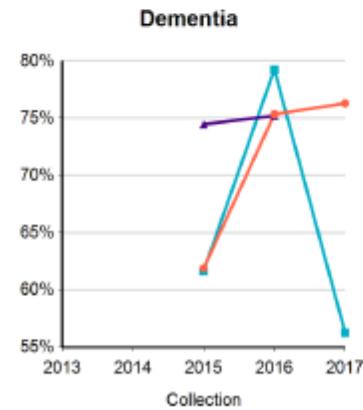
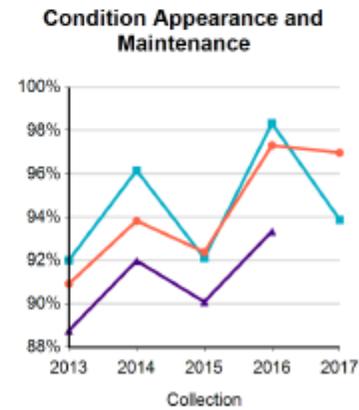
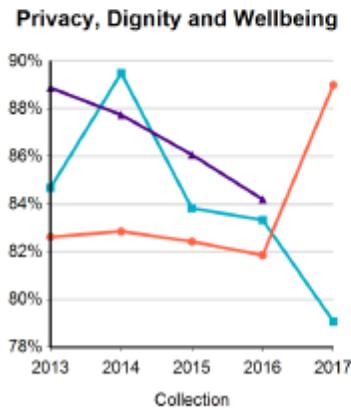
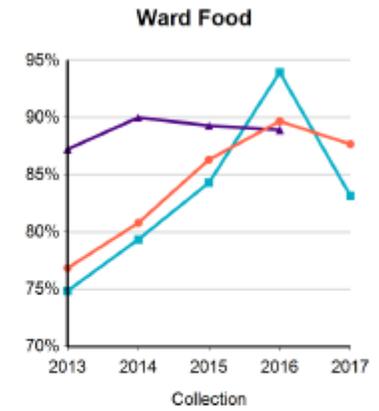
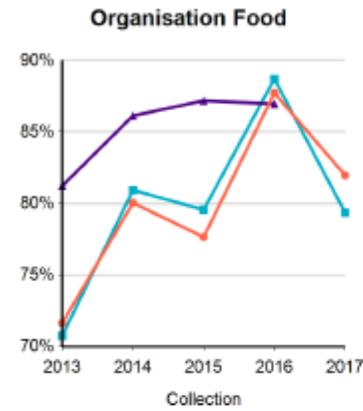
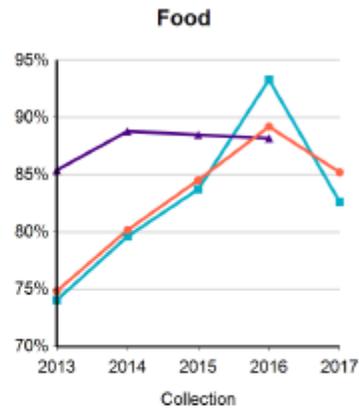
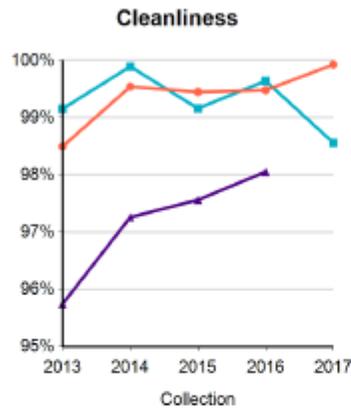
York Hospital

