Council of Governors and Board of Directors Meeting

24 April 2019 at 10.30am
Boardroom, 2nd Floor Admin Block, York Hospital

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Led by</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.30 5 Mins</td>
<td>Welcome, introduction and apologies</td>
<td>Chair</td>
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<tr>
<td>10.35 25 Mins</td>
<td>East Coast Review</td>
<td>COO</td>
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<td></td>
<td>I would like to suggest some time spent discussing the options presented in the East coast review. In particular, a briefing on the Clinical activity shift assumptions of each of the four short listed options, along with a workforce and financial implications summary.</td>
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<tr>
<td>11.00 15 Mins</td>
<td>Humber Coast &amp; Vale (STP)</td>
<td>CEO</td>
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<td></td>
<td>1. What progress has there been at HCV/HCP on further integration of health and Social Care Services.</td>
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<td></td>
<td>2. The HCV/ HCP have signed up to the mission statement <code>Start well. live well, age well</code>. How does the Trust see its role in this vision?</td>
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<tr>
<td>11.15 30 Mins</td>
<td>Digital</td>
<td>Board</td>
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<td></td>
<td>1. Now that the EPMA system is up and running successfully in both York &amp; Scarborough Hospitals, are the Trust going to move forward with more technology programmes. (We already do Family &amp; Friends but think there is money to be saved on paper and postage if more use could be made with communicating with patients electronically (where patients have this facility); we could also send texts to remind patients of appointments as Surgeries and</td>
<td></td>
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Dentists do. Make patients notes, tests and x-rays available to Hospitals outside the Trust, ie Leeds? (I know of patients who are sent to Leeds but the Doctors are unable to access notes.)

2. Other than the existing Friends and Family Test, what additional electronic feedback services will the Board consider to collect the views of patients/members on Trust services?

3. Will there be more progress with new digital technology for helping patients with chronic medical conditions achieve better health outcomes.

11.45 10 Mins

**Board Transparency**

What actions will the Board consider to enhance the transparency of Board discussions and decisions to Members of the Trust, staff, and members of the public that use the services?

11.55

**Close**

Chair

Please see Paper A

**Update on the Operational Review**

Tell us more about the new organisational structure and why it is felt to improve the service.

**Incident Reporting**

What mechanism does the trust currently have to make it easy for staff or patients to report incidents? What mechanisms are being considered to facilitate and encourage such reporting?

The Trust recognises the importance of learning from its mistakes and uses Datix as its adverse incident reporting system. It is available for use by all staff via the organisations intranet. Through listening to users and visiting and learning from other Trusts, we have taken steps to ensure that the incident reporting form is streamlined and intuitive to use in order to ensure that it encourages the reporting of all adverse incidents. As such the Trust has seen an increase in incidents reported over the past two NRLS reporting periods. Of note is that there is an increase in the reporting of incidents by consultants.

Chair

COO

Steve Reed

Chief Nurse

Fiona Jamieson
Patients are encouraged to report any adverse incidents that they might experience or witness to the Ward/Outpatient/Unit Sister or Charge Nurse. They can also report concerns through the PALs service. Leaflets are available throughout the hospital advising patients or their relatives how to raise a concern.

<table>
<thead>
<tr>
<th>Please see Paper B</th>
<th><strong>Outpatients Transformation Briefing</strong></th>
<th>COO Mark Hindmarsh</th>
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<tbody>
<tr>
<td></td>
<td>What plans are being developed to reduce outpatient attendances?</td>
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### Site Use

Are there any plans for the increased use of the community sites to help reduce the activity on the 2 main sites, York and Scarborough?

I have been asked for a statement in relation to any opportunities to increase the utilisation of community sites to relieve pressure on the main hospital sites.

In terms of inpatient use, the bed managers are always looking for opportunities to make best use of the community bed base, although this is sometimes limited by the type of patient, the locality they are from, physical capacity and nursing staff availability.