### YORK HOSPITAL- Collection: 2017

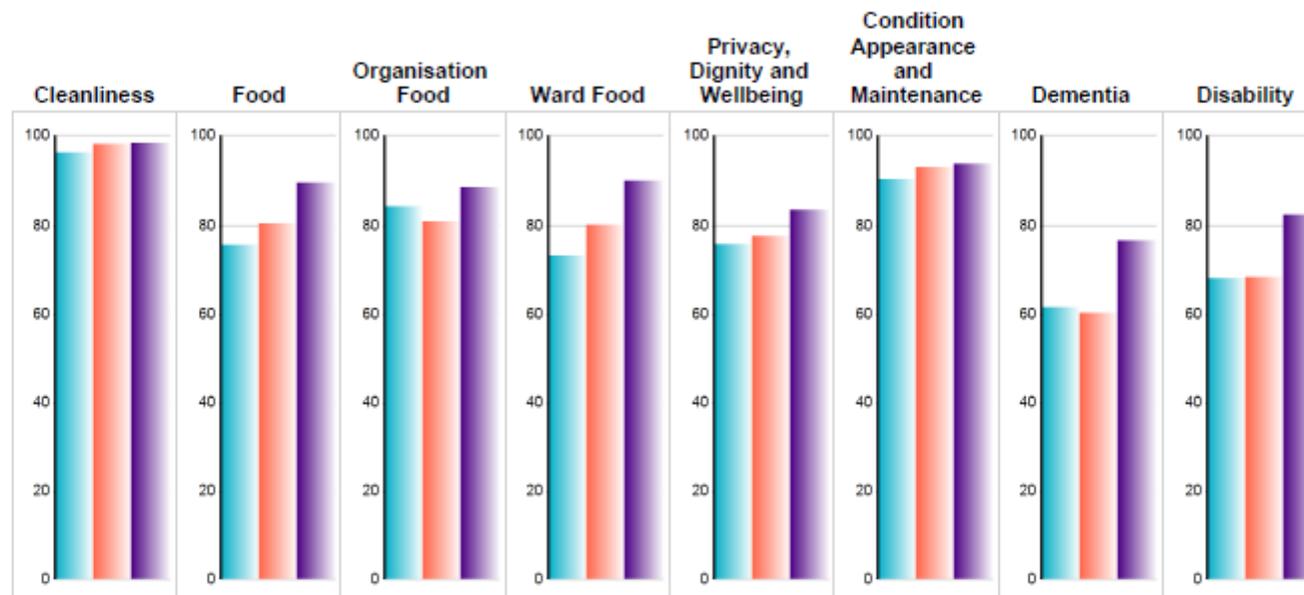


# YORK HOSPITAL

Site Scores    Organisation Average    National Average



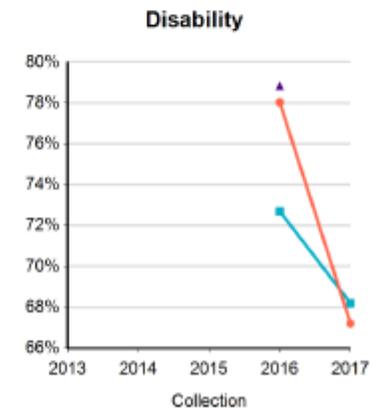
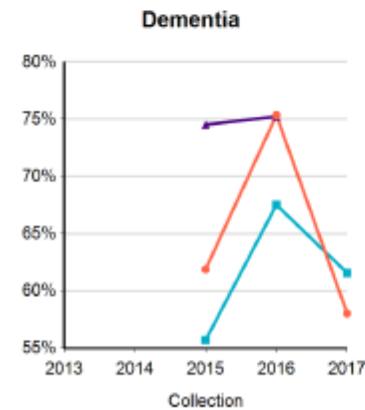
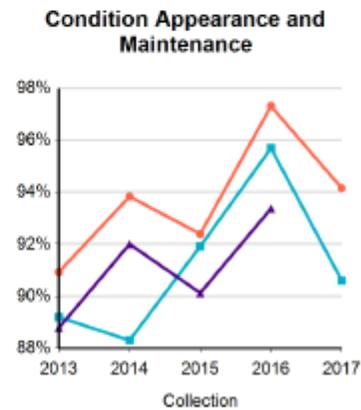
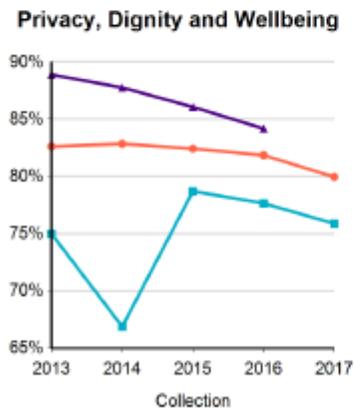
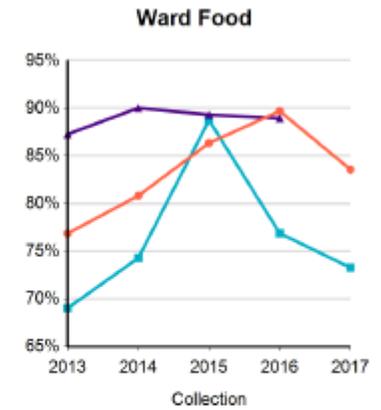
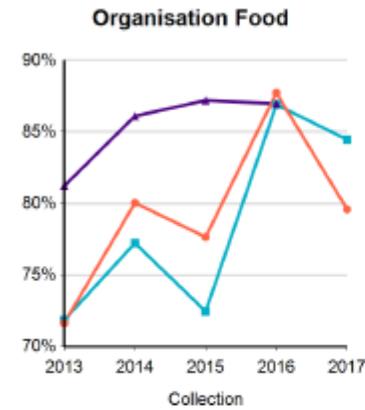
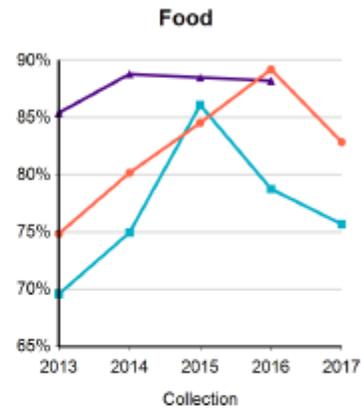
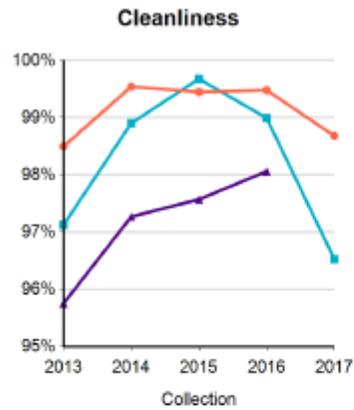
SCARBOROUGH HOSPITAL- Collection: 2017



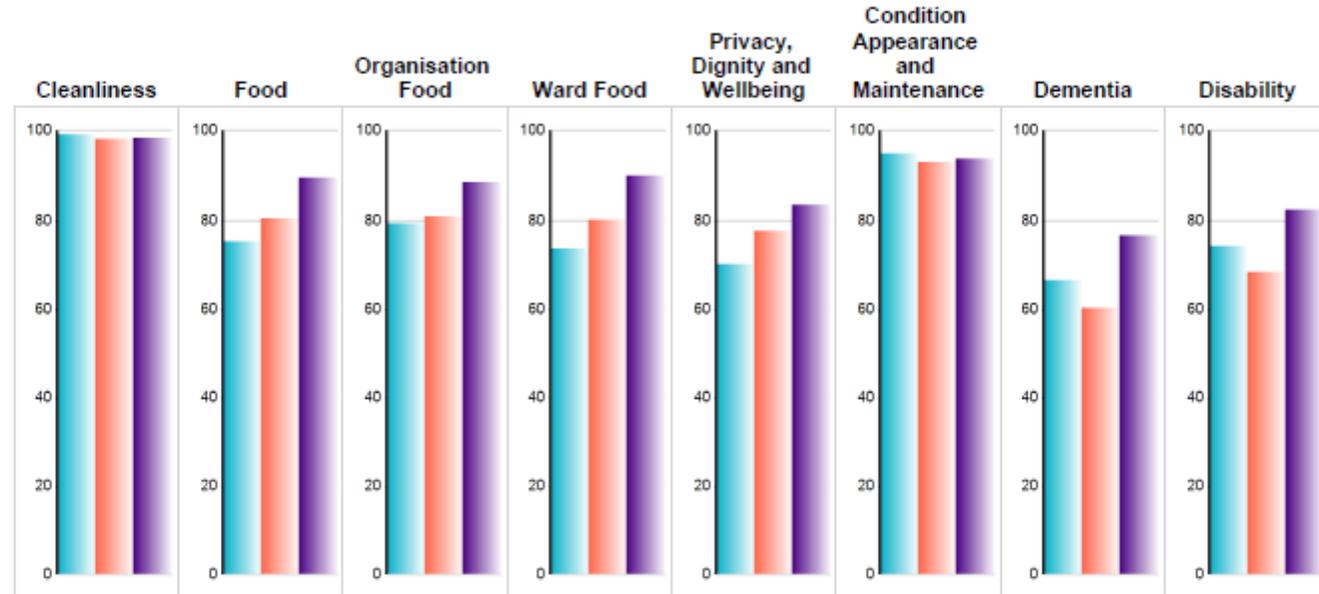
|                                 |           |          |          |          |          |           |          |          |
|---------------------------------|-----------|----------|----------|----------|----------|-----------|----------|----------|
| <b>Achieved Score (Actual)</b>  | 2890.0000 | 394.4367 | 95.2813  | 299.1554 | 332.3331 | 1455.0000 | 503.0756 | 412.3193 |
| <b>Available Score (Actual)</b> | 2994.0000 | 521.1594 | 112.8065 | 408.3529 | 438.0000 | 1606.0000 | 817.0756 | 604.5882 |
| <b>Site Score</b>               | 96.53%    | 75.68%   | 84.46%   | 73.26%   | 75.88%   | 90.60%    | 61.57%   | 68.20%   |
| <b>Organisation Average</b>     | 98.15%    | 80.45%   | 81.04%   | 80.26%   | 77.79%   | 93.32%    | 60.19%   | 68.45%   |
| <b>National Average</b>         | 98.38%    | 89.68%   | 88.80%   | 90.19%   | 83.68%   | 94.02%    | 76.71%   | 82.56%   |

# SCARBOROUGH HOSPITAL

Site Scores    Organisation Average    National Average



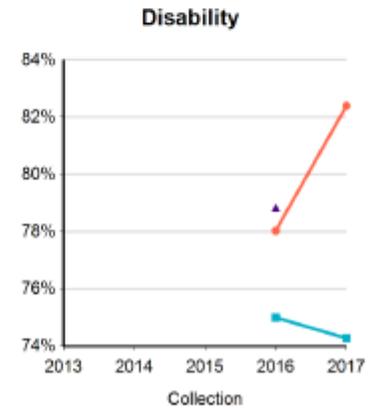
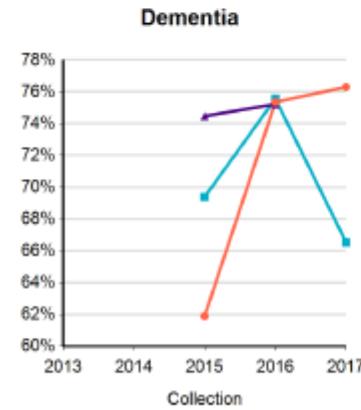
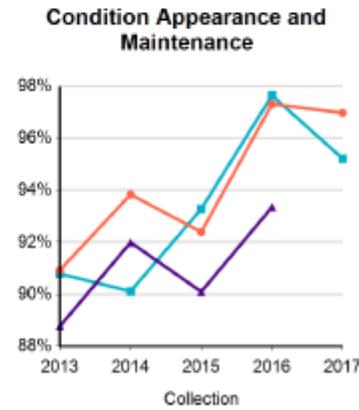
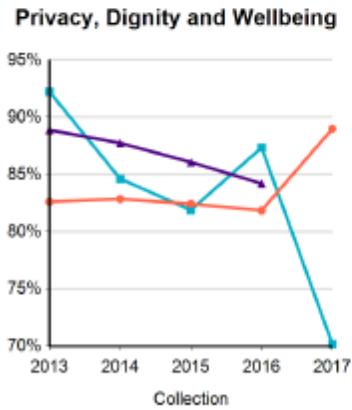
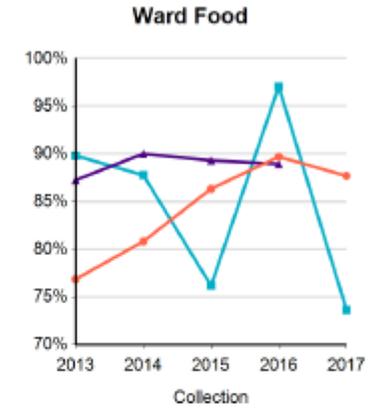
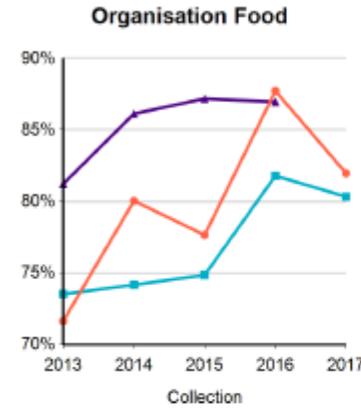
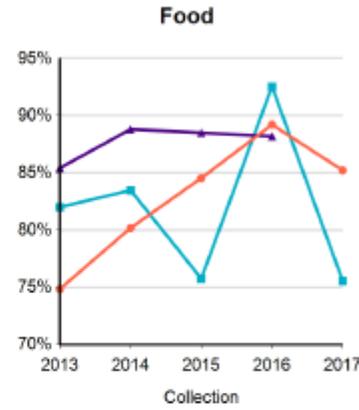
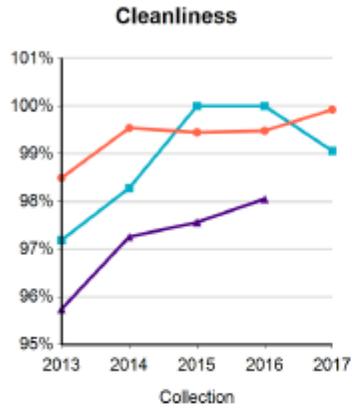
**BRIDLINGTON HOSPITAL- Collection: 2017**



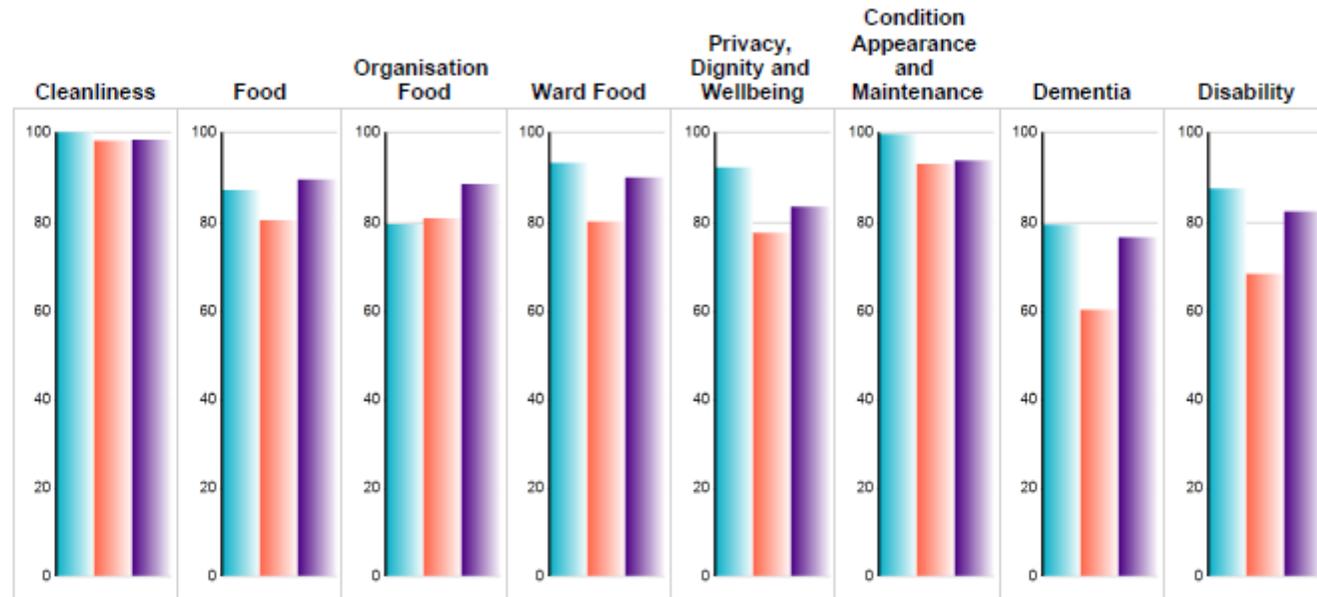
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|---------------------------------|-----------|----------|----------|----------|----------|----------|----------|----------|
| <b>Achieved Score (Actual)</b>  | 1684.0000 | 307.3990 | 92.6595  | 214.7395 | 167.0000 | 775.0000 | 327.8571 | 263.2100 |
| <b>Available Score (Actual)</b> | 1700.0000 | 408.2518 | 116.5880 | 291.6638 | 238.0000 | 814.0000 | 492.8571 | 354.3697 |
| <b>Site Score</b>               | 99.06%    | 75.30%   | 79.48%   | 73.63%   | 70.17%   | 95.21%   | 66.52%   | 74.28%   |
| <b>Organisation Average</b>     | 98.15%    | 80.45%   | 81.04%   | 80.26%   | 77.79%   | 93.32%   | 60.19%   | 68.45%   |
| <b>National Average</b>         | 98.38%    | 89.68%   | 88.80%   | 90.19%   | 83.68%   | 94.02%   | 76.71%   | 82.56%   |