In relation to outpatient services, the estates strategy is currently being refreshed, and will consider opportunities to make best use of the community sites. Meanwhile the operational teams are always looking out for scope to use the community sites - a recent example of this is the move of some plastic surgery and vascular outpatient services into Malton to make use of free slots in the Urology calendar. We will share the revised estate strategy with Governors at an appropriate meeting in the future.

### MRI & CT In-patient Capacity Report

Can greater CT and MRI coverage be arranged for the weekends? While this will cost extra, it might significantly enhance the patient experience, lead to quicker diagnosis and treatment, and potentially reduce the length of stay in the trust for those admitted on the weekends.
Board of Directors / Council of Governors – April 2019
Update on the Operational Review

Trust Strategic Goals:

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

Recommendation

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

Purpose of the Report

The purpose of the report is to provide the Council of Governors with a progress update on the restructure associated with the Operational Review.

Executive Summary – Key Points

The report summarises the background to the Operational Review and the engagement that has taken place across the organisation to inform its recommendations and how this aligns to the Trust values. It describes the ‘Care Group’ structure that has emerged and the new roles that will deliver this.

It outlines the consultation and recruitment process that is ongoing and sets out the next steps that will take place.

Recommendation

The Council of Governors is asked to note the progress to date.

Author: Steve Reed, Head of Strategy
Director Sponsor: Wendy Scott, Chief Operating Officer
Date: April 2019
1. Introduction and Background

Early in 2018, a listening exercise was undertaken with a number of staff groups in order to inform the Operational Review. The results of the listening exercise were shared at various forums including Corporate Director Meetings, Executive Board and the Operations Steering Group. General feedback was circulated widely via ‘Staff Matters’ and ‘Staff Brief’.

The listening exercise and subsequent discussions generated a wider debate about the current Trust structure and the benefits of moving to a smaller number of directorates (or divisions/care groups) predicated on groupings of services or specialities. A ‘straw man’ proposal for a care group structure was developed building on the feedback received via the operational review process. This proposal outlined how we might reconfigure existing management and nursing resource to address the key challenges facing the organisation.

In particular these were:

- site management and leadership at Scarborough and Bridlington Hospitals;
- the need to better align or integrate nursing, clinical and managerial leadership;
- to provide greater clarity on job roles, accountabilities and responsibilities;
- ensuring effective succession planning, which is essential to ensure the Trust retains staff and provides career opportunities and development.

2. Principles

The following principles were established to underpin the review and these align with the Trust values:

- Maintenance of strong clinical leadership, supported by appropriate management capacity and capability. (Always doing what we can to be helpful);
- Operational structures must support patient care and enhance patient experience, ensuring the delivery of safe and effective services. (Caring about what we do);
- Clear accountability and governance structures to support agile working and permission to act. (Respecting and valuing each other);
- Consistency and equity of roles and functions, rather than uniformity, recognising that services and sites have differing needs and requirements. (Respective and valuing each other);
- Robust engagement to ensure people have the opportunity to contribute and influence. (Listening in order to improve).

3. Process

A time out session was held in May 2018 with Executive Board members and senior clinical leaders from Scarborough and York Hospitals to consider the principles that should/could underpin a restructure into care groups as well as potential service/speciality groupings. There was general consensus that moving to a ‘Care Group’ structure was the right approach and that it would ensure the most efficient use of management resource; however the exact care group ‘groupings’ were not finalised (a number of options were proposed).
Following the retirement of the Chief Executive in May 2018, the restructure was paused pending the appointment of a new Chief Executive. However, work continued to address some of the key issues that could not wait. These included the creation of a single care group at both Scarborough and York Hospitals grouping emergency, medical and elderly care services together with a manager supporting each (previously shared management).

Following a constructive time out session with an expanded Executive Board in November, there was general agreement that the time is right to move towards a more consolidated structure. This new structure aims to strengthen clinical leadership and to ensure that each care group benefits from a quadrumvirate management team (clinical leadership, nursing leadership, Allied Health Professional leadership and general management leadership) ensuring governance responsibilities are not compromised.

Appendix 1 shows the specialties within each of the care group and the following diagram demonstrates the ‘quadrumvirate’ team in each care group.

The Care Group Directors will establish their own monthly meeting, at which the Care Group Manager, Head of Nursing, AHP Operational Manager and Clinical Directors will attend. The meetings will also be supported by the Safety and Governance Officer, Business Analyst, Finance Manager and an HR Manager. The operational board brings together on a monthly basis the senior operational managers and clinicians for the purposes of briefing on matters of priority and importance both within the Trust and at care group level.

The care group structure has been developed following extensive engagement and consultation. This was followed by a consultation with directly affected staff focused on the leadership structure to deliver this and the recruitment process that will be undertaken. The consultation materials were publically available – allowing staff from across the organisation to comment on the proposals.

Implementation of the agreed structure will occur in a phased manner which commenced with the appointment of the Care Group Directors.

To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.
The newly appointed Care Group Directors have joined the weekly Operational Review Steering Group and participated in the appointment of the Care Group Managers.

The Heads of Nursing will be allocated to Care Groups 1, 2, 3 and 6 and the Head of Midwifery will join Care Group 5. The Care Group AHP Operational Managers will be allocated to Care Groups 1-5.

Representatives from the Care Group Directors and Managers will appoint the Head of Cancer Services, Head of Community Services and Deputy General Managers. Representatives from the Care Group Managers and Deputy Care Group Managers will appoint the Business Managers, Senior Operational Service Managers, Cancer Improvement & Performance Manager and Operational Service Managers. Preferences will be requested to align employee choice with service need as much as possible.

Representatives from HR will support the recruitment process for each post.

At each stage, posts that have not been appointed to will be advertised, open to applications from other internal or external candidates.

4. **Next Steps**

Following the recent appointment of the Care Group Directors and Managers the next steps will be:

- Appointment to the remaining roles from the affected group of existing managers (Apr-Jul 19);
- External recruitment process for any unfilled posts (May-Jul 19);
- Engagement with staff not directly affected but significantly impacted by the changes (Apr-Jul 19);
- Ongoing communication with the wider organisation (Apr-Jul 19);
- Organisational development process for new care group leadership teams (starts Jun-Jul 19);
- New structures to be in place (Aug 19).

5. **Detailed Recommendation**

The Council of Governors is asked to note the progress to date.
6. Appendix 1 – Proposed Care Group Structure

CG1: Acute, Emergency and Elderly Medicine: York
- Emergency Department
- Acute Medicine
- Elderly Medicine
- Stroke, Cardiology and Cardiorespiratory, Respiratory, Sleep Service, CF Service, Renal and Gastroenterology
- Community
- Flow Teams
- Palliative Care

CG2: Acute, Emergency and Elderly Medicine Scarborough
- Emergency Department
- Acute Medicine
- Elderly Medicine
- Stroke
- Cardiology and cardiorespiratory
- Gastroenterology
- Respiratory
- Flow Teams
- Palliative Care

CG3: Surgery: Across Sites
- Theatres, Anaesthetics and Critical Care
- General Surgery and Urology, Breast, Vascular Trauma and Orthopaedics
- ENT (including Newborn Hearing and Audiology)
- Plastics
- Ophthalmology
- Max Fax
- Orthodontics and Restorative Dentistry
- Pain

CG4: Cancer and Support Services: Across Sites
- Cancer
- Oncology
- Radiology
- Endoscopy
- Pharmacy
- Breast Screening
- Laboratory Medicine
- Clinical Haematology

CG5: Family Health: Across Sites
- Obstetrics & Gynaecology
- Women’s Health
- Paediatrics (including community paediatrics)
- Sexual Health

CG6: Specialised Medicine: Across Sites
- Rheumatology
- Dermatology
- Neurology/Neurophysiology
- Psychological Medicine
- Endocrinology
- Continence
- MES
- Phlebotomy
- Outpatients and Patient Access

To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.
Board of Directors / Council of Governors – 24 April 2019
Outpatient Transformation Briefing

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

Recommendation

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

Purpose of the Report

The purpose of the report is to update the Council of Governors with a progress update on the restructure associated with the Outpatient transformation programme, which is in answer to the following question from a Governor:

What plans are being developed to reduce outpatient attendances?