# BRIDLINGTON HOSPITAL

Site Scores   Organisation Average   National Average



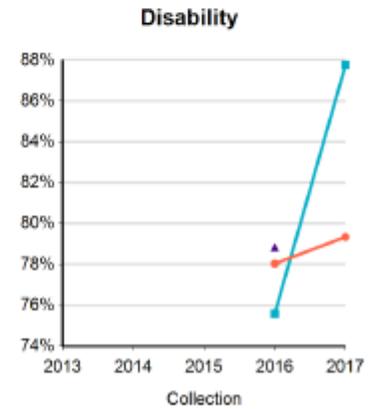
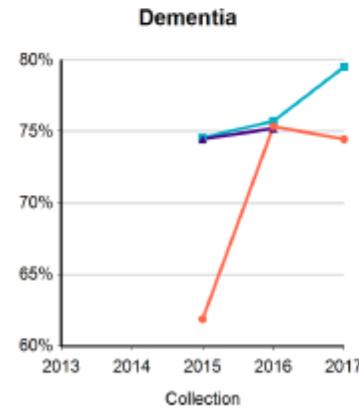
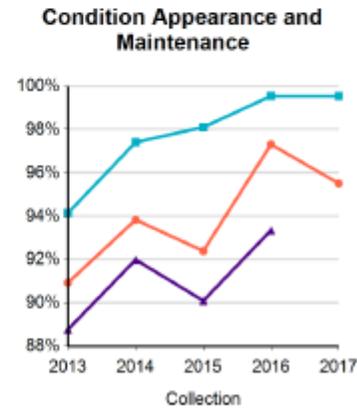
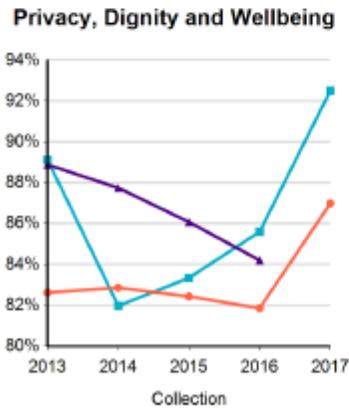
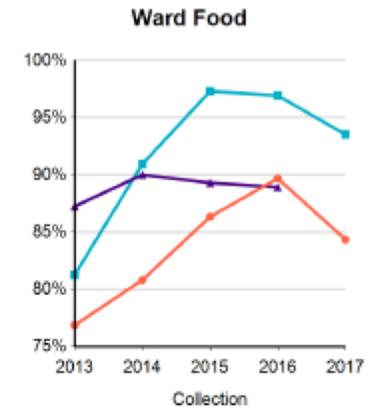
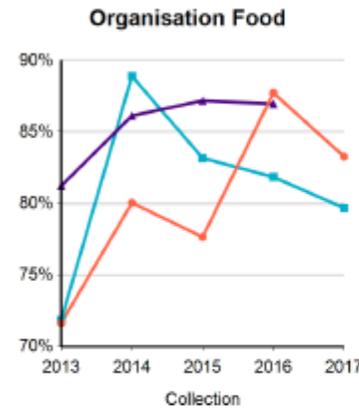
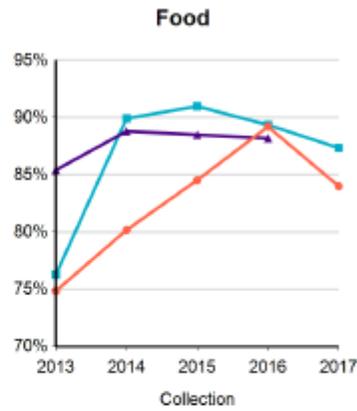
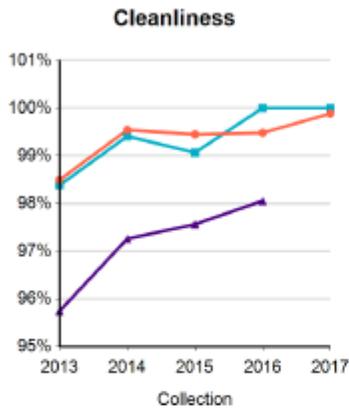
**THE NEW SELBY WAR MEMORIAL HOSPITAL- Collection: 2017**



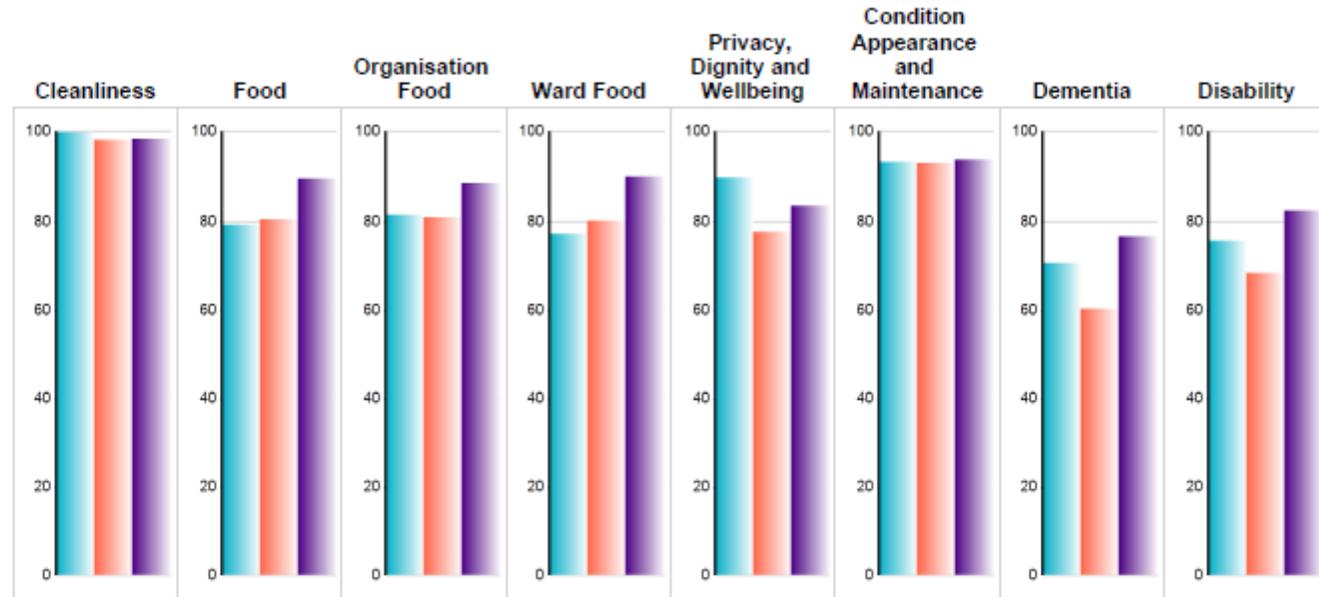
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|---------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|
| <b>Achieved Score (Actual)</b>  | 796.0000 | 228.4452 | 92.8948  | 135.5504 | 111.0000 | 428.0000 | 250.3571 | 219.7100 |
| <b>Available Score (Actual)</b> | 796.0000 | 261.5291 | 116.5880 | 144.9411 | 120.0000 | 430.0000 | 314.8571 | 250.3697 |
| <b>Site Score</b>               | 100.00%  | 87.35%   | 79.68%   | 93.52%   | 92.50%   | 99.53%   | 79.51%   | 87.75%   |
| <b>Organisation Average</b>     | 98.15%   | 80.45%   | 81.04%   | 80.26%   | 77.79%   | 93.32%   | 60.19%   | 68.45%   |
| <b>National Average</b>         | 98.38%   | 89.68%   | 88.80%   | 90.19%   | 83.68%   | 94.02%   | 76.71%   | 82.56%   |