Executive Summary – Key Points

The report summarises the work being undertaken to establish a comprehensive outpatient transformation programme of work together with successes to date.

Recommendation

The Council of Governors is asked to note the progress to date.

Authors: Mark Hindmarsh, Deputy Chief Operating Officer
Director Sponsor: Wendy Scott, Chief Operating Officer
Date: April 2019
1. Introduction and Background

The NHS Long Term Plan has set out some ambitious aspirations for the NHS to reach around outpatient services. The most high profile challenge was for the NHS to reduce the number of face to face outpatient clinic appointments by a third over the time of the plan. In response The Trust and local CCGs have established a comprehensive outpatient transformation programme of work covering a range of areas that will be covered in this short briefing paper.

2. Aims and objectives of Outpatient Transformation

- Ensure that colleagues in primary care can access specialist opinion easily, simply and promptly to support management of patients in primary care.

- Ensure that only those patients that absolutely need to be physically seen in a clinic by a hospital based clinician are booked into a clinic.

- Improve the productivity and performance of our outpatient services by maximising existing capacity and reducing DNA/CNA rates.

- Improve the experience for patients and staff attending clinic appointments.

- Increase the uptake of alternatives to traditional face to face clinic models of care - especially in how patients are followed up after a first clinic appointment.

Priority area 1 – Referrals, Primary Care and Rapid Expert Input (REI)

The way in which outpatient referrals are currently managed in this region has been under constant development for some time. The fundamental issue with current arrangements is that patients are booked into a clinic prior to any review of the referral from secondary care. This results in two core issues:

1. Once secondary care clinicians review the referral they often wish to have the original service into which the patient was booked changed. This is disruptive for patients and booking teams.

2. As patients are booked into a clinic prior to a secondary care review, it means that we miss the opportunity to manage that patient in a different way – for example over the telephone, using Skype or even just providing the GP with written advice as to how they could manage the patient in primary care.

The so called “Rapid Expert Input” (REI) work aims to address these issues by developing IT systems to give clinicians a wider range of options to manage patients differently. Early pilots in Rheumatology demonstrate that around 12% of referrals can be managed differently, without the patient needed to attend a clinic appointment.

This new way of working will be rolled out over 2019.
Priority area 2 – Efficiency and Bookings

The Trust is committed to ensuring that for all outpatient clinics that it does run, they are fully booked and any empty slots are offered to patients waiting for an appointment. It is also committed to driving down DNA/CAN rates so that available capacity is maximised.

Changes in the way calls are handled in the Trust clinic booking office coupled with increased numbers of patients receiving a text message reminder have already started to make a big difference to DNA rates. This can be seen in the chart below.

**Chart 1. Trustwide Did Not Attend (DNA) rates for Outpatient clinics for new and follow up patients from March 2017 to March 2019**

More work is planned in 2019 that will focus on individual clinics with empty capacity and making it easier for patients to re-arrange their appointment via text message and online.

Priority area 3 – Outpatient Experience

The Trust routinely collects Friends and Family responses from thousands of patients that have attended clinic appointments. This includes feedback received in the form of “free text” meaning patients have the freedom to say anything they wish about our outpatient service. Based on this feedback, the Trust will be focussed on improving the information within our clinic appointment letters and feedback about any delays occurring in clinics to patients.

We are developing a several capital and estates issues that require resolution in clinic areas too. This relates to patient waiting spaces, booking office space and signage – especially at the Scarborough site.

Priority area 4 – Transforming pathways and services

There are two main areas of focus in this area, both targeted at reducing any unnecessary face to face appointments. Firstly, the so called “Patient Initiated Follow Up” project will
give the power to the patient as to when they want to receive their follow up appointment. For many patients with long term conditions (such as arthritis), once they have been seen in clinic they are booked a follow up appointment several months into the future. However, many patients report that due to the nature of their condition, they needed an appointment when their condition flared up, and not at the point in time that their follow up appointment had been booked for. This project will allow certain patients, to contact the hospital when they need it and receive an appointment at short notice. This will improve the management of their condition and reduce the number of unnecessary appointments.

Secondly, the Trust is developing tele-clinics (or Skype clinics). For some groups of patients this will mean being able to talk to the clinical team without having to travel to the hospital. This type of clinic may apply for both new and follow up patients, and a trials are planned in diabetes and paediatrics this year.

3. Detailed Recommendation

The Council of Governors is asked to note the progress to date.
Trust Strategic Goals:

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

Recommendation

For information ☑️ For discussion ☐ For approval ☐ A regulatory requirement ☐

Purpose of the Report

The purpose of the report is to provide the Council of Governors with a progress update on MRI and CT Inpatient capacity, which is in answer to the following question from a Governor:

Can greater CT and MRI coverage be arranged for the weekends? While this will cost extra, it might significantly enhance the patient experience, lead to quicker diagnosis and treatment, and potentially reduce the length of stay in the trust for those admitted on the weekends.

Executive Summary – Key Points

This paper sets out the context and current turnaround times for requests together with actions being taken to increase capacity and current weekend cover.

Recommendation

The Board of Directors / Council of Governors are asked to note the progress to date.

Author: Kim Hinton, Directorate Manager - Radiology

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: April 2019
1. Context

The Trust currently has two Static MRI scanners and three static CT scanners on the York site and one static MRI and one static CT scanner on the Scarborough site. Both sites use mobile scanners to undertake elective outpatient work as required.

MRI scans are used to diagnose a variety of conditions, from torn ligaments to tumours. MRIs are very useful for examining the brain and spinal cord. A CT scan can diagnose muscle and bone disorders, such as bone tumours and fractures and pinpoint the location of a tumour, infection or blood clot and monitor diseases and conditions such as cancer, heart disease, lung nodules and liver masses.

Processing a request for a CT or MRI is a two part process, firstly doing the scan which is undertaken by a Radiographer. The images then need to be reported by a Radiologist.

Both sites run one CT scanner each 24/7 through a combination of resident and on call Radiographer shifts. This is the same every day of the week and is to support acute and inpatient work. Both sites have access to MRI for acute and inpatient scanning during daytime hours at the weekend which is staffed by scheduling extra contractual shifts for Radiographers, but there is no access during the evening or night. The operating hours of the MRI scanner on both site at the weekend at shorter, by 2 hours, than during the week. Reporting is provided through a combination of on call consultant and outsourcing. (Full operating hours are outlined in appendix 1).

2. Current turnaround times for IP requests

<table>
<thead>
<tr>
<th></th>
<th>Same day</th>
<th>1 day</th>
<th>2 days</th>
<th>3 days</th>
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<tbody>
<tr>
<td>MRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SGH</td>
<td>20%</td>
<td>54%</td>
<td>67%</td>
<td>75%</td>
</tr>
<tr>
<td>York</td>
<td>42%</td>
<td>77%</td>
<td>86%</td>
<td>91%</td>
</tr>
<tr>
<td>CT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SGH</td>
<td>51%</td>
<td>80%</td>
<td>88%</td>
<td>93%</td>
</tr>
<tr>
<td>York</td>
<td>60%</td>
<td>86%</td>
<td>93%</td>
<td>96%</td>
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All urgent requests for inpatient CT are accommodated and reported on the same day. There are some delays to routine requests. There is a ‘mopping up’ session on a Friday PM at York to ensure any outstanding requests for CT are undertaken prior to the weekend so there is no backlog and new requests at the weekend can be undertaken. There are very few urgent MRI requests, other than for query cord compression, for which there is a pathway on site for in hours and out of hours this is provided by Hull.