# THE NEW SELBY WAR MEMORIAL HOSPITAL

Site Scores    Organisation Average    National Average



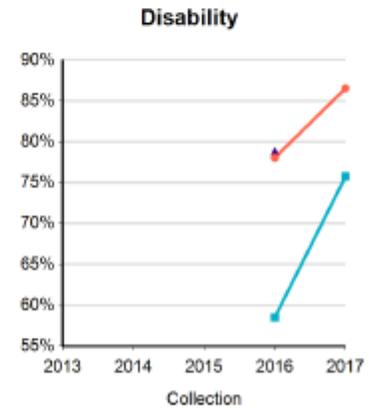
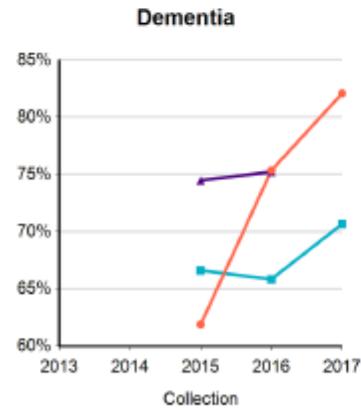
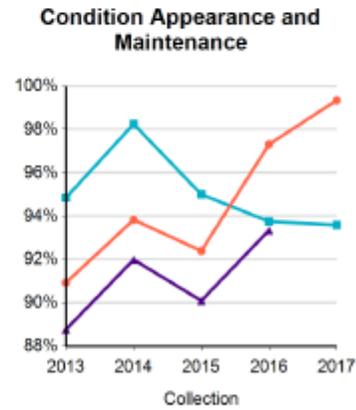
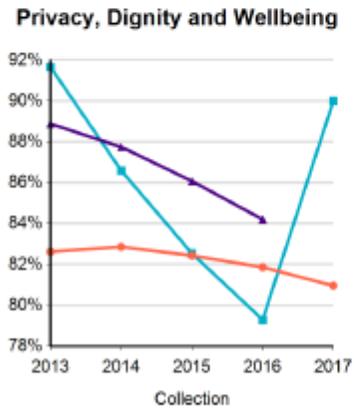
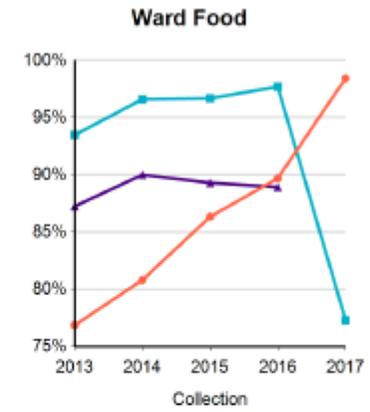
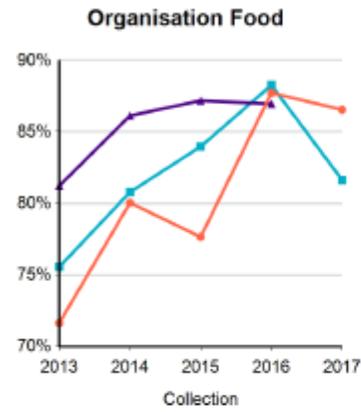
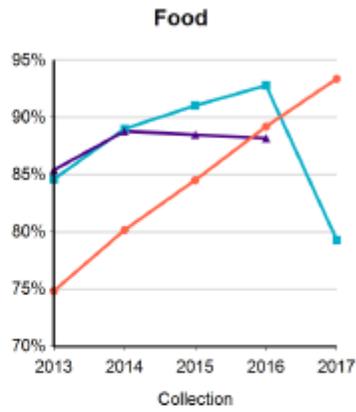
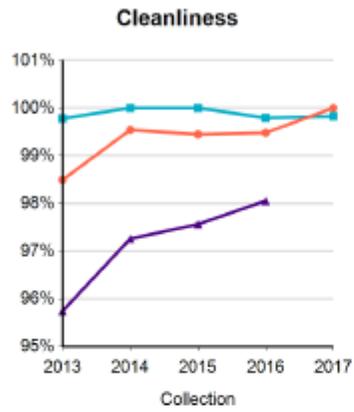
**MALTON AND NORTON HOSPITAL- Collection: 2017**



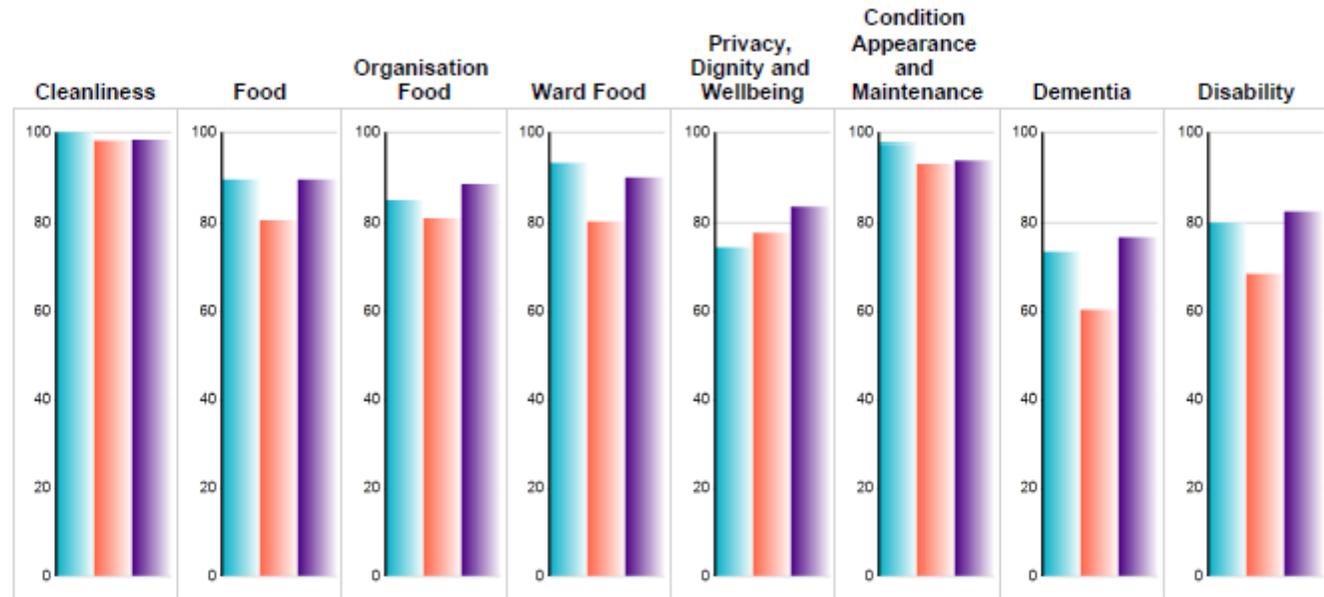
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|---------------------------------|-----------|----------|----------|----------|----------|----------|----------|----------|
| <b>Achieved Score (Actual)</b>  | 1148.0000 | 199.6511 | 95.1721  | 104.4790 | 144.0000 | 569.0000 | 273.3571 | 238.1134 |
| <b>Available Score (Actual)</b> | 1150.0000 | 251.7476 | 116.5880 | 135.1596 | 160.0000 | 608.0000 | 386.8571 | 314.3697 |
| <b>Site Score</b>               | 99.83%    | 79.31%   | 81.63%   | 77.30%   | 90.00%   | 93.59%   | 70.66%   | 75.74%   |
| <b>Organisation Average</b>     | 98.15%    | 80.45%   | 81.04%   | 80.26%   | 77.79%   | 93.32%   | 60.19%   | 68.45%   |
| <b>National Average</b>         | 98.38%    | 89.68%   | 88.80%   | 90.19%   | 83.68%   | 94.02%   | 76.71%   | 82.56%   |

# MALTON AND NORTON HOSPITAL

Site Scores    Organisation Average    National Average



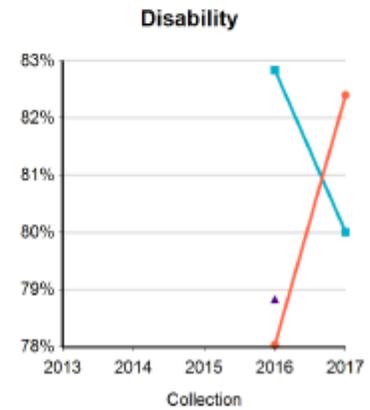
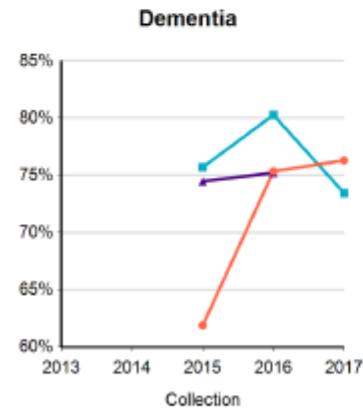
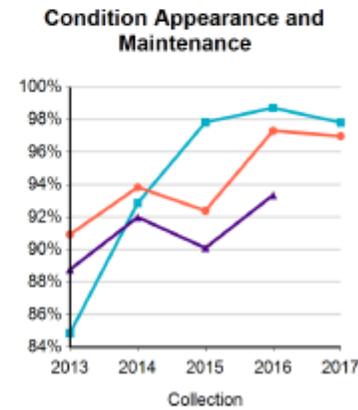
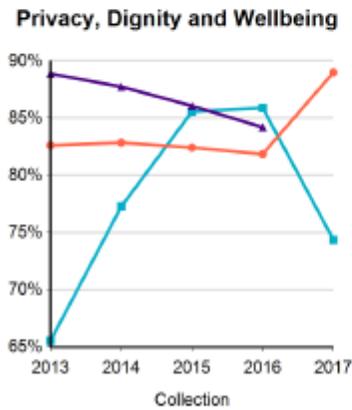
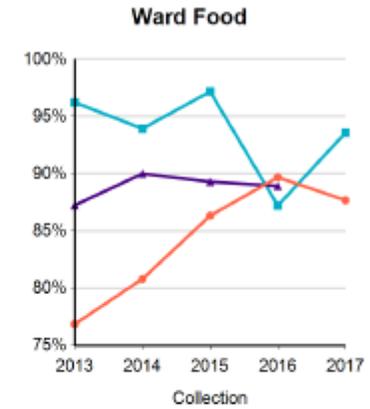
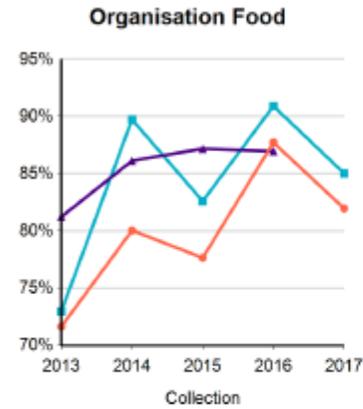
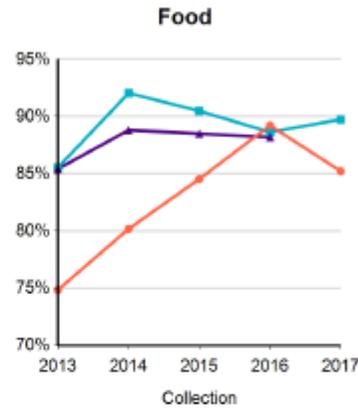
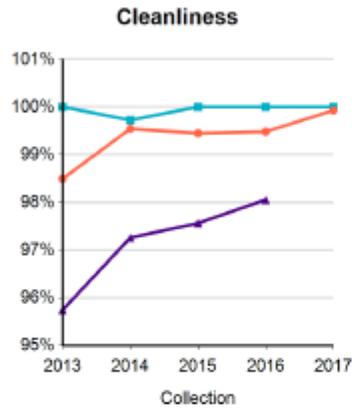
**WHITECROSS COURT- Collection: 2017**



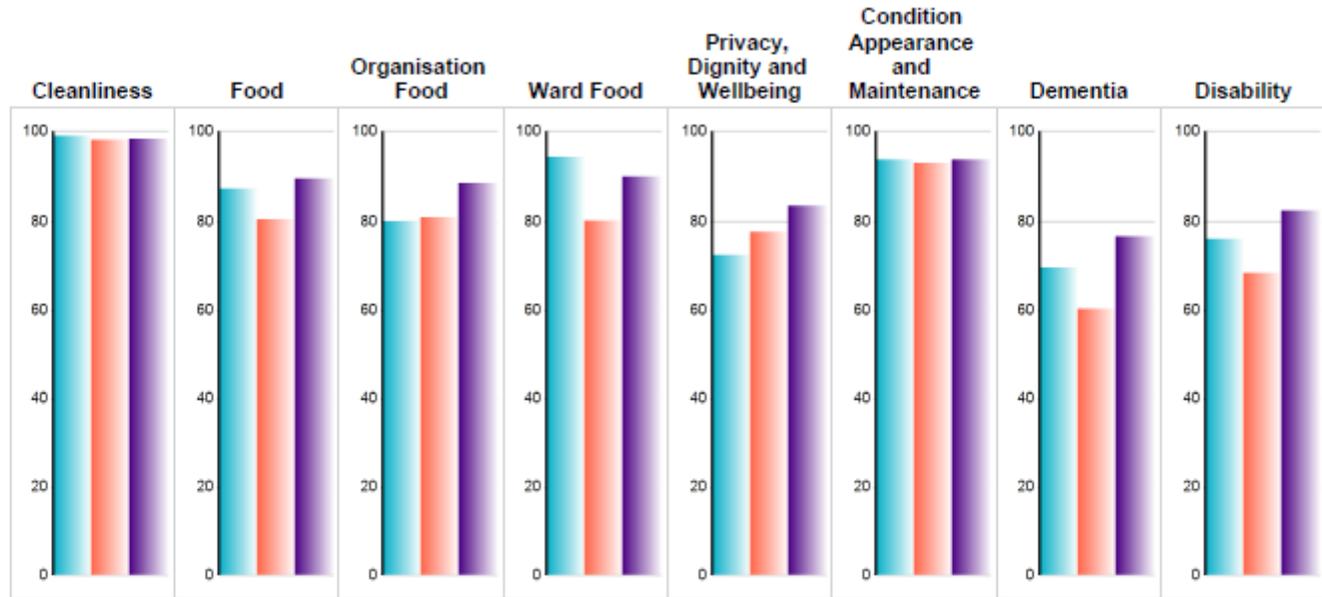
|                                 |          |          |          |          |         |          |          |          |
|---------------------------------|----------|----------|----------|----------|---------|----------|----------|----------|
| <b>Achieved Score (Actual)</b>  | 560.0000 | 232.8947 | 99.1258  | 133.7689 | 58.0000 | 268.0000 | 131.3571 | 118.7100 |
| <b>Available Score (Actual)</b> | 560.0000 | 259.5291 | 116.5880 | 142.9411 | 78.0000 | 274.0000 | 178.8571 | 148.3697 |
| <b>Site Score</b>               | 100.00%  | 89.74%   | 85.02%   | 93.58%   | 74.36%  | 97.81%   | 73.44%   | 80.01%   |
| <b>Organisation Average</b>     | 98.15%   | 80.45%   | 81.04%   | 80.26%   | 77.79%  | 93.32%   | 60.19%   | 68.45%   |
| <b>National Average</b>         | 98.38%   | 89.68%   | 88.80%   | 90.19%   | 83.68%  | 94.02%   | 76.71%   | 82.56%   |