Current challenges in increasing operating hours of the MRI and expanding use of the CT machines at the weekend:

- Radiographer vacancy rate (10%) and challenged recruitment into the specialist areas of MRI and CT. Unable to extend shifts/operating hours as we do not currently have workforce to deliver this, we are already reliant on volunteers to fill vacant shifts and many staff working 1 in 3 weekends which is not sustainable.
York Teaching Hospital NHS Foundation Trust Board of Directors: 24 April 2019
Title: MRI & CT Inpatient Capacity Report
Authors: Kim Hinton

- Radiologist vacancy rate (30%) and challenged recruitment. Currently reliant on outsourcing reporting out of hours at Scarborough. Impacts on ability to undertake contrast CT out of hours.
- Increasing overall demand from outpatients, deliver of optimal cancer pathways, cardiac CT, new Harrogate stroke pathways, etc.
- Increasing demand for inpatient scanning as clinicians lack confidence that patients would receive an appointment for an urgent outpatient if required due to capacity issues within Radiology. There are examples of clinicians keeping patients in hospital until imaging is completed, when it could have been requested to be done as an outpatient and patient discharged.
- Single CT scanner at Scarborough - no ability to expand scope as already in use 24/7
- In order to facilitate all inpatients same day we would need to displace a significant number of the outpatients to the evenings which is difficult as we are required to provide IV cover by medical staff, etc. This shift in activity is already having to be considered to support the implementation to the Harrogate Stroke and Cardiac CT but challenging due to Radiologist vacancies.

3. Current actions to increase capacity

- Moving towards shift working for weekend for CT at Scarborough so no longer an on call service and service can be provided reliably
- Business case for 2nd CT at Scarborough approved, funding to be identified through capital programme. This will need associated staffing and as long as recruitment is successful there would be expanded cover for inpatients which would improve turnaround
- Ongoing recruitment for CT and MRI radiographers on both sites
- Implementation of new consultant radiology on call arrangements which provide more sustainable reporting out of hours
- Developing internal rotational posts to increase workforce
- Development of Radiology workforce strategy to increase recruitment activities and success rate
- Review of MRI staffing with a view to extending opening hours at the weekend if workforce can be recruited.
# Appendix 1 – Current CT and MRI weekend cover

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<tr>
<th></th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td><strong>MRI York</strong></td>
<td>08:00-20:00</td>
<td>08:30-13:00 contracted and then 13:00-18:00 undertaken as Extra Contractual shifts</td>
<td>08:30-13:00 contracted and then 13:00-18:00 undertaken as Extra Contractual shifts</td>
</tr>
<tr>
<td><strong>MRI Scarborough</strong></td>
<td>08:00-20:00</td>
<td>08:00-17:00 undertaken as Extra Contractual shifts</td>
<td>08:00-17:00 undertaken as Extra Contractual shifts</td>
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<tr>
<td><strong>CT York</strong></td>
<td>CT1 operational 24/7 09:00 - 16:00 pre bookable 16:00 - 09:00 acute resident shift CT2 held from 2pm to facilitate inpatient ‘mopping up’ session</td>
<td>CT1 operational 24/7 09:00 - 16:00 pre bookable 16:00 - 09:00 acute resident shift</td>
<td>CT1 Operational 24/7 09:00 - 16:00 pre bookable 16:00 - 09:00 acute resident shift</td>
</tr>
<tr>
<td><strong>CT Scarborough</strong></td>
<td>08:30-17:00 for all IP/OP/Acute work 17:00-2030 changes to on call for acute work 20:30-08:30 acute resident shift</td>
<td>08:30-20:30 on call for acute work 20:30-08:30 – acute resident shift</td>
<td>08:30-20:30 on call for acute work 20:30-08:30 – acute resident shift</td>
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