## WHITECROSS COURT

Site Scores      Organisation Average      National Average



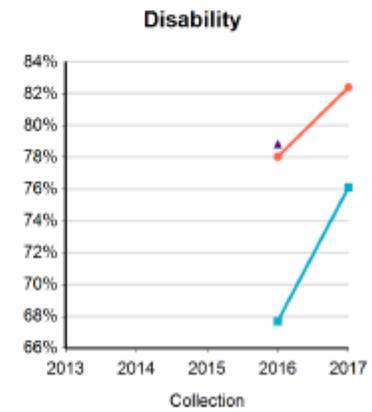
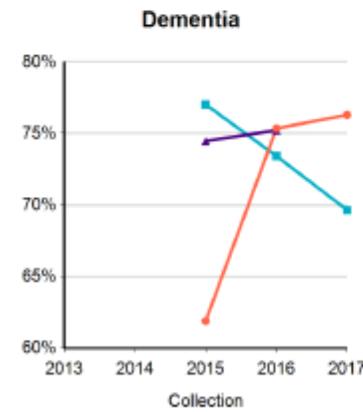
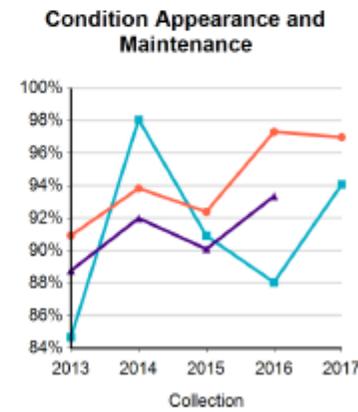
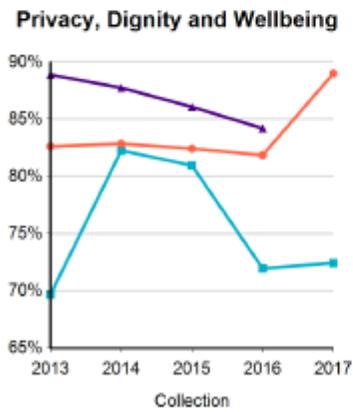
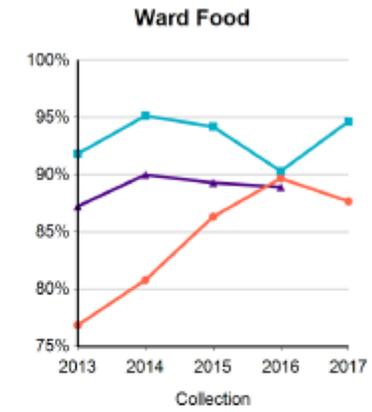
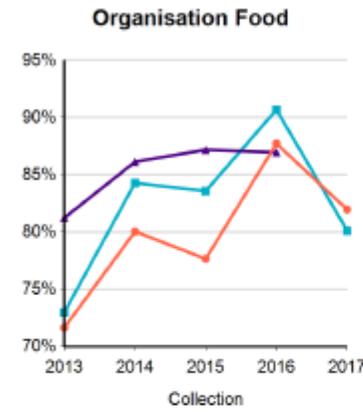
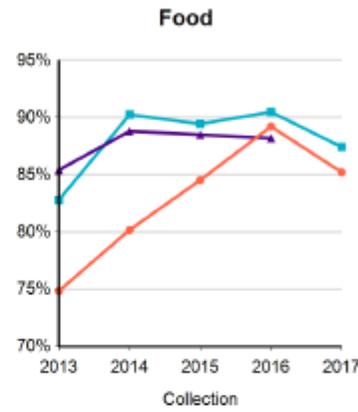
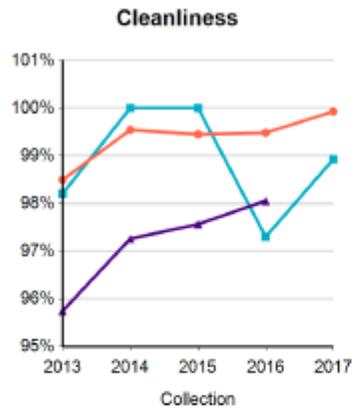
ST HELEN'S- Collection: 2017



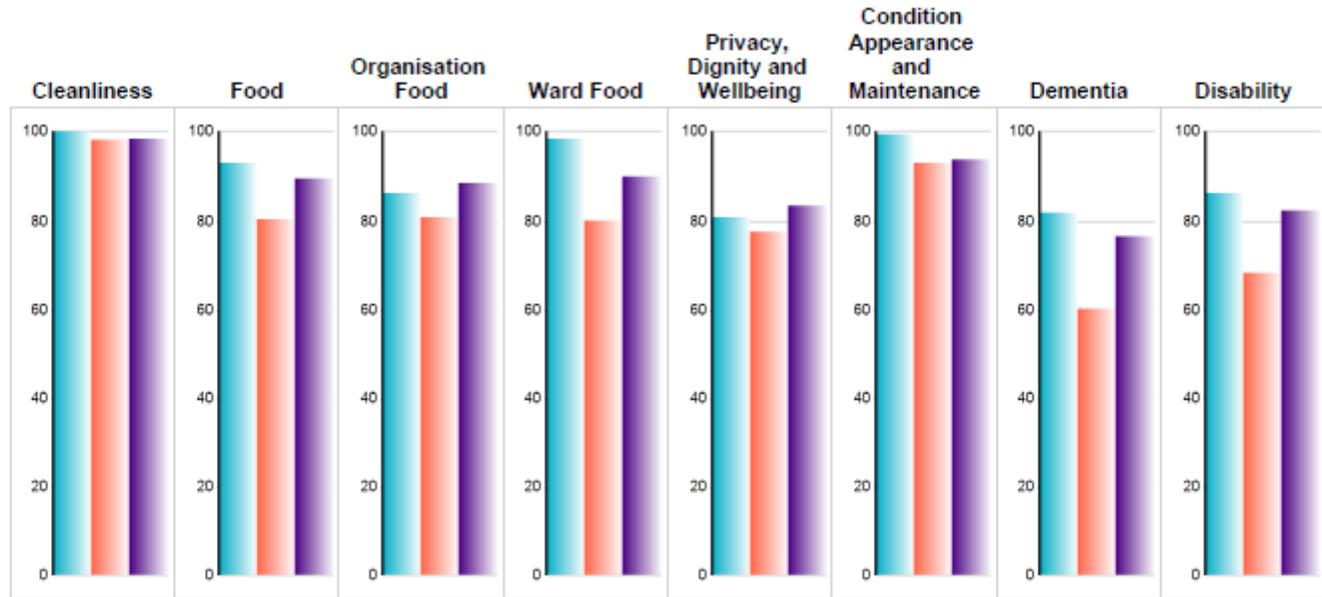
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|--------------------------|----------|----------|----------|----------|---------|----------|----------|----------|
| Achieved Score (Actual)  | 554.0000 | 204.7225 | 93.4074  | 111.3151 | 56.5000 | 222.0000 | 127.3571 | 115.9537 |
| Available Score (Actual) | 560.0000 | 234.1846 | 116.5880 | 117.5966 | 78.0000 | 236.0000 | 182.8571 | 152.3697 |
| Site Score               | 98.93%   | 87.42%   | 80.12%   | 94.66%   | 72.44%  | 94.07%   | 69.65%   | 76.10%   |
| Organisation Average     | 98.15%   | 80.45%   | 81.04%   | 80.26%   | 77.79%  | 93.32%   | 60.19%   | 68.45%   |
| National Average         | 98.38%   | 89.68%   | 88.80%   | 90.19%   | 83.68%  | 94.02%   | 76.71%   | 82.56%   |

# ST HELEN'S

Site Scores    Organisation Average    National Average



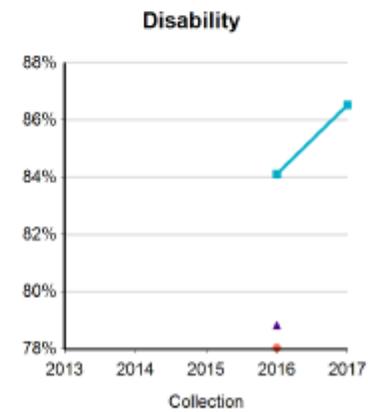
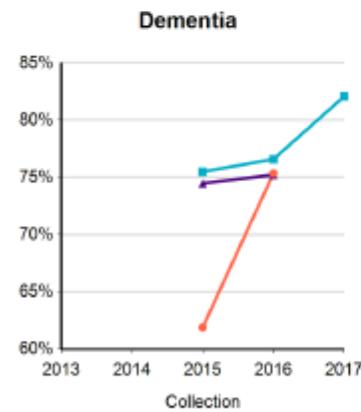
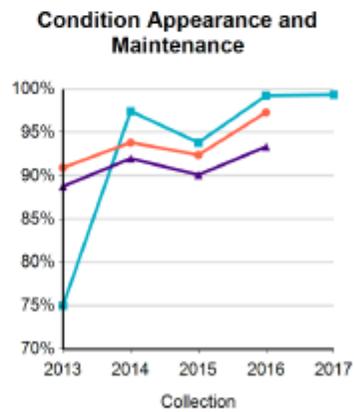
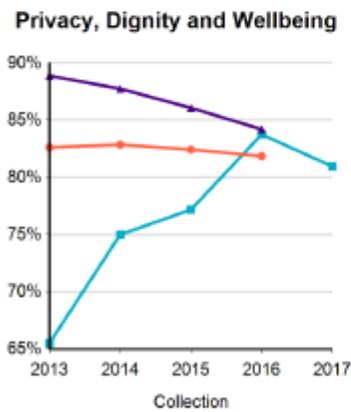
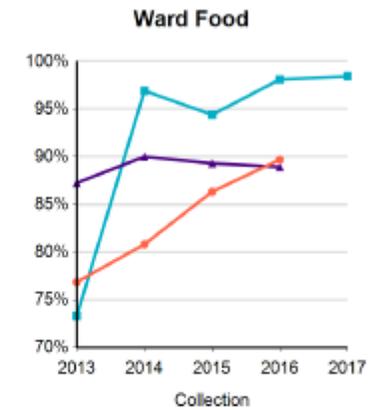
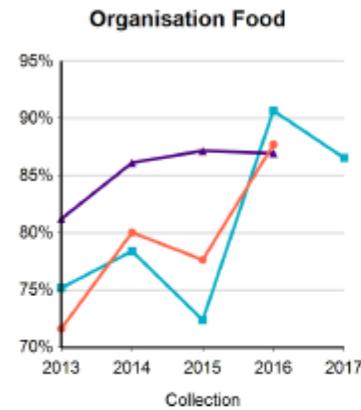
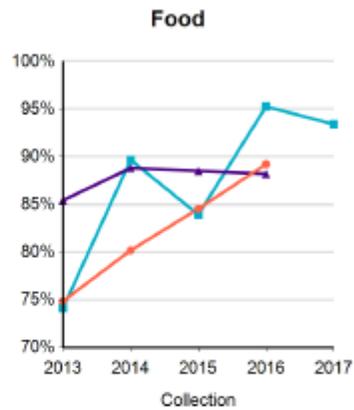
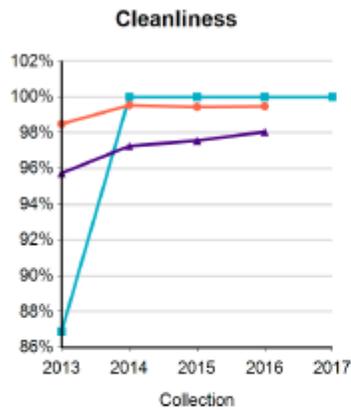
**ST MONICAS HOSPITAL- Collection: 2017**



|                                 | Cleanliness | Food     | Organisation Food | Ward Food | Privacy, Dignity and Wellbeing | Condition Appearance and Maintenance | Dementia | Disability |
|---------------------------------|-------------|----------|-------------------|-----------|--------------------------------|--------------------------------------|----------|------------|
| <b>Achieved Score (Actual)</b>  | 560.0000    | 256.9115 | 100.9073          | 156.0042  | 68.0000                        | 304.0000                             | 153.3571 | 121.4663   |
| <b>Available Score (Actual)</b> | 560.0000    | 275.0922 | 116.5880          | 158.5042  | 84.0000                        | 306.0000                             | 186.8571 | 140.3697   |
| <b>Site Score</b>               | 100.00%     | 93.39%   | 86.55%            | 98.42%    | 80.95%                         | 99.35%                               | 82.07%   | 86.53%     |
| <b>Organisation Average</b>     | 98.15%      | 80.45%   | 81.04%            | 80.26%    | 77.79%                         | 93.32%                               | 60.19%   | 68.45%     |
| <b>National Average</b>         | 98.38%      | 89.68%   | 88.80%            | 90.19%    | 83.68%                         | 94.02%                               | 76.71%   | 82.56%     |

# ST MONICAS HOSPITAL

Site Scores    Organisation Average    National Average



## **9 Public Access to results**

The public are able to view York Teaching Hospital Trust's 2017 PLACE results through NHS Digital's website.

## **10 Action Plans**

A total of 72 action plans were completed which were circulated to the individual wards and departments within 10 days of the assessments taking place. These will be tracked on a monthly basis by Facilities until all possible actions are closed out. PLACE leads will take assurances that action plans are being completed and that the environment is being monitored by conducting informal site visits on a quarterly basis.

## **11 Feedback for Patient Assessors and Governors**

The patient assessors and governors are to be invited to attend training and feedback sessions during November 2017 which will be facilitated by Dave Biggins and Carol Pack from Health Watch York. This will allow the 2017 assessment process, scores and action plans to be discussed and identify how any improvements can be made for the annual 2018 assessments and to review progress of the action plans. The training element will ensure all assessors are looking at the same elements to bring consistency to the assessments and improve the scores.

The future numbers of Patient Assessors and Governors will need to be maintained and reviewed. The Head of EME & E&F Compliance will continue to work with the Patient Experience Team to ensure adequate numbers are available for the 2017 assessment period and that adequate training is delivered.

The Head of EME & E&F Compliance will continue to work closely with local Trusts to agree reciprocal arrangements for Peer Review/External Validation.

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## Council of Governors – 7 December 2017 Constitutional Review Group Report

### Recommendation

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

### Current approval route of report

Council of Governors only

### Purpose of report

The Council of Governors is asked to note the report from the Constitution Review Group.

### Key points for discussion

This paper provides an overview of the work of the Constitutional Review Group.

### Trust Ambitions and Board Assurance Framework

([https://www.yorkhospitals.nhs.uk/about\\_us/our\\_values/](https://www.yorkhospitals.nhs.uk/about_us/our_values/))

The Board Assurance Framework is structured around the four ambitions of the Trust.  
How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

### Reference to CQC Regulations

(Regulations can be found here: <http://www.cqc.org.uk/content/regulations-service-providers-and-managers> )

Version number: v0.01

Author: Lynda Provins, Foundation Trust Secretary

Date: November 2017



## 1. Introduction and Background

The Constitution Review Group review, monitor and support the development of the Trust's Constitution and a number of areas which fall under this umbrella on behalf of the Council of Governors.

## 2. Detail of Report and Assurance

The Group met in September 2017 and was due to meet again in November, but unfortunately the meeting was cancelled as it was not quorate. The Group discussed a number of issues in September, including Governor meeting attendance and private patient income and would like to highlight the following items from the meeting:

**Holding Elections every 3 years (CoG Action)** – The group discussed having one election every three years, but thought this would potentially mean that the majority of the Council could change at election. The Trust changed its approach some years ago to avoid this happening. The group agreed to keep the format of the elections as is.

**Significant Transactions** – The group discussed the previously agreed level and agreed that it delivered greater accountability especially in the current financial climate.

**External Auditors** – The group invited the Finance Director to the meeting to discuss the possibility of extending the contract of the External Auditors for a further two years. The current contract was discussed and approved at the Council of Governors on the 10 December 2014 following a full tender process. The contract was awarded to Grant Thornton for three years starting in August 2015. An option to extend the contract for two years was built in and would need the agreement of the Council of Governors.

Following a lengthy discussion, the Constitutional Review Group will make a recommendation to the Private Council meeting.

## 3. Detailed Recommendation

The Council of Governors is asked to note the report from the Constitution Review Group.

